Wellbeing in Later Life: Experiences of Oldest-old People Ageing in Place (居家养老) in Shanghai

Wenjing Jin

Submitted in accordance with the requirements for the degree of

Doctor of Philosophy

The University of Leeds

East Asian Studies, School of Languages, Cultures and Societies

March 2019

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

The right of Wenjing Jin to be identified as Author of this work has been asserted by her in accordance with the Copyright, Designs and Patents Act 1988.

Acknowledgements

Doing a PhD project is a long journey. During the journey I have received lots of support and encouragement from many people. First, I must express my immense gratitude to my supervisors: Dr Heather Xiaoquan Zhang and Prof Sue Yeandle. They have provided me with endless support and backed me throughout my PhD project. I'm always grateful for their patience, wisdom, professional guidance and strong sense of responsibility. Dr Heather Zhang, my primary supervisor, has not only provided me with strong guidance and many opportunities to participate in international conferences – the opportunities that have enormously benefited my personal and career development, but also encouraged and supported me throughout the research process, especially when I encountered difficulties or impasse in making progress in the PhD project. I am particularly thankful for her warm encouragement and unwavering faith in my ability to conduct original research, and her rigorous academic integrity, rich knowledge and dedication to independent critical scholarship. Prof Sue Yeandle, my second supervisor, has impressed me deeply with her professionalism, kindness, enthusiasm, warmth and specialist knowledge in the field of eldercare. Sue has given me a lot of encouragement and inspiration throughout the project, which are of critical importance to my research progress. The discussions with Sue are always productive, fruitful and enjoyable. I could not be more grateful to my supervisors for their warm-heartedness and strong support.

My deep gratitude also goes to the participants in my research from the two communities in Shanghai: the older people, the carers and care workers, the neighbourhood committee members, eldercare agency staff and government officials who shared with me their experiences, feelings and perspectives. Listening to their stories and experiences has not only enabled me to collect rich empirical data, but also broadened my horizon and evoked my deep thinking about the significance of life and the meanings of wellbeing.

I am very thankful to Prof Xinping Guan at Nankai University, Prof Ka Lin at Zhejiang University and Prof Donghui Gu at Fudan University, who have provided me with valuable support during my research. Thanks also go to the Worldwide Universities Network, the 'Risk and East Asia' programme at University of

List of conference presentations

Wenjing Jin. 2018. *Ageing and Technology Use: A Local Initiative in Shanghai. WUN workshop on Social Innovation in Eldercare.* Sep 20-23, Hangzhou, Zhejiang University, China. Funder: Worldwide Universities Network (WUN).

Wenjing Jin. 2018. *Caring networks of very old people: how technology fits in.* The 2nd Student Forum of Social Science by top universities in Jiangsu, Zhejiang and Shanghai. June 16-17, Hangzhou, Zhejiang University, China. Funder: Zhejiang University.

Wenjing Jin. 2016. *Telecare and Older People's Social Relations: Case Studies of Two Communities in Shanghai.* 'Employing Information and Communications Technologies in Homes and Cities for the Health and Wellbeing of Older People' Workshop. August 15-17, Chengdu, Sichuan University, China. Funder: National Sciences Foundation of China (NSFC) and British Council, organized by Sichuan University, China & University of Bradford, UK.

Wenjing Jin. 2016. *Supporters or intruders: the role of care workers in homecare in Shanghai.* 'Risk and East Asia' Workshop. June 21-23, Duisburg, University of Duisburg-Essen, Germany. Funder: Deutsche Forschungsgemeinschaft (DFG, German Science Research Foundation).

Wenjing Jin. 2016. *Home and community based care services for older people in Shanghai.* 'East Asia Net' Workshop. May 26-28, Coimbra, University of Coimbra, Portugal. Funder: University of Coimbra & University of Leeds.

Wenjing Jin. 2016. *Developments in support for older people and their carers in two districts of Shanghai, China.* 'Care, Caring and Carers: International Perspectives' Workshop. May 17, Sheffield, University of Sheffield, UK. Funder: University of Sheffield.

Wenjing Jin. 2015. *Social interaction and interrelationships among home care actors in China.* 'Risk and East Asia' Workshop. September 14-18, Beijing, Renmin University of China, China. Funder: DFG, German Research Foundation & Renmin University of China.

Abstract

Ageing in place has become a primary policy instrument around the world to tackle the challenges associated with ageing societies, including in China. Much research emphasises the societal benefits of ageing in place with reference to its cost efficiencies. While there is an emerging literature employing a person-centred approach and paying increasing attention to older people's wellbeing, this research still centres on the identification and theorisation of determinants of wellbeing.

This study adopts a broader wellbeing approach and extends the new emphasis on the wellbeing of the oldest-old people ageing at home to the Chinese context. Applying an integrated conceptual framework, combining a relational understanding of wellbeing, theory of place and a life course perspective, the study aims to explore the experiences and meanings of wellbeing for and by older people themselves. The empirical focus of the research is a case study of two communities in Shanghai, where I conducted 6-months of fieldwork between 2015 and 2016 using qualitative research methods, including in-depth interviews, focus groups, observations and documentary analysis.

The study finds that, while the new policy emphasis on ageing in place aligns with older people's own preferences of attaining wellbeing in later life, the idea of wellbeing involves a complex set of social dynamics and shows both individual diversity and common character among the older people studied. The meanings of wellbeing for and by the older people studied reflected the multifaceted nature of wellbeing, the linked nature of human life and the great influence of historical times, earlier life events and the place in which they live. The study offers one of the first attempts to apply an integrated wellbeing framework when analysing wellbeing in old age and represents one of few empirical studies on Chinese older people's later life. As such, it contributes to the wider literature and enriches our understanding of ageing and wellbeing, both theoretically and empirically.

Table of contents

List of tables

List of figures

List of images

Chapter 1   Introduction

1.1 Background and context

China has witnessed a rapidly ageing population and faced great pressure in eldercare arrangements in recent decades as a result of increased life expectancy and a large population base, driven by industrialisation and urbanisation. While research on ageing and eldercare in China is growing, the focus tends to be placed on old-age policies and local eldercare arrangements. Much less scholarly attention has been paid to older people's real-world ageing experience and wellbeing. This study addresses the lacunae in the existing literature by developing and deploying an integrated wellbeing framework to understand the experiences and meanings of wellbeing for and by older people in Shanghai. In particular, it focuses on the oldest-old people (defined as people aged 75 and over) who are ageing in place (居家养老), a recent policy emphasis of Chinese central and local governments' efforts to tackle the challenges associated with an ageing society (Chen, 2014; Ding, 2013; Fang, 2006; Lin, 2004; Yang, 2014; Zhang, 2013). To understand the central research problem in more depth, the study draws on data collected using qualitative research methods on the ageing experiences of older people, whilst also taking into account, and building on, previous research on ageing, whether or not it specifically focuses on China.

Current ageing research and related policies show that ageing in place has become a primary policy instrument to tackle the challenges of ageing societies globally (Dobner et al., 2016; Nakanishi et al., 2015; Sixsmith & Sixsmith, 2008; Tinker, 1999; Vasunilashorn et al., 2011). In China, in the context of weakened family care, high-cost institutional care and older people's own desire to stay at home in later life, ageing in place has been promoted by the Chinese government as an important way of dealing with rapid population ageing and the increasing care needs of older people (Guo & Castillo, 2012; Sun, 2010; Wang, 2013; Zhou et al.,

2015). In China, a number of complex factors, including improved living conditions, increased life expectancy, and lower infant mortality and fertility rates have contributed to rapid population ageing and the associated growing need for eldercare over the past few decades. According to the National Bureau of Statistics of China (NBSC) the number of people aged 65 and above had reached 140 million by the end of 2015, accounting for 10.5% of the total population (NBSC, 2016). It is forecast that, between 2020 and 2050, population ageing will rise more rapidly, with the number of older people reaching more than 200 million, accounting for 30% of the total population (Ding & Wei, 2016). More seriously, a considerable proportion of older people are expected to suffer from poor health or disability, and thus need long-term eldercare. Reports show that by the end of 2014, the number of older people in China unable to look after themselves had reached 40 million. It is predicted that, by 2030, the number of older people 'with impairment' will reach 61.7 million, rising to 97.5 million by 2050 (Yang, 2016). This huge and increasing demand for eldercare is putting considerable pressure on China's existing eldercare arrangements.

Population ageing in Shanghai is taking place even more rapidly than elsewhere in China. Shanghai is one of the largest cities in China, has the highest life expectancy (83.18 in 2016), and the largest proportion of older people in its total population (Shanghai Research Centre of Ageing, 2016). By 2016, Shanghai had a total population of 14.5 million, of which 4.6 million were aged 60 and over, accounting for 31.6% of the city's total population, and people aged 75 and over (the oldest-old people) represented 8.6% of its population, or 1,243,300 people (SRCA, 2016). The oldest-old people are more likely to need eldercare. This means Shanghai faces great pressure on its eldercare services, and at the same time offers great potential for policy innovation and market interest. In 2005 the Shanghai city government put forward a '9073 Plan': through this plan, it is envisaged that 90% of citizens were expected to age at home, with older people themselves and/or family members the main eldercare supporters; 7% would age within communities and could be eligible for free or low-cost community-based eldercare services; the remaining 3%

could age in institutions (Xiong, 2018). The '9073 Plan' promotes ageing in place as the main eldercare model used in Shanghai. The Shanghai city government has subsequently developed various policies and programmes, including government subsidies, respite services, day care services, and 'caring for older people living alone' programmes, to support older people to age at home or within communities (SRCA, 2016).

Strategies to help older people remain at home or within communities are seen as having both societal benefits (reduced costs and effective solutions to the problems of rapid population ageing and increasing eldercare needs) and individual benefits, for the health and wellbeing of older people (Wiles et al., 2012). Many studies in gerontology emphasise the economic benefits of ageing in place (Vasunilashorn et al., 2011), a term that, at its simplest, means the ability to remain at home as one ages. Much research, whether on ageing in place service delivery or on personal ageing in place experience, assumes that older people should age in place and that the key to successful ageing in place is the maintenance of independence, especially by continuing to have a degree of ability and control over one's environment (Feingold & Werby, 1990; Lawton, 1982).

While literature employing a person-centred approach and paying increasing attention to older people's wellbeing is emerging, existing research on this topic still centres on the identification and theorisation of independent 'components' or 'determinants' of wellbeing, sometimes called the 'components approach' to wellbeing (Atkinson et al., 2012; Atkinson & Joyce, 2011). This approach sees wellbeing as the desired outcome, influenced by different determinants and as having a quality that inheres to the individual (Allin & Hand, 2014; Diener et al., 2009; McGillivray & Clarke, 2006). The complex and multifaceted nature, and broader sense, of the term wellbeing are often overlooked, leaving room for further and deeper exploration. In China, current literature on ageing and eldercare pays scarce attention to older people's wellbeing, especially in the broader sense of the term, or to older people's own perspectives.

1.2 Original contribution of the study

In this scholarly context, the present thesis examines experiences and meanings of wellbeing for and by older people themselves. It offers one of the first attempts to apply an integrated wellbeing framework, combining a relational understanding of wellbeing, a theory of place and a life course perspective, in analysing the meanings of wellbeing for and by older people in later life in Shanghai. In contrast to the 'components approach', which sees wellbeing as an endpoint or outcome, the integrated wellbeing framework views wellbeing as a complex and dynamic process embedded in specific temporal, spatial and cultural contexts, and experienced and perceived differentially by different individuals. As such, it contributes to the wider literature and enriches our understanding of ageing and wellbeing, evoking fresh thinking about the interrelationships between time, place, individuals, communities and society, as well as the historical, social and institutional processes and dynamics that shape wellbeing in later life.

Additionally, as one of the few empirical studies on Chinese older people's later life, the thesis contributes to Chinese ageing studies, shedding light on Chinese older people's ageing in place and eldercare experiences and practices in their specific economic and socio-cultural context. In developing a better understanding of how service provision helps achieve and sustain wellbeing for the oldest old, the study also has policy relevance in respect of meeting the needs for, and improving, eldercare services in China and globally.

1.3 Research aims and objectives

The study seeks to address the following research aims and objectives:

1) To understand the experiences and meanings of wellbeing for and by older people themselves when they are ageing at home;

2) To understand their ways of attaining and sustaining wellbeing in very old age;

3) To examine how their wellbeing has reflected and been shaped by broad social factors, e.g. wider institutional and societal change over time, the place they lived in, interactions with significant others.

4) To identify lessons and experiences in policy and practice so as to identify innovative practices and improve eldercare service planning and development in urban China.

The broader wellbeing approach implies: that the older person is an agentic self, rather than a passive recipient in their daily practice; that wellbeing is socially and culturally embedded; and that detailed attention should be paid to ageing in place experience and wellbeing (and their linkages to the self and agency) as context-dependent and shaped by the particularities of time and place (Hammarström & Torres, 2012). Thus, wellbeing needs to be understood in the context of people's past experiences, given places, and interactions with others.

Older people's wellbeing in later life is closely related to their prior knowledge and experience. According to Dannefer and Settersten (2010), ageing is a process throughout the life course; an individual's accumulated life practices and experiences that unfold in the life course are necessary and essential to understand their experiences in old age. A sense of wellbeing (or lack thereof) does not occur suddenly in older age, but is rather an outcome of a long-term and cumulative process (Crystal et al., 2016; Hudson, 2016). Advantages or disadvantages that occur during an earlier stage of life can cumulatively shape one's life trajectories and sense of wellbeing in old age (Choi et al., 2017). The social, cultural and institutional changes in which older people are embedded may also shape their experiences over time and affect their ability to age in place (Perkins et al., 2012). This broad and open understanding provides a lens for understanding wellbeing not only in the present, but also over time, and for exploring early life course events

that affect older people's present lives (Cropanzano & Mitchell, 2005). The timing of lives is emphasised in understanding later life (Stetsenko & Arievitch, 1997).

Older people's wellbeing in later life is closely related to their living environment; the place. Place, which encompasses both the physical and social aspects of the environment, acts as a source of meaning for older people's subjective experiences. Place involves and implies meanings of older people's experience and plays an important role in older people's sense of self, daily activities and life trajectories (Wiles et al., 2009). Older people's daily activities and behaviours are embedded in given places. Places are dynamic and show both change and stability over time. As people age, the role of place becomes even more important. Place and space are key to the wellbeing of older people (Bonifas et al., 2014). Wellbeing cannot be understood as independent of the geographical context and culture.

Older people's wellbeing in later life is closely related to others, that is, to their social relationships. Social relationships are generally conceptualised as consisting of two major components: social networks and social support (Sugisawa et al., 1994). Lives are embedded in social relationships and their interconnectedness, particularly bonds of kinship, play an important role in older people's experience of ageing in place and sense of wellbeing (Katz et al., 2011). Wellbeing is not a self-construct, rather, it is affected by changes in interactions with the environment and significant others. Older people' wellbeing is developed and (re)confirmed in the context of daily interactions and experiences (Alwin & McCammon, 2003; Pietilä & Ojala, 2011).

Older people construct their wellbeing (or not) through interaction with their living environments and agentic others in daily living practice (Richardson, 2004). To understand wellbeing in old age, it is necessary to place older people's accounts of their lives in national, historical and spatial contexts, and to situate their everyday life experience within the macro-level dimensions of social forces and social change. This study highlights the need to recognise diversity among older people,

and to take into account their everyday life experiences and the role of broad social factors that penetrate their everyday life experiences of ageing in place. The thesis thus considers both contexts for ageing in place and participants' views and activities relating to ageing in place.

The study considers not only older people's perspectives, understandings and feelings (and so on), but also the people who are closely involved in their everyday lives. In so doing, it aims to locate older people in broader social, spatial and temporal contexts and social relations, both in order to contextualise the data gathered from different participants, and to gain an insight into the role of social forces and social networks in eldercare and older people's wellbeing in later life. Two communities were selected for the study, with three types of participant identified and included: older people, carers and care workers, and stakeholders (e.g. eldercare agency staff, Neighbourhood Committee members, and governmental employees). In all, 49 participants (25 in community A and 24 in community B) were included in the study. Of the 14 older people interviewed, most were aged 80 or older. Great variety was found among the older participants. Taking this into consideration was important in the study, as there have been few studies on this topic, especially in the Chinese context. The study also included 13 carers, 12 care workers and 10 stakeholders with close relationships with older people and eldercare. This helped to produce a more rounded picture of ageing in place in the two communities, and enabled me to gain a deeper understanding of wellbeing in later life and its relation with broad social, spatial and temporal contexts.

1.4 Structure of the thesis

The introductory chapter provides the background and scholarly context for the study. It discusses the widespread policy preference for ageing in place, which has

been promoted to deal with rapid population ageing and increasing eldercare needs globally, nationally (in China) and locally (in Shanghai). It identifies a research gap, namely the need to advance knowledge by further exploring older people's own understanding and experience of wellbeing when ageing in place, compared with the overwhelming focus in the current literature on older people's ability to maintain independence and the economic benefits this might bring about. The chapter also outlines the research aims and objectives, and the thesis structure.

Chapter two provides a critical and systematic review of the literature. It discusses ageing, wellbeing and ageing in place in further detail. It reviews the literatures on theories of ageing and old age, approaches to ageing and old age and the more recent policy preference for ageing in place. By tracing the development of ageing research and practice, both globally and, more specifically, in China, the chapter developed a fuller understanding of ageing and old age and identified research gaps in current Chinese literature.

Chapter three develops the conceptual framework of the thesis, the integrated wellbeing framework. It evaluates the strengths and weaknesses of White's (2010) relational wellbeing framework, and highlights the need to incorporate a life course perspective and theory of place to fully address the complexity and multi-dimensionality of older people's wellbeing.

Chapter four elaborates upon the methodological approach adopted in the study. It details the research questions, research design, the selection and justification of the location of the case study, access to the field, data collection and data analysis. A reflection on the research methods and ethical considerations is also offered.

Chapters five, six and seven present the empirical data analysis and findings. Chapter five examines the influence of earlier salient events and experiences, in particular the experiences of macro social forces and social changes, life crises, and everyday life practice that older people considered critical for their wellbeing in

older age. It also explores whether, and how, the wellbeing of older people was sustained and secured (or not) in older age, and the major factors contributing to the outcome. Chapter six examines the relationship between old age, place and wellbeing. Specifically, the meaning of home, the importance of community, older people's experiences and expectations of eldercare services and their sense of belonging and attachment to place are analysed. Chapter seven looks at older people's familial ties, social relations and networks, and their perceptions of wellbeing in relation to social support and social relationships. It examines how mechanisms of social support affect wellbeing in later life. Additionally, the concepts of power, affection and harmony are employed to understand the complex and multi-faceted influence of older people's social relations on their wellbeing.

Chapter eight draws the main findings and arguments of the research together in relation to the wider literature, and highlights the study's original contribution to knowledge and understanding, and to academic and policy debates on ageing, ageing in place and wellbeing. It also reflects on the research, and suggests future research directions and ways of improving eldercare service planning and development to protect the rights, and meet the needs, of older people in urban China.

Chapter 2   Ageing Research And Practice: A Critical Review of Literature

2.1 Introduction

This chapter critically reviews current research, policy and practice on ageing and eldercare. First, it presents theories of the concept of ageing and old age, in particular, it unravels stereotypical conceptions of ageing and old age and critiques on this kind of understanding. In so doing, it aims to understand the nature of ageing and old age. Then it moves on to delineate a trajectory of development in ageing research approaches, emphasising the distinction between 'pathological' ageing, 'normal' ageing and 'successful' ageing and the recent discussions on the personal wellbeing and ageing experience of older people. The chapter also examines ageing and old age in policy and practice. Special attention is given to the widely used concept of ageing in place, and to the development of the concept and practices of ageing in place in urban China.

2.2 Theories and concepts of ageing and old age

The meanings of ageing and old age have been subject to much academic and policy debate in the existing literature. In this section, I discuss the concept of ageing and old age. First, I present the stereotypical construction of older people, which has affected not only older people themselves but also how the society sees and treats them and their condition. Secondly, I analyse and critique the stereotypical views of ageing and old age, arguing that there is great variety and heterogeneity among older people. Thirdly, the concept of ageing and old age in more recent research is discussed with emphasis given to the relationship between personal ageing processes and their broader socio-economic context.

2.2.1 Stereotypical conceptions of ageing and old age

Ageing and old age tend to be conceptually, and negatively, constructed as 'cellular changes that accumulate with time and ultimately lead to functional impairment' (Michael & Bron, 2011: 1278). Ageing and old age thus tend to be associated with stereotypical images, constructions and discourse in different theoretical perspectives. For instance, ageing and old age are viewed as a period of decline, loss and social withdrawal (Alley et al., 2010; Bengtson & Settersten Jr, 2016; Cumming & Henry, 1961; Harrison, 1983). The biomedical model of old age, for example, with its focus on the aged body, physiological changes and organic functions, perceives ageing and old age as a process only of biological decline (Kontos, 1998). As such, the model treats the entire phenomenon of old age as an individual pathology and thus highlights the dominant role of medicine in the approach to the ageing process and the aged body. 'Disengagement' theory proposes that older people undergo a natural and inevitable process of social withdrawal; as people age, they have lower levels of activity and involvement in social interaction; it is argued that this is not a problem, but a beneficial process both for the ageing individual and for society (Atchley, 1989; Cumming & Henry, 1961).

According to these theories and perspectives, older people are usually regarded as an unhealthy, unproductive and isolated population. Frailty and weakness are seen as typical for older people as a whole (Martinson & Berridge, 2014). Older people are portrayed as physically frail and/or mentally incompetent, no longer able to perform valuable productive work or make contributions to society, having little social contact and social engagement, and generally leading miserable, pathetic and pathological lives characterised by loneliness, dependence, passivity, depression or dementia, and deep seclusion (Harrison, 1983; Rowe & Kahn, 1997). The negativity and stereotypical image of older people contributes to stigma and a fear of ageing. It also helps to reinforce an instrumentalist perspective and its associated

societal attitudes and prejudice that devalue older people, and deny both their agency, social participation, social contributions and the possibility of growth and development in old age (Martinson & Berridge, 2014).

2.2.2 Diversity and heterogeneity of older people

Such a construction of ageing and old age in earlier research has been widely criticised in more recent years for its exclusive focus on physiological change, its negative representation of older people, and its denial of possibilities for continued growth and development in later life. Ryff (1989), for example, criticises the implicit negativism in many approaches to ageing and old age and calls for greater recognition of its positive aspects. Piovesana (1979) points to the respect for older people in Eastern cultures based on the advantages that one gains with age, such as calm, experience and wisdom. Morell (2003) puts forward a model of 'embodied empowerment', arguing that illness, disability and death are 'acceptable and respectable human experiences' in later life. Stone (2003) criticises age-based discrimination and stigma as ageism, arguing that this leads to the social exclusion of older people, and calling for fundamental change in the conception and attitudes towards ageing and old age. Moreover, some gerontologists have emphasised the necessity of adopting interdisciplinary approaches to studying ageing and old age to include, for example, sociology, psychology, demography, social policy and social work (Kontos, 1998).

An important argument, one that counters the homogenising and stereotypical representation of ageing and old age in some social gerontology, is that older people are diverse and heterogeneous. The 1970s saw increasing attention paid to differentiating ageing and 'within-age diversity', an idea that has since gained ground in gerontology studies (Dannefer, 2003). The notion of within-age diversity provides a counterpoint to the tendency to negatively stereotype older people. With a focus on intercultural diversity and inter-individual diversity, the notion is relevant not only to common sense and theoretical images of older people, but also

to policy and practice, as the diverse older population has a differentiated set of resource and care needs (Maddox & Lawton, 1988). Based on a longitudinal study of a defined older population, Maddox and Douglass (1974) argued that variety increased with age with regard to a variety of social, psychological and physiological indicators. Wolinsky & Arnold (1988) explored the perspectives of older people on health and health services utilisation, indicating the diversity in this respect among the older people studied. Dannefer and Sell (1988) proposed that it is misleading to 'describe older people in homogenised ways'; instead, variability and inequality tend to extend into old age. With respect to the question of 'diversity of what', Dannefer (1988) pointed out that, although researchers have diverse interest in diversity, there are certain key points that are widely agreed to be important to understand: health, psychological functioning and resource characteristics. Such research evokes fresh thinking with regard to conceptions of ageing and old age.

2.2.3 The concept of ageing and old age in more recent research

In recent years a more critical account and broader discourse of old age and ageing have developed. As a result, the concept has become more dynamic and comprehensive than ever before (Kontos, 1998). Researchers have pointed out that 'age by itself is not enough to define individual lives' (Dannefer & Settersten, 2010: 5). It is widely agreed that ageing should be seen as a dynamic process that involves changes and adjustment rather than simply as chronological age or certain specific stage of life (Dannefer, 2010; Dannefer & Daub, 2009; Rowe & Kahn, 2015; Ryff, 1989).

In understanding the process of ageing and old age some scholars pay attention to selected aspects of the ageing person, arguing that adaptation to physical, psychological and social changes and adjustment to old age are primarily determined by an individual's personality characteristics, activity levels, self-perceptions, etc. Baltes and Carstensen (2003), for example, argued that people

adapt to changes mainly through three processes: selection, compensation and optimisation. Through these processes, older people balance losses and gains and make sense of old age and ageing. Kontos (1998) has suggested that knowledge of ageing and old age should come from older people themselves and that their personal narratives need to be addressed and emphasised to give voice to the ageing experience.

Meanwhile, some other scholars have argued that ageing and old age cannot be understood entirely as a self-contained individual process. Instead, the relevance of social structure and broad social contexts, within which the ageing process occurs, should be recognised (Alley et al., 2010; Bengtson & Settersten, 2016; Bronfenbrenner, 1994; Dannefer, 2010; Elder Jr, 1994; Maddox & Douglass, 1974). Societies differ in how they recognise and deal with age. The meanings of ageing and old age 'vary historically and cross culturally' (Dannefer & Settersten, 2010: 10). It has been widely agreed that ageing and old age involve biological, psychological, sociological and cultural aspects so that they should be treated as 'both authentically human and culturally located' (Kontos, 1998: 170). There is growing recognition that 'ageing and old age cannot be understood, either at the individual or societal levels, without paying attention to the cumulated life practices and experiences of ageing individuals' (Dannefer & Settersten, 2010: 18).

2.3 The development of approaches to ageing and old age

Discussions in existing research have shown that ageing is a dynamic process that incorporates personal characteristics, perspectives, broad social structures and social contexts and assumes great diversity among older people. What is good ageing? In the next section I review major debates on this topic, tracing the development of major research approaches to ageing and old age.

2.3.1 Pathological ageing: the aged body and medical treatment

The notion of pathological ageing has been a significant approach to ageing and old age in an era of Big Science (Achenbaum, 1995; Kontos, 1998). Worshiping the idea of scientific progress, researchers tended to view the study of ageing and old age as a physical science (Katz, 1996). Embracing approaches developed and applied in scientific disciplines, including biology, medicine, chemistry and other 'hard sciences', researchers attempted to gain 'scientific knowledge' of the bodily structure, process and outcome of ageing and old age (Kontos, 1998). With the overwhelming focus on individual organic pathology and physiological etiologies, researchers of pathological ageing limited their research to the science of the aged body (Achenbaum, 1995). Ageing and old age were regarded as 'definitive physiological, pathological, and biological signs of senescence' (Knotos, 1998: 170). Medicine was seen as the major means of dealing with the ageing process and aged body. It is argued that ageing people who are disabled or impairmental are experiencing pathological ageing and thus need medical treatment (Atchley, 1989; Fenton, 2014; Martinson & Berridge, 2014; Neilson, 2012). The idea of pathological ageing is therefore marked by a biomedical and technical approach to ageing and old age research, which conceptualises older people as the mere object of 'scientific enquiries', completely ignoring the 'subjective' aspects of ageing, i.e. feelings, emotions, perceptions, experiences of older people and their agency.

The notion of pathological ageing implies that, to experience disease, decline and physical impairment is to age badly, while avoidance of disease, disability and decline is ideal and thus good ageing. Some gerontologists made distinctions between the pathologic and non-pathologic, and emphasised the importance of the latter (Andrews, 2001; Atchley, 1989; Cumming & Henry, 1961; Martinson & Berridge, 2014; Neilson, 2012). Andrews, for example, emphasised the 'seductiveness of agelessness', arguing that to age well means 'not to age at all, or at least to minimise the extent to which it is apparent that one is ageing' (1999: 305).

The pathological approach to ageing and old age was, for a long time, assumed unquestioningly, and thus became dominant. However, more recent research points out that this approach denies the experience that age brings and the possibility of growth and development in later life (Ryff, 1989). Seeing older people as passive sufferers of disease and disability and the aged body as the object of the medical machine, the pathological ageing approach neglects the importance of human agency and subjectivity with regard to making sense of and giving meaning to ageing, managing or even improving one's own health. Attributing bodily ageing, disease and impairment to individuals' past lifestyle indiscretions and dietary preference, it also 'left little room for the natural death' (Bülow & Söderqvist, 2014: 143). Some scholars thus suggested that, rather than seeing pathological ageing as a failure of bodily systems, ageing research should treat it as a process of life and accept death as an unavoidable fact (Bülow & Söderqvist, 2014; Kontos, 1998; Neilson, 2012).

2.3.2 Normal ageing: commonly encountered patterns of ageing

The notion of 'normal' ageing refers to 'usual, commonly encountered patterns of human ageing' (Atchley, 1989: 183), and differs from pathological ageing. Those whose 'age-determined responses and behaviours' are not 'contaminated' by specific disease process were considered as experiencing normal ageing (Rowe & Kahn, 1987). Highlighting the influence of age and ageing on physical, cognitive and behavioural 'functions', and perhaps on probable responses to medical treatment, the normal ageing approach emphasised the distinction between pathologic changes and changes brought about by age and the ageing process per se (Atchley, 1989; Rowe & Kahn, 1987). Although emphasising the importance of preventing disease and disability in the ageing process, the normal ageing approach accepted death as an unavoidable fact and saw age-related decline in *physical* function (e.g. loss of hearing, vision or bone density; decline in renal, pulmonary or immune function; increased blood pressure) and *cognitive* function (e.g. loss in

concentration or memory) as normal, primarily genetic, and determined by an intrinsic ageing process (Rowe & Kahn, 1987).

The normal ageing approach focuses attention on the usual and common responses, behaviours, physiological and psychological states of older people (Atchley, 1989). The approach aimed to produce a general picture of ageing that represents most older people's ageing experience within a specific culture. Because the cultures in which physical ageing processes are embedded can differ, normal ageing can be assumed to be different and diverse in distinct cultures and societies (Atchley, 1989; Kontos, 1998). For example, normal ageing in the USA in the late 1980s meant no disability, no chronic or serious disease and an independent, active, self-satisfying and purposeful life in old age; while in countries with a strong Confucian tradition, normal ageing may imply something quite different (Liang & Luo, 2012; Martinson & Berridge, 2014).

According to the continuity theory of normal ageing, although people in different cultures and societies experience and view ageing in different ways, all tend to maintain previous lifestyles, activities, behaviours and relationships in later life and use continuity strategies to adapt to changes that occur in ageing processes (Atchley, 1989). The theory argued that older people attempted to maintain internal structures, such as personality, ideas and beliefs, and external structures, such as relationships and social roles, when making adaptive choices; despite experiencing dramatic changes in external circumstances, people may still maintain internal continuity (Lieberman & Tobin, 1983). By suggesting general adaptive principles and explaining how these principles work, the continuity theory of 'normal ageing' is said to hold the potential to explain the individual's adaptation to ageing for people who are expected to experience ageing 'normally'. However, the theory is also criticised for its failure in dealing with 'pathological', or 'abnormal' patterns of ageing. For example, when older people are physically or mentally incapable of managing their living environment, or when they experience major role loss, there is a potential for them to experience both 'internal and external discontinuity'

(Atchley, 1989), but the theory is not very helpful in understanding situations of these older people.

Unlike pathological ageing, the normal ageing approach tends to neglect older people with chronic illness or impairment, and older people who experienced uncommon or unusual patterns of ageing. It also neglected the heterogeneity among older people who were viewed as experiencing normal ageing. With its emphasis on normality, the approach implied that what was normal was somehow natural and good, and that risks that may affect this were something to be avoided (Bülow & Söderqvist, 2014; Rowe & Kahn, 1987). However, it is not easy to accurately define what normal ageing and normality were. As Weindruch and Masoro (1991) pointed out, not only was it difficult to distinguish disease from ageing itself, but also to separate primary ageing processes from processes that were the results of ageing. When looking at ageing individuals, what was the result of ageing per se and the consequence of inevitable functional decline, what was the result of diseases, recent changes and life course heterogeneity, and what was the result of broad social factors, like social structures and social change? Age-related conditions are diverse and as a result of multiple complex causes (Seeman et al., 1994). This adds complexity and calls for more nuanced accounts in the ageing research area.

2.3.3 Successful ageing: establishing criteria for good ageing

'Successful' ageing has become an increasingly popular approach to the study of ageing and old age since the term was first coined by Rowe and Kahn in 1987. Highlighting the substantial heterogeneity of older people and the modifying effects of personal habits, psychosocial factors and life style, these authors called for a distinction between usual ageing and successful ageing within the category of normal ageing (Rowe & Kahn, 1987). They identified three key components of successful ageing: the avoidance of severe chronic disease and disease-related disability; the maintenance of physical and cognitive functional capacity; and active social engagement (Martinson & Berridge, 2014; Rowe & Kahn, 2015).

They argued that a single component cannot fully describe successful ageing; instead, it was the combination of the three components that represented the notion of successful ageing most fully (Rowe & Kahn, 1987).

Different from many ageing studies that emphasised substantial losses with advancing age, the successful ageing approach recognised the possibility of growth, development, maintenance and recovery of function in later life, and paid much attention to the older people with minimal or no physiologic loss and active social engagement (Baltes & Carstensen, 2003; Brandt et al., 2012; Nosraty et al., 2015; Rowe & Kahn, 1987; Ryff, 1989). These older people were seen as having aged successfully, in contrast to those who showed 'the typical non-pathologic age-linked losses' that Rowe and Kahn (1987) proposed to designate usual ageing. Older people may experience loss of function and different patterns of ageing in their later life - from successful to usual and usual to pathologic. The successful ageing approach recommended that ageing research should pay more attention to risks associated with usual ageing, transitions that have functional importance and strategies that could modify the processes of function loss to facilitate successful ageing (Bülow & Söderqvist, 2014). Recognising the effects of psychosocial interventions on physiological and cognitive variables, the approach also suggested the need to link physiologic and psychosocial aspects in ageing research (Rowe & Kahn, 1987; Ryff, 1989).

Because of these contributions for ageing research, the successful ageing approach has been widely adopted by gerontologists. Villar explains that Rowe and Kahn's successful ageing approach 'boosted interest in the biological, behavioural and social factors which determine the attainment of ageing well, and has encouraged the adoption of a new, preventive and optimistic approach to the final decades of life' (2012: 1089). However, the successful ageing approach is also contested. Critiques of the approach range from minor modifications to successful ageing frameworks, to deeper doubts and questioning of the core ideologies underpinning its respective frameworks. Riley et al. (1999) for example, criticised the notion of

successful ageing for its focus on individual success and its neglect of broad social, cultural, economic and political contexts, within which ageing processes were embedded. Recognising the importance of critical life events as determinants of successful ageing, Rowe and Kahn (2015) called for a life course perspective for understanding the ageing phenomenon.

Today, over two decades after the notion of successful ageing was first introduced, it has received sustained attention and critiques in gerontological research. Martinson and Berridge (2014) conducted a systematic literature review of critiques of successful ageing and summarised these into four categories: the '*add and stir*' group called for additional criteria for successful ageing and multidimensional expansion of the conceptualisation; the '*missing voices*' group emphasised the importance of older people's subjective meanings, personal perceptions and self-evaluation of their own ageing and the effects of earlier life experiences; the '*hard hitting critiques*' group criticised the dichotomy between successful ageing and unsuccessful ageing and called for more inclusive frameworks to embrace the full diversity of ageing, to avoid stigma and discrimination towards those that were considered as ageing 'unsuccessfully' and to include structural contexts of ageing into consideration; the '*new frames and names*' group challenged foundations of existing successful ageing frameworks and sought alternative ideas for ageing research.

As Martinson and Berridge (2014) have pointed out, the criteria for and meanings of successful ageing may marginalise and exclude older people and negatively influence their self-identities and self-esteem. They can also lead to 'a disharmony between the 'body and mind', especially among those who are compelled to meet existing social norms and expectations for 'good', 'successful' ageing (Liang & Luo, 2012). Emphasising the importance of the maintenance of functional capacity and high activity levels in old age, and driven by a 'busy ethic' (Ekerdt, 1986), the successful ageing approach, to some degree, neglects personal feelings, experiences and quality of life. The implied individualistic approach, ageism and

ableism of successful ageing have been pointed out and criticised by many scholars. Given the shortfalls of successful ageing, some scholars have asked: 'why do we remain tied to this approach?' Increasingly, scholars suggest the need to 'move toward the development of more realistic and useful concepts that better capture the personal as well as social, political, and economic contexts of ageing' (Martinson & Berridge, 2014: 65).

2.3.4 Wellbeing: a new focus in ageing research and practice

Over the past few decades, ageing research has expanded beyond the approaches mentioned above. As a result, ageing and old age have been explored and interpreted in many different ways. Liang and Luo (2012), for example, criticised the implied ageism, individualism and cultural bias of the successful ageing model and proposed an alternative model - 'harmonious' ageing - which emphasised the interdependent nature of human life. Wild et al. (2013) offered a model of 'resilient' ageing that incorporated both individual and social forms of resilience. Rather than emphasising individual responsibility and the ability to build resilience (as traditional resilience models do), Wild's model recognised the influence of social structures and social inequality on ageing and old age and emphasised the meaning that resilience had for older people themselves. Overall, the development in ageing research reflects and calls for 'more holistic, integrated, inclusive, and globally relevant understandings of ageing' (Martinson & Berridge, 2014: 65). Unlike earlier research that focuses on what ageing and good ageing should be, the new development in ageing research offers a more open and dynamic understanding. It views ageing and old age as a dynamic process that incorporates various aspects of life, recognises cultural diversity and diversity between individuals, and is cautious of the values and ideals inherent in ageing research approaches. The experiential dimension of ageing has been a key concern in ageing research (Neilson, 2012).

The notion of wellbeing in this scholarly context has emerged and been considered by many scholars as being able to help unravel and understand the experiential

dimension of ageing. The concept, as Atkinson (2013) argues, is a person-centred, locally grounded and multifaceted approach. Developing in tandem with and drawing on ideas underpinning the various ageing models and approaches, the wellbeing approach has become increasingly important in ageing research, policy and practice (Ryff, 1989). With its emphasis on wellness, rather than illness, its incorporation of multidisciplinary perspectives, and its acknowledgement of the important influence of both social factors and personal attributes on individuals' ageing experience (Allen, 2008; Fleuret & Atkinson, 2007; John, 2012; Sointu, 2005), the wellbeing approach has a great potential in producing a fuller and deeper understanding of ageing and old age and in 'capturing cultural diversities in the context of global ageing' (Liang & Luo, 2012: 328) (discussed further in Chapter 3).

2.4 Ageing in practice: the more recent policy preference for 'ageing in place'

Having looked at conceptual formations and theoretical debates about ageing and old age, I now turn to discuss the current academic and policy attention to ageing in place. Ageing in place is defined as 'the ability to remain in one's own home or in a community setting over one's life, until old age' (Cutchin, 2003: 1078). This section reviews existing literature on ageing in place, with a focus on its practical and theoretical dimensions. It discusses the ageing in place concept and examines the development of ageing in place practice in contemporary China.

2.4.1 The concept of ageing in place

The concept emerged as result of a reconsideration of older people's living arrangements. Institutional care, care provided within a 'congregate' living environment (Gellman & Turner, 2013), used to be emphasised as the most appropriate arrangement for eldercare in many countries, especially for the oldest-

old people. In contrast to this model, which is lately considered to incur high costs and pose barriers for older people's social connection and interaction, ageing in place is viewed as cost-effective and as enabling older people to maintain independence, autonomy and connection to social networks and social relations (WHO, 2015). Policies favouring the promotion of ageing in place are now widespread, and it has become a common policy response to rapid population ageing and increased demand for eldercare (Dobner et al., 2016). In many European countries, domiciliary services have been increasingly designed to meet older people's care needs within the context of their own home, in line with the policy shift from institutional care to home care. The UK, for example, has a long-established policy aim of 'promoting care in the community and minimising institutional care', and provides funding for local authorities to develop community care (Tinker et al., 2012: 6). Sweden, which emphasises strong state support for residential care, takes a hybrid approach by offering long term care and promoting domiciliary care services (Larsson et al., 2005). Reviewing care reform in nine European countries, Rostgaard et al. (2011) showed that a major emphasis is placed on home based care in England, Ireland, Austria, Germany, Italy, Finland, Denmark, Norway and Sweden.

Compared with placing older people in residential or nursing homes, helping older people to stay at home is often seen as less expensive (Tinker et al., 2012). However, although older people are encouraged to age in their own homes, expenditure on eldercare has dramatically increased in some countries, owing largely to rapid population ageing and extended lifespans. Controlling expenditure on eldercare has thus become a priority in many countries (Chen, 2002; Ding & Lv, 2013; Glendinning & Moran, 2009). Indeed, many countries have seen financial constrains in social programmes and a shift of care responsibility on to individuals, families, communities and the market (Chevreul & Brigham, 2013; Francesca et al., 2011; He, 2016; Hou et al., 2010; Huang, 2016). What is more, provision of formal and publicly funded care is increasingly challenged by financial constraints.

Older people thus may have to be more self-reliant or to rely more on informal support (Dobner et al., 2016).

Informal support provided by family members, relatives, friends or neighbours already constitutes a key though often unnoticed, component of ageing in place. Much research has frequently emphasised the important role of informal support for older people. Informal support can entail a broad range of tasks and responsibilities, and touches upon emotional, physical, and intimate personal domains (Goh et al., 2013; Wiles et al., 2012). Social organisations and local initiatives are encouraged to facilitate the practice of ageing in place (Dobner et al., 2016; Glendinning & Moran, 2009). Community support and informal neighbourhood networks can be even more crucial for older people living far from family members (Chen & Sun, 2010). Older people's ability to maintain independence, with a degree of autonomy and control over their environment, is also emphasised (Cutchin, 2003).

As stated in the Introduction, enabling older adults to remain at home and to retain independence and self-determination is often considered to be positive and beneficial for the wellbeing of both societies and the individuals involved (Sixsmith & Sixsmith, 2008; Weil & Smith, 2016). However, such assumptions have not yet adequately been investigated, especially in relation to the oldest-old population and vulnerable older groups. A few scholars have raised critical concerns about the limitations and possible disadvantages of ageing in place. These address, for example, the appropriateness of the physical design of the home and neighbourhood, and the increased risk of loneliness and lack of social support in the home and community (Wiles et al., 2012). Some authors are particularly concerned about vulnerable older adults ageing in place in disadvantaged urban neighbourhoods (Dobner et al., 2016), while some argue that ageing in place may not be the prime goal of older people with high unmet needs and inappropriate housing, or for those living in unsafe or unsupportive neighbourhoods (WHO, 2015). Because they have fewer choices, these older people may risk being 'stuck

in place' (Wiles et al., 2012). Treating older people as a homogenous category and viewing ageing in place as a 'one-size-fits-all' concept can result in inadequate recognition of the diverse needs of older people (Cutchin, 2003; Weil & Smith, 2016). In particular, the role of psycho-social and environmental factors in living longer at home have yet to be fully understood in terms of health, wellbeing and quality of life. Much literature in gerontology emphasises the individual's ability to maintain independence, but little is known of older people's everyday life experiences and how social factors affect an individual's everyday life experience of ageing in place. The complexities and socio-cultural dynamics involved in ageing in place are therefore under-examined.

Ageing in place involves a complex blend of physiological, behavioural, social, and contextual changes that occur at both the level of both the individual and the wider environment (Satariano, 2005). To promote ageing in place and to understand older people's real-world ageing in place experience, it is necessary to place older people's accounts of their lives and situate their everyday life experience within macro-level dimensions of social forces, as well as social change.

2.4.2 Ageing in place in urban China

Taking into account this wider global turn towards ageing in place, I now turn to look at China's specific policy evolution in this regard. Ageing in place has been put forward and advocated by the Chinese government as part of institutional responses to demographic ageing (owing to rapid industrialisation and urbanisation) in recent decades, and the corresponding sharp rise in population mobility, weakened family care, eldercare needs, the expense of institutional care, and older people's desire to remain in their own homes in later life. In 2006 the State Council proposed that China should establish a system in which home and community based ageing dominates, with institutional options only supplementary (Wang, 2013). It is argued that this model should play a more important role in dealing with rapid population ageing and increasing eldercare needs in China, as in

many other countries. Ageing in place is seen as having many advantages: lower cost, higher efficiency, better emotional support (compared with institution-based ageing), and the potential to increase employment (Chen, 2002; Chen, 2014; Ding, 2013; Fang, 2006; Lin, 2004; Yang, 2014; Zhang, 2013).

Indeed, most Chinese older people prefer to remain in their own homes in later life (Cao & Wang, 2013). Based on an analysis of data from the China Health and Retirement Longitudinal Study, conducted in 2011, Wang & Zhang (2015) showed that, in urban China, 30% of older people live with their adult sons; 35% with their spouse and 17% alone; 89% of older people consider living with adult children or in the same community the best living arrangement; very few older people say they would prefer to live in an institution and that fewer than 1% live in institutions.

Current Chinese literature on the theme focuses on how to support older people to age at home. Ageing in place services, either delivered at home or as services provided in communities, have developed fast in urban China (Chen, 2014; Fang, 2006; Lin, 2004). The prevalence of ageing in place services - services that are both delivered in homes and provided in communities - expanded quickly over the past decade (Chen, 2014; Fang, 2006). More older people and their families choose to buy private care services from the market (Jiang & Liu, 2014). Community based services also play an increasingly important role, and include meal delivery, daily care, senior centres, respite services and so on, usually provided free or at low cost within communities (Chen, 2014; Fang, 2006; Huang, 2005; Wang, 2004). Providing support for those who are not able to fully take care of themselves and their families, community-based services can complement family care (Wu & Xu, 2007; Zhang, 2010). It is widely recognised that efforts to promote ageing in place should address and engage communities, rather than simply help ageing individuals and families (Greenfield et al., 2012; Shen, 2014; Wu & Jin, 2007; Wu & Xu, 2007).

A number of policies to support older people to age well at their homes have been put forward, including (but not limited to):

1) *China's twelfth five-year plan on ageing.* In this plan, the State Council[1] asserted that China should establish an aggregated ageing system, of which home-based ageing is the main component and institution-based and community-based ageing play a complementary role. The overwhelming majority of older people, i.e. about 90%, would experience home-based ageing; with community-based ageing accounting for around 7% of people and institution-based ageing for some 3% (SC, 2011a). The plan proposed a goal that, by 2015, China should establish an ageing in place system with wide coverage. It also made it clear that governments' responsibilities are to promote, guide and supervise the development of ageing in place, with market mechanisms developed to optimise the distribution of ageing in place resources.

2) The State Council has issued several *opinions on promoting the development of the health and medical service sector.* It advocated cooperation between hospitals and nursing homes and encouraged hospitals to provide medical and care services within communities (SC, 2013).

3) State Council *guidance on government contracting-out.* This document states that government contracting-out is a vital and effective way of promoting ageing in place, and that local authorities should collaborate with social institutions to provide eldercare services for older people with care needs (SC, 2011b).

4) State Council *opinions on promoting the development of ageing in place services.* These propose that governments should provide preferential policies to promote the provision of ageing in place services (SC, 2011c).

Besides the State Council's policies, local authorities have also produced policies to promote ageing in place locally, including the 'Opinions on promoting old-age programmes in Shandong Province' (SdPG, 2009); 'Opinions on promoting old-age programmes in Jiangsu Province' (JsPG, 2009); 'Announcement on regulating

---

[1] State Council is China's cabinet.

ageing in place services in Shanghai City' (SMG, 2009); 'Opinions on promoting old-age programmes in Nanjing City' (JsPG, 2010). The State Council encourages local authorities to initiate pilot schemes to identify the best way to promote ageing in place appropriate for local conditions. Thus far four main patterns have emerged, each of which is described below: the Shanghai, Nanjing, Dalian and Ningbo patterns.

Shanghai pattern

Shanghai is one of the first cities to encounter population ageing. Through pilot schemes, exploration and generalisation, Shanghai has accumulated abundant experience of how home and community based care support can be provided. The most typical feature of the Shanghai pattern is government contracting-out, in which local authorities contract with senior service centres (non-for profit enterprises) to provide ageing in place support for older people (Zhang, 2013). Specifically:

1) From 2004, Shanghai began to build facilities for older people, including daycare centres, meal help centres and senior service centres.

2) Shanghai also established scientific eldercare assessment criteria, which consider the living environment, physical condition, ADL (activities of daily living) and IADL (instrumental activities of daily living) ability (Katz, 1983), emotional competence and cognitive competence. The Shanghai pattern also divides older people into different categories: those with financial difficulties, those aged over 100, those aged 80 to 100, etc. According to the level of need, Shanghai pays a subsidy towards the cost of eldercare for older people of between 100 and 250 CNY[2] per month.

3) Local authorities (district-level governments) contract with senior service

---

[2] CNY means the Chinese currency: Yuan. 1 GBP equals about 8.9 CNY.

centres to provide eldercare within communities. Older people can apply to these centres for eldercare service; a professional, third-party evaluator will assess their condition and issue them with an appropriate number of eldercare vouchers. With these, older people can obtain services from a senior service centre (which reclaims their cost from the local social relief management office).

4) Eldercare services include domestic housework, meals, help with dressing and mobility and some basic medical services.

5) Shanghai encourages unemployed people within the community and those in the 'rural surplus labour force' to accept training and join teams of care workers. There are 22 institutions permitted to provide such eldercare service training (Zhang, 2013).

In 2013, in Shanghai, there were 340 daily-care centres supporting 12,000 older people (an increase of 9.1% from 2012) and 230 support centres for older people in communities, supporting 282,000 residents (an increase of 3.7% from 2012). Also in 2013, there were 6,227 senior centres, and 533 meal-help centres for older people providing service for 60,000 residents (Table 2-1). All these centres provide services intended to help older people live a better life. However, older people do not only receive service from others, they also provide services for society. By the end of 2013, there were 4,559 older-people's voluntary teams within communities in Shanghai, in which 193,500 older people were participants. Older people aged 60-75 had become an important force in the provision of eldercare services for the oldest-old people.

Table 2- 1 Number of old-age service centres in communities in Shanghai, 2013

Type	Number
Daily care centres	340
Senior service centres	230
Senior centres	6227
Meal-help centres	533

Source: Shanghai Research Centre on Ageing (2013)

Besides nursing homes and service centres within communities, there are other various eldercare institutions and services for older people, such as older people's universities, senior clubs, and so on. Senior clubs are very popular among older people, as they provide various services, including opportunities to freely chat, dance, paint, play cards, and so on. Besides, there was a foundation for older people in Shanghai. This foundation has cooperated with enterprises, the People's Liberation Army and governments to raise money to provide financial support and various services for older people. The expenditure was 97.72 million CNY in 2013 (Table 2-2).

Table 2- 2 Older people's service institutions in Shanghai, 2013

	Number
Shanghai Foundation on Ageing	1
Colleges for older people	72
Older-people's associations	1,702
Older-people's clubs	23,367

Source: Shanghai Research Centre on Ageing (2013)

Nanjing pattern

Gulou is a district within Nanjing in which 90% of older people indicated that they did not want to be looked after in nursing homes. Gulou District consequently began to establish an ageing in place network. As in the Shanghai pattern, the most typical feature of the Nanjing Gulou pattern is government contracting-out of eldercare services. The Gulou District government contracts its eldercare service project to the 'Heart to Heart' Service Centre. Care workers in the Heart to Heart Service Centre provide free eldercare services, including housework, regular visits and security assurance[3], to the oldest-old people, older people living alone and those who have financial difficulties. The eldercare service provided can be up to 20 hours a month. Care workers are usually people living in the communities and those who were previously unemployed. Zhang found there were 300 care workers in Gulou District, of whom 90% had an eldercare service qualification certificate.

---

[3] Security assurance means personal and property safety.

The service was supervised by the Gulou District government, neighbourhood committee, older-people's associations and a third-party evaluator (Zhang, 2013).

Dalian pattern

In 2002, Dalian Shanhekou District proposed a new ageing in place initiative called the virtual nursing home. In this, each person needing eldercare has a care worker who is a community member. The person needing care and the care worker make a (nursing) care contract and the care worker attends to them at home in order to provide the services they need. Some communities also cooperate with on-site nursing homes, for example for training care workers in care skills, knowledge of common diseases and first-aid.

Shahekou District has developed an eldercare management system. To deal with home care issues, the Civil Affairs Bureau in the district established an office, the sub-district established a home-care centre and the neighbourhood committee established a home-care station to collect older people's opinions and information. Community health centres maintain health records for the residents. In terms of funding, local authorities are the main sponsors, although some charities and companies also make donations to support home care (although the amount raised from this revenue stream is quite small). Shahekou District runs welfare lotteries twice a year in order to raise additional funds. One innovation of the Dalian pattern is that it encourages older people to obtain eldercare services at their own expense. Eldercare fees range from 300 to 1300 CNY per person per month. Depending on the older person's financial circumstances and eldercare needs, local authorities allocate different levels of subsidy to them, ranging from 100 to 300 CNY pppm[4]. The old-age office and some local residents are responsible for supervising the home care service (Zhang, 2013).

---

[4] The term 'pppm' means per person per month.

Ningbo pattern

Like the other three patterns, Ningbo Haishu District government provides eldercare for the oldest-old people, older people living alone and older people with financial difficulties. The local authority contracts its home care projects to the Xingguang Old-people's Association. This organisation distributes funds to communities in Haishu District two months in advance. When care workers have already provided homecare services for the older people, they can come to the community and get paid. A specific feature of the Ningbo pattern is that the Old People's Association has established a time bank for volunteers. Volunteers' time spent assisting older people is recorded in the time bank. When the volunteers themselves need eldercare services in the future, they are entitled to the same amount of free services. Haishu District also encourages companies and individuals to provide financial support to older people (Zhang, 2013).

Comparison of the four patterns

Promoting ageing in place involves cooperation between governments, markets, third sector organisations, families and older people. The *Marriage Act* (2009) and *Older People Protection Act* (2012) state that family members have a legal obligation to look after their aged parents. The Confucian filial piety culture, which advocates a virtue of respect for elders, both in and outside the home, also requires family members to fulfil their moral obligation to take care of their aged parents. However, with rapid ageing, urbanisation, industrialisation, and population mobility, eldercare can no longer be considered as a totally personal or family affair. Rather, the time has come for a system that involves cooperation between different sectors and actors (Liu & He, 2015).

The four care patterns for older people identified and discussed in China show that the relationship among governments, enterprises and families in care provision are cooperative, complementary and mutually beneficial rather than competitive (Dang

et al., 2009; Ding, 2013). Comparing the four care patterns, we find that local authorities play a key role in eldercare services. Local authorities are the managers, supervisors and sponsors. In addition, to guarantee the quality and efficiency of eldercare service, the importance of a third-party evaluator is emphasised. Finally, various innovative practices can be seen, such as the use of eldercare service vouchers, time banks and virtual nursing homes (Table 2-3).

Table 2- 3 Comparison of the four home-and-community-based care patterns

	Shanghai Pattern	Nanjing pattern	Dalian pattern	Ningbo pattern
Core feature	Government contracting-out	Home-care service network	Virtual nursing home	Time bank
Organizing structure	District, sub-district and community cooperate with each other	Population ageing office takes responsibility of the home-care issue	District, sub-district and neighbourhood committee cooperate with each other.	Home-care leading group takes responsibility of home-care issue.
Operating mechanism	Government contracting-out, eldercare service vouchers	Government contracting out, home-care project	Eldercare service contract between older people and care workers	Government contracting-out, Xingguang Old-people Association
Funding source	Governments, welfare lottery	Governments	Governments, donation	Governments, donation
Supervisory mechanism	Supervised by home-care service assessment firm and home-care service centre	Supervised by district, sub-district, community and a third-party evaluator	Supervised by old-people committee and some volunteers	Supervised by Xingguang Old-people association and communities

Source: Comparison of typical home-and-community-based care patterns in China (Zhang, 2013)

2.5 Summary

The chapter has critically reviewed existing literature on ageing research, policy and practice. It has shown that ageing is a dynamic process in which both personal characteristics and social factors are important, with great diversity among older people. The 'pathological', 'normal' and 'successful' ageing approaches, all of which adopt dichotomous views and classified older people in terms of pathological versus non-pathological ageing, normal versus abnormal ageing or successful

versus unsuccessful ageing, to a large degree fail to capture the dynamics of the ageing process and heterogeneity and diversity among older people. These extant approaches also paid scant attention to older people's personal ageing experience and perspectives, how these are embedded in the broader social contexts and how they have impacted the later life of ageing individuals. Thus, the literature review identifies the gap that this study will address.

It has also showned that the notion of wellbeing, with its person-centred, locally grounded and multifaceted perspective, can be used by this study to gain a deeper understanding of the research problem. Wellbeing, rather than merely concern with economics or the physiologically aged body, is identified as an appropriate approach to understanding older people's ageing in place experiences.

In policy and practice, the review of the literature reveals that the majority of older people prefer to age in situ, i.e., to stay at home in later life. Ageing in place is usually considered as being good for the wellbeing of older people. Various home and community based services have been developed to support older people to successfully age in place in many countries, including China. The review of the Chinese literature demonstrates that ageing in place has been promoted by Chinese central and local governments to tackle the challenges thrown up by an increasingly ageing society over the last decades. Four patterns (Shanghai, Nanjing, Dalian, Ningbo) involving cooperation and partnerships between multiple stakeholders in the design, implementation, delivery and monitoring of ageing in place policies and initiatives have been identified.

However, despite these recent developments, the critical review of both the English and Chinese literature showed that the voices and perspectives of older people themselves on ageing and old age are scarcely represented. Further, much of the current discussion tends to be confined to empirical studies, with limited attempts to theorise the ageing in place experiences. The literature review thus reveals the importance of understanding the ways in which ageing in place, at the level of both the individual and the wider environment, impacts wellbeing of older people, and how older people adapt to changes over time both to themselves and their

surroundings. Yet, little is known about this in China. The present study thus focuses on the complex relations between older people, place, time and wellbeing. In particular, it focuses on one group of older people: the oldest old people with eldercare needs.

Chapter 3   Wellbeing in Time and Place: An Integrated Conceptual Framework

3.1 Introduction

As mentioned in chapter 2, the wellbeing of older people in urban China is the major focus of this study. Little is known, however, about their experiences of, and perspectives on, wellbeing, especially in relation to China's particular historical, cultural and spatial contexts, which are salient contributing factors for wellbeing in later life. To understand the experiences and meanings of wellbeing, for and by the oldest-old people themselves, in the context of the wider environment and institutional and societal change, the study adopts a conceptual framework that combines a relational understanding of wellbeing, a theory of place and a life course perspective. The study emphasises intersections of place, time and meaning in personal wellbeing in later life.

This chapter is structured as follows. First, it traces the development of approaches to wellbeing analysis, from which I identify that the relational approach is suitable for analysing the oldest-old people's experiences of and perspectives on wellbeing in later life. It then considers the strengths and weaknesses of the relational wellbeing framework, which sees wellbeing as a dynamic process. While recognising its important contribution, the chapter argues that a life course perspective and a theory of place are also needed, and offer a useful complement to understandings of wellbeing as a process. The chapter then considers the complex nature and different dimensions of wellbeing in the relational wellbeing framework and goes on to explain, in detail, the relevance of a life course perspective and theory of place for understanding wellbeing in later life.

3.2 The framework of relational wellbeing

The relational approach to wellbeing that emerges in the early 21st century acknowledges the multifaceted and contingent nature and domains of wellbeing (Sointu, 2005). While acknowledging the importance of material resources and individual agency in wellbeing, the relational approach nevertheless argues that wellbeing should be treated not simply as about higher living standards, material satisfaction or individual agency and self-construction. Instead, understandings of wellbeing require 'analyses within both local and broader contexts as well as how individuals and communities construe and apply it to individual decisions and choices' (La Placa & Knight, 2017: 2). It emphasises the importance of multiple collective and cultural institutions and exchanges, human relations, social interaction, interdependence and personal interpretation in wellbeing analyses (Jordan, 2008; La Placa & Knight, 2017; Sointu, 2005).

A key definition of wellbeing within the relational approach is provided by Sarah C. White. Considering the idea that people understand wellbeing in quite different ways in different contexts, White (2010) conceptualises wellbeing as 'doing well – feeling good' and 'doing good – feeling well'. According to her, 'doing well – feeling good' captures the dual aspect of wellbeing: the material dimension of welfare and living standards and the subjective dimension of personal perceptions, feelings and emotions, while 'doing good – feeling well' reflects the fact that 'wellbeing is not simply about the good life, but about living a good life' (White, 2010: 160). This means that wellbeing is not simply individual interpretation, but arises from daily practice embedded in broader social and cultural contexts, and is closely linked to relationships with others. Feeling well is not simply about good health, but also involves a moral sense about satisfaction with one's place in the world.

Wellbeing is a person-centred, locally grounded and multifaceted conception (Atkinson, 2013). However, existing research on the topic still centres on the

identification and theorisation of independent components or determinants of wellbeing, or what has been called a 'components approach' to wellbeing (Atkinson et al., 2012; Atkinson & Joyce, 2011). The 'components approach' sees wellbeing as the desired outcome, and influenced by different determinants and a quality inherent to the individual (Allin & Hand, 2014; Diener et al., 2009; McGillivray & Clarke, 2006). Contrasted with the components approach, the relational approach argues that wellbeing should not simply be treated as an endpoint or outcome that some older people have that others do not, but as a complex and dynamic process embedded in specific temporal, spatial and cultural contexts and experienced and perceived differentially by different individuals (Atkinson et al., 2012; White, 2010). Conceptually integrating various categories and dimensions, this approach argues for a relational and situated account of wellbeing (Atkinson, 2013). White's framework (2010) shows the complex and multifaceted nature of wellbeing, and its dynamic process (Figure 3-1). It identifies three key dimensions of wellbeing: the material, the subjective and the relational; this points towards the inter-relationship and co-constitution of the three dimensions and indicates the importance of time and place in the process of wellbeing. These are explained in detail in later sections in this chapter.

Figure 3- 1 Wellbeing as process

Source: (White, 2010)

38
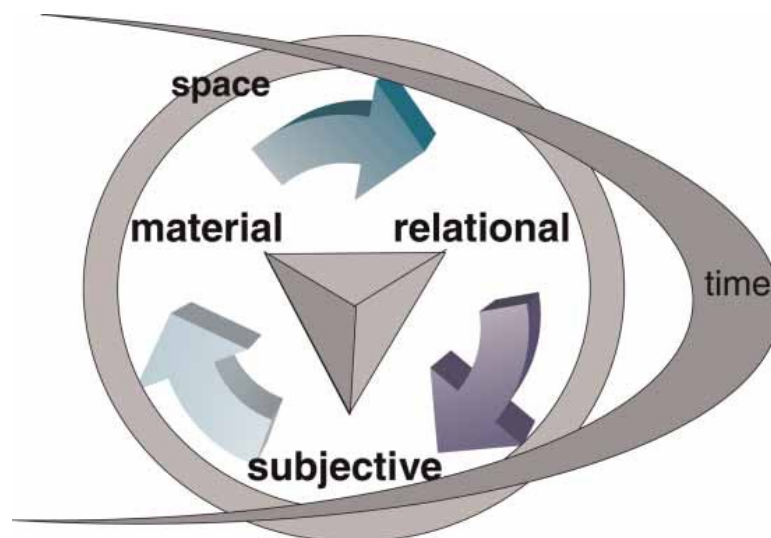
A key strength of the relational framework for this study is that it allows for a person-centred approach, and places the oldest-old people at the centre of the analysis. The oldest-old people generally have a nuanced and realistic perspective on the conditions and decisions they face (Tinker et al., 2012); they are experts on their own life, so their opinions must be listened to and respected. Rather than simply treating the oldest-old people as research objects, the relational approach allows them to actively engage in the research process, highlighting their real-world experiences, perspectives and feelings, enabling the researcher to generate rich and reliable data and develop rich local knowledge. This differentiates it from the components approach, which tends to adopt quantitative questionnaire research methods (Atkinson, 2013) and thus classifies research participants' status and feelings into different categories, such as 'feeling good', 'feeling so-so', 'feeling bad'.

Assumptions should not be made about what the oldest-old people think or feel. Much literature has emphasised the advantages of ageing in place, especially its economic benefits of cost efficiencies (Dobner et al., 2016; Sixsmith & Sixsmith, 2008). Ageing in place is usually thought to be good for older people's wellbeing (Wiles et al., 2009). Concerns with ageing in place usually centre on older people's physical ability to maintain independence and autonomy and stay at home as long as possible (Wiles et al., 2012). However, older people are not a homogeneous, but a heterogeneous category (Dannefer, 2003). The oldest-old people may face the risk of being 'stuck' in place, rather than feeling well when ageing in place (Oswald et al., 2010; Oswald et al., 2007; Weil & Smith, 2016). By adopting a person-centred approach, enabled by the relational framework, my study makes no assumptions about the ageing experiences of the oldest-old people, or their perspectives and feelings. Instead, as one of the few empirical studies on Chinese older people's later life, it tries to uncover Chinese oldest-old people's wellbeing and ageing in place experiences in their specific economic and socio-cultural context, which is examined in detail in chapters 5, 6 and 7.

Another strength of the relational framework is that it enables a comparatively broad understanding of wellbeing. The relational framework, because of its all-embracing character, provides a conceptual unifier across different domains, categories and dimensions, rather than the tight and measurable definition of wellbeing, which largely limits the potential of the concept in enabling debate and flexibility in practice and research (Atkinson, 2013; White, 2010). Thinking of wellbeing as a process, the relational framework is a powerful tool for analysing the interrelationships and interplay between different wellbeing dimensions. It is much more effective than approaches that separate material wellbeing, subjective wellbeing and health status (Atkinson, 2013). Furthermore, the notion of wellbeing as a process serves to identify multiple possible factors, from the microbiologic to the environmental levels, to enhance the chances for wellbeing (Antonucci et al., 2013). Much research understands ageing and wellbeing at an individual scale. The value of viewing wellbeing in a broader historical, social, economic, cultural and spatial context is underscored. The relational framework is thus useful for identifying and including broader social factors into our understanding of the wellbeing of the oldest-old people.

Although the relational framework provides a useful conceptual framework for understanding the oldest-old people's wellbeing and their experience of ageing in place, it has several limitations. First, time and space dimensions are limited to the level of abstract meanings. Although the relational framework emphasises the importance of the temporal and spatial context in wellbeing, it does not specify what aspects of time and place influence personal wellbeing. Secondly, the relational framework has not clearly defined or explained the dynamic interplay between people, time and place and how this influences the various dimensions of wellbeing and wellbeing as a whole.

A life course perspective and a theory of place can serve as a means through which to bolster the relational framework. Both the life course perspective and the relational framework emphasise several important factors: 'temporality' – that 'the

timing of lives impacts the plasticity of human development' (Moore, 2014: 193); 'human agency' – that human actions are purposeful and may change according to specific time and specific place; and 'social contexts' – cultural frames, institutional and structural conditions, and so on (Satariano, 2005). Through its concepts and propositions regarding changes in human lives across life domains (such as education, work, family) (Mayer, 2004), a life course perspective can suggest specific dimensions on which to characterise the wellbeing processes of the oldest-old people.

Wellbeing processes are embedded in places, which embody both physical-spatial and social-cultural dimensions (Florida et al., 2011; Joseph & Chalmers, 1995; Wiles, 2005). The theory of place, which explores how place and space influence people's wellbeing (Rowles, 1983; Wiles, 2005) is useful in describing and explaining the complex relationships between personal wellbeing and meaningful environment. The concepts most widely adopted in theory of place analyses are place attachment, sense of place and place identity (Cutchin, 2003). Perspectives based on these place concepts emphasise sociality, meanings and context. In this sense, the theory of place aligns well with the relational framework.

Places are dynamic and show both changes and stability over time, as people age (Buttimer & Seamon, 2015; Golant, 2003). The relationships between personal wellbeing and meaningful environment can be altered by physical and social changes of the place, by the oldest-old people's consciousness of the life world, by how the oldest-old people experience the self, and by how they individually interpret cultural meanings and the importance of place in later life (Moore, 2014). The theory of place is thus also congruent with the life course perspective.

By combining the relational framework, the life course perspective and the theory of place, my aim in this study is: to explore the experiences and meanings of wellbeing for and by the oldest-old people themselves; to understand their ways of attaining and sustaining wellbeing in later life; to examine how their welfare and

wellbeing have reflected and been shaped by wider institutional and societal change over time and how they are associated with a particular place; and to identify lessons and experiences in order to improve eldercare service planning and development in urban China.

3.3 The three dimensions of wellbeing

As stated above, three key dimensions: the material, the subjective and the relational are identified and emphasised in the relational framework. The three dimensions of wellbeing relate to one another and cannot exist independently (White, 2010). When discussing different dimensions of wellbeing, it is important not to neglect their interdependence and unity. The three dimensions also suggest how wellbeing emerges in the interplay of the objective and the subjective (White, 2010). When analysing wellbeing of the oldest-old people, it is important not to divorce subjective from objective.

3.3.1 The material aspect of wellbeing

The material aspect of wellbeing comprises wealth, welfare, standards of living and levels of consumption (White, 2010). There is widespread agreement that material resources have a positive effect on older people's wellbeing (Lloyd-Sherlock et al., 2012). Considering that older people usually rely on fixed income/pensions after retirement, research on material wellbeing tends to focus on these rather than on other aspects of material resources (Kim et al., 2012). However, some scholars argue that, besides personal wealth, the availability of social welfare, especially medical and care support, is also strongly associated with wellbeing in later life (Bonifas et al., 2014; Choi et al., 2017; Francesca et al., 2011; Goh et al., 2013; Kim et al., 2010; Tang & Lou, 2010; Tang & Pickard, 2008). Older people also have different spending patterns and living standards, for example, older people

with care needs may emphasise the importance of basic needs and spend much more on health care, whereas those with good mobility may pursue a higher standard of living and spend much more on leisure and hobby activities (Kim et al., 2012). Thus, it is important to conceptualise material wellbeing in a variety of ways, rather than simply focusing on personal wealth.

The material aspect of wellbeing pays attention to the entitlement of leading a decent life. The emphasis is on access to food, clothes, transportation, housing, medical services, material goods, etc. (Nordbakke & Schwanen, 2014). This raises an important question: Is wellbeing an expensive gift that only belongs to rich older people? Or is it possible for poor older people to achieve wellbeing in later life? These questions direct us to a more complex understanding of the relationship between material resources and wellbeing.

According to the relational framework, objective measures such as income and living standards may not fully explain the relationships between material resources and wellbeing for the oldest-old people. The subjective side of the material also matters (Kim et al., 2012); it concerns the oldest-old people's personal perceptions and self-assessment of their economic position, such as satisfaction with income and welfare, their assessments of living standards compared with others, and of present living standards compared with past (White, 2010). For the oldest-old people, perceptions and assessment of the material are strongly associated with self-rated health and potential risks of disease and mortality (Andrews, 2001; Bryant et al., 2001; Houston et al., 1998; John, 2012; Oswald et al., 2007). The same level of income may be perceived as sufficient for the healthy oldest-old people, but result in financial difficulty for those with high-level care needs (Kim et al., 2012). Inclusion of the subjective side of the material helps to improve our understanding of the material/wellbeing relationship.

Material wellbeing is contextual and nested in specific cultural values (White, 2010). First, material wants reflect and are shaped by 'wider ethical and

metaphysical ideas which derive from larger cultural norms' (Appadurai, 2004: 67). Based on this opinion, the specific material wants which the oldest-old people identified and sought to pursue are largely influenced by larger cultural and social norms and higher order normative contexts, which may not be expressed, but which structure the oldest-old people's particular wants through local ideas and beliefs (White, 2010). Secondly, national labour markets and sectoral differences in the organisation of work are seen to have an impact on personal career development, job opportunities, earning trajectories, pensions and welfare (Mayer, 2004), physical and psychological health (Kohn et al., 1997) and access to health care as people age (Marmot et al., 1998). The influence may accumulate and cause great diversity in material wellbeing in later life (Dannefer, 2003). Thirdly, societal contexts account for the oldest-old people's personal perceptions and self-assessment of their economic position (Atkinson & Joyce, 2011). Thus, to explore the oldest-old people's material wellbeing, we must take into consideration the specific social, cultural and historical contexts.

3.3.2 The relational aspect of wellbeing

The relational aspect mainly comprises social networks, personal relationships and access to public goods and social support (White, 2010). The major concern of the relational is the connection between the self and significant others, along with their influence on personal wellbeing. It is widely acknowledged that significant others play an important role in enabling the social connections and supports that are crucial for achieving wellbeing in later life (Barrera, 1986; Bernard et al., 2002; Chan & Lee, 2006; Gottlieb & Bergen, 2010; Hajli, 2014; Krause et al., 1992; Pengilly & Dowd, 2000; Taylor et al., 2004). Significant others also 'have the potential to shape the contours of the self' (Conradson, 2005: 340). This differs from others perspectives and approaches, which argue that relationships and networks are exterior to a person and are something that the person 'has'; the relational approach calls for a more nuanced view of relationships and networks. It

argues that relationships are constitutive of the person; that the person constructs his/her identities and selfhood in and through relatedness to, and material encounters with, significant others (White, 2010). In other words, the person 'has the capacity to internalize their experiences, in a sense folding particular events into their selves, so that even short-lived relational encounters may resonate and have effects beyond their immediate occurrence' (Conradson, 2005: 340).

In line with this view, in this study I consider that the oldest-old people's social networks and social relationships having at least two functions for their everyday life and wellbeing in very old age: first, the networks and relationships provide opportunities for them to achieve social support from significant others when in need; secondly, they help to form part of their selfhood and shape their self-images, daily encounters and life experiences. To understand this, it is necessary and important to explore subjective dimensions of the relational for the oldest-old people, including their perceptions and views on networks and relationships, how satisfied they are with their access to public goods and social support, what they think of the way they are treated, and so on.

It is also important not to forget the significance of social structure and power relations. Both relations of love and care and wider networks of support and obligation are closely related to power relations (White, 2010). According to White (2010), relationships of love and care are not independent of power, but have hierarchical characteristics. Thus, to explore relationships between social relations and personal wellbeing, it is necessary to explore power relations within the oldest-old people's daily practice.

3.3.3 The subjective aspect of wellbeing

Subjective wellbeing has its roots in classic research on psychological wellbeing. It is also referred to simply as happiness (Bradburn, 1969; Diener, 1984; Dodge et al., 2012; Kahneman et al., 1999; Lyubomirsky & Lepper, 1999; Ryff, 1989). As

early as the late 1960s, scholars tried exploring the mechanisms underlying people's psychological wellbeing or happiness. For example, Bradburn (1969) focused on the psychological reactions people exhibit when faced with day-to-day difficulties. In doing so, he highlighted the importance of positive effects and low negative effects in achieving psychological wellbeing or happiness in daily lives. Since then, subjective wellbeing or happiness has attracted much attention and been considered of primary importance. Some scholars even argue that happiness is the overreaching goal of all human actions. An economic approach to wellbeing as happiness argues that happiness is what people want to maximise in their lives; it is happiness that drives people's decision making choices (Graham, 2005; Layard, 2011). There is rapidly increasing research exploring the determinants of subjective wellbeing or happiness. These include earning capacity (De Neve & Oswald, 2012; Robertson & Cooper, 2010); health status (Bryant et al., 2001; Cattan et al., 2005; Cornwell & Waite, 2009; Thoits, 2010), positive relationships with others (Ryff, 1989), purpose in life (Diener & Suh, 1997; Seligman, 2002), and so on.

Rather than seeing subjective wellbeing or happiness as an endpoint or outcome of external factors or determinants, an equally rapidly increasing body of research tends to treat subjective wellbeing or happiness as 'internal and amendable to self-management' (Atkinson, 2013). In these studies, subjective wellbeing or happiness is not an endpoint or outcome, but an internal control process. The emphasis is on the role of personal action and personal responsibility on improving happiness or subjective wellbeing in one's life. Subjective wellbeing , or happiness as 'a self-directed approach' has become more dominant in   the wellbeing literature (Atkinson, 2013). Many scholars argue that, if people are able to achieve and foster the necessary qualities, such as optimism, engagement, resilience, and so on, they would have more positive experiences and live a better life (Cohn et al., 2009; Seligman, 2002).

In line with this view, a status of 'illbeing' can be positioned as a personal failure and a failure of responsible citizenship. Social inequality can be dismissed by

'blaming the victim' (Atkinson, 2013). Worse, an exclusive focus on subjective wellbeing or happiness as internal control may point to an important problem, as White (2010) points out:

> *If 'subjective wellbeing' is allowed to float free from other dimensions, it could validate a withdrawal of material support in the form of state-sponsored welfare or aid programmes, on the grounds that those who suffer material poverty may rate their quality of life as highly as those who have much more – a new variation on the 'poor but happy' theme. If the World Values Survey finds people in Bangladesh to be 'happier' than many in much wealthier countries, does this undermine the case for international aid? (White, 2010: 166).*

An emerging literature is beginning to challenge the internalised and universalised presentation of subjective wellbeing or happiness. For example, Ahmed (2010), a cultural theorist, argues that happiness is not simply internal and amendable to self-management, but is pre-defined within specific societies and cultures. In his opinion, our acquisition of personal subjective wellbeing and relevant elements is largely directed by normative values within specific social and spatial contexts, rather than any internal and decontextualized notion of happiness.

Bearing in mind the pros and cons of these academic studies, in my study on ageing, old age and wellbeing in urban China I will show that subjective wellbeing is more than an outcome of external factors or of self-controlled experiential happiness; rather, it is a dynamic process embedded in specific social, cultural and spatial contexts and closely related to other dimensions and factors. To understand the oldest-old people's subjective aspect of wellbeing, it is necessary to cover their cultural values, life beliefs and perceptions of their material positions, social relations and daily encounters. This more nuanced conceptualisation of wellbeing has guided my study throughout, including, as we will see in Chapters 4 to 7, in the research design, data collection and data analysis stages.

3.4 Time: the influence of the life course on wellbeing in later life

As stated above, wellbeing is not simply a possibly desirable endpoint but a dynamic process. The understanding of wellbeing as a process inevitably relates to the dimension of time. Time is a central element in understanding how the oldest-old people experience wellbeing and ageing in place processes in their own lives. As mentioned in section 3.2, the study highlights the need to think in terms of the life course, which allows factors of temporality, human agency and social contexts to be included in understanding the oldest-old people's wellbeing in later life. The focus is on how the oldest-old people have dealt with changes that happened in earlier life stages and how these changes influenced their levels of wellbeing in later life (Headey & Wearing, 1992). It also considers when necessary the influence of aspirations for the future and that of comparisons with others or a certain reference group in contemporary society.

3.4.1 Life events, historical times and wellbeing in later life

One major concern of the life course perspective is how earlier conditions and events affect trajectories and outcomes in middle or later life (Mayer, 2004). Rather than simply emphasising current needs and current resources, the life course perspective emphasises earlier life events and experiences as important elements in any explanation (O'Rand, 1996). A life event is defined as 'a significant occurrence involving a relatively abrupt change that may produce serious and long-lasting impact' (Hutchison, 2010: 15). There are actually few studies exploring the effects of life events and initial conditions on wellbeing in later life. One early exception is Holmes and Rahe's research on the degree of adjustment required for different life events. Their research shows that the events that need a high degree of adjustment include death of a spouse, divorce, detention, death of a close family member, serious injury or illness, and so on. (Holmes & Rahe, 1967). Peacock &

Kitson (1999) explored the impact of early familial disruption on subjective wellbeing in later life. Crystal and Shea (1990) highlight income, education and health in earlier life stage as factors centrally affecting wellbeing in later life. Epidemiological studies give fresh attention to the impact that biological and social factors early in life course have on health in adulthood and older age (Ferraro & Kelley-Moore, 2003).

Most research focuses on harmful life events and their negative influence on wellbeing in later life. This study argues that it is important and necessary to distinguish between positive and negative life events and to examine their differing influence on wellbeing in later life. Although some researchers are beginning to do this work, few focus on old age and ageing. Besides, specific life events may have quite different meanings for and impacts on different individuals. The study argues that it is vital to consider the individual differences when discussing the influence of critical life events on wellbeing in later life.

However, specific life events and individual characteristics by themselves are not enough to explain levels of wellbeing in later life, especially when dramatic social changes have occurred and great variability is found among peers of a similar age in society. The role of historical times, social changes, cohort location and other social dimensions as forces that impact the oldest-old people's material, subjective and relational aspects of wellbeing over their life course and, at the cultural level, shape their life beliefs and values, should also be emphasised. The life course perspective could be useful in understanding the complex relations between individual lives, social structures and social changes. This perspective emphasises the importance of historical conditions and social changes for understanding individual lives (Hutchison, 2010; Katz et al., 2011; Locke & Lloyd-Sherlock, 2011). It situates the individual life course in historical time and place, emphasises negotiations between human agency and social structure and seeks to understand how macro social forces, including historical times, social norms and cultural

practices, influence an individual's everyday life (Crystal et al., 2016; Dannefer, 2003; Ferraro & Kelley-Moore, 2003; Hudson, 2016). A typical application of the life course perspective in regard to relationships between historical time and individual lifetime is the research on system rupture and social transition in former socialist countries (Mayer, 2004). Do the sudden social changes and systemic reforms in formal socialist countries change individual lives rapidly? How do former lives extend their influence into the new circumstances? What are the sources for continuity in a rapid changing society? Research by Diewald et al. (2006) on transformation of East Germany finds that previous qualifications, skills, gender and age played the strongest roles in life trajectories after systemic reform; former political capital had big influence on employment mobility (both upward or downward); occupation and family ties were quite stable, despite or because of turbulence.

In order to understand how prior conditions and experiences affect wellbeing in later life, in this study I take into consideration multiple factors, including life events, individual characteristics, historical times, social structures, and so on. There are two different traditional approaches used to examine the multiple factors that shape individual lives. One is the sociological tradition, which focuses on cumulative advantages/disadvantages; the other is the ecological developmental psychology tradition, which emphasises challenges, resources and resilience (Hutchison, 2010). Recently, gerontologists studying the life course have tried to integrate the two traditions. For example, Ferraro et al. (2009) put forward a cumulative inequality theory that acknowledges the increasing exposure to risks for people with disadvantages and the increasing exposure to opportunities for people with advantages. It is important to note that neither tradition thinks 'early deprivations or traumas inevitably lead to a trajectory of failure' (Hutchison, 2010: 32), rather, the power of human agency and the ability to build resilience are emphasised (Elder, 1994; Masten & Reed, 2002; Pangallo et al., 2015). This study draws on ideas from both traditions.

3.4.2 Cumulative advantages/disadvantages

Cumulative advantages and disadvantages refer to the tendency of inter-individual divergence among age peers as they move through the life course (Dannefer, 2003). The original application of the concept is by Merton, who noted that scientists who have established reputations, especially those who are famous, are favoured by the reward system in science; a phenomenon he described as the 'Matthew effect' (Crystal et al., 2016). Crystal (1982) brought the concept into the ageing research area. In work begun in the 1980s, Crystal and Shea (1990) used the terms 'cumulative advantage' and 'cumulative disadvantage' to describe processes by which the effects of early economic, educational and other advantages/disadvantages can accumulate over the life course and lead to highly disparate late-life circumstances, which they described as the "two worlds of aging" phenomenon (Crystal, 1982, 1986; Crystal & Shea, 1990).

The cumulative advantages/disadvantages perspective has been employed in gerontology since the early 1990s to explore factors that affect diversity and inequality in old age. The cumulative influences of three factors - income, education and health - are underlined. Crystal's research shows that income inequality is highest among the oldest age categories (Crystal et al., 2016). Income inequality itself has also been argued to contribute to differentiated health outcomes. Health and health resources in childhood and early adulthood are increasingly seen as shaping health in later life (Ferraro & Kelley-Moore, 2003). Individuals with lower levels of schooling are several times more likely than the well-educated to experience work disability by their 50s, further influencing levels of wellbeing in later life (Crystal & Shea, 2002). Differences in income, health and other dimensions related to wellbeing do not occur suddenly in older age, but are rather the outcome of the long-term and cumulative process of advantages or disadvantages that begin early in life (Crystal et al., 2016; Hudson, 2016). Initial differences and inequality continues and even extends into old age.

A main argument of the accumulative advantages/disadvantages perspective is that

advantages or disadvantages that occur during an earlier stage of life can cumulatively shape the trajectories of both short-term and long-term outcomes (Choi et al., 2017), thus impacting wellbeing in later life. The cumulative advantages/disadvantages perspective does not deny the importance of individual action, but demonstrates the power of structural realities within which human agency must operate (Dannefer, 2003). It argues that diversity and inequality between or within groups is a by-product of the interplay between individuals' cumulative experiences over the life course and the institutional processes that regulate opportunities over time. Heterogeneity in old age, therefore, is not simply a result of the accumulation of life decisions that individuals make, but a by-product of the interconnection between aggregated individual actions and institutional arrangements that stratify available resources and rewards (Crystal et al., 2016; Dannefer, 2003; Hudson, 2016; O'Rand, 1996; Thoits, 2010). As such, the process of increasing diversity and inequality within age peers is anchored in earlier opportunity structures and individual behaviours. The cumulative advantages/disadvantages perspective suggests that the relatively high levels of observed diversity and inequality in old age partly reflect processes of social stratification that operate over the collective life course of each succeeding cohort as it ages (Dannefer & Settersten, 2010). In short, structural and temporal factors interact to produce diversity and inequality over time. To understand the oldest-old people's wellbeing in later life, it is necessary and important to include both structural and temporal factors in the analysis.

3.4.3 Challenges, resources and resilience

This section discusses the ecological developmental psychology approach, which emphasises challenges, resources and resilience. Researchers in this tradition try to identify multidimensional risk factors or challenges at one stage of development that may have lasting influence on lives and wellbeing in later ones (Hutchison, 2010). For example, Cummins (1995, 1998, 2013) examines the strength of a challenge, as well as its influence on the level of subjective wellbeing. Cummins

(1995, 1998) argues that an individual's subjective wellbeing will be stable if no challenges occur; subjective wellbeing will change slightly when the individual experiences mild challenges; subjective wellbeing will fall sharply when the challenge is too strong for the individual to manage. Thus wellbeing is a state of homeostasis or equilibrium that is influenced by prior wellbeing conditions and life events or challenges. Some scholars argue that people need challenges, and that a lack of challenge may lead to stagnation, which will also affect levels of wellbeing (Dodge et al., 2012; Hendry & Kloep, 2002).

Linked to challenges is the interest in factors that enable individuals to adapt successfully to risks and challenges. Many scholars have argued that although individuals' choices are constrained by structural arrangements and cultural practices in a specific context, they are able to construct their life course and wellbeing by using resources, developing skills and building resilience (Dodge et al., 2012; Hutchison et al., 2007; Masten et al., 2004). Resilience is defined as the ability of individuals to bounce back from hardships and adversity (Southwick et al., 2016). The ability to build resilience depends not only on individual personality, like mental toughness and physical capability, but also on available resources, including financial resources, social networks and social support (Mguni et al., 2012). The ability to build resilience and the balance between resources and challenges is considered central to the achievement of personal wellbeing (Dodge et al., 2012). Hendry and Kloep's lifespan model of development reflects their analysis, wherein wellbeing is not a stable state, but fluctuates through a dynamic process of solving challenges. People have differing resources and differing levels of resilience in the face of challenges. If challenges are solved, this will lead to development or successful transitions. If not, this may result in problems when solving future challenges (Hendry & Kloep, 2002). In essence, wellbeing is 'when individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge' (Dodge et al., 2012: 230).

The emphasis on challenges, resources and resilience in the ecological developmental psychology tradition allows for a universal application of the notion of wellbeing. The notion of wellbeing can be applied to all individuals, whether rich or poor, healthy or in poor health, living alone or staying with family, because 'each individual has a unique resource pool which determines whether or not a task an individual meets turns out to be a routine chore, a challenge or a risk' (Hendry & Kloep, 2002: 24). Viewing individuals as decision makers, with choices, preferences and possibilities, highlights the importance of human agency in the developmental process. It also reflects the current emphasis on self-responsibility and self-management in personal wellbeing. By calling upon people to build resilience and balance between resources and challenges, it 'puts the pursuit of wellbeing in the hands of individuals' (Dodge et al., 2012: 231).

For older people, the ability to maintain independence and autonomy to meet challenges or risks in daily lives is emphasised by many gerontology studies. The maintenance of autonomy is considered the key element of successful ageing in place and wellbeing in later life (Cutchin, 2003; Weil & Smith, 2016). The mainstream view of autonomy emphasises self-determination, freedom from interference by others and independence, which is defined in terms of physical function and capacity for self-care (Perkins et al., 2012). However, individual lives cannot be understood in isolation from the other. In context of ageing, chronic illness, and disability, some scholars have challenged this perspective for being too abstract and creating unrealistic expectations for some older people, especially the oldest-old people, when it comes to individual independence (Custers et al., 2012; Perkins et al., 2012). However, the linked nature of lives that it discusses calls for a relational understanding of autonomy and later life that acknowledges issues of dependency, interdependence, and care relationships.

3.4.4 Linked lives

The life course perspective acknowledges the reality of linked lives and emphasises the great influence of social ties and social relationships on individual lives

(Dannefer & Settersten, 2010a). In the extant literature, particular attention has been paid to familial relationships (Elder et al., 2015; Hutchison, 2010). It is argued that family members' lives are linked together, with opportunities and misfortune having an intergenerational impact (Hutchison, 2010). Adult children's personal problems, as well as opportunities and good fortune, may affect their parents' short-term or even long-term wellbeing (Elder, 1994; Elder & Liker, 1982; Elder et al., 2015). Children's life trajectories may be largely influenced by family resources, including economic resources, social capital, parenting styles, etc. (Barajas et al., 2008; Conger & Conger, 2008; Hutchison, 2010). Critical life events and role changes in one generation usually have consequences for other generations (Elder et al., 2015; Elder & Liker, 1982).

Family relationships are powerful influences on life course trajectories and outcomes. However, linkages that are less obvious but no less important also exist. Some research explores linkages beyond the family. For example, Daalman and Elder (2007) explore how life-course constraints and opportunities for physicians frame how people who face illness make health care choices and plans. Newman and Fox (2009) and Scherger and Savage (2010) examine how the education system influences individual and family trajectories. Dannefer (2003) points out that lives are linked globally in the age of globalisation.

The notion of linked lives draws attention not only to the scope but also to the complex nature of relationships and linkages. Hutchison (2010) argues that through expectations, rewards and punishments, relationships both support and control individual behaviours. Elder argues that the interdependence of human lives is expressed across 'the life cycle of socialization, behavioral exchange and generational succession' (1994: 6). Dannefer & Daub emphases the importance of integrating the 'fundamental relational issues of power and influence, equity and fairness' into the analysis (2009: 22). This body of research offers valuable ways of thinking about the social patterning and linked lives within which the oldest-old people's experiences and perspectives of wellbeing are embedded.

3.5 Place and wellbeing

As mentioned in section 3.2, a theory of place may be a necessary and useful complement to the relational wellbeing framework. Place, as a general concept, goes beyond the concept of environment because it involves and implies meanings of human experience (Moore, 2014). Taking into consideration both physical and social aspects of place, a theory of place could be useful in describing and explaining the complex relationship between personal wellbeing and meaningful environment. In the study, I highlight the importance of thinking about wellbeing geographically, explore relationships between personal experiences, place and wellbeing and emphasise the intersection of place, time, meaning and wellbeing.

3.5.1 Thinking about wellbeing geographically

Wellbeing cannot be understood as independent of geographical context and culture (Nordbakke & Schwanen, 2014). The importance of geographical context or place in achieving wellbeing is widely acknowledged in existing literature. A significant approach that explores relations between place and wellbeing is the environment approach. This approach emphasises the physical or material aspect of place, such as clean air and water, low levels of noise and risk (and so on) in meeting human needs and sustaining wellbeing (Fleuret & Atkinson, 2007). Lawton's person-environment fit paradigm, developed in the 1980s, was an influential starting point for discussing the relationships between physical environment and individual wellbeing. Lawton (1982) emphasises the role of the interaction between personal competence and the physical environment in older people's wellbeing. Both the physical environment and personal competence are important dimensions of wellbeing. Lawton also distinguished between environmental docility and environmental proactivity, arguing that the environment not only provides demands and limits to individuals, but also enables environment supplies or richness that could reinforce personal control over the physical environment (Edwards et al., 1998; Lawton, 1990; Lawton et al., 1997).

From the 1980s on, there has been more and more research emphasising the importance of the physical or material environment in achieving personal wellbeing. For example, Bronfenbrenner (1977, 1979, 1994) offers an analysis of the layers of environment in his Ecological Systems Theory. He suggested that individual action and human development occurs within an ecology of four nested systems: the micro system, the mesosystem, the exosystem and the macrosystem (Bronfenbrenner, 1977). Later he added the chronosystem to this to encompass environment changes and personal transitions over the life course (Bronfenbrenner, 1979). Rather than exploring the whole environment, some scholars pay attention to specific place/space or physical objects. For example, Beck (2009) highlights the impact of urban green space on health and wellbeing. By adopting a 'new materialist' lens, Chapman (2006) emphasises the role of specific physical objects, especially those that people keep over the course of their lives, in the construction of self and meanings of life.

The second is the identity and attachment approach, which emphasises the social and cultural aspect of place (Cutchin, 2003). A key idea of this approach is that 'older people with good place ties are more likely to feel in control, secure, and have a positive sense of self, and this helps adjustment to the contingencies of ageing and enhancing wellbeing' (Wiles et al., 2009: 665). A strong sense of place is usually achieved through a long-standing and possibly ongoing relationship with a certain place. Long-term emotional attachments to environmental surroundings have also been shown to contribute to wellbeing in old age. Place attachment usually gets stronger as people age (Altman & Low, 1992; Lopez & Brennan, 2000; Rubinstein & Parmelee, 1992; Wiles et al., 2009). Several researchers have shown increasing investment of meaning in objects and places over time (Chapman, 2006). Place attachment is not a state but a process that continues throughout the life course. Past environmental and life experiences can activate and interpret to shape current environmental experiences and people's sense of who they are (Rowles, 1983). Increasingly, place has been shown to have an important impact on

belonging and identity. Older people have been shown to draw meaning and security from the places in which they live (Wiles et al., 2009). A sense of belonging or attachment to place is believed to help maintain a sense of identity, and to facilitate successful adjustments in old age. The influence of place on identity and autonomy increases with age, particularly as life's challenges increase (Rowles, 1983). As people age, they inevitably encounter a decline in functions. People often need to adapt to a changing body, increased need for care or to negotiate an environment which they are familiar with before (Näre et al., 2017). This often leads to a redefining of the self in relation to the external environment and expectations. The ageing experience and self-perceptions of wellbeing are thus to a large extent based on personal adjustments and interactions between interior and external worlds (Altman & Low, 1992; Lopez & Brennan, 2000; Wiles et al., 2009).

The third is the social injustice and social inequality approach, which focus on the spatial and social inequality in access to welfare, consumption of services, standards of living, and so on. (Fleuret & Atkinson, 2007). Employing the concept of 'social exclusion' and 'elective belonging', Phillipson (2007) examines social division in old age. His research points to the division between those who are able to choose locations that satisfy their needs well and those who experience rejection or exclusion from their locality and those who see their local neighbourhood as inconsistent with their needs or identities but are not able to move out. The 'collective resources' and 'local social inequality' frameworks of Stafford and Marmot (2003) explore relationships between health and place. The collective resources model suggests that people living in areas with good collective social and material resources are more likely to enjoy better health; while the local social inequality model suggests that limitations in consumption and a comparison with rich neighbours may offset the benefits of good collective resources for the health of poorer people living in wealthy areas.

The fruitful ideas that these approaches touch upon concerning the relationship between place and wellbeing are used in my study to explore the relevance of place for the oldest-old people living in two communities in Shanghai. At the same time, I acknowledge that, to understand the wellbeing of the oldest-old people in China, where dramatic systemic reform and social change has taken place, it is necessary and important to explore the association between place and wellbeing in the context of urban change, which has not been fully addressed in the existing literature.

3.5.2 Putting place into practice

The section above has indicated the main approaches used when researching relationships between place and wellbeing, and their relevance for my study. However, theoretical thinking about place only enables a general understanding of the effects of place on wellbeing. Attention also needs to be paid to 'more detailed mediating concepts that are more suitable for empirical purposes' (Agnew, 2011: 23). Agnew specifies the meaning of place along three dimensions: location, locale and a sense of place. Location is 'a site in space where an activity or object is located and which relates to other sites or locations because of interaction, movement and diffusion between them'; locale is 'settings where everyday-life activities take place…not just the mere address but the where of social life and environmental transformation'; and the sense of place identifies place as 'a unique community, landscape, and moral order' (Agnew, 2011: 23-24). Agnew's classification indicates varying geographical scope with regard to the concept of place. In empirical studies, the focus is mainly on the home and the surrounding communities.

Home is a 'diffuse and complex condition that integrates memories and images, desires and fears, the past and the present' (Pallasmaa, 1994: 3). Research on the experience and meaning of home indicates that home is of central significance in a person's life, especially for older people (Case, 1996; Cloutier-Fisher & Harvey, 2009; Fänge & Ivanoff, 2009; Moore, 2000). Most older people prefer to stay at

home in later life (Leith, 2006). Given that they spend a considerable amount of time at home, the home environment has the potential to play an extremely important part in health and wellbeing (Sixsmith & Sixsmith, 2008). Rantz et al. (2011) argued that physical features of a home, such as the housing size, heating/cooling and housing design, may affect a person's ability to age at home and their perspectives on wellbeing when ageing at home. In addition to being a geographical location, home is a crucial setting that enables links to others (Moore, 2000). The home allows familial relationships and extra-familial relationships to be constituted, negotiated and reproduced (Wiles, 2012). Home also provides a psychological space of privacy, comfort and safety (Oswald & Wahl, 2005; Williams, 2002). Home is embedded in specific social, cultural and political contexts in which our understanding of home is framed. A particular balance between home and the surroundings is necessary for the maintenance of self-identity and personal wellbeing (Moore, 2000).

As the home is usually the most important place in peoples' lives, it has been the focus of considerable attention. Only recently though has this attention been extended to neighbourhood and community. There is growing recognition that, beyond the home, neighbourhoods and communities are crucial factors in people's ability to stay independently at home and achieve wellbeing in later life (Oswald et al., 2010). Research suggests that the context and quality of neighbourhoods, which are especially crucial for older adults, can greatly affect a person's ability to engage independently in daily life (Beard & Petitot, 2010). A growing paradigm shift emphasises efforts to promote ageing in place, not only by helping ageing individuals and families, but also by addressing and engaging communities (Glass & Plaats, 2013). The provision of a variety of flexible services that use innovative delivery systems will help to meet the changing needs of older people, facilitate ageing in place and promote wellbeing (Cloutier-Fisher & Harvey, 2009; Guo & Castillo, 2012). Services required by older people at home with care needs could include in-home services like home care, home health services, home-delivered

meals, home improvement programmes, as well as community-based services, such as senior centres, daily care centres, transportation programmes and so on. (Tang & Pickard, 2008). Appropriate use of in-home and community-based services is related to delaying nursing home placement, reversing the decline in physical ability, and increasing survival (Harris & White, 2013; Nakanishi et al., 2015; Tang & Pickard, 2008). Greenfield et al. (2012) identified three categories of activities and services (civic engagement and empowerment activities; social relationship building activities; services to enhance access to resources) related to the long-term goal of promoting ageing in place and wellbeing. Wiles (2005) argued that, although neighbourhood conditions and individual functional capacity are important, subjective feelings about a neighbourhood can be a significant source of satisfaction, regardless of objective measures of suitability or safety. Consequently, it is not just the immediate home, but also the neighbourhood and community, that have been found to be crucial when discussing the wellbeing of older people (Oswald et al., 2007). Ageing in place should be a process of place integration, in which both home and community are central to older people's wellbeing (Cutchin, 2003). As physical mobility and ability tend to decline as people age, the context and qualities of place, in terms of home and community, gain even more importance. The study explores this in chapter 6.

3.5.3 The life course, place and wellbeing

According to Agnew's definition, place is not just a physical setting in which activities and social relations occur, but also a dynamic process invested with integrated physical, social, emotional, and symbolic aspects, which interact over time and serve as a source of meaning for subjective experiences (Agnew, 2011; Kontos, 1998; Moore, 2014). In line with this, Wahl and Lang (2003) put forward a model of social and physical places over time, which suggested that the concept of place could be used to understand older people's daily lives in three ways: first, older people's daily activities and behaviours are embedded in given places, which is to say, specific physical-spatial and social-cultural surroundings; second, places

are socially constructed physical environments; and third, place is a dynamic process within which both continuity and changes occur. Golant (2003) introduced three temporal factors in understanding person-place relationships: past experiences, future expectation, and the influence of change on personal attributes. Moore (2014) argued that place affects people's lives and achievement of wellbeing across the life course. The theory of place suggests that both time, place and socially constructed meaning are key factors in personal wellbeing and its variation in old age.

The intersection of place, time and meaning as experienced through the life course is thus emphasised in this study. The study attempts to recognise the continuity and transformation of physical and social places over time, their linkages to personal biographies and wellbeing in later life, as well as the plasticity in individual abilities and the importance of personal motivation, personal preference and personal choices. The study agrees with Hall's opinion that wellbeing is an 'individually judged, yet socially experienced, state of happiness, freedom, safety and capability, shaped by interrelations with social, cultural (and physical) environments' (Hall, 2010: 277).

3.6 Summary

By combining the relational wellbeing approach, the life course perspective and the theory of place, this chapter has provided a conceptual framework for understanding the oldest-old people's experiences of and perspectives on wellbeing in later life. In the first part, I introduce White's (2010) definition of wellbeing, the relational wellbeing framework and dimensions of wellbeing and provided the rationale for combining the three perspectives for use as my analytical framework. By adopting the analytical framework, the study sees wellbeing as a dynamic process, embedded in specific temporal, spatial and cultural contexts and experienced and perceived differentially by different individuals, rather than an

endpoint or outcome that some older people have and some do not.

In the second part, I discussed the different dimensions of wellbeing: the material, the relational and the subjective, as well as the relationships between these dimensions. The material comprises wealth, welfare, standards of living and levels of consumption; the relational mainly comprises social networks, personal relationships and access to public goods and social support; and that the subjective mainly covers the oldest-old people's cultural values, life beliefs and perceptions of their material positions, social relations and daily encounters. When analysing the wellbeing of the oldest-old people, it is important not to neglect the interdependence and unity of these dimensions or to divorce the subjective from the objective.

In the third part, I discuss the life course perspective, the theory of place and their relevance for discussing wellbeing in later life. The life course perspective highlights the importance of multiple factors, including life events, individual personality, history, social structures, and so on, and the principle of linked lives in understanding the oldest-old people's wellbeing in later life. To understand how these multiple factors and linked lives shape individual lives and affect personal wellbeing, the study draws on ideas from the two research traditions: the sociological tradition, which focuses on cumulative advantages/disadvantages and the ecological developmental psychology tradition, which emphasises challenges, resources and resilience. The theory of place highlights the importance of thinking about wellbeing geographically, the necessity of putting place into practice and the significance of introducing temporal factors into our understanding of wellbeing-place relationships. Drawing on ideas from various approaches within the theory of place, such as the environment approach, the attachment and identity approach and the social inequality approach, the study explores the varying geographical scope that is important for wellbeing in later life, but mainly focuses on the home and communities. The intersection of place, time and meaning as experienced through the life course and its influence on wellbeing in later life is the focus of this study.

Chapter 4 Methodology

4.1 Introduction

This chapter provides an overview of the methodological approach used and the rationale behind researching wellbeing in later life. An integrated wellbeing framework, as elaborated in Chapter 3, implies that wellbeing of older people is socially and culturally embedded, rooted in a particular time and place and emergent through relations with institutions, communities, families and other individuals.

This integrated wellbeing framework guided my empirical research. This meant that the examination of wellbeing should consider contextual and institutional factors, as well as personal attributes and experiences. Addressing these research aims and objectives requires gathering and analysing micro-level, deep and detailed data, which can only be obtained through qualitative research methods. The research tools employed in this study thus include Everyday Life Analysis (ELA), visits with older people, focus groups with carers and care workers, in-depth interviews with stakeholders, observations, and documentary research.

This chapter is structured as follows. First, in line with the research aims and the analytical framework, specific research questions are presented. This was followed by a discussion of why the case study approach was adopted to address the research questions. Participant recruitment, data collection and data analysis are then presented, highlighting the sampling method, recruitment process, data collection methods and the necessity of the iterative data-analysis approach that was adopted. This is followed by a reflection on the research methods and ethical considerations. Finally, I present a summary of the chapter.

4.2 Research questions

The research provides a qualitative study on the experiences and meanings of wellbeing for and by older people when they are ageing at home. The lack of focus on ageing experiences and wellbeing of Chinese older people and the necessity of adopting a broader approach in understanding wellbeing are discussed in earlier chapters. This chapter notes the importance and necessity of taking into consideration both the context underpinning wellbeing and ageing in place and participants' views and activities relating to wellbeing and ageing in place. It thus considers not only older people's perspectives, understandings and feelings (etc.), but also the people who are closely involved in their daily living practice. In so doing, it aims to produce a fuller picture of ageing in place and gain a deeper understanding of wellbeing in old age. The research questions have been formed around this research gap and research interest, which is a necessary first step for the project.

The research questions are:

1) What makes for a good life for and by older people ageing at home in Shanghai?

2) How do the older people attain and sustain wellbeing in very old age?

3) How has their wellbeing reflected and been shaped by broad social factors, e.g. wider institutional and societal change over time, the place they lived in, interactions with significant others?

4.3 The case study approach

4.3.1 Why the case study approach?

The primary research strategy used in the study is a qualitative case study of older people's wellbeing in two communities in Shanghai. The case study approach

provides useful tools for understanding a complex issue (wellbeing in later life). It enables contextual conditions being taken into consideration, allows researchers to explore a phenomenon using a variety of data sources, and has advantages in answering 'how' and 'why' questions (Baxter & Jack, 2008).

The case study approach was chosen for this study because its focus was on wellbeing in later life, which could not be fully understood without an illustration of spatial, historical and social contexts. Taking into consideration the dimensions of time and place, the social, historical, spatial and cultural context of wellbeing, allows me to connect older people's daily living experiences with local settings, earlier experiences and historical events, thus enabling me to understand how important they were for older people, how they shape older people's daily living experience, their beliefs, values, autonomy, belonging and sense of self. It is in time and place that ageing in place occurs and wellbeing is constructed. Without considering the context within which wellbeing is situated it would be impossible to produce a compelling picture of older people's wellbeing in later life.

The case study approach encourages open-ended and flexible research, multi-perspectival orientation and longitudinal research (Snow & Trom, 2002). These are principal guidelines in my research. A flexible and open-ended approach to data collection allows me to generate fruitful, first-hand data and provides a higher chance of encountering real-world experiences and tapping into the true feelings and perspectives of research participants. By embracing the integrated wellbeing framework, I look at older people's wellbeing in a both holistic and longitudinal way, which enables time, place and meaning to become focal points of the research.

A collective case study covers two or more cases, and thus is able to produce more reliable forms of knowledge (Baxter & Jack, 2008). With an interest in the context of wellbeing, I adopt a collective case study approach to examine the role of place in older people's wellbeing. Two cases, community A and community B, were chosen. The aim of the study was not to undertake a comparative study between the

two communities (that is, to explore how older people's wellbeing status in the two communities differs or is similar); rather, the focus is on the factors that affect older people's wellbeing in later life. Thus, the focus is on older people, rather than communities.

I choose two cases to produce more reliable knowledge about the role that place plays in older people's daily living practice and the construction of wellbeing. But, in collective case studies, cases need to be selected carefully. I choose the two communities in Shanghai for several reasons.

First, the selection takes into account the economic and social conditions and characteristics of each community, thus providing the necessary socio-spatial distinctions and context. Both communities had seen changes to ageing and eldercare embedded in broader socio-economic changes that had taken place across the city over recent years. Following documentary analysis and policy review of ageing in place in Shanghai and contacting gatekeepers in each, I discovered many similarities in the two communities. For example, in both communities aged populations reached above 30% of their total population; both cooperated with social institutions to provide ageing in place support for older people. They thus faced similar ageing situations. Ageing situations in the two communities reflected social, economic, political and demographic changes that have taken place in Shanghai and, indeed across China, over recent decades.

Secondly, the two communities differed in how they provided ageing in place support for older people. Community A was a 'star' community that received visitors from within China and abroad keen to understand its good work on promoting ageing in place and the wellbeing of older people. Community B was more ordinary, with little known about its ageing in place practice. Will these differences impact older people's wellbeing and ageing in place experience? If yes, in what ways, and to what extent? Differences between the two communities allowed me to explore the role of place in older people's daily living and sense of wellbeing.

Thirdly, the two communities chosen allowed me access to potential research participants. Access was necessarily an important consideration to take into account (Palinkas et al., 2015). In this regard, it was my acquaintance with a government official working in a citizen service sector near community A, and my own intern experience in community B that explained why these two communities were chosen. Being familiar with gatekeepers in each community and having some prior knowledge of the two areas made it easier for me to access local institutions and people. As both communities are located in Shanghai, I could spend more time in each and, thus, was better able to develop a more in-depth picture of older people's daily life.

4.3.2 A brief history of the two communities

Community A, located in the centre of Shanghai, a fast-growing mega-city, was a rich district when it was built in the 1920s. At that time people living in community A usually had high incomes and a high level of education. Nowadays, the young generation has moved out and community A has become an old community. Because it is located in the city centre, the areas around the community have undergone major change and development since the 1980s, driven by China's open and reform policy. Various companies, NGOs, well-known hospitals and so on, moved to and developed in the area.

Community B, located in the northeast Shanghai, was once an industrial area and was built in the 1980s. Because of the welfare-oriented public housing distribution system at that time, most residents in community B got their properties through public distribution. Most were factory workers and their family members. In recent years, the industry in this area has declined. Community B, which was near to - and supported - by this industrial sector, is now far from the regional business centre.

4.4 Sampling

4.4.1 Research participants

As stated above, the study considers not just the perspectives, understandings and feelings of older people, but also of others involved in their daily lives. Three types of participant were included in the study: older people, carers and care workers, and stakeholders (including eldercare agency staff, Neighbourhood Committee members and government officials).

Older people

Older people are a heterogeneous group and come from a variety of socio-economic backgrounds. They differ greatly in various respects, including health status, living status, and the support they require. Rather than treating them as a homogenous group, I wished to focus on their heterogeneity and variety. The study's purpose is to identify key themes, categories and concepts that emerged and recurred across the diverse range of participants and to explore the potential relationship between older people and wider spatial and temporal contexts. The experiences of older people were also of interest.

The data obtained was based on participants' personal and specific experiences, and thus cannot be generalised across all older people in Shanghai. The study did not use random sampling or seek to be a statistically representative study of older people. Instead, it used a purposive sample, which enabled me to identify and select information-rich cases related to my research interests, to capture major differences between research participants and to achieve in-depth understanding of the research phenomenon (Palinkas et al., 2015). Although several purposive sampling strategies were available, criterion sampling is most commonly used in implementation research (Palinkas et al., 2015). With that in mind, all older people recruited met the following criteria: they were aged 75 years or older; they lived at home, they had care needs, they were able to communicate with the researcher.

These criteria were chosen to reflect that the study's focus on older people's experience of ageing at home.

Since most Chinese older people prefer to age at home (Yang, 2016), targeting older people ageing at home could increase the possibility of getting access to research participants and enable me to further understand their experiences and perspectives. Assuming that older people with care needs may face more challenges when ageing at home, the study focuses on this vulnerable group and tries to identify the challenges and risks they faced in daily life. Older people were also selected on the basis of their health conditions. I chose older people able to communicate with me, so that I could gather the necessary information directly through interviews and observation.

Regarding sample size, I was influenced by Guest et al (2006: 78), who argued: '…If we were more interested in high-level, overarching themes, our experiment suggests that a sample of six interviews may have been sufficient to enable development of meaningful themes and useful interpretations…' (2006: 78). Thus, I recruited at least six older people from each community and conducted face-to-face interviews with a total number of 14 older people.

As pointed out in Chapter 2, few studies of older people in China have been conducted. Data obtained from older people ageing at home is thus valuable and rare, particularly as the perspectives and experiences of older people ageing at home had not been included in governmental documents or fully studied in Chinese scholarship.

Carers and care workers

In order to locate older people in broader social, spatial and temporal contexts and social relations, multiple perspectives are needed. As carers and care workers play an important role in older people's daily lives, my research included this group. Carers and care workers were asked about their opinions of their experiences of

providing care, and their relations with, and perspectives towards, older people. This part of the research design enabled me to study the role carers and care workers played in older people's daily lives, and including them in the research enabled me to produce a fuller picture of older people's daily lives.

The selection criteria for carers and care workers were that they were providing care for an older person receiving eldercare support in the selected communities. Those who met these criteria were involved in interviews and focus groups. At least 6 carers and 6 care workers were selected from each community.

Stakeholders

The study also includes interviews with stakeholders. Stakeholders, carers and care workers formed older people's social relations and social networks and thus played an important role in older people's daily living and wellbeing. It is necessary and important to include stakeholders in the research. Including them allowed me to contextualise the data gathered from other participants and to gain an insight into the role of stakeholders and place in older people's daily living and their construction of wellbeing. Stakeholders did not necessarily need to be working directly with older people in the study. The intention was to encourage stakeholders to provide information and opinions about existing eldercare policies, practices and challenges within the two communities. In doing so, I was able to locate older people in the wider social, spatial and temporal contexts and treat older people's wellbeing and ageing in place experience as a product of social interaction, rather than an individual construction. Research with stakeholders included interviews with at least one representative from the the eldercare agency, one from the Neighbourhood Committee and one from the local authority in each of the two communities. The criteria for inclusion was that they should be a key member of staff who had responsibility for eldercare, or who had worked closely with older people.

4.4.2 Recruitment process

Older people

This study had carefully considered potential methods to recruit older people. This included snowball sampling, knocking on doors, contacting (letters, e-mails, etc.), advertising, referral by gatekeepers and so on. Considering difficulties of accessing older people who met the recruitment criteria, their availability and willingness to participate, and their ability to communicate ageing in place experiences and opinions of wellbeing, this study decided that obtaining the best approach to take would be to seek the recommendations of gatekeepers.

Local Neighbourhood Committees were important gatekeepers able to provide access to older people ageing at home. Since I once undertook an investigation and course practice in community B, making contact with the head of Neighbourhood Committee was straightforward. In community A though, I had no direct contacts with the Neighbourhood Committee members. However, through an introduction of a government officer in district A, I finally connected with the head of the Neighbourhood Committee there. The Neighbourhood Committee had a close relationship with its residents and was familiar with the living status and health status of the older people in its care. The heads of Neighbourhood Committees were able to identify and get access to older people who met the recruitment criteria. After being informed about the purpose of the research and the recruitment criteria, the head of the Neighbourhood Committee identified potential participants and made a call to each of them to inquire whether they had any interest in taking part in my research.

For those who agreed to meet me, the head brokered an appointment. Their names and addresses were only provided after they had given their permission. Before I visited the older people, the head of the Neighbourhood Committee also suggested an appropriate time and way to approach them. During my first visit, I talked about

my research project, provided a consent form and allowed the older people time to consider whether they would like to be involved in my research. Interviews were conducted only after the older people knew clearly about the research project and completed the consent form. Their privacy and feelings were protected in this research.

Carers and care workers

The selection of carers and care workers was based on an understanding of the two selected communities and eldercare agencies. Neighbourhood committees and eldercare agencies acted as gatekeepers to get access to carers and care workers. Before recruiting carers and care worker participants for group interviews, I visited the heads of the Neighbourhood Committees and the managers of the various home care agencies.

Much as with the older people, after being informed about the research purpose, recruitment criteria and interview process, the head of the Neighbourhood Committee identified potential carers and made a call to each of them to inquire whether they would like to join the focus group interviews. After communicating with each of the potential carer participants, the focus group members, time and location were finally decided. Considering the fact that carers did not have much free time to go outside, the focus group interviews were limited to two hours. The Neighbourhood Committee provided a meeting room for the focus group interviews. Although the head of the Neighbourhood Committee had already informed the focus group participants about the research aim and interview process, I still handed out the information packs and consent forms to each of the members. Only after they knew clearly what the focus group was about and had signed the consent form were the focus group interviews conducted.

The recruitment of care workers was conducted with the help of eldercare agencies. Eldercare agencies acted as gatekeepers to access to care workers. Before doing a

focus group interview with care workers, I first got in touch with the bosses of the eldercare agency in each community. Discussions with them about my research purpose, recruitment criteria and the interview process helped to identify potential care worker participants. This study initially intended to recruit six care workers for each focus group. With the help of the managers, care workers were successfully recruited for each focus group. Before the focus group interviews took place, information packs and consent forms were provided for each participant.

Stakeholders

As discussed above, three types of stakeholders were identified in this study: eldercare agency staff, Neighbourhood Committee members and government staff. In order to better understand the support provided for older people, and to validate the data, it was important to include the three types of stakeholders from both communities into this study. I was keen to have an interview with at least one key representative from each group of stakeholders. It was the gatekeepers that made this possible.

Making contact with stakeholders in community A was much easier than in community B. In community A, although I had no prior contact with stakeholders, an introduction by a government officer in the district meant I became connected with the head of the Neighbourhood Committee, the chief staff of the eldercare agency and a government officer who took responsibility for old-age issues. In community B, since I had once conducted an investigation and participated in a course in this community, making contact with the head of the Neighbourhood Committee was much easier. However, with regard to the chief staff of eldercare agency and governmental staff in district B, access was not easy. With no gatekeepers to grant access to the two types of stakeholders, I searched online for relevant contact information and made a call to potential appropriate participants to introduce myself and my research project. After agreeing to a meeting, I visited the eldercare agency and local authority, provided information packs and consent

forms, and discussed my project with them face to face. Finally, they agreed to take part in my research. Interviews with stakeholders were necessary and valuable, for they helped to obtain a deep understanding of the context surrounding wellbeing in the two communities.

4.4.3 Overview of research participants

Once the selection criteria were met, 49 participants (Table 4-1) were included in the study (see Appendix 1 for the profile of research participants). In community A, there were 25; in community B, there were 24. Fourteen older people were interviewed in total. The majority of these older participants were aged 80 or above at the time of the interview. The study recruited the oldest-old people because this group of older people accounted for a large percentage of those who had impairment and thus long term care needs in China (Jiang & Wei, 2015).

Great variety was found among the older participants. Some had slight impairment, some had moderate impairment, while others had severe impairment. Some lived alone, some lived with care workers, while others lived with carers. Taking these various statuses into account was important in the study, given that there had been few studies carried out with older people in the Chinese context. Thirteen carers and twelve care workers took part in focus group interviews in total. Most of carers were retired. They were either adult children or spouses of the older people. Care workers interviewed were generally migrant workers who came from provinces near Shanghai. Ten stakeholders were interviewed in total. In each community, two Neighbourhood Committee members, two eldercare agency staff members and one governmental representative took part. Interviews with stakeholders, carers and care workers who had close relations with older people and eldercare helped me to paint a more nuanced picture of wellbeing and ageing in place in the two communities and allowed me to gain a deep understanding of older people's wellbeing and its relation with broad social, spatial and temporal contexts.

Table 4- 1 Research Participants

Types of participants	Number of participants (community A)	Number of participants (community B)	Total
Older people	8	6	**14**
Carers	6	7	**13**
Care workers	6	6	**12**
Stakeholders	5	5	**10**
Total	**25**	**24**	**49**

Source: field work data

4.5 Data collection

In order to address the overarching question, which concerns the experiences and meanings of wellbeing for and by older people ageing at home, this study adopted qualitative research methods, constituting in-depth interviews, observations, focus groups and documentary research, to collect fieldwork data in two distinctive communities in Shanghai between 2015 and 2016. This methodological choice was made on the basis of the study's focal interest in understanding the wellbeing and ageing in place experiences of older people. The extensive fieldwork allowed me to intimately interact with and closely observe the older people and their carers and care workers in the two communities, thus generating rich, deep and detailed microscopic and longitudinal data. This enabled me to analyse, interpret and present the data from the perspectives of the subjects of the study, especially the older people, as well as to shed light on the broad spatial and temporal contexts that have shaped older people's wellbeing and ageing in place experiences. Through the fieldwork, a whole picture of wellbeing will be painted, including: the broad contexts of wellbeing in the two communities; older people's experience of wellbeing, with regard to their preferences, chosen activities, attitudes, aspirations, and so on; the shift in the older people's networks of relations and its impact on their wellbeing and everyday life; the interface, interaction and conflict of eldercare among older people and the spatial, temporal and social contexts.

The integration of these methodological tools helped to corroborate and enhance the quality of data because it allowed for the triangulation of data and allowed me to understand older people's wellbeing and its relation to spatial and temporal contexts, and social relations.

4.5.1 Everyday life analysis with older people

Everyday life analysis (ELA) is a useful research method to adopt when analysing older people's wellbeing and ageing in place experience. 'Based on established principles and practices used in qualitative sociological research… ELA was innovative in: its longitudinal aspect and its holistic but person-centred approach' (Yeandle et al., 2014: 14).

Longitudinal aspects involved repeat household visits, over up to six months, to frail older people. This doesn't mean that this study only focused on older people's daily living practice in the six months. Instead, everyday life analysis with older people inevitably involved their past experiences and life course events. Actually, older people did like to talk about their past experiences during the interview. Thus, rather than only emphasising daily life, this study also emphasises older people's experiences of days gone by, historical events, self-defined transitions, trajectories and turning points, to pursue how their wellbeing in later life was linked to past experiences, wider social factors and changing contexts. In contrast to the components approach of wellbeing, this study provided a dynamic view on how past experiences affect older people's ageing in place experience and wellbeing in later life. The holistic but person-centred approach adopted here meant that each set of ELA visits focused on a specific older person with care needs living at home. By placing older people in the centre of the data that was gathered, this study tried to explore their own perspectives, feelings and understandings of ageing and wellbeing. As time passed, a holistic picture of the older person's whole life was painted, including: their full set of relationships and sources of support, their preferences, chosen activities, attitudes, values and aspirations.

Data was collected by ELA visits to, interviews with, and photographs and observational data of older people. ELA visits with 14 older people were conducted; eight from community A, and six from community B. Each was visited twice. Each visit lasted for at least one hour, although some lasted for three to four hours. Taking account of the interviewees' health conditions, breaks were taken during the interviews, and an interview often took several sessions to complete. Due to the mobility barriers of the older participants, and with their consent, interviews usually happened at their homes, where I was also able to observe their daily living practices. Others involved in the older people's care, including family members, friends, neighbours, carers or care workers who provided support to the older people, were also investigated. Those people were usually identified by older people during the ELA visits. Interviews with those people were only conducted when older people agreed to do so. Observation was also used to capture information and perceptions that interviews could not cover. Those information and perceptions included older people's physical disabilities, features of their homes, attitudes and emotions expressed by older people, and dynamics between older people and those present in the home. Photographs were used to capture the physical environments in which the older people lived. Photographs were only taken though when permission was sought and granted, either from the old person themselves or from appropriate staff member. The photographs were most typically of communities, meal stations, daily care centres, dwellings, and so on.

In order to keep the older participants 'on topic', ELA topic guides were produced. A set of questions were used as a guide for all interviews that were conducted with the older people. Some of the questions addressed social-demographic information about older people. These included: their health status, living status, pension, medical insurance, family status, community support, and more. Other questions in the interview guide focused on older people's wellbeing and ageing in place experiences, including daily living activities, sources of support, critical life course events, perspectives on their life today, and so on. These questions allowed older

people to tell their own ageing stories and experiences and helped to identify people or events important to older people and their wellbeing (see Appendix 2 for the ELA interview guide).

4.5.2 Focus groups with carers and care workers

As discussed above, this study also included focus group interviews with carers and care workers as a way of gaining insight into their perspectives on the provision of care support for older people. Focus groups helped to elicit opinions and information from different group participants in a short time period and to encourage various perspectives and debates on a given subject. Through focus group interviews different ways of looking at the same subject emerged. What is more, the focus groups also promoted peer support, enabling participants to discuss caring experiences more freely. They thus provided fruitful data.

The study set up two repeated focus groups, one with carers and the other with care workers. A focus group plan was made during research design. The plan covered goals, characteristics, the timeline, the specific plan and the budget of the focus groups (see Appendix 3 for the focus group plan). Each focus group recruited at least six participants. Each focus group lasted for about two hours. Topic guides of focus group interviews were developed, focusing on carers and care workers' experiences of providing care support for older people and their views about it (see Appendix 4 for the focus group interview guide). Data generated through this technique allowed me to gain insights into the diversity of experiences, practices and perspectives, as well as of the local support networks and resources that the older people were able to draw on.

Before group interviews, five-minute ice-breaking games were conducted to increase familiarity between group participants and to avoid poor-responses to interview questions. Specific concern was taken during focus group interviews to make sure each group participant had a chance to participate in the discussion and

avoid a situation in which one or a couple of members dominated the group. Open ended questioning techniques were used to facilitate the focus group interviews. Group participants showed a high interest in the interview questions. During the focus group interviews, each participant had a chance to talk about their caring experiences, views, and feelings. The focus group interviews provided an approach for high quality debates and a good atmosphere was fostered between group participants, who had no trouble sharing caring experiences with each other. The data varied between the two types of focus groups in caring experience details, relations with older people, difficulties, emphasis and feelings in caring practice etc.

4.5.3 Interviews with stakeholders

Interviews were conducted with three types of stakeholders (eldercare agency staff, Neighbourhood Committee members and governmental representatives) in order to gain an understanding of the necessary background information and contextual features on wellbeing in older people's later life. Topic guide for interviews with stakeholders were produced, coving the following issues: eldercare policies / support in the two communities, including current eldercare policies/support and how they fit in broader national/local contexts and what drives this agenda; challenges in implementing eldercare policies/supports; the impact of eldercare policies/supports on older people and their carers or care workers; the benefits and limitations of current eldercare policies/supports, including what the situation was in the past and how they could be improved in the future; the health, living and financial status of older people in general; links and relations with local communities and authorities and other relevant questions. Questions surrounding experiences and challenges faced by older people ageing at home were also included in the topic guides (see Appendix 5 for the interview guide with stakeholders) . This enabled me to obtain multiple perspectives on the wellbeing and ageing experiences of older people.

Most of the interviews lasted for one to two hours. In some cases, for example, when the interviewee was quite keen to talk about the issues, the interview would last for three or more hours. All stakeholders interviewed were familiar with their own work and work responsibilities for caring for the aged and were able to reflect on this issue. The heads of the Neighbourhood Committee and managers of eldercare agencies interviewed were knowledgeable about the ageing context in local communities, including older people's needs, existing eldercare supports/policies, challenges faced by older people and local institutions, limitations of existing eldercare supports/policies, and so on. Governmental representatives were very knowledgeable when it came to eldercare policies, but compared with Neighbourhood Committee members and eldercare agency staff, they were not very familiar with the context surrounding local ageing in place practices. In-depth interviews were conducted to ensure knowledgeable stakeholders have enough flexibility to provide contextual information on ageing in place. Geographical locations did not impact on responses to questions. There was no great response variation between the two communities. Data collected varied in the specific wellbeing and ageing in place contexts. The topic guides for interviews with stakeholders were suitable and appropriate in terms of the research themes explored. Interviews with governmental staff, Neighbourhood Committee members and eldercare agency staff enabled me to gain an understanding of both the policy context and the local context surrounding older people's wellbeing in later life.

4.5.4 Documentary analysis

Document analysis is an important social research tool in its own right and is an invaluable part of most attempts at triangulation schemes (Bowen, 2009). Documentary work involves reading lots of written material. Primary and secondary data about ageing in place in Shanghai and the two selected communities was collected from a number of sources, including scholarly journals, books,

business reports, newspapers, databases, statistical yearbooks, government reports, and so on.

The data collected in the course of this documentary analysis included: relevant central and local government policies, "grey literature", i.e. internal documents, working papers, leaflets, brochures, etc., produced by government and non-government organisations; newspaper articles and media reports; academic publications in Chinese pertaining to the topic and themes of our study; and so forth. This kind of data provided information on the wider background, against which the narrations and recounts of the interview data generated through individual interviews and focus groups could be triangulated. This kind of data was helpful to establish our understanding of the local context and to triangulate the qualitative data that formed the backbone of the research.

4.6 Data analysis

Data analysis was not a linear process from analytical framework, methodology, data collection then to data analysis, rather, it was an iterative one which means that during the research the researcher moved between collecting data, reviewing data and connecting the data to existing concepts and theories in literatures (Tracy, 2012). The iterative approach made the data analysis a reflexive process and allowed me to refine the analytical framework, improve the fitness between the existing concepts and the qualitative data gathered and refine my focus and understandings on older people's wellbeing. The data analysis began at the same time as data collection. Given the research topic, which focuses on the wellbeing of older people, the data was managed using an inductive and exploratory approach. The integrated wellbeing framework, which was justified through a broad and critical literature review, was used to guide data collection and data analysis. The concepts and categories identified in the framework were adopted as exploratory

themes to structure the analysis, and presentations of findings and arguments. The analytical framework, which argues that wellbeing is socially and culturally constructed and rooted in a particular time and place and is the product of social relations, helped to organise the three empirical chapters, chapters 5, 6 and 7, and the conclusion chapter, chapter 8. Chapter 5 discusses findings related to everyday life experience and changes in time periods; chapter 6 deals with findings related to place and wellbeing; chapter 7 deals with findings related to social networks, social relationships and wellbeing. Finally, chapter 8 summarises the main findings and arguements and reflects on the relevance of the findings for policy practice.

The data was organised using thematic analysis to explore themes and categories that emerged and recurred across each transcript. The emerging themes and categories were then referenced back to debates in the literature and linked to existing concepts within the literature to analyse how these could be used to understand the wellbeing of older people. This helped to test and verify the solidity of the analytical framework and to increase the reliability of the research findings. Careful consideration was given to the retaining of individual meanings, participants' perspectives and the integration of the data sets. By careful reading each phrase, sentence and paragraph and extracting its meaning, categories were grouped thematically and sorted, first under different headings and then using different sub-headings.

The analysis was carried out using NVivo 11.0 and involved three steps. The first step was to transcribe and provide an overview of the data. Audio files were downloaded onto my university computer after each interview was conducted. All audio files were transcribed in full as soon as possible. Then the transcripts were uploaded into NVivo 11.0 and read through several times. The transcription and overview of the data were the start of the data analysis. It helped me familiarise myself with the data and to provoke thoughts and reflections. In the next stage, frequent comments were made beside passages in the transcripts. Areas of interest which may help to address the research aims and research questions were identified.

Nodes which helped to group and structure the data were produced. Interesting ideas, themes and categories emerged during this process. This was followed by a third step, which focused on interpreting and grouping the nodes into broader themes and connecting them to existing concepts within the literature. This involved comparison between nodes and between the nodes, themes and existing concepts in the literature.

Besides interview data, this study also took into consideration observational data, documentary data and photographs that were collected during the fieldwork. Although they could not be coded in the same way as the interview data, the examination of these kinds of data helped to deepen understandings of the ageing in place experience of older people. For example, observation of the living environment of older people and the interaction between older people and carers or care workers contributed to a vivid understand of the real daily living practice of older people and their interaction with the environment. Although this may have been mentioned in the interviews, it was not captured in the same way as observations and photographs. Documentary materials, observations and photographs of the communities, daily care centres, eldercare agencies, government departments, older people's homes and interactions between these participants all contributed to a better understanding of the contexts and experiences of ageing in place in the two communities.

4.7 Reflections on the research methods

This study adopted qualitative research methods to gather data. Besides ELA visits with older people, focus groups with carers and care workers and interviews with stakeholders were also included. Wellbeing is a complex issue involving both social, spatial and temporal contexts and personal characteristics and experiences. The complexity of wellbeing created considerable methodological challenges in

this study. The methods above proved valuable and suitable for exploring older people's ageing experiences and wellbeing.

ELA visits with older people helped me capture their current understandings, feelings, perceptions, motivations and so on, and the relations with past experiences. The ELA approach provided a flexible means of exploring older people's personal lives, experiences and feelings. It enabled the older people participants to talk about their past and present events, daily life practices and opinions about wellbeing in later life. Visiting the older people participants twice allowed me to observe clearly their daily life practices and to build trust and good relations with them. This helped to encourage the older people to share with me a wide range of perceptions and feelings that they seldom told others.

Focus groups with carers and care workers and interviews with stakeholders enabled me to explore the broader contexts within which older people's ageing in place experience was embedded, and to produce a holistic understanding of their wellbeing and ageing in place situation. Although data collected through carers, care workers and stakeholders strayed beyond the direct experience and practice of older people, it proved valuable and was necessary for understanding older people's wellbeing. Using multiple methods in this way allowed me to paint a detailed picture of both personal experiences and the broader contexts relating to my research.

During the fieldwork I was aware of, and paid attention, to my personal position and standpoint. I acknowledged that I was not a passive but rather an active participant in the interviews and focus groups (Holstein & Gubrium, 2004). I did not just interview or observe the participants, but myself was a participant in the production and reproduction of knowledge. Thus, I was conscious of my prior knowledge of wellbeing and older people. This reflexive approach helped prevent me from wearing a coloured lens in the research process. I acknowledged that I am a young person coming from a province that is far from Shanghai. Because of this

identity, I had no experience of old age. My knowledge about later life mostly came from my contacts and communication with my grandparents, whose ageing experiences were quite different from those people living in Shanghai. Although I had studied in Shanghai for several years and practiced internship in community B, I still had relatively less knowledge of the lives of Shanghai citizens, especially those of older people. Reflecting on my own personal position made me realise that I had only a layperson's understanding of older people's wellbeing and ageing in place experience in Shanghai. So, fieldwork participants who were experts of their own life and work were given great flexibility to discuss their daily lives, arrangements and to voice their own feelings, understandings, perceptions, and so on. This helped to put older people at the centre of the research and was in line with the person-centred approach employed in this study. The person-centred approach brought significant value to this study. It allowed me to build trust with the participants, to foster comfort and ease amongst the participants during the interviews and to obtain a wide range of in-depth data from them. During the data analysis process, I acknowledged that my analysis of research findings had a symbolic feature. It is not able to reflect the social reality. My analysis of the data and production of the final research results was also a social construction, one impacted by, and embedded in, social contexts and specific cultures. As Gergen pointed out, 'For the constructionist, all claims to knowledge, truth, objectivity or insight are founded within communities of meaning making — including the claims of constructionists themselves' (2001: 2).

4.8 Ethics

In researching the wellbeing of older people, a number of ethical considerations arose. First, it was essential that participation was totally voluntary, which means that individuals were not coerced to participate. With this in mind, the study made sure participants were aware of the aims, process, benefits and risks of the research.

To keep alignment with this ethical principle, an information sheet and an informed consent form were created and handed out to the prospective participants at least three days in advance (see Appendix 6 for the information sheet and Appendix 7 for the informed consent form). I also explained the aims, process, benefits and any risks to the participants to make sure the participants had a clear understanding of the research. If the participants changed their mind, they were able to withdraw from the study at any time. Older people who were not able to communicate with the researcher fluently or who had cognitive impairment was excluded from this research. The rationale for this was that it would not be ethical to collect data from people who lack the mental capacity to consent to participation in the research, and not practical to use communication aides in situations where an older person had a major impairment affecting hearing or speech.

Showing respect and avoiding harm to the participants were also important. This involved choosing a quiet and safe place in which to conduct the interviews and focus groups, discussing the meeting time and duration with the participants, only asking sensitive questions where needed and doing so with respect, listening carefully to the participants, and so on. Maintaining respect, empathy and sensitivity was very important when speaking to older people, because the interviews about wellbeing and ageing experiences may involve sad and painful memories, such as the death of a family member, and can result in a range of negative feelings. Considering the physical conditions of the older people, this study also paid attention to the length of the interviews. Much care was taken when conducting the interviews with older people, to avoid discomfort and exhaustion. Building trust with research participants was always important. Allowing research participants to speak freely about their understandings and experiences of wellbeing contributed to the establishment of good relations between the researcher and research participants and helped to make the interviews go smoothly. The interviews with older people were usually challenging, because they inevitably recalled painful memories of the past and could focus on feeling of loneliness and

the impact of poor health on their wellbeing. Listening attentively and showing empathy made them feel better. The older people interviewed were very pleased to share their ageing in place experiences with me and were looking forward to the next household visit. It was important to inform them of the dates of the household visits and say farewell to them during the last such visit.

Another important issue was the confidentiality of the research data. Confidentiality was paramount when storing and publishing research data. All the materials and data generated in the fieldwork, including interview and focus group records, transcripts, translation and notes, were stored in my password protected computer. When transferred into the computer and then to the University of Leeds password secured hard disk, the initial version was destroyed. When published, any information that could identify an individual, for example living address or employers would be kept anonymous. Direct identifiers were removed entirely and indirect identifiers were obscured under the guidance of University of Leeds protocols. Each participant was referred to using a code name rather their real name. When participants were signing the consent form, I suggested that they do so using their initials. The data was coded by myself. Specific personal information, like names, personal address, postcodes, faxes, emails and telephone numbers were removed from any written work.

4.9 Summary

Identifying a suitable methodology is a major concern for all research. This chapter has described the methodological approach used and its appropriateness in this context. This study employed a case study approach to understand the wellbeing of older people in two communities in Shanghai. The case study approach provided appropriate tools to understand the complex ageing in place phenomenon and wellbeing in later life. It enables contextual conditions to be taken into

consideration and allows me to explore older people's wellbeing using a variety of data sources. This study covered two cases (referred to as community A and community B) to look at what factors impact older people's wellbeing when ageing at home. The two communities were suitable cases, as both reflected the ageing and eldercare changes that were embedded in the broad socio-economic changes that have taken place in Shanghai over recent years. Thus, they offered the opportunity to refine understanding, both conceptually and empirically, about ageing and wellbeing. Through the analysis of wellbeing contexts and experiences and the linkages between them, I tried to produce an in-depth picture of older people's ageing in place experience in the two communities and gain an understanding of wellbeing for and by older people in Shanghai.

Purposive sampling was used to recruit research participants. The purposive sample helped to identify and select information-rich cases related to my research interests, to capture major variations between research participants and to achieve in-depth understanding of the research phenomenon. Considering purposeful sampling strategies, criterion sampling was employed. Clear recruitment criteria were established in advance to guide the selection of participants. All the older people recruited met the following criteria: aged 75 years or older; living at home; having care needs; being able to communicate with the researcher. Carers and care workers must have a close relation with and take care of older people. Stakeholders did not need to have direct relations with older people, but must play an important role in ageing and care. Considering the difficulties associated with gaining access to potential research participants who met the recruitment criteria, who were willing to participate, and who were able to express their ageing in place experiences and opinions of wellbeing, this study decided that obtaining research participants would be best achieved through recommendations of gatekeepers.

Qualitative research methods, which involved ELA visits with older people, focus groups with carers and care workers and interviews with stakeholders, were used to collect fieldwork data in the two communities. The multiple methods adopted

proved valuable and suitable for exploring older people's wellbeing. The integration of the above methods helped to corroborate and enhance the quality of data through a process of triangulation and allowed me to understand older people's wellbeing and its relation with spatial and temporal contexts, and social relations. The extensive fieldwork allowed me to intimately interact with and closely observe the older people and their carers, which helped generate rich, deep and detailed microscopic and longitudinal data. This enabled me to shed light on the broad spatial and temporal contexts that have shaped older people's wellbeing in very old age.

Given the research topic, which focuses on the wellbeing of older people, the data was managed using an inductive and exploratory approach, but also guided by the integrated analytical framework, which combined a relational understanding of wellbeing, the life course perspective and theories of place. The integrated wellbeing framework highlighted the importance of place, time and social relations in understanding wellbeing in old age. Researching wellbeing therefore needs to appreciate the spatial, temporal and social contexts within which personal experiences were embedded. An iterative approach was adopted to analyse the data. An iterative approach makes the data analysis a reflexive process and allows me to refine the analytical framework, thus improving the fit between existing concepts and qualitative data and refining my focus and understanding of wellbeing.

Chapter 5   Historical Times, Life Events and Wellbeing in Later Life

5.1 Introduction

As discussed in Chapter 3, older people's wellbeing in later life and its close relations to health, income and emotions are well documented in the literature (Allen, 2008; Cattan et al., 2005; Findlay, 2003; Gabriel & Bowling, 2004; Kenkmann et al., 2010; Skingley & Bungay, 2010). It is clear from past studies that a good status of health, income and emotions helps to promote wellbeing in later life (Andrews, 2001; Casey & Yamada, 2002; Houston et al., 1998). This study confirms such findings of other parts of the world since the data obtained from interviews with older people highlighted the importance of health, money and positive emotions for securing wellbeing in very old age. That being said, the chapter contributes to the existing literature by presenting and analysing the Chinese experience and arguing that whilst these connections are not insignificant, it is not sufficient to simply equate wellbeing solely with health, wealth or happiness. This chapter furthers an understanding of wellbeing in older age by going beyond the identification of determinants of wellbeing, and puts the older people participants in broader social, historical contexts. This entails considering how earlier life experiences and the social, historical contexts may shape wellbeing in older age. Key questions addressed include, firstly: what were the salient events and experiences in their lives that were considered as critical for their wellbeing in older age? Secondly: how was wellbeing (or a lack thereof) sustained or how did it shift in older age?

The chapter is structured as follows. Section 5.2 explores the macro social forces and social changes shaping older people's wellbeing in later life. Section 5.3 discusses changes, especially life crises and experiences of loss, which entailed change and adaptation and thus led to new ways of living and being. It covers key

disruptive events, changes, losses, corresponding adaption, the meaning and significance older people attached to them; and the 'inner reorientation and self-redefinition' (Kralik et al., 2006: 323) that they went through. Section 5.4 focuses on the ways in which older people secured wellbeing when they experienced lifestyle change and were constrained to a narrow space in very old age. The question – what was essential for wellbeing in very old age – is addressed, highlighting the ability of building resilience, as well as the importance of social support. Section 5.5 presents a summary of this chapter.

5.2 Historical events, historical times and wellbeing in later life

As discussed in earlier chapters, ageing and wellbeing could not be understood entirely as a self-contained individual process (Crystal et al., 2016; Dannefer, 2003; Ferraro & Kelley-Moore, 2003; Hudson, 2016). This study underscores the importance of historical conditions and social change for understanding individual lives and the meaning of wellbeing for older people. It positions individual lives in historical times and emphasises the sequence of structure and the socio-historical context for understanding individual life experiences. Placing detailed accounts of older people's lives in national and historical contexts, situating their everyday life experiences within macro-level dimensions of social forces as well as social change brings a better understanding of older people's ageing in place experiences and their wellbeing in later life. Adopting the integrated wellbeing framework and treating wellbeing as a process (see Chapter 3), this section tries to explore how social change altered older people's lives, thinking about older people's personal characteristics and its social pathways in rapid changing Chinese societies; and how macro social forces, including social norms and cultural practices, shape older people's lifestyles, beliefs and values. I will show that both aspects play an important role in older people's wellbeing in later life.

Experiences of social changes or historical times were regarded as turning points or points that played a key role in the older people's life course. They reflected the times through which older people had lived, the continuity of the self and the changes that occurred physically, socially and psychologically during the life course (Elder & Liker, 1982). The majority of older people participants in my study were aged between 80 and 90. They were born at the end of the 1920s or at the beginning of the 1930s. This birth cohort or generation experienced great social upheavals in China. In the older people's narratives, they emphasised the relevance of wars, the work unit system and the social insurance system as social forces and a social context that, at the material level, influenced, their income, social welfare and standard of living over the life course; and at the cultural or subjective level, shaped their beliefs, values and the very meaning and significance of ageing and wellbeing.

5.2.1 Childhood in wartime

A common theme running through the interview data is the influence of wars on this generation. Most of the older people interviewed spent their childhood in wars and described being affected by the almost 20-year continuous wars, the War of Resistance Against Japan's Invasion (1931-1945) and the second Civil War (1946-1949). Many studies have emphasised the damaging impacts of wars on children, such as death, disability, psychological suffering, loss of family members and the trauma suffered as a result (Carpenter, 2007; Kuwert et al., 2007; Lamberg, 2004; Simon, 1996). My research has echoed existing research, finding negative ramifications of wars and civil conflicts. It also finds that wars not only brought disaster and suffering but also in a large degree, both in negative and positive ways, changed the older people participants' life trajectories and thus influenced their wellbeing, especially the material aspect of wellbeing, in later life.

Job opportunities and employment

For some older people, wartime provided both suffering, pain, losses – as well as – employment opportunities and developmental experiences. Some older people had served in the forces and their stories focused on how their lives had been changed by the experience. Mr Fan (86, moderate impairment, a government officer before retirement, community A) recounted in the interview how his childhood was changed by the wars; how his experience in the army had involved a major shift in occupation and how this shift influenced his access to eldercare resources in older age.

> *I came from a large family. Bringing up 6 children was not an easy job for my parents. Things became even worse after my father died in an air attack by the Japanese air force. My mother had no choice but to send me to Shanghai to let a friend bring me up. However, since the year 1937 when Japan invaded Shanghai the lives of my parents-by-adoption became hard as well. I had to quit my schooling and go to the street to sell small items to earn a living. Two to three years later I joined the Eighth Route Army. I learnt many valuable skills when I served in the forces. This enabled me to achieve a good position in the army after the wars. As a veteran, my pension is high, it is sufficient for me to employ a care worker to support my daily living. Government staffs and neighbourhood committee members visit me quite often. People show me great respect. I live a good life here. I'm thankful and satisfied (interview with Mr Fan).*

Schooling and education

A powerful theme in the narratives of older people about their childhood was schooling and education, which had played an important role in older people's wellbeing in this study. Some scholars emphasise the role of social class and social-economic status in schooling and education, for example, Marjoribanks (1979) indicates that family background has an important influence on children's educational life chances and educational experiences. My research echoes part of

these studies. During the first half of the 20th century when China was under constant foreign invasion and occupations, wars, civil conflicts, as well as during the rule of the Nationalist government which represented the interests of the very minority of the urban super-rich after the victory of the Chinese resistance war against Japanese Fascism in 1945, the school system was adversely affected. Only a minority of children, therefore, could receive adequate education, most of whom came from rich families. Rich family background-good education-good occupation and income was a general social pattern for children growing up in families of higher social-economic class in China (Liang et al., 2012).

In my research, out of 14 older people participants, six came from better-off families. Five of them had received a high education and only one received just senior high school education, because of illness. Good education enabled them to acquire professional skills and knowledge and thus helped them to achieve professional and well-paid jobs which made possible the material aspects of wellbeing in later life. Access to material or financial resources played an important role in older people's wellbeing in later life, especially when they faced restrictions or had care needs. Mr Tang's experience is illustrative. Mr Tang (91, severe impairment, community A) grew up in a better-off family. His father, a banker, could afford to send him to learn accountancy in a top university. Only very few people could receive higher education at that time, so after graduation Mr Tang obtained a position in a big company. What is more, higher education certificates and professional skills in financial management made it much easier for Mr Tang to continue his well-paid job until retirement in the dramatically changing Chinese society. The well-paid job also enabled Mr Tang to have enough money to afford various household appliances and high-tech equipment to support his daily living in later life. For example, Mr Tang can afford to buy very expensive therapeutic apparatus to treat his insomnia and help to improve his sleep and thus his overall health status.

In contrast, children growing up in poorer families had few opportunities to receive a good education. Developments such as literacy classes, night schools and public schools in wartime opened up educational opportunities and developmental experiences for those growing up in a lower social-economic class. Mrs Ouyang (84, moderate impairment, community A), joined the People's Liberation Army at 15, learnt to read and achieved a diploma in a night school5 established by her army. Mrs Shao (83, slight impairment, community A) at the time of my interview, came from a poor village, attended a free public junior school in Nanjing city after passing an examination. Although Mrs Ouyang and Mrs Shao's educational level was not as high as those of their counterparts who grew up in rich families, their educational experiences helped them to acquire skills and confidence by supporting themselves and offered them a possibility of a different life.

Besides income and affordability, educational experience also enabled older people to learn quickly knowledge of care and health, which was of critical importance to keep well and manage ill health in later life. Compared to peers who were of a similar age, the older people who had a higher level of education tended to have good knowledge of their health status and treatment, and to be able to find more ways to deal with their care dilemmas. Mrs Wu (86, slight impairment, community A), who graduated from a school of chemistry in a top university under the Nationalist government, knew clearly not only the development of her eye disease but also how to avoid deterioration of the condition. She purchased natural supplements imported from foreign countries to improve her health status and was able to learn new technology for obtaining health services, such as to make an appointment online to seek medical advice. She owed her ability of quick learning and searching for information to scientific trainings and learning experience in the university: *You get used to learning new things and finding its inner logic quickly after four years of scientific trainings'*.

---

5 A night school provided trainings for adults who had no time to learn in daytime.

5.2.2 Working lives and family life under the work unit (danwei) system

In describing life in early adult and prime age, what was salient in most of the older people's accounts was work and their work units: danwei under socialism (1950s-1980s). Danwei is a specific term denoting the workplace in pre-reform urban China (Bray, 2005). During that period, danwei served as the basic unit of political, economic, social and spatial organization in which economic production and social life were integrated (Bjorklund, 1986; Bray, 2005). To a large extent, danwei replaced the role of the local state to provide free or low-cost public services and entitlements to meet its members' needs. Besides employment, danwei provided employees with a comprehensive package of welfare and services, ranging from basic daily living support, like housing, dining services, barbers, kindergartens, entertainment facilities, to – in some large danwei, medical care in big hospitals; and high education in universities or colleges. (Bjorklund, 1986; Chai, 1996; Wang & Chai, 2009). Working lives and family life under the danwei system influenced not only older people's material aspects of wellbeing in terms of eldercare resources, but also the subjective aspect of wellbeing such as evaluations of their financial status, lifestyles and life beliefs that they subsequently lived by and the relational aspect of wellbeing in terms of social networks and social relations.

Danwei, employment and eldercare resources

The establishment of the danwei system largely changed individuals' work lives. Work and resources were distributed by the state under a planned economy. People's work lives were dominated by the danwei system (Liu & Chai, 2012). Around 95% of the urban workforce were danwei employees in 1978 in China (Bray, 2005). On the one hand, a job for life in danwei provided a key source of status, meaning and a feeling of self-esteem and lasting value; good spatial organization of danwei helped to reduce commuting time, provided easy access to basic facilities of everyday life, guaranteeing daily living needs, and maintaining

work-home balance; even development within danwei enabled a high level of social equality and social interaction inside, and thus promoting a sense of security, belonging and attachment to place and social organisation (Bjorklund, 1986; Chai & Zhang, 2010). During the interviews most of the older people showed a strong attachment to their previous danwei. Working experiences in a danwei were considered as memories treasured in their lifetime. Working in a danwei for several decades not only provided older people with a sense of security and self-esteem in later life, but also broadened their social networks and social relations which could last for a lifetime. Mrs Shao (83, slight impairment, community A) recalled her working experience in an enterprise and how this experience had influenced her relational aspect of wellbeing in later life:

> *My work in my danwei was somewhat like social work. It is about helping those with difficulties or problems. I remembered clearly that once a young worker took hostage by using a knife in my danwei. I was called to deal with this critical situation. I talked patiently with the young person for about four hours. Finally, the young person put down his knife. After that the young person has maintained contact with me until now. He has often called me and visited me. This contact has lasted for several decades. There are many examples like this in my working experiences. I had a notebook in which there are many contacts and phone numbers. Almost every day there will be one person that gives me a call (interview with Mrs Shao).*

On the other hand, the danwei system thrust these older people interviewed into new situations that challenged the means, pathways, and ends of accustomed life. Under the danwei system, work and resources were distributed by the state under a planned economy (Knight & Yueh, 2004). The general pattern: rich family-good education-good occupation in a large degree lost meaning. Work migration increased which reflected a discontinuity from the past. Among the 14 older people interviewed there are 10 that had work migration experiences. These work migration experiences could be classified into two types: one was from Shanghai to other places and the other was from other places to Shanghai.

Those who moved from Shanghai to other places generally had a good education and worked as teachers or doctors. Most of them were those from rich families. Migration from the big city, Shanghai, to other places marked a disjuncture in their life course. It was not easy for some of them to adapt to the new environment. Going back to Shanghai was a universal desire at that time. Some managed to satisfy that desire. Mrs Wu (86, slight impairment, community A), giving up her job in a university in Hebei Province, grasped at an opportunity to teach in a junior school in Shanghai after sending an application for going back. Some others had to remain in their working place until retirement. Because different provinces and cities had different levels of social welfare, the place where one retired greatly affected his/her retired social welfare and social insurance. Mrs Ru (80, severe impairment, community A) who worked and retired in Sichuan Province, had a much lower pension level and medical reimbursement level compared to her counterparts who worked and retired in Shanghai. What is worse, since she retired in Sichuan Province, her medical expense could only be reimbursed in Sichuan Province. This brought big problems for Mrs Ru and her family. Since Mrs Ru had brain atrophy, she needed regular medical treatment and long term care support. Her husband, Mr Ru (83, slight impairment, community A), had to go to a special office far from their home quite often to do her medical reimbursement.

Those who moved from other places to Shanghai usually came from areas near Shanghai, such as Zhejiang, Jiangsu, Anhui Provinces. In the 1950s and 1960s great demand in the industrial sector provided work opportunities for those people. They worked in various factories, like machinery plants, printing plants, bicycle plants, etc. Migration from their hometown to Shanghai provided them a taste of a different life. Compared to their life before, working in a public ownership danwei was considered as an honourable and pleasant experience. Mrs Yu (85, moderate impairment, community B) who came from a poor village in Zhejiang Province, was employed in a textile mill in late 1950s. She expressed her satisfaction for working in the textile mill: *'Becoming a factory worker was considered to be a*

good way out of the locality at that time. It meant that you could have a regular salary during your work life and a pension after retirement'.

Danwei, lifestyles and life beliefs

During this period, an ethos of 'work first, life second' was promoted (Wang & Chai, 2009). Social life and entertainment was considered to be secondary to work commitment; lifestyle choices were quite limited. Hardworking and simple living were the general expectation at that time. The theme of work marked most male older people's middle life. For women, besides work, another important theme emerging from my fieldwork data was childcare. Young married women took the main responsibility of bringing up children in a family. It was not easy to maintain a balance between work and childcare for them, especially for those whose husband worked in another city and could not provide necessary support. Mrs Shao (83, slight impairment, community A) recounted her hard times when she managed alone for about five years with three young children whilst her husband worked in another city: *'I struggled almost every day to ensure that each of my children was healthy and happy.'* Although struggling with caring for children, most women managed to do well in their jobs. *'What I thought was "I must make contributions to my danwei and the country". Seldom did people concern too much for one's own benefits at that time,'* Mrs Shao explained.

Plain living was another life belief of most people at that time. This was in part because of the economic development idea of 'giving priority to the development of heavy industry' which limited the development of light industry and the service industry that provided articles and services for people's daily living and in part because of the socialist ideology at that time. Mrs Cao (81, moderate impairment, community A) described the lifestyles during that period:

> *'We were poor at that time. Daily living materials were often in short supply. We struggled so that we did not go hungry. Entertainment and leisure activities were limited. Individual differences were minimised. People dressed*

in green, blue or grey, no matter if they were male or female. Dressing up and pursuing personal entertainment was thought of as bad. An image of a plain worker, a peasant or a soldier in a military uniform was preferred by people at that time. We experienced that historical time. It left its imprint on us for life. Even now I still live a plain-living' (interview with Mrs Cao).

5.2.3 Retirement under the social insurance system (1980s - present)

The market-oriented economic reform that began at the beginning of 1980s has seen the gradual disappearance of the danwei system. Danwei functions of providing social welfare have been gradually removed (Wang & Chai, 2009). This means that the danwei no longer needed to provide life facilities and living support for its employees. Many reformed danwei systems no longer contain both work space and living space. This went hand in hand with the urban housing reform, i.e. privatisation of public housing and the emergence of a housing market and the rapid commercialisation of urban housing. Original danwei-based communities saw the move-out of danwei members and the move-in of non-danwei members. Some old industrial danwei sold off their old sites and relocated to suburban areas, while some simply closed down (Chai, et al., 2007). The decline of the danwei system broke down the previous social security system, and thus called for a new one. Social insurance systems which involve cooperation between governments, danwei, communities and individuals thus developed quickly after the breakdown of the danwei system. Shanghai played a leading role in pioneering and establishing suitable and sustainable social insurance systems. After over 30 years of development, Shanghai has established a series of social insurance systems and eldercare support policies for citizens (see Appendix 8 for old-age related policies and systems in Shanghai). The older people interviewed retired in the 1980s or at the beginning of the 1990s. Their retired life and wellbeing were much shaped by the changing social welfare systems.

The legacy of the danwei system

The economic reform has seemed to render the danwei system increasingly irrelevant to people's personal life. However, this was not true for some older people interviewed in this study. Notwithstanding all the changes, the danwei had taken such a central place in the welfare and wellbeing of this generation that some of them still turned to the danwei for help. Miss Hua (82, slight impairment, community B), still kept a connection with her danwei: a railway station, more than 30 years after her retirement. In winter once a week she went to the railway station to have a shower. When her boiler was broken she called the station to repair it for her, however, her request was refused. Miss Hua felt confused and hurt about it. *'Why did not they help me? What's wrong with my danwei? They visited me regularly before'*, she asked. Mr Sun (78, slight impairment, community A), who had been retired for more than 20 years, happily joined a trip held by his danwei with former colleagues a few days before being interviewed. He felt quite good about it and described his danwei as home when interviewed:

> *'My danwei often held such kind of activities. I'm very glad to take part in them. Representatives of my danwei sometimes visited me in festival days. It made me feel that I still belong to my danwei. My danwei is just like my home. This was really a good feeling' (interview with Mr Sun).*

Social insurance: the key source of material wellbeing

For the older people who were interviewed, social insurance systems that closely related to their retirement life were: the pension system, medical insurance system and care support policies. These systems or policies played a significant role in dealing with eldercare and material wellbeing which were common themes in the narratives of older people. Eldercare involves both daily living support and medical and nursing care. For those who just needed daily living support, pensions and medical insurance, this proved sufficient and effective. Their evaluation of material status was usually positive. Holding a life belief of plain-living, Mrs Liu (78, slight

impairment, community B) expressed satisfaction with her material status, thus:

> *'Compared to many others, my pension is not very high. However, I am quite satisfied with it, because it is enough for me. My major expenditure was the costs of medicine. It is not very high after reimbursement of medical insurance. I'm over 80. At this age life is simple and plain. You don't need too many things' (interview with Mrs Liu).*

However, for those with high levels of medical and nursing care needs, the evaluation of material status could be negative. The medical insurance system did not cover eldercare expenditures. Only care policies provided limited care support for older people and their families. Older people, especially those with limited resources, faced great challenges in eldercare arrangements. Spending for medical or nursing care has proved to be a major factor contributing to material ill-being in old age and to a family's financial burden in this study. Mrs Gao's experience was illustrative:

> *'I have been in bed for over 10 years. My husband's health status is not good either. He is frail and deaf. At first my two daughters took care of us in turn. However, it is too hard for them because they had to work at the same time. Then we decided to use a care worker. However, the medical insurance doesn't cover eldercare expenditure; the salary of a care worker is too high; our pensions can't afford it. Only after my two daughters provided financial support can we employ one care worker (interview with Mrs Gao).*

5.3 Disruptive events, changes, losses and the sense of wellbeing

Older people inevitably experienced transitions, changes and losses in their decades of living. The transitions, especially life crises and loss experiences, entailed change and adaptation, and thus leads to 'new ways of living and being in the world

that incorporate the changes' (Kralik et al., 2006: 327). Experiences of transitions and losses could extend even into old age, and can have enduring consequences for older people's wellbeing, even after many years (Elder & Liker, 1982; Evans-Campbell, 2008). In this section, I describe key disruptive events, changes, losses and corresponding adaption in the lives of the older people interviewed. I consider the meaning and significance they attached to them and the 'inner reorientation and self-redefinition' they went through.

5.3.1 Bereavement

Bereavement, particularly the loss of important others, is an unequalled tragedy for most bereaved people. For those in very old age, bereavement occurs with increasing frequency and brought cumulative losses. Most of the older people interviewed had bereavement experiences, some even occurred during my fieldwork period. For them, bereavement brought both suffering, challenges and changes, which greatly impacted on their wellbeing, especially the subjective and relational aspects of wellbeing, in later life.

Loss of children

How older people respond to bereavement largely depends on the nature of the loss and the quality of the relationship with the deceased person. It is known that certain bereavements tend to be associated with overwhelming reactions and severe adjustment problems (Parkes & Prigerson, 2013; Shuchter & Zisook, 1988, 1993; Stroebe et al., 2001); the loss of a young child is particularly hard to bear. For those losing their children, chronic grief is more likely to occur, especially if the death was sudden and unanticipated; the lost child is the only one; social support is lacking; or the bereaved person is in poor physical health (Parkes & Prigerson, 2013; Stroebe et al., 2001). Mr Tang (91, severe impairment, community A), who suffered a sudden death of his only child, maintained a timeless emotional involvement with his child – even after 40 years of the bereavement – remaining

preoccupied with his child and highly invested in the lost relationship:

> *'It is very painful. My son died while running. My only child… He was not yet 30 at that time and planned to go abroad for study. He was such a good boy that if he was still alive my later life would be very happy. My health status is bad. No children are by my side. My only child, he was gone' (interview with Mr Tang).*

Conjugal bereavement

Conjugal bereavement is another type of hard-to-bear loss (Stroebe et al., 2001). Among the older people interviewed more than a half experienced the loss of a spouse. Different from the loss of young children, there were many and varied ways that the older people grieved towards the loss of a spouse. Timing and the spouse's health status were important factors influencing these responses. For the newly bereaved spouses, confronted by the death of a spouse, most experienced some form of initial shock, disbelief, pain of grief and sense of loss. Mrs Ouyang (84, moderate impairment, community A), who lost her husband two months before the interview, rapidly shed tears when interviewed, described herself as sad, depressed and weak:

> *'I can't help to think of my deceased husband. Each time I thought of him I can't help but shed tears. We have lived together for more than 60 years. He is such a good person that even in the last year of his life when he was in hospital and suffered from the disease, he still kept calm and showed care for me. I lived together with him in the hospital at that time. He relied on me a lot. I knew the farewell moment would come soon. However, when it really came, I found it so unbearable. I cried a lot. My body became weaker and weaker. I just can't help but grieve a great deal of the time. I felt that part of myself had gone with him' (interview with Mrs Ouyang).*

For Mr Tang (91, severe impairment, community A), who lost his wife during my fieldwork period, the meaning and feelings of conjugal bereavement seemed different. Mr Tang was aged 91 and very frail. His wife, Mrs Tang, had dementia

for more than ten years. Mr Tang employed two care workers to take care of her and himself. In my last home visit, he told me that his wife had gone. Regarding his wife's death, Mr Tang showed complex feelings and responses: on the one hand, he felt very sad and experienced a sense of loss; on the other, accompanying these profound emotional and cognitive disruptions was a sense of relief. The relief was felt for his deceased wife, who had suffered through prolonged dementia and was now free from disease and pain. He also felt relief for himself and for his personal suffering in looking after his sick wife: the worry and anxiety of dying first with nobody caring for his poor wife and the empathic resonance with his wife's suffering and lost dignity.

Grief and recovery

For people who are in the early stages of bereavement, their subjective wellbeing seems to be far gone and all joy seems to be taken out of their life. As time goes on, most of the bereaved persons learn to tolerate the loss and grief, discovered new ways of living, and reorganise his or her own life (Shuchter & Zisook, 1993). In this study more than two-thirds of the bereaved experienced conjugal bereavement more than 10 years ago. For them, living without a spouse was not a new problem. With time and continued survival and growth, most transformed their tragedy into new directions: in friendships and relationships, community engagement, personal interests etc. During this process new feelings and self-images emerged; a sense of strength, autonomy, independence and maturity came into being. Mrs Wu (86, slight impairment, community A) widowed for 14 years, renewed her old friendship ties that had loosened over the years, attended a community college for older people and developed interests in piano, singing and languages. She explained her widowhood life thus:

> *'Since the bereavement I get out almost every day, meeting friends, eating dinner, attending the community college, etc. Connecting with others has reduced my emptiness and loneliness. Learning new skills has helped to*

improve my mental and physical health. Grief should not consume a person's whole existence. Anyway, life goes on.' (interview with Mrs Wu).

5.3.2 Bodily frailty

Frailty commonly refers to 'the increasing infirmities that accompany ageing' (Nicholson et al., 2012: 1426). Bodily frailty was a common feature and common experience of the older people interviewed in this study. All of the older people interviewed experienced some degree of functional decline and of gradual deterioration. This section explores the influence of the bodily frailty on older people's daily activities and their subjective and relational wellbeing. It identifies which daily activities were affected by the bodily frailty and what attitudes or feelings were generated towards ageing and frail bodies.

Gradual deterioration, traumatic life events and serious disease

Health, or its opposite illness, was one of the major preoccupations of the older people interviewed. Most, including the very active ones, experienced at least one chronic health problem or sudden injury. Common health problems they reported include poor memory, fading eyesight, loss of hearing and insomnia. Besides the common health problems that most older people encounter in old age, some also experienced sudden injury or serious disease. Mr Ru (83, slight impairment, community A) had a car accident and fractured his leg a year before my interview with him. Mrs Cao (81, moderate impairment, community B) fell twice, broke her hip joints and since had to rely on a walker to move around. Mrs Yu (85, moderate impairment, community B) had intestinal cancer and needed to attend hospital weekly for her colostomy bag to be changed. Mrs Shao (83, slight impairment, community A) had stomach cancer and the operation on this 12 years ago. Their experiences of chronic illness, sudden injury or serious diseases brought a deep consciousness and awareness of body and mind and a sense of pride and gratitude for surviving from disease or hurt as expressed in their own accounts. 'Listening'

more to your body, and not taking your body for granted became common sense for the older people.

> *Mrs Shao: 'One day I was surprised to find that my faeces was black. The doctor's diagnosis showed that I had a stomach cancer. After discussing this with my children, I decided to undergo surgery. I had already written a will at that time. Luckily, I survived. Serious disease can happen at any time in old age. You must learn to listen to your body and to pay attention to your health status when you are older' (interview with Mrs Shao).*

> *Mrs Cao: 'Once there was a time when I found that my body was always itching, sometimes beyond endurance. Then I was diagnosed with liver cirrhosis. The symptoms of my disease were easily to be neglected. If I did not attach importance to it, my condition would grow worse rapidly. Even though I was very careful about my health status, I fell twice and broke my hip. I also had vision problems. I always felt tired and weak. You know, body deteriorates as people are getting older; it could let you down at any time. You must get more conscious of what you can do and what you can't do. I pay close attention to what I eat, because if I eat cold or hard food now, I will soon be in hospital. When you are younger, you can eat anything you like, but now when you are older you can't do that anymore (interview with Mrs Cao).*

Bodily frailty and limited daily activities

The health loss led to a range of changes in the older people's daily lives. Fry (2014) pointed out that bodily frailty may affect older people's personal care activities, household activities and recreational activities. In this study, interviews with the older people participants and observations during research visits to their homes also showed that bodily frailty not only limited their daily activities, but also influenced their self-perceptions and social relations. Most older people interviewed said that regular daily activities helped their physical and mental functioning; increased their psychological benefits; provided a meaningful life; and enhanced their wellbeing in older age. However, because of the specific types or combinations of bodily

frailty, each was now either constrained in undertaking or unable to continue with some activities which they valued. Based on their accounts, these activities have been classified as daily living activities, leisure activities and 'social' activities.

Daily living activities – These mainly refer to Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), widely used tools that measure people's daily independent and self-care activities (Katz, 1983). The accounts that older people gave included: maintaining personal and toilet hygiene, self-feeding, moving within the house, cleaning and maintaining the house, preparing meals, taking prescribed medications, managing money, shopping etc. Almost all older people in the study said that among these activities, at least one was difficult for them to conduct without support. For them, accepting assistance from others with self-care activities, especially foundational basic functioning activities, like self-feeding and toilet hygiene, undermined their sense of dignity and increased a sense of vulnerability. Mr Ru (83, slight impairment, community A) explained it thus: *'Food is delicious only when you eat it by yourself. If you have to be fed by others, the food would be tasteless'*.

Difficulties in conducting daily living activities may also bring with them a sense of losing control of one's own home. Most of the older people expressed a desire to remain active and to be in control of their homes. For them, cleaning and maintaining the house, preparing meals, shopping for daily necessities, etc., were not only daily living tasks, but also a meaningful part of their lives. However, they were now constrained in doing, or unable to continue, these activities:

> *'I was diligent and usually kept myself busy all day before. I cooked delicious food for my family; I cleaned my house; I bought things that my family needed…but now because of the frailty I cannot cook meals and wash laundries any more. The home appliances are just over there, but I cannot use them any more' (interview with Mrs Cao).*

Leisure activities - Besides daily living activities, leisure activities were also valued a lot by older people who were limited by bodily frailty. These were activities developed in earlier life and could include traveling, reading, painting and watching TV. Many older people said that leisure activities brought them great pleasure and a sense of calmness and relaxation. However, in very old age, most found it difficult to continue practising their leisure activities. Mrs Wu (86, slight impairment, community A), who liked traveling around the world, now had to stay at home because of her weakness and eye disease. Mrs Cao (81, severe impairment, community A) who practised Chinese painting almost every day before, had now given this up because her hands shook and she had vision problems. Mr Tang (91, severe impairment, community A) who read a newspaper every day now had to rely on a magnifying glass to continue his hobby.

> *'When you are older, you have to give up many activities you liked before. I liked swimming very much when I was young, but now in my 90s I have to stay at home most of the time. The only hobby that I can continue is reading newspapers. I bought a magnifying glass to read newspapers because my eyesight is fading fast these days. I can just read for a while, otherwise I feel tired.' (interview with Mr Tang).*

Social activities - Bodily frailty could also affect older people's socialising activities. For some older people, health loss had led to a reduction in social contacts and social relationships and an increase in loneliness and social isolation. Mr Gao (87, severe impairment, community B) suffered hearing difficulties and found it challenging to interact with others. The loss of hearing made Mr Gao increasingly isolated at home. Miss Hua (82, slight impairment, community B) found that weakness and restricted mobility compromised her ability to engage with local communities, preventing her from visiting friends and neighbours, from visiting local markets, and from attending religious groups which she regularly attended before. Mrs Cao (81, severe impairment, community A), afraid of embarrassment arising from her frailty, was reluctant to eat dinner outside with her family members.

'I had to rely on a walker to move around. Each time we went outside to have dinner, they had to wait for me. It made me feel uneasy. I don't want my mobility problems prevent them from enjoying themselves. Besides, sitting there for about two hours to have dinner was too long for me. It usually made me feel tired.' (interview with Mrs Cao).

Ageing and bodily frailty: acceptance, fear and ambivalence

Ageing and its major disruptive consequence – bodily frailty – represented potential threats to wellbeing, in so far as they reduced or impeded people's ability to be able to continue daily activities that they valued and thus led to a number of challenges for their daily living. For those who experienced difficulties on account of chronic illness or disability, however, their sense of ageing and bodily frailty was presented in different ways.

Acceptance - Some older people accepted that their bodily frailty required changes in their daily life peacefully. They saw these as a normal, and sometimes inevitable, consequence of the ageing process. Mrs Yu (85, moderate impairment, community B), for example, expressed a positive attitude towards her illness and frequent visits to hospital for treatment:

'When I first heard that I was diagnosed with intestinal cancer I was very worried, shocked and felt disbelief …As time passed by, I accepted the reality. I accepted surgery and from then on to wear a colostomy bag on my belly. Once a week I have to go to hospital to change the bag. Birth, senility, illness and death are so natural that everyone will experience them. I should enjoy the time left, is it not right?' (interview with Mrs Yu).

Similarly, Mrs Gao (82, severe impairment, community B):

'I have been in bed for more than 10 years. The doctor said that I had serious osteoporosis… That's bad, but not so bad. My children provided me with good care and bring me love. My neighbour visits me and brings me news and joy…' (interview with Mrs Gao).

Fear - Some older people presented a response of fear, anxiety and despair towards their situation. Mr Cao (82, moderate impairment, community B), who was suffering from combinations of different types of bodily frailty, expressed pain, anxiety and despair about his later life:

> *'I have various types of disease: hypothyroidism, depression, heart disease ... I take lots of tablets every day. I don't get a good sleep even for a single night. It is so painful. I live alone. Maybe one day I will die in my home and no-one will know' (interview with Mr Cao).*

For some older people, pride in a previously active life made changes arising from bodily frailty difficult to accept. Mrs Cao (81, severe impairment, community A) expressed grief and despair at the discontinuity between her previous active life and limited activities imposed by illness and bodily frailty nowadays.

> *'All of the things I enjoyed doing before have gone far away from me. I can't do them any more ... reading novels ... watching movies ... painting ... going to theatre ... I have serious eye disease... Instead of watching TV I was listening to the TV ... I have been very depressed recently ... I'm always worried about my safety - I'm weak and living alone' (interview with Mrs Cao).*

Ambivalence - Among the older people interviewed, the dominant response and attitudes towards ageing and bodily frailty was ambivalence. On the one hand, most of the older people seemed to accept the inevitable fact of function decline and death. On the other hand, they were reluctant to face the human's final destination and were always thinking of past energetic days. Death is a taboo topic when communicating with older people. Many older people refused to think of the future. Mrs Shao's accounts were illustrative.

> *'I'm quite active. I can still manage to do housework. Age isn't a problem ...[Later] I spend much time cleaning my room. It almost drains my energy. I always think of my early days when I was young and full of energy and dream about if I did not have so much disease... This makes me feel worse... I tell myself to stop thinking about it and pay attention to and be*

thankful for what I can do and what I have ... You've got to fight between the
two kinds of thinking' (interview with Mrs Shao).

This narrative reflects Mrs Shao's ongoing struggle for balance. It also shows that an older person's assessment of wellbeing is not only related to the here and now but is also based on their evaluation of themselves over the life course. Reflecting on the past had a great influence on their wellbeing in later life for many people in the study.

5.3.3 Lifestyle change and shrinking social worlds

All of the older people in the study reported an active life in their early retirement. However, as discussed above, as they moved into very old age, most became less mobile and less involved in outdoor activities; most experienced bereavement; their lifestyles changed; their social worlds shrunk. This may affect wellbeing. In the discussion below, I focus on the shifts and changes that occurred as people moved into advanced age; examine patterns of their early retirement lifestyles; trace lifestyle changes in their very old age; and explore circumstances that contributed to their shrinking social worlds and then consider how these may affect their wellbeing in later life.

Early retired lifestyles

Centring on personal or family life – For some older people interviewed, retirement, when it came at the end of a statutory working life, was welcomed, because it meant that they could have more time to spend with their family or to enjoy personal life. Some older people, especially the women, put their hearts into home and family after retirement. Mrs Cao (81, severe impairment, community A), for example, helped her daughter take care of her child for many years. She dressed her granddaughter, cooked meals for her, sent her to kindergarten and then to primary school, taught her classic poetry. She was pleased with her granddaughter's growth and felt proud and happy when she got a good job. But she also complained

that taking care of the child had taken much of her energy and destroyed her health. Some older people spent time with their spouse. Mr Ru (83, slight impairment, community A), for example, joined a singing group within his community with his wife after retirement. As the group leaders, they held singing activities regularly, took part in various competitions, taught new members how to sing… Singing brought them a lot of fun and increased their intimacy. *'Our singing group once won a big prize. My wife and I both like singing very much. We are an exemplary married couple. People in this community know it'*, Mr Ru smiled. Some older people spent much of their time on personal interests and personal life. Mrs Wu, for example, pursued her interests and expanded her learning after retirement. She met friends, travelled abroad and took part in various groups: *'you must keep going, rather than staying at home. Otherwise, your physical and mental ability will decline soon'*.

Continuing in paid work – While some older people centred on personal or family life, some remained in paid work until long after reaching retirement age. For some of these older people, increasing their income in case of eldercare needs in later life was a major concern. Mr Tang (91, severe impairment, community A), an accountant before retirement, continued to work part-time until his late 70s.

> *'My wife and I have to continue to work to make money because we have no children to rely on. Our only child died in his 20s…It is very painful…I worked as a part-time accountant for two companies until I was unable to continue… My wife went abroad and worked as a care worker after retirement…We must save money in case of eldercare needs in our very old age… Without this post-retirement working experience, we would not be able to afford to pay two care workers to look after us, as we do now'* (interview with Mr Tang).

For some older people, continuing in work brought them not only income but also a sense of self-esteem: *'I would never stay at home and sit around all day like some people. I must find a job to do'*. Not wishing to be seen as a 'dead loss', Mr Ru (83, slight impairment, community A) worked as a counsellor for his former company

for many years after retirement. For him, work was not a task but a source of joy and self-esteem.

Working for the community – A distinctive characteristic of many of the older people interviewed was their spirit of dedication. They placed high value on 'working hard and making contributions', the life belief they learnt during the danwei period. In old age this life belief was expressed in active engagement in community groups and activities to make a better life and a better community for residents. Mrs Cao (81, severe impairment, community A), for example, became a community volunteer after retirement, working as a community advisor for residents in her building until she had a fall and was unable to go out independently. She explained:

> *'When people encountered difficulties or problems, they came to me to seek advice or just to pour out their grievances. I served as a peacemaker among neighbours, took responsibility for the safety of our building and the safety of older people living alone, arranged cleaning and sanitation work for our building… It made me happy when I saw people solve their problems with my advice and help. I just want everyone in our community to live a good life.' (interview with Mrs Cao).*

Shrinking social worlds in very old age

Housebound – Many of the older people interviewed had seldom left their homes. Although some could still manage to leave the house independently, they did not go far beyond their communities. Mrs Qi (93, slight impairment, community A), for example, rarely left her home. She explained: *'Although I can still move around slowly, I'd rather stay at home. Because my legs are weak. I'm afraid of falling. I don't want to hurt myself and make my children worried.'* Her social contacts had narrowed to her immediate family living in Shanghai: one of her children lived with her and provided daily support; her other children visited and regularly brought her necessities; grandchildren sometimes came for a chat. Similarly, Mr Gao reported

that his social contacts and activities had considerably narrowed over the past decade. Suffering from the loss of hearing and poor mobility, he seldom left his room: *'It would be embarrassing and awkward when others talked to you and you couldn't respond. That would make me feel hurt, anxious and helpless. I'd rather stay at home.'* Mr Ru (83, slight impairment, community A)'s experience of being housebound was different: although he had been injured in a car accident in the previous year, he had soon recovered. It was Mrs Ru's chronic illness that limited how much they could go out. Mrs Ru was diagnosed with cerebral atrophy more than 10 years ago. After this, Mr Ru began to take care of her, feeding her, dressing her, and talking to her: *'her health status became worse and worse, but I couldn't bear to send her to a nursing home. Staying at home is the best choice for her. Even though that means I had little free time for myself ...'* Mrs Ru's illness narrowed their social environment because, apart from family, they could no longer attend the singing group and see friends and acquaintances.

Analysis of the examples above shows that for the housebound older people, it was not simply bodily frailty that restricted them to the home or community, but a complex mix of social, psychological and physical difficulties, a combination of physical impairment, loss of confidence and concern for family members.

Social isolation – Lifestyle change in very old age brought with it a sense of loneliness and social isolation, a feeling that had its roots in how the others view the ageing group and how older people themselves view their current lifestyle compared to their previous lifestyles. Mrs Cao (81, severe impairment, community A), who had experienced a lifestyle change and was housebound when interviewed, described herself as lonely and socially isolated:

> *'In my early retirement life, I was an active community volunteer…But now you see I can just stay at home and move around with a walker… Although the neighbourhood committee members visit me on festival days and my children come in every one or two weeks, most of the time I am alone… I don't like to go outside. What could I do outside? The younger generation doesn't*

like us older people. It is hard for us to call a taxi. Taxi drivers won't take you when they see you are a frail older person. Travel agencies don't accept people who are more than 75 years old… You always find such kind of ageism…I can only stay at home and became a waiting person: waiting for breakfast, waiting for lunch, waiting for supper and then waiting for death…' (interview with Mrs Cao).

Mrs Cao's comments reflected that being housebound and socially isolated result not only from bodily frailty, but are also a consequence of older people's internalisation of negative attitudes and behaviours towards older age and ageing. This brought with it feelings of anger, despair and loneliness, making it hard to accept lifestyle changes in very old age, and greatly affected older people's sense of wellbeing.

5.4 Wellbeing as resilience: responses and adaptations to transitions, changes and losses over the life course

This section explores how and in what ways older people's wellbeing was sustained when they experienced lifestyle changes and were constrained to a narrow space in very old age. A key question of interest was: what is essential for wellbeing in very old age? As discussed above, all of the older people in this study experienced social transitions, personal changes and some kind of losses during their lives. Resilience – the ability to cope with life's challenges and to adapt to adversity; helped to protect them against lasting negative effects of disruptive events and changes in earlier life and helped to maintain wellbeing in very old age (Masten et al., 2004; Masten & Reed, 2002; Southwick et al., 2016). In this study, although the older people experienced difficulties on account of illness, impairment and bereavement, most were able to find ways of managing daily life, keeping well and securing wellbeing.

5.4.1 Managing health and keeping well

Being positive

For the older people in their 80s or 90s, being positive did not necessarily mean maintaining an independent and happy life, being out and keeping going like a young person. Rather, it was more about choosing positive emotions and ways of thinking. It was seeing the good in people and life, even with pain, sorrow, loneliness and illness. It was about trusting oneself and believing that struggle and pain were not all that is there. It was about not regretting the past, not being afraid of the future and never giving up on the joy of current life.

All older people in the study encountered disruptive events and critical losses over the course of their lives. Their losses accumulated in very old age. Being positive helped most to endure hardships and to keep a peaceful mind. Mrs Yu (85, moderate impairment, community B), for example, described a life dominated by losses: of health, of her husband and the serious illness of her daughter. However, when asked *'how do you like your current life'*, she replied with a warm smile: *'Good, my life is good. My children and the neighbours both treat me well'*. She did not focus on the negative side of life, rather, she chose to see its bright side. Maybe this was why she survived more than 10 years after being diagnosed with intestinal cancer.

Keeping healthy living habits

It is well known that good living habits are important for health. Keeping healthy living habits was particularly emphasised by the older people interviewed, who experienced chronic illness or impairment in their very old age. Some emphasised the importance of maintaining a healthy diet with regular hot meals, eating fresh food, drinking more hot water etc. Some emphasised the need for good sleep: going to bed early, getting up early and having a deep sleep. Some emphasised the importance of exercise – whether it was walking within the community, cleaning

the room, or doing the laundry. Others paid attention to keeping warm and avoiding becoming tired… Each one had their own health theory. Miss Li (82, slight impairment, community A), who was a doctor of traditional Chinese medicine before retirement, paid detailed attention to her daily schedule and daily diet:

> *'I usually go to sleep at 9pm and get up at 5am. In the morning I mainly eat congee, egg and whole grains, like boiled corn, Chinese potato, taro… For lunch I eat rice, vegetables, fish or prawn… For supper I eat only a little, just a little bowl of congee and a small plate of pickled vegetables… Less oil and salt is good for older people's health. The food sold is too oily and greasy, so I cook the food myself… I have kept to a daily schedule and diet for my life. This is very helpful. I have no disease. You see, all my hair is still black now, without even one grey hair' (interview with Miss Li).*

Remaining active

A strong theme across the interviews was a desire to remain active. Being aware of limitations that bodily frailty presented on daily activities, most realised they had to work to remain well and keep going. As bodily frailty began to limit what they could do, they tried to sustain, at some level, valued social activities, interests and relationships to keep independence. Mr Ru (83, slight impairment, community A), afraid of losing self-care functions like his wife (completely bedridden for over a decade) sang every day and thought that this was a good way to exercise his body and mind, and help to maintain his physical, mental and social functioning. Mrs Cao (81, severe impairment, community A), who was passionate about reading novels, had sought other forms of expression for her interests when declining eyesight curtailed her hobby: she now bought a radio to listen to novels. Mrs Shao (aged 83, slight impairment, community A), despite stomach cancer and her surgery twelve years before, remained active, managing most of her daily living, like cleaning the room and washing laundry.

5.4.2 Managing daily life

Maintaining time-space routines

A time-space routine is 'a set of habitual bodily behaviours which extends through a considerable portion of time' (Buttimer and Seamon, 2015: 158). Reports from the older people interviewed indicated that considerable parts of their daily life were organised around such routines. Mrs Cao (81, severe impairment, community A), for example, described a daily routine which she followed practically every day. She would be up at nine, performed her morning toilet, washed her face and then moved slowly (because of two falls and a broken hip) to her kitchen to make breakfast (usually two pieces of toast and a bowl of porridge) by about nine thirty. Then she would move into her living room, take medicine, sit on a sofa to listen to radio or TV, and wait for her care worker to come at eleven to do some housework for her. She would chat with her and sometimes ask her to buy daily living goods for her. The care worker left at twelve. After that Mrs Cao continued sitting or lying on her sofa until around one o'clock when her pre-ordered lunch arrived. Mrs Cao spent 9 CNY on her daily lunch pre-ordered from a meal station in her community. Sometimes she would re-cook the lunch because she thought that it was too hard or too oily for her. After lunch she would have a long siesta until five o'clock, or go outside her door with the help of her neighbour and enjoy the sunshine if the weather was good. At around half past five she began to prepare for supper (usually reheating the leftover lunch). At around seven o'clock she would be in bed if the weather was cold. She listened to her favourite radio channel in bed until eleven and then went to sleep. She was always in a particular place at a particular time and usually doing a particular thing there. As she explained, she did not figure out her daily routine; rather, it unfolded and she followed it.

Time-space routines were considered important for the older people's daily living because they allowed them to conduct daily activities automatically through time; helped to maintain continuity in their lives; and freed their cognitive attention for

more important or joyful events and needs. When they had established daily or weekly time-space routines, they usually became attached to them; any change could cause irritation or emphasis and was usually avoided.

> *'I am used to my daily routines. Keeping the routines makes me feel safe and comfortable. If one part of the routine changes - for example, if my care worker doesn't come that day, or if my favourite radio channel doesn't broadcast stories as usual I would be upset and bothered. If not necessary, I don't change my daily routines' (interview with Mrs Cao).*

Managing daily living tasks

Managing care needs – In most cases, the older people satisfied their care needs themselves when able to conduct daily living activities independently or had enough money to buy care services. Wishing to maintain an independent life, most of the older people only turned to adult children or other network members for help when they could not manage by themselves. Some felt it was undesirable or unnecessary to receive support with daily activities from others. Mrs Shao (aged 83, slight impairment, community A), for example, felt she could still manage her own living and thus refused her son's suggestion of recruiting a care worker to assist her. Some, especially those with long term conditions, chose to hire care workers for daily living support. Mr Tang (aged 91, severe impairment, community A), for example, hired two care workers to help with housework and nursing care. Having enough money to pay for this released him from having to suffer the frustration of being unable to do them himself.

Managing risks – Many older people said that as they entered very old age they inevitably confronted risks. The risks they identified usually related to their homes or activities. Certain parts of their home (for example, stairs, kitchens or bathrooms) and activities (for example, heavy housework, bathing or household repairs) had now become risky. Three central risk management strategies were developed by the older people to deal with these risks: changing their activities, changing things

in their homes, and changing their care arrangements. Mr Tang (91, severe impairment, community A), who lived in a third floor, now seldom came down to the ground floor. He explained: *'Our building did not have an elevator. It's very risky for me, a 91-year-old man, to get down to the ground floor. Most of the time I just stay at home'*. Mrs Ouyang (84, moderate impairment, community A), who found doing housework impossible, hired a full-time care worker to provide daily living support. She explained:

> *'My back was painful. I don't have enough energy to do housework. If I continued to do it, I may hurt myself. Hiring a care worker is a good choice – both for me and for my children who were always worried about my health status and care arrangement'*.

Some older people used technologies to tackle what they perceived to be risks in the home. Mr Ru (83, slight impairment, community A), for example, established an indoor monitor in his room in case of risks and danger. He explained:

> *'The indoor monitor is very useful - children who live far away from their parents can monitor their aged parents' daily living status and thus enable them to respond quickly to dangerous situations. My two daughters both live far from me. My wife has been in bed for more than ten years. It's convenient for them to use mobiles to monitor our daily living: checking our safety, talking with us… The indoor monitor increased our sense of safety and the intimacy between children and parents'* (interview with Mr Ru).

5.4.3 Securing wellbeing on a narrow space

Choices, priority and optimism

In exploring wellbeing in old age, an underpinning view of this study is that 'wellbeing should not be understood simply as a state that people do or do not experience. Rather, it is a process, realised through the 'work' that people put into making meaning out of their lives' (White, 2010: 165). In this sense, wellbeing is more about personal choices, priorities and personalised subjective feelings and understandings. Mrs Wu (86, slight impairment, community A) described a good

life as active and outward. She embraced an outing for dinner once a week with friends and a daily routine – learning English in the morning in a hobby group within the community, learning singing in the afternoon in another hobby group and playing piano and singing songs in the evening. *'Keeping active makes me full of energy and brings me much joy in life. I spent most of my time on these activities,'* she explained.

For Mrs Cao (81, severe impairment, community A), who once was active in community activities, but was now constrained to her home after two falls, simple activities, greetings of neighbours and visits of children and grandchildren were sources of pleasure.

> *'When the weather is good, I will move slowly to the outside to enjoy the sunshine… My neighbour takes my desk outside and helps me settle down… She would chat with me. I like to talk with her… When it is cold, I stay at home all day. I listen to the radio… There are so many good stories there: love stories, detective stories… They are so good! On weekends my children and granddaughter may come to visit me, bringing me delicious food…' (interview with Mrs Cao).*

For people who were very old or completely bedridden, pleasures mainly came from the company of children or care workers and good memories of the past. Mrs Gao, completely bedridden for many years, was quite optimistic about her current life: 'This is life. At least I can still talk with my daughters and grandchildren. I'm content'.

The role of social support

Social support is exceptionally important for securing wellbeing in very old age. It appears that positive social support of high quality can enhance resilience to disruptive life events, losses and changes, help to protect against negative feelings and emotions, and promotes a sense of wellbeing (Ozbay et al., 2007). In this study, it was evident that older people had differential access to resources and support for wellbeing. Those with minimal or no obvious social support, had little in their lives

that gave them pleasure, and their wellbeing was compromised. Miss Hua (82, slight impairment, community B) had almost no social contacts, explaining:

> *'I took care of myself… This is what I do for my life… I didn't get married… Seldom did my relatives visit me… Most of the time I was alone in my room, dark and cold… My room has no heating this winter because repairing the boiler is too expensive… I had no energy to clean the room, so it is kind of messy… I had to everything by myself. No one to rely on… I don't know how long I could continue do it… I don't want to think about the future…'* (interview with Miss Hua).

For Miss Hua, the lack of social support and resources led to a stark life. For those engaged in networks of social relationships and social support, life was different, as elaborated in detail in chapter 7.

5.5 Summary

This chapter has explored older people's earlier life experiences and wellbeing in later life. A key argument is that wellbeing was not a state that some older people experienced and some not, rather, it was a process. Older people's wellbeing in later life was shaped by their experiences, care resources and values that formed over the life course. For some older people, especially those growing up as members of relatively poor class, wars in childhood and the danwei system in midlife provided them with educational and employment opportunities and developmental experiences. For others, experiences of these historical times and historical events may have brought sufferings, pains and a discontinuity from past life. But it could not be simply said that one group had good experiences of the historical times and historical events, and the others not. The influence of these earlier experiences was complex and profound. They not only influenced the material aspect of wellbeing - mainly pensions and social insurance - in later life, but also affected the subjective aspect of wellbeing, to say, older people's sense of security, self-esteem, life beliefs and values and their social networks, social

relations.

Older people inevitably experienced disruptive events, changes and losses over life. The influence of disruptive events and losses extended even into old age, and can have enduring consequences on older people's senses of wellbeing. Bereavement, especially the loss of young children and spouses, was particularly hard to bear and may generate profound pain of grief or change ways of living. Bodily frailty, whether caused by gradual deterioration, traumatic life events or serious disease, presented limitations on the older people's daily living activities, leisure activities and social activities, and led to a sense of ambivalence towards ageing and disability. Shrinking social worlds and lifestyle change, to say, from an active early retired lifestyle – centring on family or personal life, going on paid work or working for the community – to housebound led to a sense of social isolation, which partly reflected some older people's internalisation of attitudes and behaviour that devalued ageing.

Resilience, that is, the ability to deal with life's challenges and to adapt to adversity, as well as the available social support, helped the older people to protect against the lasting negative impacts of the disruptive events and changes and to maintain wellbeing in very old age. For most of the older people, they were able to seek ways of managing daily life, keeping well and securing wellbeing on a narrow space.

Whilst there was no single lifestyle reported that encapsulated a good life in older age, several themes or factors appeared necessary to sustain wellbeing in older age in this study: being positive, keeping healthy living habits, remaining relatively active,, maintaining time-space routines, having capacity to manage daily care activities and risks and being engaged in social relations and social networks which will be elaborated in detail in chapter 7.

Chapter 6　Wellbeing in Older Age: Place Matters

6.1 Introduction

An important trend in ageing in place research is the growing interest in 'the place in ageing' (Williams, 2002). The importance of place is increasingly being recognised by academics, public health practitioners, medical professionals and the general population. However, little remains known about the relationships between person, place, ageing and wellbeing, especially in the Chinese context. This chapter, based on talking with older people themselves and with stakeholders in two communities in Shanghai, examines older people's ageing experience and daily lives in the context of the place in which they had lived their lives, and explores the relationships between older people, place and wellbeing. It addresses the following research questions: How were the older people related to their social and physical environments? How important were home and locality to them and how do characteristics of home and locality contribute to or constrain older people's wellbeing?

The chapter is structured as follows. First, the meaning of home is explored (section 6.2). The physical, psychological and relational aspects of home are examined. The focus is the older person's personal experience of home and its significance in maintaining or constraining wellbeing in later life. Next, the importance of the community is presented (section 6.3). Available eldercare services, existing eldercare support systems, older people's experience and expectations of the services and their sense of belonging and attachment to place are discussed. Finally, a summary of the chapter is presented (section 6.4).

6.2 The meaning of home

While early definitions of ageing in place do not connect place exclusively with one's own home, over the years, the definition has shifted to be more home specific (Weil & Smith, 2016). Home is central in the lives of most people. People live their lives within homes that have physical, social, psychological and cultural dimensions (Andrews et al., 2013; Cloutier-Fisher & Harvey, 2009; Custers et al., 2012; Moore, 2000; Oswald & Wahl, 2005). Clearly, home has special meanings, and those meanings are important to people's wellbeing (Moore, 2000). Given that older people, especially those in very old age spend a considerable amount of time at home (Sixsmith & Sixsmith, 2008), the home space has the potential to play an extremely important role in wellbeing. However, little is known about this relationship, in particular, the home as a determinant for ageing and wellbeing, especially in relation to experience in China. Drawing from existing literature on the home, this section examines key themes that emerged from older people's narratives on home in the two communities studied in Shanghai. The focus is the older people's personal experience of home and its significance in maintaining their wellbeing (or as a source of poor wellbeing) in later life. This approach aims to broaden the current debate on home-wellbeing relationships in existing literatures and to develop an understanding of home in the Chinese context.

6.2.1 The home: a safe and comfortable place for older people?

An important theme that emerged from the older people's narratives on home concerned its physical aspects. This section considers the role of the physical home environment in older people's wellbeing, that is, it explores how housing conditions contributed to or constrained older people's wellbeing. Three sub-themes were identified from the analysis under this theme: a safe and comfortable home (which covers older people's views and experiences of a good home); barriers and risks within the home (which mainly covers difficulties older people with long term care

needs face when living at home); and limited alternatives (a comparison of home and alternative housing options).

Safe and comfortable home

When considering older people's experiences, views and expectations of their homes, it is necessary to know about their housing conditions and living environment. In this study, housing conditions were quite different in the two communities. Although both were old communities, they had quite different histories and building styles. Community A was built in the 1920s and was located in the city centre of Shanghai; it was once, and until the 1950s, a wealthy district. Buildings in community A are all two or three-story brick-built single-family villas, in which rich persons and their families once lived, such as company owners, senior managers, film stars, etc. After the 1950s more families moved into the community A and the single-family villas were often shared by two to three families. From the 1980s, when China began to adopt the open and reform policy, more and more migrant workers began to rent or settle in community A. So a villa in community A housed more than one family when I did my fieldwork there. These families usually had to share bathrooms and kitchens (see Image 6-1 for community A).

Image 6- 1 Community A

Source: the author

Community B is located in northeast Shanghai. It was built in the 1980s, a few years after China began to adopt its open and reform policy. It was built by heavy industry plants in the locality, and was allocated cost-free to their employees. Buildings in community B were among the first modern dwellings in Shanghai. They were six-storey high ferro-concrete buildings with a centralised supply of gas, water and electricity. Each storey had one or two apartments, and each apartment had a bathroom, kitchen and one or two bedrooms, and was between 60 and 90 m2. Each apartment had one family living in it, and each building had an access control system at the front door (see Image 6-2 for community B).

Image 6- 2 Community B

Source: the author

When sharing experiences of their home, older people in both communities emphasised the importance of tidiness, light and aeration-drying. Having a tidy home was a common desire of the older people interviewed. Those who were able to do housework usually cleaned their home regularly and that those who needed support usually hired a care worker to make their home tidy. Mrs Cao (81, lived alone, moderate impairment, community A), for example, hired an hourly-paid care

worker to clean her home. She explained the significance of a tidy home thus:

> *'Having a tidy home makes me feel happy and proud. It shows that I have a decent life. Putting things in a fixed location and not buying things that are unnecessary help to make the home look tidy. As people age, their memory inevitably declines. A tidy home helps to make life much easier. You know the location of everything at home' (interview with Mrs Cao).*

The preference for light and aeration-drying was related to Shanghai's climate and location. Shanghai has a humid subtropical climate with four distinct seasons: a warm windy spring, a hot rainy summer, a cool dry autumn and an overcast cold winter. The weather in Shanghai is usually moist and wet because of its location at the estuary of the Yangtze River to the East China Sea. Residents in Shanghai thus preferred dwellings with good aeration-drying and bright light, as Mrs Shao (aged 83, living alone, slight impairment, community A) described:

> *'The weather in Shanghai is humid, especially in rainy months. It rains for almost one-third of a year. In rainy months the floor may be wet, the shoes and clothes may be musty…Everything is damp. So the dwelling must have good ventilation and bright light…I have a very nice apartment. It has windows and doors on both sides. When the weather is bad I close the windows and back door to avoid humidity coming in. In sunny and breezy days I open the windows and doors to let sunshine and breeze come in. Everywhere in my home is bright. My apartment has a small yard. I usually sit there to enjoy the sunshine and hang out my clothes and quilt. It makes me feel very comfortable' (interview with Mrs Shao).*

In addition, having a separate bathroom and kitchen was preferred, especially for older people in community A who had to share them with other residents (see Image 6-3 for the shared kitchen). *'The only shortcoming of my apartment is that I have to share the bathroom and kitchen with others. There are too many people using them. It's very inconvenient'*, said Mrs Wu (86, living alone, slight impairment, community A). The older people in community B also emphasised the importance

of an appropriate size of home. For Mrs Liu (78, slight impairment, community B), an apartment of about 60 m^2 with three people living in it was too crowded: *'There are only two bedrooms in my apartment. My grandson lives in one bedroom. So I have to share another one with my daughter-in-law. The apartment is too small.'* However, for Mr Cao (82, moderate impairment, community B), his apartment seemed too big: *'An apartment about 90 m^2 with only one person living in easily gets the person lonely. Late at night it even makes you feel scared. To be honest, I want someone else to live with me.'*

Image 6- 3 The shared kitchen

Source: the author

Barriers and challenges within the home

Matching an older person's capabilities, defined as the total of a person's physical, mental, and social abilities, and his or her level of autonomy (Weil & Smith, 2016), to his or her environmental requirements is essential to an older person's wellbeing (Lawton et al., 1997). As people age, there is often a change in personal capabilities, which influences their ability to maintain a balance between personal capabilities and their familiar home environment (Edwards et al., 1998; Moore, 2014).

Obstacles and challenges in dealing with the home environment, especially for those with moderate and severe impairment, was a common theme of both interviews with older people and focus groups with carers and care workers.

The older people, carers and care workers in both communities mentioned that the greatest problem that older people encountered in ageing in place was that there were no elevators in their residential buildings. Living upstairs and having no elevators restricted older people to their homes, especially those with lower levels of mobility (see Image 6-4 for stairs in a residential building in community A). *'I just stay all day at home. The only way for me to go downstairs is being carried out by my care workers. Seldom do I go out'*, said Mr Tang (aged 91, severe impairment, community A), who lived on the third floor. Mrs Liang (focus groups with carers, community B) explained this challenge further: *'My parents live on the fifth floor. They are both in very old age. Their health status is not good. If they were sick, it's very challenging for me to take them down from upstairs to a hospital.'*

Image 6- 4 Stairs in a residential building in community A

Source: the author

A lack of central heating was another big problem the older people encountered when ageing in place. In regions south of the Qinling Mountains-Huaihe River line in China, there is no central heating in most residential buildings. Thus, older people in the two communities had to use a variety ways to deal with the cold winter in Shanghai, a city located in south China (see Image 6-5 for items for keeping warm in cold winter). In the fieldwork for this study, no air conditioners were found in older peoples' homes. The most common way for them to keep warm was staying in bed. Miss Hua (82, slight impairment, community B), for example, described her daily life in winter thus:

> *'It's too cold in winter. Sometimes the weather could be below zero degrees. As an older person, I get cold easily. So I usually get up late in winter mornings. My heating equipment is a hot-water bag. It's put in my bed. After meals I usually go back to my bed immediately, covering with a thick quilt and holding the hot-water bag. Otherwise, my hands and my feet would as cold as ice. My eyes are not very good. In overcast days, it's not easy for me to pour boiled water into the hot-water bag. Once a time, I poured the boiled water on my hand. Winter is not a good season for older people' (interview with Miss Hua).*

Image 6- 5 Items for keeping warm in cold winter

Source: the author

A lack of central heating also makes it difficult for older people to have a bath on cold days, as explained by Mrs Zhao (focus group interviews with care workers, community A), who had been a care worker for about twenty years:

> *'Having a bath could be dangerous for a frail older person. Most older people in very old years have cardiovascular disease. Having a bath in winter in a home with no heating should be avoided in any case. So many older people have to go to a bathhouse to have a bath. However, staffs of the bathhouse may refuse them because they have a high risk of falling or fainting' (focus groups interview with Mrs Zhao).*

Limited alternatives

Interviews with government officers in the two local authorities revealed that there were three main modes of living for older people in Shanghai: living at home, living in an institution or living in a laonian gongyu（老年公寓）[6].

> *'Senior housing developed quickly in Shanghai in recent years. Besides traditional public yanglao yuan（养老院）[7], various types of senior housing emerged, like private huli yuan（护理院）[8], Laonian gongyu（老年公寓）. However, it hasn't satisfied older people's care needs yet. One reason is that the number of senior housings is still limited. Another reason is older people's consumption custom and financial limitations' (interview with a government officer).*

Although older people encountered various challenges and obstacles when ageing at home, seldom did they choose relocation. One major reason was the accessibility and affordability of alternative housing and eldercare services, as explained by Mr Ru (83, slight impairment, community A):

---

[6] Laonian gongyu（老年公寓）means a kind of special flat designed for older people with care needs.

[7] Yanglao yuan（养老院）is a kind of care institution, which is similar to a residential home.

[8] Huli yuan（护理院）is another kind of care institutions, which is similar to nursing homes.

'The private yanglao yuan（养老院）and huli yuan（护理院）are too expensive. You have to spend at least 4,000 CNY a month to live there... Although there are a few cheap ones which cost 2,000 CNY to 3,000 CNY a month, their facilities and service quality are bad… I heard from others that there are Laonian gongyu（老年公寓）which have very good facilities, services and living environment in suburbs of Shanghai. You could buy or rent an apartment there. However, it costs a lot of money… My pension is less than 4,000 CNY a month. How could I afford them?' (interview with Mr Ru)

Mrs Gao (82, severe impairment, community B) argued that the best choice was a public Yanglaoyuan, if an older person had to move out of their home. A public Yanglaoyuan was cheap, which usually cost about 3,000 CNY a month, but had very good service quality and housing conditions. However, the problem was that beds in a public yanglao yuan（养老院）were very limited but demand was high. Older people usually had to wait a long time before moving in: *'sometimes you have to wait several years. So, you'd better hire a care worker and receive care at home'*, said Mrs Gao.

In addition, service quality and the location of senior housing were major concerns for older people and their families. A fear of elder abuse and poor service quality was a major reason older people refused other types of senior housing and remained at home. *'You won't be treated well in an institution. Care workers may even hit you,'* said Mrs Liu (78, slight impairment, community B). Most of the older people and their adult children preferred senior housing located in the city centre of Shanghai. *'I could visit my parents everyday if they lived in an institution in the city centre. It's very inconvenient if they lived in an institution in the suburb. You will spend almost half a day on transportation. That's why all the institutions in the city centre are full.'* Mrs Qin (focus group interviews with carers in the community A), explained.

6.2.2 The home: a place of psychological comfort

Besides the physical aspects of home, psychological aspects of home were another recurrent theme in the older people's narratives. The older people considered the psychological comfort of living in one's own home as even more important than the physical aspects of home in maintaining wellbeing in later life. Their narratives on psychological aspects of home focused on three sub themes: safety, freedom and a sense of control; joy and pleasure; pride and rootedness.

Safety, freedom and a sense of control

The biggest advantage of ageing at home that was greatly valued by the older people interviewed was having control of one's own life, as explained by Mrs Cao (81, moderate impairment, community A): *'Living at home enables me to do what I like, to express myself freely and to behave as I am. This is impossible if I move into an institution where a person has to learn rules.'* The sense of control was closely related to freedom of choice and a sense of safety. Older people emphasised the importance of freedom of choice about their daily life, as described by Miss Li (82, slight impairment, community A):

> *'When you live at home you could decide when to get up, when to have a walk in nearby parks, when to have meals, when to sleep… You could also decide what to buy to make your home comfy, who can visit your home… You are free at home. You are decision makers of your daily life' (interview with Miss Li).*

Feeling safe was a typical feature of most of the older people in the two communities. An apartment of one's own, a steady pension, and reliable network members were key sources of a sense of safety, as explained by Mrs Yu:

> *'I have a solid apartment to keep out wind and rain, a steady pension to maintain everyday life and three children to rely on when I need help. I don't need to worry about anything. I know some older people who have an unhappy later life. Some of them even have no roofs over their heads. It's terrible if you*

don't have your own dwelling in later life. You would totally lose the control of your life' (interview with Mrs Yu).

Feeling safe is also referred to as a sense of being protected from external dangers, such as violence and crime. This was influenced by good community policing, volunteer security work, and physical elements such as solid community gates and video surveillance at the gate entrance. Each community had two gates, making it a confined space which a voluntary security team patrolled every day. These measures helped to form a strong sense of safety for the residents. The older people interviewed seemed never to worry about their safety when staying at home or walking in the community. '*Safety is not a problem. I never think about it. It's quite safe here. Shanghai is a safe city'*, said Mrs Wu (86, slight impairment, community A).

Joy and pleasure

Another advantage of home was that it provided a place to conduct one's favourite activities and hobbies, and thus brought the person great joy and pleasure. The older people interviewed considered it a great source of joy and pleasure to do their favourite activities in a favourite corner of their home. Mrs Wu (86, slight impairment, community A), for example, liked to sit by the window and play the piano. *'It's bright. The sunshine comes in my room. I play my favourite old tunes or try a new one. Sometimes I sing songs while playing. When doing this, I enjoy myself. I get inner peace.'* For Mrs Cao (81, severe impairment, community A), a corner with a sling chair was her favourite. *'I like to sit in the chair to listen to the radio in warm days. The chair is put near the window. Sitting there I could watch out from the window and enjoy the sunshine'*, said Mrs Cao. For Mr Cao (82, moderate impairment, community B), a room with a computer was his favourite. *'The room is my playroom. I search online to invest in stocks there. I exercise there. I see old pictures and diaries there. I do what I like there.'* Mr Cao explained it thus.

It's notable that having delicious food was a big source of joy and pleasure as well. One reason the older people refused to move to eldercare institutions or other types of housing was that they were afraid that they would be unable to get used to the food there. *'If you live in an institution, you have to eat what they cook. But if you stay at home, you could eat what you like.'* Mr Ru (83, slight impairment, community A) explained. Shanghai is a city of gastronomy. Tasty food can be found on almost every corner of the city. It is convenient for local people to enjoy delicious food, and they know how to cook delicious food. Cooking tasty meals and enjoying them with family members were considered valuable aspects of daily life. Take Mrs Qi (93, slight impairment, community B) for example; for her, the best time of the day could be having dinner with her son.

> *'I live together with my son. He cooks dinner every day. Every morning he goes to a supermarket to buy fresh vegetables, fish, prawn etc., then he cooks delicious food, like gold carp soup, lightly fried mustard greens, boiled prawns, braised pork, stew bamboo shoot…Sometimes he also buys various dessert from shops, like Nanxiang Bun, rice cake, red bean cake, pan-fried bun, crab shell cake, sparerib rice cake… There is numerous tasty food in Shanghai. Both my son and I have pension. It's enough for our daily living. Eating well is important and necessary. We sit by a table, enjoying the delicious food. Life is as easy as three meals a day' (interview with Mrs Qi).*

Pride and rootedness

The theme pride and rootedness involved long-term residence in a home, being the host of the home and being able to take care of the home. The older people interviewed had spent most of their lives in their current home. Their life, their happiness and sadness were bound up with their home. The home provided continuity with previous life stages. There was a deep rootedness for the home. Miss Li (82, slight impairment, community A), for example, explained it thus:

> *'I was born and brought up in my current home. Here I once lived together with my parents and my siblings. Every corner of the home reminds me of*

good past days. Except the years that I was assigned to Nantong city to work, I have lived all my life in this house. My parents and my eldest sister died here. I never got married. Once my brother asked me to live with him, or said he would buy a new apartment for me. He was very rich, having a big company and living in a very big nice villa. I refused. I don't want to move anywhere. I just want to live in my parents' house' (interview with Miss Li).

Similarly, Mrs Ouyang (84, moderate impairment, community A) emphasised the importance of home as a place of previous intimate relationships and expressed a strong desire to live in the current home through her rest of life.

'My husband and I have lived here for more than 40 years. We are a couple, but we are also close friends. My husband passed away here just a few months ago. I won't move out from my home, because my husband lived here' (interview with Mrs Ouyang).

Besides a place of previous intimate relationships, home was also a source of pride. Having one's own home enabled the older people to access the socially respected roles of hosts (Juhila et al., 2016). Being a host of a home, the older people could control the access to their home, make the rules and decisions in their private home and expect guests to respect their self-determination and privacy. Being a host of a home also reminded older people of past glories and achievement. Mr Cao (82, moderate impairment, community B), for example, recalled his experience of being allocated a good apartment for his hard work as a railway staff.

'I was cited as the pacesetter of our Danwei at that time. People in our Danwei, a railway station, all knew that I was a hard working person. So, unsurprisingly, I was one of the first to be allocated a good apartment at that time. I clearly remembered the first time that my family and I moved into the new apartment. Everything was so nice. Till now I have lived here for nearly 40 years' (interview with Mr Cao).

Like Mr Cao, Mr Ru (83, slight impairment, community A) spoke about his successful career which had enabled him to own the apartment he now lived in.

'I worked in an international trading company. My job was negotiating and signing contracts with foreign companies. I once successfully brought about a multi-million CNY contract for our company. Since I did well in my job, I was allocated two apartments. By converting the two apartments I had a larger home. Few people could be allocated two apartments at that time' (interview with Mr Ru).

The sense of pride and accomplishment continued when the older people remained at home and acted as hosts governing their home space. Actually, being able to take care of their home was a big source of pride in very old age. Mrs Shao (83, slight impairment, community A), for example, expressed a sense of pride for being able to do almost all the household activities by herself. *'I cook dinner, wash clothes, clean the home… There is no problem for me to live alone in my home. I could take good care of myself and my home'*, said Mrs Shao.

6.2.3 The home: a place of connection to the broader social and physical environment

It is obvious that the home in which older people lived was not an isolated place, but a place embedded in broader social and physical environments: the community, streets and parks.Besides being a place in which social connection and social interaction occurs, the home enabled the older people to access the wider environment outside their home. This study shows that one important reason why the older people interviewed stayed at home in very old age was that it allowed them to connect to the people they knew well and the surroundings they were familiar with.

Connection to the people they knew well

The home space enabled gatherings of older people and their family, friends and neighbours, which was essential for wellbeing in later life. The home provided a flexible and important place within which visitors felt welcomed, comfortable and

at ease. Through regular visits or co-residence, older people shared the home space with those important others and maintained bonds and relationships between them. Many older people refused to move into an eldercare institution and expressed a fear of losing connection with people they knew well if they moved out of their home. Mrs Ouyang (84, moderate impairment, community A), for example, explained it thus:

> *'I have good neighbours, good friends and my children living nearby. They visit me quite often. My daughter lives in the building right next to mine. She visits me almost every day and brings me delicious food when she cooks tasty meals. My next door neighbours usually enter my home, chat with me and sometimes help to repair my home appliances. When they have troubles they talk about them with me and I comfort them and give them suggestions. The neighbourhood committee members and leaders and colleagues of my Danwei also visit me and bring me small gifts at festival times. All these are very valuable. Everything is nice. I never think about moving out from my home and moving into an institution where everything is strange and I know nobody' (interview with Mrs Ouyang).*

In addition, some older people also emphasised the importance of connection with younger generations. Mrs Wu (86, slight impairment, community A), for example, argued that one advantage of living at home was that it enabled the older people to have more opportunities for contact with younger generations. She explained:

> *'If you move into an eldercare institution or a Yanglaoshequ, you are just in contact with older people; you will be isolated from the real society; hardly can you see a young person with black hair. Staying at home is different. Some young volunteers visit me, chatting with me and teaching me new technologies. I can also chat with young people in my community, in shops nearby… I enjoy this a lot. I like chatting with young people. They are full of energy' (interview with Mrs Wu).*

Connection to familiar surroundings

The home exists within surroundings: the communities, the streets, the parks and the shops. Staying at home enabled the older people to easily access these places which were familiar and important for them. The older people's narratives showed that besides local communities (the importance of which will be illustrated in detail in the section below), parks, squares and hospitals nearby were important places that had a big influence on their daily life and sense of wellbeing.

For the older people with good mobility, parks and squares nearby were the most attractive place. Shanghai's 16 districts have 151 parks in total (Shanghai Toutiao, 2018). Each district has at least two parks. Most citizens can visit a park near them by less than 30 minutes' walking. The parks cover a wide area, with numerous trees, grass, flowers, rocks, birds, long corridors, desks, and public toilets. Retired people like to gather together in the parks and squares. They play musical instruments, sing songs, play chess, dance and chat. There is a festive and lively atmosphere in the parks and squares from day to night. Older people enjoyed this atmosphere a lot and considered visiting the parks or squares as beneficial for their health and happiness. Visiting parks and squares has become a daily routine for some older people. Mrs Yu (85, moderate impairment, community B), for example, visited a park every day. After having breakfast she went to the park to chat with friends she made in the park and watch people playing instruments, singing songs, dingo square dancing, etc.

> *'This made me feel happy and relaxed. In the park I had many people to chat with. We are of the same generation, so we can understand each other easily. Sometimes I just sit there and watch people playing music instruments or practicing Tai Chi. This makes my heart full of joy and peace' (Mrs Yu, 85, moderate impairment, community B).*

For the older people with severe impairment or serious diseases, hospitals nearby were of crucial importance. Generally, there are three levels of hospitals in

Shanghai: community healthcare service centres, district-level central hospitals and the city-level big hospitals. Each district has a district-level central hospital and several community healthcare service centres. So, staying at home enabled the older people to easily get access to hospitals, as explained by Mr Ru (83, slight impairment, community A):

> *'My wife has severe encephalatrophy. She has to see a doctor every other day or so. If we move into a suburban eldercare institution, it will be very inconvenient for her to have a treatment. Staying at home allowed us to easily go into the community healthcare service centre and have the best treatment in a city-level big hospital. Living in a place near hospitals is convenient for people in very old age' (interview with Mr Ru).*

6.3 The importance of local communities

As home is usually the foremost place in people's lives, home has received considerable attention, but only recently has this attention been focused on neighbourhood and community. A growing paradigm shift emphasises efforts to promote ageing in place not only by helping ageing individuals and families, but also by addressing and engaging communities (Greenfield et al., 2012). In fact, the appropriate use of in-home and community-based services was related to delaying nursing home placement, reversing deterioration of physical functioning, and increasing survival (Tang & Pickard, 2008). The provision of a variety of flexible services under innovative delivery systems will help meet the changing needs of older people and facilitate ageing in place (Chen & Sun, 2010; Chen, 2014; Huang, 2005; Wu & Xu, 2007). This section examines existing eldercare support systems in the two communities in Shanghai, older people's experience and expectations of the eldercare services, their attachment to the localities and sense of belonging and influences of these on wellbeing in later life.

6.3.1 Community-based models of eldercare services

As one of the country's largest cities with the longest average life expectancy (83.18 in 2016) (SRCA, 2016), Shanghai has a strong motivation in exploring ways to support older people to age in place. This section, based on interviews with older people and stakeholders, and focus groups with carers and care workers, identifies three types of community-based eldercare support in the two communities in Shanghai, including the supportive neighbourhood committees; the telephone-based eldercare support system and various voluntary groups of older people.

Supportive neighbourhood committees

Neighbourhood committees play an important role in providing public services and maintaining social order in urban China after the collapse of the Danwei system. Few local-level institutions could have the same degree of influence on residents' lives as neighbourhood committees do (Gui et al., 2009). For the older people in very old age, who are more likely to be restricted to the communities, neighbourhood committees assume considerable significance in their daily lives.

On the one hand, as 'an arm of local governments reaching out into the grassroots' (Gui et al., 2009: 407), the neighbourhood committees take responsibility for old-age welfare and old-age security in local communities. According to Mr Wu (a leader of neighbourhood committee in community A, in-depth interview) and Mr Shang (a leader of neighbourhood committee in community B, in-depth interview), the two communities had similar arrangements in old-age welfare and old-age security.

First, both communities provided care support for vulnerable older people, including those with financial difficulties, those with no children and those with severe impairment, and respite services for carers who had no support from others. For example in the community A older people with low income and severe

impairment could have care services (valued at 1,000 CNY per month) and carers eligible for respite services could have 100 hours of free care services per year; in community B, older people with low-incomes and aged 80 and over could have homecare services at a 50% discount. The neighbourhood committees received residents' applications, checked their validity, submitted them to local authorities for confirmation and then contacted local eldercare agencies to provide the services. Also, both neighbourhood committees took responsibility for providing social security for vulnerable older people, including medical relief, housing assistance and legal aid.

Secondly, both communities provided old-age welfare for older residents. For example, in both communities all people aged 90 and over could get a cup of free milk every day; all people aged 100 and over received a free birthday cake (valued at 100 CNY) and a gold medal (valued at 1,000 CNY) on their birthday, and could then receive monthly subsidies (in community A 400 CNY a month and in community B 300 a month). Thirdly, one major duty of the neighbourhood committees was to keep the communities clean, safe and harmonious. Neighbourhood committee members and volunteers worked together to provide measures for fire prevention, burglary prevention, electricity guard, sanitation and civic virtues both in the public area and residents' home.

On the other hand, as self-government organisations of local residents, neighbourhood committees had more autonomy and were sensitive to their role of serving the residents. For example, both communities established a supportive scheme called 'caring for older people living alone' as a response to older people's feelings of loneliness and expectations for security. Being part of the communities, neighbourhood committees were seen as a trusted place where people could go for help. While there was no expectation that neighbourhood committee members would do anything, they were considered to be people who would help, as explained by Mrs Li (a leader of the neighbourhood committee in community B):

'The neighbourhood committee gives the older-people residents a sense of security, especially for those whose children are not in the community. They know whom they can turn to for help when in need of support. We provide help for almost everything, ranging from home appliance repair, cleaning rooms, computer technology teaching, advice on estate distribution, and family conflict mediation' (interview with Mrs Li).

The telephone-based eldercare support system

Against the background of increasing long term care needs, older people's strong desire to age in place, weakened family care, the breakdown of the danwei system and limited roles of neighbourhood committees, local authorities and local communities in Shanghai began to exploit new ways of dealing with eldercare and promoting ageing in place as early as the 1990s. According to Mrs Qin (district-level government officer, district A where community A is located, in-depth interview) and Mr Zheng (district-level government officer, district B where community B is located, in-depth interview), at first the local authorities covered all medical treatment and nursing care fees for the older people who applied for ageing-in-place support. However, this policy resulted in many long-stay older people in hospitals, significant health care costs and shortage of medical resources. Then, the policy was abolished. The local authorities began to provide necessary and limited care support for older people (mainly vulnerable older people), whether through the local authorities themselves or by cooperating with local institutions. By 2015, when I did my fieldwork in Shanghai, both districts had established telephone-based eldercare support systems to deal with their residents' eldercare needs.

In community A, the telephone-based eldercare support system was mainly operated by a private not-for-profit corporation called Qingniao, which grew out of a public eldercare support centre in 2004, conforming to the national policy direction of simpler administration and public-owned enterprise reform (see Figure 6-1 for the telephone-based community support system in community A).

Figure 6- 1 The telephone-based community support system in community A
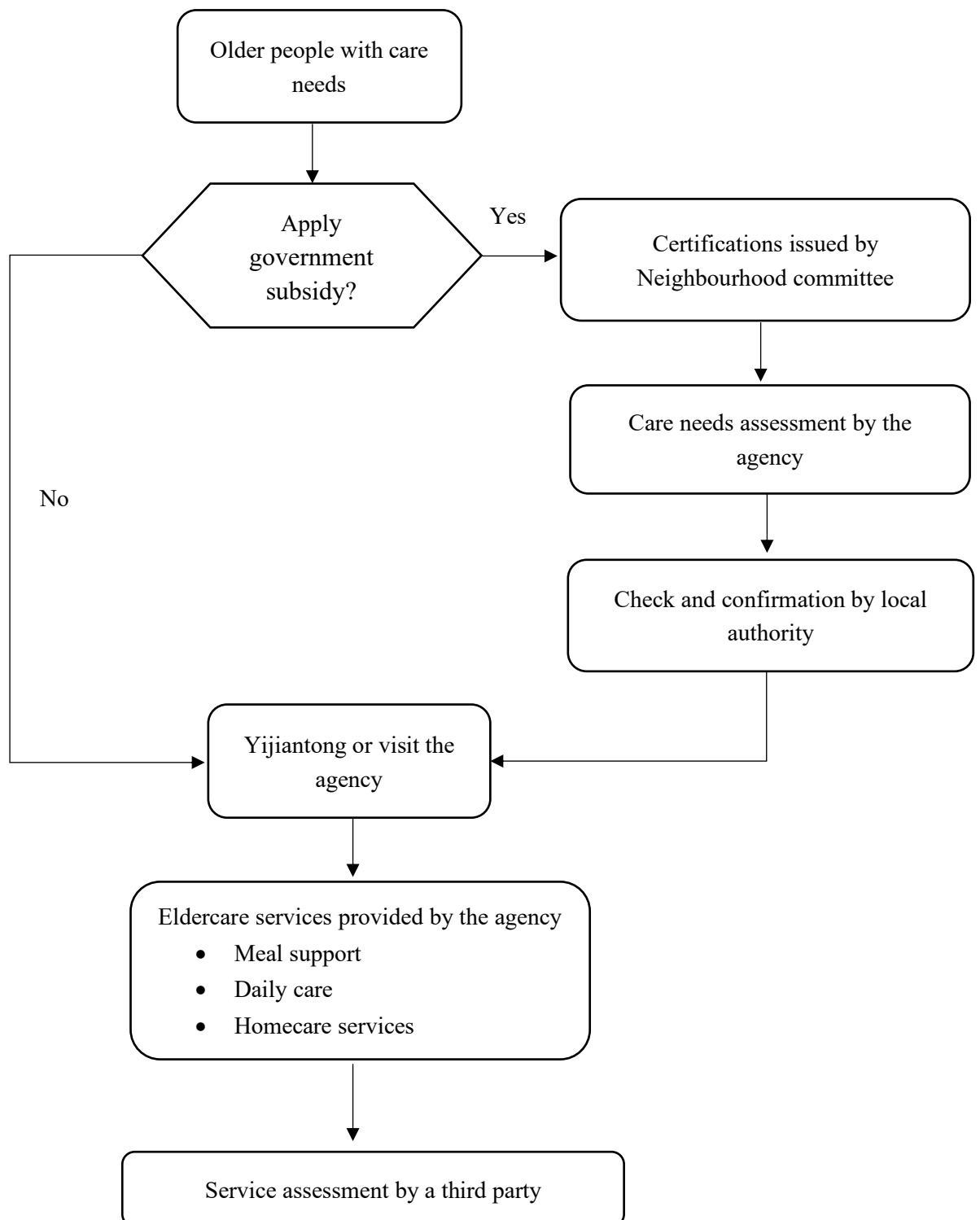
Source: the author

Qingniao was an independent organization, drawing on a range of funding sources, including annual subsidies from local authorities (approximately 200,000 CNY a year), agency fee, care service charge, government awards for achieving honourable titles and time-limited funding for various projects from local authorities. A staff team of around 40 people took responsibility for care service provision at all levels: managing relationships between older people and care workers, managing 600 care workers (providing trainings and job opportunities, health examination and tracking service quality) and providing station-based care services.

Qingniao was supported by a large backup group: food companies, hospitals, hotels, neighbourhood committees, local authorities, libraries, supermarkets and psychological clinics. According to Mrs Wang (a chief staff of Qingniao, community A, in-depth interview), there were 81 institutions in the backup group. Through cooperating with the backup group, Qingniao was able to integrate various resources nearby and to provide abundant eldercare services for the older residents. It provided not only station and centre based services, but also homecare services (see Image 6-6 for the eldercare service centre in community A). This included both daily living support, medical and nursing care support. Support was not only for older people but also for their families. These services were not only regular and stable services but also flexible services in the form of eldercare projects. They provided both rehabilitation and assistive support and also preventative support. Older people who needed care support could establish a special phone called Yijiantong to call the agency or visit in person to book services they wanted. A call centre organised by Qingniao responded to these calls 24 hours a day, 7 days a week.

In community B, things were a little different. First, unlike community A, homecare services, meal support services and daily care services were provided by different organisations or administrators in community B. A not-for-profit corporation called

Jianghe, similar to Qingniao, established and operated a telephone-based eldercare support system, called 96890 Eldercare Platform, and provided homecare services for residents in district B (including those located in community B), especially for vulnerable older people eligible for government subsidies. The sub-district level government took responsibility for meal support and daily care support through cooperating with a third party. Secondly, different from community A, there were no meal stations and daily care centres located in community B. Older people who need meal support or daily care support had to contact meal stations or daily care centre nearby to get relevant services.

Image 6- 6 The eldercare service centre in community A

Source: the author

Various groups of older people

Besides neighbourhood committees and the telephone-based eldercare support system, there were various groups voluntarily organized by older people that

provided support for the older residents in the two communities. These groups could be mainly classified into two types: volunteer groups and hobby groups. Activities organised by volunteer groups included assisting neighbourhood committee members in the work, cleaning the community, providing free lectures on health, disease recovery and self-care and community security patrol (see Image 6-7 for a volunteer group in community B). Hundreds of older people had registered as community volunteers in the two communities. There were also various hobby groups in both communities: singing groups, dancing groups, instrumental music groups, chess and cards groups, language learning groups, and computer skill training groups. Older people could participate in these groups and attend the activities freely. Organising various social and leisure activities, these groups sought to enrich older people's daily lives, to facilitate mutual support and to enhance their enjoyment and happiness.

Image 6- 7 Volunteers in community B

Source: the author

Older people played a key role in organising and participating in these activities – planning events, developing new members and managing groups. One distinct feature of these groups was that most of their members were older people who had good mobility and remained active. The active older people may be engaged in many different groups, being both volunteers and active participants in hobby groups. Although these group memberships were open to all older people aged 60 and over in the communities, older people who were restricted to their home could hardly be included in these groups and activities.

6.3.2 Using the services: experiences and expectations

The section above examined existing community-based models of eldercare services in the two communities. This section focuses on older people's experience of using the services in maintaining wellbeing in later life and their perceptions about service priorities and barriers in accessing to or using these services. It explores older people's experience of homecare services, older people's experience of community-based care services and older people's perceptions of unmet needs.

Experience of homecare services

Generally, the older people interviewed gave a high appraisal of the services that were delivered into their homes, especially for those with government subsidies. The fact that they could get support from the locality helped to enhance their sense of security, to satisfy their desire to age at home and to promote their subjective and objective aspects of wellbeing. Mrs Wu (86, slight impairment, community A), for example, described the services she received thus:

> *'It's very nice that I could have a care worker to help with household tasks for free. She visits me for one hour a day and helps to cook meals, wash laundry and clean the room. To be honest, I don't have enough energy to do these things, so the services are very helpful. Since I'm living alone and have no children, the daily visits of the care worker and the greetings from Qingniao*

staff through Yijiantong – I installed the special phone – makes me feel secure and warm' (interview with Mrs Wu).

However, only a few older people had government subsidies, typically those with financial difficulties; those who had no children and those with severe impairment. There were many other older people interviewed who received no or little support from the local authorities. For these older people, having enough money was of critical importance. Although money was not a dominant theme in the older people's narratives, having enough money was considered critical in maintaining wellbeing in later life. The older people who were able to manage financially and afford eldercare services expressed a higher degree of confidence, security and life satisfaction than those with limited financial resources. For those with limited financial assets and who had high levels of care needs, being excluded from social support may cause a feeling of disappointment and envy towards those who had government subsidies. Mrs Cao (81, severe impairment, community A), for example, described her opinions thus: *'The older people having no children benefit a lot from current policies. Governments and communities show much concern for them. While people like us who have children are left behind.'*

Whether rich or poor, the majority of older people raised frequently the importance of savings in earlier life in case of serious diseases and accidents in later life. They spoke highly of the thrifty habits they learned under the Danwei period when a lifestyle of 'hard working and plain living' was advocated and lived a simple life that fulfilled modest wants. *'It is a natural thing that you save money each year to provide against a rainy day, especially in case of possible diseases and inevitable death.'* As explained by Mr Cao (82, moderate impairment, community B).

Worries about the high cost of possible diseases and inevitable death resulted in high savings and little consumption. Most of the older people interviewed purchased eldercare services only when they were no longer able to take care of their home or themselves. Mrs Qin (district-level government officer, district A, where community A is located, in-depth interview) explained: *'The older people's*

generation encountered many financial hardships in early life stages, so they are unwilling to spend money on care services in later life. They choose to do things themselves as long as they are able to do it.' Actually, many of the older people recounted financial hardships that they had experienced in the danwei period and during times of war, when interviewed. Mrs Gao (82, severe impairment, community B), for example, spoke about the hard work involved in bringing up two daughters in the danwei period.

> *'You bought everything by coupons at that time, food coupon, cloth coupon, meat coupon… My parents-in-law had no pension. My two daughters were still young. You always found that the coupons were insufficient for buying the whole family's food and clothes' (interview with Mrs Gao).*

Compared with earlier days, many older people felt that they had a much better life now, with abundant material products and services within their reach, stable pensions and home ownership. After several decades of hard work and a lifetime of saving, older people could afford to buy eldercare services when in need of long term care in very old age. The three most popular homecare services among the older people interviewed were meal support, housework support and nursing care. Service qualities were seen as having an important impact on older people's wellbeing. Flexibility and responsiveness to specific personal needs were valued by the older people. For example, older people placed a high value on the qualifying period of care workers. *'The qualifying period of care workers makes sure you establish a good relationship with the care worker, although sometimes you have to do without because the care workers are in shortage.'* Mr Ru (83, slight impairment, community A) explained. Quick and appropriate responses were also valued. *'We respond quickly. We try our best to satisfy older people's needs. Otherwise they would feel disappointed and no longer use our services'* said Mrs Wang (chief of staff, Qingniao, community A, in-depth interview).

Nevertheless, older people may still have a negative experience when using homecare services. For example, some older people complained that the meals provided by the meal stations within communities were 'too oily' or 'hard' and thus were unsuitable for frail older people to eat. *'I always recook the meals that they deliver to me'* said Mrs Shao (83, slight impairment, community A). There were also older people who did not want others to enter their life. Miss Hua (82, slight impairment, community B), for example, was angry about the neighbourhood committee's help to clean her home: *'I don't want someone else to tell me what my house should look like.'*

Experience of community-based care services

Community-based care services had quite different meanings for those who remained active and those facing limitations. For those actively engaged in community groups, social activities were seen as important for wellbeing in later life. From the accounts of the group members, the groups provided opportunities to be involved in social activities, to learn new skills, to make new friends, to receive companionship, to reduce loneliness and to experience a sense of belonging. Mr Ru (83, slight impairment, community A), for example, who had once been a leader of a singing group, described how being a leader of a hobby group had changed his later life:

> *'I learnt singing all by myself. Singing makes me happy and healthy. It's true that singing is good for health. Both my wife and I once were core members of the singing group. We taught new members how to sing, printed music scores, made discs, took part in various singing competitions with our group members… Organising the singing group gave me a sense of meaning in my later life. Being together with group members I never felt lonely and bored'* (interview with Mr Ru).

The opportunity to help others was also a key motivator for many group members, especially the volunteer group members. For these older people, being able to help others and making one's own contribution to building a good community were

major sources of pleasure and enjoyment, as well as a source of pride. Alongside their sense of responsibility were feelings of love. Mrs Ouyang (84, moderate impairment, community A), for example, spoke of her volunteer experience thus:

> *'I'm on duty for one day a week. My duty is keeping an eye on the security of our community and any emergencies that occur within our community. On the day I'm on duty, I wear the community volunteer uniform and sit in front of the gate of our community with other volunteers. Although my health is not very good, I can do what I can to contribute to our community. I don't need to have a day-to-day responsibility, so it's ok for me. I enjoy my volunteer work.' (interview with Mrs Ouyang).*

For those facing limitations, the value of community-based eldercare services lay in the fact that they could provide practical support, advice and guidance when in need of help. Being rooted in the locality and through building alliances with various institutions and groups, the neighbourhood committees and eldercare agencies were able to mobilise care resources to sustain older residents' wellbeing, even in the face of mobility restriction. They played an important role in linking older people with available services, advice and assistance.

For example, older people in community A spoke highly of the eldercare service centre operated by Qingniao and located within the community. In the eldercare service centre they could have a bath, eat meals, have a haircut, have laundry washed, etc. *'If you want to have a bath or wash your laundry, you can just drop in. The facilities there are new and good'*, said Mrs Shao (83, slight impairment, community A). According to Mrs Wang (a chief of staff of Qingniao in community A), the eldercare service centre was not only a place where older people could stay in the daytime, but also an 'eldercare service shop'.

> *'We provide a service menu. The older people can choose what services they'd like to have and where they'd like to have these services. We then contact relevant back-up groups to provide these services or provide services ourselves. For example, older people can have meals in our centre or call for*

a meal delivery. They can also have a bath in the centre or ask for professionals to assist them to have a shower in their home. Since many older people don't have good bathing facilities at home, the bathing project is very popular' (Interview with Mrs Wang).

Unmet needs

Although the eldercare services were valued by the older people interviewed and seen as important in securing their wellbeing in later life, they did not offer a panacea and could not solve all problems. Themes of unmet need emerged from some older people's narratives, which were confirmed and extended by other research participants. For many older people, especially those who were isolated, worries about being unable to get support from a reliable person when in need of help were linked to perceptions of unmet need. Some older people spoke of the lack of help with daily living tasks, especially things to be done outside the home, like shopping, managing financial matters, seeing a doctor. Mrs Cao (81, severe impairment, community A), for example, expressed her difficulties in later life thus:

'I have fallen once. Soon after that I fell again. Before my children came I laid on the floor for a long time. It's hard for an older person who lives alone to get timely help when in a crisis, even if you have children. I don't want to live with my children. After my second fall, I still live alone. My care worker visits me every day. Sometimes I ask her to buy daily living goods for me, but I don't bother her that much. She has to go elsewhere to do her job after visiting me. I can't waste her time on my personal matters. Sometimes I ask my children to buy things for me when they come to visit me. Having problems with mobility, I have no choice but to rely on others for shopping' (interview with Mrs Cao).

Some older people spoke of the fear of dying and not being found. Mr Cao (82, moderate impairment, community B), for example, expressed a feeling of despair towards his future:

'Although my neighbour knocks on my door and says hello to me every one or two days, it doesn't mean that you could call her whenever you encounter problems. For example, how could I bother her if I came to a sudden onset in the middle of the night? Every person has his/her own business. You have to rely on yourself. No one can help you. Sometimes I can't help but wonder if anybody will be by my side in my last day of life' (interview with Mr Cao).

Although services delivered by eldercare agencies and support provided by neighbourhood committees were seen as good ways to address older people's security, they could not offer the availability for all older people in need of help and could not ensure that all care needs would be addressed. In practice, isolated older people seemed to be less likely to get access to eldercare services. In fact, awareness of available care services was a precondition for care service use. The isolated older people, having few social contacts and being restricted to their home, might not know much local information and thus be less likely to benefit from it. Miss Hua (82, slight impairment, community B), for example, knew nothing about available eldercare support within her district when interviewed. *'No one tells me about that'*, she said.

Availability of eldercare services within the local community was another important factor that influenced older people's care strategy and wellbeing in later life. In the study, most of the older people in community B (unlike community A) did not know they could get meal support and homecare services from local eldercare agencies and institutions. *'Our community doesn't have such kind of institutions, so few people know about that. Our community does cooperate with local institutions, but the focus is on vulnerable older people who have various difficulties,'* Mr Shang (a leader of neighbourhood committee in community B, in-depth interview) explained.

Affordability was also seen as playing a central role in eldercare service use. Most of the older people in the two communities considered that they could afford to buy meal services and community-based eldercare services, which usually cost them

around 10 CNY a time, although they thought the price was high. However, most said that they were unable to afford the pay of care workers, especially live-in care workers. *'My pension is just 4,000 CNY a month. How am I able to hire a live-in care worker whose pay is at least 3,500 CNY a month?'* asked Mrs Cao (81, severe impairment, community A). 4,000 CNY was the average level of pension of the older people interviewed, so, generally, they had to use their savings or receive financial support from their children when in need of a high level of care. *'It's difficult to solve this problem. Demand for care workers is high, but provision is insufficient. The price is decided by the market'* said Mrs Qin (district-level government officer, district A, where community A is located, in-depth interview).

6.3.3 A sense of community

The older people had lived their lives within local communities. Besides the material aspect of wellbeing – in terms of the eldercare services and daily living support, local communities were likely to have an important impact on the psychological aspect of older people's wellbeing, that is, their sense of belonging and attachment to their local communities. This section, in examining older people's own perceptions and feelings of local communities, has shown there were significant differences between the two communities in the older residents' attachment to place and sense of belonging.

Strong attachment and belonging: community A

Most of the older people living in community A had spent most of their lives in the local area. For them, the locality represented a significant element of their personal identities. Their sense of identity was closely related to the place in which life course events, experiences and daily activities occurred. Mrs Cao (81, severe impairment, community A), for example, recalled her past life in the locality as a vivacious and happy young woman:

'The area around our community was a rich area before. There were various cinemas, theatres, shops and restaurants at that time. I remember that when I was a young girl, I usually watched movies with my girlfriends on weekends. We dressed in cheongsam, held a fine handbag in our hands and took cars to enjoy wonderful foreign movies, like 'Gone with the Wind'. The famous department store - 'Yongan' company - was just on the way to the cinema. Sometimes we also did the shopping in the department store. My father had a big company, so my family was able to provide me with the best living conditions and good education. My parents wanted my sisters and I to be 'fair ladies'. I could never forget the good habits I learnt when I was young' (interview with Mrs Cao).

Recalling past lives sat side by side with a sense of loss in terms of the changed physical and social features of the landscape. *'The community is quite different from before. Now the community we live in has become an old one. Old shops, restaurants and cinemas nearby have all disappeared. Migrant workers and various strangers have moved into the community'*, Mr Ru stated (83, slight impairment, community A). However, the gap between community A in the past and the present did not undermine the older people's sense of belonging and their attachment to the locality. First, memories of past lives and the remaining residential buildings in the community provided them a sense of continuity that helped reinforce their sense of community and attachment to place. Mrs Shao (aged 83, slight impairment, community A), for example, explained: *'Our community has become an officially protected monument and site. It won't be torn down. I will live here until the last day of my life, just like my parents-in-law and my husband.'*

Secondly and more importantly, for most older people, especially those who had moved into the community only a few years ago, it was the available eldercare support and the warm community spirit that sustained and reinforced their sense of belonging and sense of the community. Generally, supportiveness and neighbourliness were viewed as notable features of community A, which the older people spoke highly of and considered essential for sustaining their wellbeing in

later life. Mrs Ouyang (aged 84, moderate impairment, community A) was deeply moved by the warm and supportive spirit in the community and described it thus:

'I like to live here very much. I won't move anywhere. When I moved into the community a decade ago, I didn't make up my mind, but soon I told my children I will put down roots and never move again… I was and still am moved by the lovely spirit of our community. The neighbours are friendly… The neighbourhood committee members are responsible and reliable… They visit me and give me warm greetings and concern… The eldercare agency provides various care services… I know where I can get support when I need help. The community work is excellent in our community. Living here I feel warm, happy and secure.' (interview with Mrs Ouyang).

It was the lovely community spirit – rooted in the older people's daily community life – that formed the basis for their strong attachment to place and their active engagement in community activities. For the older people, community A was not only a place to live, but also a place central to personal identities, shared memories and social connections. Through ongoing contact with neighbours, neighbourhood committee members and eldercare agency staff the older people reinforced a deeper sense of belonging within existing networks that provided a basis of social support (as discussed more fully in chapter 7).

Varied attachment status: community B

Unlike community A, the older people living in community B had not spent most of their lives in the locality. Generally, the older residents in community B had moved to the locality in the 1980s when the community was established. For them, it was not the place where they grew up, went to school or got married, but the place where they had spent the latter half of their lives. Actually, many older people living in community B had not been born or grown up in Shanghai, but had migrated from nearby provinces, like Jiangsu and Zhejiang, in the Danwei period when there were great job opportunities in heavy industry in this area.

It is notable that the meaning and importance of the community varied considerably among the older people in community B. For those with good mobility and who were actively engaged in community activities, a strong sense of belonging and attachment to the locality was sustained. The sense of belonging was mainly sustained through interaction with neighbours with shared memories of place, people and working experience in earlier life stages. It was the similar experience of earlier life stages and community engagement in later life that formed the basis of the older people's sense of community. Mrs Liu (78, slight impairment, community B), expressed her attachment to the community thus:

> *'I spend all my day in the community. After meals, I usually go downstairs to chat with neighbours. People gather together in groups of four or five, playing cards/chess or just chatting. We talk about old past days when we worked hard in the Danwei. We also talk about life nowadays, like our health, our children etc. You will quickly know the community news through this kind of gathering. Sometimes I also exercise my body by using fitness equipment installed in the community. I don't go far away. I just like to walk around within the community. This makes me happy and comfortable' (interview with Mrs Liu).*

Similarly, those who received care support from local authorities and neighbourhood committees had a strong sense of belonging and attachment to the community. They spoke of the community with affection, appreciation and satisfaction. Mrs Gao (82, severe impairment, community B) expressed her affection and appreciation towards the locality thus:

> *'The neighbourhood committee leaders care for me and my family. I have successfully obtained eldercare subsidies after making an application to the neighbourhood committee. Since I'm over 80 years old, the neighbourhood committee provides me with a free birthday cake valued at 100 CNY every year. The neighbourhood committee staff and government policies are very good. I have nothing to complain about' (interview with Mrs Gao).*

Mrs Gao's experience reveals an important facet of life in the locality – the central role played by the neighbourhood committee members who, by virtue of their work, had close relations with the older residents, knew their real status and dealt with their most pressing needs. Those who were restricted to home and did not receive much support from the neighbourhood committee may be less deeply rooted in the locality and lack some of this sense of belonging. For those with slight or moderate impairment, their home was crucial in securing wellbeing in later life. They spoke of their attachment to home rather than to the wider community in which their home was located. Mr Cao (82, moderate impairment, community B) expressed his disappointment towards the local community thus: *'I'm lonely and always feel scared on dark nights. Seldom do neighbourhood committee members visit me. I don't know where I can get help. I have been used to staying at home and solving problems by myself.'* For those with severe impairment, a lack of professional eldercare support may lead some older people to move into nursing homes.

6.4 Summary

The concept of place adds an important dimension to understanding personal, ageing and wellbeing relationships. Place – in the sense of home and localities – assumed considerable importance in the lives of older people in the two communities in Shanghai. The home, 'as both a physical entity and a meaningful context for everyday life' (Moore, 2000), had significant influence on their ageing experience and maintaining wellbeing. When sharing experiences of their home, the older people emphasised the importance of good quality and appropriate housing conditions for ageing in place. For example, older people in the two communities emphasised the significance of tidiness, good light and aeration-drying conditions, appropriate size and separate bathroom and kitchen of a home. Home in poor conditions may constrain an older person's ability to maintain independence and autonomy, decrease their willingness to stay at home and thus

impact their sense of wellbeing. For example, the lack of lifts in residential buildings in the two communities limited the ability of older people with lower mobility to go outside; the lack of central heating made older people's lives in cold winters more difficult.

Although they encountered various challenges and obstacles when ageing at home, seldom did the older people move to other types of housing, such as nursing homes or yanglao gongyu (养老公寓). One reason was the shortage of alternative housing and its high cost. Another was the fear of elder abuse and poor service quality that may exist in care institutions. More importantly, it was the psychological comfort of living in one's own home which the older people considered to be more important than the physical features of the home in maintaining wellbeing in later life, and largely decreased their choice of relocation. The narratives of the older people showed that living in one's own home enabled older people: to have control of their own lives; to have freedom of choice about their daily lives; to be protected from external danger, violence and crime; to conduct their favourite activities and hobbies to achieve joy and pleasure; to achieve a sense of continuity with previous life stages; and to obtain a sense of pride in being the host of their home.

Besides a geographical location and a place of psychological comfort, home was also a crucial setting through which social connection and social interaction were constituted and maintained. The home space not only enabled older people to gather with their family, friends and neighbours but also provided more opportunities for the older people to communicate with younger generations, both of which were essential for wellbeing in later life. Furthermore, the home also enabled older people to easily access places which were familiar and important for them. The older people's narratives show that for older people with good mobility, parks and squares nearby were attractive places; for older people with severe impairment or serious diseases, hospitals nearby were very significant; while for all older people, local communities were of crucial importance.

The local communities were found to be as important as the immediate home in maintaining wellbeing in later life. In the two communities the neighbourhood committees, local eldercare agencies, volunteer groups and hobby groups worked together to provide abundant supportive services, like emergency help, domestic help, medical and nursing care and emotional support, to the older residents. Being rooted in the locality and building alliances with various institutions and groups, the local institutions and groups were able to mobilise care resources to sustain older residents' wellbeing, even in the face of restriction. Older people's experiences of using the services had indicated that communities, together with the eldercare services available within the localities, were crucial in offering valued practical support and maintaining wellbeing in very old age.

Relying on government subsidies, savings in earlier life or family support, most older people were able to purchase relevant eldercare services when in need of support. Generally, the older people interviewed spoke highly of the services delivered to their homes and/or used in their communities. Good service quality, flexibility and responsiveness to specific personal needs were valued. The fact that they could get practical support, advice and guidance from the locality helped to enhance their sense of security, to reduce loneliness and to promote their sense of wellbeing. However, there were still some older people who received no or little support from their local community when in need of help; there were themes of unmet needs emerging from the older people's narratives. For many older people, especially those who were isolated, worries about being unable to get reliable and sufficient support when in need of help were linked to perceptions of unmet needs.

Besides providing eldercare services and daily living support, the localities had an important influence on the older people's place attachment and sense of belonging. This study finds that there were significant differences between the two study communities in the older residents' attachment to the localities and sense of belonging. Most of the older people living in community A had spent most parts of their lives in the local area. For them, the locality represented a significant element

of their personal identities. Besides this, the available eldercare support and the lovely community spirit were considered major sources of their strong attachment and sense of belonging. In contrast, the meaning and importance of the community varied considerably among the older people in community B. For those who actively engaged in the community and those who received care support from local authorities and neighbourhood committees, a strong sense of belonging and attachment to the locality was sustained. They spoke of the community with affection, appreciation and satisfaction. While for those who were restricted to home and did not receive much support from the neighbourhood committee, there may be less sense of belonging. They spoke of their attachment to the home rather than to the wider community within which their home was located.

Chapter 7 Wellbeing, Social Relations and Social Support

7.1 Introduction

As discussed in Chapter 3, older people's sociability and social ties are also critical to their construction of wellbeing. Existing literature has shown the role that social networks and social relationships play in the wellbeing of older people (Chen & Silverstein, 2000; Fratiglioni et al., 2000; Hajli, 2014; Krause & Borawski-Clark, 1994; Lyyra & Heikkinen, 2006) but (especially in the Chinese context) less is known about the mechanisms and pathways of this. There is limited research on any negative influence social networks and relationships may have, and the complex nature of older people's social ties remains under-researched. This chapter explores the complexity of older people's social relations; the influence of social networks on older people's wellbeing; and the broader sociocultural context in which their social relations were embedded.

The chapter is structured as follows. First, to develop an overview of older people's social networks and social relations, characteristics of their social networks (size, composition, proximity and patterns) are described. Next, three broad categories of social support are discussed: 'social embeddedness'; 'perceived support'; and 'received support', and mechanisms and pathways of social support, and their impact on older people's wellbeing are considered. The chapter then discusses the complex nature of older people's social relationships, using the concepts of power, affection and harmony. Particular reference is made to the relationships between older people and their immediate family members; older people and their care workers; and older people and neighbourhood committees. The chapter concludes with a short summary.

7.2 Older people's social networks

Social networks may play a crucial role in supporting older people to age well in place. Much gerontological research has emphasised the support function of social networks and the role they play in shaping older people's psychological, physical and material wellbeing in later life (Phillipson, 1997; Wong et al., 2007). Being able to maintain close contact with important others has been found to be beneficial for wellbeing in later life, with wellbeing at this stage positively related to the availability of social support (Martí et al., 2017). This study found that, even in very old age, the people interviewed remained part of the social networks from which they derived social support. Although social networks provide supportive resources and can be important for wellbeing, it cannot be assumed that they provide effective support to all older people when they need assistance; that they will always be available and adequate in terms of quality and quantity; or that they involve the same degree of closeness, or provide the same level of support, in all cases. There can be differences within an older person's networks, and different older people may have networks that vary in size, composition, proximity and/or accessibility.

For these reasons, an examination of older people's social networks requires clarity about their different characteristics and the social support they provide. Specifically, it is important to address four research questions: first, who is related to the older person in his/her practices of everyday life? Second, who provides, or is considered to be responsible for providing their support? Third, what kind of support do network members provide? Fourth, who is considered close to, or to have a central place in the life of the older person concerned? Everyday life analysis with older people, focus groups with carers and care workers, and interviews with stakeholders were adopted as appropriate research methods to collect information about these questions and themes. The methods used adopted a person-centred approach and made no prior assumptions about the characteristics or nature of older people's social networks, such as their size, composition, proximity and accessibility.

7.2.1 Network composition and size

The networks of older people in the study included family members and relatives, care workers, neighbours, friends and acquaintances (Table 7-1). For most of the older people in the study, the dominant network members were: key family members (especially children, daughters-in-law and sons-in-law), care workers and neighbours. Others (relatives, friends, acquaintances) appeared to be less important. The size of older people's networks also depended on the number of adult children they had, and whether or not the older person hired a care worker.

Table 7- 1 Network members of older people in the study

Characteristics of network members		Older people (n=14)
Family members	Spouse	3
	Child(ren)	10
	Son(s)-in-law and daughter(s)-in-law	10
	Grandchild(ren)	10
	Sibling(s) or cousin(s)	4
	Nephew(s) or niece(s)	2
Care workers	Hourly-paid care worker(s)	4
	Live-in care worker(s)	4
Neighbours	Neighbourhood committee member(s)	13
	Other neighbour(s)	5
Others	Friend(s)	2
	Acquaintance(s)	4

Source: fieldwork data

Adult children

In the study, key family members (usually adult children, as many older interviewees were widowed) formed the core of most of the older people's social networks. Seldom did an older person mobilise the whole of their social network when in need of support. When asked to name those who were central in their later life, most older people mentioned an adult child(ren) as the main person with whom intimate relations were maintained. Mrs Liu (78, slight impairment, community B), for example, viewed her children as natural supporters. *'Who will I turn to when I*

need care or support? Of course it's my children. When you are older, you automatically rely on your children, and they will automatically support you.'

Although relationships with grandchildren, siblings, cousins, nephews and nieces also featured in some older people's networks, they were less important in their daily lives. Only one older person, Mr Tang, who was now childless, had regular support from a more distant relative: *'My only son passed away several decades ago. I had no children to rely on. My nephew visits me once a week.'*

Adult children were considered to have moral and legal responsibility for supporting their aged parents. The Confucian cultural tradition, with its emphasis on family ties, paternalism and filial piety (Liu, 2016; Yuan, 2013; Zhan et al., 2011), still had a strong influence on eldercare provision in both communities. In the focus groups and interviews with carers, participants reported that caring for aged parents was taken for granted by adult children and their spouses. Mr Chen (caring for his aged mother) explained: *'Hundred good filial first. Filial piety is the foundation of all virtues. As a son or a daughter, we must remember filial piety in our heart. Because it's our obligation.'*

Care workers

Care workers were also part of many older people's networks. Their support was an important theme in many older people's narratives, with the role of hourly-paid care workers evident for those with slight or moderate impairments, and live-in care workers important in some cases of severe impairment. For some older people, especially those with severe impairments or who had no children, their care worker(s) dominated their social network and was a significant source of support. Mrs Wu (86, widowed, childless, with slight impairments and living alone, community A) had an hourly-paid care worker for daily living support, such as cooking, washing and cleaning: *'I have no children. The care worker is just like my child'* Mr Chen (81, living with his wife and a live-in care worker, community A)

relied heavily on the support of a live-in care worker following a serious stroke. His daughter explained:

> *'My father is unable to move around after the stroke… I have to work. My mother is too weak to take care of my father… So we hire a care worker from the eldercare agency based in our community… She is very professional. She has a certificate on caring… My father is very satisfied with the professional care. He prefers the professional care to care from my mother and I, because we don't have relevant skills and could make him feel uncomfortable' (interview with Miss Chen).*

Neighbourhood Committee members

As well as key family members and care workers, older people's networks central to their daily life could also involve Neighbourhood Committee members; dealing with matters related to older people is a major responsibility of these committees. Older people with financial difficulties, who had no children to count on and had severe impairments or other problems, would often turn for support to neighbourhood committee members. The neighbourhood committee office was based in the community and older people could easily visit it or call it if they needed help. Some interviews with older people and carers showed how important the support of neighbourhood committee members could be; Mrs Ouyang (84, widowed, moderate impairments, living with a care worker, community A) illustrated this vividly:

> *'One afternoon I went back home from outside. Just then, someone shouted: 'Mr Sun has fainted!' Someone called the neighbourhood committee leaders. They quickly ran to the scene of the accident and called the nearest hospital. As Mr Sun's children live far away from our community, the leaders completed the hospitalisation procedures and accompanied Mr Sun until he was out of danger… I was very touched… They serve the residents; they are good neighbours and good leaders.' (interview with Mrs Ouyang).*

A similar thing happened in community B. The neighbourhood committee was vital in both communities in dealing with emergencies and securing the safety of older people. The leader of community B recounted his experience of an emergency thus:

> *'Once an older woman in our community fell in her bathroom, naked and bleeding… Her neighbour heard her call for help and called me… As soon as I heard, I quickly asked a female neighbourhood committee member to dress the older woman; then we sent her to a hospital, although it was in midnight and I had gone home after work. (…) After everything was done, it was almost 3am the next day. (…) When people encounter problems they usually call us first, especially for older people whose children live far away. We have dealt with many issues related to older residents, including resolving family conflicts, managing old-age welfare, securing the safety of those who live alone, providing health information and technical support, etc.' (interview with Mr Ou).*

7.2.2 Network proximity and contact

The study also included some examples of fragmented kinship networks, especially when there were great distances between older people and their adult children, or when older people lived alone (Table 7-2). This is consistent with the national trend in older people's living arrangements in China, which shows increasing numbers of older people living alone or with only their spouse, and many in the younger generation moving out of their parents' households after graduation and entering the labour market (Hu & Peng, 2012; Hu & Peng, 2011; Shi, 2012). In both of the communities studied, economic and social pressures had fragmented some older people's kinship networks, in part reflecting broader economic and social factors, affecting their living arrangements and broader social networks. Increasing population migration and labour mobility had led to mobility in housing and the dispersal of adult children. Mr Ru (83, slight impairment, community A) had two daughters; the elder lived in Shanghai and the younger had moved to Beijing after graduating. The greater distance between Mr Ru and his younger daughter had

made managing his care needs more difficult and had to some extent weakened the obligations and contacts between them.

Table 7- 2 Living arrangement of older people in the study

Living arrangement	Community A n= 8	Community B n=6
Living with an adult child	0	2 [Mrs Qi, Mrs Yu]
Living with a care worker	1 [Mrs Ouyang]	0
Living with a friend	1 [Miss Li]	0
Living alone	4 [Mrs Cao, Mrs Shao, Mrs Wu, Mr Fan]	2 [Mr Cao, Miss Hua]
Complex living	2 [Mr Tang, Mr Ru]	2 [Mrs Liu, Mrs Gao]

Source: fieldwork data

By contrast, the study also found that some older people lived close to key members of their network (Table 7-3). For some, the closest network member lived within the household or local community; these people included adult children and/or their family, care workers, friends, spouses and neighbourhood committee members, and in some cases there was extensive contact with them.

Table 7- 3 Proximity of nearest network member

Living situation		Older participants in Community A	Older participants in Community B
Living in the same household	with adult child	0	2 [Mrs Qi, Mrs Yu]
	with care worker	1 [Mrs Ouyang]	0
	with friend	1 [Miss Li]	0
	with spouse + care worker(s)	2 [Mr Tang, Mr Ru]	1 [Mrs Gao]
	with adult child + their family	0	1 [Mrs Liu]
Living in the same community	neighbourhood committee member	4 [Mrs Cao, Mrs Shao, Mrs Wu, Mr Fan]	2 [Mr Cao, Miss Hua]

Source: fieldwork data

Most older people had been in touch with a key network member (mainly an adult child or care worker) within the previous 24 hours, either by phone or face-to-face. Some older people with little kinship support or adult children living far away considered neighbourhood committee members to be their nearest network member. For those with severe impairments, a care worker (and for some, their spouse as well) was the person who provided the most essential support.

Labour migration and housing mobility did not prevent links between older people and their children. The older people interviewed still had close access to their children. Among those with at least one child in their network, the nearest child lived in the same household, the same community, the same district or the same city (Table 7-4). Children usually kept in regular contact with their aged parents (daily, weekly or once a fortnight). Older people and their adult children seemed to have a tacit understanding of the best distance between them, which could be expressed as 'staying in close contact but living separately'. Mr Chen (caring for his aged mother and living in the same community as her) stated: *'The best distance between aged parents and adult children is the distance of a bowl of hot soup. That is to say, being able to walk to your parents' home with the soup still hot.'*

Table 7- 4 Proximity of nearest child

Proximity of nearest child	Older participants Community A	Older participants Community B
Lives in same household	0	3 [Mrs Qi, Mrs Yu, Mrs Liu]
Lives in same community	1 [Mrs Ouyang]	0
Lives in same district	3 [Mrs Cao, Mrs Shao, Mr Fan]	0
Lives in same city	1 [Mr Ru]	2 [Mrs Gao, Mr Cao]

Source: fieldwork data

There were also older people who lived with an adult child, in which case the adult child usually lived in the parent's home. High housing costs had led to some children staying in their parents' home well into adulthood, and for some, co-residence comprised more than two generations. Mrs Liu (78, slight impairment,

community B) lived with her daughter-in-law and grandson in a quite limited space. For her, this arrangement stemmed less from choice than from economic pressure:

> *'Housing is too expensive; we can't afford to buy even a small flat… Without a new flat it's impossible for my grandson to have a girlfriend and get married…My son died more than 10 years ago, and it's hard for my daughter-in-law to earn a living (…) At present, I live with my daughter-in-law in one room and my grandson lives in another room. The space is quite limited… I have thought of moving to a residential home, but the price is too high (…) My heart is painful.' (interview with Mrs Liu).*

7.2.3 Network Patterns

Family-based networks

'Family based' networks are networks in which family members, usually spouses and adult children, are involved in identifying care needs and arranging care support for the older person. In this type of network, family members controlled or greatly influenced older people's care arrangements, such as the kind of support that should be provided, and who should provide it. Family members' involvement and dominance in determining older people's care arrangements and support often happens when a sudden or risky situation occurs, such as a fall, cancer diagnosis, bereavement, or when the older person is considered too frail to take care of him or herself. Key family members, including the older person him or herself, may communicate and discuss the support the older person needs, and then make appropriate arrangements to ensure necessary assistance is available and sufficient. In this study the care arrangements made could be classified into two types: 'simple family care' and 'professional care combined with family support'. These two types of care will now be explained below.

Simple family care meant that an older person's care support was mainly provided by family members, usually a spouse and/or adult child(ren). The interviews and

focus groups with carers indicated that family members, especially adult children, were the main source of support. Mr Jin, living in community A with his wife, took the main responsibility for caring for his aged mother with severe dementia, with whom the couple lived. Each day he fed her, changed her diapers and persuaded her to walk slowly within the room. He tried various ways to make his mother feel comfortable and played a dominant role in her care arrangements and provision. Although the local community provided 100 hours of free services a year for him to have a break, he seldom left his home. *'The care workers don't know how to take good care of my mum. I have taken care of her for more than ten years. I know all of her preferences. I must be there.'*

'Professional care combined with family support' was seen in cases where the older person had moderate or severe impairments. Here, care workers took on the main responsibility of caring for the older person, while family members visited and called the older people regularly. This required financial resources to purchase professional care through the market. Therefore, this was available only to those with enough money. It was also seen in some cases where family members provided financial support. Mrs Gao (82, severe impairment, community B) had a live-in care worker to care for her and her frail husband paid for by financial support from her two daughters, who visited almost every day. The elder daughter explained:

> *'My mother has been confined to bed for more than 10 years… My father is frail as well. He has severe hearing impairment…At first, my younger sister and I took care of them in turns, but this was so hard and energy-draining, because we have to work during the day…Very tired…Then we decided to hire a care worker to take care of my parents… Since my parents' pension is not enough to cover the whole cost, my sister and I provide some of the financial support…Now all of us feel better…My parents are satisfied with this care arrangement' (interview with Miss Gao).*

Community-based networks

'Community-based networks' are networks in which the local community or local authority was the dominant source of support and played a major role in organising and providing care support. This was especially true for vulnerable older people, like those with few or no kin support, those with financial difficulties or those with severe impairments. In the interviews with neighbourhood committee members, eldercare agency staff, government officials and older people, it was evident that both communities made various supportive arrangements for vulnerable older people. These included 'caring for older people living alone'. In these cases, local communities had established special 'pairs' for the older persons to ensure their safety and security. Each older person living alone had one such person to take responsibility for his/her personal safety; usually a neighbour, care worker or relative. Every day the person visited the older person or gave him/her a call to make sure that he or she was safe. Mr Cao (82, living alone, with moderate impairment, community B) was paired with his neighbour. Each day the neighbour would knock on his door, greet him and have a small chat with him. This special pair arrangement broadened and strengthened Mr Cao's social network and brought him a sense of security.

7.3 Social support and its importance for maintaining wellbeing

Many studies have documented the beneficial effects of social support on the wellbeing of older people. 'Social support arises from the conduct of personal relationships' and is an important function of social networks and social relations (Gottlieb & Bergen, 2010: 511). It is important to examine which aspects of social support were responsible for these beneficial effects, as little is known about this, especially in the Chinese context. In this section, the focus is on three broad

categories of social support: 'social embeddedness', 'perceived support' and 'received support' (Barrera, 1986; Chan & Lee, 2006; Gottlieb & Bergen, 2010) and the data collected is used to explore mechanisms and pathways to show some of the ways social support functioned and influenced older people's wellbeing in later life.

7.3.1 Social embeddedness

Connection, security and self-esteem

'Social embeddedness is that social support concept that refers to the connections that individuals have to significant others in their social environments' (Barrera, 1986: 415). Being socially connected with significant others is protective for people in very old age, because it provides them with a sense of security and belonging (Cornwell & Waite, 2009). In both the communities studied, the 'Caring for older people living alone' project (mentioned above) and the installation of a special phone ('Yijiantong') which enabled older people to contact an emergency service or order eldercare services, helped to extend and enhance older people's social connections and to promote their sense of security and attachment to community. Both were essential for forming a sense of wellbeing. Mrs Wu (86, widowed, community A) lived alone and had no children, and greatly appreciated the 'Yijiantong' phone service. *'It's much better to have this kind of appliance. If I have an emergency situation or need any support, I can contact the call centre at any time. This really makes me feel safe and warm.'*

Besides providing this sense of security, social connection and social embeddedness also gave older people meaningful roles, bolstered feelings of self-worth and self-esteem and generated a sense of purpose in life. Mrs Ouyang (84, widowed, with a live-in care worker, community A) had been a community volunteer since her retirement. This experience had strengthened her connections with neighbours, brought her a strong sense of pride, self-worth, self-esteem and attachment to the community, and helped her to endure the hardships of early

bereavement.

> *'I must go outside and do something. Otherwise, I can't help but think of my late husband and cry… I interrupted my voluntary work for several months because of the bereavement, but now I continue it…I like serving my neighbours…Working in the community and chatting with others bring me peace of mind and make me feel the warm spirit of our community'.*

Disconnectedness and perceived isolation

While the study shows the benefits of social connection and social embeddedness on older people's sense of wellbeing, other questions also emerged: 'What is the influence of social disconnectedness?' 'Does it inevitably result in a lack of wellbeing?' Evidence suggested that social disconnectedness did not inevitably lead to a lack of wellbeing; perceived isolation mediated the relationship between social disconnectedness and a sense of wellbeing. Social disconnectedness presented a risk for wellbeing only when it led to perceived isolation, which indicated loneliness and a perceived lack of intimacy, companionship or social support in one's personal networks (Cornwell & Waite, 2009).

For some older people, network size and frequency of interaction with network members was quite weakly related to a sense of wellbeing; being alone did not cause a feeling of loneliness. Some of the older people studied expressed satisfaction and happiness with time spent alone, for example in practising a hobby, engaging in religious activities, or reminiscing. Miss Hua (82, slight impairment, community B) was single, lived alone, and spent most of her time and money on her cats. She was a devout Buddhist and had adopted stray cats for many years; there were more than ten in her room when she was interviewed. She seldom interacted with other people and had even refused the help of the neighbourhood committee, which had offered help with cleaning her flat. For her, the flat was her own world in which she was free to worship Buddha and enjoy time with her cats and this, rather than interacting with another person, seemed to be the greatest joy of her life.

For some people in the study, living alone did not represent loneliness; instead, the extent to which an older person viewed himself or herself as lonely or isolated seemed to depend on his or her personal characteristics and life experiences. Subjective experience of a lack of intimacy, companionship and support was a major source of perceived isolation and lack of wellbeing (Cornwell & Waite, 2009). Those without close attachments to important others were at a higher risk for loneliness and perceived isolation, despite having support resources. Mrs Cao (81, moderate impairments, living alone, community A) had three children and a care worker who supported her, but described herself as lonely: *'We don't have many things to talk about'*. The lack of close attachments caused her to feel lonely and that she did not 'belong', negatively affecting her sense of wellbeing.

7.3.2 Received support

Practical support and avoiding institutionalisation

Social support can also be conceptualised as receiving practical assistance from network members. It could include: household and domestic help (e.g. cooking, cleaning, shopping, repairs); personal care (e.g. dressing, bathing, using the toilet, reminding the person to take medication); emergency responses (e.g. to a call for help, in relation to a fall or other crisis); or financial support (e.g. providing money to hire a care worker or buying daily living goods). Some older people had network members living close by (an adult child, a care worker, a neighbourhood committee member) and received practical help with such tasks or activities. For some, this met their changing needs or requirements and (they felt) enabled them to avoid being 'sent' to a residential or nursing home. Those with 'diverse' social networks comprising family, care workers and the community were more likely to receive a high level of practical support and to enjoy a higher level of wellbeing than those with simpler networks. Mrs Ouyang (aged 84, slight impairment, community A), for example, had a live-in care worker, a daughter living in her community and four other children living in the same city. She received various types of support and

expressed great satisfaction with her current life. *'Almost every day there would be one child visiting me, bringing me daily living goods or delicious food... Ayi (a form of address to the care worker) helps to cook meals, clean the house and wash clothes... Good. Everything is good'*, she explained.

7.3.3 Perceived support

Perceived social support refers to 'the cognitive appraisal of being reliably connected to others' (Barrera, 1986: 416). This kind of social support emphasises the information and feedback function of social support. Having a belief or faith that adequate support would be available, if needed, may decrease stress, increase confidence and promote a sense of wellbeing. Some research argues that perceived support has greater influence on wellbeing than received support (Martí et al., 2017).

For some older people, especially those with children, perceived support depended mainly on existing strong ties and close relations. Filial piety, with its roots in Chinese society over thousands of years, still has great influence on people's cultural psychology and personal expectations. Almost all the older people with children expressed a strong belief that, when they became frail and needed support, their children would provide what they could. This personal expectation and cultural psychology also influenced an older people's decision to seek support. When they encountered accidents or risks and needed support, they naturally turned to their children for help. Through this, the older people gained confidence, reduced fear of death and loneliness, and the courage to face bodily frailty and impairments.

For some others, especially those without children, perceived support was more related to formal care relations and expectation of the state. There was a strong belief, or hope, that governments would solve older people's care problems when needed. This seemed to help reduce fear of death or living alone and to maintain a sense of wellbeing. Mrs Wu (86, living alone, slight impairment, community A)

was widowed and had no children. When asked about care arrangements in the future, she replied:

> *'There are so many older people that have no children and need care support…I think our government will solve this problem. The government will arrange care for us…The local authority do well in eldercare. They arrange an hourly-paid care worker for me…They will do well in the future as well…' (interview with Mrs Wu).*

7.4 Linked lives: the complex influence of social relations

The previous section emphasised the beneficial effects of social networks and social support for older people's wellbeing. However, some older people's narratives suggested that social networks and social relations could also be a source of conflicts, harm and other negative feelings. Interaction with network members could bring not only support and pleasure, but also conflict and harm; sometimes negative exchanges with network members could offset and even outweigh the beneficial role of social networks and social relations. When asked about satisfaction with social relations and social support, the older people usually responded with both positive assessments and negative perceptions. Thus, instead of treating social networks as naturally supportive, this study indicates the need for a more complex understanding of social relations and social networks, with the complexity of older people's social relations; their complex influence on older people's wellbeing; and their broader sociocultural context taken into consideration.

To explore these issues, the concepts of 'power' and 'affection', as mentioned by the integrated wellbeing framework in Chapter 3, as well as the concept of 'harmony' that is emphasised by the harmonious ageing approach mentioned in Chapter 2, are employed as analytical tools. Power is a basic component of all relationships. In gerontology, there is a wide scope of research on influence and

power in eldercare, ranging from older people's or other actors' (e.g. carers' and care workers') collective influence on eldercare policies to individual influence in specific eldercare situations (Bradbury-Jones et al., 2008; Harnett, 2010; Kuokkanen & Leino-Kilpi, 2000). This section does not aim to explore older people's political or economic power, but considers power as a relational phenomenon in concrete everyday eldercare situations and explores power at an individual level. To explore complex social relations, it is necessary to explore power relations within older people's daily practice. Power can also be associated with status, action, responsibility, expertise and knowledge. To make power relations visible within older people's social relations, this section examines these more precise factors and tries to identify power relations in different situations and contexts.

Affection is defined as 'feeling warmth and fondness toward someone, which can be manifested through affectionate communication, involving verbal and nonverbal messages that communicate feelings of fondness, support, and love' (Horan, 2012: 109). Affection is a basic interpersonal need. It helps to enhance relational bonds and improves biological and subjective wellbeing. Using the concept of affection helps to facilitate a more thorough understanding of older people's relationships. Affection in older people's social relationships is mainly examined through expressive satisfaction, commitment and investment size.

In China, with its long history of collectivist orientation, people tend to pay great attention to their relationships and are greatly motivated to pursue and maintain harmony in relationships. Harmony means a status of peace in a relationship, which is central in interaction with others in Chinese culture and is essential for wellbeing for Chinese older people. Thus, the concept of harmony is adopted to analyse the complex social relationships of Chinese older people. Specifically, this section considers how a status of harmony is achieved in a relationship, and how power and affection are interwoven to influence the achievement of harmony in older people's relationships. As indicated earlier, older people's relationships mainly

included relationships with immediate family, care workers and neighbours. This section examines power relations, affection and the mechanism of harmony in these relationships respectively.

7.4.1 Key family members: obligation and affection

Family played a dominant role in most of the older people's lives; their relationships with key family members were complex, involving power, responsibility, love and affection. Power and affection worked together to construct eldercare in families. This section examines older people's relationships with key family members (adult children in particular), through analysis of power relations, bonds of affection and mechanisms of harmony.

Cultural power and care obligation

Power is achieved, maintained and transferred through culture (Torelli & Shavitt, 2010). To understand power relations between older people and their immediate family, it is necessary to explore cultures relevant to eldercare and families. There is no doubt that in Chinese families and eldercare the central feature is the culture of filial piety. This defines how younger generations should treat older generations in a broad sense and how children should treat their parents in a narrow sense, and shapes individual beliefs, desires and expected responses in eldercare interactions.

Care obligation and filial children - Filial piety is related to strict principles of hierarchy and obligation. It gives older generations considerable power over younger generations and helps form a kind of authority relationship between parents and children (Hu & Peng, 2012; Zhan et al., 2011). Aged parents are considered to have rights to receive support and respect from adult children and adult children are considered to have an obligation to support and respect their aged parents. The obligation to care for aged parents is a powerful social expectation and provides a basis for behaviour evaluation. A person who is considered unfilial will be criticised and cannot obtain blessings and respect. People are educated to be filial to their parents when they are young. Education, surveillance, judgment and

punishment work together to produce filial children. Interviews and focus groups with carers showed that almost all adult children acted according to their positions as adult children. Mrs Liu (retired, community A) demonstrated her efforts to meet the obligations of care for her aged mother in her contribution to a focus group discussion:

> *'My mother had problems with her legs and needed to do a prosthetic replacement for her joints… One month ago she received a surgery… Although we don't have too much money, we still choose the best joints for my mother… My health status is not good, either. My back is always painful, but I keep washing clothes and cooking dinner for my mother… It's hard, but this is what a child should do… Doing what I need does makes my mother and I feel happy' (focus group interview with carers).*

Mrs Liu internalised the requirements of filial piety, met the obligation to care for her aged parents and acted as a filial daughter, a position which brought pride and happiness for both her aged mother and herself. In this way, caring for aged parents is more than obligation. It is also a way to fulfil social expectations towards oneself and each other. The fulfilment of social expectations towards oneself and others could be a source of wellbeing. For Chinese older people, having a filial child was a big source of wellbeing because it means not only reliable support when needed, but also good family education, noble personality of the child and good family relations. Mrs Shao was proud that all of her children were filial and dutiful: *'Our family is well known for family harmony. My children were well known for filial piety'*, she said with a smile.

Care obligation and tensions - The cultural power of filial piety does not mean families are always harmonious and that children are always filial. For some adult children, family relationships in youth had been characterised by quarrels, abuse and conflicts, which made it difficult for them to offer available and adequate eldercare support. Mr Cao, who had two children, said they seldom visited him. *'I sued them but they said that there were too many quarrels in the family when they were young and that they never felt the warmth of the family'*. For some others,

tensions occurred between strong care desires and limited care resources. Mr Fang (community B, individual interview) illustrated the difficulties of caring for his aged mother: *'My mother has severe impairment. We don't have enough money to buy a wheelchair so I made a wooden one by myself. It's not so good but we have no choice.'*

Affection, interdependence and independence

Care and intimacy - Although filial piety and obligation provide a fundamental basis for understanding relationships with immediate family, there is no doubt that these kinds of relationships are also based on affection, intimacy and fondness. The emotional nature of family care cannot be denied. Affection and intimacy may strengthen the will and motivation of adult children to provide good care for their parents. Mr Shen (retired, community A) expressed strong attachment bonds to her aged mother and thus visited her every day.

> *'My mother is 91 years old. She loves living alone…I respect her choice but I'm a little worried about her health status so I visit her every day… My mother is a good and versatile person… I love my mother a lot… Every morning I come to her house and cook breakfast for her…I stay there until my mother goes to bed…She listens to videos and I do Chinese painting…' (focus group interview with Mr Shen).*

For both Mr Shen and his mother, care is not considered burdensome or demanding, but a valuable and good way to spend time. For most of the older people in the study, adult children were the closest network members and natural supporters. Receiving support from adult children was not considered shameful or to involve loss of dignity, but as a treasured and valued part of an intimate relationship. For adult children, caring for aged parents was usually seen as a taken-for-granted thing, an opportunity to repay parents for their love and upbringing, and a valuable time to increase intimacy.

Concern for each other - Besides adult children's obligation and affection towards their aged parents, an opposite flow of support, namely, support from older people

to adult children, was also common. The study demonstrated that older people were not solely support receivers, but also important providers of support. The support they provided to their children could include: financial resources, emotional support, knowledge and information. Mrs Liu (78, widowed, slight impairments, community B), lived with her daughter-in-law and a grandson and spent her pension on household expenditure. She explained: 'My son has passed away many years ago. It's very hard for my daughter-in-law to raise a family. I must use my pension to help her'. Mrs Cao (81, widowed, moderate impairments, community A) expressed great concern for her children. '*I would be sad and worried if any of my children was sick or encountered bad things. I would give them several calls a day to ensure they are all right.*' These examples indicate both giving and receiving in later life. The relationship between older people and key family members was not one-sided dependence on adult children, rather, it was an interdependence in which both the older person and their immediate family showed concern for each other.

A desire to maintain independence - Although the older people were strongly attached to their adult children, most expressed a desire to live separately and maintain their independence. This did not mean refusing their adult children's support or concern, or expressing no financial or emotional needs; instead, it was more about being in control of one's own life. Living separately and having an appropriate distance was considered a good way to do this. Mrs Shao (83, widowed, slight impairment, community A) expressed a strong desire to do this.

> '*Living in my own apartment makes me feel comfortable…If I break a bowl, I just need to clean   up, without feeling I did something wrong…But if I lived with my children and their family, this would be unsettling…Living with them face to face would inevitably lead to inconvenience and even conflicts… Living separately is good. I manage my own daily life, doing what I want… If I need help I just call them... They also call me, visit me and bringing me necessities every two or three days… This arrangement is good for both my children and me… Nobody feels uncomfortable in this relationship…*' (interview with Mrs Shao).

Achieving harmony

As already discussed, eldercare in the familial context involved a web of obligations and affection. Although this led to a strong desire to provide care among adult children, tensions could still occur. In recent years, population mobility, small family size and rising female employment have put great pressure on family care (Dang, 2005). Often it is difficult for adult children to take care of their aged parents, and this can affect family harmony, undermine filial piety and affect older people's sense of wellbeing. Often family members co-operated to use the resources available to solve eldercare problems and achieve family harmony.

Sharing care responsibility – Most of the older people in the study had more than one child. Sharing care responsibility between adult children, a common practice in Chinese society, helped to reduce tensions between strong care desires and limited care resources, such as lack of money, time, or energy, and to increase family harmony and solidarity. Mrs Feng (retired, community A, carers focus group participant) shared care responsibilities with her sister, taking turns to care for their aged father and mother. *'My father and my mother both had impairments. If one of them was sick, it was not possible for me to take care of both of them. Thank God I had a sister who could share the care responsibility with me'.* Similarly, Mrs Yu (retired, community B, also a focus group participant) shared care with her siblings. Every day one of them went to the home of their aged mother who had cancer, cooked her supper and stayed overnight. *'It's good to have siblings to share the care responsibility. It gives me confidence and strength in eldercare. I can't image if I was the only child of my mother'.*

The distribution of care responsibility was not governed by fixed or established rules, rather, it was a complex process in which older people and the immediate family examined their available resources, communicated with each other, and together agreed a plan. Generally, those living close to the older person, with more free time and with fewer financial resources provided more personal care for the

older person; those living far away, with little free time or who were better-off provided more financial support.

Purchase of private eldercare services - Given the difficulties of family care and older people's desire to maintain independence at home, the purchase of private care services was widely adopted by the older people and their immediate family in the study. It was thought of as a good way to combine care obligations, affection and independence. As Mrs Cheng (a carer, living in the community A) explained:

> *'Each generation and each person have their own life beliefs, views and characteristics…The older people and the young generation sometimes just cannot understand each other… Living together is not a good choice, at least for me and my parents…Having a care worker to take care of them is a good choice. The care worker is professional and provides a good quality of care… I visit them daily, talking with them, bringing them necessities… Both my parents and I feel released and pleasant…' (focus group interview with Mrs Cheng).*

7.4.2 Care workers: supporters or intruders?

Employing a care worker to provide daily living support was a common practice in the two communities. About two thirds of the older people interviewed had received support from care workers. As already mentioned, care workers included both hourly-paid and live-in workers. Hourly-paid care workers made regular home visits and provided household and domestic support for the older person (cooking, cleaning, washing, shopping, etc.). Live-in care workers lived with the older person as well as providing household and domestic help. They also gave medical and nursing care assistance and other everyday support that the older person needed. Being supported by a care worker enabled the older people to maintain independence and to stay in their own homes in advanced old age. Giving and receiving support involved close relationships between the older people and their care workers in their specific home context. This section examines these

relationships and contexts, and explores power relations, conflict resolution and bonds of affection.

Power relations between older people and care workers

Financial and cultural power of older people - Filial piety was not only a family value, but also a social norm that gave older people considerable power over care workers. As a member of a younger generation, a care worker was expected to show respect and concern for the older person, as described by Mrs Zhou (community B, care workers focus group interview), who had been a care worker for over 20 years: 'caring for older people requires carefulness and patience. They are older people, you should humour them and be tolerant'.

As employers of care workers and hosts in their houses, older people also had considerable financial power over care workers. While receiving care at home, older people retained the right to control who accessed their home and could include or exclude care workers as they wished. This may reinforce older people's power in care provision; may strengthen their capacity to fulfil care needs, and enable them to express themselves in a more personal manner. The interaction between Mrs Ouyang and her care worker offers an example. At the beginning of the interview, Mrs Ouyang asked her care worker, Mrs Zhang, to get a cup of water and peel an apple for me (the interviewer). At the end of the interview, she asked Mrs Zhang to air the quilt. Mrs Zhang just did what Mrs Ouyang asked. Seldom did she voice her opinions. When interviewed with Mrs Zhang, she explained: *Mrs Ouyang's children told me: "just do what mum asks and make her happy".* Care workers, whether they visited the home regularly or lived in, were expected to behave like an employee and a guest, according to social norms and local cultures. For them, the homes were the older people's territories and thus 'strange' places. Their role as guests and employees made it hard for them to resist the older person's dominance, or say 'no' to their requirements or orders, when undertaking care activities in his or her home. *'This is our job. You have no choice because you earn money from them,'* said Mrs Zhao (community A, care workers focus group

interview), who had been a care worker for over 15 years.

Professional power of care workers - The dominance of older people did not mean that care workers were powerless. Power relations between the parties were not fixed but were enacted in situations and depended on contexts. When professional care giving/receiving took place in older people's homes, care workers were more likely to control the process and manage the agenda. As professionals, care workers were more powerful than care receivers, especially when the older person had a high level of impairment. In these situations, care workers could take a leading, controlling and authoritative role in interactions within the home. Thus, the older people's private homes can be transformed into sickrooms, and effectively institutionalised. Mr Tang (91, severe impairment, community A) and his care worker, Mrs Ma (individual care worker interview), provide an example. Mrs Ma had worked for Mr Tang and his wife for over nine years. Both Mr and Mrs Tang had severe impairments. They had no children, so Mrs Ma arranged everything for them. She set the daily schedule, decided when they should get up, take medicine and go out in the sun. *'Both of them were assessed as having severe impairment. They totally rely on me now, so I have to make decisions'.*

Conflicts and mechanisms of harmony

Distrust, disappointment and anger - The power relations between older people and care workers decided their orientation to each other and the roles they constructed for themselves and each other. The inconformity of role construction between the parties sometimes led to conflicts. For example, the first few times that care workers entered an older person's home, they usually viewed themselves as a stranger and a guest; however, the older person might view them as a professional care worker and expect them to solve their daily living problems. If the care worker did not meet this expectation, a feeling of distrust and disappointment could occur. Mr Ru (83, slight impairment, community A) had experiences of this with care workers who he had once hired.

'They even didn't know how to use household electric appliance… As a person born and living in Shanghai, I like sweet food a lot… However, they just put a lot of salt or chilli into the food… Inedible… I needed to teach them everything… What's more, another problem was how I should treat the care workers. Of course I should not treat them as guests because they lived with us. Then I treat them as family members or friends? But they were strangers and we had different backgrounds…The experiences were not pleasant…I thought they brought more trouble, rather than support…' (interview with Mr Ru).

Conflicts could still occur after the adaption period. This was especially true for live-in care workers. It was more difficult for them than for hourly-paid care workers to balance opposing roles and separate professional work and personal life, because both occurred in the workplace - the private homes of older people. For some older people, their home was both their private territory and a public workplace and thus should not be a place for care workers' personal activities such as chat on the phone. However, for care workers, the homes were not only their workplaces but also the only place where they could conduct their personal activities. This blurred boundary between public workplace and private living spaces could be a source of conflict. Mrs Guo (community A, care workers focus group interview) expressed anger about having no personal time when in the home of an older person: *'They just want you stay at their home and keep busy every minute. Seldom could I go out to have a breath. No personal time and no personal life'.*

Mediation and compromise - Negative exchanges between older people and care workers could sometimes result in high levels of conflict; quarrels, quitting the job, dismissal etc. This had a bad effect on the wellbeing of both older people and care workers. To prevent conflicts from escalating, adult children and/or eldercare agency managers usually intervened and mediated, trying to recognise the opinions of both sides and find a compromise. Mrs Wei (community B, care workers focus group interviews) worked as an hourly-paid care worker for an older person living

alone. One day the older person lost her money and treated Mrs Wei in a way which made her very angry. She called the eldercare agency and told them that she no longer wanted to provide a service for this older person. The eldercare agency intervened to mediate between Mrs Wei and the older person. Later, the money was found; the older person had forgotten that she had put it in a corner in her home. Through the eldercare agency, the older person apologised to Mrs Wei and asked for her forgiveness. Finally, Mrs Wei agreed to continue working for the older person. The efforts of the eldercare agency, enabled both sides' opinions to be heard and avoided a higher level of conflict.

Affection and intimacy between older people and care workers

Treating each other like family - Although negative exchanges sometimes occurred between older people and care workers, many older people and care workers, especially those who had known each other for many years, described their relationships as 'family-like'. Maintaining a relationship for many years enabled them to develop strong bonds of attachment. Mrs Xia (a care worker in community A) shared her caring experience:

> *'The older person I cared for even gave me the keys of her home… She trusted me a lot. She even asked me to keep her bank cards… We have known each other and lived together for many years. She treats me like her daughter and I treat her just like my aged parents… Last year I took her to my home to celebrate Chinese New Year. We stayed at my home for more than one month… Although it's true I earn money by caring for her, I think the most important thing is the trust, affection and intimacy between us…' (focus group interview with Mrs Xia).*

7.4.3 Formal neighbouring: responsibilities, dilemmas and neighbourliness

Neighbours are people who live in a short distance and there is an extensive literature on the positive role neighbours can play in supporting older people (Buffel et al., 2013; Phillipson et al., 1999). However, as residents in a community

move in and out, for example when old friends or neighours die, a community population may become more mixed, and contact between neighbours may reduce. In this situation, formal neighbouring and the role of neighbourhood committees become increasingly important.

The rising power of neighbourhood committees

Power in eldercare management - In recent years, China has increasingly emphasised the importance of local communities and local institutions in eldercare (Wang, 2004; Wu & Xu, 2007). The rising power of local neighbourhood committees was a notable feature in the two communities; they were the official institutions for assessing older people's eligibility for eldercare subsidies, dealing with family conflicts and elder abuse and providing old-age welfare. As described by a leader of the community B neighbourhood committee:

> *'The neighbourhood committee takes responsibility for almost all old-age related issues… Older people and their family call or visit us when they encounter problems. Seeking help from the neighbourhood committee has become a daily practice for residents… For example, once an older person called us to teach him how to search online… An older person visited us to seek help with having a bath…Some older people ask us to mediate family property disputes… Some adult children call us to take their aged parents to the hospital… Every day we encounter various problems… Managing old-age issues is both our power and our responsibility. Neighbourhood Committee members are selected by community residents so we should be responsible for them.' (interview with Mrs Li).*

Responsibilities and dilemmas - The neighbourhood committee was the most important local institution at the grassroots level and played a key role in supporting older people to age in place. However in the two communities, tensions between rapidly increasing care needs and limited care resources made it impossible for neighbourhood committees to respond to all eldercare needs. Thus, for older people and their families seeking support from the neighbourhood committee, feeling of

disappointment and helpless could occur. Mr Chen (community A, carers' focus group interviews) cared for his aged mother alone. He had applied for an eldercare subsidy several times without success, and was quite disappointed about this: *'The neighbourhood committee said my mother is not eligible to apply for the subsidies. I'm her only child. No one helps me'*. As well as limited financial resources, the neighbourhood committees also faced dilemmas regarding shortages of human resources. The leader of neighbourhood committee in community A said, '*Our neighbourhood committee has only seven members, but we have to take responsibility for thousands of residents' civil affairs, not limited to old-age issues. It's impossible to meet every older person's needs.*'

Affection, neighbourliness and harmony

Supporting each other - Although care resources were limited, the two communities, especially community A, showed a high degree of friendliness and neighbourliness. The principle of neighbourliness was the main mechanism for community harmony. The older people interviewed showed understanding and concern for the neighbourhood committee. When asked their views on community support, they usually replied: There are so many older people in our community. The neighbourhood committee members have already done a very good job. Further, older people did not only seek support from the neighbourhood committee, but also provided support to other residents. In each community there was a volunteer team in which the majority of members were older people. These older people helped to maintain the safety, cleanliness and harmony of the community, under the management of the neighbourhood committee. Both leaders of the two neighbourhood committees said: *'They make great contributions to community harmony'*.

7.5 Summary

Social networks and social relationships were of great importance for the wellbeing of the older people. The study found that older people's social networks were dominated by immediate family, care workers and neighbours. The nearest network member of an older person was usually an adult child, care worker or neighbourhood committee member, who lived in the same household or at least in the same community as the older person. Older people did not mobilise their entire networks to get support, but mainly relied on a family-based network or a community-based network when they needed assistance. For those with children, adult children and their families were seen as 'natural' supporters with whom close and intimate relationships were maintained; for those without children, neighbourhood committee members were the ones they turned to for help.

Social support was a major function of social networks and social relations. While older people's social networks differed from each other, most provided opportunities for social embeddedness, and included both 'received' and 'perceived' support, central for wellbeing in very old age. Social embeddedness not only provided a sense of security and belonging for older people, but also gave them meaningful roles and thus generated a sense of purpose in life. Received support enabled older people to get practical assistance, including domestic help, medical and nursing care, emergency responses and financial support, when needed. Perceived support (the belief that adequate support will be available if needed) helped decrease stress and increase confidence, and thus promote a sense of wellbeing in later life.

Social networks and social relations were sources of social support, but could also be sources of conflicts and harm. The influence of social networks and social relations on wellbeing was complex, rather than naturally supportive. Power relations and bonds of affection interwove to influence the nature, status and function of older people's relationships and how older people and network

members dealt with conflicts and achieved harmony (a key value for older people in both communities).

In their relationships with immediate family, power and affection were both present. Filial piety enabled older people to have considerable power over younger generations and the rights to receive support from their adult children. This helped produce filial children and a reliable source of support, but could also increase tensions between older people and adult children, especially for those with limited resources, or whose childhood had been unhappy. On the other hand, older people and adult children showed great concern for each other. Older people were not only support receivers, but also important support providers. Adult children did not see caring for their aged parents as burdensome or demanding, but as a valuable and good way to spend time with them. Concern for each other, while maintaining independence, was considered the best approach for both older people and adult children. To achieve this, adult children often shared care responsibilities among siblings and joined forces to purchase private eldercare services.

The close relationships between older people and care workers were based on care giving and care receiving in the particular home context. As they were older, employers and hosts, the older people had considerable financial and cultural power over care workers. This reinforced their dominance in care provision and strengthened their capacity to have their care needs met. However, when professional care giving and care receiving occurred in older people's homes, care workers were more likely to control the process and manage the agenda, especially if the assessed care needs were high. It was hard for older people and care workers to balance different roles and orientations in the home context. A sense of distrust, disappointment and anger could occur during the care giving and care receiving process. This is not to deny that affection and intimacy between older people and care workers can also exist, and for those who had known each other for many years, relationships were family-like.

As contacts with neighbours declined, formal neighbouring, especially through the neighbourhood committee, became more and more important for older people. The neighbourhood committee took responsibility for almost all old-age related issues. This was convenient for older people's daily living, but there could also be tensions between increasing care needs and limited care resources. These caused feelings of disappointment and helplessness for some older people and their families who sought support from the neighbourhood committee. This did not mean relationships between older people and neighbourhood committees were full of tensions; indeed community residents showed understanding and concern for the neighbourhood committees. Older people did not only seek support from neighbourhood committees; some also took part in voluntary activities to maintain the friendliness, neighbourliness and harmony of their community, which contributed to their sense of wellbeing.

Chapter 8 Conclusion

8.1 Introduction

This thesis explores the meanings of wellbeing for and as understood by the oldest-old people ageing in place in two communities in Shanghai in the broader context of rapid population ageing, industrialisation and urbanisation witnessed in China during the past few decades. The thesis finds that the idea of wellbeing involves a complex set of social dynamics and shows both individual diversity and common character among the older people studied. The study was guided by an integrated conceptual framework that combines a relational understanding of wellbeing, the life course perspective and theory of place, and drew on data gathered through 6-months of fieldwork in Shanghai between 2015 and 2016. Situated in wider theoretical, empirical and policy debates, the thesis argues that wellbeing in later life is better understood by applying a multi-dimensional wellbeing approach, incorporating the material, the subjective and the relational, and taking into account the hetereogeneity of older people and the complex influence of time, place and social relationships.

By adopting an integrated wellbeing conceptual framework, the study represents a departure from the prevailing academic and policy focus on the determinants of wellbeing and the economic benefits of ageing in place, which tends to lead to a relatively narrow understanding of older people's wellbeing and ageing experiences. Additionally, it uncovers Chinese older people's ageing in place and eldercare experiences and practices in their specific economic and socio-cultural context. These relate to the meanings of wellbeing for and as interpreted by older people, ways to secure wellbeing in very old age and the contextual variables most prominent in shaping their wellbeing in later life. Below I further elaborate these findings.

8.2 Key findings and arguments

8.2.1 The meanings of wellbeing for and as understood by older people

One of the aims of the study was to understand the meanings of wellbeing for and by older people. Before presenting my findings, it is necessary to return to the conceptualisation of wellbeing discussed in Chapter 3. As mentioned there, the study stresses the person-centred, locally grounded and multifaceted nature of wellbeing, seeing wellbeing as a dynamic process embedded in specific temporal, spatial and cultural contexts and experienced and perceived differentially by individuals, rather than as an endpoint or outcome that some older people have, while others do not. Wellbeing is a human construction that is derived through the 'work' older people put into making meaning out of their lives (White, 2010). The study argues that discussions of wellbeing must be rooted in specific cultures and societies, be based on local knowledge and older people's own experiences and perspectives, be related to multi aspects of wellbeing - the material, the subjective and the relational - and their interdependence, and should capture the diversity of ageing individuals.

With regard to the meanings of wellbeing for and by very old people ageing in place in Shanghai, the study finds that, while the new policy's emphasis on ageing in place aligns with older people's own preferences, their experiences, perceptions, attitudes and feelings in later life show great diversity. The idea of wellbeing may mean different things for older people with different mobility levels, levels of care need and residence arrangements. Whilst there was no single lifestyle that defines the meanings of wellbeing in very old age, common themes that emerged in older people's narratives and accounts of wellbeing did appear: having sufficient material resources, having someone who is and will be there for you, having something to enjoy and being concerned for others.

Individual difference

In developing understandings of the meanings of wellbeing for and by older people, it is important not to make assumptions about what older people think or feel. Rather, it is relevant to take into consideration the real ageing in place experiences and the diverse voices and situations of older people. As discussed in chapters 5, 6 and 7, experiences, perspectives, attitudes and feelings of wellbeing show great diversity amongst older people.

With respect to the material aspects of wellbeing, health status and functional abilities were shown to have significant influence on very old people's perceptions and assessment of material wellbeing. For those with high functional abilities and low levels of care needs, pensions and medical insurance proved sufficient and effective. Their evaluation of material status was usually positive. Holding a life belief of plain-living and comparing present living standards with the past, the older people expressed high material satisfaction. However, for those with severe impairment and a high level of care needs, the evaluation of material status could be negative. Older people, especially those with limited resources, may face great challenges in meeting their own care needs. Expenditure on medical and nursing care was a major source of material illbeing of older people and presented a heavy financial burden for families in this study.

In terms of attitudes towards ageing and bodily frailty, ageing and its major disruptive consequence - bodily frailty - represented potential threats to wellbeing, as they reduced or impeded people's ability to continue daily activities they valued and thus led to a number of challenges for their daily living. For those who experienced difficulties on account of chronic illness or disability, however, their sense of ageing and bodily frailty was presented in different ways. Some older people calmly accepted that their bodily frailty required changes in their daily life. They saw these as normal, and sometimes inevitable, consequences of the ageing process. Some older people, especially those with limited social support, were

extremely worried about their own situation. Between these two attitudes was the dominant one: ambivalence. On one hand, most older people seemed to accept the inevitable fact of declining ability and eventual death as they aged. On the other hand, others were reluctant to face this reality, refused to think about the future, tended to be nostalgic and tried to be as active as before（不服老）. This attitude reflects older people's ongoing struggle for inner peace and balance between the present, the past and the future in very old age.

With regard to the relational aspect of wellbeing, the study finds that older people with high levels of mobility and outgoing personalities particularly valued strong social ties and active social engagement. They spoke highly of active social engagement, close ties with important others, large social networks and strong feelings of belonging and attachment to (a local) place. Through frequent interaction with other people and the local environment, whether in the form of serving the community and local residents, attending hobby groups, continuing paid work, spending time with friends and family members, chatting with neighbours or visiting parks nearby, the older people not only experienced an enhanced sense of security, belonging and social connection, but also generated and achieved meaningful roles, bolstered feelings of self-worth and self-esteem and experienced a sense of purpose in life, both essential for subjective wellbeing. For older people constrained to their homes or close neighbourhood because of bodily frailty or severe impairment, simple activities (e.g. listening to the radio, watching TV, reading newspapers), greetings from neighbours, visits by children and grandchildren and good memories of the past were major sources of pleasure.

While some older people embraced an outward lifestyle, some others expressed satisfaction and happiness with time spent alone, for example in practising a hobby, engaging in religious activities, or reminiscing. For some of the older people, the extent of their social networks and the frequency of interactions with network members were not necessarily linked to a strong sense of subjective wellbeing; social disconnectedness did not inevitably lead to a lack of wellbeing. My study

provided evidence that perceived isolation mediated the relationship between social disconnectedness and subjective wellbeing. Social disconnectedness presented a risk for wellbeing only when it led to perceived isolation, which indicated stress, loneliness and a perceived lack of intimacy, companionship and social support.

Things in common

Although great diversity was found among the older people, the study also identified common themes shared by older people on the meanings of wellbeing for older people （晚年幸福）. These are rooted in, and partly reflect, Chinese culture in general, and the local Shanghai culture in particular. The first theme was 'having sufficient material resources'. Being able to manage financially was considered critical for achieving wellbeing by the older people studied. Although their material resources differed both in quality and quantity, most of them were able to manage financially. This was partly because of modest wants in later life, a thrift lifestyle developed during the socialist period when 'hard working and plain living' were encouraged, and a deep-rooted Confucian belief typified in the expression that 'content is happiness'（知足常乐）. Older people's generally good financial condition was also partly due to the development of the social security system, which, after their retirement, provided them with a relatively large pension, medical insurance, as well as their accumulated savings and high home ownership. A comfortable apartment of one's own, savings in earlier life, a decent pension and medical insurance were considered as main sources of material wellbeing.

The second theme was 'someone there for you'. This was of critical importance in Chinese culture where filial piety, Confucianism and the collectivist tradition still had a strong influence on later life and eldercare arrangement. Unlike the negative stereotype of older people that sees them as having few social engagements and social connections, this study found that older people in the communities retained a certain level of social connections and maintained their social networks in very old age. The older people studied all seemed to agree that they could decrease

stress, increase confidence and promote a sense of security (thus promoting wellbeing) by: having network members living close; by being able to receive practical assistance (e.g. household support, personal care, emergency responses etc.) from network members; being convinced that adequate support would be available if needed; and maintaining strong ties and close relationships with important others, whether adult children, relatives, close friends or neighbourhood committee members. In contrast, a lack of intimacy, companionship and support was a major source of perceived isolation and lack of wellbeing. Those without close attachments to important others were at a higher risk of loneliness, depression and perceived isolation, despite having support resources. In fact, for the older people studied, having a filial child was a big source of wellbeing, because it meant not only reliable support when needed but also a symbol of good family education and good family relations.

The third theme was 'having something to enjoy'. This was about never giving up the joys once has in life, even though illness and disability represented potential threats to daily life in very old age. Unlike the negative stereotype of older people that sees them as physically and/or mentally incapable and suffering from illness, loneliness and depression, the older people's narratives showed that joy and pleasure widely existed in very old age. In very old age, they had time and space to enjoy themselves, without having to compete with others in the labour market to earn a living or to bear the burden of bringing up families. Sources of joy and pleasure varied, ranging from enjoying good weather, having a good sleep, to practicing hobbies, having delicious food, having a harmonious and flourishing family, etc. The joy and pleasure derived from daily life formed the foundation of wellbeing in later life, or even the foundation of living.

The fourth theme was 'concern for others'. The 'others' not only referred to other people, but also to other species and the place they lived in. Unlike the negative stereotype of older people that sees them as dependents and passive recipients of

support, the older people studied showed a spirit of 'concern for others' and were active in providing support to others and making contributions to their communities. They not only sought support from others, but also provided support for others. They expressed their concern for their children, for their communities, for the city and for the country. Some worked as volunteers to maintain the safety, cleanliness and harmony of the community. 'Concern for others' enabled the older people to sustain a sense of social embeddedness, to maintain close ties with families, communities and society, and thus to avoid social isolation and generate self-esteem and a purpose in life.

Overall, the meanings for and by the older people studied reflected the linked nature of human life and the multifaceted nature of wellbeing. Older people's wellbeing and ageing experiences cannot be understood in isolation from other people and the environment. It was the interdependence and mutual support between older people and others that made wellbeing in later life possible. A single aspect of wellbeing, whether material, subjective or relational, could not define what a good life is in old age. It is the unity and interdependence of the three dimensions, and the interplay of the objective and the subjective, that produced the meanings of wellbeing. In general, ageing in place aligns with older people's own preferences of attaining wellbeing in later life, even though the physical aspect of home and a lack of community care support may influence their ability to age well. Ageing at home provided the older people with psychological comfort, e.g. safety, freedom, a sense of control, joy and pleasure, pride and rootedness, and enabled them to connect with familiar people and surroundings, which were considered more important than the physical aspects of home in maintaining wellbeing in later life.

8.2.2 Ways to secure wellbeing in very old age

Understanding how and in what ways older people's wellbeing was sustained in very old age was an important aim of the study. In the study, wellbeing is not perceived as a state that people do or do not experience, rather, it is a dynamic

process through which older people built resilience and balance between challenges and resources and found meaning in their lives. The older people were decision makers, with choices, preferences and possibilities. They generally had a nuanced and realistic perspective on their own situations, priorities and available choices. As discussed in chapters 5, 6 and 7, although they experienced difficulties on account of illness, impairment and bereavement, most were able to find ways of managing daily life, keeping well and securing wellbeing.

Changes, losses and adjustment

All the older people in this study experienced changes and some kind of losses during their life course. Changes and losses at earlier life stages could have lasting influence on lives and wellbeing in old age. According to their narratives, the key challenges and losses that the older people considered to have significantly influenced their wellbeing in later life were bereavement, bodily frailty and shrinking social worlds. Bereavement, particularly the loss of children and spouses, is an unequalled tragedy for most older people, which brought both suffering, challenges and changes and could bring with it overwhelming reactions and severe adjustment problems. Bodily frailty was a common feature and common experience of the older people interviewed in this study. All the older people interviewed experienced some degree of functional decline and gradual deterioration. This limited the activities they valued (e.g. daily living activities, leisure activities and social activities) and influenced their self-perceptions and social relations. All the older people in the study reported an active life in their early retirement. However, as they moved into very old age, most were constrained to home or communities. This lifestyle change in very old age may bring with it a sense of loneliness and social isolation, a feeling with roots in how others view the ageing group and how older people themselves view their current lifestyle relative to past ones.

The ability to build resilience and the balance between resources and challenges were considered central to tackling these changes and losses, and to achieve

wellbeing in very old age. As time went on, most older people learned to tolerate the losses and changes, discovered new ways of living, reorganised their own life and accepted their identities as very old people. By choosing positive emotions and ways of thinking, keeping healthy living habits and remaining active, they tried to manage their health and keep well; through maintaining time-space routines, they tried to maintain continuity in their lives and freed their cognitive attention for more important or joyful events and needs; by conducting daily living activities independently or buying care services using their own money, they tried to satisfy their care needs themselves; by developing risk management strategies - changing activities, changing things in the home or changing care arrangements – or utilising technologies, they tried to tackle what they perceived to be risks when living at home. Unlike the negative stereotype of older people and previous approaches to ageing and old age that tended to neglect older people's own efforts in keeping healthy and maintaining wellbeing, the study found that older people's own contributions mattered in achieving wellbeing in very old age and highlighted the importance of active human agency in achieving this.

The role of social support

Achieving wellbeing in very old age depends not only on individual ability to build resilience, but also on available social support to build a balance between challenges and resources. Social support, for its positive role in enhancing resilience to disruptive life events, losses and changes and in protecting against negative feeling and emotions (Ozbay et al., 2007), is exceptionally important for securing wellbeing in very old age. Social support was a major function of social networks and social relations. While older people's social networks differed from each other, most provided opportunities for social embeddedness, and included both 'received' and 'perceived' support, both of which are central for wellbeing in very old age.

Older people did not mobilise their entire network to get support, but mainly relied on a family-based network or a community-based network when they needed assistance. For those with children, adult children and their families were seen as 'natural' supporters, with whom close and intimate relationships were maintained. Family members' involvement in, and dominance in determining, older people's care arrangements and support often happens when a sudden or risky situation occurs, such as a fall, cancer diagnosis, bereavement, or when the older person is considered too frail to take care of him- or herself. In some cases, especially when the older people had moderate or severe impairments and high levels of care needs, simple family care was insufficient. Professional care combined with family support was a common way to tackle this. For those with limited or no kin support, neighbourhood committee members were who they turned to for help. The local communities, as both 'an arm of local governments reaching out into the grassroots' (Gui et al., 2009: 407) and self-governing organisations of local residents, were the main source of support and played a major role in organising and providing care support for vulnerable older people.

8.2.3 Wellbeing: more than a self-contained individual process

As discussed in earlier chapters, wellbeing was not a self-construct, rather, it reflected and was shaped by historical times, macro-level dimensions of social forces, and was associated with the place where they live and their interactions with significant others. The study located older people in times, places and social relationships and considered wellbeing in its national, historical and spatial contexts. It indicated how the time, the place and the social relationships interacted to impact older people's wellbeing in very old age.

The impact of historical times and social changes

As discussed in Chapter 5, the older people participating in the study had experienced dramatic social changes over the course of their lives and were influenced strongly by the War of Resistance Against Japan's Invasion (1931-

1945) and the second Civil War (1946-1949), the danwei period (1950s – 1980s) and the open and reform period (1980s - present). Experiences of the social changes and historical times were regarded by the older people in this study as turning points, or as playing a key role in their wellbeing in very old age. In their narratives, the older people emphasised the relevance of wars, the work unit system and the social insurance system as social forces and social context that, at the material level, influenced their income, social welfare (pensions, reimbursement of medical services etc.), standard of living over the life course; and at the cultural or subjective level, shaped their beliefs, values and the very meaning and significance of ageing and wellbeing.

Their experiences of social changes and historical times brought the older people both suffering, pain, a discontinuity from their past life, and opportunities and developmental experiences. For those growing up in the lower social-economic class, educational opportunities in childhood (enabled by scholarships provided by the Nanjing National Government or the Chinese Communist Party's armed forces, and employment opportunities in early adulthood, enabled by the expansion of heavy industry in the danwei period in the 1950s and 1960s) provided them with chances to change their life, and possibilities to obtain stable pensions and medical insurance in retirement under the social insurance system. This was crucial for sustaining their wellbeing in old age. For those growing up in better-off families, the danwei system brought with it a discontinuity of past lives and thrust them into new situations that challenged the means, pathways and ends of their accustomed life. However, good education in earlier life enabled them to acquire professional skills and knowledge and thus helped them achieve professional and well-paid jobs. These made possible their material wellbeing in later life. For both, working lives in the danwei period largely changed and shaped their welfare, values and world views. The life belief of 'hard working and plain living', formed in the danwei period, to a large degree decided the older people's later life and the meanings of wellbeing for and by them. For them, wellbeing was not just high living standards

and good welfare, but was more about contributing to society, to the country and expressing concern for others.

The importance of place

As discussed in Chapter 6, the wellbeing of the older people studied was closely related to place (their living environment). Place, specifically the home and the community in the study, acted as a source of support and meaning for the older people studied. On one hand, place enabled them to meet basic physical and survival needs, and live a decent life in old age. First, the ownership of a home, achieved through hard work and as a result of housing distribution in the danwei period, enabled the older people to access shelter, water, gas, electricity etc., even though their physical homes in some respects presented barriers and challenges (e.g. a lack of central heating) for daily living. Secondly, the community-based models of eldercare services, including the supportive neighbourhood committees, the telephone-based eldercare support systems and various groups of older people, helped to meet their changing care needs. Being rooted in the locality, and building alliances with different institutions and groups, the community-based models of eldercare services could mobilise care resources to provide abundant supportive services (i.e. emergency help, domestic help, medical and nursing care and emotional support) to the older residents so they could sustain wellbeing when ageing at home, even in the face of restrictions. Older people's experiences of using these services indicated that communities, together with the eldercare services available within the localities, were crucial in offering valued practical support and maintaining wellbeing in very old age.

On the other hand, and as well as the material aspects of wellbeing – in terms of the eldercare services and daily living support - place often had an important impact on the subjective aspects of older people's wellbeing: their feelings, emotions, sense of belonging and attachment to local communities. The older people's narratives showed that the psychological comfort of living in one's own home was

even more important than the physical features of home in maintaining wellbeing in later life, and thus tended to decrease their willingness to move to a care institution. For the older people, locality was not where they lived, but represented a significant element of their personal identities and sense of belonging, even though their residence experience and the strength of their attachment to the locality varied.

The complex influence of social relationships

The study shows the linked nature of human lives. As discussed in Chapter 7, the interconnectedness of lives, particularly relationships with important others, such as family members, care workers and neighbourhood committee members, played a significant role in the older people's daily life practice and in their perceptions of wellbeing. Much research has indicated the beneficial role of social support and social networks in sustaining wellbeing; this study, however, found that the influence of social networks and social relations on wellbeing was complex, rather than naturally supportive. Power relations and bonds of affection interwove to influence the nature, status and function of older people's relationships and the ways they, and network members, dealt with conflicts and achieved harmony, a key value for sustaining wellbeing for the older people in both communities.

On the one hand, the influence of relationships with key family members, and of the filial piety culture, helped to produce filial children, and a reliable source of support. The affection, fondness and close ties between older people and their adult children helped to strengthen the willingness and motivation of adult children to provide good care for their parents. On the other hand, the cultural power of filial piety and the obligation to care for aged parents could increase tensions between older people and their adult children, especially for those with limited resources, or whose childhood had been unhappy. Concern for each other, while maintaining independence, was considered the best approach by both older people and adult children in the two communities. To achieve this, some adult children shared care

responsibilities and joined forces to purchase private eldercare services. Relationships with care workers varied and were affected by: the cultural and financial power of the older people receiving support at home; the professional power of care workers (who often controlled the care process); and the shifting roles and orientations of older people (as an older person, a host, an employer or a care recipient) and care workers (as a younger person, guest, employee or care giver). In the home context, this could lead to both conflicts and negative feelings, including a sense of distrust, disappointment and anger; affection and intimacy (in some older people's words, 'family-like') could occur in the caregiving and receiving process. Because of fragmented kinship networks, formal neighbouring, specifically the neighbourhood committee, became more and more important for many of the older people studied. However, tensions between increasing care needs and limited care resources could limit the neighbourhood committee's ability to provide adequate support for its older residents, generating feelings of disappointment and helplessness among older people needing care support, and their families. In most cases, research participants showed concern and understanding for the neighbourhood committees and the country, saying *'It is not easy to make eldercare arrangements in our country because there are so many older people. It is not possible for the neighbourhood committee to take care of every older resident'*.

8.3 Contributions and implications of the research

Researching the experiences and meanings of wellbeing for and by older people in two communities in Shanghai, the study demonstrates that wellbeing is relational and contextual, shaped by historical times, locality and the ageing individual's personal social relationships. It involves the material, the subjective and the relational aspects, as well as the interdependence between them, and shows both individual diversity and common character among the older people studied. The

research contributes to the wider literature and enriches our understanding of ageing and wellbeing, both theoretically and empirically.

Theoretically, the study offers one of the first attempts to apply an integrated wellbeing framework when analysing older people's later life. First, it employs a person-centred approach and puts the focus on older people's personal experiences and wellbeing. Many studies in gerontology emphasise the economic benefits of ageing in place and pay attention to individual capacity to remain independent as one ages, and strategies to support older people to remain at home or within communities. The voices and perspectives of older people themselves on ageing and old age, however are scarcely represented. Most approaches to ageing and old age, including the 'pathological', 'normal' and 'successful' ageing approaches, adopt a binary framework and often do not capture real-world ageing experiences and perspectives of older people or the heterogeneity and diversity among them. By focusing on older people's wellbeing and ageing in place experiences, rather than just on economic concerns or the physiologically aged body, the study allows older people's experiences, perspectives, strategies, feelings and understandings to be included and articulated in the research, producing a deeper understanding of the research problem. In so doing, it contributes to the emerging literature on wellbeing, ageing and old age.

Secondly, by adopting a relational wellbeing framework, the study offers a broader and more open understanding of older people's wellbeing in later life. Most existing research on wellbeing still centres on the identification and theorisation of independent 'components' or 'determinants' of wellbeing. The complex and multifaceted nature, and the broader sense, of the term wellbeing are often overlooked. Acknowledging this, the study offers one of the first attempts to apply a relational wellbeing framework (rather than the dominant components approach) to understanding older people's wellbeing in later life. Because of its all-embracing character, the relational framework provides a conceptual unity across different domains, categories and dimensions. Adopting the relational wellbeing framework

enables the researcher to take into consideration the interrelationships and interplay between different wellbeing dimensions and broader social factors in the understanding of older people's wellbeing.

In addition, after analysing the strengths and weaknesses of White's (2010) relational wellbeing framework, I have developed an integrated wellbeing framework that combines relational wellbeing, the life course perspective and the theory of place. This integrated wellbeing framework helps me identify the role that time and place play in older people's wellbeing and explain the dynamic interplay between older people, time and place and how this influences different dimensions of wellbeing and wellbeing as a whole, which are not clearly articulated in White's relational wellbeing framework.

On a practical level, the thesis represents one of the few studies that uncovers Chinese older people's ageing in place and eldercare experiences and practices in their specific economic and socio-cultural context. While research on ageing and eldercare in China is growing, the focus tends to be placed on old-age policies and local eldercare arrangements; little is known about older people's real-world ageing experiences, perspectives, feelings and understandings, as well as how these are related to China's national and local contexts. Focusing on older people's ageing in place experience and wellbeing, this study thus contributes to Chinese ageing studies, shedding light on Chinese older people's later life, uncovering their ageing in place and eldercare experiences and practices, their perspectives and understandings of wellbeing, the ways they attempted to secure wellbeing in very old age and how their wellbeing and ageing experiences reflected and were shaped by historical times, life events, the place they lived in and social interaction with important others.

As one of the few empirical studies on Chinese older people's later life, the study has important implications for: older people, carers/care workers, local institutions involved in eldercare provision and policymakers. Older people and those who will

soon enter old age can benefit from the study, by: being aware of, and thus better prepared for, ageing experiences, changes, losses and obstacles, and the challenges of ageing at home in advanced old age; knowing what kinds of support they can get in their locality; gaining ideas about how to live a good life in very old age. Knowing it is possible to sustain wellbeing in very old age decreases fear of impairment, impairment and death.

Carers and care workers can benefit from the study by: becoming better informed about the needs of very old people; understanding more about the experiences and efforts of older people in maintaining wellbeing, thus allowing a sense of trust and close ties to be established more easily; gaining ideas of how to solve conflicts and achieve harmony between older people and carers/care workers.

Local institutions involved in eldercare provision, particularly the neighbourhood committee and eldercare agencies, can benefit from the study by: being aware of older people's experiences of eldercare support and eldercare service use, and thus improving eldercare support provision and promoting community harmony. A lack of awareness of available eldercare services in the locality, for example, is one of the factors that prevents older people from seeking social support when they need help, so informing them, and their families, about available eldercare services and how to access them is an important task for local institutions.

Policymakers can directly hear the voices of very old people, for whom they must provide support in line with national commitments. In serving the people, they can thus better address old-age issues and improve eldercare service planning and development in urban China. The analysis of ageing in place experiences of the older people in the two communities in Shanghai indicates that achieving and maintaining wellbeing in very old age requires not only individual agency (exercised by older people themselves), but also institutional and government-led initiatives. These include providing, diversifying and expanding eldercare services at the community level; updating living environments, e.g. designing age-friendly

homes, communities and cities; bringing about positive change in informal institutions (for example in beliefs and attitudes, such as the instrumentalism that tends to construct ageing as 'unproductive' or 'useless') and investing more in supporting local institutions to provide better and more accessible eldercare services. Considering the diversity and heterogeneity that were found among the older people in this study, this study found that it is important for policy makers to account for the heterogeneity of older people and to identify those with higher level of care needs when coming up with policy targets for eldercare policy planning. Not doing so may cause difficulty in anticipating care needs, inaccurate policy feedback and inefficient resource allocation.

8.4 Future research

The thesis serves as a starting point for further research on Chinese older people's later life by addressing the experiences and accounts of very old people in Shanghai, a major city in China. Due to limited information about, and the difficulty of accessing, private eldercare companies, the study did not include private eldercare service providers. Future research could produce a fuller picture of older people's ageing in place in urban China by involving a wider range of stakeholders, including the private eldercare service enterprises that play an increasing role in eldercare provision.

As for developing new eldercare provision in Shanghai, opportunities include unifying eldercare needs assessment across the whole city; establishing nursing homes that are located in local communities and which provide short term support for community residents who need care support (长者照护之家); developing information and communication technologies to support older people to safely age at home. Attention could be paid to very recent changes and developments in eldercare arrangements in Shanghai, as well as to the ageing in place experiences

and wellbeing of older people under new eldercare arrangements. In light of large differences between China's cities, provinces and regions, attention could also be paid to ageing experiences and eldercare practices in other cities, provinces and areas, for example in rural China.

Bibliography

Achenbaum, W. A. (1995). *Crossing frontiers: Gerontology emerges as a science.* New York: Cambridge University Press.

Agnew, J. (2011). Space and place. In J. Agnew and D. Livingstone (eds), *Handbook of geographical knowledge.* London: Sage, pp 316-331.

Ahmed, S. (2010). *The promise of happiness.* Durham: Duke University Press.

Allen, J. (2008). *Older people and wellbeing.* London: Institute for Public Policy Research.

Alley, D. E., Putney, N. M., Rice, M., & Bengtson, V. L. (2010). The increasing use of theory in social gerontology: 1990–2004. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 65*(5), 583-590.

Allin, P., & Hand, D. J. (2014). *The Wellbeing of Nations: Meaning, motive and measurement.* Chichester: John Wiley & Sons.

Alwin, D. F., & McCammon, R. J. (2003). Generations, cohorts, and social change. In Jeylan T. Mortimer & Michael J. Shanahan (eds), *Handbook of the life course.* New York: Springer, pp 23-49.

Amineh, R. J., & Asl, H. D. (2015). Review of constructivism and social constructivism. *Journal of Social Sciences, Literature and Languages, 1*(1), 9-16.

Anderson, J. R. (2000). *Learning and memory: An integrated approach.* Hoboken: John Wiley & Sons Inc.

Andrews, G. (2001). Care of older people: Promoting health and function in an ageing population. *BMJ: British Medical Journal, 322*(7288), 728.

Andrews, G. J., Evans, J., & Wiles, J. L. (2013). Re-spacing and re-placing gerontology: relationality and affect. *Ageing & Society, 33*(8), 1339-1373.

Andrews, M. (1999). The seductiveness of agelessness. *Ageing & Society, 19*(3), 301-318.

Antonucci, T. C., Ajrouch, K. J., & Birditt, K. S. (2013). The convoy model: Explaining social relations from a multidisciplinary perspective. *The Gerontologist, 54*(1), 82-92.

Appadurai, A. (2004). The Capacity to Aspire: Culture and the Terms of Recognition. In Vijayendra Rao and Michael Walton (eds), *Culture and Public Action.* Stanford: Stanford University Press.

Atchley, R. C. (1989). A continuity theory of normal aging. *The Gerontologist, 29*(2), 183-190.

Atkinson, S. (2013). Beyond components of wellbeing: The effects of relational and situated assemblage. *Topoi, 32*(2), 137-144.

Atkinson, S., & Joyce, K. E. (2011). The place and practices of wellbeing in local governance. *Environment and Planning C: Government and Policy, 29*(1), 133-148.

Atkinson, S., Fuller, S., & Painter, J. (2012). *Wellbeing and place.* Abingdon: Ashgate Farnham.

- Bibliography -

Baltes, M. M., & Carstensen, L. L. (2003). The process of successful aging: Selection, optimization, and compensation. In Staudinger U.M., Lindenberger U. (eds), Understanding human development. Boston: Springer, pp 81-104.

Barajas, R., Philipsen, N., & Brooks-Gunn, J. (2008). *Handbook of families and poverty*. London: Sage.

Barrera, M. (1986). Distinctions between social support concepts, measures, and models. *American journal of community psychology, 14*(4), 413-445.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report, 13*(4), 544-559.

Beard, J. R., & Petitot, C. (2010). Ageing and urbanization: Can cities be designed to foster active ageing? *Public Health Reviews, 32*(2), 427.

Beck, H. (2009). Linking the quality of public spaces to quality of life. *Journal of Place Management and Development, 2*(3), 240-248.

Bengtson, V. L., & Settersten Jr, R. (2016). *Handbook of theories of ageing.* New York: Springer.

Bernard, M., Ogg, J., & Phillipson, C. (2002). *Family and community life of older people: social networks and social support in three urban areas.* London: Routledge.

Bjorklund, E. (1986). The danwei: socio-spatial characteristics of work units in China's urban society. *Economic Geography, 62*(1), 19-29.

Bonifas, R. P., Simons, K., Biel, B., & Kramer, C. (2014). Aging and place in long-term care settings: Influences on social relationships. *Journal of Aging and Health, 26*(8), 1320-1339.

Bouwen, R., & Steyaert, C. (1990). Construing organizational texture in young entrepreneurial firms. *Journal of Management Studies, 27*(6), 637-649.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative research journal, 9*(2), 27-40.

Bradburn, N. M. (1969). *The structure of psychological wellbeing*. Oxford: AIdine.

Brandt, M., Deindl, C., & Hank, K. (2012). Tracing the origins of successful aging: the role of childhood conditions and social inequality in explaining later life health. *Social science & medicine, 74*(9), 1418-1425.

Bray, D. (2005). *Social space and governance in urban China: The danwei system from origins to reform.* Stanford: Stanford University Press.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American psychologist, 32*(7), 513.

Bronfenbrenner, U. (1979). *The ecology of human development.* Cambridge: Harvard university press.

Bronfenbrenner, U. (1994). Ecological models of human development. *International encyclopedia of education, 3*(2), 37-43.

Bryant, L. L., Corbett, K. K., & Kutner, J. S. (2001). In their own words: a model of healthy aging. *Social science & medicine, 53*(7), 927-941.

Buffel, T., Phillipson, C., & Scharf, T. (2013). Experiences of neighbourhood exclusion and inclusion among older people living in deprived inner-city areas in Belgium and England. *Ageing & Society, 33*(1), 89-109.

- Bibliography -

Bülow, M. H., & Söderqvist, T. (2014). Successful ageing: A historical overview and critical analysis of a successful concept. *Journal of Aging Studies, 31*, 139-149.

Bureau, N. S. o. C. (2016). China Statistical Yearbook 2016.   Retrieved from http://www.stats.gov.cn/tjsj/ndsj/2016/indexch.htm.

Bureau, S. S. (2016). Shanghai statistical yearbook. See http://www.stats-sh.gov.cn/html/sjfb/201701/1000339.html.

Buttimer, A., & Seamon, D. (2015). *The human experience of space and place*. London: Routledge.

Calhoun, C., Gerteis, J., Moody, J., Pfaff, S., & Virk, I. (2012). *Classical sociological theory*. Hoboken: John Wiley & Sons.

Cao, Y., & Wang, J. (2013). Review of the Long － term Care for Elderly. *Social Security Studies*, 56-65.

Carpenter, R. C. (2007). *Born of war: Protecting children of sexual violence survivors in conflict zones.* Bloomfield: Kumarian Press.

Case, D. (1996). Contributions of journeys away to the definition of home: An empirical study of a dialectical process. *Journal of environmental psychology, 16*(1), 1-15.

Casey, B., & Yamada, A. (2002). *Getting older, getting poorer? A study of the earnings, pensions, assets and living arrangements of older people in nine countries.* Paris: LIS Cross-National Data Center in Luxembourg.

Cattan, M., White, M., Bond, J., & Learmouth, A. (2005). Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions. *Ageing & Society, 25*(1), 41-67.

Chai, Y. (1996). Danwei-based Chinese cities' internal life-space structure - a case study of Lanzhou. *Geographical Research, 15*(1), 30-38.

Chai, Y.-w., Chen, L.-j., & Zhang, C. (2007). Transformation of Danwei System: an Angle of View on City Changes in China [J]. *World Regional Studies, 16*(4), 60-69.

Chai, Y., & Zhang, Y. (2010). Rethinking Danwei community in urban China: Actions to global climate changes. *Urban Planning International, 25*(1), 20-23.

Chan, Y., & Lee, R. P. (2006). Network size, social support and happiness in later life: A comparative study of Beijing and Hong Kong. *Journal of Happiness Studies, 7*(1), 87-112.

Chapin, R., & Dobbs-Kepper, D. (2001). Aging in place in assisted living: Philosophy versus policy. *The Gerontologist, 41*(1), 43-50.

Chapman, S. A. (2006). A 'new materialist'lens on aging well: Special things in later life. *Journal of Aging Studies, 20*(3), 207-216.

Chen, C., & Sun, X. (2010). Community care for the old people: practices and implication of UK, America and Japan's mode. *Socialism Studies* (1), 116-120.

Chen, W. (2002). A Comparative Study on Long-term Care Systems in the EU Member States. *European, 2*, 55-61.

Chen, X. (2014). Building the community- based long- term care system. *Medicine and Philosophy, 35*, 11-14.

219

- Bibliography -

Chen, X., & Silverstein, M. (2000). Intergenerational social support and the psychological wellbeing of older parents in China. *Research on Aging, 22*(1), 43-65.

Chevreul, K., & Brigham, K. B. (2013). Financing long-term care for frail elderly in France: The ghost reform. *Health Policy, 111*(3), 213-220.

Choi, E., Tang, F., & Copeland, V. C. (2017). Racial/ethnic inequality among older workers: focusing on Whites, Blacks, and Latinos within the cumulative advantage/disadvantage framework. *Journal of Social Service Research, 43*(1), 18-36.

Cloutier-Fisher, D., & Harvey, J. (2009). Home beyond the house: Experiences of place in an evolving retirement community. *Journal of environmental psychology, 29*(2), 246-255.

Cohn, M. A., Fredrickson, B. L., Brown, S. L., Mikels, J. A., & Conway, A. M. (2009). Happiness unpacked: positive emotions increase life satisfaction by building resilience. *Emotion, 9*(3), 361.

Conger, R. D., Conger, K. J., & Martin, M. J. (2010). Socioeconomic status, family processes, and individual development. *Journal of Marriage and Family, 72*(3), 685-704.

Conradson, D. (2005). Landscape, care and the relational self: therapeutic encounters in rural England. *Health & Place, 11*(4), 337-348.

Cornwell, E. Y., & Waite, L. J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of health and social behavior, 50*(1), 31-48.

Cropanzano, R., & Mitchell, M. S. (2005). Social exchange theory: An interdisciplinary review. *Journal of Management, 31*(6), 874-900.

Crystal, S. (1982). *America's old age crisis: Public policy and the two worlds of ageing.* New York: JSTOR.

Crystal, S. (1986). Measuring income and inequality among the elderly. *The Gerontologist, 26*(1), 56-59.

Crystal, S., & Shea, D. (1990). Cumulative advantage, cumulative disadvantage, and inequality among elderly people. *The Gerontologist, 30*(4), 437-443.

Crystal, S., & Shea, D. G. (2002). Prospects for retirement resources in an aging society. *Annual review of gerontology and geriatrics, 22*(1), 271-281.

Crystal, S., Shea, D. G., & Reyes, A. M. (2016). Cumulative advantage, cumulative disadvantage, and evolving patterns of late-life inequality. *The Gerontologist*, *57*(5), 910-920.

Cumming, E., & Henry, W. E. (1961). *Growing old, the process of disengagement*. New York: Basic Books.

Cummins, R. (1995). On the trail of gold standard for life satisfaction. *Soc Indic Res, 35*, 179-200.

Cummins, R. (1998). The Second Approximation to an International Standard of Life Satisfaction. *Social Indicator Research*, vol. 43.

Cummins, R. (2013). Subjective wellbeing, homeostatically protected mood and depression: A synthesis. In: Delle Fave A. (eds), *The exploration of happiness*. Dordrecht: Springer, pp 77-95.

Custers, A. F., Westerhof, G. J., Kuin, Y., Gerritsen, D. L., & Riksen-Walraven, J. M. (2012). Relatedness, autonomy, and competence in the caring relationship: The perspective of nursing home residents. *Journal of Aging Studies, 26*(3), 319-326.

Cutchin, M. P. (2003). The process of mediated aging-in-place: A theoretically and empirically based model. *Social science & medicine, 57*(6), 1077-1090.

Dang, J. (2005). Strategies of Facing the "Aged Society" in China (Zhong guo ying dui lao ling she hui de zhan lue si lu). *Journal of the Central University for Nationalities: Philosophy and Social Sciences Edition (Zhong yang min zu da xue xue bao: zhe xue she hui ke xue ban), 32*(4), 74-76.

Dang, J., Pei, X., Song, Y., & Lin, Y. (2009). Why should China establish long term care service system? *Population & Development, 15*.

Dannefer, D. (1988). Differential gerontology and the stratified life course: Conceptual and methodological issues. In George L. Maddox and M. Powell Lawton (Eds), *Varieties of ageing.* Berlin: Springer, pp 3-36.

Dannefer, D. (2003). Cumulative advantage/disadvantage and the life course: Cross-fertilizing age and social science theory. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 58*(6), 327-337.

Dannefer, D. (2010). *The SAGE handbook of social gerontology.* London: Sage Publications.

Dannefer, D., & Daub, A. (2009). Extending the interrogation: Life span, life course, and the constitution of human aging. *Advances in Life Course Research, 14*(1-2), 15-27.

Dannefer, D., & Sell, R. R. (1988). Age structure, the life course and" aged heterogeneity": prospects for research and theory. *Comprehensive gerontology. Section B, Behavioural, social, and applied sciences, 2*(1), 1-10.

Dannefer, D., & Settersten, R. A. (2010). The study of the life course: Implications for social gerontology. In Dale Dannefer (ed), *The SAGE handbook of social gerontology.* London: Sage Publications, pp 3-19.

De Neve, J.-E., & Oswald, A. J. (2012). Estimating the influence of life satisfaction and positive affect on later income using sibling fixed effects. *Proceedings of the National Academy of Sciences, 109*(49), 19953-19958.

Derry, S. J. (1999). A fish called peer learning: Searching for common themes. *Cognitive perspectives on peer learning, 9*(1), 197-211.

Diener, E. (1984). Subjective wellbeing. *Psychological bulletin, 95*(3), 542.

Diener, E., & Suh, E. (1997). Measuring quality of life: Economic, social, and subjective indicators. *Social indicators research, 40*(1-2), 189-216.

Diener, E., Lucas, R., Helliwell, J. F., Helliwell, J., & Schimmack, U. (2009). *Wellbeing for public policy.* New York: Oxford University Press.

Diewald, M., Goedicke, A., & Mayer, K. (2006). *After the fall of the wall: life courses in the transformation of East Germany.* Stanford: Stanford University Press.

Dillaway, H. E., & Byrnes, M. (2009). Reconsidering successful aging: A call for renewed and expanded academic critiques and conceptualizations. *Journal of applied gerontology, 28*(6), 702-722.

- Bibliography -

Ding, J. (2013). The homecare services: recognizing mistakes, rational principles and perfecting measurs (ju jia yang lao fu wu: ren shi wu qu, li xing yuan ze ji wan shan dui ce). *Journal of Renmin University of China (zhong guo ren min da xue xue bao), 27*(2), 20-26.

Ding, Y., & Lv, X. (2013). Literature review of long term care institution for the elderly in developed countries and districts (Fa da guo jia (di qu) lao nian ren chang qi zhao hu zhi du yan jiu zong shu-jian lun zhong guo lao nian ren chang qi zhao hu zhi du de dui ce). *Academic Forum (Xue shu lun tan), 12*, 028.

Ding, Z., & Wei, H. (2016). Willingness and impact factors to buy long term care insurance of older people in urban China (Zhong guo cheng shi lao ren gou mai chang qi hu li bao xian yi yuan ji qi ying xiang yin su). *Population Research (Ren kou yan jiu), 40*(6), 76-86.

Dobner, S., Musterd, S., & Fortuijn, J. D. (2016). 'Ageing in place': experiences of older adults in Amsterdam and Portland. *GeoJournal, 81*(2), 197.

Dodge, R., Daly, A. P., Huyton, J., & Sanders, L. D. (2012). The challenge of defining wellbeing. *International journal of wellbeing, 2*(3).

Doolittle, P. E., & Hicks, D. (2003). Constructivism as a theoretical foundation for the use of technology in social studies. *Theory & Research in Social Education, 31*(1), 72-104.

Edwards, J. R., Caplan, R. D., & Van Harrison, R. (1998). Person-environment fit theory: conceptual foundations, empirical evidence, and directions for future research. In: C. L. Cooper (ed), *Theories of organizational emphasis.* New York: Oxford University Press, 29-67.

Ekerdt, D. J. (1986). The busy ethic: Moral continuity between work and retirement. *The Gerontologist, 26*(3), 239-244.

Elder Jr, G. H. (1994). Time, human agency, and social change: Perspectives on the life course. *Social psychology quarterly*, 4-15.

Elder Jr, G. H., & Liker, J. K. (1982). Hard times in women's lives: Historical influences across forty years. *American Journal of Sociology, 88*(2), 241-269.

Elder Jr, G. H., Shanahan, M. J., & Jennings, J. A. (2015). Human development in time and place. In: Richard M. Lerner, Marc H. Bornstein and Tama leventhal (eds), *Handbook of child psychology and developmental science.* Hoboken: John Wiley & Sons, pp 6-54.

Ernest, P. (1999). Forms of knowledge in mathematics and mathematics education: Philosophical and rhetorical perspectives. In *Forms of mathematical knowledge.* Dordrecht: Springer, pp 67-83.

Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of interpersonal violence, 23*(3), 316-338.

Fang, X. (2006). Community's role in dealing with aging: theoretical analysis and empirical exploration. *Journal of Hangzhou Party School*(5), 50-54.

Fänge, A., & Ivanoff, S. D. (2009). The home is the hub of health in very old age: Findings from the ENABLE-AGE Project. *Archives of gerontology and geriatrics, 48*(3), 340-345.

Fenton, S.-J. (2014). Ageing and agency: The contested gerontological landscape of control, security and independence and the need for ongoing care and support. Birmingham: Birmingham Policy Commissions.

Ferraro, K. F., & Kelley-Moore, J. A. (2003). Cumulative disadvantage and health: long-term consequences of obesity? *American Sociological Review, 68*(5), 707.

Findlay, R. A. (2003). Interventions to reduce social isolation amongst older people: where is the evidence? *Ageing & Society, 23*(5), 647-658.

Fleuret, S., & Atkinson, S. (2007). Wellbeing, health and geography: a critical review and research agenda. *New Zealand Geographer, 63*(2), 106-118.

Florida, R., Rentfrow, P. J., Sheldon, K., Kashdan, T., & Steger, M. (2011). Place and wellbeing. *Designing positive psychology: Taking stock and moving forward*, 385-395.

Francesca, C., Ana, L.-N., Jérôme, M., & Frits, T. (2011). *Help Wanted? Providing and Paying for Long-Term Care: Providing and Paying for Long-Term Care.* OECD Publishing.

Fratiglioni, L., Wang, H.-X., Ericsson, K., Maytan, M., & Winblad, B. (2000). Influence of social network on occurrence of dementia: a community-based longitudinal study. *The lancet, 355*(9212), 1315-1319.

Fry, G. (2014). Coping with Change: frail bodies and daily activities in later life. In CIRCLE, *The Role of Telecare in Older People's Daily Lives: experiences, practices and attitudes–Working Papers from the AKTIVE project 2011-2014.* Leeds: University of Leeds.

Gabriel, Z., & Bowling, A. (2004). Quality of life from the perspectives of older people. *Ageing & Society, 24*(5), 675-691.

Garcia, D., & Siddiqui, A. (2009). Adolescents' psychological wellbeing and memory for life events: influences on life satisfaction with respect to temperamental dispositions. *Journal of Happiness Studies, 10*(4), 407-419.

Gergen, K. J. (2001). *Social construction in context.* London: Sage.

Glass, A. P., & Vander Plaats, R. S. (2013). A conceptual model for aging better together intentionally. *Journal of Aging Studies, 27*(4), 428-442.

Glendinning, C., & Moran, N. (2009). *Reforming Long-term Care: Recent lessons from other countries.* York: Social Policy Research Unit, University of York.

Goh, Z.-Y., Lai, M.-M., Lau, S.-H., & Ahmad, N. (2013). The Formal and Informal Long-Term Caregiving for the Elderly: The Malaysian Experience. *Asian Social Science, 9*(4), p174.

Golant, S. M. (2003). Conceptualizing time and behavior in environmental gerontology: A pair of old issues deserving new thought. *The Gerontologist, 43*(5), 638-648.

Gottlieb, B. H., & Bergen, A. E. (2010). Social support concepts and measures. *Journal of psychosomatic research, 69*(5), 511-520.

Graham, C. (2005). The economics of happiness. *World economics, 6*(3), 41-55.

Gredler, M., & Schwartz, L. (1997). Factorial structure of the self-efficacy for self-regulated learning scale. *Psychological Reports, 81*(1), 51-57.

Greenfield, E. A., Scharlach, A., Lehning, A. J., & Davitt, J. K. (2012). A conceptual framework for examining the promise of the NORC program and Village models to promote aging in place. *Journal of Aging Studies, 26*(3), 273-284.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods, 18*(1), 59-82.

Gui, Y., Ma, W., & Muhlhahn, Klaus. (2009). Grassroots transformation in contemporary China. *Journal of Contemporary Asia*, *39*(3), 400-423.

Guo, K. L., & Castillo, R. J. (2012). The US long term care system: Development and expansion of naturally occurring retirement communities as an innovative model for aging in place. *Ageing International, 37*(2), 210-227.

Hajli, M. N. (2014). The role of social support on relationship quality and social commerce. *Technological Forecasting and Social Change, 87*, 17-27.

Hall, E. (2010). Spaces of wellbeing for people with learning disabilities. *Scottish Geographical Journal, 126*(4), 275-284.

Hammarström, G., & Torres, S. (2012). Variations in subjective wellbeing when 'aging in place'—A matter of acceptance, predictability and control. *Journal of Aging Studies, 26*(2), 192-203.

Harris, J., & White, V. (Eds.). (2013) A dictionary of social work and social care. New York: Oxford University Press.

Harrison, J. (1983). Women and ageing: experience and implications. *Ageing & Society, 3*(2), 209-235.

Harvey, D. (1990). The condition of postmodernity: An enquiry into the conditions of cultural change. Hoboken: Blackwell.

He, H. (2016). Abroad Experience of long term care insurance: based on comparison between Korea, Japan and Germany (Guo wai she hui chang qi zhao hu bao xian zhi du jian she jing yan yu qi shi: ji yu han guo ri ben he de guo de bi jiao yan jiu). *Social Sciences Abroad (Guo wai she hui ke xue)*(2), 76-83.

Hendry, L. B., & Kloep, M. (2002). *Lifespan development: Resources, challenges and risks*. Mason: Cengage Learning.

Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. *Journal of psychosomatic research, 11*(2), 213-218.

Holstein, J. A., & Gubrium, J. F. (2004). The active interview. *Qualitative research: Theory, method and practice, 2*, 140-161.

Horan, S. M. (2012). Affection exchange theory and perceptions of relational transgressions. *Western Journal of Communication, 76*(2), 109-126.

Hosking, D.-M. (2002). *Constructing changes: A social constructionist approach to change work (and beetles and witches)*. Tilburg: Katholieke Universiteit Brabant.

Hou, X., Shang, S., Wang, Z., Xie, H., Jin, X., Wang, M., Deng, S. (2010). The Development And Enlightment of Long Term Care Both at Home And Abroad. *Chinese Nursing Management, 10*, 11-13.

Houston, D. M., McKee, K. J., Carroll, L., & Marsh, H. (1998). Using humour to promote psychological wellbeing in residential homes for older people. *Aging & Mental Health, 2*(4), 328-332.

Hu, Z., & Peng, X. (2012). China' s Family Policies in the Context of Family Changes. *Population Research, 36*(2), 3-10.

Hu, Z., & Xizhe, P. (2011). China's Population Aging from the Perspective of Public Policy. *Social Sciences in China, 32*(4), 106-124.

huang, J. (2016). A comparative study on long term care insurance of Japan and Korea: social welfare policy analysis (ri han chang qi zhao hu bao xian de bi jiao yan jiu: ji yu she hui fu li zheng ce fen xi kuang jia). *Journal of Fujian Normal University: Philosophy and Social Sciences Edition (fu jian shi fan da xue xue bao: zhe xue she hui ke xue ban), 4*, 003.

Huang, S. (2005). A Survey of the Needs of the Community Services to the Elderly in Guangzhou. *South China Population, 20*, 48-54.

Hudson, R. B. (2016). *Cumulative advantage and disadvantage: Across the life course, across generations.* New York: Oxford University Press.

Hutchison, E. D. (2010). A life course perspective. In: Hutchison (Ed), *Dimensions of human behavior: The changing life course,* Thousand Oaks: Sage, pp 1-38.

Hutchison, E. D., Matto, H. C., Harrigan, M. P., Charlesworth, L. W., & Viggiani, P. A. (2007). *Challenges of Living: A multidimensional Working model for social workers.* Thousand Okas: Sage Publications.

Jameson, F. (1991). *Postmodernism, or, the cultural logic of late capitalism.* Durham: Duke university Press.

Jiang, X., & Liu, N. (2014). A Study of the Option of the Elderly on Long-term Care Modes and Influencing Factors (Lao nian ren chang qi zhao liao mo shi xuan ze de ying xiang yin su yan jiu). *Population Journal (Ren kou xue kan), 1*, 16-23.

Jiang, X., & Wei, M. (2015). Activity of Daily Living of the Chinese Oldest-old and its change between 2002 and 2011 (Zhong guo gao ling lao nian ren ri chang sheng huo zi li neng li ji qi bian hua qing kuang fen xi). *Population & Development (Ren kou yu fa zhan)*(2), 93-100.

John, M. (2012). Wellbeing and older people. *From Public Health to Wellbeing: The New Driver for Policy and Action*, 97-113.

Jordan, B. (2008). *Welfare and wellbeing: Social value in public policy*: Policy Press.

Joseph, A. E., & Chalmers, A. L. (1995). Growing old in place: a view from rural New Zealand. *Health & Place, 1*(2), 79-90.

JsPG. (2009). Opinions on promoting the issue of aging in Jiangsu Province. Retrieved from http://www.shanghaigss.org.cn/news_view.asp?newsid=6303.

JsPG. (2010). Opinions on promoting the issue of aging in Nanjing City. Retrieved from http://www.shanghaigss.org.cn/news_view.asp?newsid=7086.

Juhila, K., Hall, C., & Raitakari, S. (2016). Interaction during mental health floating support home visits: managing host–guest and professional–client identities in home-spaces. *Social & Cultural Geography, 17*(1), 101-119.

Kahneman, D., Diener, E., & Schwarz, N. (1999). *Wellbeing: Foundations of hedonic psychology.* New York: Russell Sage Foundation.

Katz, J., Peace, S., & Spurr, S. (2011). *Adult lives: a life course perspective.* Bristol: Policy Press.

Katz, S. (1983). Assessing self-maintenance: activities of daily living, mobility, and instrumental activities of daily living. *Journal of the American Geriatrics Society, 31*(12), 721-727.

Katz, S. (1996). Disciplining old age: The formation of gerontological knowledge. Charlottesville: University of Virginia Press.

Kavanagh, D. (1990). *Thatcherism and British politics: the end of consensus?* New York: Oxford University Press.

Kaya, I. (2004). *Social theory and later modernities: the Turkish experience.* Liverpool: Liverpool University Press.

Kenkmann, A., Price, G. M., Bolton, J., & Hooper, L. (2010). Health, wellbeing and nutritional status of older people living in UK care homes: an exploratory evaluation of changes in food and drink provision. *BMC geriatrics, 10*(1), 28.

Kim, B. (2001). Social constructivism. *Emerging perspectives on learning, teaching, and technology, 1*(1), 16.

Kim, S., Sargent-Cox, K. A., French, D. J., Kendig, H., & Anstey, K. J. (2012). Cross-national insights into the relationship between wealth and wellbeing: a comparison between Australia, the United States of America and South Korea. *Ageing & Society, 32*(1), 41-59.

Knight, J., & Yueh, L. (2004). Job mobility of residents and migrants in urban China. *Journal of comparative economics, 32*(4), 637-660.

Kohn, M. L., Slomczynski, K. M., Janicka, K., Khmelko, V., Mach, B. W., Paniotto, V., Heyman, C. (1997). Social structure and personality under conditions of radical social change: A comparative analysis of Poland and Ukraine. *American Sociological Review*, 614-638.

Koike, S., & Furui, Y. (2013). Long-term care-service use and increases in care-need level among home-based elderly people in a Japanese urban area. *Health Policy, 110*(1), 94-100.

Kontos, P. C. (1998). Resisting institutionalization: Constructing old age and negotiating home. *Journal of Aging Studies, 12*(2), 167-184.

Kralik, D., Visentin, K., & Van Loon, A. (2006). Transition: a literature review. *Journal of Advanced Nursing, 55*(3), 320-329.

Krause, N. (1999). Assessing change in social support during late life. *Research on Aging, 21*(4), 539-569.

Krause, N., & Borawski-Clark, E. (1994). Clarifying the functions of social support in later life. *Research on Aging, 16*(3), 251-279.

Kukla, A. (2013). *Social constructivism and the philosophy of science.* London: Routledge.

Kuwert, P., Spitzer, C., Träder, A., Freyberger, H. J., & Ermann, M. (2007). Sixty years later: post-traumatic emphasis symptoms and current psychopathology in former German children of World War II. *International psychogeriatrics, 19*(5), 955-961.

La Placa, V., & Knight, A. (2017). The emergence of wellbeing in late modern capitalism: Theory, research and policy responses. *Int'l J. Soc. Sci. Stud., 5*, 1.

Lamberg, L. (2004). When military parents are sent to war, children left behind need ample support. *JAMA, 292*(13), 1541-1542.

Larsson, K., Silverstein, M., & Thorslund, M. (2005). Delivering care to older people at home. In M. Johnson (Ed.), *The Cambridge Handbook of Age and Ageing.* Cambridge: Cambridge University Press, pp 630-637.

Lawton, M. P. (1982). Competence, environmental press, and the adaptations of older people. In: Lawton MP, Windley PG, Byerts TO, (eds), *Aging and the Environment: Theoretical Approaches.* New York: Springer, 97-120.

Lawton, M. P. (1990). Knowledge resources and gaps in housing for the aged. In: David Tilson (ed), *Aging in place.* Glenview: Pearson Scott foresman, pp 287-309.

Lawton, M. P., Weisman, G. D., Sloane, P., & Calkins, M. (1997). Assessing environments for older people with chronic illness. *Journal of Mental Health and Aging, 3*(1), 83-100.

Layard, R. (2011). *Happiness: Lessons from a new science.* Strand: Penguin UK.

Leith, K. H. (2006). "Home is where the heart is… or is it?": A phenomenological exploration of the meaning of home for older women in congregate housing. *Journal of Aging Studies, 20*(4), 317-333.

Liang, C., Lee, J., Zhang, H., Li, L., Yuan, D., Kang, W., & Yang, S. (2012). A silent revolution: Research on family backgrounds of students of Peking University and Soochow University (1952–2002). *Social Science in China,* 1, 98-118.

Liang, J., & Luo, B. (2012). Toward a discourse shift in social gerontology: From successful aging to harmonious aging. *Journal of Aging Studies, 26*(3), 327-334.

Lieberman, M. A., & Tobin, S. S. (1983). *The experience of old age: Emphasis, coping, and survival.* New York: Basic Books.

Lin, N. (2004). Home-based care for the old people. *Journal of Fujian Party School*(12).

Liu, C. (2006). Social changes and neighbourhood policy in Shanghai. *Policy and Society, 25*(1), 133-155.

Liu, D. (2016). The Family Solidarity and National Responsibilities in the Long-term Care System: Based on the Comparative Analysis of Some EU Countries (Chang qi zhao hu zhi du zhong de jia ting tuan jie yu guo jia ze ren: ji yu ou zhou bu fen guo jia de bi jiao). *Population Journal (Ren kou xue kan)*(4), 36-47.

Liu, T. (2016). German Long-term care insurance from the angle of Welfare Pluralism (Fu li duo yuan zhu yi shi jiao xia de de guo chang qi zhao hu bao xian zhi du yan jiu). *Journal of Public Administration (Gong gong xing zheng ping lun), 9*(4), 68-87.

Liu, T., & Chai, Y. (2012). The Meaning, Content and Prospect of Danwei System Research in the Perspective of Geography. *Progress in Geography, 31*(4), 527-534.

Liu, Y., & He, D. (2015). Analysis of American long term care services and suppor: from the perpective of medical subsidy (Mei guo chang qi zhao hu fu wu yu zhi chi ti xi fen xi ji qi dui zhong guo de qi shi: cong mei guo yi liao bu zhu shi jiao kao cha). *Monthly Journal of Theories (Li lun yue kan)*(12), 173-179.

Lloyd-Sherlock, P., Barrientos, A., Moller, V., & Saboia, J. (2012). Pensions, poverty and wellbeing in later life: Comparative research from South Africa and Brazil. *Journal of Aging Studies, 26*(3), 243-252.

Locke, C., & Lloyd-Sherlock, P. (2011). Qualitative life course methodologies: Critical reflections from development studies. *Development and change, 42*(5), 1131-1152.

- Bibliography -

Lopez, F. G., & Brennan, K. A. (2000). Dynamic processes underlying adult attachment organization: Toward an attachment theoretical perspective on the healthy and effective self. *Journal of Counseling Psychology, 47*(3), 283.

Lyubomirsky, S., & Lepper, H. S. (1999). A measure of subjective happiness: Preliminary reliability and construct validation. *Social indicators research, 46*(2), 137-155.

Lyyra, T.-M., & Heikkinen, R.-L. (2006). Perceived social support and mortality in older people. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 61*(3), 147-152.

Maddox, G. L., & Douglass, E. B. (1974). Aging and individual differences: A longitudinal analysis of social, psychological, and physiological indicators. *Journal of Gerontology, 29*(5), 555-563.

Maddox, G. L., & Lawton, M. P. (1988). *Varieties of aging*. Berlin: Springer.

Marjoribanks, K. (1979). Family and school environmental correlates of intelligence, personality, and school related affective characteristics. *Genetic Psychology Monographs, 99*(2), 165-183.

Marmot, M. G., Fuhrer, R., Ettner, S. L., Marks, N. F., Bumpass, L. L., & Ryff, C. D. (1998). Contribution of psychosocial factors to socioeconomic differences in health. *The Milbank Quarterly, 76*(3), 403-448.

Martí, J., Bolíbar, M., & Lozares, C. (2017). Network cohesion and social support. *Social networks, 48*, 192-201.

Martinson, M., & Berridge, C. (2014). Successful aging and its discontents: A systematic review of the social gerontology literature. *The Gerontologist, 55*(1), 58-69.

Masten, A. S., & Reed, M.-G. J. (2002). Resilience in development. In C. R. Snyder & Shane J. Lopez (Eds), *Handbook of positive psychology*. New York: Oxford University Press, pp 74-88.

Masten, A. S., Burt, K. B., Roisman, G. I., Obradović, J., Long, J. D., & Tellegen, A. (2004). Resources and resilience in the transition to adulthood: Continuity and change. *Development and psychopathology, 16*(4), 1071-1094.

Mayer, K. U. (2004). Whose lives? How history, societies, and institutions define and shape life courses. *Research in human development, 1*(3), 161-187.

McGillivray, M., & Clarke, M. (2006). *Understanding human wellbeing*. New York: United Nations University Press.

McMahon, M. (1997). *Social constructivism and the World Wide Web-A paradigm for learning*. Perth: Paper presented at the ASCILITE conference.

Mguni, N., Bacon, N., & Brown, J. F. (2012). *The wellbeing and resilience paradox*. London: *The Young Foundation*.

Michael, R., & Bron, A. (2011). The ageing lens and cataract: a model of normal and pathological ageing. *Philosophical Transactions of the Royal Society B: Biological Sciences, 366*(1568), 1278-1292.

Moore, J. (2000). Placing home in context. *Journal of environmental psychology, 20*(3), 207-217.

- Bibliography -

Moore, K. D. (2014). An ecological framework of place: Situating environmental gerontology within a life course perspective. *The International Journal of Aging and Human Development, 79*(3), 183-209.

Morell, C. M. (2003). Empowerment and long-living women: Return to the rejected body. *Journal of Aging Studies, 17*(1), 69-85.

Nakanishi, M., Shimizu, S., Murai, T., & Yamaoka, A. (2015). " Ageing in Place" Policy in Japan: Association Between the Development of an Integrated Community Care System and the Number of Nursing Home Placements Under the Public Long-Term Care Insurance Program Among Municipal Governments. *Ageing International, 40*(3), 248.

Näre, L., Walsh, K., & Baldassar, L. (2017). Ageing in transnational contexts: transforming everyday practices and identities in later life. *Identities, 24*(5), 515-523.

Neilson, B. (2012). Ageing, experience, biopolitics: Life's unfolding. *Body & Society, 18*(3-4), 44-71.

Newman, K., & Fox, C. (2009). Repeat tragedy: Rampage shootings in American high school and college settings, 2002-2008. *American Behavioral Scientist, 52*(9), 1286-1308.

Nicholson, C., Meyer, J., Flatley, M., Holman, C., & Lowton, K. (2012). Living on the margin: understanding the experience of living and dying with frailty in old age. *Social science & medicine, 75*(8), 1426-1432.

Nin, A. M. R. (2005). Consumerism and 'compulsory individuality': Women, will and potential. In: *Transformations*. London: Routledge, pp 292-306.

Nordbakke, S., & Schwanen, T. (2014). Wellbeing and mobility: A theoretical framework and literature review focusing on older people. *Mobilities, 9*(1), 104-129.

Nosraty, L., Jylhä, M., Raittila, T., & Lumme-Sandt, K. (2015). Perceptions by the oldest old of successful aging, Vitality 90+ Study. *Journal of Aging Studies, 32*, 50-58.

O'Rand, A. M. (1996). The Precious and the Precocious: Understanding Cumulative Disadvantage and Cumulative Advantage Over the Life Course. *The Gerontologist, 36*(2), 230-238.

Oswald, F., & Wahl, H.-W. (2005). Dimensions of the meaning of home in later life. In: Graham D. Rowles, Habib Chaudhury (eds), *Home and identity in late life: International perspectives*. New York: Springer, pp 21-45.

Oswald, F., Jopp, D., Rott, C., & Wahl, H.-W. (2010). Is aging in place a resource for or risk to life satisfaction? *The Gerontologist, 51*(2), 238-250.

Oswald, F., Wahl, H.-W., Schilling, O., Nygren, C., Fänge, A., Sixsmith, A., . . . Iwarsson, S. (2007). Relationships between housing and healthy aging in very old age. *The Gerontologist, 47*(1), 96-107.

Ozbay, F., Johnson, D. C., Dimoulas, E., Morgan III, C., Charney, D., & Southwick, S. (2007). Social support and resilience to emphasis: from neurobiology to clinical practice. *Psychiatry (Edgmont), 4*(5), 35.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 533-544.

Pallasmaa, J. (1994). Identity, intimacy and domicile. *Finish Archit. Rev, 1*, 16.

Pangallo, A., Zibarras, L., & Lewis, R. (2015). Resilience Through the Lens of Interactionism: A Systematic Review. *Psychological Assessment, 27*, 1-20.

Parkes, C. M., & Prigerson, H. G. (2013). *Bereavement: Studies of grief in adult life.* London: Routledge.

Peacock, J., & Kitson, G. (1999). *The limited impact of early familial disruption on subjective wellbeing in later life.* Chicago: Annu. Meet. Am. Sociol. Assoc., 94th.

Pengilly, J. W., & Dowd, E. T. (2000). Hardiness and social support as moderators of emphasis. *Journal of clinical psychology, 56*(6), 813-820.

Perkins, M. M., Ball, M. M., Whittington, F. J., & Hollingsworth, C. (2012). Relational autonomy in assisted living: A focus on diverse care settings for older adults. *Journal of Aging Studies, 26*(2), 214-225.

Phillipson, C. (1997). Social relationships in later life: A review of the research literature. *International journal of geriatric psychiatry, 12*(5), 505-512.

Phillipson, C. (2007). The 'elected'and the 'excluded': sociological perspectives on the experience of place and community in old age. *Ageing & Society, 27*(3), 321-342.

Phillipson, C., Bernard, M., Phillips, J., & Ogg, J. (1999). Older people's experiences of community life: Patterns of neighbouring in three urban areas. *The Sociological Review, 47*(4), 715-743.

Pietilä, I., & Ojala, H. (2011). Acting age in the context of health: Middle-aged working-class men talking about bodies and aging. *Journal of Aging Studies, 25*(4), 380-389.

Piovesana, G. K. (1979). The aged in Chinese and Japanese cultures. *Dimensions of aging: Readings*, 13-20.

Rantz, M. J., Phillips, L., Aud, M., Popejoy, L., Marek, K. D., Hicks, L. L., . . . Miller, S. J. (2011). Evaluation of aging in place model with home care services and registered nurse care coordination in senior housing. *Nursing Outlook, 59*(1), 37-46.

Reeves, S., Kuper, A., & Hodges, B. D. (2008). Qualitative research methodologies: ethnography. *BMJ: British Medical Journal (Online), 337*.

Richardson, M. S. (2004). The emergence of new intentions in subjective experience: A social/personal constructionist and relational understanding. *Journal of vocational behavior, 64*(3), 485-498.

Riley, M. W., Foner, A., & Riley Jr, J. (1999). The aging and society paradigm. In Vern L. Bengtson and Richard Settersten, Jr (eds), *Handbook of theories of ageing*. New York: Springer, pp 327-342.

Robertson, I. T., & Cooper, C. L. (2010). Full engagement: The integration of employee engagement and psychological wellbeing. *Leadership & Organization Development Journal, 31*(4), 324-336.

Rostgaard, T., Glendinning, C., Gori, C., Kroger, T., Osterle, A., Szebehely, M., . . . Vabo, M. (2011). *LIVINDHOME: Living independently at home: Reforms in home care in 9 European countries.* Copenhagen: The Danish National Care for Social Research.

Rowe, J. W., & Kahn, R. L. (1987). Human aging: usual and successful. *Science, 237*(4811), 143-149.

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist, 37*(4), 433-440.

Rowe, J. W., & Kahn, R. L. (2015). Successful aging 2.0: Conceptual expansions for the 21st century. *The Journals of Gerontology: Series B, 70*(4), 593-596.

Rowles, G. D. (1983). Place and personal identity in old age: Observations from Appalachia. *Journal of environmental psychology, 3*(4), 299-313.

Ryff, C. D. (1989). Beyond Ponce de Leon and life satisfaction: New directions in quest of successful ageing. *International journal of behavioral development, 12*(1), 35-55.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological wellbeing. *Journal of Personality and Social Psychology, 57*(6), 1069.

Satariano, W. (2005). Aging, health, and the environment: an ecological model *Epidemiology of aging: An ecological approach* (pp. 39-84).

SC. (2011a). China's twelfth five-year plan of aging issues. Retrieved from http://www.shanghaigss.org.cn/news_view.asp?newsid=8371.

SC. (2011b). State Council's guidance on government contracting-out.

SC. (2011c). State Council's several opinions on promoting the development of LTC service. Retrieved from http://www.shanghaigss.org.cn/news_view.asp?newsid=9437.

SC. (2013d). State Council's several opinions on promoting the development of health and medical service industry. Retrieved from http://www.shanghaigss.org.cn/news_view.asp?newsid=9349.

Scherger, S., & Savage, M. (2010). Cultural transmission, educational attainment and social mobility. *The Sociological Review, 58*(3), 406-428.

Scott, J. (2006). *Social theory: Central issues in sociology.* London: Sage.

SdPG. (2009). Opinions on promoting the issue of aging in Shandong Province.

Seeman, T. E., Berkman, L. F., Blazer, D., & Rowe, J. W. (1994). Social ties and support and neuroendocrine function: The MacArthur studies of successful aging. *Annals of Behavioral Medicine, 16*(2), 95-106.

Seligman, M. E. (2002). Positive psychology, positive prevention, and positive therapy. *Handbook of positive psychology, 2*(2002), 3-12.

Shanghaitoutiao. (2018). Parks in Shanghai. Shanghai Headline. Retrieved from http://www.sohu.com/a/218713549_161398

Shen, Y. (2014). Community building and mental health in mid-life and older life: Evidence from China. *Social science & medicine, 107*, 209-216.

Shi, C. (2012). Literature review on care security for the old people in the context of aging. *The World of Labor and Security*, *34*(4), 29-32.

Shuchter, S. R., & Zisook, S. (1988). Widowhood: The continuing relationship with the dead spouse. *Bulletin of the Menninger Clinic, 52*(3), 269.

Shuchter, S. R., & Zisook, S. (1993). The course of normal grief. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention.* New York, NY, US: Cambridge University Press, pp 23-43.

Simon, R. J. A. B. (1996). *Minefields in their hearts: The mental health of children in war and communal violence.* New Haven and London: Yale University Press.

Sixsmith, A., & Sixsmith, J. (2008). Ageing in place in the United Kingdom. *Ageing International, 32*(3), 219-235.

Skocpol, T., & Finegold, K. (1982). State capacity and economic intervention in the early New Deal. *Political science quarterly, 97*(2), 255-278.

SMG. (2009). Announcement on regulating home care service based on communities in Shanghai City. Retrieved from http://www.shanghaigss.org.cn/news_view.asp?newsid=6263.

Snow, D. A., & Trom, D. (2002). *The case study and the study of social movements* (Vol. 16). Minneapolis: University of Minnesota Press Minneapolis.

Sointu, E. (2005). The rise of an ideal: tracing changing discourses of wellbeing. *The Sociological Review, 53*(2), 255-274.

Southwick, S. M., Sippel, L., Krystal, J., Charney, D., Mayes, L., & Pietrzak, R. (2016). Why are some individuals more resilient than others: the role of social support. *World Psychiatry, 15*(1), 77-79.

SRCA. (2013). Statistics of ageing issues of Shanghai in 2013. Retrieved from http://www.shanghaigss.org.cn/news_view.asp?newsid=9614.

Stafford, M., & Marmot, M. (2003). Neighbourhood deprivation and health: does it affect us all equally? *International journal of epidemiology, 32*(3), 357-366.

Stetsenko, A., & Arievitch, I. (1997). Constructing and deconstructing the self: Comparing post-Vygotskian and discourse-based versions of social constructivism. *Mind, Culture, and Activity, 4*(3), 159-172.

Stone, S. D. (2003). Disability, dependence, and old age: Problematic constructions. *Canadian Journal on Aging/La Revue canadienne du vieillissement, 22*(1), 59-67.

Stroebe, M. S., Hansson, R. O., Stroebe, W. E., & Schut, H. E. (2001). *Handbook of bereavement research: Consequences, coping, and care.* Washington: American Psychological Association.

Sugisawa, H., Liang, J., & Liu, X. (1994). Social networks, social support, and mortality among older people in Japan. *Journal of Gerontology, 49*(1), 3-13.

Sun, H. (2010). Study on home-based aging in urban China (zhong guo cheng zhen ju jia yang lao fu wu ti xi yan jiu). *Lan Zhou Academic Journal (Lan zhou xue kan)(5)*, 90-93.

Tang, F., & Pickard, J. G. (2008). Aging in place or relocation: Perceived awareness of community-based long-term care and services. *Journal of Housing for the Elderly, 22*(4), 404-422.

Tang, Y. (2007). Literature review on home care service. *Social Work*(2), 12-14.

Taylor, C. (1991). Sources of the Self. Cambridge: Harvard University Press.

Taylor, S. E., Sherman, D. K., Kim, H. S., Jarcho, J., Takagi, K., & Dunagan, M. S. (2004). Culture and social support: Who seeks it and why? *Journal of Personality and Social Psychology, 87*(3), 354.

Thoits, P. A. (2010). Emphasis and health: Major findings and policy implications. *Journal of health and social behavior, 51*(1_suppl), 41-53.

Tinker, A. (1999). *Ageing in Place: What Can We Learn from Each Other?* Ecumenical Housing Incorporated and Copelen Child and Family Services.

Tinker, A., Kellaher, L., Ginn, J., & Ribe, E. (2012). *Assisted Living Platform -The Long Term Care Revolution.* London: Housing Learning and Improvement Network.

Torelli, C. J., & Shavitt, S. (2010). Culture and concepts of power. *Journal of Personality and Social Psychology, 99*(4), 703.

Tracy, S. J. (2012). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact.* Chichester: John Wiley & Sons.

Vasunilashorn, S., Steinman, B. A., Liebig, P. S., & Pynoos, J. (2011). Aging in place: evolution of a research topic whose time has come. *Journal of Aging Research*, 2012, 1-5.

Villar, F. (2012). Successful ageing and development: The contribution of generativity in older age. *Ageing & Society, 32*(7), 1087-1105.

Wahl, H.-W., & Lang, F. R. (2003). Aging in context across the adult life course: Integrating physical and social environmental research perspectives. *Annual review of gerontology and geriatrics, 23*(1), 1-33.

Wang, B. (2004). The development of care service and community service for the older people. *China Social Welfare*.

Wang, D., & Chai, Y. (2009). The jobs–housing relationship and commuting in Beijing, China: the legacy of danwei. *Journal of Transport Geography, 17*(1), 30-38.

Wang, F. (2004). Community endowment: orientation, problems and countermeasures. *social Science Research*, *26*(6), 110-113.

Wang, J., & Zhang, L. (2015). Comparison of Elderly Long-term care system: reflection on the responsibilities of family, market and government (lao nian chang qi zhao hu ti zhi bi jiao: guan yu jia ting shi chang he zheng fu ze ren de fan si). *Zhejiang Social Sciences (zhe jiang she hui ke xue)*(8), 60-68.

Wang, L. (2013). Study on the Development of China's Aging-in-place Policy (zhong guo ju jia yang lao zheng ce fa zhan li cheng fen xi). *Northwest population (Xi bei ren kou)*(2), 66-72.

Weil, J., & Smith, E. (2016). Revaluating aging in place: from traditional definitions to the continuum of care. *Working with Older People, 20*(4), 223-230.

Weindruch, R., & Masoro, E. J. (1991*). Concerns about rodent models for aging research*. Citeseer.

White, S. C. (2010). Analysing wellbeing: a framework for development practice. *Development in Practice, 20*(2), 158-172.

WHO. (2015). World report on aging and health.

Wieland, D., Kinosian, B., Stallard, E., & Boland, R. (2013). Does Medicaid pay more to a program of all-inclusive care for the elderly (PACE) than for fee-for-service

long-term care? *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences, 68*(1), 47-55.

Wild, K., Wiles, J. L., & Allen, R. E. (2013). Resilience: thoughts on the value of the concept for critical gerontology. *Ageing & Society, 33*(1), 137-158.

Wiles, J. (2005). Conceptualizing place in the care of older people: the contributions of geographical gerontology. *Journal of Clinical Nursing, 14*(2), 100-108.

Wiles, J. L., Allen, R. E., Palmer, A. J., Hayman, K. J., Keeling, S., & Kerse, N. (2009). Older people and their social spaces: A study of wellbeing and attachment to place in Aotearoa New Zealand. *Social science & medicine, 68*(4), 664-671.

Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. E. (2012). The meaning of "aging in place" to older people. *The Gerontologist, 52*(3), 357-366.

Williams, A. (2002). Changing geographies of care: employing the concept of therapeutic landscapes as a framework in examining home space. *Social science & medicine, 55*(1), 141-154.

Wolinsky, F. D., & Arnold, C. L. (1988). A different perspective on health and health services utilization. In George L. Maddox and M. Powell Lawton, *Varieties of Ageing*. Berlin: Springer, pp 71-101.

Wong, S. T., Yoo, G. J., & Stewart, A. L. (2007). An empirical evaluation of social support and psychological wellbeing in older Chinese and Korean immigrants. *Ethnicity and Health, 12*(1), 43-67.

Wu, B., & Xu, Q. (2007). Community-Based Long-Term Care in Urban Setting (Cheng shi she qu chang qi zhao liao ti xi de xian zhuang yu wen ti). *Population Research (Ren kou yan jiu), 31*(3), 61-70.

Wu, Y., & Jin, Y. (2007). Research on the feasibility and countermeasures of community endowment. *Journal of Liaoning Administ ration College, 9*, 252-253.

Xiong, F. (2018). Changes of Shanghai eldercare system (cong '9073' ge ju dao wu wei yi ti, Shanghai yang lao fu wu ti xi you na xie bian hua). Eastday.com. http://sh.eastday.com/m/20181029/u1ai11937909.html

Yang, T. (2016). Policy options for long term care in China (zhong guo chang qi zhao hu de zheng ce xuan ze). *Social Sciences in China (zhong guo she hui ke xue)*(11), 87-110.

Yang, X. (2014). Exploration on home care service in urban areas: based on a surey of ten cities. *Scientific Research on Aging, 2*(9), 36-43.

Yeandle, S., Buckle, P., Fry, G., Hamblin, K., Koivunen, E.-R., & McGinley, C. (2014). The AKTIVE project's social, design and prospective hazard research: research methods. Leeds: University of Leeds.

Yeandle, S., Kröger, T., & Cass, B. (2012). Voice and choice for users and carers? Developments in patterns of care for older people in Australia, England and Finland. *Journal of European Social Policy, 22*(4), 432-445.

Young, R. A., & Collin, A. (2004). Introduction: Constructivism and social constructionism in the career field. *Journal of vocational behavior, 64*(3), 373-388.

Yuan, X. (2013). Family relations and effects on adult children in long term care (chang qi zhao liao zhong de jia ting guan xi ji qi dui cheng nian zi nv zhao liao zhe de ying xiang). *Lan Zhou Academic Journal (Lan zhou xue kan.) 34*(1), 138-141.

Zhan, H. J., Feng, Z., Chen, Z., & Feng, X. (2011). The role of the family in institutional long-term care: cultural management of filial piety in China. *International Journal of Social Welfare, 20*(1), 121-134.

Zhang, B. (2013). Comparison of typical home care patterns in China. *Jianghan Academic, 32*(4).

Zhang, Y. (2010). *Research on Problems and Countermeasures of Community Services for the Aged.* Changsha: Hunan University.

Zhou, S., Xie, M., & Kwan, M.-P. (2015). Ageing in place and ageing with migration in the transitional context of urban China: A case study of ageing communities in Guangzhou. *Habitat International, 49,* 177-186.

Appendixes

Appendix 1 – Profile of research participants

Research participants in the two communities in Shanghai

		Code name	Gender	Age	Martial status	Health status	Living status	Carers and care workers
Community A	Older people	Ouyang	Female	84	Widowed	With slight impairment	Live with a care worker	5 children and 1 care worker
		Cao	Female	81	Widowed	With moderate impairment	Live alone	1 care worker and 3 children
		Shao	Female	83	Widowed	With slight impairment	Live alone	2 children
		Tang	Male	91	Married	With severe impairment	Live with spouse and 1 care worker	2 care workers
		Ru	Male	83	Married	With slight impairment	Live with spouse and 1 care worker	2 children and 1 care worker
		Wu	Female	86	Widowed	With slight impairment	Live alone	1 care worker
		Li	Female	82	Single	With slight impairment	Live with a good friend	1 friend
		Fan	Male	86	Widowed	With slight impairment	Live alone	1 child
	Carers	Code name	Gender	Age	Retired or not	Focus group or individual interview		
		Shen	Male	63	Y	Focus group		
		Ru	Male	83	Y			
		Liu	Female	62	Y			

		Cheng	Female	66	Y		
		Feng	Female	74	Y		
		Chen	Male	65	Y		
		Jin	Male	66	Y	Individual interview	
		Qin	Female	53	N	Individual interview	
		Sun	Male	72	Y	Individua interview	
	Care workers	**Code name**	**Gender**	**Age**	**Province**	**Focus group or individual interview**	
		Xia	Female	53	Henan		
		Guo	Female	51	Zhejiang		
		Xu	Female	50	Anhui	Focus group interview	
		Zhao	Female	42	Jiangsu		
		Ma	Female	48	Henan		
		Jiang	Female	53	Anhui		
		Zhu	Female	48	Anhui	Individual interview	
		Zhang	Female	60	Jiangsu	Individual interview	
	Stakeholders	**Code name**	**Gender**	**Occupation**			
		Wang	Female	Chief Staff of an eldercare agency			
		Liang	Female	Head of a meal station			
		Wu	Male	Key member of the neighborhood community			
		Fei	Female	Key member of the neighborhood community			
		Qin	Female	A sub-district-level government officer			
Community B	Older people	**Code name**	**Gender**	**Age**	**Martial status**	**Health status**	**Living status**	**Carers and care workers**
		Qi	Female	93	Widowed	With slight impairment	Live with her son	4 children
		Cao	Male	82	Married	With moderate impairment	Live alone	2 children
		Hua	Female	82	Single	With slight	Live alone	No

					impairment		
		Yu	Female	85	Widowed	With moderate impairment	Live with children	3 children and 1 care worker
		Gao	Female	82	Married	With severe impairment	Live with spouse and a care worker	2 children and 1 care worker
		Liu	Female	78	Widowed	With slight impairment	Live with daughter-in-law and a grandson	1 daughter-in-law

	Code name	Gender	Age	Retired or not	Focus group or individual interview
Carers	Fang	Male	63	Y	Individual interview
	Gao	Female	58	N	Individual interview
	Dong	Male	71	Y	Focus group interview
	Li	Male	69	Y	
	Liu	Male	62	Y	
	Gu	Female	68	Y	
	Yang	Female	71	Y	
	Xin	Female	64	Y	
	Liang	Female	72	Y	

	Code name	Gender	Age	Province	Focus group or individual interview
Care workers	Zhu	Female	35	Henan	Focus group interview
	Niu	Female	48	Anhui	
	Zhou	Female	49	Anhui	
	Zhang	Male	49	Henan	
	Ning	Female	50	Jiangxi	
	Xu	Female	38	Jiangsu	
	Xia	Female	42	Hubei	Individual interview

		Wei	Female	51	Anhui	Individual interview
Stakeholders		Code name	Gender	Occupation		
		Li	Female	Key member of the Neighborhood community		
		Shang	Male	Key member of the Neighborhood Community		
		Wangl	Female	Chief staff of an eldercare agency		
		Wang	Female	Chief staff of an eldercare service centre		
		Zheng	Male	A district-level government officer		

Appendix 2 – Interview guide for ELA visits with older people

I Essential information

1. Name (code name) _____

2. Gender _____

3. Age _____

4. Marital status _____

5. Education level _____

6. Occupation before retirement _____

7. Pension and medical insurance _____

8. Living arrangement _____

9. Health status _____

10. Home address _____

II Everyday life in old age

11. Please briefly describe your daily life practices and activities.

_____

12. Do you encounter any difficulties in you daily life? If so, what are they? What factors contribute to this? Do you have any joy or pleasure in your daily living? If so, what factors contribute to this?

_____

13. What are your perspectives, feelings and understandings of ageing, old age and impairment?

_____

14. How do you like your later life? What's your opinion of wellbeing in later life? What you think is critical for securing wellbeing in old age?

_____

15. What are your strategies to secure wellbeing in old age? How do you deal with physically or psychologically discomfort?

_____

III Earlier experience and wellbeing in old age

16. What were the salient events and experiences in your lives that you consider as critical for wellbeing in older age?

_____

17. How the earlier experiences influence your wellbeing in later life?

_____

IV Place and wellbeing

18. How are you related to your social and physical environments?

_____

19. How important are living environment, particularly the home and locality, to you? How do characteristics of home and locality contribute to or constrain your wellbeing?

_____

V Social networks, social relations and available social support

20. Do you need help in your daily life? If so, what help do you need? Who help you with these? What support you received from them?

_____

Older people's social networks and social support

Network members	Relations with the older people	What support they provide?
1st network member		
2nd network member		
…		

21. What is your feeling while being taken care of?

_____

22. What is your relation with key network members? How does this influence your wellbeing in later life?

_____

23. Do you know whom to turn to for help when you need support? Do you know any eldercare policies or available local eldercare support? If yes, could you please tell me more details?

_____

24. Does the exiting social support meet your needs? If yes, in what ways? If not, what are your most pressing needs?

_____

Appendix 3 – Focus group plan

I Name of the Focus Group: Tell Your Story

II Goals of the Focus Group

Overall goal

Have a deep understanding of the influence of care relations and care networks on older people's wellbeing.

Specific goal

The focus group will be held for twice.

The goals of the first time are to have a general idea of the caring experience of cares/care workers and their relation with the older people.

The goals of the second time are to have a deep understanding of relations between carers/care workers and older people, in terms of power relations, conflicts, affection, intimacy, social support etc.

III Characteristics of the Focus Group and its members

Characteristics of the Focus Group

Sub group: the members of the group don't know each other well before they join the focus group.

Closed group: All the members stay in the focus group from the beginning to the end. There are no new members that join in the group once the group begins.

Characteristics of the members

Characteristics of the members can be analysed from three aspects: individual level, environmental level and interacting level. Individual level means the personal information of the carers/care workers, including economic-social status, educational background, working experience and so on. Environmental level

including the working environment, family environment and social environment. Interacting level means the level that individual interact with the environment, including the relation between carers/care workers, the relation between carers/care workers and the old people, available social support for the carers/care workers and social stress to the cares/care workers.

IV Recruitment

This focus group will recruit at least 6 members. The group members will be recruited mainly by:

Recommended by a Neighbourhood Committee member;

Recommended by an eldercare agency staff;

Snowball sampling.

V Timeline of the Focus Group

Date	Progress
2015. 10	Contact with the gatekeepers, recruit members, prepare needed materials
01.11.2015 – 07.11.2015	Session 1 of Focus group A
08.11.2015– 15. 11.2015	Summarize session 1 of focus group A, prepare for session 1 of Focus group B
16.11.2015 – 23.11.2015	Session 1 of Focus group B
24.11.2015 – 30.11.2015	Summarize session 1 of focus group B, prepare for session 2 of focus group A
01.12.2015 – 07.12.2015	Session 2 of Focus group A
08.12.2015 – 15.12.2015	Summarize session 2 of focus group A, prepare for session 2 of focus group B
16.12.2015 – 23.12.2015	Session 2 of Focus group B
24.12.2015 – 31.12.2015	Summarize session 2 of focus group B

VI Specific plan of the Focus Group

Duration	Progress	Goals
10 minutes	Icebreaker	Let group members be familiar with each other，establish group rules, break the ice.
30 minutes	Question 1: talk about your caring experience	Have a understanding of cares/care workers' life.
30 minutes	Question 2: talk about the relations between you and the older people.	Have a knowledge of how carers/care workers interact with the older people.
20 minutes	Summary	Understand each member's idea more clearly.

VII Budget

Materials needed	Price	Amount	Sum
Gifts	100 RMB	24	2400 CNY
Papers and pens	80 RMB	4	320 CNY
Posters	120 RMB	4	480 CNY
Snacks and drinks	300 RMB	4	1200 CNY
Total			4400 CNY

Appendix 4 – Topic guide for focus group interviews with carers/care workers

I Essential information

1. Name (code name)   ————————————

2. Gender   ————————————

3. Age   ————————————

4. Relations with the older people ————————————

5. Address   ————————————————

II Support provided by carers/care workers

6. When you help the older people, what kinds of help do you offer? Could you please tell me more about that?

————————————————————————————————

Support provided by carers/care workers

Support provided	Yes (details)	No
Domestic help		
Nursing care		
Emergency respond		
Financial support		
Emotional support		
Information support		
……		

III Experiences of care provision

7. How do you perceive the needs of the old people? Do you think whether you have met their needs or not?

_____

8. What's your feeling when taking care of the old people? What's the greatest challenge of taking care of the older people?

_____

9. How do you deal with challenges and difficulties?

_____

10. Do you receive any support from others? Could you please tell me more details?

_____

IV Relationships between carers/care workers and the older people they cared for

11. What do you think of the relation between you and the older people you cared for? Will this influence older people's wellbeing in later life? If yes, in what ways? Could you please tell me more about this?

_____

12. Does conflicts once occur between you and the older people? If yes, what are they? How did you solve the problem?

_____

Appendix 5 – Topic guide for interviews with stakeholders

Topic guide of interviews with government officers

I Essential information

1. Name (code name) ————————————

2. Gender ————————————

3. Age ————————————

4. Occupation ————————————

5. Address ————————————

II The past and current eldercare policies

6. What's the history of eldercare arrangement in Shanghai in general and in the district in particular? Could you please tell me more about that?

————————————————————————————

7. What are the current eldercare policies in Shanghai in general and in the district in particular? Could you please tell me more about that?

————————————————————————————

8. Could you please tell me your opinion on how eldercare fits in broader national/local authority policies and what drives this agenda?

————————————————————————————

9. What are the challenges in implementing eldercare policies?

————————————————————————————

III Eldercare policies and wellbeing of older people in later life

10. What is your opinion of the impact of eldercare policies on service users? Could you please tell me more about that?

————————————————————————————

11. What's your opinion on the benefits and limitations of current eldercare products and service?

————————————————————————————

12. What's your opinion on how to improve eldercare products and service in the future?

_____

Topic guide for Neighbourhood Committee member interview

I Essential information

1. Name (code name) _____

2. Gender _____

3. Age _____

4. Occupation _____

5. Address _____

II Eldercare situation in the community

6. What's the history of eldercare in your community?

_____

7. What's the most common type of eldercare in your community? Could you please tell me more about that?

_____

8. What are the difficulties the older people with care needs in your community face?

_____

III Neighbourhood Committee and wellbeing of older people in later life

9. What is the role of neighbourhood committee in eldercare? Could you please tell more about that?

_____

10. Is there any support for older people with care needs in your community? Who organises it? Who provide it? How does the community-based support influence older people's wellbeing in later life?

_____

11. What are the relations between the Neighbourhood committee, older people, local authorities and eldercare agencies? How do these influence older people's wellbeing in later life?

_____

12. What are the difficulties that hinder Neighborhood Committee to provide more and better eldercare service for the older people in your community?

_____

Topic guide for eldercare agency manager interviews

I Essential information

1. Name (code name) _____

2. Gender _____

3. Age _____

4. Occupation _____

5. Address _____

II Basic information of the eldercare agency/institution

6. What's the history, objective, structure and sources of funding of your agency/institution?

_____

7. What services do you provide? Whom do you provide the services and support for?

_____

8. How are the services and support provided?

_____

III Eldercare agency and wellbeing of older people in later life

9. How does the support provided influence local residents' wellbeing in later life?

_____

10. What's the relation between your agency/ institution, care workers and older people? How does this influence wellbeing in later life?

_____

Appendix 6 – Information sheet for research participants

Wellbeing in later life: experiences of older people ageing in place in Shanghai

The researcher

Hello! I'm Wenjing. I graduated from Fudan University and am a PhD student at the University of Leeds, UK. My PhD research project is about ageing in place experiences and wellbeing in later life. I'm now doing fieldwork in Shanghai. I look forward to working with you!

The research

This research is about wellbeing in later life and the experiences of older people ageing in place in Shanghai. The research aims to explore the experiences and meanings of wellbeing for and by older people themselves. In particular, I'm interested in addressing what makes for a good life in old age, how older people sustain wellbeing when age at home, and how older people's wellbeing is shaped by earlier experience, the locality, social relations and social networks. Through household visits, interviews, focus groups and observation, this research tries to address the research aims and further hopes to contribute to knowledge of how to improve and enhance wellbeing in old age.

Who this research is looking for…

I'd like to involve older people who need long term care and are taken care of in their homes in this community. I would also like to talk to people who provide help, care or support to older people living at home, e.g. carers, care workers, stakeholders.

What you are expected to do…

- Older people

You will be visited twice. The interval between each visit is about two to three months. During each visit, I will look around your living environment if you are happy for me to do this. I will also have an interview with you. During the interview, I will ask you some questions about your ageing experiences and perspectives of wellbeing. With your consent, your supporter, whether he/she is a family member, a friend, a neighbour or a care worker, will also be invited to participate in part of the interview.

- Carers/care workers

You will be interviewed twice as part of a focus group. The interval between each focus group interview is about two to three months. During the interview, I will ask you some questions about your caring experiences, your relationships with the older people and how these influence their wellbeing in old age.

- Stakeholders (neighbourhood committee members, eldercare agency staffs, government officers)

You will be interviewed once. During the interview, I will ask you some questions about existing eldercare policies, services and support, as well as how these influence older people's wellbeing in old age.

What will happen to your data?

The interviews will be recorded, with your consent. The researcher may also take notes during the interviews. The audio recordings will be stored on my password protected computer. Only I will have access to them. If you wish to end the interview at any point, let me know and recording will stop.

My supervisors may be involved in the research outputs and data analysis, for example in conference papers or articles. Your name will not be included and any information that may reveal your identity will be removed. Everything you say will

be kept confidential. The data will be destroyed five years after the research has finished.

How can you take part?

You can call me at + 86 15968881256 so that I can contact you to arrange a convenient date and place for an interview. You can withdraw from the research at any time without giving any reason.

You are not able to take part, but know someone who might?

Please pass this leaflet on to any friends, neighbours or colleagues who age at home or take care of an older person at home.

Do you have any questions?

Please feel free to contact me at any time. I will be happy to give you further information.

I look forward to hearing from you!

Appendix 7 – Consent form for qualitative research interviews

Consent to take part in: Wellbeing in later life: experiences of older people ageing in place in Shanghai

Please circle the appropriate response:

I confirm that I have read and understand the information sheet explaining the above research project	**Yes No**
I confirm that I have had the opportunity to ask questions about the project.	**Yes No**
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.	**Yes No**
I understand that should I withdraw from / be withdrawn from the study for any reason, the research team will retain the data already collected about me unless I request that all data relating to me are withdrawn from the study.	**Yes No**
I agree for the data collected from me to be stored and used in relevant future research in an anonymised form.	**Yes No**
I understand that other genuine researchers will have access to this data only if they agree to preserve the confidentiality of the	**Yes No**

information as requested in this form.	
I understand that other genuine researchers may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	**Yes No**
I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	**Yes No**
I agree to take part in the above research project and will inform the lead researcher should my contact details change.	**Yes No**
I agree that this session will be audio recorded.	**Yes No**

Name of participant	
Participant's signature	
Date	
Name of lead researcher	
Signature	
Date	

If you have any further questions, please contact:

Email: mlwj@leeds.ac.uk   Telephone: + 86 15968881256

Appendix 8 – Old-age related policies and systems in Shanghai

Eldercare support policies in Shanghai in 2015

Year	Support receivers	Subsidies	Services provided
2003	1. Older people who are 60+ and whose living standard are below the minimum living level. 2. Poor older people who have great contributions to the society. 3. Older people who are 80+, who live alone or those who have other living difficulties.	No more than 200 CNY pppm	
2004	1. Poor older people or older people with long term care needs. 2. Older people who are 100+ 3. The other older people who are 80+	1.100-250 CNY pppm 2. 50-250 CNY pppm 3. 50% discount, no more than 150 CNY pppm	Services delivered into older people's home, including daily life support, medical and nursing service, emotional support.
2005	1. Older people with LTC needs who are 90+, and whose living standard are below the minimum living level. 2.80-89 3.70-79 4.60-69	1. 250 CNY pppm 2. 200 CNY pppm 3. 150 CNY pppm 4. 150 CNY pppm	Services delivered into older people's home, services available in the daily care center
2006	Older people with LTC needs who are 60+, and whose living standard are below the minimum living level. According to assessment, the caring level could be divided into three categories: slight impairment, moderate impairment and severe impairment.	General LTC subsidy: 200 CNY pppm; Special LTC service subsidy: 100 CNY pppm for Moderate impairment, 200 CNY for severe impairment.	
2007	1. Older people who lives in this district and has no children. 2. Older people who are 100+ 3. Older people between 90-99	1. 200 CNY pppm 2. 200 CNY pppm 3. 100 CNY pppm	

Year	Objects	Subsidy	Services
2008	1. Original objects 2. Older people with LTC needs who are 80+, live alone or live with aged spouses, at the same time whose pension is below the average salary level of urban workers in Shanghai.	1. Increase the subsidy from 200 CNY pppm to 300 pppm. 2.50% discount of general LTC subsidy and special LTC subsidy.	1. Services delivered into older people's home 2. Services available in the daily care center 3. Services provided by meals support center.
2008	Older people who are 90+ and who is assessed as severe impairment.	200 CNY pppm LTC subsidy	
2009	1. Older people with LTC needs (slight, moderate or severe) 2. Older people between 80-89 (moderate or severe) 3. 90+	1. 180 CNY pppm 2. Add 60 CNY 3. Add 120 CNY	These subsidy is not provided by cash, but by service.
	The objects are assessed and decided by Disabled Person's Federation	390 CNY pppm	1. Services delivered into older people's home 2. Services available in the daily care center
2014	1. Older people with low income. 2. Older people who are 80+, and whose pension is below the average salary of urban workers in Shanghai.	1. Slight impairment: 450 CNY pppm; 2. Moderate impairment: 680 CNY pppm; Severe impairment: 1000 CNY pppm	LTC projects
2015	1. Older people who live in a family that its living standard is below the minimum living level. 2. The income of older people and his/her spouse is higher than the minimum living level but lower than the line of low-income family. 3. Older people who are 80+, and whose pension is below the average level of that of urban workers in Shanghai. 4. Older people belongs to category 2 or 3, at the same time they have no children or are 90+.	1. 100% of the LTC subsidy. 2. 80% of the LTC subsidy. 3. 50% of the LTC subsidy 4. Add 20%	LTC projects

Old-age related social insurance systems in Shanghai

Year	Social insurance systems	Supports provided for older people
1998	Workers Pension Insurance of Shanghai	Established individual accounts for those who have employers (including self-employed) and public accounts for these people as a whole. According to specific calculation methods, older people get pensions every month.
2014	Shanghai Citizenship Pension Insurance	Established individual accounts for Shanghai citizens who have not participated in Worker Pension Insurance. Individual payments and government subsidies go into individual accounts. According to specific calculation methods, older people get pensions every month.
2013	Workers Medical Insurance of Shanghai	Workers Medical Insurance covers 70%-85% outpatient fees and 92% in hospital fees for those who have retired, if their self-payment was over a specific amount (generally the amount is 700 CNY).
2015	Shanghai Citizenship Medical Insurance	Shanghai Citizenship Medical Insurance covers 50%-80% outpatient fees and 60%-90% in hospital fees for those who have not participant in Workers Medical insurance and who have retired, if their self-payment was over a specific amount (generally the amount is 300 CNY or less).
2017	Long term care Insurance of Shanghai (Trial)	After application and care needs assessment, older people who meet requirements can have long term care services in cash or in kind.