

老龄化社会中的地方和非正式照护^①

——地理老年学最新研究进展

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摘要:发达国家政策制定者和执行者正面临着一个重要问题,即如何照护身体衰弱的老年群体,以应对人均寿命延长给社会经济与福利带来的影响。当然寿命延长本身是人类取得的一个巨大成功。然而,预期寿命的增加也引发了老年人口尤其是高龄老人数量的增长,这些高龄老人面临疾病高发和工具性日常生活活动能力(Instrumental Activities of Daily Life, IADLs)下降的情况,而这种能力对保持他们晚年生活的独立和尊严非常重要。与此同时,政策和实践的重心已经从机构养老转为“就地养老”,即支持老年人尽可能长时间地住在自己家里。从概念上讲,这意味着之前由机构提供的服务和照护(care)将改为由家庭来提供,这样脆弱的老年人也可以得到来自家人、朋友和邻居的非正式照护。一方面,这意味着许多老年人能够享受到由家庭照护所带来的亲密感、安全感和情感支持;另一方面,家庭结构的变化,社区的衰落,以及经济紧缩时期保障和福利的大幅削减,造成越来越多的老年人要面对孤独、孤立及风险。于是,老年人的照护者、照护地点和照护方式,及老年人对这些因素的差异化体验,将成为对健康和老龄化研究感兴趣的地理学家越来越关心的问题。本文回顾了地理老年学对非正式照护和家庭研究的最新进展,指出该领域的工作对老年人口照护的多学科探讨具有重要贡献。

关键词:居家养老;地理老年学;照护技术;工具性日常生活活动能力;英国

1 引言

在全球范围内,人口正在迅速老龄化。随着年龄增长,许多原本过着健康活跃生活(尤其是在退休的早期阶段)的老年人,逐渐向健康状况和移动性下降的方向发展。研究表明,年龄增长使人们罹患共存疾病、认知和生理出现障碍、孤独感和社会隔离感加剧的可能性不断增加(Stenholm et al, 2014)。对85岁以上的高龄老人来说更是如此;他们很可能需要外界照顾和帮助才能完成工具性日常生活活动能力(IADLs)范畴内的活动。IADLs最早于20世纪60年代末被提出(Lawton et al, 1969),用于评估完成诸如烹饪,购物,做家务,驾车或乘坐公共交通工具,使用电话或其他通信方式,服用药物和管理财务等活动的能力。目前,健康专家常用

IADLs来评估老年人独立生活的能力,及为了继续在家中顺利生活所需要的支持。

非正式(或家庭)照护者在支持老年人完成IADLs活动方面起着重要作用。在英国这类照护传统上都由女性承担,然而从20世纪早期到中期,照护模式开始发生改变。这很大程度上是国家福利制度发展的结果,老年人的照护更多地由家庭转向公共养老机构,由来自公共、私人 and 志愿者系统的照护者提供。这时期,地方政府对社区和家庭服务的贡献主要是资助从事流动送餐和日托中心服务的志愿者部门,这导致了服务供给的不均衡(Milligan, 2001)。20世纪80年代末,随着福利制度的改变,许多不那么富裕的老年人也能够支付机构养老的费用,这带来了私人养老院的大量兴起。然而20世纪后半叶起,对机构养老质量的批评日渐增多,

收稿日期:2015-12;修订日期:2015-12。

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①本文原稿系英文,以中英文对照形式发表,其中中文由中国科学院地理资源所刘燕君副编审翻译,《地理科学进展》编辑部刘春风副编审、郭利平博士校改。

引用格式:Milligan C. 2015. 老龄化社会中的地方和非正式照护:地理老年学最新研究进展[J]. 地理科学进展, 34(12): 1558-1576. [Milligan C. 2015. Place and informal care in an ageing society: reviewing the state of the art in geographical gerontology[J]. Progress in Geography, 34(12): 1558-1576.]. DOI: 10.18306/dlkxjz.2015.12.005

以及将家庭及其周边环境当作最佳养老地点的政治立场和意识形态的转变,使得“就地养老”的相关照护政策和实践被广泛接受并在许多高收入国家得到推广。一些人认为这种转变更大程度上代表的是回归现状,他们认为以1976-1995年间的英国为代表的“经典福利国家”应被视为例外(Offer, 1999)。然而重要的是,目前就地养老的相关政策和实践却是在社会结构发生了重大变化的阶段展开的,这些变化表现在人均寿命大为延长,女性外出工作比例不断增加,核心家庭和第二家庭现象普遍,劳动力流动性的增加导致家庭居住分散和社区衰落,以及近期经济紧缩所带来的保障和福利全面削减(Milligan, 2009)。所有这些因素造成了传统上承担照护老年人职能的家庭照护者现在无力再承担这种角色,这引起人们对潜在“照护缺口”的关注。越来越多年老体弱者身边没有(或很少有)能为其提供支持和照护的家庭成员。福利的削减和有偿照护工作者的缺少,也意味着那些照护老年人的家庭成员仅能得到公共和志愿部门的有限支持。福利削减很可能对家庭照护者的照护意愿和持续时间产生负面影响,鉴于照护者数量减少是脆弱的老人不得不迁入养老机构的主要原因之一(Milligan, 2009),这可能会导致机构养老需求增加,或者越来越多身体虚弱的老年人陷入孤独、孤立和危险的处境。

但是,在人与家庭的关系中,究竟是什么使得政策制定者和执行者以及学者一致认为就地养老是为老龄人口提供照护和支持的最合适地点?如何在家中实施照护?应怎样判别“家是为老年人提供照护和支持的最佳地点”这个观点?本文以地理学视角审视上述问题,综述了对于老年人非正式照护和家庭作用研究的最新进展,指出地理老年学(geographical gerontology)在该领域的工作对有关老年人养老场所和照护的多学科研究做出了重要贡献。

2 家在就地养老问题上地位重要?

2.1 地理老年学角度

就地养老作为许多高收入国家养老政策的一个重要支撑和为老年人提供照护的主要来源,是基于对家及其邻接环境的以下认识的:a)对于大多数老年人来说,即使在需要照护和支持的情况下,家

(有时并不能提供这种照护和支持)仍是其首选地点;b)家可以增加老年人获得家人、朋友和邻居支持的机会,从而减少他们对正式照护和保健服务的需求。Andrews等(2007)在一篇地理老年学研究综述中指出,地理学家在该领域的贡献是分析地方(特别是家)对老年人口照护和支持的重要作用(Dyck et al, 2005; Herron et al, 2013; Milligan, 2003, 2009; Twigg, 2000; Wiles et al, 2009)。大部分这类工作是基于局部或微观尺度,并在早期地理老年学家如Rowles(1978)、Harper等(1995)工作基础上,分析老年人和地方之间的关系,以及在此框架下照护和支持所起的作用。其具体内容包括理解老年人对家及周边环境的体验,参与周边环境活动的情况,上述空间的社会、情感和物质特征,以及它们如何影响老年人及其家庭照护者的生活质量和身心健康。

2.2 人种学角度

Rowles关于老年人生活体验的细致的人种学(ethnographic)报告,详细刻画了随着年龄增长,老年人居住的“生活世界(lifeworlds)”不断下降的图景。这是首次关注到老年人的生活世界如何随年龄增长逐渐收缩到家及其邻接环境范围内。健康和社会地理学家进一步推动了这方面的研究。他们聚焦于地方依恋和身份认同,论证了家作为对老年人身体和情感具有重要意义的地方,如何成为其晚年获得照护和支持的核心基础(Milligan, 2009)。为了解决老年人移动性和社会隔离问题,有关部门制定了很多干预措施,主要是一些使其免于成为“困在家里的囚徒(prisoners of space)”的支持项目。然而Rosel(2003)和其他学者认为,老年人居住的生活世界收缩未必是一件坏事。事实上,他们认为老年人与自己周围环境息息相关的感觉,以及他们生命历程中待过的地方和结识的人,使他们能够凭借当地社会网络的支持,做到尽可能长久地生活在自己家里。

2.3 感性支撑

“家可能是老年人感觉自己最独立、最能掌控的地方”这一认识是支撑就地养老观点的动力。为了了解为什么家对老年人的晚年生活特别重要,Blunt(2005)将注意力转向研究日常活动、社会关系、记忆和情感如何塑造和重塑家之于老年人的意义和体验。适合个人口味和需要的布局和设计,使用方便或是能够带来回忆和安慰的熟悉物件,都使

得家成为一个可以提供安全感、亲切感和鼓励的地方(Tuan, 2004)。家是远离了睽睽众目的地方,是老年人自行决定谁可以、谁不可以进入的地方(Twigg, 2000; Milligan, 2009)。因此,家可为老年人,尤其是那些在私人空间范围之外感到无助的老人,提供安全感、认同感、自我和独立性的重要支撑。家对个人的意义还在于,可以通过如Rowles(1993)所说的前意识(preconscious sense)活动促使老人成功就地养老。也就是说,以前对这个家的了解,对家在物理上的依赖,在家中开展的惯常活动,都可以增强老人与其“家庭空间”和平相处而不受伤害的能力——即使他们的身体机能或认知能力开始下降。

2.4 潜在脆弱性

将老年人的照护由养老机构转向家庭使其变得更私密了,不容忽视的是,这也造成老年人和他们的家庭照护者处在远离公众视线的地方,两者都有与世隔绝的感觉——这就给个人和医疗保健系统人员虐待老人提供了机会。这凸显了居家养老中一个重要却常被忽视的侧面,即可能给家庭照护者和被照护者带来更大的脆弱性(Cloutier-Fisher et al, 2006)。一些批评者因此对居家养老持反对态度,认为居家养老可能会导致更多难以被发现的虐老行为(Taylor et al, 2006; McGarry et al, 2008)。而且,正如Wiles等(2003)所指出的,鉴于家庭照护不像机构那么透明,照护供给由机构转移到家庭和社区就具有了非正规化或私人化的特征,即照护成本随之由集体责任转移至个人和家庭。例如,在英国及拥有类似福利制度的国家,对家庭非正式照护提供支持的服务通常是由志愿和私营部门根据与政府签订的合同来执行。在经济紧缩时期,这些服务在一些地区被大大削减,使得(家庭)非正式照护者不得不努力想办法“填补缺口(plug the gap)”(Milligan, 待刊)。Allen等(2006)特别注意到,加拿大联邦政府对照护服务支持力度的缩减,再加上历史上服务供应的不均衡,对大量农村老年人的不利影响越来越凸显。

因此,研究居家养老必须认识到家的复杂性:既可能是宁静的避风港也可能是冲突发生的地方(Lowestein, 2009)。有关家庭照护的政策可能兼具积极和消极作用,因为以家庭为基础的照护并不是对所有老年人和/或家庭照护者都代表着“安全”和有保障,在由于缺乏替代方案才不得不选择居家养

老的地方尤其如此。因此Brickell(2012)认为,大部分宣扬“家庭高尚情感”的文献犯了夸大其词的错误,因为它们忽略了有些家庭环境可能充满了紧张和冲突。

3 家庭照护角色的模糊性

3.1 不确定性

虽然大部分关于家庭和照护的文献与政策都是基于“家是居家养老后盾”这一立场的,但正如上一节提出的,照护和支持需要改变,老年人与家的关系也是如此。Schröder(2006)指出,家是一个具有不确定性的地方,因为它的保护功能是与其局限性相互关联的。安全 and 有保障的感觉往往是排除和管制行为的结果,这种排除和管制可能是关于谁可以或不可以进入自己家或家中的特定空间,以及允许或禁止谁在自己家里做什么、及什么时候做的问题。然而,随着老人日益依赖正式的和非正式的支持才能完成ADLs类活动,可能导致其排除能力的下降,甚至是家里那些最个人和私密的空间也无法完全限制他人进入。面对这些变化,重要的是了解随着脆弱性逐渐增加,家庭内如何为(和被)老年人及其家庭照护者构建和重构居家环境。需要注意的是,当老人变得需要照护设备(如起重机、坡道、洁具、轮椅、病床和喷雾器等)的帮助时,关于家的所有前意识都将瓦解,而家庭改变其环境以容纳这些设备的需求则不断增加。这也就突显了私人 and 公共空间之间界限的可变性,以及随着老年人身体和认知能力的改变和下降,其力量、独立性和自主性不断丧失(Milligan, 2009; Milligan, Mort et al, 2010)。

家不会自动成为一个舒适和包容的地方。最近一项关于老年男性充当配偶看护者的研究表明,尽管他们做得很好,常采用最新的策略提高自己妻子的应对能力,老年男性照护者在那个被认为属于女性、男性性别会遭到质疑的圈子里还是感到被排挤(Milligan et al, 2013)。Varley等(2000)的研究发现,即使那些相对健康和有能力的老年男性,也会发现自己过去作为养家糊口的男性身份已一去不复返,不得不适应晚年大部分时光生活在被视为女性圈子里的局面。

Hillcoat-Nallétamb等(2014)认为,家作为照护的场所,被过于浪漫地想像成为了支持和维护个人

独立性的理想生活环境。他们指出,这种观点忽视了家也有可能成为使人感到孤独、孤立、疏离和无助的地方(Barrett et al, 2012; Rabiem, 2013),特别是当家成为实施医疗和服务之地点的时候。有证据表明,当由家庭(而不是养老机构)为老年人提供日益增多的照护和支持,以及为了满足照护要求而对家里作出的改变,可能对家庭的社会性、象征性以及物理维度产生重大影响(Milligan, 2009)。Hillcoat-Nallétamby等(2014)由此认为,当健康和身体机能降低,运行或维护家庭养老成本过高,或者家庭结构发生变化时,就地养老可能不再是老年人安享晚年的最好选择。他们指出,人们常常拿老年人留在家里的愿望与晚年搬迁的压力作对比,但这种压力取决于多种因素,如新家或照护机构的环境适宜性,搬家的理由,尤其是其生命历程中曾经重视的一切是否成功整合到了新的环境。这表明研究重心首先应放在老年人在多大程度上预期他们将从家里搬到一个可以得到更好的照护、更多的社会参与度和更便利设施的地方;其次,老年人一生中搬迁的经历可能会在多大程度上影响到其成功转换到新的照护环境。

3.2 对衰老身体的家庭照护

健康和社会地理学的重要转向,是很多研究不再把老年人作为一个统计数字或研究对象来对待,而是聚焦于与老年人本身进行个人的、密切的、也是更实质性的深入接触。Harper和Laws及其他学者的早期工作证明了研究“身体怎样成为地方体验的一个特殊而关键的决定因素”的重要性。理解老化的身体与地方之间的关系(*relationalities*)是贯穿这项工作的一个重要主题(Dyck et al, 2005; Huang et al, 2012),特别是地方对身体日常生活的意义和理解老龄化的作用,重点是逐渐老化的身体在这些地方能做和不能做什么,地方对衰老身体有哪些有利或限制的方面。该研究从理论上主要借鉴了围绕“环境压力”的早期研究,也使用了Bourdieu的“惯习(*habitus*)”和“身体资本(*body capital*)”的概念(Antoinetti et al, 2012)。这突出了关注衰老身体与地方之间相互作用的重要性,以及身体资本的减少(生理衰退)不仅改变老年人的惯习,还改变年轻群体对老年人的态度。身体资本的减少也就意味着个人生命历程中积累的其他资本的递减,从而造成身体能力与其所处环境之间的不匹配。

衰老的身体不仅是老年人晚年生活社会建构

的关键,也是使他们远离年轻人社区而居住于边缘化位置的主要原因(Schwanen et al, 2012)。例如,衰老的身体经常被描绘成脆弱的和依赖他人的(尤其是在西方社会),因而总是和家、照护支持和居住设施联系在一起。此外还有一些针对照护(*care*)和身体护理(*bodywork*)的研究,特别是关于性别和身体衰老如何影响空间的使用和意义(Dyck et al, 2012)。

在对老年人的照护和支持(再次)转向家庭时,非正式的照护者承担了许多照顾衰老身体的日常事务,包括私密性的身体料理工作,如帮老人擦洗、洗澡、穿衣、如厕和喂食。由他人承担这些原本是个人和私密的事情触犯了当代西方社会的禁忌,尤其是跨性别的照护行为。由配偶来实施此类照护可能还不那么难堪,而如果由异性成年子女来承担则特别困难。因此,照护过程可能改变或挑战与家庭有关的人际关系(Milligan, 2009)。

鉴于西方社会的禁忌通常标志了身体照护的社会边界,专业人员更为超然的身份可以使这种身体照护工作更易管理。所以,对照护对象身体的管理和由谁来完成管理是将家建设成为照护空间的关键。身体不仅是非正式照护者管理的对象,也要被正式的照护服务机构依据专业标准对其所受照护进行量和质的评估。然而值得注意的是,对照护的评估不是单纯解释老人身体符合医学标准的程度;若要避免其与世隔绝和“社交死亡”(Lawton, 1998),家也要成为培养和保持个体社会价值的地方。换句话说,重要的是必须认识到,不仅要照顾老年人的身体,还要了解和满足其社会和情感需求。越来越多的证据表明,与社会隔绝对老年人的身心健康都有不利影响(Luanaigh et al, 2008; Holt-Lunstadt et al, 2010; Cacioppo et al, 2014)。然而,专为老年人设计的住宅通常假定衰老身体是相对静止的,所以只需要有限的空间;而狭小的空间反过来又会影响到老年人的社交能量和机会。只有认识到家和身体作为相互关联的地点(*interrelated sites*)和分析尺度是在不断变化的过程中,我们才能深入理解形成照护体验的复杂关系结构。还必须认识到对就地养老的认识是建立在一定的社会和文化背景基础之上的,因此随着时间和空间的变化,这些有关衰老身体的高度西化的概念将会发生变化并被以不同的方式重新建构。

3.3 家庭照护的多向性

围绕照护的大部分讨论都涉及到照护和关爱

老年人的方式,特别是在特定环境中对老年人进行照护的方式。近年来已经有一些学者指出先前的研究存在一个问题,即往往只关注老年人接受照护这一个方面(Watson et al, 2004; Fine et al, 2005; Milligan et al, 2010; Wiles et al, 2013)。批评者认为不应把照护看作是主动照护和被动接受的过程,而应认识到它存在多向流动性并形成复杂的互惠网络,即参与照护的各方通常紧密交织在一起。照护过程中的互惠性(reciprocity), (从时间上)可能是即时的或者延迟的(比如成年子女对年老父母的照护是对童年时期接受父母照顾的延迟回馈), (从方式上)可能是身体上或者情感上的。正如 Meintel 等(2006)所言,重要的是这种照护关系能够延伸到家庭以外,比如有偿护工就可能从照护关系中获得互惠利益。事实上, Meintel 等的研究表明,尽管拿着众所周知的低工资,一些照护工作者还是把这个岗位看作一份职业而不是一个饭碗。Wiles 等(2013)在最近一篇关于照护和就地养老的论文中强调,老年人对家庭和当地社区各种方式的依恋会引导他们为“照料地方(caring for place)”作出积极贡献,以此对认为照护是单向的观点提出了一个有趣的挑战。他们的研究表明,为了帮助保持当地社区在自然、社会和情感上的特色,并通过积极倡导——常常是用他们一生所获技能——来推动变革,许多老年人在志愿服务、宣传和相关行动中发挥了重要作用。

4 家庭与技术在未来照护中的作用

4.1 新照护技术带来的问题

老龄化人口的社会—经济影响、有关就地养老的相关政策、对预期中照护缺口的担忧,意味着许多高收入国家的政府承认,必须构建新的可持续的照护模式,以满足老年居民养老的需要。新兴照护技术已成为这些策略的一个重要支撑(Goodwin, 2010; Hogenbirk et al, 2005; Ministry of Health, New Zealand 2008; Mort et al, 2008)。一方面,这些技术可能维护和增强很多老年人的健康和独立性,帮助他们独自在家生活;另一方面,它们还有助于减少住进养老院和医院的老年人数量(Bayer et al, 2007)。这种“技术措施(technological fix)”有望增强老年人就地养老的能力,但同时也产生了一些重要问题,例如老年人如何感受这些技术,技术怎样重

塑照护的性质和景观,谁能从技术开发和实施中受益等。

照护技术在照护“支持”(care ‘support’)中被广泛使用,包括那些能够帮助老年个体完成本来无法实施的任务,或者使任务实施变得更容易和安全的设备和系统(Milligan, 2009)。很多低水平辅助照护技术如起重机、手杖、坡道和轨道等多年前已开始普遍使用。目前,从环境控制系统、红外线监控、可穿戴设备,到为缓解社会隔离而设计的机器人宠物等新技术,正在被越来越多地开发出来并应用于家庭环境中(Mort et al, 2008)。

不可否认的是,从好的方面说高科技可以为老年人的生活提供原本可能无法拥有的控制力和独立性。无需依赖看护者而能独立完成开灯、开门或关闭窗帘等简单任务,可以增强老人的独立性和融合感(Mort et al, 2008)。某些形式的非侵入性监控也可以提高老人在家中的安全感(Essén, 2008; Milligan et al, 2010)。照护技术能够监测摔倒、移动、饮食方式、不规律心脏活动等情况,以确保独居或身体都很脆弱的两位同住老人保持尽可能健康和独立的生活方式,使其住在自己家里时间能够更久一点。因此,这些技术的拥护者极力宣扬它们在通过减少对人工照护的依赖性从而提高老年人独立性方面的作用(Hogenbirk et al, 2005; Essén, 2008)。他们进一步指出,用于监测老年人状态的技术可以显著提高非正式照护者的健康和幸福感,使他们有能力继续照护更长时间(Carretero et al, 2012)。然而,对此我们应批判地接受。例如,其他研究指出,这些技术只是产生了新的或不同的依赖形式而已。也就是说,从目前对人力照护的依赖转向对远程照护的依赖,而远程照护仍离不开人力在远程监控中心的操作(Roberts et al, 2012)。因此批评者称,照护技术的作用只是重新定义了病人和专业照护者的角色——引入了新的医护工作者类别及重新界定了照护存在和实施的空间(Oudshoorn, 2011)。

有人表示,这些新的照护形式可能导致人们社会隔离感的增加。虽然老年人仍然需要非正式和正式照护者提供诸如穿衣、洗澡和如厕等个人照护,但同时能够远程诊断和监控的新技术减少了面对面照护的需求。通过互联网技术远程监控老年人的活动,还可以减轻非正式照护者对他们年长亲人的担忧,这对非正式照护者显然是有益的,但也可能导致家庭照护提供和接受者之间面对面接触

机会的减少。因此实施中要注意避免新照护技术增加人们的社会孤立和孤独感,因而对老年人健康和福祉带来不可预见的不利影响。这些并不是微不足道的小问题,事实上最近的一则评论指出,与社会隔离相关的死亡风险与吸烟或糖尿病一样高(Loxtercamp, 2014)。因此,一方面,这些技术在增强老年人在家中管理自己生活的能力上发挥着积极作用;另一方面,它们有可能加剧老年人的被排斥感和孤独感。

各种专为家庭设计的照护技术已经存在很多年并且还在快速发展。鉴于上述问题,重要的是了解什么样的家用照护技术是可以为老年人所接受的。Friedewald等(2003)认为,将新照护技术引入家庭时必须牢记,技术不应该主导家的整体功能和人的体验。相反,技术的目标应该是“通过促进和支持居民的日常活动与社会化,来提高其生活质量”。换句话说,照护技术应该尽可能做到不显眼,其设计目标应是满足照护对象社会和医疗两方面的需求,正如上文所述,这点很重要。实施照护政策和就地养老的支持措施也可能改变家庭的意义和家人对此的认同。老年人甚或可能把那些一般认为是“日常”的技术(如电视和电脑)看作是对其关于家的认同方式的入侵。例如,在Dickinson等(2003)举出的实例中,有些老年人试图用布盖住不使用的电视和电脑,以一种与他们对家的观念相融合的方式,努力使这些技术设备的外表得以改观。重要的是,不同个体和家庭对入侵(intrusiveness)的反应和照护技术响应可能大相径庭。

4.2 文化价值观对新照护技术接受度的影响

显然,文化价值观和生命历程中对技术的接触经验会影响人们对照护技术的接受程度,不过照护技术大致可分为两类。其一是旨在提高老人管理自己日常生活能力的便利技术;其二是可以监控“远处的人(distant other)”健康和活动情况的监测技术。后者可能使具有认知障碍的老年人感到困扰,因为他们也许难以理解监测传感器的概念和远程技术装置发出的声音(Mort et al, 2008)。

需要照护和支持的老年人经常明显感觉自己缺乏对生活 and 家的控制力,而对监测技术和通过人力操控的远程照护技术的依赖会加剧这种失控感。一些研究关注了老年人如何通过改变其生活习惯或适应技术应用,有意寻求“颠覆系统(ubvert

the system)”(Wu et al, 2005)。监控技术的“误用”恰恰引发了它们试图减少的社会反应(Mort et al, 2008)。这不仅突显了理解新照护技术所处环境的重要性,而且强调了确保老年人的社会和情感需求不被归入医疗需求。例如,Morris等(2003)证明了有不同程度认知能力下降的老年人如何强烈地感到孤独和被囚家中的无奈,以及他们对保持社会关系的需求。因此,满足这些社交需求是保持老年人健康状况的核心。一些照护技术设计师已开始重视通过开发相关技术解决上述问题,包括帮助老年人维持和拓宽社会交际的技术,或有助于情感表达的技术——如可抚摸或互动的机器宠物。Pols等(2009)认为技术的发展有可能弥合传统上被视为“温暖”(人本)与“冰冷”(非人本)照护技术之间的鸿沟。

4.3 照护技术对信息获取的影响

家庭内照护技术的实施的确引发了信息获取方面的问题。健康和社会保健提供者和非正式照护者之间关于照顾对象的信息沟通和交换尤其重要。一方面,研究表明健康专家掌握着是否向同事和非正式照护者披露病人信息的决定权——以保证病人最大利益的名义——即使并未得到后者的同意(Tracy et al, 2004)。然而这并非没有问题。有证据表明,这样的信息获取方式不仅影响到非正式照护者与其父母的关系(父母可能由于自己的隐私受到成年子女侵犯而不快),也影响其与兄弟姐妹的关系,可能会引起对谁参与或不参与照顾年老父母问题“较劲(rivalry)”的感觉(Morris, 2005)。因此新的照护技术有可能介入到以前被视为隐私性质的关系之中。

然而批评者认为,对新照护技术影响的上述解读是片面和无根据的(Lianos, 2003; Blythe, 2005)。事实上监测和控制都是照护工作不可分割的组成部分,因此无论从概念还是从实践上都很难摆脱(Essén, 2008)。很难想象我们若非密切监护自己照料的对象,如何能够对其进行照护。但我们也不应该假设人们监视被照护对象的行为永远是一个良性过程。权力转移关系是照护行为不可避免的一个部分。这并不能推断出权力关系是(或者应该是)单向流动,然而,当老人变得越来越脆弱而依赖他人照顾时,他们就变得越来越难以运用权力和力量(Twigg, 2000; Milligan, 2003)。此外批评者认为,监

测和监控是否应该被视为“坏”事取决于用户背景和监控项目的作用。也有人认为,比起机构养老这样的替代方案,事实上这些技术对居家养老干扰更少而支持更大(Lyon, 2007)。这些都是重要的观点,但是为了维持平衡,我们需要注意不应因为对复杂因素过度简化而造成矫枉过正。

新照护技术作为一揽子居家养老方案的一部分,任何对其的讨论离不开终端使用者——特别是对那些他们认为有能力或无力使用新技术的老人。进一步讲,这样的讨论不应出于对机构养老是唯一替代方案的担忧,而是应该基于如下考虑:什么是对老年人有利的照护,这类照护最好在哪里开展,照护技术如何才能有助于构建更有利和可持续的照护模式。为了使老年人对在家中使用时新照护技术做出积极反应,决策者应该了解,技术设计中需要考虑到技术对家庭物理和情感两方面的作用方式。Heywood(2004)引用一系列文献来说明由健康专家提供和实施照护技术时,如不考虑到照护对象的心理因素和家庭对他们的意义,将会对其健康产生不利影响。比如,将不受欢迎的照护设备安装在家里,就会使照护对象感觉到无助和无力。因此新照护技术如何重塑家以及人“在家(at home)”的体验就成了发展“好的照护(good care)”的关键。事实上,正如Friedewald等(2003)所言,与其说家是帮助老年人获取日常生活所需照护和支持的一系列技术装备,不如说“家是为人而存在的,人的生活质量可望通过技术和环境智能得到提高。家是充满感情的地方和个人的生活摇篮,既是物理空间也是社会—文化环境和一种精神状态”。

5 结论与讨论

老龄化人口、围绕就地养老的政策以及对预期中照护缺口的担忧,使得家和家庭照护被置于照料脆弱的老年人口的核心位置。对地方的聚焦意味着健康和老年地理学家在该领域大有可为。笔者

试图综合一些有关身体照护工作引发照护方式转变的最重要见解。关键是聚焦于理解在就地养老为主的老年人照护事业发展中,家以及家的意义是如何被重构的;新的照护形式如何重建照护工作和实践的空间秩序;及这种转变对老年人及其家庭照护者意味着什么。家原本是有利于老年人保持相对独立性的一个安全、认同、熟悉和社会关系交织的地点,随着时间推移和老人衰弱日甚,可能成为老年人与其家庭照护者关系重组的地点。

在考虑不断发展的照护技术可能是解决照护缺口的潜在方案时,我们必须认识到虽然很多相关设备确实安装在家里,但技术也促使一些远离家庭和照护机构的新地点在照护中发挥作用。例如呼叫中心、远程诊断和监测站都是远离患者家庭却参与相关照护的地点。因此,虽然新照护形式可以提高老年人能力以便在家停留更长时间,但也要平衡对新照护形式的依赖所带来的成本,依赖新照护形式所带来的好处是否大于依赖人工照护的好处,以及这是否是一个理想结果。

然而,本文也关注到少部分地理学研究(此类研究在增加)表明家,作为照护地点有其不确定性。这些工作恰恰对就地家养老赖以建设的前提——家庭及周边环境是为老年人提供支持 and 照护的最佳地点——提出质疑。这些新出现的批评指出,该前提将家的概念过分夸大和浪漫化了,忽视了老年人和家庭照护者关系的固有模糊性,以及这种关系如何随着时间推移和身体日益衰弱而变化。在寻求构建未来新的照护模式时,我们首先需要考虑老年人到家之间关系微妙而复杂的特性,以及这种关系随着年龄和脆弱性渐增将发生怎样的变化;其次,新照护模式如何改变人对家庭和照护的体验,照护在什么地方实施,以及加入到新兴照护网络的新角色所起的作用。

参考文献:见英文稿。

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

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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.

Key words: ageing in place; geographical gerontology; care technologies; instrumental activities of daily life (IADLs); UK

1 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 (Stenholm et al, 2015). 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 (IADLs). First developed in the late 1960s

(Lawton et al, 1969), IADLs 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 multi-disciplinary debates around place and care of our older populations.

2 The importance of home for ageing in place?

2.1 Geographical gerontology

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 (Dyck et al,

2005; Herron et al, 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 Rowles(1978) and Harper(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.

2.2 Ethnographic

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.

2.3 Perceptions

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 'home space' without coming to harm-even as physical or cognitive abilities begin to decline.

2.4 Potential vulnerability

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 et al, 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 et al, 2008). Further, as Wiles et al(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 et al(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 in 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.

3 Home, care and ambiguity in later life

3.1 Uncertainty

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 protec-

tive 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(Milligan 2009; Milligan, Mort 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 et al, 2013). Drawing on the experiences of even relatively fit and able older men, Varley et al(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 et al (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 et al (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 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 to 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.

3.2 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(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’ (Antoinetti et al, 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 et al, 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 (Luanaigh et al, 2008; Holt-Lunstadt et al, 2010; Cacioppo et al, 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.

3.3 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 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 (Watson et al, 2004; Fine et al, 2005; Milligan et al, 2010; Wiles et al, 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 life-course.

4 Care futures? Home and technology

4.1 Problems from new and emerging care technologies

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(Hogenbirk et al, 2005; Ministry of Health, 2008; Mort et al, 2008; Goodwin, 2010). 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 indepen-

dence 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, Mort 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(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 care-givers' 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 et al (2003) 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 tech-

nologies 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.

4.2 Impact on perceived acceptability by cultural values

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 et al, 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 et al(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.

4.3 The implementation of care technology

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(Lianos 2003; Blythe et al, 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 caregiving. 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 et al (2003) 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 expect-

ed 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.'

5 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 for 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 bring into play new sites of care that can be remote from both the home and the institution. Call centres, teliagnosis 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 people's 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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