

Place and informal care in an ageing society: reviewing the state of the art in geographical
gerontology

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by

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ABSTRACT

Who cares for our frail older populations and where is fast becoming a critical issue for policy-makers and practitioners in many high income countries as they grapple with the economic and welfare implications of increasing longevity. This demographic shift is, of course, a major success story. However, increased life expectancy is also bringing with it a growth in those numbers of older people, particularly the oldest old, who are experiencing multiple morbidities and a declining ability to undertake those instrumental activities of daily life (IADLs) that are so important to maintaining independence and dignity in later life. At the same time, policy and practice has shifted away from residential or institutional care for our older population to focus on 'ageing in place'. Here, older people are to be supported to remain within their own homes for as long as possible. Conceptually, this has meant that services and care previously delivered within a single institutional environment, have been redesigned for delivery within domestic settings where frail older people would also benefit from the informal care support from family, friends and neighbours. On the one hand, this has meant that many older people have benefited from the familiarity, sense of safety and support that care provided within the domestic setting has engendered; on the other, changing family structures, a decline in community and sweeping health and welfare cuts in an era of economic austerity have left growing numbers of older people increasingly lonely, isolated and at risk. Understanding who cares, where, the form that care takes and how this is being differentially experienced by our older populations have been issues of growing concern for geographers interested in health and ageing. In this paper I review the current 'state of the art' of geographical gerontology around informal care and the home and illustrate how those working in this field are making an important contribution to multidisciplinary debates around care of our older populations.

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Introduction

Globally, the population is rapidly ageing; and whilst many older people lead healthy and active lives – especially in early retirement - with increased age comes an increased risk of declining health and mobility. Clearly exceptions apply, but as the research evidence attests, with increasing age, there is a greater likelihood of experiencing co-morbidity, cognitive or physical disability, loneliness and social isolation (e.g. Stenholm et al., 2014). This is particularly true for the ‘oldest old’ (those over 85 years of age), who are most likely to require care and support to undertake what are referred to as instrumental activities of daily life (IADL). First developed in the late 1960s (see Lawton and Brody, 1969), IADL measures ability to undertake activities such as cooking, shopping, housework, driving or using public transport, using the telephone or other forms of communication, taking medications and managing money. Such measures are now commonly used by health professionals to assess an older person’s ability to function independently and the level of support they may require to manage to continue living successfully at home.

Informal (or family) care-givers play a crucial role in providing the support needed for those who experience difficulties in undertaking IADLs. Historically in the UK this care has been undertaken by women. From the early to mid- 20th century, this model of care, however, began to change. In large part, this was a consequence of the development of a welfare state, in which care for older people was increasingly located away from the home to communal residential and nursing home settings provided either through the public, private or voluntary sectors. The contribution of local government to community and home based services at this

time was largely limited to grant-making to voluntary sector providers of meals-on-wheels and day centres, resulting in an uneven patchwork of provision (Milligan, 2001). Changes to the benefits system in the late 1980s had also enabled less affluent frail older people to claim the costs of residential care resulting in a mushrooming of private sector care homes. Growing criticism of the quality of residential care in the latter half of the 20th century, however, combined with a shifting political and ideological stance that viewed the domestic home and its environs as the best site in which to support older people saw a widespread adoption of care policies and practice focused around ‘ageing in place’ – a policy shift that has been replicated across many high income countries. Some have argued that this shift represents more of a return to the status quo and that the ‘classic welfare state’, as epitomised by the UK between 1995-1976, should be seen as exceptional (Offer, 1999). Importantly, however, policies and practices focused around ageing in place have been developed during a period of significant social and structural change. This is manifest not just through increased longevity, but also through increasing participation of women in the workforce; the growth of nuclear and second family phenomena; increased workforce mobility leading to greater family dispersion and a decline in community; and more recently, sweeping health and welfare cuts in an era of economic austerity (Milligan, 2009). All these factors have contributed to decline in the availability of those family caregivers that have traditionally taken on the caring role and a growing concern about the potential ‘care gap’. Increasing numbers of frail older people now find themselves with no, or few, family members living proximate to support and provide that care. Welfare cuts and a lack of sufficient paid care workers also means that those family members who *do* provide care are finding themselves with limited (and declining) public and voluntary sector support. Given the evidence that carer breakdown is one of the primary causes of frail older people having to enter residential care (Milligan, 2009), these cutbacks are likely to impact adversely on how long they are

willing or able to continue caring. A knock-on effect of these cutbacks then, is likely to be either an increasing demand for residential care, or increasing numbers of frail older people finding themselves lonely, isolated and at risk.

But what is it about people's relationship with the home that makes policy makers, practitioners and academics alike view ageing in place as the most appropriate site for the maintenance and delivery of care and support for our ageing populations? How is care being performed within the home – and should we accept the notion that home is the best site of care and support for older people uncritically? In this paper I bring a geographical lens to these issues, reviewing the current 'state of the art' around informal care for older people and the home and illustrate how those working within the field of geographical gerontology are making an important contribution to multidisciplinary debates around place and care of our older populations.

The importance of home for ageing in place?

As a key plank of policy and the provision of health and care for older people in many high income countries, ageing in place is predicated on the notion that the home and immediate environs: a) is the preferred location for most older people even when care and support is required; and b) facilitates the ability of older people to draw on the support of family, friends and neighbours – therefore reducing the requirement for formal care and health services. In a review of work within geographical gerontology Andrews et al. (2007) noted that one way in which geographers have sought to contribute to these debates has been by focusing on understanding how and why place - and in particular the home - is important in the care and support of our older populations (see for example, Dyck et al., 2005; Herron and Skinner,

2013; Milligan, 2003, 2009; Twigg 2000; Wiles et al. 2009). Most of this work has been at the local and/or micro-scale and builds on the work of early geographical gerontologists such as Graham Rowles (1978) and Sarah Harper and Glenda Laws (1995) to examine the relationships between older people and place and the role of care and support within this context. It involves understanding older people's experiences of, and engagement with, the home and its immediate environs, the social, emotional and physical characteristics of these spaces, and how they influence the quality of life, health, and mental wellbeing of older people and their family carers.

Rowles' detailed ethnographic account of the lived experience of older people's lives, painted a rich and detailed narrative of the ever-decreasing 'lifeworlds' that people inhabit as they age. It was arguably the first work to draw attention to the ways in which older people's lifeworlds contract with age to become more focused on the home and its immediate environs. Health and social geographers have sought to develop this body of work further by focusing on place attachment and sense of identity, highlighting how the home as a site of both physical and emotional meaning for the older person, becomes a central base for care and support in later life (Milligan, 2009). While many of the interventions designed to address mobility and social isolation of older people focus on support programmes that will mitigate against their becoming 'prisoners of space,' Rosel (2003) and others suggest that the declining lifeworlds that older people inhabit is not of necessity a bad thing. Indeed, they maintain that an older person's sense of connectedness to their local environs, and their personal knowledge of where and with whom they are growing older, enables them to draw on local social networks and hence it can be supportive in enabling them to manage within their own home for as long as possible.

The drive toward ageing in place is underpinned by perceptions that the home is where older people are likely to feel most independent and in control. Thinking about why the home may be particularly supportive in later life, Blunt (2005) has drawn attention to the ways in which the meaning and experience of home are both shaped and reshaped by everyday practices, social relations, memories and emotions. A layout and design that has been organised to suit the taste and needs of the individual, the presence of familiar objects that are known, easy to use or which may bring memories and comfort to the individual all serve to construct the home as a site which can offer security, familiarity and nurture (Tuan 2004). As a site removed from public scrutiny, the home is often seen as a place where the older person can control decisions about who enters or who is excluded (Twigg, 2000; Milligan, 2009). The home can thus provide an important buttress to an older person's sense of security and identity, self and independence, particularly for those who may feel vulnerable outside the bounds of their own private spaces. The personal meaning imbued within the home is further seen to have the potential to promote successful ageing in place through what Rowles (1993) has referred to as a preconscious sense of setting. That is, temporal knowledge of the home, combined with physical attachment to it, and the routines performed within it, can facilitate an older person's ability to negotiate the 'homespace' without coming to harm - even as physical or cognitive abilities begin to decline.

While the shifting of care provision from institutional settings to the home makes it more private, we should not forget that it also makes it a less visible and more isolating experience for both the older person and their family care-giver – one that is open to abuse by both individuals and health care systems. This highlights an important, but often overlooked aspect of home-based care – that is that it can lead to greater vulnerability for both the family carer and the care recipient (Cloutier-Fisher and Skinner, 2006). Some commentators have gone so

far as to take an oppositional stance, noting that the home offers greater potential for elder abuse to go undetected (Taylor et al. 2006; McGarry and Simpson 2008). Further, as Wiles and Rosenberg (2003) maintain, given home care is less visible than care provided within institutional settings, the shift from provision within institutional to home and community settings has been characterised by a stealthy informalisation and privatisation of that care as costs are shifted away from collective responsibility to that of the individual and families. In the UK and countries with similar welfare systems, for example, services to support informal care-giving within the home are often delivered by the voluntary and private sectors under contract from the state. In an era of austerity these are being significantly reduced in some areas leaving informal carers struggling to find ways to ‘plug the gap’ (Milligan, in press). Allen and Cloutier-Fisher (2006) have raised particular concerns about how state withdrawal and downsizing of health care provision in Canada, combined with historical patterns of unequal provision may increasingly disadvantage the significant numbers of rural dwelling older people.

Hence, any focus on the home as the site of care needs to recognise the complex nature of home in that it can represent both a tranquil haven and a site of conflict (Lowenstein, 2009). Policies designed around care within the home can have negative as well as positive connotations in that home-based care does not represent ‘safety’ and security for all older people and/or their family carers. This can be especially so where ‘choice’ about ageing is place is predicated on a lack of alternatives. Brickell, was thus led to argue that much of the literature that promotes ‘the emotional nobility of the home’ (2012, p.225) is guilty of exaggeration in that it ignores those domestic environs that are replete with tension and conflict.

Home, care and ambiguity in later life

While much of the literature and policy focusing around care and the home does so from the standpoint that the home is supportive of aging in place, as the previous section begins to suggest, as care and support needs change, so too can older people's relationships with home. As Schröder (2006) points out, the home is also a site of ambiguity since its protective functions are interconnected with its limiting characteristics. Feelings of safety and security are often achieved as a result of acts of exclusion and regulation. For example, exclusion and regulation may be about who can and cannot enter the home and certain spaces within the home, as well as who is permitted, or forbidden, to do what and when within the home. Growing dependence on both formal and informal support to maintain ADLs, however, can result in a declining power to exclude - even from those most personal and private areas of the home. Alongside these changes, it is important to recognise how the domestic sphere is constructed and reconstructed for and by older people and their family carers as frailty increases. Importantly, this can lead to a breakdown in any preconscious sense of setting as the requirement for the technologies of care (such as hoists, ramps, commodes, wheelchairs, hospital beds, nebulizers etc.) to support caregiving, and the need to reorganise the home to accommodate this paraphernalia, escalates. This, then, highlights the fluidity of the juxtaposition between private and public space and the shifting relationships of power, independence, and autonomy that accrue for older people as physical and cognitive abilities change and decline (see Milligan 2009; Milligan et al., 2010).

The home, then, does not automatically function as a site of comfort and inclusion. As a recent study of older male spousal care-givers illustrated, despite adopting often novel strategies designed to maximise their wives' ability to cope, older male carers can find

themselves excluded in a landscape deemed to be feminine and where their gender identity as men can be called into question (Milligan and Morbey, 2013). Drawing on the experiences of even relatively fit and able older men, Varley and Blasco (2000) noted how some can feel significantly alienated and divorced from their previous identity as a breadwinning male as they find themselves having to adapt to spending much of their later life within a territory deemed to be feminine.

Hillcoat-Nallétamby and Ogg (2014) argue that the home as a context for care has become over-romanticised as an ideal living environment for supporting and maintaining independence. They point out that such claims ignore the potential of the home to become a site of loneliness and social isolation, alienation and disempowerment (Barrett et al., 2012; Rabieem 2013) – particularly where the home becomes a site of medical and service intervention. Indeed, the evidence suggests that the provision of increasing amounts of care and support to older people within the home rather than within institutional settings, together with the requirement to reshape the home to accommodate the requirements of that care, can have a significant impact on the social and symbolic as well as the physical dimensions of home (Milligan, 2009). Hillcoat-Nallétamby and Ogg (2014) thus maintain that where health and functional abilities decrease, where the costs of running or maintaining the home become prohibitive, or where family composition changes, ageing in place may not be the best option for enhancing the wellbeing of older people. These same authors also point out that the desirability of remaining at home is often drawn in contrast to the stress of moving in later life, but argue that this depends on various factors, such as the ‘environmental fit’ of the of the new home/care setting, the rationale for moving and, importantly, the extent to which the individuals concerned have integrated successfully into new environments across the lifecourse. This suggests that research should place a greater focus firstly, on the extent to

which older people may *anticipate* moving from the domestic home where they perceive opportunities for better care, social engagement and more manageable settings may be available; and secondly, on the extent to which successful transitions to new care environments may be influenced by people's housing transitions across the lifecourse.

Care of the ageing body and home

The critical turn in health and social geography has seen the emergence of a corpus of work that moves away from treating older people as a statistic, or as the objects of study, and has instead focused on the personal and intimate and a more qualitative, in-depth engagement with older people themselves. The early work of Harper and Laws and others, highlighted the importance of focusing on the ways in which the body functions as a particular and fundamental determinant of the experience of places. Understanding the relationalities that exist between the ageing body and places has been an important theme running through this work (e.g. Dyck et al. 2005; Huang et al., 2012). A particular concern has been to examine the place of the body in everyday meanings and constructions of ageing, bringing into focus what the ageing body can and cannot do within places and how places can facilitate or constrain the ageing body. Theoretically this research draws on some of the early work around 'environmental press' but there has also been an engagement with Bourdieu's concept of habitus and the notion of 'body capital' (see Antoinetti and Garrett 2012). This highlights the importance of focusing on the interaction between the ageing body and places and how any reduction in body capital (physiological decline) not only changes habitus, but how younger age groups see older people. Diminished body capital is also viewed as diminishing *other* capacities accrued by the individual over the lifecourse creating a mismatch between the capacity of the body and the environment within which it is located.

The ageing body is conceived as being not only pivotal to the social construction of later life but also to the peripheralization of older people in discrete locations that may be segregated from those used and inhabited by younger people (Schwanen et al., 2012). Images of the ageing body, for example, are often depicted as frail and dependent (particularly in western societies) and as a consequence have become identified with the home, supported care, or residential settings. Here, there is also a strand of work around care and bodywork that has specifically looked at how gendered as well as ageing bodies affect the use and meaning of space (Dyck and England, 2012).

In the [re]turn toward care and support within domestic settings, informal carers take on many of the routinized tasks of caring for the ageing body, including the intimate and personal bodywork involved in care, such as washing and bathing, dressing, toileting, and feeding the older care-recipient. Undertaking these normally personal and private acts gives rise to transgressions of contemporary social taboos around care in western society—particularly cross-sex care. While the transgression of such social taboos may be less acute in spousal care-giving it can be particularly difficult where an adult child is providing personal care for a frail older parent of the opposite sex. As a result, relationships associated with the home can be altered and challenged by the process of caring (Milligan, 2009).

Given the social taboos that often mark the social boundaries of bodywork in western society, the more detached stance of the professional carer can be important in helping to make it more manageable. So the management of the care-recipient's body and who undertakes that management can be critical to the construction of the home as a caring space. It is a body that is subject not only to management by informal carers, but that has also been assessed by

formal care services in relation to the quantity and nature of care it should receive against some institutionally defined norm. It is important, however, that the assessment of care is not interpreted solely in terms of meeting the medically defined needs of the corporeal body; if segregation and ‘social death’ (Lawton, 1998) is to be avoided, the home also needs to be understood as a place where valued aspects of the social body can also be nurtured and preserved. In other words, it is important to recognize that it is not just the physical body that is attended to but that the social and emotional needs of the ageing body are also recognized and met. Indeed, there is a growing evidence base of the adverse effects of social isolation amongst older people on both their physical health and mental wellbeing (e.g. Luanaigh and Lawlor 2008; Holt-Lunstadt et al., 2010; Cacioppo and Cacioppo, 2014). The design of specialist housing for older people, however, often assumes an ageing body that is relatively static so requiring only limited space. This in turn can impact on an older person’s ability and opportunities to socialize within these settings. It is only through recognizing the home and body as interrelated sites and scales of analysis, that are both fluid and constantly in process, that we can gain real insight into the complex structuring of the relations that shape experiences of care. It is important, to recognize, however, that the construction of ageing identities in place is both socially and culturally ascribed, hence these highly westernized conceptualizations of the ageing body will vary and be reconstituted in different ways over both time and space.

Home and the multi-directionality of care

Much of the discussion around care refers to the ways in which older people are cared *for*, cared *about* – or the ways in which care is practiced *upon* the ageing body in particular

settings. In a recent years, we have begun to see the emergence of a body of work that has sought to address the often uni-directional ways in which this work is written (e.g. Watson et al. 2004; Fine and Glendinning, 2005; Milligan and Wiles, 2010; Wiles and Jayasina, 2013). Critics argue that rather than seeing care as a process of active care-giver and passive care-recipient, we need to recognise the complex multi-directional flows and networks of care that exist - and that reciprocity is often intimately interwoven within what should be viewed as the co-production of care. Reciprocity in care-giving may be immediate or delayed (as in reciprocal care given by an adult child for care received by a parent in childhood), physical or emotional. But importantly, as Meintel et al. (2006) point out, this relationship of care can extend *beyond* the family to include paid care-workers who may also gain reciprocal benefit from the care-giving relationship. Indeed, their work suggests that despite often notoriously low wages, some care workers view their employment as a vocation rather than a job. In a recent paper on care and ageing in place, Wiles and Jayasina (2013) take an interesting twist on the challenge to care as uni-directional by highlighting the various ways in which older people's attachment to home and local community can lead them to contribute positively to 'caring for place'. They point to the active role in volunteering, advocacy and activism that many older people take in order to help maintain the physical, social and affective composition of the local community and through actively advocating for change – often drawing on skills acquired over the lifecourse.

Care futures? Home and technology

The socio-economic implications of an ageing population, policies focused on ageing in place and concerns around the projected care gap means that governments in many high income countries recognise the imperative to develop new and sustainable models of care that will

meet the needs of their older citizens. New and emerging care technologies have become an important plank of these strategies (Goodwin, 2010; Hogenbirk et al. 2005; Ministry of Health, New Zealand 2008; Mort et al. 2008). On the one hand, these technologies are viewed as having the potential to enhance and maintain the well-being and independence of a wide range of older people who would otherwise be unable to live independently in the home; on the other, they are seen as part of a strategy to reduce the numbers of older people entering residential care and hospitals (Bayer et al. 2007). This ‘technological fix’ opens up some exciting possibilities for enhancing people’s ability to age in place, but it also raises important questions about how older people experience these technologies; how they may be reshaping the nature of care performed; who benefits from the development and implementation of these technologies; and how they may be reshaping the landscape of care.

Care technologies include a broad spectrum of care ‘support’ encompassing devices and systems that either enable individuals to perform tasks they would otherwise be unable to do, or increase the ease and safety with which these tasks can be performed (Milligan, 2009). A wide spectrum of lower level assistive care technologies such as hoists, canes, ramps and rails have been commonly available for many years. Newer technologies, however, from environmental control systems, infra-red monitoring and wearable devices, to robotic pets designed to alleviate social isolation, are increasingly being developed and adopted within domestic settings (Mort et al., 2008).

Undeniably, at their best, hi-tech solutions can offer older people a level of control and independence in their lives that they may not otherwise have enjoyed. Being enabled to undertake simple tasks such as switching on a light, opening the door or closing the curtains without having to rely on a carer increases an older person’s sense of independence and

inclusion (Mort et al. 2008). Some forms of non-intrusive monitoring can also increase an older person's sense of safety and security in the home (Essén, 2008; Milligan et al., 2010). Care technologies have the ability to monitor for falls, movement, eating patterns, irregular heart activity and so forth, to ensure that lone dwellers or older households in which both partners experience frailty, can maintain as healthy and independent a lifestyle as possible, enhancing their ability to remain in their own homes for longer. Proponents of these technologies thus make significant claims about their ability to increase independence through a decreased reliance on human-centred care (e.g. Hogenbirk et al. 2005; Essén 2008). They further note that the ability of care technology to monitor the older person can significantly improve the health and wellbeing of informal carers increasing their ability to continue caring for longer (Carretero et al., 2012). We should not, however, accept these developments uncritically. Other research, for example, points out that these technologies simply create new or different forms of dependence. That is, dependence is shifted from physically present human care to distance care, through care systems that still rely on a human presence but within a remote monitoring centre (Roberts et al., 2012). As a consequence, critics claim that care technologies act to redefine the role of patients and care professionals, introducing new categories of healthcare workers and redefining the spaces within which care is situated and performed (Oudshoorn, 2011).

Concern has been voiced that these new forms of care could result in increased social isolation. Whilst informal and formal carers will still be required to deliver personal care such as dressing, bathing and toileting, new care technologies enable remote diagnosis and remote monitoring - reducing the need for face-to-face care by practitioners. Remote monitoring of an older person's activity patterns through internet technology can also alleviate informal caregivers' concerns about their older relative. This is clearly beneficial to the informal carer, but

could also result in a reduction in face-to-face contact between family carers and care-recipients. Hence, unless carefully implemented, new care technologies could have an unforeseen adverse impact on the health and wellbeing of older people as social isolation and loneliness increases. These are not trivial issues, indeed one recent review noted that the mortality risks associated with social isolation are as great as those of smoking or diabetes (Loxtercamp, 2014). So on the one hand, these technologies can be seen as having a role to play in enhancing the ability of older people to manage their lives within their own homes, on the other, they hold the potential to exacerbate exclusion and isolation.

A wide range of different forms of care technologies designed for the home are now available and are rapidly developing. Given some of the issues raised above, it is important to understand what forms of care technology, designed for the home, are seen as acceptable by older people themselves. Friedewald and Da Costa (2003, 28) maintained that in integrating new care technologies into the home it is important that the technologies do not dominate the overall function and experience of the home. Rather they should seek to ‘enhance the quality of life of residents, not only by facilitating their daily activities, but also supporting their socialisation’. In other words, care technology should aim to be as unobtrusive as possible and designed to meet both the social and medical needs of the care-recipient. This is important, given as already discussed, the implementation of care policies and practices designed to support ageing in place can also create changes in the meaning of home and how people identify with it. Yet older people can also view what might be considered ‘everyday’ technologies such as televisions and computers as intruding on the way in which they identify with home. Dickinson et al. (2003), for example, pointed to instances in which older people have sought to cover televisions and computers with cloths when not in use in an attempt to reconstruct the physical appearance of these technologies in a way that blends with their

perception of home. Importantly, responses to the intrusiveness or otherwise of care technologies are highly individualised and contextually dependent.

Clearly, cultural values as well as exposure to technologies during the lifecourse will impact on perceived acceptability, but in the main, these appear to fall largely into two groups. Firstly, there are facilitative technologies designed to enhance an older person's ability to manage their own daily lives and secondly, there are surveilling technologies designed to enable a 'distant other' to monitor health and activity. The latter can be particularly disturbing for older people with cognitive impairment who may find it difficult to understand the concept of sensor surveillance and voices coming from remote technology apparatus (Mort et al., 2008).

Older people requiring care and support can often feel a clear lack of control over their own lives and homes – a feeling that can be exacerbated by surveilling technologies and reliance on remote care technologies over personal attendance. Research has drawn attention to how older people can purposefully seek to 'subvert the system' through varying their routines or adapting the use of the technology to see what will happen (Wu and Miller, 2005). Significantly, monitoring technologies are often 'mis-used' to trigger the very social responses they are designed to reduce (Mort et al., 2008). This not only highlights the importance of understanding the environment within which new care technologies are to be located, but also of ensuring that the social and emotional needs of older people do not become subsumed by their medical needs. Morris et al. (2003), for example, illustrated how older people with varying states of cognitive decline feel very strongly about loneliness, about being sequestered within the home and the need to maintain social ties. Meeting these social needs is central to older people's health status. Some care technology designers have begun to take the importance of addressing these issues on by developing technologies that help older people to

monitor and broaden their social interactions, or express affection – for example, through stroking or interacting with a robotic pet. Pols and Moser (2009) suggested that such developments have the potential to blur the divide between what has traditionally been seen as ‘warm’ (human-centred) care and ‘cold’ (non-human centred) care technologies.

The implementation of care technology within the home does raise issues around access to information. This is particularly important in relation to communication and the exchange of information about the care-recipient among health and social care providers and informal carers. On the one hand, research reveals that health professionals valued disclosure of information to both colleagues and informal carers - justified as being in the patients' best interests - even if disclosure came without the latter's consent (Tracy et al., 2004). Yet this is not without its problems. Evidence suggests that such access can impact not only on informal carers’ relationships with their parents (who may feel aggrieved at having their privacy invaded by their own adult child) but also with the informal carer’s siblings, where a sense of ‘rivalry’ about who is or is not participating in the care of the elderly parent may emerge (Morris, 2005). New care technologies, then, hold the potential to intervene in relationships previously thought to be private.

Critics, however, maintain that such interpretations of the impact of new care technologies are one-sided and analytically unfounded (e.g. Lianos 2003; Blythe 2005). Indeed, they argue that surveillance and control are integral parts of care and as such, they are both conceptually and empirically difficult to disentangle (Essén, 2008). It is hard to imagine how we can give care without watching over those we care for. But we should not fall into the trap of assuming that the human act of watching over those we care for is always a benign process. Shifting power relationships are an inevitable part of the act of care-giving. This is not to infer that the power

relationship is – or indeed should be – a one-way flow, yet as an older person becomes increasingly frail and reliant on human care, it can become increasingly difficult for that person to exert power, and therefore agency (Twigg, 2000; Milligan, 2003). Furthermore, critics maintain that the issue of whether or not surveillance and monitoring should be viewed as ‘bad’ is contingent on both the user-context and the agency of the surveilled subject. Others have argued that such technologies can, in fact, be enabling in that they are *less* intrusive and supportive of home based care than the alternative option of residential care (Lyon, 2007). These are important points, however, in attempting to redress the balance we need to take care that such critiques do not over-compensate through minimising or over-simplifying complex considerations.

Any discussion about the implementation of new care technologies as part of a package of home care needs to engage with end-users of these technologies – particularly in relation to those they consider to be empowering or disempowering. Further, such discussions should not be set against fears that residential care is the only alternative option, rather they need to be framed within debate about what constitutes good care for older people, where that care should best take place and how care technology can contribute toward the construction of more enabling and sustainable models of care. Enabling older people to respond positively to the use of new care technologies in the home requires policy makers to recognise that design needs to take into account the ways that technologies may shape the physical and affective aspects of the home. Heywood (2004) cited a range of literature which points to the detrimental impact upon health when care professionals involved in the delivery and implementation of technological adaptations fail to consider psychological factors and the meaning of home to recipients. When unwelcome adaptations are installed, recipients can feel helpless and disempowered. How new care technologies act to reshape the home and people’s experiences of being ‘at home’ is thus

key to the development of 'good care'. Indeed, as Friedewald and Da Costa (2003,19) point out, the home is more than an array of technological tools whose function is to help older people requiring care and support to survive in their daily lives, rather, 'Home is for humans, whose quality of life is expected to improve via technology and ambient intelligence. Home is an emotionally charged and personally furnished cradle of living – physical space as much as a socio-cultural context and a state of mind.'

Concluding Comments

Population ageing, policies designed around ageing in place combined with concerns about the projected care gap, places the home and family caregiving centre stage in the construction of care for our frail older populations. This focus on place means that health and gerontological geographers working in this field have much to offer. In this paper, I have sought to synthesise some of the most significant insights around the shifting landscapes of care that are emerging from this body of work. Key to this, has been a focus on understanding: how the home, and the meaning of home, is being reconfigured as a consequence of developments in care designed around ageing in place; how new forms of care may be creating a spatial re-ordering of care work and care practices; and what this means for older people and their family caregivers. What starts out as a site of security, identity, familiarity and social relations that enhances an older person's ability to maintain a level of independence, can, over time and with increased frailty, become a re-ordered site of care that can both alienate and socially isolate both the frail older person and their family caregivers.

In thinking about the growing imperative toward care technologies as a potential solution to the care gap, we have to recognise that while much of their physical manifestation is, indeed, writ within the home, they also brings into play *new* sites of care that can be remote from both the home and the institution. Call centres, tediagnosis and monitoring stations, for example, all involve sites of care that are linked to, but remote from, the home. So while new forms of care may enhance an older persons' ability to remain at home for longer, this needs to be balanced against the cost of increased dependence on alternative forms of care; whether the benefits of this new dependence outweigh dependence on human caregivers; and whether this is a desirable outcome.

The paper has also, however, drawn attention to the growth of a small body of geographical work that points to the ambiguity of the home as a site of care. This work questions the very premise upon which ageing in place is built; that is, that the home and its environs is the best site in which to support and provide care for older people. Rather this emerging critique suggests such a premise over-exaggerates and romanticises the concept of home. In doing so, it fails to take account of the ambiguities inherent within older peoples' and family carers' relationships with the home and how these can change over time and with increasing frailty. In seeking to develop new models of care for the future then, we need to take account firstly, of the nuanced and complex nature of older people's relationships with home and how this changes with increasing age and frailty; and secondly, how new models of care change the experience of home and care, where that care takes place and the impact of new actors that become enrolled in these emerging care networks.

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