

2017

Towards active ageing: A comparative study of experiences of older Ghanaians in Australia and Ghana

Daniel Doh
Edith Cowan University

Follow this and additional works at: <https://ro.ecu.edu.au/theses>



Part of the [Gerontology Commons](#), and the [Medicine and Health Commons](#)

Recommended Citation

Doh, D. (2017). *Towards active ageing: A comparative study of experiences of older Ghanaians in Australia and Ghana*. Edith Cowan University. Retrieved from <https://ro.ecu.edu.au/theses/2010>

This Thesis is posted at Research Online.
<https://ro.ecu.edu.au/theses/2010>

Edith Cowan University

Copyright Warning

You may print or download ONE copy of this document for the purpose of your own research or study.

The University does not authorize you to copy, communicate or otherwise make available electronically to any other person any copyright material contained on this site.

You are reminded of the following:

- Copyright owners are entitled to take legal action against persons who infringe their copyright.
- A reproduction of material that is protected by copyright may be a copyright infringement. Where the reproduction of such material is done without attribution of authorship, with false attribution of authorship or the authorship is treated in a derogatory manner, this may be a breach of the author's moral rights contained in Part IX of the Copyright Act 1968 (Cth).
- Courts have the power to impose a wide range of civil and criminal sanctions for infringement of copyright, infringement of moral rights and other offences under the Copyright Act 1968 (Cth). Higher penalties may apply, and higher damages may be awarded, for offences and infringements involving the conversion of material into digital or electronic form.

**Towards active ageing: A comparative study of
experiences of older Ghanaians in Australia and Ghana**

This thesis is presented for the degree of
Doctor of Philosophy

Daniel Doh

Edith Cowan University
School of Arts and Humanities

2017

Dedication

To Yvonne, Deborah, Kenneth and Sandra

Abstract

Population ageing has become a central feature of the 21st century, as most countries search for economically viable strategies to support and manage their ageing populations to live in a dignified way. In 2002, the World Health Organisation (WHO) proposed the active ageing policy framework to guide countries to develop policies that promote the quality of life for their older people. However, the interpretation and application of the active ageing model in the literature and policy discussions are inconclusive on the most important elements that promote the quality of life of older people. The discussions have largely focused on health promotion and economic aspects of the model without much attention to other aspects. In addition, there are questions about the extent to which the active ageing model is adaptable to different contexts. The lack of consensus among researchers and policy actors on the meaning of active ageing, and its application to different contexts has resulted in calls for the need for studies that explore active ageing from the perspectives of older people themselves.

This thesis presents findings from a study that examined the meaning of active ageing from the lived experiences of older Ghanaians living in Ghana and Australia, and compared the findings theoretically and conceptually with the World Health Organisation's (WHO) active ageing model. The study also investigated the extent to which research participants' socio-cultural and political contexts influenced their respective experiences and the meaning they ascribed to active ageing, and the factors that contributed to their perceived quality of life at old age. The study was designed as an interpretive phenomenological analysis (IPA) in combination with a comparative case study situated within the life course theoretical framework. The study drew on an in-depth qualitative data collected from 30 older Ghanaians, comprising 15 who were living in Ghana and 15 who were living in Australia.

Two key findings emerged from this research. First, experientially, active ageing is multidimensional and comprises social interaction, activity, health, independence, work and employment, spirituality, happiness, and public safety.

However, social interaction—which included strong family support systems, friendship networks and community activities—emerged as the single most significant experiential meaning of active ageing, and was considered critical for quality of life at old age. Despite the importance of social interaction for research participants' quality of life, comparatively, the study found that social interaction is subsumed under the participation pillar of the WHO's active ageing model, which is not particularly well understood or developed by policy makers compared with the pillar of health. In addition, there were notable variations in participants' experiential meaning of active ageing between respondents in Ghana and Australia, reinforcing how different policy contexts shape people's experiences.

Second, the study found four types of quality of life from the typologies of quality of life at old age created in the data using a matrix of high and low levels of social interaction and access to essential social policy services. The types of quality of life in the matrix were optimum agers, happy poor agers, disconnected agers and destitute agers. The data showed that acquiring, creating and maintaining a high level of social interaction together with the development of knowledge, useful skills and personal initiatives in a favourable social, economic and health policy environment are likely to lead to optimum ageing.

The overall contribution of this thesis relates to the need for active ageing stakeholders to contextualise the WHO's active ageing model based on the perspectives and experiences of older people within their respective socio-cultural and political contexts. In addition, population ageing policy makers may need to consider taking steps to strengthen older people's family systems, while creating opportunities for them to deepen their social networking and communal living. The study shows the usefulness of creating avenues for older people's continuous engagement in activities that allow social interaction. Finally, the study also illustrates how optimum ageing occurs as a culmination of life course events, making it imperative for social policies to facilitate sound human capital development, as they have implications for income and the creation of assets needed to fuel social interaction.

Declaration

I certify that this thesis does not, to the best of my knowledge and belief:

- i. incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education;
- ii. contain any material previously published or written by another person except where due reference is made in the text of this thesis; or
- iii. contain any defamatory material.

Signed:

A black rectangular box redacting the signature.

Date: 15/09/2017

Acknowledgements

To God be the glory, great things He has done. It has taken God's mercies to come this far, and I am forever grateful to God for this privilege and grace. I am indebted to the Edith Cowan University for granting me the Edith Cowan University Post-Graduate Research Scholarship (ECUPRS), International, to undertake this study. My special thanks to the Scholarship Unit, the School of Graduate Studies and the School of Arts and Humanities for their support throughout the period. I wish to thank my supervisors, Dr Kwadwo Adusei-Asante (Principal) and Dr Vicki, Banham (Co-supervisor) for their valuable contributions to this project. Kwadwo, you did more than a supervisor could do. Thank you. I also acknowledge the support of Associate Professor Peter Hancock who started the journey with me. Thanks, Peter, for giving me a good head start.

To all research participants in Ghana and Australia, thank you so much for providing such valuable information about your lived experiences. I am also grateful to the Ghana Community Associations of Western Australia and New South Wales, and the Church of Pentecost in Australia for their referral roles. Special thanks also to the Ghana Pensioners Association and HelpAge Ghana for their support during the project.

The following people deserve my deepest appreciation in various roles throughout this journey: Dr Patrick Aboagye-Safo, Mrs. Rose Aboagye-Safo, Dr Isaac Bofo, Dr Isaiah Awidi, Mr Ebenezer Adjete-Sorssey (Executive Director, HelpAge Ghana), Miss Selorm Agbeli, Rev Luke Barson, Mr. Sosthenes Tsribi, Dr Stephen Afranie and the many others I cannot single out here. Thank you all. I also want to express a special thank you to Dr John Hall and Dr Ruth Smith for proofreading the these and also providing useful suggestions. I am most grateful. A special thanks also to Linda Jaunzems for formatting the thesis. Thank you so much, Linda.

Finally, I am extremely grateful to Yvonne, my wife and to Deborah, Kenneth and Sandra, my children, for their patience, tolerance and love during the hard times, constant absence from home and the sacrifices. Guys, we can now have some fun! Thank you.

Table of Contents

| | |
|--|------|
| Abstract..... | i |
| Declaration..... | iii |
| Acknowledgements..... | iv |
| Table of Contents | v |
| List of Tables..... | viii |
| List of Figures | ix |
| Outputs Arising from the Research | x |
| List of Abbreviations..... | xi |
| CHAPTER ONE: INTRODUCTION..... | 1 |
| 1. Overview..... | 1 |
| 1.1 <i>Background</i> | 3 |
| 1.2 <i>Population ageing in Ghana and Australia</i> | 6 |
| 1.3 <i>Research problem</i> | 14 |
| 1.4 <i>Research Questions</i> | 20 |
| 1.5 <i>Thesis structure</i> | 20 |
| CHAPTER TWO: THEORETICAL AND CONCEPTUAL FRAMEWORK | 24 |
| 2. Introduction | 24 |
| Part One: Theoretical framework | 24 |
| 2.1 <i>Introducing the life course approach: A historical discussion.</i> | 24 |
| 2.2 <i>The life course approach to human ageing</i> | 26 |
| Part Two: Conceptual framework..... | 33 |
| 2.3 <i>Understanding active ageing: A conceptual framework</i> | 33 |
| CHAPTER THREE: ACTIVE AGEING AND QUALITY OF LIFE: A LITERATURE REVIEW | 42 |
| 3. Introduction | 42 |
| 3.1 <i>Health and Ageing</i> | 42 |
| 3.2 <i>Ageing and physical activity</i> | 47 |
| 3.3 <i>Ageing, social interaction and quality of life</i> | 50 |
| 3.3 <i>Ageing, social activity, employment and income</i> | 54 |
| 3.4 <i>Approaches to the care of the elderly in contemporary societies</i> | 57 |
| CHAPTER FOUR: THE POLITICAL ECONOMY OF AGEING IN GHANA AND AUSTRALIA: A CONTEXTUAL REVIEW | 62 |
| 4. Introduction | 62 |
| 4.1 <i>Political economy of ageing in Ghana: A historical overview</i> | 62 |
| 4.2 <i>Political economy of ageing in Australia: A historical overview</i> | 75 |

| | |
|---|-----|
| CHAPTER FIVE: METHODOLOGY..... | 88 |
| 5. Introduction..... | 88 |
| 5.1 <i>Research Design</i> | 88 |
| 5.2 <i>Defining the research population</i> | 92 |
| 5.3 <i>Case Selection</i> | 95 |
| 5.4 <i>Data collection</i> | 102 |
| 5.5 <i>Transcription and coding</i> | 103 |
| 5.6 <i>Data Analysis</i> | 105 |
| 5.7 <i>Ethics and ethics clearance</i> | 115 |
| CHAPTER SIX: UNDERSTANDING ACTIVE AGEING THROUGH THE EXPERIENCE OF OLDER PEOPLE..... | 117 |
| 6. Introduction..... | 117 |
| 6.1 <i>Meaning of active ageing: An interpretive phenomenological analysis</i> | 117 |
| 6.2 <i>Discussion</i> | 120 |
| 6.3 <i>The conceptual fit between research participants' experiential active ageing and the WHO model of active ageing.</i> | 132 |
| 6.4 <i>Summary</i> | 135 |
| CHAPTER SEVEN: POLICY CONTEXTS AND EXPERIENTIAL ACTIVE AGEING: A COMPARATIVE CASE STUDY | 137 |
| 7. Introduction..... | 137 |
| 7.1 <i>Comparing the experiential meaning of active ageing of participants in Ghana and Australia</i> | 137 |
| 7.2 <i>Context and experiences of active ageing</i> | 145 |
| 7.3 <i>Summary</i> | 146 |
| CHAPTER EIGHT: QUALITY OF LIFE AND EXPERIENTIAL ACTIVE AGEING..... | 149 |
| 8. Introduction..... | 149 |
| 8.1 <i>Developing a typological theory of quality of life for older people</i> | 149 |
| 8.2 <i>Causal pathway analysis of quality of life</i> | 162 |
| 8.3 <i>Summary</i> | 174 |
| CHAPTER NINE: CONCLUSION | 175 |
| 9. Introduction..... | 175 |
| 9.1 <i>The meaning of active ageing</i> | 176 |
| 9.2 <i>The fit between the experiential meaning of active ageing and the WHO model</i> | 176 |
| 9.3 <i>Context and lived experiences of active ageing</i> | 177 |
| 9.4 <i>What factors contribute to differences in quality of life among research participants?</i> | 178 |
| 9.5 <i>Policy implications and recommendations</i> | 179 |
| 9.6 <i>Limitations and opportunities for future research</i> | 181 |
| REFERENCES..... | 184 |

| | |
|---|-----|
| APPENDIX 1: In-depth Interview Guides | 212 |
| APPENDIX 2: Short Questionnaire | 213 |
| APPENDIX 3: Consent Form | 214 |
| APPENDIX 4: Information Sheet..... | 216 |

List of Tables

| | |
|---|-----|
| Table 1.1: Regional proportion of the population aged 60 years or over: 1950-2050..... | 5 |
| Table 1.2: Educational status of older people in Ghana..... | 9 |
| Table 1.3: Occupation of the economically active elderly by sex, 2010-Ghana..... | 10 |
| Table 1.7: Australia: population aged 65+ by birthplace, 1971-2011 | 14 |
| Table 4.1: Mapping of policies and legislation on ageing issues: Ghana (1992-2016) | 68 |
| Table 4.2: Mapping of major policies and legislations on ageing in Australia: (1983 – 2016)..... | 81 |
| Table 4.3: Mapping of some major actors in the ageing sector of Australia..... | 83 |
| Table 4.4: Aged Care Places in Australia as at June 2015 | 84 |
| Table 5.1: Manual Propensity score matching of cases between Ghana and Australia | 101 |
| Table 5.2: Profiling of research participants..... | 105 |
| Table 5.3: Sample extract of the IPA process | 107 |
| Table 5.4: Codebook on IPA for experiential meaning of active ageing..... | 108 |
| Table 5.5: Code book on pathways and factors contributing quality of life during old age | 109 |
| Table 5.6: Clustered codes for relevant meaning..... | 111 |
| Table 5.7: A process of creating a typology of active ageing using dimensions and indicators | 114 |
| Table 6.1: Emerging codes and the meaning of experiential active ageing | 118 |

List of Figures

| | | |
|-------------|---|-----|
| Figure 1.1: | Old age support ratio by regions and the world..... | 6 |
| Figure 1.2: | The Map of Ghana..... | 8 |
| Figure 1.3: | Population ageing trend and projection of Ghana (2000-2050) | 9 |
| Figure 1.4: | Map of Australia..... | 11 |
| Figure 1.5: | Projected population aged 65 years and over-Australia | 12 |
| Figure 1.6: | Older persons, highest year of school completed by sex, 2011 | 13 |
| Figure 2.1: | A conceptual framework of active ageing | 34 |
| Figure 2.2: | Conceptual framework of 'quality of life' in old age | 39 |
| Figure 4.1: | Institutional mapping of actors in the ageing sector of Ghana | 70 |
| Figure 5.1: | Distribution of Ghanaian Community in Australia..... | 93 |
| Figure 5.2: | Regional demographic map of Ghana..... | 95 |
| Figure 5.3: | Normal probability plot of regression..... | 102 |
| Figure 6.1: | Overall experiential meaning of active ageing..... | 120 |
| Figure 6.2: | Experiential meaning compared with WHO's active ageing model .. | 133 |
| Figure 6.3: | The proportion of experiential active ageing in the WHO model. | 135 |
| Figure 7.1: | Experiential active ageing in Ghana (n=15) | 138 |
| Figure 7.2: | Experiential active ageing in Australia (N=15) | 138 |
| Figure 8.1: | Typology of quality of life (n=30) | 152 |
| Figure 8.2: | Typological of quality of life (All Participants, n=30) | 153 |
| Figure 8.3: | Typology of quality of life of participants in Ghana (n=15) | 160 |
| Figure 8.4: | Typology of quality of life of participants in Australia (n=15) | 160 |
| Figure 8.5: | Pathway to optimum ageing (Case AR-10- Mr Felix). | 165 |
| Figure 8.6: | Pathway to optimum Ageing (Case GR-17- Vero)..... | 169 |
| Figure 8.7: | A synthesis of causal pathway of optimum active ageing | 171 |

Outputs Arising from the Research

Doh, D. & Adusei-Asante, K. (2017). *Active ageing with the African in mind: An interpretive phenomenological analysis*. Proceedings of the 39th African Studies Association of Australasia and the Pacific (AFSAAP) Annual Conference, 5-7 December 2016, The University of Western Australia (June 2017). ISBN: 978-0-9942689-2-1.

List of Abbreviations

| | |
|--------|--|
| DP | Development Partners |
| ECUPRS | Edith Cowan University Postgraduate Research Scholarship |
| EU | European Union |
| GSS | Ghana Statistical Services |
| IPA | Interpretive Phenomenological Analysis |
| MMDAs | Metropolitan, Municipal and District Assemblies |
| MSSD | Most Similar System Designs |
| NGO | Non-Governmental Organisation |
| OECD | Organisation for Economic Co-operation and Development |
| UN | United Nations Organisation |
| WHO | World Health Organisation |

CHAPTER ONE: INTRODUCTION

1. Overview

This thesis examines the lived experiences of older people to understand what active ageing means to them and the extent to which their experiential meaning compares with the conceptualisation and modelling of active ageing by the World Health Organisation (WHO). The thesis is based on an interpretive phenomenological analysis (IPA), combined with a comparative case study, conducted with 30 older Ghanaians living in Ghana and Australia. The study explored i) the manner in which research participants' socio-cultural and politico-economic milieus influenced their experiences of, and meaning ascribed to active ageing; and ii) factors that contributed to respondents' differential experiences of active ageing and quality of life, focusing particularly on the highest form of quality of life during old age.

The study arose out of the researcher's observations of the difficult situations some older people in Ghana face; and listening to international media and conference discussions about issues of older people globally- some of which showed a need to develop efficient and cost-effective ways of promoting and improving the quality of life of older people (Blom et al., 2016; Government of South Australia, 2009; World Health Organization, 2015). This need has arisen worldwide because of the rising population of older people; its perceived threats to economic and development gains; and concerns about the human rights and dignity of old age (Pakulski, 2016; Rada, 2016). Previous approaches that addressed issues relating to the quality of life of older people have been limited in scope (Barth, 2000; Phillipson, 2001). Thus, in 2002, the WHO proposed an active ageing model as a possible guide for countries who wish to ensure that older people live healthily and in a dignified way (Boudiny & Mortelmans, 2011). The model has three pillars, namely: health, participation, and security, and is further governed by seven principles, including activity, inclusion, prevention of disease, maintenance of

intergenerational solidarity, rights and responsibilities, participation and empowerment and respect for national and cultural diversity.

The WHO active ageing model has become the idealised concept underlying global policy responses to population ageing (Boudiny, 2013; Walker & Foster, 2013; Walker & Maltby, 2012). However, the interpretation of the concept in contemporary literature, and its application in national-level policy actions, remain conceptually inconclusive on elements that constitute a quality of life at old age (Constança, Ribeiro, & Teixeira, 2012). While some scholars have focused on promoting physical activity and health (Hamer, Lavoie, & Bacon, 2013; Marquet & Miralles-Guasch, 2015; Rechel et al., 2013), others have given consideration to maximising economic participation for older people (Foster & Walker, 2014; Principi, Jensen, & Lamura, 2014). But overall, there is a lack of consensus among researchers and policy actors on the meaning of active ageing and its application to different contexts (Boudiny, 2013; Boudiny & Mortelmans, 2011; Constança et al., 2012; Walker & Foster, 2013).

This study is important for contemporary debates on human ageing and quality of life at old age for four reasons. First, the representation of older people's views in international level policy proposals is necessary within the framework of participatory policy processes and actions on ageing (Dankl, 2017; Van Malderen, De Vriendt, Mets, & Gorus, 2016). Walker and Foster (2013) and Bousquet et al. (2015) have suggested that the time has come for older people themselves to be more involved in determining what active ageing means to them. This study presents real life experiences of what active ageing means to older people, which have implications for policies that seek to promote quality of life of older people. The study therefore contributes to an important aspect of policy discussions on how the voices of older people can be incorporated into policy actions.

Second, as argued by Bowling and Dieppe (2005), lay views about policy concepts are critical in validating existing models and expanding measurement options. Similarly, Bowling and Iliffe (2006) observed that lay models provide a better measure of successful ageing than other structural models. Therefore, establishing the meaning of active ageing through the lived experiences of older

people will generate useful contextual information that can be further analysed and tested in future studies.

Third, the study has implications for strengthening arguments about context and global policy adaptation of active ageing. The arguments presented in the thesis rest on the assumption that older people are not a homogeneous group; therefore, old people in different settings should not be classified as requiring same services (Canadian Library Association, 2002). Developing policies and programs for dealing with ageing issues will, therefore, require a targeted approach to policy adaptation. As this study will show, the African context for active ageing is unique and requires a contextually appropriate strategy to demographic ageing. It implies that policy approaches to population ageing should be context specific.

Fourth, as argued by Gerring (2012), it is not sufficient to *know* what has happened in the way of describing phenomenon, but more important to know *why* the phenomenon has happened. Therefore, understanding the causal pathways through which different qualities of active ageing occur presents opportunities for developing remedial policies to address negative consequences and strengthen positive factors that promote the best quality of life at old age. In addition, knowledge of different clusters of experiential active ageing provides opportunities for policy makers to develop targeted interventions that address specific needs of specific older people.

1.1 Background

In most regions throughout the world, people are now living much longer than in the past. Global average life expectancy is currently 73 years for women and 68 years for men, representing an increase of about six years for both genders since the year 2000 (World Health Organization, 2015). In effect, population ageing has become a central feature of the 21st century. Most regions of the world are experiencing this demographic transition, with the proportion of people aged 60 and above increasing significantly. For example, 901 million inhabitants in the world in 2015 were 60 years and above. This number represents an increase of 48 per cent from the year 2000's figure of 607 million (United Nations, 2015). It is predicted that the total number of older people who will be living in the world will

increase to about 2.1 billion by the year 2050 (HelpAge-International, 2013; United-Nations, 2013; United Nations, 2015). This projection represents an increase of over a 100 per cent in the number of people aged 60 and above who will be living in the world by 2050. Also, the proportion of older people compared to younger people has increased, and this is attributed to an overall decline in death rates as a result of medical advances and improved healthcare systems, coupled with declining birth rates across many parts of the world (United Nations, 2015; World Health Organization, 2015).

There are regional and country level disparities in the rapid demographic transitions. While there are marked increases in some countries and regional areas, it has been rather gradual and steady in others. Table 1.1 shows the demographic transition in the 100-year period between 1950 and 2050. Developed regions of the world - Europe, Northern America and parts of Oceanic regions- will continue to have the highest concentration of older people (60 years and above) during the period. On average, the proportion of the elderly in these regions is estimated to be more than 20 per cent of the total population. This percentage has been projected to rise to about 30 per cent, especially for Europe, by 2050 (United-Nations, 2013). However, the UN further notes that two-thirds of the global population of older people are presently living in Asia, Latin America and Sub-Saharan Africa. Sub-Saharan Africa, in particular, is predicted to experience one of the most rapid demographic transitions in the future, with the number aged 60 years and older reaching about 215 million by 2050 (HelpAge-International, 2013; United-Nations, 2013).

To date, industrialised regions of the world are experiencing sharper effects of this rapid demographic transition than the less industrialised countries, and has implications for dealing with the old-age support ratio in both settings (OECD, 2011; United-Nations, 2013).

Table 1.1: Regional proportion of the population aged 60 years or over: 1950-2050.

| Region | Percentage of population aged 60 years and above | | | | |
|--------------------------------|--|------|------|------|------|
| | 1950 | 1975 | 2000 | 2025 | 2050 |
| Asia | 6.7 | 6.6 | 8.6 | 14.8 | 24.4 |
| Europe | 12.1 | 16.5 | 20.3 | 27.3 | 33.6 |
| Latin America/Caribbean | 5.6 | 6.5 | 8.4 | 14.9 | 25.0 |
| Northern America | 12.4 | 14.6 | 16.3 | 24.7 | 27.0 |
| Oceania | 11.2 | 11 | 13.4 | 19.1 | 23.5 |
| Sub-Saharan Africa | 5.2 | 4.8 | 4.8 | 5.5 | 8.3 |

Source: Based on estimates of UN (2013)

The old age support ratio is another important demographic marker for understanding some of the perceived challenges of population ageing. Old age support ratio measures the number of working-age persons (aged 15-64 years) per older person (aged 65 years or over). Figure 1.1 reveals that old-age support ratio has been on the decline since the 1950s. The global old-age support ratio in the 1950s was 12 working persons per each older person. This global ratio decreased to eight in 2013, and is expected to further drop to four by 2050. There are also significant regional variations in the old-age support ratios. Figure 1.1 shows that on the one hand, developed regions of the world are expected to experience declines that peak at about two working persons per older person by 2050. Developing regions, on the other hand, are predicted to experience a sharp decline in support ratio from 16 to 9 working persons per older adult between the period of 2013 to 2050. The implication is that the burden of old age is much more profound in developed regions of the world than in the developing ones.

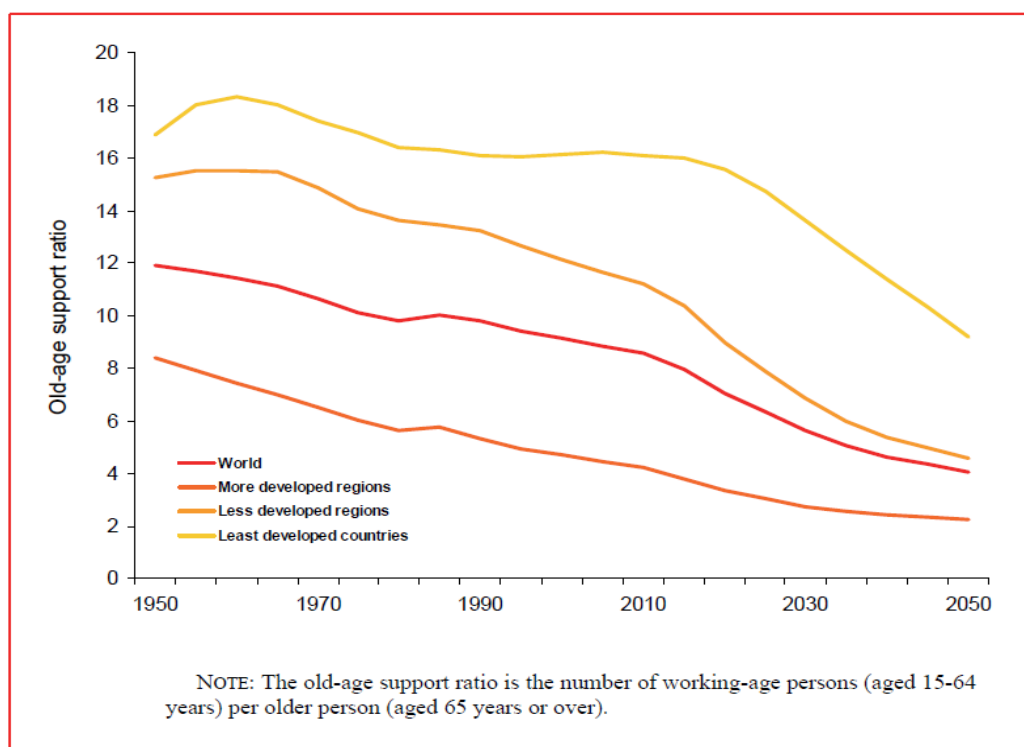


Figure 1.1: Old age support ratio by regions and the world.

Source: United-Nations (2013)

Clearly, the decline in the old-age support ratio presents a critical developmental challenge that needs the attention of all countries (United-Nations, 2013). As observed by Beard et al. (2011), population ageing comes with both individual level and societal level challenges for which many nations appear to be inadequately prepared. To some policy makers, population ageing represents an opportunity to maximise both social and economic benefits (Per Capita Australia, 2014; World Health Organization, 2015). To others, it is a challenge that must be addressed through radical policies to reduce fiscal pressure on governments and maximise development gains (Beard et al., 2011; Productivity Commission, 2013).

1.2 Population ageing in Ghana and Australia

This study was conducted in Ghana and Australia. Both countries are currently experiencing rapid population ageing; however, the pace and the stage of the transition are much higher in Australia than Ghana. In Ghana, there is less mention of demographic ageing in the media, government and public discourses, whereas discussions on population ageing in Australia remain active. It is important to provide a brief discussion on the demography of ageing in these two settings. For

Ghana, an analysis of demographic ageing is important because Ghana is the country of origin for all participants in the study. Additionally, Ghana provided the initial socio-cultural orientation for the research participants, including those that have migrated to Australia. The discussion of Australia's demographic ageing is included because many older Ghanaians live in Australia, and their presence has implications for issues pertaining to population ageing in the country (McDonald, 2016). In particular, the analysis of Australia's demographic context is important because managing migration and population ageing has become linked with the country's reliance on skilled migrants to meet its labour needs (Graeme Hugo, 2014; Jakubowicz, 2016). In addition, the extent to which Australia's policies for ageing influence the experiences of older migrants (Jakubowicz, 2016), such as those from Ghana present opportunities for an investigation within the context of migration and ageing.

1.2.1 Population ageing in Ghana

Ghana is located in West Africa, (See Figure 1.2). The country has a warm tropical climate and is culturally diverse. Ghana is made up of several ethnic groups including the Akans, the largest group (48%), the Mole-Dagbani (17%), Ewe (14%), GA-Dangme (7%), and others. The current population is almost 26 million (Ghana Statistical Service (2013a). Life expectancy in Ghana is 62 years (World Health Organization, 2016).

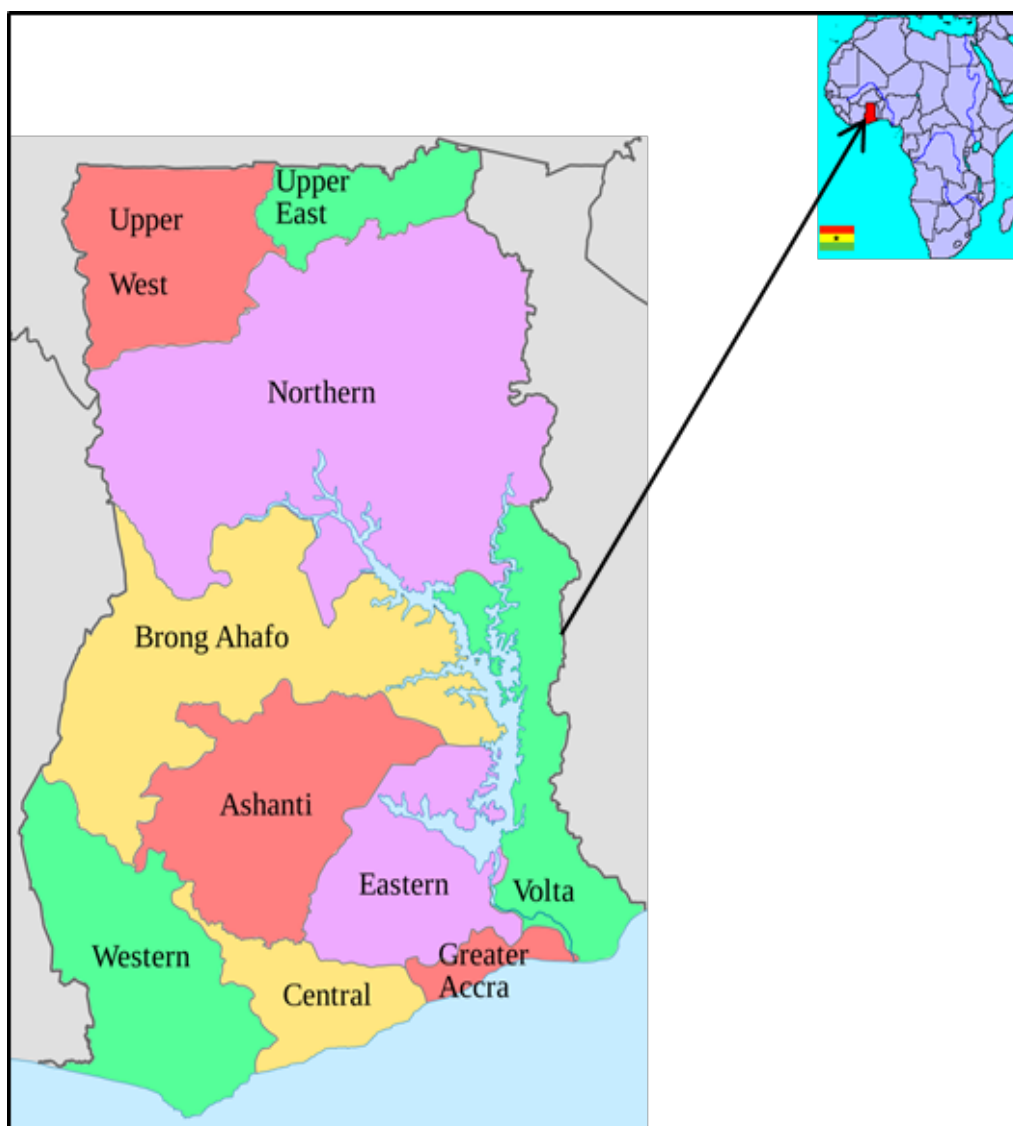


Figure 1.2: The Map of Ghana.

Source: <http://www.ghanaweb.com/GhanaHomePage/geography/region.php>

A trend analysis of population ageing in Ghana shows a steady increase in the number of older people from 60 years and above. In 1960, older people constituted about 4.9 per cent (0.3 million) of the total population. In 2010, the population increased to 6.7 per cent (1.6million) (Ghana Statistical Service, 2013a; Mba, 2010). Figure 1.3 shows that since the year 2000, the number of older people in Ghana has risen from 988,000 to about 1.6million by 2015. This figure is expected to increase to about 6.3 million by 2050 (12%). Mba (2010) and Tawiah (2013) argue that the increase in the population of older people in Ghana has been consistent, and that the level of vulnerability and destitution among older people has also been rising rapidly.

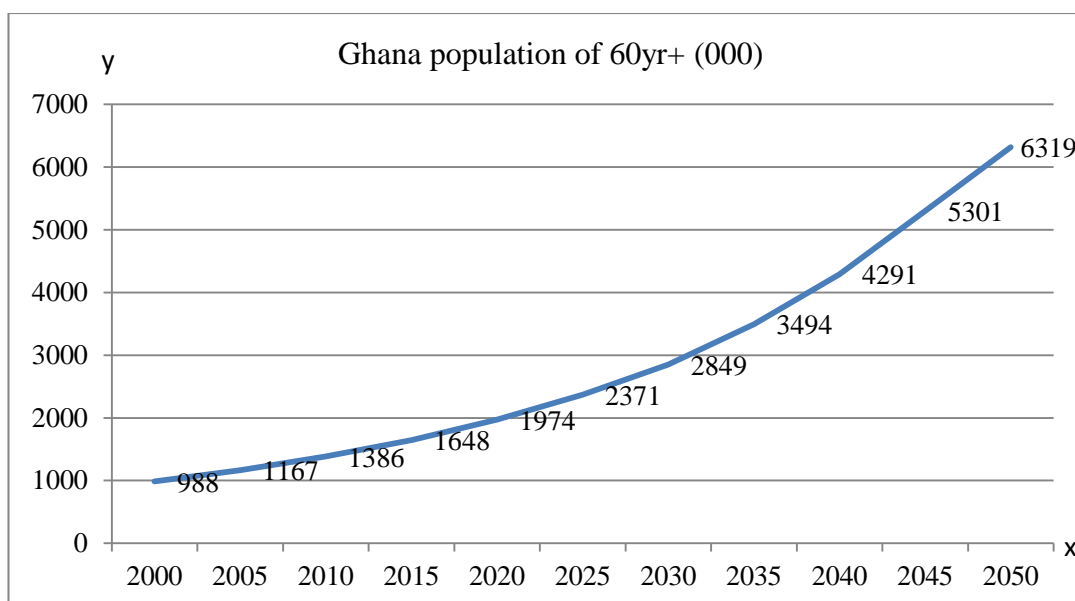


Figure 1.3: Population ageing trend and projection of Ghana (2000-2050)

Source: Based on estimates from the Ghana Statistical Service (2013b)

Relative to the gender distribution of older people in Ghana, in 2013, the female population constitute 56 per cent, and the male population 44 per cent. The higher representation of women is attributable to higher life expectancy of the female population in Ghana (Ghana Statistical Service, 2013b). However, illiteracy is higher among older female Ghanaians than their male fellows; although generally, the literacy rate among older people in Ghana is low. As Table 1.2 shows, over 60 per cent of older people in Ghana had no formal education, and only a fraction (1.5%) had obtained higher education as of 2010.

Table 1.2: Educational status of older people in Ghana

| Education | Male | Female | Total |
|-------------------------------|-------|--------|-------|
| no formal education | 44.9 | 72.6 | 60.4 |
| primary | 8.4 | 8.8 | 8.6 |
| middle/JSS/JHS | 30.0 | 13.0 | 20.5 |
| secondary (SSS/SHS/'A' Level) | 5.4 | 1.8 | 3.4 |
| post-secondary | 8.5 | 3.4 | 5.6 |
| higher | 2.8 | 0.4 | 1.5 |
| Total | 100.0 | 100.0 | 100.0 |

Source: Ghana Statistical Service, 2010 Population and Housing Census

Notwithstanding, the Ghana Statistical Service (2013a) estimated that about 96.3 per cent of economically active older persons were employed in the country. To be “economically active” means being engaged in work that brings income (Ghana Statistical Service, 2013a). Table 1.3 provides a snapshot of the occupation and nature of economic activity of older Ghanaians. The economically active older Ghanaians predominantly work in agriculture and forestry (63.1%), and others in services and sales (13%), the craft sectors (8.4%), and professionals and managers (5%). In 2013, formal sector workers on national pension schemes who had retired at the compulsory retirement age of 60 years accounted for only 10 per cent of the total population of older Ghanaians (Alidu, Dankyi, & Tsiboe-Darko, 2016; Quartey et al., 2016). The socio-demographic and economic characteristics of older Ghanaians, as described above, suggest the need to examine the subject of active ageing and the lived experiences of older people’s quality of life.

Table 1.3: Occupation of the economically active elderly by sex, 2010-Ghana

| Occupation | Total | | Male | | Female | |
|---------------------------------------|---------|-------|---------|-------|---------|-------|
| | No. | % | No. | % | No. | % |
| Total | 961,776 | 100.0 | 480,314 | 100.0 | 481,462 | 100.0 |
| Managers | 20,683 | 2.2 | 10,789 | 2.2 | 9,894 | 2.1 |
| Professionals | 26,165 | 2.7 | 18,397 | 3.8 | 7,768 | 1.6 |
| Technicians & Associate Professionals | 12,364 | 1.3 | 9,580 | 2.0 | 2,784 | 0.6 |
| Clerical Support Workers | 7,614 | 0.8 | 6,243 | 1.3 | 1,371 | 0.3 |
| Service and Sales Workers | 127,725 | 13.3 | 31,806 | 6.6 | 95,919 | 19.9 |
| Skilled Agriculture & Forestry | 607,152 | 63.1 | 327,092 | 68.1 | 280,060 | 58.2 |
| Craft and Related Trades | 81,218 | 8.4 | 37,146 | 7.7 | 44,072 | 9.2 |
| Plant and Machine Operators | 18,545 | 1.9 | 17,420 | 3.6 | 1,125 | 0.2 |
| Elementary Occupations | 32,411 | 3.4 | 9,522 | 2.0 | 22,889 | 4.8 |
| Other | 27,899 | 2.9 | 12,319 | 2.6 | 15,580 | 3.2 |

Source: Ghana Statistical Service, 2010 Population and Housing Census

1.2.2 Australian context of ageing and migration

Australia, as shown in Figure 1.4, is composed of five States and two Territories. In June 2016, the total population of Australia was about 24million, Australian Bureau of Statistics (2016). Graeme Hugo (2014) observed that

Australia's population comprises native Australians and migrants. Overall, Australia's current life expectancy rate was estimated at 82.1 years, one of the highest in the world (World Health Organization, 2016).

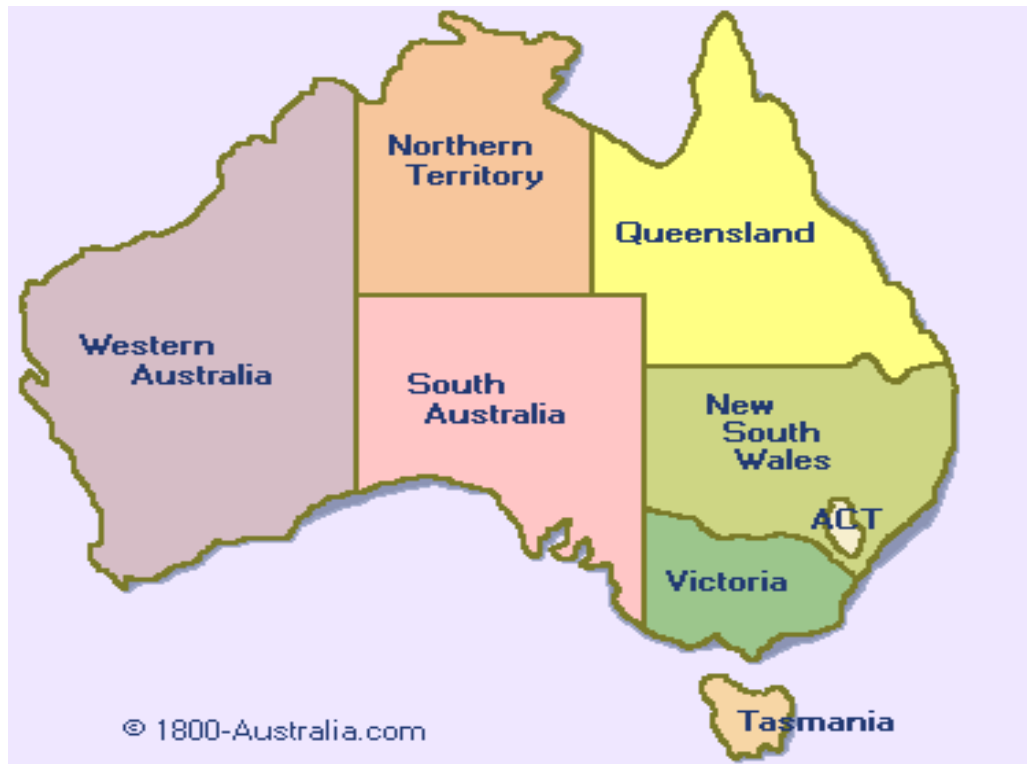


Figure 1.4: Map of Australia

Source:

http://www.travelnotes.org/1800/Countries/Maps/australia_maps.htm

A trend analysis of the demographic ageing of Australia shows that the number and proportion of older people, 65 years and above has consistently increased over the years. According to the Australian Bureau of Statistics (2014) and the Australian Government Productivity Commission (2013), in 1970 the population of older people 65 years and above in Australia was eight per cent of the total population; this increased to 13 per cent by 2001. The projected population of older people, 65 years and above between 2011 and 2101 is expected to increase sharply. In particular, the population of older people is projected to increase from 3.2 million in 2012 to about 5.8 million in 2031; and that population is expected to increase to about 10 million in 2061, and further rise to 15million by 2101 (Australian Bureau of Statistics, 2016).

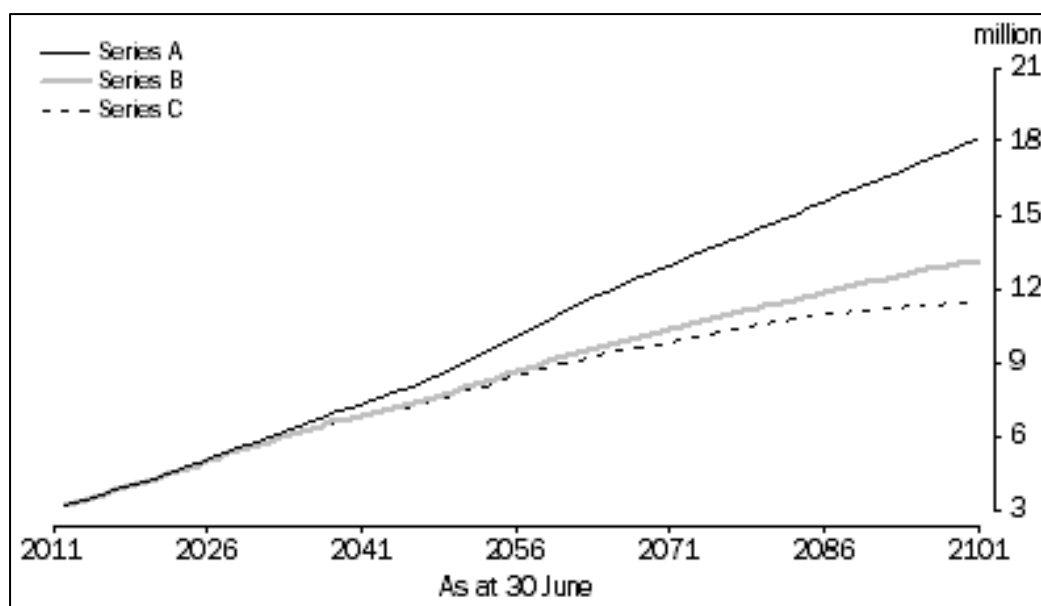


Figure 1.5: Projected population aged 65 years and over-Australia

Source: Australian Bureau of Statistics (2016)

There is difficulty in comparing old age of Ghanaians and the Ghanaian Australian migrants; old age in Ghana comprises people above 60 years, in Australia, older people are those aged 65 years and above. However, HelpAge International (2013) estimated that there were about 4.5 million older people in Australia, aged 60 years and above in 2012; which represented 19.6 per cent of the population. It has been predicted that the number of Australians aged 60 years and above will rise to about 6.6 million in 2050, representing about 29 per cent of the total population (HelpAge International, 2013).

Figure 1.6 shows that as of 2011, more than 60 per cent of older people in Australia had completed at least Year-10¹ or equivalent and those who had completed Year-12 or equivalent² constituted 28 per cent. In terms of gender, older men (33%) were more likely to have completed Year-12 than women (25%). Overall, only 2.4 per cent of older people in Australia have no formal education (Australian Bureau of Statistics, 2012).

¹ Equivalent of General Certificate Examination Ordinary Level.

² Equivalent of General Certificate Examination Advanced Level.

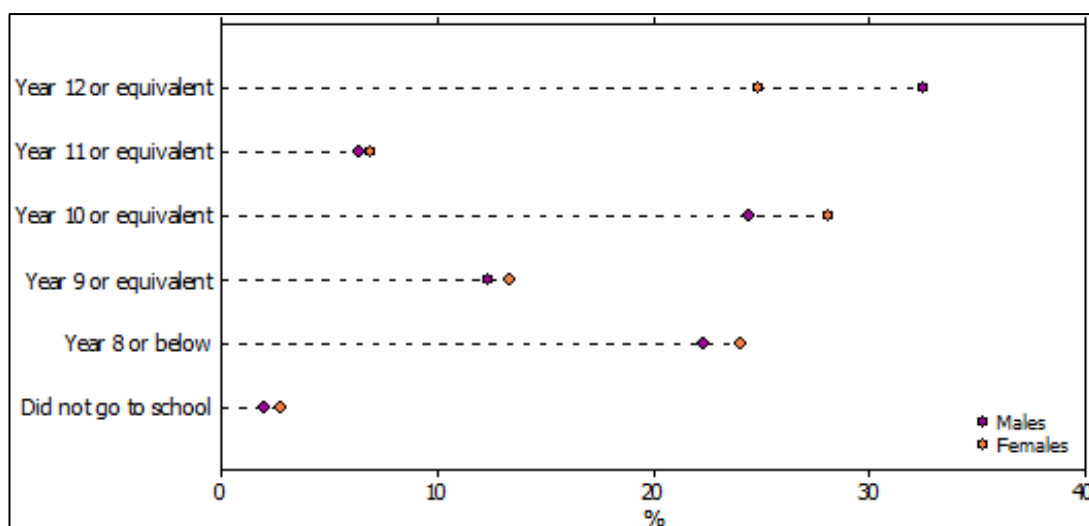


Figure 1.6: Older persons, highest year of school completed by sex, 2011

Source: Australian Bureau of Statistics (2012).

Table 1.7 shows that the proportion of older migrants within the demographic transition of Australia is significant. In 2011, overseas-born people living in Australia aged 65 years and above constituted 19 per cent of the population. The Australian Bureau of Statistics (2016)³, on the other hand, noted that overseas-born Australians represented 36 per cent of the total population in 2011. Therefore, the proportion of older migrants in Australian was high. The migrant population has implications for policies that meet the need of all older people, irrespective of their countries of origin. For example, the Australian National Ageing and Aged Care Strategy (Commonwealth of Australia, 2015b), made specific provisions for people from Culturally and Linguistically Diverse (CALD) Backgrounds, in terms of developing culturally appropriate ageing support services for all migrant older people in the country, Ghanaians.

³ The report was written before the release of the detailed 2016 Census was released.

Table 1.7: Australia: population aged 65+ by birthplace, 1971-2011

| Year | Australia-Born | | | Overseas-Born | |
|------|----------------|------|-------------------|---------------|------|
| | No. | % | % Growth pa | No. | % |
| 1971 | 816,396 | 8.0 | | 248,599 | 9.6 |
| 1976 | 913,075 | 8.4 | 2.3 | 295,911 | 10.9 |
| 1981 | 1,053,565 | 9.2 | 2.9 | 350,839 | 11.7 |
| 1986 | 1,188,679 | 9.8 | 2.4 | 458,041 | 14.1 |
| 1991 | 1,323,473 | 10.4 | 2.2 | 528,335 | 14.1 |
| 1996 | 1,418,879 | 10.7 | 1.4 | 620,898 | 15.9 |
| 2001 | 1,485,462 | 10.9 | 0.9 | 726,558 | 17.7 |
| 2006 | 1,560,584 | 11.1 | 1.0 | 840,503 | 19.0 |
| 2011 | 1,787,009 | 11.9 | 2.7 | 1,004,641 | 19.0 |

Source: Graeme Hugo (2014)

Given that the population projections of both Ghana and Australia for older people aged 60 years and above to reach more than 6 million inhabitants by the year 2050, the two countries present interesting cases for examining ageing issues in two distinct policy environments with similar demographic ageing concerns. Of particular interest is the fact that Australia's ageing population is made up of older people from diverse socio-cultural backgrounds as a result of emigration (Graeme Hugo, 2014), such as those from Ghana. Chapter Four provides a detailed discussion of the context of ageing in Ghana and Australia.

1.3 Research problem

In responding to population ageing, several countries, such as Australia, Ghana, Mauritius, South Africa, United Kingdom and United States have developed social security systems to protect people at old age. However, many of the social security policies have faced severe constraints recently (Ehnes, 2012; Goss, 2010). Concerns about social security arrangements in the developing countries include, for example, that they have limited coverage scales and are supported by minimal social protection mechanisms such as unconditional cash transfers (Bloom, Jimenez, & Rosenberg, 2011; Devereux, 2010; Ehnes, 2012; Handayani & Babajanian, 2012). As observed by Creedy and Scobie (2005) and by Bonoli and Shinkawa (2005), even though many countries appear to have sound social security and social protection

systems, their rapid population ageing is threatening the sustainability of their policies.

In Australia, for example, given the current trend in population ageing, it is estimated that health care for the aged care and aged pension will collectively add six per cent of increased demand on the budget by 2060 (Productivity Commission, 2013). This has led to the Federal Government foreshadowing policy measures to reduce fiscal pressure imposed by population ageing on the country's economy (Productivity Commission, 2013). For example, pensions and other forms of social protection at old age are likely to be reduced. Similarly, in Central and Eastern Europe, ageing-related spending has exacerbated fiscal sustainability; hence, the critical issue faced by many countries is how to reduce the ageing pressure by shrinking public spending on age-related matters (Zaidi, 2012; Zaidi & Rejniak, 2010). Furthermore, post global financial crisis, austerity measures and budget constraints in many countries have not been conducive to state allocations to ageing issues (Goss, 2010; Hall & van Gool, 2016; Rollins, 2014).

Beard et al. (2011) observed that most countries in the world have not made adequate preparations to transition into an emerging social structure, which is predicted to be dominated by older people; and as a result, have resorted to stringent economic measures (J.R. Beard et al., 2011; Pakulski, 2016). At present, some countries are exploring strategies to address the challenges that come with rapid population ageing, including looking to the WHO for answers (Boudiny, 2013; Walker & Maltby, 2012). The WHO has, since 2002, been promoting 'active ageing' as the paradigm for addressing ageing issues globally. And, following the WHO's proposition, some countries, especially those within the European Union, regional bodies and international development organisations, have developed frameworks and policies that are fashioned on the WHO's active ageing model (European Union, 2012; United Nations Economic Commission for Europe, 2012).

The WHO defines active ageing as "the process of optimising opportunities for health, participation and security to enhance the quality of life as people age" (World Health Organization, 2002, p. 12). The model defines 'active' to mean "continuing participation in social, economic, cultural, spiritual and civic affairs, not

just the ability to be physically active or to participate in the labour force" (World Health Organization, 2002, p. 12). There are three main pillars of active ageing, including health, participation, and security. The active ageing model advocates for health promotion and prevention in safe environment so that older people can be active (Boudiny, 2013; Hutchison, Morrison, & Mikhailovich, 2006). Active ageing emphasises employment, health, pension, retirement, and citizenship (Boudiny, 2013; Walker, 2002, 2006). Seven principles govern the active ageing model, consisting of "activity, inclusion, prevention of disease, maintenance of intergenerational solidarity, rights and responsibilities, participation and empowerment, and the respect for national and cultural diversity" (Walker, 2002, p. 125). Walker (2002) argued that the principles of active ageing should be seen as a mix of ideas of productive ageing with an emphasis on mental and physical health and the overall promotion of quality of life.

The European Union (EU) adopted the WHO's active ageing model in 2012, describing it as a tool to empower older people to remain active as workers, consumers, volunteers and citizens; and a tool to strengthen the intergenerational solidarity between older individuals and the younger generation (European Union, 2012). The EU has also developed 19 principles of active ageing under three broad themes: 1) employment, which highlights all the essentials of a working life; 2) participation in social life; and 3) independence, including health promotion, housing and a friendly environment.

The active ageing policy contexts for Australia and Ghana are different. In Australia, there is no clear-cut national level active ageing policy (Hutchison et al., 2006). There are, however, state, territory, and local council level active ageing policies that are to a large extent, modelled after the WHO active ageing framework (Hutchison et al., 2006). Some state or city level active ageing policies emphasise the health and wellbeing of older people, access to essential services, economic security and protection of rights, well-planned communities, and opportunities to participate in social life or contribute to development (see, for example, City of Mandurah-Western Australia, Active Ageing Plan 2013-2017). The Australian Productivity Commission's Report (2013) has provided a possible national policy

direction on ageing, which is somewhat consistent with the WHO model. However, the focus of the proposed policy option in the report seems to centre on economic dimensions of active ageing, with the emphasis on modalities to reduce financial pressure created by health, aged care and age pension on government.

Ghana, on the other hand, adopted a National Ageing Policy in 2010 that is consistent with the WHO model. The policy emphasises health promotion and protection and participation of older people, especially in the labour market. In Ghana, local governments, such as District Assemblies do not have specific policies and programme for ageing (see Chapter Four).

As previously noted, active ageing, according to the WHO (2002), has three central pillars aimed at promoting the quality of life at old age: health, participation, and security. Of these three, the WHO considers health to be paramount in promoting active ageing. The emphasis on health is justifiable because old age has high rates of non-communicable disease conditions, including hypertension, stroke, diabetes and cancer (Agyemang et al., 2013; Hofman et al., 2009). Aikins and Marks (2007) defended the promotion of health for older people by stating that through health promotion, the occurrence of disease conditions, especially conditions from non-communicable diseases (NCDs), can be delayed or completely prevented so that people can age devoid of disability (Aikins & Marks, 2007; Walker, 2002). Others have argued that older people have potentials, including knowledge, skills and experiences, that can be accessed to enhance development while keeping themselves active (Beard et al., 2011; European Union, 2012; Per Capita Australia, 2014). Skarupski et al. (2007) asserted that if the potentials of older people are unused, the ageing process may be inactive, dull and may result in early death or increase the cost of healthcare. Thus, the WHO's model advocates for policies and programs that promote old peoples' participation in social and economic life using good health as a means to an end. Recently, the security pillar has also come into recognition with the proliferation of policies and programs for building age-friendly environments (Paúl, Ribeiro, & Teixeira, 2012).

Walker and Maltby (2012) argued that the proliferation of different policy models for ageing is attributable to paradigm shifts in the conceptualisation of

ageing itself. Katz (2001) asserted that contrary to the traditional, dogmatic and negative stereotypic images of ageing in the past, the new waves of images of ageing were positive. The new images reinforce activity, autonomy, mobility, choice and quality of life rather than dependency, decline and burden. Some of the new images of ageing include, as noted earlier, successful ageing, productive ageing, healthy ageing, and active ageing. The concept of successful ageing, for example, stresses low probability of disease and disability, high cognitive and physical functioning and active engagement in life (Hsu, 2007; Katz & Calasanti, 2014; Rowe & Kahn, 1997). Productive ageing emphasises activity by older people that produce goods and services (Kaye, Butler, & Webster, 2003; Morrow-Howell, Hinterlong, & Sherraden, 2001). And healthy ageing as advocated by Sixsmith et al. (2014) transcends biological and medical aspects of ageing to include autonomy, participation and wellbeing.

The different theoretical propositions notwithstanding, Katz (2001) and Katz and Calasanti (2014) argued that many of the new images of ageing were mere marketing rhetoric concepts. Before this, Minkler (1989) suggested that some of the emerging views of ageing that sought to recast later life as an active, youthful experience aimed at extracting the 'gold from grey'. Holstein and Minkler (2003) further argued that the concept of successful ageing, for example, ignores the potential influences of the broader society and the differences in access to resources. Although the current generation of activists of successful ageing, such as Zacher (2015) and Dillaway and Byrnes (2009), emphasised a reconceptualization of successful ageing to include considerations for age differentials, personal level factors and other contextual factors. The successful ageing model remains a mere economic tool reinforcing productivity among older people.

Closely linked to the issue of successful ageing is the concept of productive ageing, which has also received some criticism because it ignores the possible health differences among older people and emphasises productive activity. The concept, productive ageing, therefore, will most likely result in stereotyping non-productive older people as learners rather than lifters, who by ill-health cannot produce (Buys & Miller, 2006).

Like many other similar proposals, such as productive ageing and successful ageing, the active ageing framework has been criticised. For example, Minkler and Holstein (2008) believed that making active ageing the ideal strategy for global ageing might be 'counterproductive and oppressive' it imposes standards on only the positive aspects of ageing (Foster & Walker, 2014). Furthermore, Barrett and McGoldrick (2013) contended that the notion of 'active' alone has the tendency to reduce country-level ageing policies to promoting physical activity at the expense of other equally important aspects of ageing.

Additionally, because the expectations of active ageing are driven by agencies such as government Departments and Ministries, national level policy processes may not be consistent with the experiences of all older people (Reed, Cook, Childs, & Hall, 2003). Walker (2002) argued that there is the high risk of 'active ageing' becoming coercive and overbearing because all countries will be expected to adopt it. Minkler and Holstein (2008) affirmed Walker's view and bemoaned the possible oppressive nature of active ageing.

Furthermore, according to the WHO's (2002) 'active ageing' is an extension of the general determinants of health. Dodge, Daly, Huyton, and Sanders (2012) argued that conceptualising active ageing as an 'extension of determinants of health limits our understanding of active ageing and its application in every part of the world. Boudiny (2013) observed that given the nature of the concept of active ageing, many of the debates have focused on health and sometimes, the economic aspects of 'active' without any significant recourse to the overall framework. Constança et al. (2012), affirmed that the interpretation of 'active ageing' in the literature and some national level policy actions mainly focused on health and labour market participation of older people. Given the preceding criticisms of 'active ageing', Walker and Foster (2013) and Bousquet et al. (2015) have suggested that the time has come for older people themselves to be more involved in determining what active ageing means to them.

The discussion above reinforces the need for researchers to seek greater understanding of active ageing based on the lived experiences of older people, which is lacking in the literature, a gap this study seeks to begin to fill. Clearly, the

WHO's active ageing framework is broad, leaving interpretation and application of the concept in contemporary ageing policy somewhat lacking in direction as to what should be most important in promoting quality of life at old age. On the basis of the above theoretical and conceptual discussions, the following research questions were formulated.

1.4 Research Questions

1. What does active ageing mean for a sample of older Ghanaians living in Ghana and Australia?
2. How do the participants' experiential meanings of active ageing compare with the original active ageing model proposed by the WHO?
3. To what extent do different policy contexts influence participants' experiential meaning of active ageing?
4. What factors contribute to different experiences of quality of life among research participants?

1.5 Thesis structure

The study is made up of nine chapters. The current introductory chapter has discussed the background to the study, showing the nature of demographic transition for older people who are 60 years and above globally. The discussion indicated the extent of the threat of population ageing to countries and how policies were developed in the past to provide social security for people at old age. The chapter also articulated the research problem, and research questions which emanated from the theoretical arguments about the validity of the active ageing framework as proposed by the WHO. Overall, the chapter argued that there is an apparent lack of consensus among researchers and policy practitioners about what active ageing should be – in other words, what should be most important in promoting the quality of life at old age. The chapter emphasised that a study such as this can provide information on the lived experiences of older people to help shape policies and programs to enhance the quality of life of older people.

Chapter Two presents the theoretical and conceptual framework of the study. The study draws on the life course approach to ageing, which presumes that

later-life experiences are a reflection of events of the life of an individual beginning from birth to old age. This theoretical approach is critical given that the study is based on the lived experiences of older people. The chapter further discusses the dimensions of the life course approach and its principles as they pertain to the concept of ageing generally and active ageing in particular. Finally, the chapter examines the dimensions of WHO's model of active ageing and offers a variant to the model based on other theoretical perspectives of ageing.

Chapters Three and Four of the thesis are literature review chapters. Chapter Three discusses arguments about the relationships between ageing and health and the role of active ageing in promoting the quality of life at old age. The chapter also reviews the literature on ageing, social interaction and quality of life, focusing on empirical arguments about the role of social capital, including families, friends and other social network systems in shaping the quality of life at old age. Also presented in the chapter is a review of the literature on activity, work and employment of older people and its relationship with the quality of life. Finally, the chapter outlines various approaches to care of the elderly in the contemporary world. Chapter Four is a contextual discussion of the political economy of ageing in both Ghana and Australia. The chapter will seek to provide a contextual analysis about the social policy environment for ageing, which considers the nature of political ideologies and how they have shaped decisions on ageing issues. The chapter further considers the key players, policies, programs and legislations on ageing in Ghana and Australia.

Chapter Five is the methodology chapter. As will be shown, the research design is an interpretive phenomenological analysis (IPA) combined with a comparative case study. The two research methodologies served different purposes based on the research questions and the selection of cases. For example, the research question on lived experiences of active ageing was analysed using an interpretive phenomenological approach, whereas the research question that explored the differences between experiences across two different settings and the analysis of causal pathways for quality of life used a comparative case study approach. A detailed discussion of the case selection, data collection and analysis

are also presented in the chapter. Finally, the chapter discusses issues relating to ethical consideration of the study.

Chapters Six, Seven and Eight present the findings of the study. The sixth chapter contains findings on the experiential meaning of active ageing based on the lived experiences of older people, juxtaposed with the active ageing model proposed by the WHO. The data show that there are significant variations between experiential, active ageing and the model proposed by the WHO in terms of what the older people who participated in the study consider to be most useful in maximising their quality of life at old age. Chapter Seven presents the comparison between the experiential meaning of active ageing between respondents living in Australia and their counterparts in Ghana. The purpose of this comparison is to observe differences and similarities in the construct of the experiential meaning of active ageing and the extent to which different policy environments have influenced their experiences. Chapter Eight discusses the findings on the pathways through which various forms of experiential, active ageing has been attained and the factors that shaped the process. The chapter emphasises the life-course influence on active ageing, highlighting key moments in older people's lives that strengthened or impaired the process of active ageing. Furthermore, the chapter reveals four types of qualities of life produced from the experiences of older people using two main dimensions of experiential, active ageing (which is sometimes to in the study as quality of life). The main dimensions comprise the level of social interaction available to the individual and the range of critical social service provision accessible to the individual. The causal pathways leading to each of the highest form of quality of life at old age have also been discussed. Theoretically, the chapter seeks to argue that creating an optimum quality of life at old age requires maximising the interplay between social interaction and critical social service provision.

Chapter Nine is the conclusion of the study. The chapter presents a synthesis of the key findings of the study framed by the research questions. The chapter reiterates the most significant variations in the experiential meaning of active ageing and the WHO model, and puts forward some theoretical propositions

for the future examination of the concept of 'active ageing', and comments on the policy implications of the main findings of the study. The limitations and prospects for future research are also discussed in this chapter.

CHAPTER TWO: THEORETICAL AND CONCEPTUAL FRAMEWORK

2. Introduction

This chapter presents the theoretical and conceptual frameworks of the study. The central theory adopted for the study is the life course approach to ageing. In addition, two main concepts have been discussed in the chapter: 1) active ageing and 2) quality of life. The life course approach as the theoretical foundation is most suitable for this study because, as discussed below, understanding events of later-life experiences requires stepping back in time to understand how life circumstances have evolved and the factors that shape them. The theoretical and conceptual discussions have implication for policy makers to mitigate undesirable later life experiences for older people. There are two parts to the chapter.

The first part of the chapter is the theoretical framework, which discusses the historical development of the life course approach. This is followed by a discussion of the life course approach to human ageing and the associated themes. The issues addressed are the interaction between human life and historical time, the timing of lives, interdependent lives, and human agency (Elder Jr, 1994). The conclusion of the first part draws a connection between the theoretical arguments and the overall study. The second part of the chapter is the conceptual frameworks of active ageing and quality of life of older people. The conceptual framework discusses the defining attributes of the concepts and how they could be measured.

Part One: Theoretical framework

2.1 Introducing the life course approach: A historical discussion.

Historically, the life course approach emerged as a theoretical model in the 1960s (Elder Jr, Johnson, & Crosnoe, 2003, p. 3). However, before this period, W.I Thomas and Florian Znaenieceki had published *The Polish Peasant in Europe and America* in 1920 (Elder Jr, 1994, 1998; Elder Jr et al., 2003). Thomas and Znaenieceki stressed the need for a different approach to longitudinal and life history studies by

examining life record data and further advocated studies on family experiences in various situations and at different times (Elder Jr et al., 2003). However, the scientific community did not respond positively to Thomas and Znaenieceki's proposal. In the 1950s, C. Wright Mills proposed the field of life course study. The life course discipline was expected to include studies in history, biography, and how these interact with the social structure to shape human experience (Mills, 1959). However, Mill's idea was not taken up until the 1960s.

By the 1960s, the life course approach had gained prominence when a remarkable study was conducted by Glen Elder Jr. (1974) on the impact of the Great Depression of the 1930s on families and World War II in the United States. (Elder Jr, 1994; Elder Jr et al., 2003; Elder Jr & Rockwell, 1979; Moffitt, 1993; Sampson & Laub, 1990; Streib & Binstock, 1990). As observed by Bengtson and Allen (2009), the life course approach gained further prominence in the 1990s as a result of the significant social change in patterns of human life, coupled with threats of demographic ageing. Consequently, there was the need for researchers to examine the complex mix of historical and contextual factors that underlie social change including changes in family patterns and continuity (Bengtson & Allen, 2009). The life course approach brought the development of new methodologies to collect and analyse longitudinal data. By this time also, some social science researchers had examined the relationship between the individual and social change, which also included the relevance of age, period and cohorts. For example, Clausen (1991) examined how life course shaped adolescent competence, concluding that the interaction between cultural and social factors, together with physical and psychological characteristics of the individual, constituted the life course events. And Elder Jr (1994) studied, time, human agency and social change as a perspective on the life course. Others who used the life course approach were Clausen (1995) and Shanahan, Elder Jr, and Miech (1997)

Towards the end of the 1990s, Elder Jr (1998) championed a revolution within the life course approach by defining the core principles and frameworks that shape the nature of problem identification and conceptual development within this emerging field of social enquiry. From the year 2000 to date, the life course

approach has expanded in usage to include family studies (Huinink & Feldhaus, 2009; Huinink & Kohli, 2014; Macmillan & Copher, 2005); organisation development (W. R. King, 2009; A. M. Pettigrew, Woodman, & Cameron, 2001); and health, and social gerontology (Ben-Shlomo & Kuh, 2002; Halfon & Hochstein, 2002; Kuh, Ben-Shlomo, Lynch, Hallqvist, & Power, 2003). Thus, researchers have applied the life course approach to almost every field of social enquiry, and it remains a crucial theoretical approach for understanding social experiences throughout the life span (Browne, Mokuau, & Braun, 2009; Gardner, 2002; Kendig, Loh, O'Loughlin, Byles, & Nazroo, 2016; Kuh & Network, 2007; Kwok & Ku, 2016).

2.2 The life course approach to human ageing

As outlined above, the life course approach is an experiential tool used in the study of the interaction between the lives of individuals and social change. Functionally, it provides a window to the meaning of life within the family, society and historical time (Bengtson & Allen, 2009). The approach provides a checklist of principles for studying people's lives, emphasising issues of time, context, and social process within which people live (Kuh, Cooper, Hardy, Richards, & Ben-Shlomo, 2013; World Health Organization, 2000). Kendig et al. (2016), stated that the life course approach shows the interaction between the individual life exposures and the changing social structure over time. It provides a framework that examines, for example, how wellbeing and health in later life are affected by individual and social factors over time (Kendig et al., 2016, p. 51).

As argued by Elder Jr (1994), the life course approach is a multilevel phenomenon, which includes constructed pathways through social institutions and organisations to the social and developmental trajectory of the individual. Conceptually, the life course is made up of a series of interrelated social events created over time (Bengtson, Elder Jr, & Putney, 2012; Quadagno, 2013). In theory, this perspective provides researchers and policy actors with the platform to recognise the extent to which historical conditions and change define human and family lives (Bengtson et al., 2012). Elder Jr (1994) proposed five principles of the life course perspective: linked lives, historical time and place, lifespan development,

social context, time and transition and agency (Bengtson & Allen, 2009; Elder Jr, 1994).

The principle of *linked lives* states that every life is dependent on others over generations through bonds of kinship or community. This implies that human life is embedded in the lives of other people and human lives mutually influence each other (Elder Jr, 1994; Stowe & Cooney, 2015). The central drivers of this interconnectedness are time, place and social institutions, such as marriage and family. Thus, within these social systems, whatever happens to a member of a unit affects other members (Bengtson et al., 2012). Marshall and Mueller (2003) asserted that within the principle of linked lives, there is interdependency of social relationships beyond formal family ties and extends to neighbours, friends, slaves, housemaids, what Coe (2016) referred to as non-kin relationships. Thus, individuals events of life are shaped by the nature of social linkages as seen in the principle of linked lives (Black, Holditch-Davis, & Miles, 2009).

The notion of linked lives has implications for the care of older people. For example, Coe (2016) argued that beyond the idealised framework of adult children providing care for aged parents, there is an obscure but critical role of non-kin care relationships, primarily driven by negotiation and commitment. The non-kin care relationship typifies the principle of linked lives, which extends to actors beyond formal family ties. It is further assumed that family networks and shared relationships connect with societal level experiences. For example, Elder Jr (1998) observed that societal level events, like war, could affect an individual's behaviour, which may in turn, have an impact on the person's relationship with the family. In effect, life events have the tendency to alter individual responses, which have implications for the overall social functioning of the person in both kinship and non-kinship ties.

The principle of linked lives is critical to this study because later life experiences of an older person connect with family and social relationships of the past. Invariably, the nature of social networks created in the past has implications for the quality of life at old age (Bartolini, Bilancini, & Sarracino, 2016; Lucumí, Gomez, Brownson, & Parra, 2015; Nyqvist & Forsman, 2015). For example, in

demonstrating the importance of familial relationships in old age experiences, Byles, Vo, Thomas, Mackenzie, and Kendig (2016) concluded that older men (70 years and above) who are living alone are more likely to have high psychological stress compared with older men who live with their spouses. Furthermore, it is important to recognise that the principle of linked lives includes intergenerational solidarity, which is also critical to the understanding quality of life at old age.

Darteh, Nantogmah, and Kumi-Kyereme (2016), asserted that in Ghana, the reciprocal ties between adult children and their aged parents remained one of the strongest supports for people at old age. The authors referred to the nature of the mutual relationship between adult children and aged older people as 'filial piety' ((Darteh et al., 2016, p. 48). This kind of mutual interdependence between parents, children and other family members is an important aspect of the quality of life at old age. In addition to the above, within the framework of linked lives, people vary in the way they engage with social relationships, social norms and institutions. In certain circumstances, the engagement may be disrupted or discontinued (Giele & Elder, 1998). It is, therefore, imperative to examine the nature and level of the older aged individual's social relationships, social norms and institutions.

A second principle of the life course approach is the principle of *historical time and place*. Time and place are believed to be fundamental in any life course research. As explained by Elder Jr (1985, 1998), history and social contexts, including geography, shape the lives of individuals. Stowe and Cooney (2015) noted that moments of critical juncture, such as war or famine, influence people's lives in many ways. For example, a war may shape the individual's psychology, family interaction, and overall perspective of life, which consequently affect later-life experiences. The principle of historical time and place also suggests that the socio-cultural, political and economic environments of individual's influence their perceptions and choices. As a result of historical changes, different birth cohorts have different contexts, defined by their unique opportunities and constraints, which also shape their life experiences. Life course analysis is concerned with studying the interaction between life events, economic forces, institutional arrangements and cultural changes. In effect, the principle of time and place are of

great importance in the quest for a contextual understanding of the socio-political environments within which a sample of people lived throughout their life course. An important element of time and place for this study is the political economy context of ageing in the two study locations.

The political economy analysis within a life course approach rests on the assumption that structural factors and processes contribute significantly to the experiences of ageing (Estes, 1979). According to Walker (2006), there is an intricate relationship between the social structure, age, the individual socio-economic status, gender, ethnicity, life-course and institutions of state. Political economy is concerned about how economic and political forces and ideologies shape social policies over time and the current public level arrangements for ageing. The constraints placed on an agency in service delivery through the life course emanate from the structure of society and social policy failures, which may have caused less than ideal conditions for older people (Baldwin, Harris, & Kelly, 1993; Fry, 2005). Thus, in examining ageing experiences, it is important to look beyond the individual level factors to the broader social policy environments within which ageing occurs, including international exposures and influences and ideological circumstances.

For example, Estes and Mahakian (2001) asserted that the political economy of ageing in the past was highly rooted in the principles of capitalism, such as productive ageing. They argued that productive ageing devalues disadvantaged segments of the older population, especially women and minorities. Likewise, Estes and Mahakian (2001) argued that within the framework of political economy, constructs such as productive ageing present economic, social and policy barriers to successful ageing. In a prior study, Estes, Swan, and Gerard (1982) proposed a new line of enquiry into understanding human ageing: political economy of ageing, which hinges on the influences of social history, social class, and the world economy on the process of ageing and the nature of policies that are designed by nation states to address issue of ageing.

A year earlier, Walker (1981) noted that challenges of old age, including poverty among seniors, occur as a result of a weak social and economic

environment over the life course and relatively low levels of public services that benefit older people. Walker (1981) further argued that a central failure of social policies in many nations is the lack of recognition by governments of inequalities in old age and their inability to address issues of vulnerability and poverty over the life course. Thus, there cannot be a useful analysis of human ageing without critical attention to the policy environments within which people age.

The third principle of the life course perspective is the *life-span development*. As explained by Elder Jr (1985), the life-span development approach states that human development is a life-long process and events at an earlier stage of life have implications for later life development. Elder Jr et al. (2003) indicated that the central feature of the human development is the interaction of the biological, social and psychological factors. Biologically, as noted by J. M. Adams and White (2004) ageing can be explained as a person's progressive decline in physiological status and ability to meet the demands of daily living. This gradual decline in physiology and decreased ability to function over time is the result of accumulated cellular damage within the organism; and the process is influenced largely by genetic and environmental factors. Regarding biology, from inception human life is set in motion and cells are naturally designed to include a start and expiration date (Goldsmith, 2011). In principle, the period between the start date and expiration date of life comprises the process of ageing. However, between the beginning of life and the end of life, there is a complex mix of factors, including nutrition, that contributes to the metabolism of the individual, with the resultant effects of either healthy ageing or abnormal ageing (Whitbourne & Whitbourne, 2010). Solomon, Helvitz, and Zerach (2009).

Psychological ageing relates to genome-based ageing, which affects perception, cognition, motor and emotional functioning of the individual (Marcoen, Coleman, & O'Hanlon, 2007). As noted by Stuart-Hamilton (2012), psychological ageing refers to psychological changes, including those involving mental and cognitive functioning and personality of the individual as a result of advances in age (chronological age). Old age results in a reduction in cognitive ability similar to declines in physical body functioning (C. Brown & Lowis, 2003; Eysenck, 1987).

Marcoen et al. (2007), indicated that another important assumption of the psychological theory of ageing is the recognition that the individual is inherently capable of creating positive images of ageing even in the face of irreversible decline. Some researchers have focused on the way older people create images of their lives, which they referred to as perceptual age, subjective age, or age identity (Bowling, See-Tai, Ebrahim, Gabriel, & Solanki, 2005). This current study is concerned with the way participants have created images of their process of ageing.

Within the lifespan development principle, human ageing is a social construct defined by changing roles and relationships and the ability of the older person to adjust to these functions (Phillips, Ajrouch, & Hillcoat-Nallétamby, 2010). Furthermore, social ageing defines an individual's identity as created by social and cultural processes (Bengtson, Gans, Putney, & Silverstein, 2009). Some of these roles relate to whether older people actively engage in a social life or disengage from social life. For example, Lynott and Lynott (2013) argued that disengagement from social processes at old age, leads to disconnection from the social contracts assigned to younger adults, such as employment. The authors also noted that as people disengage from an active social life, they seek exemptions from other social obligations as well (Lynott & Lynott, 2013). Contrary to this, Boudiny (2013) proposed that instead of society imposing withdrawal from engagement, there is the need to promote activity (cf. Martin et al., 2015). Martin et al. (2015) asserted that physical, intellectual or social activities are imperative in creating positive images of self at old age, thus advocating for a continuation of aspects of the middle-aged lifestyle (Martin et al., 2015). Activity entails support in role performance within the larger social context and this, in turn, improves personal self-esteem and wellbeing at old age (Reitzes, Mutran, & Verrill, 1995). However, a central criticism of the activity notion is that it ignores the diversity of human ageing and compromises on life course consideration for human ageing (Marshall 1994). Given this criticism, Litwin and Shiovitz-Ezra (2006) acknowledged that even though activity is critical to the ageing process, it is only relevant if it occurs within the wider social context. The subject of social engagement, or activity, is relevant to

the aim of this study to understand participants' lived experiences of quality of life during old age.

The fourth principle of the life course approach, which is relevant to this study, is the principles of *social context, time and transition*. Elder Jr (1994) referred to social context, time and transition as the timing of lives. Elder Jr (1994) stated that the interaction of social context within which the individual lives and the timing of individual decisions and choices have implications for later life issues (Kuh et al., 2013; Stowe & Cooney, 2015). As noted by Elder Jr (1994), the notion of transitioning from social life refers to the incidence, duration and sequence of roles assigned by age. For example, an individual's decisions about marriage may be early or late depending on age norms that regulate marriage in a given society, or depending on demographic patterns (Elder Jr, 1994). According to Price, McKenry, and Murphy (2000), there are three distinct times of life: the individual time, generational, time and historical time. Individual time is the chronological age, which defines roles and rights in society as defined by culture. Generational time concerns the cohort groups to which the individual belongs. For example, people born between 1946 and 1962 are referred to as baby boomers (Whitbourne & Willis, 2014). And the notion of historical time refers to massive social changes and events that affect individuals, families and communities over time. For example, technological advancement and urbanisation have weakened the traditional family system in Ghana (Apt, 2012; Darteh et al., 2016).

The fifth and final principle associated with the life course approach is the principles of *agency*, which holds that individuals are active agents in creating their lives. For example, people make choices and take advantage of opportunities created by structural arrangements, such as making use of public education to develop human capital for their employment (Hoffmann, 2016; Marshall & Mueller, 2002). Elder Jr (1994) stated that individuals have the ability to take initiatives for their wellbeing. People can plan, and make informed choices between alternations. However, Elder Jr et al. (2003) argued that human agency is affected by the constraints and opportunities in a given context. The constraints and opportunities

are created within the larger social, political and economic environment of the individual.

In the context of ageing, the subject of agency becomes critical. It implies that ageing provides a range of economic and social opportunities for actors. To some people, ageing is an opportunity to maximise and customise business products for older people (Coughlin, 2010; Panagos, 2003; Ring, 2002). To others, ageing is a threat to the economic sustainability of nations (David E Bloom, Canning, & Fink, 2010; Bosworth, Bryant, & Burtless, 2004; Panagos, 2003; Productivity Commission, 2005). To many others, ageing is a human right and welfare issue for which nation states must take responsibility (Kulik, Ryan, Harper, & George, 2014; Walker & Maltby, 2012; World Health Organization, 2015). This study examines the manner in which human agency-how older people take initiatives and had control over their own lives; and constraints and opportunities placed on them by social policies created by the governments.

In conclusion, the life course approach provides an important theoretical basis for examining the lived experiences of older people in this study. In particular, the approach anchors one of the critical areas of focus in this study, that is how early life experiences shape the quality of life at old age. For example, the extent to which older people linked their lives to others in the past through kinship and non-kinship ties, and the implications for social capital accumulation on later life. It also examines the extent to which socio-cultural, political and economic environments contribute to the creation of images about later life experiences. On the other hand, choices and decisions made by older people during their life course has influenced their experiences and conceptualisation of ageing.

Part Two: Conceptual framework

2.3 Understanding active ageing: A conceptual framework

In defining concepts or ideas, experiential learning theorist such as Kolb and Kolb (2012) have argued that one of the best ways to 'know a thing' is through experience and reflection. Therefore, the best way to know a thing – which is as yet undefined – will be to find out from those who have experienced it. Consequently,

as explained by Lakoff and Johnson (1980), the human conceptual system is both metaphorical and non-metaphorical. They argued that the non-metaphorical concepts are those that are directly drawn from the lived experiences of people and defined in their terms. The metaphorical concepts are those meanings derived from other theoretical ideas of the phenomenon. The concern of this study is to understand how the non-metaphorical (experiential) meaning of active ageing compares with the metaphorical meaning (WHO model). Thus, conceptualisation of active ageing in this study relies on the non-metaphorical aspect of knowing things (lived experience), and on the analysis of the metaphorical aspects of knowing things.

The 'active ageing' concept was proposed by the World Health Organisation (WHO) in 2002, as: "The process of optimising opportunities for health, participation and security to enhance a quality of life as people age" (WHO, 2002, p. 12). There are three distinct pillars of active ageing according to the WHO: health, participation and security. The health component deals with issues of health promotion and prevention; participation relates to being actively involved in the social, cultural and economic life of society; and the security pillar deals with independence, safety and security of older people. Figure 2.1 is the conceptual framework of active ageing adapted from the WHO's model for this study. The purpose of adapting the WHO model is to investigate how the experiences of research participants fit the model.

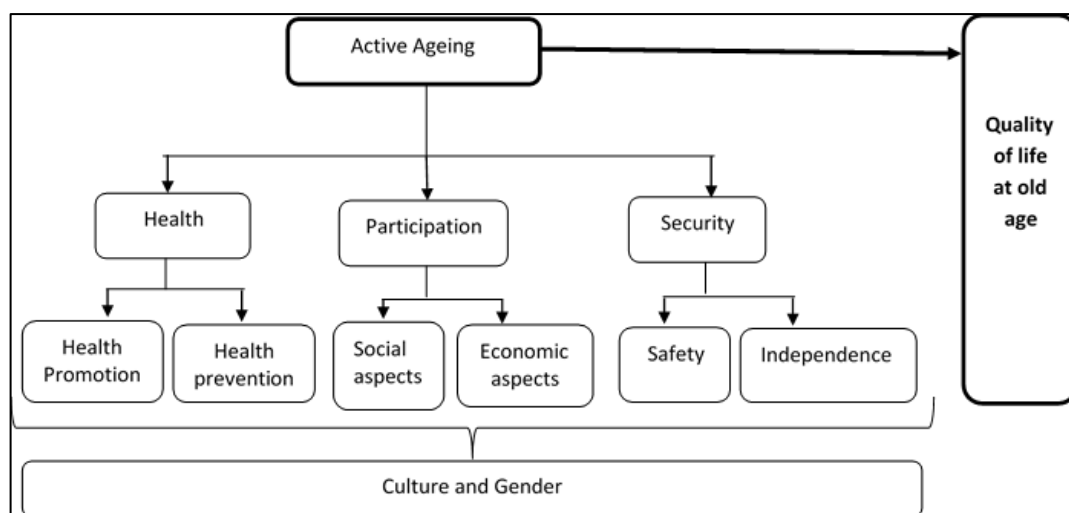


Figure 2.1: A conceptual framework of active ageing

Source: Authors construction based on the understanding of the WHO model

In addition to the above, in conceptualising and measuring 'active ageing', WHO (2002) outlined six primary determinants of active ageing, which provided measurement indicators for the model: economic, health and social service, social, physical environment, personal, and behavioural. Overall, the economic determinant comprises income, work, pension, and social protection for older people. Constança et al. (2012) stated that the determinant of health and social services emphasised the promotion of health and the prevention of disease with equitable access to quality care services. The social determinant is concerned with social support for older people, issues of abuse and violence against older people, and opportunities for continuous education. The physical environment determinant relates to issues of providing a friendly environment, falls prevention, safety, and the state of the environment for older people. Personal determinant includes the unique biological and genetic makeup of the individual. It also includes other psychological factors, such as mental and cognitive functioning and the behavioural determinant is concerned with lifestyle issues, such as smoking, physical activity food intake, oral health, alcohol use and medication. Finally, gender and culture are integrated into each of these dimensions (Constança et al., 2012; World Health Organization, 2002).

The reason for adapting and testing this model is based on arguments advanced by Constança et al.(2012), Boudiny (2013), Walker (2002), and several other researchers that whereas the WHO's framework broadly captured essential aspects of biological, psychological and social determinants of ageing at the conceptual level, the actual measurement of these concepts at the micro level have focused mostly on health, work, and activity (Boudiny, 2013; Walker, 2002). In addition, Constança et al.(2012) argued that the issue of the complex relationship among all the determinants of active ageing has not received adequate attention in both policy and research. In particular, there has not been sufficient research about the extent to which the political environment, which is shaped by other external factors, affects the six critical determinants of active ageing in a given context. The neglect of the influence of the political environment is one of the interest areas for

this study. The other interest area has been previously stated: understanding how the model's dimensions fit with lived experiences of older people.

The WHO's active ageing model has received several criticisms. For example, Minkler and Holstein (2008) argued that making active ageing the ideal strategy for global ageing might be 'counterproductive and oppressive' as it appears to compel all countries to adopt it. Furthermore, the notion of being 'active' itself has the tendency to reduce country-level ageing policies to promoting physical activity at the expense of other equally important aspects of ageing (Barrett & McGoldrick, 2013). Also, the fact that agencies such as Government Ministries and Departments drive the expectations of active ageing means that national level policy processes may not be congruent with the experiences of all older people (Reed, Cook, Childs, & Hall, 2003). Walker (2002) argued that there is a high risk of the philosophy of active ageing becoming coercive and overbearing because all countries feel obliged to adopt the model; however irrelevant it may be for their particularised setting.

Furthermore, WHO (2002), stated that active ageing is an extension of the general determinants of health; thus extending the focus of health to ageing, has the tendency to reduce other considerations of the complex and dynamic process of ageing. On the other hand, Dodge et al. (2012) argued that conceptualising active ageing simply as an 'extension to determinants of health', may lead to a limited understanding and narrow application of the active ageing philosophy everywhere. Boudiny (2013) observed that given the nature of the concept of active ageing, apart from health considerations, many of the debates have also focused on the economic aspects of being 'active' without any significant recognition for the overall framework.

Constança et al. (2012) argued that even though the WHO has proposed a multidimensional approach to active ageing, its interpretation in the literature and some national level policy actions have mostly focused on labour market participation with a strong focus on health. There is also some emphasis on employment, health, pension, retirement, and citizenship (Walker 2002; 2006), which blurs the opportunity for exploring other aspects of the ageing process. Given the above criticism of the active ageing concept, Walker and Foster (2013)

and Bousquet et al. (2015) have contended that the time has come for older people themselves to be more involved in defining what active ageing means. This suggestion supports the aim of this research to seek greater understanding of active ageing based on the lived experiences of a sample of 30 older people using an interpretive phenomenological approach. The next section of the conceptual discussion will focus on the concept of 'quality of life' within the context of ageing.

Another important concept in this study is 'quality of life' of older people. The concept is sometimes used interchangeably with active ageing but is mostly considered as an outcome of active ageing, according to the WHO (2002). Butterworth, Steer and Whitney-Thomas (1997) asserted that the concept of quality of life is a unique personal construct, which cannot be easily defined due to the level of differences between people. The WHO (2002.pg 13) defined quality of life as:

An individual's perception of his or her position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept, incorporating in a complex way a person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features in the environment (WHO, 2002, pg13, 1994)

From the WHO's definition above, quality of life comprises physical health, psychological state, independence, social relationships, beliefs and influences of the environment. Physical health in this case, refers to the absence of disease and general wellness of the body. Psychological state refers to the mental and cognitive stability of the individual; independence refers to the functional ability to perform an activity without any limitation; and social relationship refers to having supports from families and friend. Personal belief deals with the notion of religion and faith practice that provide satisfaction to the individual; and the role of the environment relate with how socio-cultural norms affect the individual's satisfaction with life. Lawton (2014) stated that quality of life of older people is complex and multi-dimensional, which means there are several aspects to its meaning.

Quality of life according to Lawton (2015) involves the evaluation of intrapersonal and social-normative criteria of a person's environment from the past, at present and in the future. Evaluation in this instance refers to considerations for both positive and negative aspects of life's satisfaction. The social-normative criteria refer to standardised socially defined quality of life, which provides an objective understanding for interpreting a person's subjective view of quality of life.

Butterworth (1997) outlined eight dimensions of quality of life. They include the emotional aspects of life, which comprise a state of happiness and satisfaction with life, physical wellbeing, interpersonal relationships, measuring the extent of social ties and connections of the individual, material satisfaction, social inclusion, personal development and rights.

In line with the life course perspective of ageing outlined above, the study conceptualises 'quality of life' as a two-dimensional phenomenon. The life course perspective assumes that the state of later-life experiences is directly dependent on experiences from birth throughout the life course (Bengtson et al., 2012; Komp & Johansson, 2015). Within the life-course perspective are issues of social network systems and individual level factors referred to as micro-level life course issues, and the wider macro level or systemic problems such as policies and programs (Komp & Johansson, 2015; Stowe & Cooney, 2015). Thus, life course proposes a combination of both macro and micro level factors to shape the quality of life at old age. The two dimensions of quality individual and community level factors, collectively referred to as social interaction, and the macro level factors which are concerned with state level or wider policy and legislative environment in which older people live. The macro level factors are collectively termed as service provision. The study therefore argues that quality of life of older people should be understood from the two dimensions stated above.

Social interaction in the study refers to individual level factors, which include the level of social capital--social network available to the individual, opportunities for continuous activity and work life, and income-related issues (Stowe & Cooney, 2015). Within the life course approach, family connectedness through the linked

lives principle is critical in the understanding of the quality of life at old age (Bengtson & Allen, 2009; Huinink & Feldhaus, 2009). Macro-level issues, on the other hand, comprise the overall structural and policy environment embodied in service provisions that affect the individual level factors from birth up to old age. This conceptualisation connects with the political economy perspective of ageing discussed above. Each of these two dimensions has its particular sub-dimensions and indicators within which to understand quality of life. Figure 2.2 provides the details of the conceptual framework of quality of life.

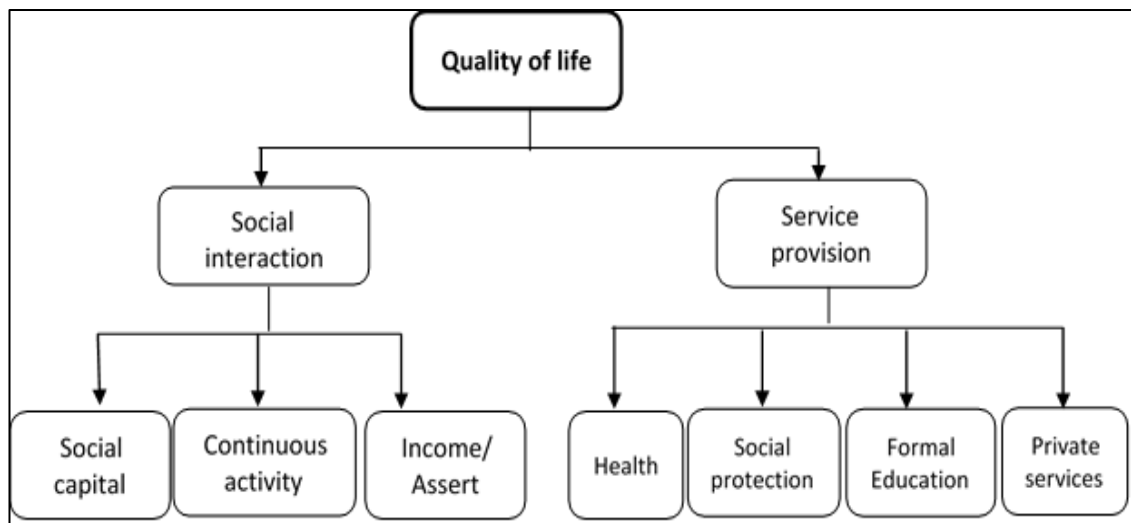


Figure 2.2: Conceptual framework of 'quality of life' in old age

Source: authors construct based of different literature sources

Theoretically, social interaction is critical for understanding later life experiences and the quality of life (Ageing & Unit, 2008; Bowling & Stafford, 2007; Grundy, Fletcher, Smith, & Lamping, 2007), and is grounded in the ideals of social functioning, or what Donald, Ware Jr, Brook, and Davies-Avery (1978) termed as 'social health'. According to Berkman and Glass (2000), social interaction comprises interpersonal engagement and the level of social participation of the individual. In this study, social interaction is made up of social capital, continuous activity, income/ assets and considerations for the nature of the lifestyle of the individual. Figure 2.2 shows that social interaction comprises social capital, which measures the individual's level of family relationships/interaction and other social networks systems that the person uses (Adams, Leibbrandt, & Moon, 2011; Cramm, Van Dijk, & Nieboer, 2013).

Rowe and Kahn (1987) cited social interaction in their work by introducing the concept of active engagement with life in their model of successful ageing. In this sense, social interaction has everything to do with how the individual functions in society relative to the family and to every other person. As demonstrated by Baltes and Baltes (1990), at old age, social interaction can help compensate for other health-related issues associated with ageing. Overall, the central issues within social interaction, as shown in this study, relate principally to matters of family relationship and cohesion, opportunities to talk with someone, physical presence, membership of associations or the extent of social networking, friendship and play. It is also noted that the functionality of social interaction depends largely on the nature and level of activity between the individual and other people within the social network (Adams et al., 2011; Hong, Hasche, & Bowland, 2009; Silverstein & Parker, 2002).

According to Lemon, Bengtson, and Peterson (1972), the continuity of role performance or role replacement through an appropriate activity in a supportive familial environment significantly contributes to the individual's sense of meaning or purpose and maintenance of a sense of identity. Furthermore, Adams et al. (2011) argued that the income or assets of older persons at old age facilitate the functionality of social interaction. In addition to these, social interaction is known to have a significant influence on physical and mental health especially for older people (Seeman, Lusignolo, Albert, & Berkman, 2001). In their work on the meaning of active ageing among older Australians, Buys and Miller (2006) stressed that older Australians placed the subject of social interaction above everything else as critical in their well-being.

The second dimension of service provision refers to public policies and programs that have implications for the quality of life at old age. Morel, Palier, and Palme (2012) asserted that public investment in social services could significantly address challenges associated with old age. This suggests that public social investments are imperative in modern welfare states in dealing with issues related to population ageing (Vandenbroucke, Hemerijck, & Palier, 2011). In this study, the essential services considered comprise health services, social protection services

and education services. Areas of focus regarding healthcare services included in this study: availability of health services, their accessibility (geographical) and affordability (financial access); and acceptability of allied health schemes, such as national health insurance (see Tanahashi, 1978; Adusei-Asante and Doh, 2016). Regarding social protection services, the essential services considered in the study included contributory-based pensions, non-contributory based cash transfers, old age pension, and subsidised public services (Bloom et al., 2011). In addition to these, the study also considers private level service provisions such as those services provided by not-for-profit organisations and faith-based institutions (Chestnov, Obermeyer, St John, Van Hilten, & Kulikov, 2014; L. Wong & Jun, 2006).

In conclusion, the chapter has discussed the life course approach as the theoretical basis for the study. Two central concepts: active ageing and quality of life have been discussed. The two concepts, as discussed above, provide the focus of this study, which include exploring the conceptual fit between active ageing and the experiences of research participants. The discussion also included examining different qualities of life of research participants and the factors that contribute to higher quality of life. The next chapter is a literature review of active ageing and the quality of life of older people. The review focuses on health and active ageing, social interaction, activity and the care of older people in contemporary society.

CHAPTER THREE: ACTIVE AGEING AND QUALITY OF LIFE: A LITERATURE REVIEW

3. Introduction

This chapter reviews the literature on the relationship between ageing and health and the role of active ageing in promoting the quality of life at old age. The chapter also reviews literature on older people's social interaction, independence and an issue associated with ageing, which is quality of life during old age. The research on social interaction focuses on the role of social capital, including families, friends and other social network systems in shaping the quality of life at old age. Also, there is discussion of previous research on the relevance of activity, work and employment for people during old age. The chapter also considers the topic of care of the older people in contemporary society, which draws on current practices around the world. The conclusion of the chapter indicates the central gap in the overall literature, which warrants the need for the current study.

3.1 Health and Ageing

The health of older people together with the associated issues of their quality of life has been one of the most important topics discussed in the ageing literature (Andrews, 2009; Organization, 2015). The World Health Organization (2015), for example, reported in 2015 that there was an urgent need for public health action on demographic ageing because health issues threatened the essence of quality life for people at old age (World Health Organization, 2015). Ellen, Panisset, de Carvalho, Goodwin, and Beard (2017), argued that ageing comes with some health complications that require concerted efforts from all stakeholders. These authors argued that ageing has generally become a phase of life for enduring chronic health conditions, disability, dementia and cognitive impairments. Similarly, Gagliardi, Papa, Postacchini, and Giuli (2016) noted that several health conditions are associated with human ageing, especially pointed out the rising incidence of dementia and other cognitive impairments; they also discussed the extent to which physical activity might prevent or treat such conditions.

Other researchers have emphasised that ageing increases the likelihood in the adult population of diabetes, obesity, cardiovascular conditions, arteriolosclerosis, oral health, cancer, and osteoporosis (Briggs et al., 2016; Ighodaro et al., 2017; Scannapieco & Cantos, 2016). According to a WHO report authored by Beard et al. (2016), although bed-ridden disability among the aged has shown a slight decline globally, there has been no significant reduction of levels of severe disability among old people in the past 30 years.

One of the diseases associated with ageing is dementia. World Health Organization (2012) indicated that the incidence of dementia was rising, especially among older people. The global incidence of dementia in 2010, according to the WHO report was 35.6 million people, and it was projected to increase to 65.7 million by 2020. Each year, a total of 7.7 million new cases of dementia are recorded (World Health Organization, 2012). A previous WHO's report on the Global Burden of Diseases issued in 2003 had indicated that dementia alone contributed 11.2 per cent of years lived with disability in people aged 60 years and older. The figure for dementia was higher than for stroke (9.5%), musculoskeletal disorders (8.9%), cardiovascular disease (5.0%), and all forms of cancer (2.4%), according to Ferri et al. (2006). The 2015 World Alzheimer Report 2015 showed that more than 46 million people live with dementia globally, and this is projected to rise to 131.5 million by 2050 (Prince et al., 2015). Thus, dementia remains one of the major health conditions affecting older people in many parts of the world (Jones & Greene, 2016; Matthews et al., 2016), however the rates are different for the different regions of the World. For example, in 2015, there were 9.4 million people living with dementia in the Americas (North and South), 10.5 million in Europe, 4.0 million in Africa and 22.9 million in Asia (Prince et al., 2015). Overall, 58 per cent of the total global dementia population live in developing countries, and this is projected to rise to 68 per cent by 2050 (Prince et al., 2015; Wu et al., 2016). Gagliardi et al. (2016) and Wu et al. (2016) attributed the predicted increase of dementia in developing countries to poor awareness and health care systems which have virtually ignored risk factors such as cardiovascular diseases (i.e. hypertension), smoking, diabetes (Type II) and hyperlipidaemia. Accordingly,

dementia was projected to represent a huge proportion of disease burden and cost of health care in developing and developed countries.

Another health condition strongly associated with ageing is diabetes. Research has identified a rising incidence of diabetes (Type II) among older people throughout the world. For example, the 2013 global diabetes prevalence rate, according to the International Diabetes Federation (2013), had doubled over the preceding two decades, with some 80 per cent of cases found in low-income and middle-income countries (See, Werfalli, Engel, Musekiwa, Kengne, & Levitt, 2016). Werfalli et al. (2016) asserted that Africa was among the fastest growing regions for diabetes, with an annual average estimate between 2007 and 2015, 3.1 per cent for persons aged 55 years and older. This percentage was higher than the global average, and was also projected to appreciate further to 3.3 per cent between 2015 and 2050. Werfalli et al. (2016) further argued that although diabetes incidence in people aged 60-79 was 18.8 per cent in Africa currently; the region remained highly susceptible to incidences of diabetes (Type II), given the 43.2 per cent population growth rates in people aged 40-59 years. Trends in Europe are somewhat similar to those in Africa. The proportion of the European population predicted to be over 60 years by 2050 is one third; and Williams (2009) has predicted that accordingly diabetes (Type II) would increase significantly.

In terms of managing diabetic conditions, Manas and Sinclair (2017) noted that positive changes in lifestyle and people's increasing ability to control chronic medical condition would possibly delay mortality compared to the current prognosis. To this end, Manas and Sinclair (2017) advocated for the avoidance of proximal risk factors such as functional decline, manifest frailty and disability resulting from obesity, sedentary lifestyle, osteoarthritis, peripheral neuropathy and vascular diseases, chronic obstructive pulmonary disease, and cancer.

A third disease condition strongly associated with human ageing is hypertension. Globally, hypertension is a cause of death in a high proportion of older people in many parts of the world. For example, in Chad, 3.8 per cent of older people died of hypertension whereas in Georgia, USA, as many as 40.4 per cent of reported deaths related to hypertension (Lloyd-Jones, 2017). Like diabetes,

hypertension is attributed to genetic factors, lifestyle, ageing, and demographic and socio-economic risk conditions. Overall, hypertension is now a public health issue, and it cuts across the adult age spectrum (Lloyd-Jones, 2017). According to Lloyd-Jones (2017), the United States National Health and Nutrition Examination Survey spanning 2011 and 2014 yielded 29 per cent hypertension prevalence among the adult population aged 18 years and above. In many countries, reliable data on hypertension and its associated conditions are not readily available. In Australia, for instance, CVDs accounted for 13.9 per cent of all deaths in 2010, and the percentage is higher among the aged, yet a national health survey published in 2016 revealed substantial levels of underreporting of hypertension related cases (Peterson, Jacobs, Allender, Alston, & Nichols, 2016).

Another disease strongly related to ageing is cancer. According to Torre, Siegel, Ward, and Jemal (2016), cancer is the new leading cause of mortality worldwide; and, furthermore, high cancer prevalence in the aged population occurs regardless of the development status of countries. Torre et al. (2016, p. 16) stated that the global occurrence of high levels of cancers stems in part from lifestyle choices and exposure to risk factors; some of which include the use of tobacco, physical inactivity, excess body weight, and reproductive patterns. Torre et al. (2016), Wong et al. (2016) and Hashim et al. (2016) posited that lung, prostate, breast and colorectum cancers, which were previously typical of high-income countries (HICs), are fast becoming endemic in many low and middle-income countries (LMICs) due to their adoption of western lifestyles.

Wong et al. (2016) identified prostate cancer (PCa) as a leading cause of death and sickness in LMICs, and it was on the ascendency in HICs. Records from the US Center for Disease Control and Prevention quantifies new cases of prostate cancer in the US at 233,000 in 2014 alone (Bhuyan et al., 2017). M. C. Wong et al. (2016) envisage increases in absolute PCa incidence due to growing life expectancy; and they urged policy-makers to turn their attention to this pandemic.

Ellen et al. (2017), working to develop evidence-informed health strategies for the aged in Brazil, have identified ischaemic heart disease, stroke and chronic obstructive pulmonary disease (COPD) as some of the most prevalent diseases that

accompany ageing in developing countries. The ability to cope with COPD is more precarious in LMICs given that level of the ageing population tend to be expanding faster, for example, it took Brazil only two decades for the older population to double whereas in France, the doubling took 100 years. Ellen et al. (2017) proposed that the health needs of the aged need to be managed within the framework of cultural, financial, services and human resources availability; emphasising that knowledge in the field of ageing and health must guide the management process.

Health in old age is largely associated with chronic diseases such as diabetes, hypertension, cancers, cardiovascular, kidney, dementia and cognitive impairment. However, McClintock, Dale, Laumann, and Waite (2016) argued that restricting definitions of health in old age to mean the absence of the diseases is not adequate. In light of this, the WHO's definition since 1956 of what constituted good health remains a useful contextual framework for developing the principles of active ageing (cited in McClintock et al., 2016, p. 3071): The WHO's definition of health is, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

The goals of active ageing involve a broad range of activities to keep the aged economically, socially, politically, medically and psychologically active in the last stage of life. Active ageing is designed to maximise the older population's ability to continue to participate meaningfully in the day-to-day activities of society within the limits of their strength, needs, interest and abilities (Dajak, Mastilica, Orešković, & Vuletić, 2016). At the same time, active ageing is intended to delay the onset of health complications that can negatively impact the individual's ability to enjoy an independent life, and remain useful to society and self (Ainsworth, 2016; Büla, 2016; Groot et al., 2016). The WHO's definition of the concept reiterates the primacy and the correlation between ageing actively, health and health care of the aged. As previously stated in Chapter Two, the WHO defined the active ageing concept as a "process of optimising opportunities for health, participation and security to enhance the quality of life as people age" (World Health Organization, 2007, p. 5). The definition is an embodiment of culture and individual differences,

gender, personal, economic, social, health and social services, physical environment and behavioral factors (World Health Organization, 2007).

Researchers of the health complications mentioned above have emphasised the avoidance of lifestyle risk factors as the most effective ways of ageing actively. In the same vein, Boudiny (2013) argued that the fulcrum of the concept of active ageing should be the entirety of the life course of individuals, which entails focusing attention on 'healthy ageing' and 'productive ageing' such that the needs of the aged are not compromised (Boudiny, 2013). Boudiny (2013) also acknowledged that active ageing goes beyond considerations for economic engagement or involvement in physical activities to include health conscious processes that ensure older people's adaptability, such as the "maintenance of emotionally close relationships and removing structural barriers related to age or dependency" (Boudiny, 2013, p. 1077). To avoid misconceptions about Boudiny's proposition, the Boudiny formulated four thematic phases of old age which serve as a focal point for active ageing and health policy makers: "preretirement health; living independently as a retiree; "early dependent living; and 'dependent living up until death" (Boudiny, 2013, p. 1093). The author also distinguished between healthy young-old and frail old-old. This latter notion corresponds with the views of Kribernegg, Maeirhofer & Mörtl, 2011; cited in Boudiny (2013) that active ageing should centre on "empowering...the healthy young-old by encouraging them to remain active, and by providing them with the opportunities to do so.

3.2 Ageing and physical activity

Physical activity is acclaimed by many researchers to be crucial for managing most disease conditions, such as cognitive decline and dementia, if factored into the life course of the individual (Ainsworth, 2016; Büla, 2016; Devereux-Fitzgerald, Powell, Dewhurst, & French, 2016). The (World Health Organization, 2015) ranked physical inactivity as the fourth highest risk factor for mortality and the burden of diseases amongst the aged across the world (Devereux-Fitzgerald et al., 2016). Büla (2016) asserted that primary and clinical data from observational studies and interventional trials have lent credence to the importance of physical activities and exercise such as aerobics and walking as the most effective and essential

intervention strategies for improving cognitive impairment and dementia in older people. In the words of Bauman, Merom, Bull, Buchner, and Singh (2016), physical activity (PA) is one of the most important strategies for delaying the morbidity associated with ageing.

Furthermore, Devereux-Fitzgerald et al. (2016, p. 269) agreed with the WHO that physical inactivity is the underlying cause of "cardiovascular diseases, Type (II) diabetes, and some cancers ... these conditions can lead to impairment, disability or death" among persons aged 65 years and above (WHO, 2010a, cited in Bhuyan et al., 2017; Devereux-Fitzgerald et al., 2016, p. 14). Bauman et al. (2016) and Devereux-Fitzgerald et al. (2016) have accordingly advocated that health policy intervention programs concerning PA for the aged must necessarily incorporate what they term 'pull factors' that project health values as well as physical enjoyment.

In their paper, *Experiences of Habitual Physical Activity in Maintaining Roles and Functioning Among Older Adults*, Halaweh, Svantesson, and Willén (2016) pointed out the specific regular physical activities that are consistent with the maintenance and the preservation of active roles in old age. Some of these include walking, cycling, household chores, gardening, games and sports, family and community roles (Halaweh et al., 2016). Ainsworth (2016) underscored the need for community leaders and governmental policy decision makers regarding the well-being of the aged to be aware of the physical activity needs of the aged. Ainsworth argued that active ageing policies should provide supportive environments for older adults that will contribute to their maintenance of active and healthy lifestyles. The most vital strategy for maintaining physical activity and active functioning among the aged, the study concluded, is walking.

Furthermore, in investigating the differences in self-estimated quality of life between active ageing and passive ageing from the perspectives of old people, Dajak et al. (2016) measured the variables of physical and social functioning, limitations due to physical and emotional difficulties, mental health, energy and vitality, pain, and overall health. On the whole, all variables scored active ageing much higher than passive ageing. Their proposition, therefore, is that elderly

persons are better off physically, socially and mentally if they remain active in all spheres of political, economic and social endeavours. Thus, Gagliardi et al. (2016) stated that a lack of social engagement will likely lead to a low quality of life, adverse health outcomes, functional decline and mortality in old age.

The debate about physical activity is reinforced by the need to safeguard the psychosocial and physical health of the aged as advocated by activity theory, which strongly endorses the maintenance of social roles and activities to improve the quality of life in older age (Bowling, 2008, p. 293). In other words, any policy or institutional arrangement that denies the healthy-aged an active participation in all domains of social endeavour, within the limits of their strength, has negative outcomes for the health of the individual. Therefore, health policies for older people should strongly focus on the older person's rights and entitlements; including ensuring the creation of an age-friendly physical environment (Bowling, 2008, p. 294).

Phoenix and Tulle (2017) and Chaudhury, Campo, Michael, and Mahmood (2016) reinforced the important role of physical activity in delaying health decline among old people by stressing that intervention policies must address issues of access. Phoenix and Tulle argued that physical activity is central to the general fitness of all individuals, and recognised the need for creating awareness across the following disciplines "health science, social gerontology, sociology of sports, and geography" (Phoenix & Tulle, 2017, p. 1). Chaudhury et al. (2016) proposed a neighbourhood socio-physical environment with particular reference to the home, such that the desired attention is paid to such issues as cost, routine, proximity, intensity, formality/informality, sustainability and levels of social interaction and support. Phoenix and Tulle (2017) reiterated that a central issue which presents a challenge for older people's ability to engage in physical activity is the disconnect between physical activity, policy prescriptions and practices, and the lived experiences of older people. Older adults require special kinds of interactive physical activities that induce a sense of belonging, which itself is a worthwhile impact of exercise on health.

Nies, Troutman-Jordan, Branche, Moore-Harrison, and Hohensee (2013) identified three factors that enhanced the interest of people and their preparedness to participate in physical activity in the United States. These included the excitement for fitness, physical activity in a group, and the safe location for physical activity. In effect, Nies et al. found that physical activity must lead to emotional satisfaction and socialisation through bridging and linking relationships, and must be in a safe environment. However, access to such conducive conditions may not come cheaply. Kok, Aartsen, Deeg, and Huisman (2016) found that the key factors that influence participation in physical activity, health and well-being in old age among older Dutch were educational attainment, occupation and income. Apart from deepening social inequalities, Kok et al. (2016) noted that low income had a far-reaching ramification for people's cognitive or psychological functioning because it can limit efforts to avoid physical disability due to their financial constraints on accessing needed healthcare (Kok et al., 2016; Nies et al., 2013; Phoenix & Tulle, 2017).

3.3 Ageing, social interaction and quality of life

Some researchers have focused on the positive relationship between social interaction and quality of life in old age (Bowling & Stafford, 2007; Derksen et al., 2015; Grundy et al., 2007; World Health Organization, 2008). A person's social interaction can be determined by the extent of the person's integration into the overall social life of a group of people. It also refers to the overall interpersonal interaction and the level of social participation of the individual (Berkman & Glass, 2000). Abbott and Pachucki (2016) argued that the maintenance of physical and mental health in old age is dependent on the nature and level of social interaction or social integration. Similarly, Algar, Woods, and Windle (2016) acknowledged the significant role of social interaction in promoting quality health for people in old age.

Pillemer et al. (2016) stated that social interaction for older people represents their continuous engagement in economic or income generating activities, or community volunteerism, and their relationship with peers and family members as well as establishing new social networks. Liao and Brunner (2016)

noted dimensions of social relation that have implications for quality of life at old age. These include "the avoidance of negative aspects of close relationships; having confiding support; having an extensive network of friends; and having a partner" (Liao & Brunner, 2016, p. 160). Furthermore, as observed by Abbott and Pachucki (2016), one of the reasons for the increasing vulnerability of older people to chronic illness and disability is their shrinking levels of socialisation and social networking (Abbott & Pachucki, 2016; Huxhold, Miche, & Schüz, 2014; McHugh Power, Tang, Lawlor, Kenny, & Kee, 2016). According to Chipps and Jarvis (2016), the indicators of social isolation are: social exclusion, rejection, apparent social disconnection, inability to build social networks, and sometimes difficulty in forging personal social relationships. Social isolation typically results in deleterious health repercussions (Chipps & Jarvis, 2016; de Jong Gierveld, Van Tilburg, & Dykstra, 2016; Mohd, Senadjki, & Mansor, 2016). K. B. Adams et al. (2011) asserted that social interaction is the primary predictor of well-being at old age. Similarly, Darteh et al. (2016) confirmed the importance of familial relationships in promoting the quality of life at old age.

Social interactions and integration are of immense significance to the physical and mental health of the aged (Abbott & Pachucki, 2016; Algar et al., 2016). Dementia, for example, has no curative treatments as yet; therefore, social integration is recommended as the most useful strategy in promoting the quality of life for older people living (Abbott & Pachucki, 2016; Algar et al., 2016; Liao & Brunner, 2016). In their work, *Social Relationships and Mortality Risk: A Meta-analytic Review*, Holt-Lunstad, Smith, and Layton (2010) conducted a multidimensional assessment of social integration and reported that older people with satisfactory social relationships have up to 91 per cent chance of living longer and with better health. And in a longitudinal social network study, Yang, Boen, and Mullan Harris (2015) found that increased social connections prospectively reduced the risk of hypertension by lowered systolic blood pressure in older persons.

Furthermore, evaluating the importance of structural and functional social relationships for quality of life, and the extent to which diagnosed chronic diseases modify these associations, Liao and Brunner (2016) identified the following four

mutually related social relation elements that augment, sustain and promote quality of life in the old aged beyond the medical perspective of ageing: “(a) avoiding negative aspects of close relationships; (b) having confiding support; (c) having an extensive network of friends; and (d) having a partner” (Liao & Brunner, 2016, p. 160). Menkin, Robles, Gruenewald, Tanner, and Seeman (2016) agreed with Huxhold et al. (2014) on the importance of social relationships, adding that subjective well-being (SWB) is best nurtured by social relationships at old age and driven fundamentally by the opportunity for participation (Huxhold et al., 2014). Huxhold et al. (2014), further suggested that there are different depths of informal social activities that promote well-being in old age, depending on the quality of structural and functional dimensions of the relationship. They asserted that the qualitative effect of relationship on well-being resonates with the degree of fulfilment in the anticipated outcome; and that older people who keep both obligatory (family) and voluntary (friends) relationships age with better health and more actively (Huxhold et al., 2014). They also explained that as older people get bonded into voluntary relationships, they become mentally healthier by exploring opportunities for supporting their peers in “building and maintaining friend-based social networks. For example, by encouraging volunteering in old age in elder-helping-elder programmes, or programmes aiming at increasing informal social interactions, such as cultural programmes, university programmes, or occupational therapy programmes” (Huxhold et al., 2014, p. 374). Given the unique psychosocial, physical and mental age-related changes that influence social perspectives of older people, informal socialising with friends appears to compare favourably with family interactions (Huxhold et al., 2014; Menkin et al., 2016).

Chipps and Jarvis (2016) and Coll-Planas et al. (2016) echoed the protective health dynamic and structural impacts of social capital on the self-perceived health, especially the quality of life and the general well-being of older people. Coll-Planas et al (2016) reviewed the concept of social capital within the context of three defining components – the objective or structural component, the cognitive or subjective component, and the bonding/bridging or linking element. Under this classification, they placed social networks, social contacts, and participation in the

domain of objective or structural social capital. Social support, sense of belonging and trust came under cognitive or subjective social capital, depending on the directions of social ties (i.e. intra-group bonding, bridging gaps between diverse groups). And finally, they assessed the relationship between people who possessed different wealth, power and status (Coll-Planas et al., 2016, p. 1). However, Chipps and Jarvis (2016) questioned whether the presence of the above elements *per se* constitute satisfactory quality of life for older people, unless they lead to improvements in quality of life, level of trust, level of independence, happiness and social engagement. Social relationship ought to trigger well-being by serving as a precursor for an increased frequency of interaction among group members; as well as mental well-being markers. These include positive affect, optimism, life satisfaction, trust and hopefulness" (Blazer, 2002; Gallagher & Lopez, 2009; Nyqvist et al., 2012, reviewed in Chipps & Jarvis, 2016).

Another distinctive marker in the social capital research and policy discourse is ageing in place (AIP). The *Centre for Disease Control and Prevention* in the United State defined AIP as being able to live in one's home and community safely, independently, and comfortably, regardless of age, income, or ability level" (Centres for Disease Control and Prevention, 2016; quoted in Jiang, Lou, & Lu, 2016, p. 1). It is assumed that globally AIP allows wide-ranging opportunities to optimise the advantages the family system offers to older people. It also includes what older people can offer the family in return (Paltasingh & Tyagi, 2017). In the context of AIP, allowing older people to stay with their families will avoid the high cost of institutional care without compromising cultural norms and values. AIP entails the "maintenance of a sense of independence, autonomy, attachment, connection to social support, security and familiarity (Jiang et al., 2016, p. 1) which is weighed up against loneliness. According to Paltasingh and Tyagi (2017), in modern Indian societies where parents are often busy with jobs, grandparents become significant to the younger generation by caring for them. This intergenerational support promotes a mutual affinity between grandchildren and grandparents while boosting well-being and mental health for both parties. Rico-Uribe et al. (2016) and

de Jong Gierveld et al. (2016) undertook studies into the health implications of loneliness.

Rico-Urbe, in a three-country study involving Finland, Poland and Spain, discovered that loneliness was the most strongly correlated variable to poor health after controlling for depression, age, and other covariates. Indeed, the result confirmed earlier postulates that old adults who are lonely have more challenges with their heart functioning than those who have affinities; furthermore, "they are more likely to present deterioration in the immunological system and obesity, poorer sleep efficiency and quality, depressive symptomatology, alcoholism, Alzheimer's disease, and suicidal ideation and behaviour" (Rico-Urbe et al., 2016, p. 2).

3.3 Ageing, social activity, employment and income

There are important discussions in the literature about the subjects of income, social activity and employment among older people and the extent to which these actors can affect the quality of life in old age. On income and ageing, for example, Abiola (2016) reiterated that healthy ageing is dependent on effective social integration which is contingent to a large extent by financial resource endowment that tends to correlate with maintenance of social status, social connectedness and the capability to afford participation in physical activity. Van der Geest (1997) argued that money is used to maintain social bonds at old age. Contrary to Van der Geest (1997), K. B. Adams et al. (2011) found out that when the effects of the quality of the social relationship are controlled in a regression analysis the amount of income did not impact well-being at old age. K. B. Adams et al. (2011) concluded that money was linked to quality of life in old age when there was a social interactive context for the money to be spent. Money, therefore, served as a medium for maintaining social relationships even into old age.

Other researchers have found that income at old age predicted the willingness for older people to access services (Heinrich, Rapp, Rissmann, Becker, & König, 2010; Macha et al., 2012; Xu et al., 2003). For example, (De Nardi, French, & Jones, 2009) found that older people who had a reasonable level of financial resources were better able to pay for specialised services when needed. Likewise,

Rehnberg and Fritzell (2016) found that a healthy lifestyle was hugely dependent on income or wealth level, and had a direct relationship with the quality of health care available to the individual through the life course. They also claimed that poverty at old age destroyed independence and constrained the overall welfare of older people.

Hwang (2016), studied pension income inequalities in South Korea and discovered that the factors accounting for the widening income disparities among older people were embedded in the structure of the pension scheme and the interactive and complex nature of old age incomes. Foos, Clark, and Terrell (2006) found that in North Carolina, in spite of the importance of physical activity in old age, income disparities did not allow equal access among black and white older people; this finding showed that income was a factor working against the optimisation of exercise. While white older adults considered this period as their happiest time, the same was not said by their relatively poorer black counterparts (Foos, Clark, and Terrell, 2006; cited in Nies et al., 2013). In effect, income, money or any economic assets are valuable contributors to the quality of life of older people.

Closely related to the notion of social interaction is social activity. In Korea, Choi, Lee, Shin, Kwon, and Park (2016) explored the impact of social activity on quality of life among older people and found a strong correlation between quality of life and social activities such as religious activities, voluntary community work, family reunions, and leisure clubs. Active social contacts and intervention programs, which focus on social roles and activity in the environment of older people, according to Greaves and Farbus (2006), positively impact their health and quality of life. The researchers established small group meetings in the United Kingdom using a mentor-based approach aimed at decreasing the occurrence of what they termed 'emotional and social estrangement'. Based on a six month randomised controlled trial, Greaves and Farbus (2006) found that 108 older women who hitherto lived in isolation acquired higher self-esteem and lower blood pressure.

A similar trial test for older people with depression, called *Programme to Encourage Active, Rewarding Lives for Seniors* was conducted by Greaves and

Farbus (2006) in the United Kingdom for 12 months. After controlling for social and physical activation, depression and health-related quality of life, the results found that the participants improved considerably. Greaves and Farbus (2006) prescribed two main interventions, which in their opinion, comprised gate-keeping: 1) specific problems identified in the community and the right people assigned to deal with them; and 2) group support was provided to enrich friendships and empower participants.

As foreshadowed above, employment and work issues among older people have also received close attention in research concerned with promoting quality of life for older people (Börsch-Supan, Brandt, Litwin, & Weber, 2013; Boudiny, 2013). The assumption is that maximising the economic participation of older people will go a long way towards keeping them healthy. This proposition corresponds with the participation pillar of the WHO's model of active ageing. However, there have been debates about how to promote employment among older people. For example, the WHO recognises that the engagement of older people in employment beyond retirement creates opportunities for participation and income generation, which sustains independence, choice and quality of life (World Health Organization, 2002). And, among many European countries, a core element of active ageing has been to promote employment for older people (European Union, 2012).

Studies have demonstrated that a significant number of older people were willing to continue with work beyond the retirement age, but there have been formidable barriers to older people accessing employment opportunities due to lack of coordinated policy and ageism, that is prejudice against older workers (Georgiou, 2015; Porcellato, Carmichael, Hulme, Ingham, & Prashar, 2010). Notwithstanding, the relationship between employment at old age and active ageing has been well established.

Of course, the employment of older people after retirement is dependent on some conditions. According to Majeed, Forder, Tavener, Vo, and Byles (2017), education and health status are preconditions in determining whether and where older people would be employed. In their study among older Australians aged 65 and above, Majeed et al. (2017) argued that the probability of undertaking paid

employment were higher with educational level. Therefore, more highly educated men and women were more likely to gain regular employment after retirement than those with low levels of education. The authors further asserted that the ability to work declines with age due to poorer physical function and health.

3.4 Approaches to the care of the elderly in contemporary societies

Arguably, caring for older people is a matter of rights. The WHO constitution mandates that it is a fundamental entitlement of all people to have the highest attainable standards of health (Baer, Bhushan, Taleb, Vasquez, & Thomas, 2016). Some of the entitlements of older people include the right to life, as well as social, economic, and cultural rights (Baer et al., 2016, p. 207).

The care provisions for the elderly vary in accordance with countries' cultural and gender dynamics, environment, degree of interdependence, conformity to conventional human rights precepts, and level of socio-economic and political development (Janssen, Jongen, & Schröder-Bäck, 2016; Southwell-Wright, Gowland, & Powell, 2016). Westwood and Daly (2016) noted that in Asia, Africa and most developing countries, there is a bonded relationship between older people and their families and communities; however, in most developed countries, such family bonds hardly exist, making care arrangement different from place to place. Notwithstanding, Westwood and Daly (2016) argued that there is need for policy makers to take a closer look at promoting family and kinship systems in caring for older people. When such policies are made, they will enhance the maintenance of cultural identity, privacy, independence and comfort and quality ageing (van Leeuwen et al. 2014; quoted in Westwood & Daly, 2016, p. 11).

As an example of cultural influences on kinship roles in aged care, in East Asian societies, such as Hong Kong, the relationship between the older folks and the young ones is guided by filial piety embraced by Confucianism (Chong & Liu, 2016). Under the system of filial piety, the young are required to demonstrate an exemplary reverence in their relationship and treatment of older people. For this purpose, children are obliged to live close to their frail elderly parents and take care of them as long as they are alive. However, Chong and Liu (2016) stated that though children and parents show readiness and anticipation to maintaining the traditional

aged care system, there has been a gradual decline in modern generations' beliefs and commitments to filial piety. Chong and Liu's study reveals that the expectations of Chinese adults in Hong Kong about the traditional care regime have dipped very low, even though parents still anticipate adult children will provide them with emotional and companionable support (Chong & Liu, 2016).

Among the Akwapims, a tribal group of Ghana, Coe (2016) observed that adult children felt typically responsible for caring for their aged parents; however, the author noted an additional source of care and support for older people was provided by non-kin and the extended kin members. In contemporary Ghana, for example, adult children currently tend to play more remote roles, such as providing money and other in-kind remittances with the day-to-day care arrangements sometimes being made by non-kin members through negotiations. Coe (2016) also observed that in Ghana, helping an older person depended on previous and expected entrustments. And within this system of entrustment, those who were recruited to provide support were typically individuals who were vulnerable, dependent, and indebted persons to either the older person or the adult children.

The institutionalised health care system is an important source of care for older people in high-income countries. However, quality health care for the aged is beginning to be constrained by income inequalities and pension resources due to the rising number of aged population (Drożdżak & Turek, 2016; Reeves, McKee, Mackenbach, Whitehead, & Stuckler, 2017). Janssen et al. (2016) in their study of Belgium and Netherlands contended that national budgetary allocations to the care of older people were directly linked to supporting the degree of functional disability. Moreover, institutional long-term care providers are deprived of the necessary financial incentives. This development, according to Janssen et al. (2016), has dire repercussions for the care providers and care recipients. In the same study, Janssen et al. asserted that the policy environment for providing "long-term care was a disincentive to non-governmental organisation". In addition, most participants in the study advocated for better residential facilities and biographical, cultural, religious sexual sensitivity in the long-term care services for both patients and personnel (Janssen et al., 2016).

Globally, access to and delivery of palliative care (i.e. relief from pain) has also received considerable attention (Davidson et al., 2016; van der Steen et al., 2014). Davidson et al. (2016) argued that given the cultural connotations of death, policy initiatives and planning in health services must give palliative care the due attention. So that palliative care providers do not get trapped in cultural and ethical dilemmas. Davidson et al. recommended that the cultural competency and professionalism of service providers and community values should be an integral part of the need assessment of those who need care.

Closely linked to the cultural and professional dynamics is adequate funding for caring for the aged (Davidson et al. 2016). The authors asserted that along with sufficient funds comes the advantage of health parity and equity underscored by “approachability, availability, accommodation, affordability and appropriateness, culture....” (Davidson et al., 2016, p. 11).

Pensions and social security used to be a reward for living beyond age 60 because the average life expectancy was below sixty years (Abel-Smith, 2016). But the normal age of retirement keeps increasing (Coile, Milligan, & Wise, 2016), so the pension has become the most reliable guarantee of social protection in old age (Rofman & Apella, 2016). The rationale for social security is to insure individuals against the risk of income and social deprivation in the event of unforeseen hindrances such as disability, illness, accident, or death, but most essentially against retirement and old age (Arza, 2017; Rofman & Apella, 2016). Aikins et al. (2016) investigated various pension reforms and protection intervention schemes for older people in Latin America (Argentina) and Africa (Ghana). They found that social security was more extensive in coverage in Latin America than Africa. Social security schemes comprised those who subscribe to regular social security programmes by employment, non-formal contributors, unemployed and the vulnerable. Social security also included social interventions schemes like non-contributory transfer schemes and health insurance schemes; there were also equity plans in many parts of Latin America and Africa (Barrientos & Lloyd-Sherlock, 2002; Rofman & Apella, 2016; Sultan & Schrofer, 2008).

In the course of their work in twelve European countries titled *Social Security Programmes and Retirement Around the World The and Capacity to Work at Older Ages*, Coile et al. (2016) found that consistent with increasing life expectancy and the nexus between health and work after retirement, policy makers needed to consider how the additional years could be apportioned in consonance with years of work and retirement. Juwei (2016) expressed uncertainty about the maintenance of current social security schemes in China. For example, a problem was looming due to the rapid increases in retiree population without a commensurate growth in replacement rate in the job market. Juwei (2016) recommended the need to balance the scale of the pension replacement rate such that it did not culminate in “welfare disease”, with implications for social vitality and the danger of placing basic livelihood after retirement in jeopardy. Coile et al. (2016) argued that the continuing discourse about policy reforms aimed at getting active and able older people to work after retirement must be primarily grounded in the issue of health. However, due to rapid increases in the proportions of older people in societies globally, debates and policy discourses on pensions and social security and social protection are increasingly needing to focus on funding retirement consumption.

At the moment, the general framework for care of older people worldwide is through the health care and social security systems. Stakeholders such as Governments, International development organisations and the private sector are concerned about how to improve the health of the aged through an improved health care system within the purviews of disengagement and dependency theories (Clarke & Warren, 2007). Implicitly, the retiree must be healthy enough to remain independent, and if possible continue to participate and engage in socio-economic activities by way of an active contribution to society (Department of Work & Pensions, 2005; cited in Bowling, 2008). However, if the older person becomes completely unable to engage, the WHO proposed that the health support system should enable individuals, including frail and disabled people in need of care, to realise their potential capabilities and independence (WHO, 2002; quoted in Clarke & Warren, 2007, p. 466).

In summary, the review of the literature on the relevant aspects of ageing for this study shows that overall, the discussions on ageing has been dominated by health considerations with very limited focus on other equally important aspects of the ageing experience such as the social and community life of older people and how these affect their quality of life. Understandably, ageing comes with some health conditions, which result in high health care cost. I have shown in this chapter that previous models of care for older people such as social security systems, healthcare services and the traditional family support systems are under serious pressure. The critical question which remains unanswered from the literature is how best to provide care for the increasing number of older people to promote a high quality of life. Through this review I have also shown that older people's voices are less represented in policies and programs that seek to provide them with quality care. Accordingly, this study seeks to fill this gap through an exploration of the lived experiences of a sample of older people about their active ageing experiences and themes they consider to be important for enhancing their quality of life at old age.

CHAPTER FOUR: THE POLITICAL ECONOMY OF AGEING IN GHANA AND AUSTRALIA: A CONTEXTUAL REVIEW

4. Introduction

In Chapter Two, it was established that ‘context’ is important for examining people’s lived experiences according to the life-course perspective. In particular, it was established that the socio-cultural and the politico-economic environments influence the nature of policies – services and programs on ageing; and also affect the quality of life of older people (Bahle, 2008; Bengtson & DeLiema, 2016; Carney, 2010; Walker, 2005). This chapter focuses on the political economy of ageing in Ghana and Australia. The purpose of the chapter is to provide a description of the social policy environments –services and programs within which ageing occurs in these two countries and to consider the implications of each environment for the quality of life at old age. There are two parts to this chapter: The Ghanaian context and the Australian context. The review also involves a mapping of actors, including state and non-state actors, their mandates and ageing-related service provisions arrangements. Furthermore, each country’s context also includes a discussion of factors motivating agencies or actors to make policy decisions towards population ageing and the quality of life of people at old age. The chapter provides a mapping of the main ageing policies and legislations of both countries and conducts a brief review of the socio-cultural context of ageing. The chapter concludes with a summary of the key differences and similarities in the social policies of both countries with respect to older people.

4.1. Political economy of ageing in Ghana: A historical overview

Ghana achieved political independence in 1957, and later suffered a series of military interventions between 1966 and 1982. These created an unstable political space and involved several incidences of human rights abuses (Abdulai, 2009). The dominant political ideology in Ghana between 1957 and 1966 under Kwame Nkrumah was far left socialist. President Nkrumah’s orientation to development was evident in the 1964 Development Plan (Agyepong & Adjei, 2008;

Grischow & Weiss, 2015; Kankam, 2016). In the plan, development processes were vested in the state. According to Debrah (2002), the post-independence Gross Domestic Product of Ghana between 1957 and 1966 was about six per cent, which meant Ghana was one of the promising economies in Sub-Saharan Africa at the time. However, the Nkrumah regime pursued a high level of industrialisation, with stringent state controls that led to an almost complete dissipation of national reserves (Aryeetey, Harrigan, & Nissanke, 2000; Debrah, 2002). During the immediate post-colonial period, population ageing was not considered a critical social problem. Hence, there were no known policies addressing issues of ageing except continuation of the already existing colonial policies such as the 1946 Pensions Ordinance⁴ that became popularly known as CAP-30 (Kumado & Gockel, 2003; Tawiah, 2013). That notwithstanding, the aforementioned 1964 Development Plan of Ghana acknowledged the need for social security and pensions for retired workers (Government of Ghana, 1964). In 1960, a compulsory savings scheme was set-up, and all formal sector workers were informed that they were obliged to make contributions into a consolidated fund, but the scheme failed due to lack of patronage from workers (Hanson, 2014). The scheme was replaced with the Social Security Act of 1965, which provided the needed legislation to enable implementation of aspects of the 1964 Development Plan.

As noted by Hanson (2014), the *1965 Social Security Act* made provision for a 7.5 per cent employee contribution and a 15 per cent employer contribution paid monthly into a provident fund. Thus, the Act provided lump-sum retirement benefits for workers, sufficient enough to meet the needs of the moment. A central flaw in this policy, however was the absence of support for the vast majority of employees in the informal sector once they aged. This absence being inconspicuous at the time mirrored some of the inherited social inequities in Ghana at the time and was also caused by pragmatic difficulties of monitoring the informal sector. By 1972, a new Act, the *National Social Security and Insurance Trust (SSNIT)* was enacted to replace the 1965 Social Security Act-National Redemption Council Decree 127 (Hanson, 2014; Kumado & Gockel, 2003). The new Act led to the

⁴ The 1946 Pensions Ordinance was passed by the British Government to Compensate the World War II veterans and their widows. It was a non-contributory-based pension schemes.

establishment of an autonomous body, the Social Security and National Insurance Trust (SSNIT), to implement the provisions of the Act. Beyond the pension schemes, there was no known state policy or program aimed at promoting the quality of life of older people.

Parallel to these provisions in 1972, was another pension scheme known as CAP 30, which derived its name from Chapter 30 of the Pension Ordinance of 1946. The former colonial government had developed the non-contributory pension scheme for civil servants who had worked for at least ten years (Ashidam, 2011; Kpessa, 2010; Kumado & Gockel, 2003). All public-sector workers who were on the 1965 pension scheme were given the option to move onto the new, 1972 scheme.

Ghana's political landscape experienced relative stability between 1981 and 1991 when Jerry John Rawlings and his Provisional National Defence Council (PNDC) ruled Ghana. During this period, all previous constitutions were suspended, and all political activities outlawed. During this period, there were no substantive discussions about population ageing. The focus was on stabilising the country and economic recovery following a sustained period of political anarchy. As a result, the Rawlings government signed up for the Bretton Wood Institutions' Structural Adjustment Programmes (SAP) led by the International Monetary Fund. The stringent economic policies pursued under the SAP did not consider social welfare issues, but instead focused on economic rationalism, limited state interventions in the market, proliferation of deregulatory activities, trade liberalisation and job cuts (Adedeji, 2001; Kumado & Gockel, 2003).

The SAP led to the redeployment of older people, which resulted in deepening deprivation of older people who had to look after themselves and their grandchildren (Kumado & Gockel, 2003). As was typical of International Monetary Fund (IMF) led economies, Ghana's general welfare was minimised and inequality deepened; pensions were pushed towards a pay-as-you-go model (Walker, 2005). In effect, there was no specific policy for older people, apart from the 1965 and 1972 Social Security Acts, which provided only a meagre retirement income for older people. The 1972 Act was repealed in 1991 to give way to the new Social Security Law, PNDC Law 247; which was intended to correct some of the striking

anomalies in the 1972 Act. The changes included the abolishment of lump-sum payments and the introduction of monthly pension payments and the inclusion of other sectors of workers —especially those from the private and the informal sectors— in making contributions to the scheme (Kpessa, 2010; Tawiah, 2013).

Ghana returned to constitutional rule in 1992 after the promulgation of the 1992 Republican Constitution, which created opportunities for a multi-party democracy and had different implications for older people, which are spelt out in Chapters Five and Six of the Constitution. For example, Chapter Five of the Constitution articulated the human rights of all people including older people. And, Chapter Six of the Constitution, under the Directive Principles of State Policy, made a direct reference to older people in Article 37(2b): "the state shall enact laws to protect and promote all fundamental human rights and freedoms including the rights of the disabled, the aged, children and other vulnerable groups". This provision has been the basis for most subsequent policy actions affecting the aged population in Ghana.

Ghana has had five successive democratic elections since 1992, with government alternating between two main political parties: the National Democratic Congress (NDC) and the New Patriotic Party (NPP). Each of the successive governments has had different policy orientations with various implications for ageing issues. For example, the NDC Government between 1992 and 2000, under J.J Rawlings claimed to be a social democratic party; and adopted a centre-left ideological approach to development (Agyepong & Adjei, 2008). By this orientation, the government was expected to create a common welfare that allows state control and regulations of the market (Lavelle, 2015). However, as a spill over from the IMF and World Bank influences, the government pursued a neo-liberal agenda, which restricted opportunities for enacting effective social policies for the poor and vulnerable, including older people (Grebe, 2015). Notwithstanding, the existing social security scheme, (Social Security and National Insurance Trust) was the only recognised contributory-based pension scheme operating at the state level after the Act was amended in 1991. This meant that the majority of older people at

the time did not have access to social security and pensions because they had mostly worked in the informal sector.

In 2001, the NPP party led by John Agyekum Kufuor took over the government. The political party is aligned to the conservative centre-right ideology (Agyepong & Adjei, 2008). Therefore, as they were a neo-liberal regime, the NPP Government, there was anticipation that they would pursue a more market-driven economy. However, paradoxically, the government pursued a mixture of socio-liberal principles and a vigorous social protection agenda for the poor and vulnerable. The period between 2001 and 2008 saw an unprecedented proliferation of social policies and legislations with implications for ageing and the quality of life at old age. For example, there was the enactment of the National Health Insurance Act (2003), which made significant provisions for older people with a view to promoting health and wellbeing at old age. In particular, the Act provided for free health care for older individuals aged 70 years and above, and free entrance into the scheme for retired workers who had pensions from SSNIT (Adusei-Asante & Doh, 2016). In addition to this, there was the development of the National Social Protection Strategy in 2008, with its flagship social cash transfer program known as the Livelihood Empowerment Against Poverty (LEAP) program. The LEAP provided unconditional cash transfers to targeted older people who were 65 years and above and who had no other means of support. Apart from the formal pension systems running in Ghana, this strategy was the only known social grant system in Ghana where selected older people had direct benefit (Abbey, Odonkor, & Boateng, 2014; Government of Ghana, 2010). The strategy was however limited in scope as it benefited very few people. As said previously, the scope of the program was limited and the cash transfer was targeted.

Below (section 4.1.2) is discussed in some detail drivers of ageing issues in Ghana. For now, it is important to state in attenuation though that the paradox between the NPP's political and economic orientation and their social policy agenda, particularly on ageing issues, was induced by some factors worth mentioning. As Aikins and Apt (2016) argued that between the year 2000 and 2008, the international policy environment on rapid population ageing had matured, and

there were more discussions about ageing issues globally. Furthermore, there were several international protocols and plans of actions to which nation states committed themselves (Aikins & Apt, 2016; Apt, 2012). Examples include the Madrid International Plan of Action on Ageing (MIPAA) and the African Union Policy Framework and Plan of Action on Ageing (African Union & HelpAge-International, 2002), both in 2002. Also, the activities of HelpAge International within the African continent and the declaration of 1999 as the United Nations' International Year of Older Persons, spurred policy debates and research on ageing in Africa. Thus, the international policy environment, the role of local politics, and international actors all contributed significantly to the Ghanaian Government's approach to social policies on ageing in the 2001 and 2008 period (Apt, 2012).

Notwithstanding its supposedly socially sensitive policies, the NPP lost the December 2008 elections to the NDC. From 2009, the NDC Government under John Evans Atta-Mills continued with all the policies of the previous government, albeit without a great deal of enthusiasm. And in 2010, the first ever National Ageing Policy Framework was launched. This framework drew inspirations from the MIPAA, the AU Policy Framework, the WHO active ageing framework, and other international documents. The focus of the policy was to safeguard the rights of older people and encourage economic participation of older people, while paying attention to key welfare issues such as housing, pensions, healthcare and poverty reduction. The policy also made provisions for strengthening the traditional family system and creating opportunities for quality ageing experience (Government of Ghana, 2010; Tawiah, 2013). The subsequent NDC Government in 2012, led by John Dramani Mahama also continued with all the previous policies such as the cash transfers and the health insurance scheme to remain politically competitive⁵. The Mahama Government developed a draft National Social Protection Policy in 2015, which acknowledged the need for universal non-contributory pensions for older people but without any actual action point (Government of Ghana, 2015). Unfortunately, since its launch in 2010, the National Ageing Policy is yet to be implemented because the proposed National Council of Ageing to implement the

⁵ President JEA Mill died in 2012, while in office and was succeeded by John Dramani Mahama, the Vice President at the time.

policy has not been established. Table 4.1 provides a summary of the social policies and legislations for the ageing of political regimes in Ghana from 1992 to date.

Table 4.1: Mapping of policies and legislation on ageing issues: Ghana (1992-2016)

| Political regime/Year | Dominant political ideology | Major social policies and legislations | Key provisions |
|-----------------------|-----------------------------|--|--|
| NDC 1992 - 2000 | Claims of social democracy | Implemented the Social Security Law 1991 | Abolished lump-sum and paid monthly pensions; included workers from informal sector. |
| NPP 2001 - 2008 | Claims of liberal democracy | Nation Health Insurance Scheme (2003) | Gave free coverage for older people, 70 years and above and SSNIT pensioners. |
| | | Ghana Poverty Reduction Strategy I 2003-2006 | Mainstreamed issues of poor and vulnerable people including older people into sector level plans and set the basis for NSPS. |
| | | Ghana Poverty Reduction Strategy II (2006- 2009) | |
| | | National Disability Act 715 (2006) | Promoted rights of persons with disability including older people with disability, free public transport. |
| | | The New Pensions Act (2008) | Implemented the three tier schemes to provide better investment security at old age. |
| | | National Social Protection Strategy (2008) | Established overarching national social protection framework with precise action points for older people. |
| | | LEAP (2008) | Initiated state-led cash transfer initiative that provides bi-monthly cash transfer to targeted older people who are 65 years and above. |

| Political regime/Year | Dominant political ideology | Major social policies and legislations | Key provisions |
|-----------------------|-----------------------------|--|--|
| NDC 2008- 2016 | Claims of social democracy | Ghana Shared Growth Development Agenda I and II -2010 -2017) | Deepened some of the provisions of GPRS I and II and acknowledged the need for a composite social protection policy. |
| | | National Ageing Policy Framework (2010) | Formulated the first ever national level policy framework on ageing aimed at securing and promoting the rights of older people. It promoted the integration of older people into mainstream economic life. |
| | | National Social Protection Policy - 2016 | Acknowledged the need for a universal non-contributory pension for older people |

4.1.1 Institutional mapping of actors and ageing issues in Ghana

A map of institutional actors within the ageing sector in Ghana is presented in Figure 4.1: The interaction between different players for ageing policy development, budgeting and direct service delivery as shown is based on the National Ageing Policy Framework.

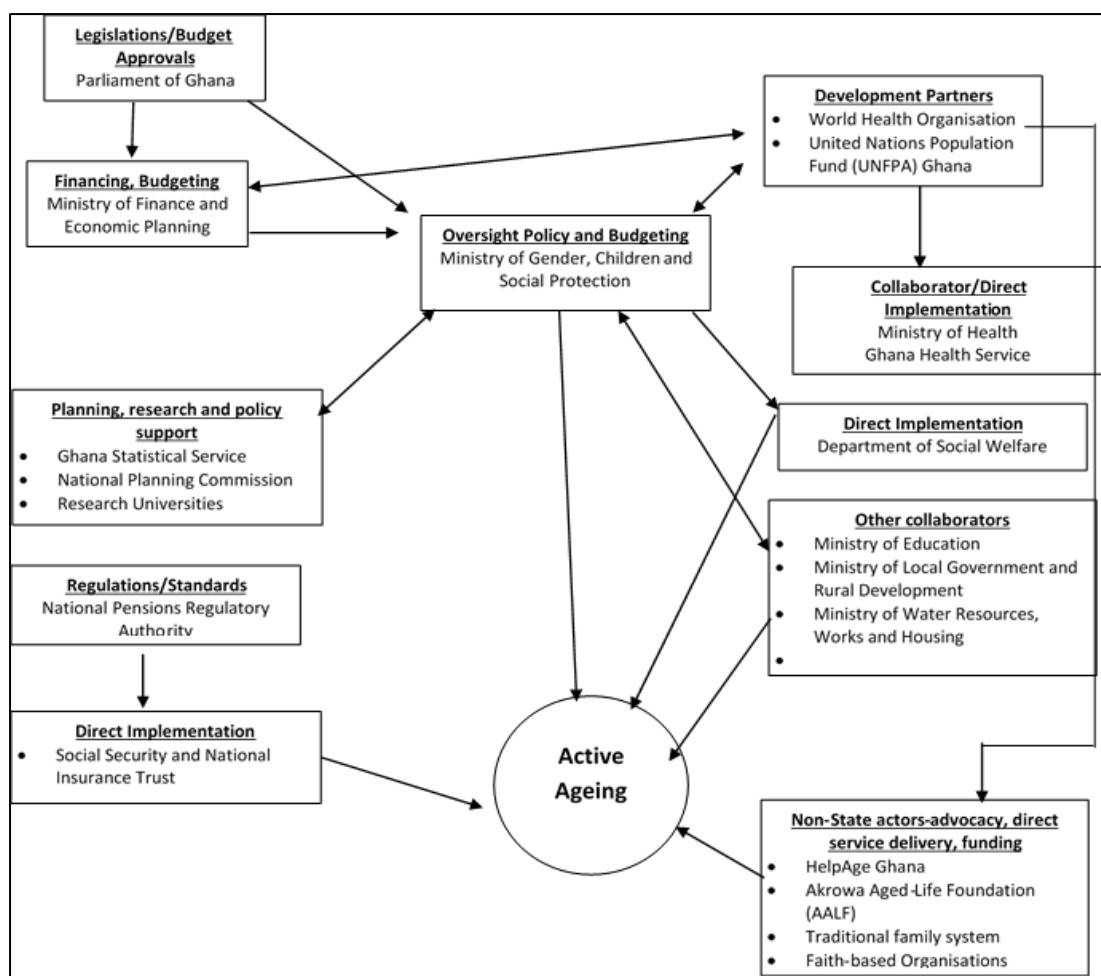


Figure 4.1: Institutional mapping of actors in the ageing sector of Ghana

Source: Constructed based on Government of Ghana (2010).

The mapping was based on secondary information contained in the National Ageing Policy Framework (Government of Ghana, 2010), and the National Social Protection Policy (Government of Ghana, 2015). Overall, the Ministry of Gender, Children and Social Protection (MGCSPP) is the focal government agency for ageing issues in Ghana. The ministry has the mandate to lead the development of policies and budgeting for ageing issues, with a desk officer at the position of Director in Charge of Ageing issues. Furthermore, through the Department of Social Welfare, the Ministry provides direct service delivery to older people. For example, the Department of Social Welfare is responsible for the implementation of the social cash transfer, LEAP, to older people and other beneficiary groups (Government of Ghana, 2015). The Department is also mandated to provide monitoring and evaluation and to develop standards for practice in the aged care industry. The

overall responsibility for financing and budgeting decisions for all sectors rests with the Ministry of Finance and Economic Planning (MoFEP). However, the budget is subject to Parliamentary approval. This means the Parliament of Ghana has regulatory responsibility for both the MoFEP and the MGCSP. Policies of the MGCSP on ageing issues must also receive Parliamentary approval.

Furthermore, Ghana's Development Partners (DPs) such as the World Health Organisation (WHO) and United Nations Population Fund (UNFPA) have interactions with the Ministry of Finance regarding budget support. The Development Partners also interact with MGCSP in strengthening policies and capacity building about ageing issues. For example, in 2012-13, the WHO supported a national level study on ageing and health (World Health Organization, 2014). There are other forms of direct support to the Ministry of Health on various matters of ageing. The Ghana Statistical Service (GSS), the National Development Planning Commission (NDPC) and public research universities provide technical, research and planning support for the MGCSP in all policy actions on ageing issues. The Ghana Statistical Service, for example, undertakes the collection, compilation, analysis, publication and dissemination of official statistics in Ghana for general and administrative purposes (Ghana Statistical Service, 2013b). The NDPC also ensures that the medium to long-term development plan adequately integrates strategies and policy objectives to improve the well-being and standard of living of older persons. Like the GSS, the National Population Council also provides information on national and international population dynamics, and demographic trends to aid policy development at the Ministry of Gender, Children and Social Protection.

Other collaborating government ministries on ageing issues in Ghana are the Ministry of Local Government and Rural Development (MLGRD), the Ministry of Education (MoE), the Ministry of Information and the Ministry of Water Resources, Works and Housing (MWRWH). The MLGRD, under the national ageing policy framework, is mandated to ensure that Metropolitan, Municipal and District Assemblies (MMDAs) locate appropriate measures for mainstreaming ageing issues into their medium-term development plans. The MoE is responsible for promoting curriculum development that includes lessons on ageing in Ghana and the value of

older people, and is expected to enhance knowledge on the need for intergenerational solidarity and reciprocity among the Ghanaian populace. The MWRWH has the mandate of reviewing and updating housing policies that promote age-friendly communities. The National Pensions Regulatory Authority (NPRA) also plays a critical role within the ageing sector by coordinating and overseeing the implementation of the new three-tier pension schemes, thereby ensuring the adherence to standards in the pensions sector in Ghana. Closely linked to the NPRA is the Social Security and National Insurance Trust (SSNIT), which has the responsibility of managing the Pensions Fund and implementing the SSNIT Act.

Non-state actors are an important part of the ageing sector in Ghana (Frimpong, 2015). The non-state actors include civil society organisations, faith-based organisations, and the traditional family system. The presence of civil society engagement with ageing issues in Ghana is rare. Apart from HelpAge Ghana, and through its partners HelpAge International, who are actively involved in issues of ageing through policy advocacy and direct program interventions, there is no civil society engaged actively on ageing issues. There is, however, an emerging home care sector in the country (Frimpong, 2015). For example, there is a private institutional age care home, Akrowa Aged-Life Foundation, which provides some respite for older people within its catchment area. There are also reports of private homes springing up in various parts of the country, but none of these is officially documented. Faith-based organisations, such as Christian churches and the Islamic communities have also become critical actors within the ageing sector. Some of these provide forms of social protection for older people. As observed by Apt (2013) and Doh, Afranie, and Bortei-Dorku Aryeetey (2014), the traditional family in Ghana also provides enduring support and care for many older people amidst threats of urbanisation and modernity.

4.1.2 Drivers of state interest and motivations towards provisions for ageing in Ghana

Reviews of the factors that influence state interest or motivation for addressing ageing issues in Ghana have identified five primary drivers: the prevailing international environment on ageing issues (Apt, 2012), the provisions of

the 1992 Republican Constitution, the role of advocacy groups (Aikins & Apt, 2016), political capital and moral obligations. It is observed that since the year 2000, the frontiers of social policy in Ghana have been expanding. In particular, expansion of the state's interest in ageing issues has been remarkable, due partly to the influences of international ageing protocols and policy proposals (Aikins & Apt, 2016; Kwankye, 2013). As noted by the Government of Ghana (2015), Ghana is a signatory to almost all the major conventions, treaties and protocols of the United Nations and the African Union on ageing issues. Some of these include the Madrid International Plan of Action on Ageing (MIPAA, 2002) and the African Union Policy Framework and Plan of Action on Ageing. As a signatory to the MIPAA, Ghana is expected to provide a periodic progress report to the MIPAA Secretariat about its implementation of the Plan of Action (Government of Ghana, 2007; Kwankye, 2013). This places a demand on the government to be active in its implementation of the MIPAA. The WHO, through its active ageing framework, also significantly influences activities of the Ministry of Health towards ageing issues (World Health Organization, 2014).

The 1992 Republican Constitution of Ghana has been another important driver of state interest on ageing issues. As mentioned above, Chapters Five and Six of the Constitution made important provisions for policies and programs that promote the rights and dignity of poor and vulnerable members of society including older people. As alluded to by the Government of Ghana (2015), the constitution is the basis for all social policies including the National Ageing Policy Framework. However, Kwankye (2013) observed that the role of non-state actors including Non-Governmental Organisations (NGOs) in demanding state response to key provisions of the constitution have been critical. For example, HelpAge Ghana was a pioneer in pushing the country towards making commitments to ageing issues. The first draft of the National Ageing Policy in 2003 was a collaborative work between HelpAge Ghana and the Centre for Social Policy Studies of the University of Ghana. These two entities have held a series of advocacy workshops to open national discussions about population ageing; all of which culminated into the current state of the National Ageing Policy (Government of Ghana, 2010).

Another driver of state interest in ageing issues in Ghana can be understood in terms of it being a subject used in political expediency or clientelism, which Abdulai and Hickey (2016) referred to as 'competitive clientelism'. Over the years, political actors have used the subject of providing social welfare to poor and vulnerable people, including older persons in society, as bait to win political power. Then, as a payment or reward to voters, certain public policies are made (Abdulai & Hickey, 2016; Khemani, 2015). For example, to appeal to the older generation of voters, some political actors (patrons) have made promises to various bodies (e.g. associations and unions) of older people to win their vote; and in return the politicians have developed policies that promote the welfare of older people. Also, it was noted by Kuyini (2015) that the LEAP social cash transfer in 2008, like many other social protection programs was used as a political tool. Finally, there has been a moral obligation on the part of the state and society, in general, to provide support to older people, thereby recognising both their vulnerability and their past contribution to social and economic life.

4.1.3 Socio-cultural context of ageing in Ghana

The Ghanaian socio-cultural environment represents a favourable context for growing old because, culturally, older people are respected. In most communities in Ghana, old age is considered as a sacred stage of life due to the proximity of the older person to the ancestors (Van der Geest, 1997b). Thus, there is the high recognition of the older people, which encourages respect and dignity for older people. In addition, Nukunya (2003), argues that the older persons within the extended family system – family head are symbols of wisdom, trust and fair judges who are able to adjudicate family conflicts and provide leadership in the family. It is important to recognise that the traditional family in Ghana is a unique institution, which transcends a man, the wife and their biological children to include all people believed to have some form of blood or kinship ties. Thus, a typical family is composed of father, mother, children, grandparents, cousins, uncles and all other forms of family relationships. Indigenous families in Ghana live together, own properties together and share the family resources together (Ardayfio-Schandorf, 2006). This practice puts the older person in a very important position in the family.

According to Van der Geest (1997b), the nature of the traditional family arrangement among the Akan in Ghana promotes a reciprocal interaction, which ensures that the older person is supported and cared for.

Even though the current evidence suggests that the traditional Ghanaian extended family has weakened amidst urbanisation and modernisation (Van der Geest, 2016), the socio-cultural values placed on old age remains relevant, and older people in most indigenous families maintain their respected status as leaders. Notwithstanding, the attitudes of some communities and individuals towards older people, especially older women, need to be acknowledge within a socio-cultural discussions of old age in Ghana. Van der Geest (2002), observed that there is a changing sentiment of younger people towards older people. Some of these sentiments portray older people with less formal education and diminished social statuses as witches and evil people who are able to curse and destroy young people. Some of these older people are subjected to torture to confess or admit to witchcraft (Adinkrah, 2015). These infractions on the dignity of old age among some individuals and communities in Ghana are in the minority. Overall, older people in Ghana are undoubtedly respected and valued.

4.2 Political economy of ageing in Australia: A historical overview

Australia has a long history of having relatively progressive political and socio-economic systems (Brown, 2016; Coleman, 2016; Mendes, 2008). This history has implications for the quality of life of older people. Since the settlement of non-Indigenous people in the late 18th Century, the Australian political system has evolved from colonial British Governors, who acted on behalf of the British Parliament, to the current representative democracy. Although Australia is a representative democracy, it still clings to a constitutional monarchy with the British monarch as the Head of State. Economically, Australia is endowed with vast land space, and mineral resources; and it has benefitted from post-war and subsequent migration in terms of human resource supply (Cousins, 2005; Shann, 2016). The country also has built a knowledge economy and utilises its educational infrastructure to provide high-level technical capacity building (Harman, 2002).

Politically, in January 1901 Australia adopted a federal system of government, mostly inspired by the United States' Federal Constitution (S. Bennett & Webb, 2006; Buss & Buss, 2015). In the Federal Constitution, political powers are shared between the Commonwealth Government and the six founding states. According to Section 51 of the Australian Constitution, each state has powers to make laws over certain matters; and the states also retain the structure of a three armed government systems, including a legislature, an executive and judiciary (Taylor, 2010). Coleman (2016) and Brown (2016) have described the nature of the power relationship between the Federal Government and the state governments as imbalanced, arguing that the Federation wields too much power (Brown, 2016; Coleman, 2016). Coleman (2016), for example, described the Australian federal system as a façade of federalism because the Federal Government controls fiscal flow and the six states, along with two territories, are responsible for administering social programs (See also, Healy, 2002).

Implications for the political arrangement described above for social policies, including policies on ageing, are explained subsequently. According to Brown (2016) Australia's commitment to federal politics created liberal individualism and social justice, which in turn created opportunities for national equity through expansion of federal social and economic programs. The nature of social justice at the time of federation has impacted the extent to which social policies for older people were made. Brown (2016) argued further that Australia's federal system created a sound financial management system on the idea of horizontal fiscal equalisation between states. For example, at the time of Federation in 1901, an Old Age Pension policy was introduced in New South Wales and subsequently extended to the rest of Australia in 1908 as an alternative to the existing indoor relief for indigent aged which was operational at the time (Nolan, 2016).

Courtney, Minichiello, and Waite (1997) argued that within the context of social justice, some policy reforms on ageing have taken place in Australia. For example, in 1951, the Hospital Benefits Act was passed, which classified the chronically ill and the elderly as 'bad risk' and so became the responsibility of

government. The Act also established the pensioner medical services. This was followed by the *National Health Act of 1953*, which defined the operations of nursing homes. In 1954, the Aged Persons Homes Act was passed to provide capital cost coverage for aged homes as the direct responsibility of the Commonwealth Government. This Act was later amended in 1957 to provide extra funding to aged homes. Between 1983 and 1996, the Age Care Reforms Strategy was operational, establishing benchmarks for the operations of nursing homes, the establishment of community care programs and other innovations within the age care industry. For example, in 1984, the Home and Community Care (HACC) program was introduced, which provided opportunities for very frail older people to remain in their homes with their caregivers receiving income support.

As explained by O'Connor, Orloff, and Shaver (1999), Australia and many other first world countries experienced a drastic ideological shift towards market liberalisation in the early 1990s. This change gave way to contentions about the role of the state, market and family in policies that address social problems, including issues of rapid demographic ageing. During this period, the market (business) was pushed to provide solutions to social problems. This led to restricting social policies, including eliminating and scaling back entitlements, increasing work incentives, and addressing gender dimensions of social issues (Mendes, 2008). Consequently, Encel, Ozanne, Borowski, Encel, and Ozanne (2007) noted that Australia has become a neo-liberal welfare state with some different policy levers, which has implications for policy actions towards ageing. Overall, neo-liberal systems have three particular characteristics that affect ageing policies: decommodification, calibration and cost containment (Castles & Uhr, 2005). Decommodification entails a protection of citizens from the control of the market, and provides entitlements to citizens, calibration involves the setting and standards and benchmarks for best services possible, and cost containment relates with deliberate government policies to check the cost of services for citizens. Other features of a neo-liberal government are wage deregulation, flexible employment conditions and open market operations, constraints on public sector employment, means-tested transfer systems, and private participation in pensions and social services (Connell, Fawcett,

& Meagher, 2009; Myles & Pierson, 2001). The consequences of these ideological shifts were that people were expected to make substantive contributions to their aged pensions.

Before the emergence of the new waves of discussions about ageing in the 1980s, the Commonwealth Government's policies on ageing were focused on two main issues: old age pensions and subsidies for nursing homes (Kendig, 2017). The Labor Government between 1983 and 1996 led by Bob Hawke (1983-1991) and Paul Keating (1991-1996) have been described as pro-capitalist and pro-business; and have been criticised for creating the mirage of wage restraints, labour market deregulation and microeconomic reforms (Lavelle, 2010). However, despite such accusations, the Labor government developed a more comprehensive approach to population ageing issues compared with previous governments. For example, they introduced the Age Care Reforms Strategy in 1985, which sought to improve access to services and greater resource allocation and general improvement in the quality of care of older people (Kendig & Duckett, 2001). That notwithstanding, by 1996, when the Labor party lost the election, the reforms were stalled because they lacked the necessary legislative backings (Encel et al., 2007). As observed by Encel et al. (2007), the Labor Government had been deeply involved in the planning and financing of residential care systems.

According to Ryan (2005), the Liberal-National Coalition Government led by John Howard from 1996 to 2007 was primarily characterised by strict adherence to conservative social values, control of the policy process, mainstreaming, market-oriented models of service delivery and emphasis on individual responsibility for government involvement in social services. Regarding demographic ageing, there was a complete realignment of the responsibility of government in policy actions for older people. The Coalition in 1996 set up the National Audit Commission, which recommended among other things the need to strengthen self-reliance during old age while reducing government involvement (Encel et al., 2007).

This recommendation was made with respect to the pressing background issue that the age dependency ratio was increasing, and the government alone could no longer bear the burden of ageing; hence, the need to promote private

savings towards retirement. As a result, the Howard government introduced some reforms within the ageing sector, which were primarily driven by neo-liberal considerations. Some of the reforms to encourage private provision for old age were superannuation, taxation offsets, a concession for retired workers, and other labour market programmes (Borowski, Encel, & Ozanne, 1997). The 1996 budget also made some provisions for a tax rebate for self-funded retirees and low-income earners. For the first time, the budget further acknowledged the WHO's healthy ageing agenda and made an allocation of 1.5 million dollars for a three-year period towards healthy ageing. Disney (2004) asserted that despite its neo-liberal ideology, the Howard Government was relatively generous to older people. For example, the National Strategy for an Ageing Australia (2002) was developed in response to the Madrid International Plan of Action on Ageing (2002) and the WHO's Active Ageing Framework; and it made generous provisions for pensioners, increased the number of residential aged care homes and places, and increased levels of home-based assistance (Biggs & Kimberley, 2013; Encel et al., 2007).

Warburton (2014) acknowledged that since 2002, the Australian political and economic context for policies on ageing have shifted from concentrating on frailty and illness to more productive notions of ageing. Both Labor regimes under Kevin Rudd (2007-2010, 2013) and Julia Gillard (2010 -2013) and the Liberal regime under Tony Abbot (2013-2015) oscillated between dual welfare systems in which private welfare spending co-existed with direct Government expenditure (Butler, 2015). Overall, the Commonwealth Government's decisions on population ageing since 2002 were influenced by the production of four Intergenerational Reports (Commonwealth of Australia, 2002, 2007, 2010, 2015a). These reports emphasised four key issues, sometimes referred to as the '4 Ps' of policy direction on ageing. Pakulski (2016). The '4 Ps' were: people, productivity, participation and provision. Nonetheless, each of these reports painted gloomy pictures of population ageing and its implications for the economy and future generations (Biggs & Kimberley, 2013; Pakulski, 2016). According to Fine (2014), the first two reports (2002 and 2007) were mostly used to justify austerity measures, cut down on government funded programs, and promote self-reliance at old age. In that regard, there was a

policy shift towards promoting privatisation and the reliance on the market to drive social processes, including welfare at an old age, while reducing the public provision of welfare (Fine, 2014; Pakulski, 2016).

Since 2011, there have been significant structural changes in the aged care system, with the aim of improving access, quality, and financial sustainability and promote excellent consumer choice (Australian Government, 2015). For example, there was the introduction of the Living Longer, Living Better reform by the Labor Government in 2012 with its subsequent legislative provision in 2013. The overall goal of the reform was to provide a better age care system that was consistent with national ideals over a ten-year period. There have been ongoing discussions towards providing wide-ranging modifications aimed at providing a market centred service provision so that consumers can have choices (Australian Government, 2015).

4.2.1 Mapping of some major policies and legislations on ageing in Australia 1983-2016

The policy, legislative and programming environment for ageing issues in Australia is complex. Apart from policies at the Commonwealth level, each state government has its unique approach and programs on ageing issues. Table 4.2 is a summary of national level policies, legislations and programmes that address issues relating to ageing and older people. As shown in the table, one important policy proposal during the 1980s was the Aged Care Reforms Strategy of 1985, which aimed at increasing access to quality care services as a way of promoting an equitable distribution of public resources. This policy introduced residential, home and community care service for older people.

Another important legislation for ageing issues in Australia since 1997 that continues to be relevant is the Aged Care Act (1997). The general purpose of this Act was to improve quality care services while promoting self-reliance in old age. The Act also made provisions for private sector participation in ageing services, which meant further devolution of aged care policies and reduced government involvement. Other important policies on ageing in Australia include the National Strategy for an Ageing Australia (2002), the Living Longer Living Better Aged Care

Reform in (2012), and the Aged Care Roadmap (2015) which sought to promote various services within the aged care sector, including promoting independent living and restorative care arrangements, where older people are provided with new skills to overcome any dysfunctionality. The overall goal of the Aged Care Roadmap was to promote a consumer-driven, market based, sustainable aged care system.

Apart from national level policies and programs for older people in Australia, there have been several non-state level programs. Table 4.2 provides a summary of the key policies and legislations. It is acknowledged that it would be beyond the scope of this study to discuss the entire volume of policies and legislations of ageing in Australia.

Table 4.2: Mapping of major policies and legislations on ageing in Australia: (1983 – 2016)

| Political regime/Year | Dominant political ideology | Key social policies and legislations | Key provisions |
|----------------------------------|------------------------------------|--|--|
| Labor government | Socialist orientation | Aged Care Reform Strategy (1985) | <ul style="list-style-type: none"> • Increased access to quality care services and enhanced greater equity in federal resource allocation, • Introduced residential, home and community care service |
| Liberal-Coalition 1996 - 2007 | Neo-liberal conservatives | Aged Care Act (1997) | <ul style="list-style-type: none"> • Improved quality of care service • Promoted self-reliance at old age, and private sector participation. • Devolved health and aged care services. • Reduced government involvement. |
| | | National Strategy for an Ageing Australia (2002) | <ul style="list-style-type: none"> • Secured and sustained retirement income. • Promoted labour market participation for mature aged workers. • Created positive public |

| Political regime/Year | Dominant political ideology | Key social policies and legislations | Key provisions |
|-----------------------|-----------------------------|--|--|
| | | | <p>images of older people.</p> <ul style="list-style-type: none"> • Created opportunity to maximise physical, social and mental health. • Improved overall care infrastructure and systems. |
| Labor government | Socialist orientation | Living Longer Living Better Aged Care Reform in (2012) | <ul style="list-style-type: none"> • Provided better age care system that is consistent with national ideal over a ten-year period. • Expanded consumer choice. • Provided market-based service provision. |
| Liberal Government | Neo-liberal conservatives | Aged Care Roadmap (2015) | <ul style="list-style-type: none"> • Promoted consumer driven, market-based, sustainable aged care system. • Promoted quality and efficient screening systems through reablement strategies by teaching new skills to promote independent living |

Source: Constructed based on varied sources of information from extant literature

4.2.2 Institutional mapping of some major actors in Ageing in Australia

Actors in the Australian ageing and aged care sector can be classified into two main groups: government and non-government. Table 4.3 provides a summary of key actors in the age care sector in Australia. Overall, the Department of Health through Ageing and Aged Care Unit has the mandate for policy and regulatory compliance within the sector. Their work is complemented by the Australian Aged Care Quality Assurance who provides accreditation for service providers. Another important national level actor is the Aged Care Complaints Commissioner. The

commissioner manages and resolves complaints on aged care issues. Furthermore, the Department of social service has the mandate for providing different support services to seniors through programs and services, and payments and funding for organisations providing services for seniors. Similarly, the Department of Human Services provides some service support to older Australians, including payments. Another major institution is the Australian Bureau of Statistics, which provides demographic data on the distribution of older people for planning. There are several other organisations with different service delivery mandates for older people in Australia.

Table 4.3: Mapping of some major actors in the ageing sector of Australia

| Sector | Actor | Key Responsibility |
|----------------|--|--|
| Government | Department of Health – Ageing and Aged care | Policy and regulatory compliance. |
| | Australian Aged Care Quality Assurance | Accreditation of care providers. |
| | Aged Care Complaints Commissioner | Manages complaints on age care issues. |
| | Department of Social Services | Provide support to seniors through programs and services, payments and funding for organisations providing services for seniors. |
| | Department of Human Services | Various payments to older Australians. |
| | Australian Bureau of Statistics (ABS) | Provide demographic statistics including for ageing to aid planning. |
| Non-Government | <ul style="list-style-type: none"> • National Seniors Association • Advocare • Aged and Community Services Australia • Aged Care Network • ARPA Over 50s Association • Carers Australia • Centre for Education and Research on Ageing • Council on the Ageing Australia (COTA) • National Ageing Research Institute | All collectively seek to provide supports to various categories of older people. |

Source: Based on varied sources of literature

In addition to government agencies, several non-government organisations work for or with older people, including the National Seniors Association, and the Council on the Ageing Australia (see Table 4.4). Furthermore, another important feature of the Australian aged care system is the wide range of aged care service providers. There are three types of care systems in Australia: care at home, residential care, and flexible care. As shown in Table 4.4, as at June 2015, there were 273, 503 aged care places in Australia, with New South Wales having the highest number of 92,074 and the Northern Territory the lowest of 1,827. Table 4.4 shows the extent of spread of age care service delivery across Australia.

Table 4.4: Aged Care Places in Australia as at June 2015

| Total Operational Aged Care Places by State/Territory as at 30 June 2015 | | | | | | | |
|--|-------------------------------|------------------------|-----------|-----------------|-------------------------------|-----------------------|-------------|
| State/Territory | Residential care ¹ | Home care ² | | | Total residential + home care | Total transition care | Grand total |
| | | Low care | High care | Total home care | | | |
| NSW | 67,258 | 18,244 | 5,194 | 23,438 | 90,696 | 1,378 | 92,074 |
| Vic | 51,131 | 13,787 | 4,020 | 17,807 | 68,938 | 1,000 | 69,938 |
| Qld | 34,915 | 10,203 | 3,612 | 13,815 | 48,730 | 733 | 49,463 |
| WA | 16,350 | 5,178 | 3,278 | 8,456 | 24,806 | 346 | 25,152 |
| SA | 18,390 | 4,581 | 1,223 | 5,804 | 24,194 | 347 | 24,541 |
| Tas | 4,987 | 1,421 | 440 | 1,861 | 6,848 | 109 | 6,957 |
| ACT | 2,247 | 719 | 527 | 1,246 | 3,493 | 58 | 3,551 |
| NT | 675 | 922 | 201 | 1,123 | 1,798 | 29 | 1,827 |
| Australia | 195,953 | 55,055 | 18,495 | 73,550 | 269,503 | 4,000 | 273,503 |

Source: Australian Government (2015).

4.2.3 Drivers of state interest and motivations towards ageing in Australia

According to Biggs and Kimberley (2013), ageing policy efforts in Australia in the past fifteen years have been driven primarily by panic and fear about the future of the economy. The fear and panic have been sustained by the production of the Intergenerational Report of Australia by the Productivity Commission. Each of these reports painted a blurred future for the Australian economy due to increasing demographic ageing (Daley, McGannon, & Hunter, 2014; Duckett, 2015). For example, Kendig and Woods (2015) pointed out that the perspective of the most recent Intergenerational Report of 2015 should be replaced to provide a more objective outlook of the Australian economy in the context of rapid demographic ageing, and to show, in effect, that public efforts have been shifting towards promoting self-reliance, and private participation in shrinking government financing

(Fine, 2014; Pakulski, 2016). Over the life course, this policy approach has implications for how people organise their lives towards ageing. For example, promoting self-reliance will encourage personal savings and contributory-based superannuation, which has implications for financial security at old age. Effectively, those who are least able to actively prepare for their old age stand to suffer the most from this philosophy.

Another motivation for governments' actions on ageing issues in Australia, as observed by Butler (2015), is the issue of political expediency. In an era of active political contestation, older people in Australia are viewed by major parties as a critical mass of voters whose interests cannot be overlooked. For example, in 2014 there were about 3.4million people 65 years and above in Australia (Australian Bureau of Statistics, 2014). Thus, Butler (2015) noted that within a clientelistic atmosphere, older people, through their representative associations, such as the National Senior Association, have become prominent political actors. In fact, it is commonplace for them to refer to "Grey Power" (Ginn, 1993). Similar observations about the importance of votes from older people in the making political commitments have been reported by Encel et al. (2007) and Davidson (2016). Invariably, the potential for political lobbying exists for older people.

A third important motivating factor that shapes ageing policies in Australia is social justice and human rights considerations (Giddens, 2013). The Australian Government's social justice strategy⁶ seeks to provide equitable distribution of economic resources, provision of essential public services, and equal rights and opportunities to every Australian without prejudice or discrimination. However, social justice considerations have not always been prominent under welfare actions undertaken by the Australian Government (Warburton, 2014). For example, despite recent acknowledgment of the invidious treatment of Indigenous Australians, the Australian Government has been slow and reluctant to make reparation. Furthermore, international policy environments have played a role in influencing some of the national decisions made on ageing in Australia. For example, Kendig,

⁶ <https://www.dss.gov.au/our-responsibilities/settlement-and-multicultural-affairs/programs-policy/a-multicultural-australia/national-agenda-for-a-multicultural-australia/participation/social-justice>. Accessed 5th March 2017

Elias, Matwijiw, and Anstey (2014) noted that the WHO's policy guidelines on developing age-friendly cities have influenced different state governments in shaping local level policies. In turn, these policies have created age-friendly cities; have led to designated facilities for older people and have led to development of infrastructure such as redesigning of public places and homes that facilitates the functionality of older persons in Australia.

4.2.3 Socio-cultural context of ageing in Australia

Australia is a highly multicultural nation with a complex mix of people from diverse backgrounds. There are the indigenous Australians – Aboriginals and Torres Strait Islanders, and the non-indigenous Australians – mainly from European descents, Asians, Africans and Latin Americans⁷. The dominant family life in Australia is characterised by the Western and secularised culture, underpinned by the nuclear family system, which provides limited space for the recognition older people (Fox, 2005). Thus, Bartlett et al. (2013) and Beer et al. (2016) asserted that due to the nature of the Australian contemporary family arrangement, older people are experiencing social isolation.

In order to meet the needs of its multi-cultural population, which includes values placed on older people, the Government of Australian is guided mainly by the principles of social justice and human rights considerations (Giddens, 2013). Thus, unlike Ghana where respect for older people is embedded in their cultural values and enshrined in the Constitution, Australian older people are mostly protected by laws and policies on ageing with limited cultural influence except among indigenous Australians (Crosato et al.2007). Crosato et al. (2007) observed that the Aboriginal people are highly interconnected to each other with older Aboriginals occupying important social position. In the mainstream Australian society, Human rights provisions make it mandatory for the enjoyment of fundamental human rights and protection from abuse. The Australian Government's social justice systems also to provide equitable distribution of

⁷ *"About Australia: People, culture and lifestyle". Dfat.gov.au. Archived from [the original](#) on 12 May 2012. Retrieved 8th September 2017*

economic resources, provision of essential public services, and equal rights and opportunities to every Australian without prejudice or discrimination.

Summary

The ensuing discussion shows that Australia and Ghana have similar political ideologies, alternating between a socialist orientation (i.e. NDC in Ghana and the Labor Party in Australia) and a neo-liberal orientation (i.e. NPP in Ghana and the Liberal Party and the Coalition in Australia). This means that, in terms of promoting the quality of life for older people, the policy approaches under the respective ideological orientations may be similar. However, the motivations and country level policy actions towards fostering better ageing policies vary markedly. The difference i) pertains to the rate of demographic transition, which is faster in Australia than Ghana, and ii) dissimilarity in the socio-cultural contexts of ageing which appears to be richer in Ghana than Australia. Australia's policy environment is consistent and proactive about demographic ageing and is promoting self-reliance in old age to safeguard the public purse. On the other hand, Ghana's policy environment is more relaxed on ageing issues and has not demonstrated any sense of urgency, which is due to the country's reliance on the cultural and family support systems. Notwithstanding these differences, political motivations towards developing policies for older people are present in both Ghana and Australia. The present study's findings on the extent to which the respective policy environments have shaped the research participants' experiences and a description of its impact on active ageing is presented and discussed in Chapter Seven.

CHAPTER FIVE: METHODOLOGY

5. Introduction

This chapter presents the methodology of the study over four sections. As the study was theoretically grounded in the life-course approach to human ageing (see Chapter Two), it was important to design the research to rigorously capture and analyse the life experiences of the research participants over their life-courses, and as they pertained to what active ageing meant to them. The first section discusses the research design, which comprised two research methods: an interpretive phenomenological analysis (IPA), and comparative case studies (CCS). Section Two provides the theoretical justifications for the choices of IPA and CCS methods, and discusses the process of selecting research participants from Ghana and Australia. Section Three contains a detailed description of the processes for data collection and analysis for each of the investigative parts of the study. The fourth section is a discussion of the ethical issues of the study.

5.1 Research Design

This study was designed as an interpretive phenomenological analysis (IPA) in combination with comparative case studies (CCSs). Theoretically, the design draws on the constructivist epistemology, which assumes that knowledge and meaning about a phenomenon are constituted by participants' interactions, experiences and ideas (Andrews, 2012; Fosnot, 2013; Glasersfeld, 2005). Constructivist epistemology underscores the importance of combining subjective meaning with objective meaning (Stake, 1995; Yin, 2003). The constructivist view is based on the social construction of reality, which is enriched by contextual factors, feelings and emotions about what is true (Fosnot, 2013). In this study, therefore, the construct of active ageing was based on the reported real-life experiences of older people as they interacted with their social environments.

5.1.1 *Interpretive phenomenological analysis (IPA)*

Interpretive phenomenological analysis (IPA) evolved as a methodological approach in the 1990s within the field of psychology through the works of Smith (1996) and Smith, Flowers, Osborn, and Yardley (1997). Brocki and Wearden (2006) argued that IPA is grounded in the social enquiry fields of phenomenology and symbolic interactionism. The authors argued further that IPA enables researchers to involve their respondents in constructing their social realities. Smith (2004), asserted that IPA is a qualitative research approach that describes the lived experiences of participants in a particular context. IPA goes beyond the description of lived experiences to include an interpretive analysis of the available theoretical, social and cultural environment (Pringle, Drummond, McLafferty and Hendry, 2011).

IPA is grounded on three key philosophical pillars: phenomenology, hermeneutics, and ideography (Larkin, Eatough, & Osborn, 2011; Pietkiewicz & Smith, 2014; Shinebourne, 2011). According to Gallagher (2012), *phenomenology* is both a theoretical framework and a method of social inquiry, and that social reality is made up of objects and events that are understood within human consciousness. Edmund Husserl (1970), one of the original proponents of the phenomenological approach, argued that phenomenology entails studies of the lived experiences of individuals leading to a detailed description of the phenomenon being researched. The difference between traditional phenomenology and IPA is that while traditional phenomenology aims at providing a description of the phenomenon, IPA extends the description with hermeneutics and ideography (Larkin, Watts, & Clifton, 2006). This study applies IPA, hence, next will be a discussion of hermeneutics and ideography.

Hermeneutics deals with the process of interpretation, typically of texts (I. Pietkiewicz & Smith, 2014; Pringle et al., 2011), and *ideography* relates to the individual level description of a phenomenon (I. Pietkiewicz & Smith, 2014). Larkin et al. (2006) argued that one of the most important aspect of an IPA study is the idiographic level. Pringle et al. (2011), and Pietkiewicz and Smith (2014) noted that there are two clear stages in the IPA process: participants making sense of their

experiences, and the researcher attempting to interpret how participants make sense of their world while paying attention to context. This is what Pringle et al. (2011) referred to as “double hermeneutics”. Overall, IPA focuses on exploring people’s experiences and understanding their perceptions to provide a voice to research participants within the necessary theoretical context (Larkin et al., 2006).

The IPA approach has evolved as an important methodology in previous ageing and life course studies. For example, Clare, Rowlands, Bruce, Surr, and Downs (2008) applied IPA in their study to examine the subjective experience of life with dementia in a residential homes in England and Wales; and to understand the psychological impact of their living with dementia. Similarly, Danivas et al. (2016) used IPA to examine lived experiences of older people with dementia in South India. Burton, Shaw, and Gibson (2015) studied living with age-related muscular degeneration, and finally, Shaw, West, Hagger, and Holland (2016) studied older people living well to the end in an extra care housing system for older people in the UK. These studies demonstrated that IPA is a credible approach for researching ageing and social gerontology, especially for studies such as the present one which seeks to understand the lived experiences of older people over the life course. The IPA approach was used to collect data relating to what active ageing meant for older Ghanaians living in Ghana and Australia, and the extent to which their experiences compared to the WHO’s active ageing model.

5.1.2 Comparative case study

A case study is a research approach, which is very popular with political scientists, and has also gained considerable traction in other fields of social enquiry in recent times (Gerring, 2007). A case study has been defined as an “intensive study of a single unit in order to understand a larger class of similar units” (Gerring, 2007, p. 342). A unit refers to a geographically bounded phenomenon, which can either be observed at a single point in time or over a repeated period of time (Gerring, 2007). Yin (2013) noted that case study is a method of empirical inquiry that investigates a contemporary phenomenon, in depth and within its real-life context, especially when the boundaries between the phenomenon and its context are not clearly evident. George and Bennett (2005) defined a case study as an

“instance of class event where class event meant the phenomenon of scientific interest regarding the causes of similarities or differences among the instances of the class of event” (George & Bennett, 2005, p. 17). There are situations, as in this current study, where more than two instances of class event or cases can be studied simultaneously, and comparatively (Bryman, 2008).

According to Bryman (2008), typically, “a comparative case study is an in-depth study of two contrasting cases using relatively identical methods” (p.58). Also, a comparative case study is said to include a thorough examination of the context of a phenomenon in a bounded system. The purpose is to explore differences and similarities that may exist between or among the cases (Gerring, 2013; Yin, 2013). The comparative case study method evolved as a reliable technique for analysing contextual factors of a phenomenon in a bounded system over time (Gerring, 2007). Stake (2013) proclaimed that, in theory, the elements or observations within a multiple case study are treated as homogeneous entities and not as individual cases alone. This process allows for both within case and cross-case analysis (Gerring, 2013). Overall, comparative case study methodology has a strong contextual analytic strength (Creswell, 2012; R. K. Yin, 2013), hence its suitability for exploring the issues concerning a phenomenon such as active ageing. Bryman (2015, p. 64) summed up the definition of the comparative case study as “the study of two contrasting cases using relatively identical methods”. Goodrick (2014) argued that comparative case study methodology is useful for answering questions about causal attribution, especially when the cases are systematically selected. The present study aims are considered a good fit for a comparative case analysis because there are two clear spatially delineated cases for in-depth comparative analysis – the case of older Ghanaian migrants living in Australia and the case of older Ghanaians living in Ghana.

An important aspect of a comparative case study is how the cases are selected (Gerring, 2007; Lor, 2011). Given the cross-national nature of the study, selecting cases for comparative analysis was critical (Engeli & Allison, 2014). It was however important to be mindful of the need for a rigorous case selection technique as observed in previous comparative case studies (Lor, 2011). As noted

earlier, the comparative case study approach is also noted for its analytic rigour and was deemed the appropriate tool for comparing the experiences of older people in the two different settings and the extent to which the various policy environments can affect participants' experiences of active ageing. The comparative case study approach was used to collect data pertaining to how policy environments contributed to the experiences and meaning of active ageing among the study's participants; and the factors contributing to different experiences of quality of life among research participants.

5.2 Defining the research population

The 2011 Australian census data revealed that there were 3,866 Ghanaian-born people living in Australia (Australian Department of Immigration and Citizenship (DIAC), 2011; Commonwealth of Australia, 2014). This number represented a 40 per cent increase from the 2006 census (Commonwealth of Australia, 2014). Figure 5.1 shows that 50 per cent of Ghanaians living in Australia reside in New South Wales, followed by Victoria (17.2 %), and Western Australia (11.3%). The remaining 21 per cent are distributed across the other states. Regarding age distribution, the DIAC report reveals that the number of older people aged 65 and above (115) account for about three per cent of the Ghanaian population in Australia. The ethnolinguistic distribution of Ghanaians in Australia comprises the Akan-speaking people (43%), followed by Ewe speaking people (5%), and the rest from other backgrounds in Ghana. The report further indicates that 57 per cent of the Ghanaians in Australia profess Christianity, while the rest profess other religions such as Islamic, Hinduism and traditional African religion.

Further to these statistics, personal communication with the Ghana High Commission in Australia showed that about 12, 000 Ghanaians lived in Australia in 2015⁸, and so it can be deduced that there were about 360 older Ghanaians aged 65 years and above living in Australia⁹. This number would likely be higher if the estimates were done with people who are 60 years and above, which is the population of interest for this study amongst the cohort of participants still living in

⁸ Personal communication with the Ghana High Commission in Australia

⁹ Assuming the population of older people (65+) to be about 3 per cent of the Ghanaian population according to DIAC (3% of 12,000 = 360)

Ghana. Specifically, this study targeted middle class older people who were i) 60 years and above, ii) had at least above secondary education, ii) professionals and iv) lived in an urban location at the time of the research.

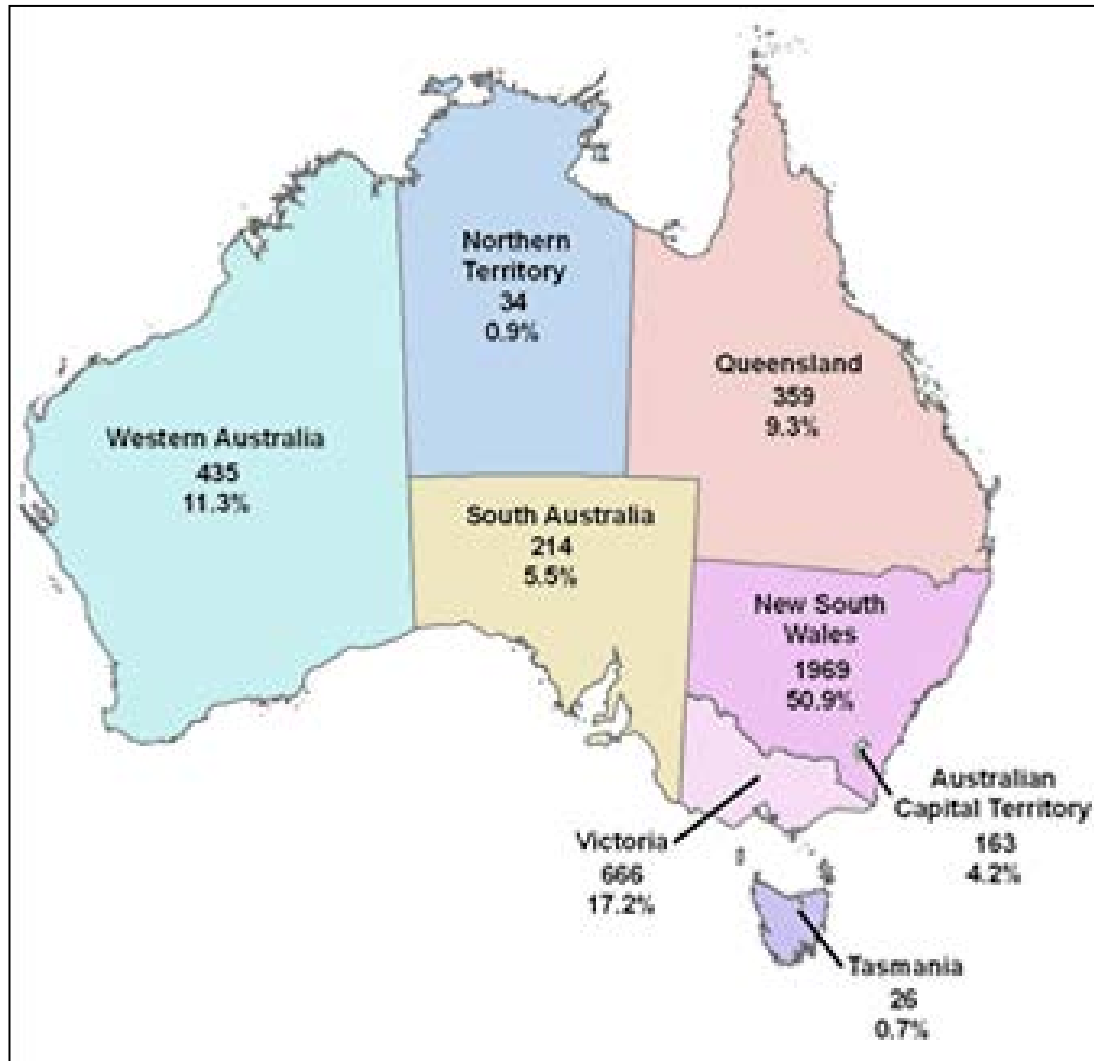


Figure 5.1: Distribution of Ghanaian Community in Australia

Source: Australian Department of Immigration and Citizenship (2011)

As indicated in Chapter One, the definition of an older person in Ghana is different from that in Australia. In Ghana, an older person is anyone who is 60 years and above, while in Australia, the benchmark is 65 years. This study adopted the Ghanaian standard of 60 years and above. It is important to note that the age categorisation is a matter of country-level policy and does not affect the recruitment of research participants at the cut-off age of 60 years. However, the 5-year age difference primarily meant that while all participants in Ghana were

mostly pensioners (formally), some of their counterparts in Australia aged between 60 and 65 years were actively employed, depending on their circumstances. The aged categorisation in the two countries is one of the differences in the policy environment, which is of interest to the current study.

The next section focuses on Ghana's demographic context of ageing. Ghana's population as at 2010, was estimated at 26 million people; and the estimate for older people was 1.6 million (6.2%) (Ghana Statistical Service, 2013b). As shown in Figure 5.2 below, in 2013, the Asante Region has the highest concentration of older people in the Ghana, representing 17.5 per cent, followed by the Greater Accra Region (12.9%), Eastern Region (12.8%), and the Volta Region (11.4%). The rest of the country has less than 10 per cent of older people in their respective regional areas. The Upper West has the lowest percentage of older people in Ghana. The Ghana Statistical Service (2013b) report on older people showed that the Akan ethnic groupings has the largest concentration (46%) of older people in Ghana, with the Mole-Dagbani's and Ewes having 16.6% and 14.6% respectively. The regional and ethnic representation of older people in Ghana is reflective of the distribution of older Ghanaians in Australia (Akan speaking people 43% & Ewes speaking people 5%, see above).

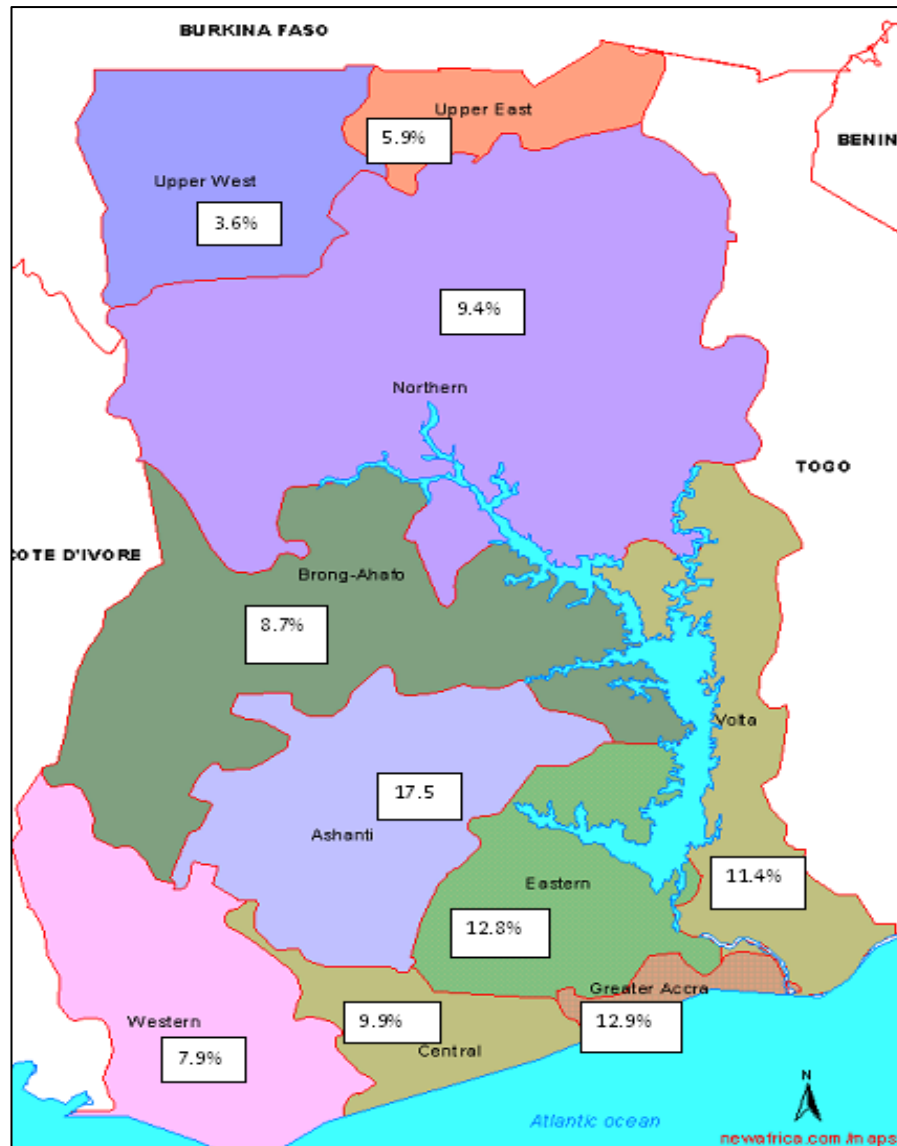


Figure 5.2: Regional demographic map of Ghana

Source: Ghana Statistical Service (2013b)

5.3 Case Selection

As indicated above, this study combined an interpretive phenomenological analysis (IPA) with a comparative case study to explore experiences and examine causal relationships concerning active ageing in two different settings. As with most studies of this type, recruiting and selecting participants is crucial. Brocki and Wearden (2006) and Pietkiewicz and Smith (2014) have respectively associated the purposive sampling approach with IPA studies due to the need to provide a clear focus on the phenomenon under investigation. Purposive sampling approaches are non-random ways of ensuring that individual cases within a population are represented according to their unique characteristics of relevance to the overall

study (Robinson, 2014). On the other hand, a comparative case study involving cross-national considerations requires a rigorous case selection technique (Engeli & Allison, 2014; Gerring, 2013; Seawright & Gerring, 2008a; Simons, 2014). Regarding case studies — some scholars have argued that cases should be selected based on scores of explanatory variables (Engeli & Allison, 2014; King, Keohane, & Verba, 1994), whereas others have argued for a variety of case selection approaches including cases that prove general points, typical cases, or deviant cases, which may be appropriate for qualitative research (Seawright & Gerring, 2008a). Ebbinghaus (2005) argued that there have been biases and errors with case selection in both quantitative and qualitative approaches. In responding to these concerns, this study used a three-staged case selection approach.

Stage One: selecting participants in Australia

The first stage involved selecting participants in Australia using the purposive sampling method. Purposive sampling rests on the principle that individual participants that meet a research project's criteria are available and willing to participate in the study (Creswell, 2002; Onwuegbuzie & Collins, 2007). The main criteria used to select participants were: i) identifying as a Ghanaian; ii) aged 60 or above; iii) must have resided in Australia at least five years before the study and; iv) availability and willingness to participate in the study. To mitigate selection bias and identification errors, multiple sources of referral were used, including snowballs, expert reference, contacts from members of Ghanaian Association of Australia, religious groups, and other individual level recommendations in Australia.

A notable disadvantage of the purposive sampling process is the problem of sample bias (Gabor, 2007). For example, in using referrals to reach participants, there is the likelihood of selecting 'cronies' who are entirely aligned with the views of the referrer (Gabor, 2007). Using multiple referral channels as explained under case selection mitigated this bias. Specifically, participants were selected from Sydney and Perth. Sydney was purposively selected because it has the largest concentration of older Ghanaians in Australia (About 50.9% of Ghanaians live in the New South Wales) (Australian Department of Immigration and Citizenship, 2011).

Perth was also chosen because it was the station of the researcher and the city with the third largest number of resident Ghanaians in Australia. In all, a total of 25 participants were pre-selected in Australia to constitute an initial sample for further selection.

The decision to stop the data collection upon reaching the 25th participant was due pragmatic restrictions as discussed subsequently. Even though there are no specific rules regarding sample size in an IPA study, small samples are encouraged because they provide a better opportunity for idiographic analysis (Pietkiewicz & Smith, 2014). That notwithstanding, Pietkiewicz and Smith (2014) suggested that sample size in IPA should be guided by four key considerations namely, “the depth of analysis of a single case study; the richness of the individual cases; how the researcher wants to compare or contrast single cases; and the pragmatic restrictions one is working under (Pietkiewicz & Smith, 2014, p. 9). Pragmatic restriction; that is, keeping to a sample size that can be accommodated given time and resources. In view of these restriction, an initial sample size of 25 for each of the study areas was deemed appropriate

Stage Two: Selecting participants from Ghana

The criteria used in selecting participants in Australia were replicated in Ghana. The selection process in Ghana also involved purposefully selecting older people from multiple sources of referral including those from the Ghana Pensioners Association, snow-balling, expert referrals, and referrals from Churches and other religious organisations. The process in Ghana also resulted in selecting and interviewing 25 older people to match the sample size from Australia. It is important to note that the 25 participants selected from Ghana also constituted a sample frame from which another sample was to be drawn. This process is discussed below:

Stage Three: Selecting comparable cases between Ghana and Australia

A key component of this current study was a comparison of the experiential meaning of active ageing between participants in Ghana and Australia to determine the extent to which context had shaped their conceptualisation of active ageing. In this regard, there were two cases for comparison: older people in Ghana and their

counterparts in Australia. Thus, at the third stage of the sampling process, there was a need to ensure that, to some extent, the individual cases can be compared for homogeneity. (Gerring, 2013; Seawright & Gerring, 2008a; Simons, 2014).

Apart from the need to find comparable individuals from the sample of 50 participants selected from Australia and Ghana under stage one and two of the sampling process, there was also the need to address some case selection concerns of IPA. As previously stated, IPA studies use small sample size to enable deeper idiographic analysis (Pietkiewicz & Smith, 2014; Smith, Flowers, & Larkin, 2009). Therefore, there was the need, in this study, to scale down the sample size of 50 to allow for considerable comparability. Furthermore, a central feature of an IPA sample is the level of homogeneity of the sample (Pietkiewicz & Smith, 2014). To achieve the level of homogeneity required for this analysis between participants in Ghana and Australia, there was the need to conduct one-to-one matching of participants to ensure that they have similar characteristics of interest. The process of ensuring the homogeneity is referred to as “yoked pairs”, which is recognised as being difficult to achieve in qualitative studies (Luborsky & Rubinstein, 1995).

The difficulty in case selection notwithstanding, as argued by Lor (2011), the underlying principle of any case selection for comparative analysis is that the cases should neither be too different nor too similar. Therefore, comparison thrives when there are elements with suitable potential for comparison. In achieving the comparability required, the study adopted the most similar system design (MSSD) case selection approach (Seawright & Gerring, 2008b). The MSSD approach is most effective where the cases for comparison are similar in all explanatory variables except one or two variables of interest (Gerring, 2013; Kolodner, 2014; Lor, 2011; Yin, 2013). Nielsen (2016) explained that the most similar case selection approach can involve choosing two or more cases that have similar characteristics. Historically, this approach is related to the work of Mill (1858) on methods of difference, later modified to ‘most similar systems’ by Teune and Przeworski (1970), and further classified as ‘comparative method’ by Lijphart (1971).

In order to make use of the most similar case selection approach, Nielsen (2016) advocated four critical processes: i) define the population of the cases; ii)

identify the variable of interest that should be similar to the cases; iii) identify the variable that should be different; iv) and select a desired number of cases, often in pairs. In this study, the population of the cases was divided amongst older people in Ghana and older Ghanaian migrants in Australia. The key variables that needed to be similar among the groups of research participants were educational level, average income per month, skills status, employment status, and house ownership. The key variable of difference was the dissimilar policy environments of the two countries in which participants were residing. Thus, the approach hinged on constructing an appropriate matching process.

Ebbinghaus (2005) argued that case selection methods that integrate quantitative and qualitative elements provide an opportunity to reduce researcher bias. A similar assertion was made by Mahoney (2003) and Seawright and Gerring (2008a) that the use of both qualitative and quantitative means of selecting study participants can mitigate against the weaknesses of each approach. Furthermore, Nielsen (2016) argued that there are important advantages to selecting cases using statistical matching for qualitative analysis. Two of these advantages are: providing confidence that the cases are similar, and allowing for transparent processes. Thus, the study integrated a quantitative matching technique into the case selection process as described below.

In this study, propensity score matching (see next paragraph) was conducted using quantitative data generated from the sampled 50 participants during the data collection process. As described under the section about data collection, as part of the in-depth interview process, two tools were used: A semi-structured interview guide for the in-depth interview process, and a one-paged structured interview guide to collect quantitative data was deployed for the matching exercise. The purpose of using these tools was to whether the participants had the background and variables for cross matching and comparison.

Dehejia and Wahba (2002) asserted that 'propensity score matching' has gained prominence in non-experimental causal studies and is useful for matching treatment and control groups for comparative analysis. Also, despite propensity score matching being traditionally used as a purely statistical tool, it has been found

to be very useful in strengthening case selection in qualitative studies (Caliendo & Kopeinig, 2008; Nielsen, 2016; Seawright & Gerring, 2008a).

The statistical method of the propensity score assumes a binary action X (or treatment) and a set of covariates denoted by ' S '. Caliendo and Kopeinig (2008) argued that the propensity score $L(s)$ is the probability that a participant from the treatment group ($X= 1$) will be chosen based on the measured covariate by a participant from the control group ($S = s$). The nearness in neighbour matching, which explains the closeness of an element to the other given certain conditions, was used.

In determining the propensity score matching for this study, a predicted probability score based on binary logistic regression was estimated for each participant. Thus, the probability of having similar socio-economic background between those in Australia and Ghana was achieved by classifying participants in Australia as the treatment group ($X= 1$), and those in Ghana were the control group ($X =0$). The covariates used in the estimates of the propensity score were: educational level (tertiary and above/below tertiary); average income per month on the basis of the prevailing market rate between the Australian Dollar and the Ghanaian Cedi (1GHS = 0.292AU as at March 2015) (Above AU\$1000 /below AU\$1000); skills status (skilled professional/ Non-skilled), current employment status (paid or unpaid/ not working) and house ownership (owned/not owned). The dependent variable was the participants' reported perception of quality of life at old age, and estimates of the predicted probability scores were conducted using SPSS software.

The factors that were used to match participants, as explained previously, were directly drawn from the literature. As shown in Table 5.1 and Figure 5.4, using the nearness in neighbour matching, only 15 participants from the assumed control group (Ghana) matched with participants from the assumed treatment group (Australia). The yellow highlighted sections of Figure 5.3 show the participants, who were manually matched based on the closeness of their probability score. Figure 5.4 demonstrates the distribution of participants in Australia and Ghana on the probability line. In effect, 15 participants were selected from among participants in

Australia, and 15 from among participants in Ghana, to create the model using Most Similar System Design. All further analyses were conducted based on the sample, N=30. An inherent limitation of using the propensity score matching for case selection, as noted by Nielsen (2016), is the difficulty in estimating the distance between the cases efficiently, thus a perfect pair was not possible.

Table 5.1: Manual Propensity score matching of cases between Ghana and Australia

| Australia | | Ghana | |
|----------------|-----------------------|-----------------------|----------------|
| Participant ID | Predicted probability | Predicted probability | Participant ID |
| AR11 | 0.9889 | 0.9089 | GR15 |
| AR22 | 0.9889 | 0.7317 | GR1 |
| AR8 | 0.9307 | 0.7317 | GR9 |
| AR19 | 0.9307 | 0.7317 | GR17 |
| AR10 | 0.9089 | 0.6696 | GR2 |
| AR21 | 0.9089 | 0.6696 | GR11 |
| AR1 | 0.7317 | 0.6696 | GR19 |
| AR4 | 0.7317 | 0.3245 | GR4 |
| AR12 | 0.7317 | 0.3245 | GR12 |
| AR15 | 0.7317 | 0.2345 | GR3 |
| AR23 | 0.7317 | 0.2345 | GR6 |
| AR2 | 0.6696 | 0.2345 | GR7 |
| AR3 | 0.6696 | 0.2345 | GR10 |
| AR5 | 0.6696 | 0.2345 | GR14 |
| AR6 | 0.6696 | 0.2345 | GR23 |
| AR13 | 0.6696 | 0.1160 | GR8 |
| AR14 | 0.6696 | 0.1160 | GR16 |
| AR16 | 0.6696 | 0.1160 | GR24 |
| AR17 | 0.6696 | 0.1160 | GR25 |
| AR24 | 0.6696 | 0.0195 | GR5 |
| AR25 | 0.6696 | 0.0195 | GR13 |
| AR7 | 0.3926 | 0.0195 | GR21 |
| AR18 | 0.3926 | 0.0145 | GR18 |
| AR9 | 0.2345 | 0.0145 | GR20 |
| AR20 | 0.2345 | 0.0145 | GR22 |

Source: Developed by researcher

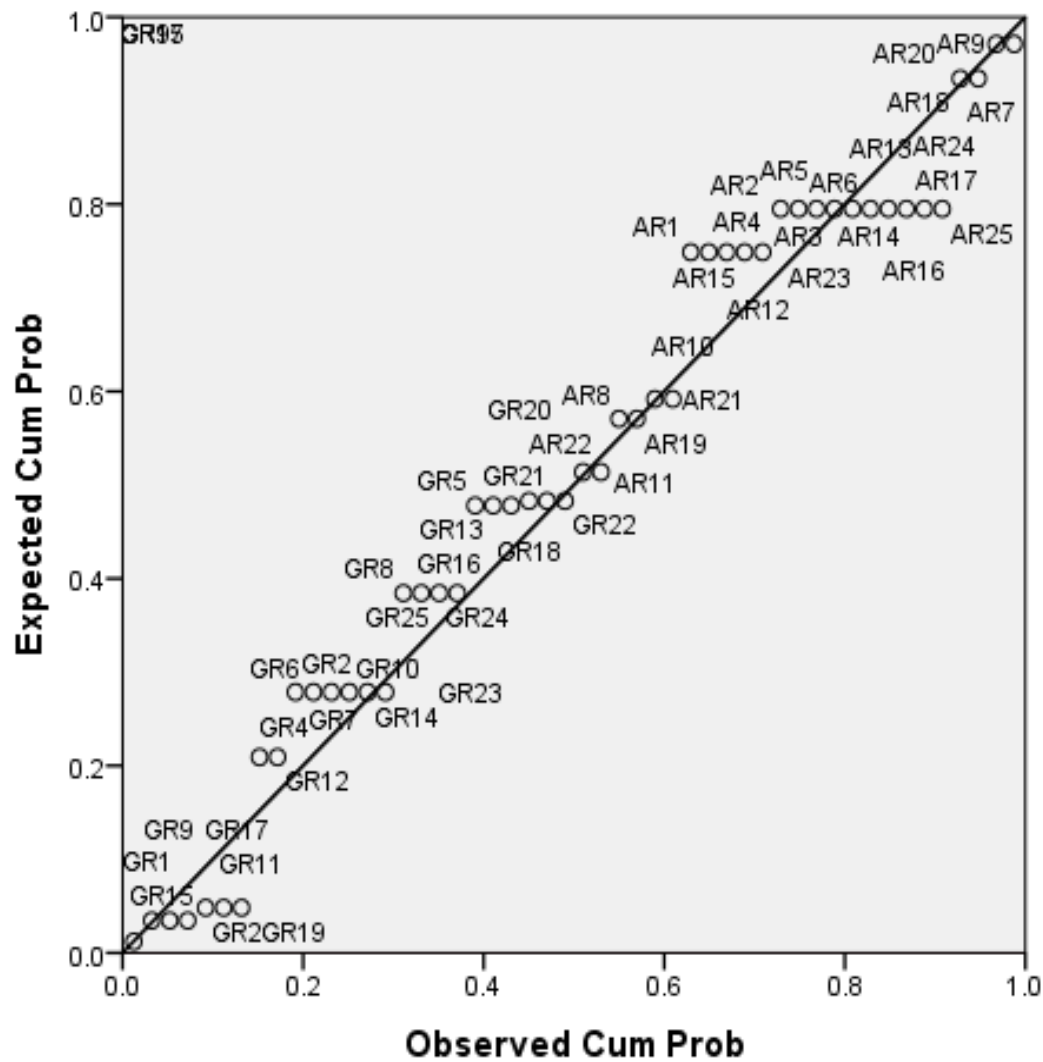


Figure 5.3: Normal probability plot of regression

Source: Developed by researcher

5.4 Data collection

The primary process of data collection for this study was in-depth interviews with all respondents using a semi-structured interview schedule. In addition to the IDI, a one-page structured interview guide (See Appendix 2) was developed and used to generate quantitative data only for matching and case selection. The one-page structured question guide was administered to the 50 participants who were initially selected through purposive sampling. The purpose of the structured interview was to generate some background variables data required for finding a match between participants in Australia and Ghana. Apart from demographic variables such as age and sex, the questionnaire was made up of questions about educational level, current employment status, average income per month,

ownership of place of residence, and many others. All interviews were conducted by the researcher in person and involved face-to-face interviews only.

Individual in-depth interviews with participants were conducted and were directed towards understanding the lived experiences of older people with active ageing and participants' perceptions of active ageing. Participants were encouraged to tell their life stories relating to the ageing process. The interviews also explored contextual issues about the participants' lives, which had implications for their lived experiences. All interviews were conducted in English in the homes of participants and were audio recorded. The interviews lasted between 45 minutes to 1 hour depending on the circumstances of the participant. As indicated under selecting participants above, the researcher used telephone calls or personal visits to schedule interviews with potential participants when he received referrals from contact persons and organisations. Participants who agreed to take part in the study were provided with an information sheet (See Appendix 3) and a consent form (See Appendix 4). After consent was obtained, the interview was conducted.

5.5 Transcription and coding

The first part of the data analysis process was the transcription from the audio file to text file of the 30 in-depth interviews from the matched participants. The transcription was done in three stages. The first stage involved engaging an independent transcriber to transcribe the voice files. Even though the researcher took down detailed field notes, it was deemed critical to explore an objective transcription from an independent and experienced researcher. Thus, since all voices were recorded from the first minute on personal introduction, it was possible to de-personalise the file to maintain confidentiality before the transcription was conducted. Each participant was given a case identifier (ID), using AR1 to AR25 for participants in Australia and GR1 to GR25 for participants in Ghana. 'AR' refers to Australia Respondents and 'GR' refers to Ghana Respondents.

It was not possible to send the transcripts to all participants for validation other than in eight cases, as a result, at the second stage, another transcriber was employed to conduct a 'voice to text validation' of the first transcript. The validation was needed to ensure that the voices in the interviews matched with text

files, and that the statements reflected the exact intentions of the respondents (Hefferon & Ollis, 2006). In the eight cases where it was possible, the transcripts were sent to the respondents for validation after the voice to text validation was completed; they unanimously confirmed the validity of the transcript. This process was important as part of the recommendations for ensuring rigor in qualitative analysis (Tong, Sainsbury, and Craig, 2007). The final stage of the transcription involved the researcher reading through the transcripts while listening to the audio files to ensure consistencies between the text files and the audio. That stage was also used to reflect upon all the data and to prepare the data for coding in the Nvivo software.

The Nvivo Software Version 10 was used for the coding process, which involved reorganising the data and classifying them into their appropriate categories. And it included creating separate project folders for the In-depth Interviews from Ghana and Australia for comparative purposes. Each of the interviews was separately coded and merged subsequently. The data was further classified into those items or themes that provided information on the participants' meaning of active ageing and those that indicated factors that shape different active ageing processes. The approach to the coding was an inductive process to allow for the emergence of codes instead of aligning with pre-defined codes (Corbin & Strauss, 2014). The researcher did the initial coding, which has been labelled 'solo coding' (Saldana, 2009).

In order to authenticate the researcher's reflections on the codes, three procedures were followed (see Corbin and Strauss (2014); Saldana (2009). First, the researcher shared the code-book (See Table 5.1) and sample transcript with senior researchers as a check on whether the codes were reflective of the general stories in the transcripts. This check resulted in the relabeling of some of the codes and also using other codes as child nodes instead of the parent node. Second, the coding process also involved having a discussion with my principal supervisor about the codes and how they reflected the general stories of participants. The discussions led to minor revisions in the classifications of the codes. For example, changing codes that sounded like 'health' but better fit for 'activity'. The third

coding process involved developing analytic memos in Nvivo, which were later used to provide content for the discussion.

5.6 Data Analysis

5.6.1 Interpretive phenomenological analysis

Profiling of participants

The first approach to data analysis in this study was to conduct a summary profile analysis of each of the respondents, as is typical of many IPA studies. The extent of profiling (i.e. providing anonymous socio-demographic information), however, can be challenging in phenomenological and other qualitative studies due to the problem of deductive disclosure, which is where other people can easily identify respondents by the kinds of data they provide, particularly on socio-demographic variables (Kaiser, 2009). In the deductive disclosure, given a certain amount of information about participants, it is possible for people located in the study area to recognise the research participants. The dilemma is that deductive disclosure may breach confidentiality (Kaiser, 2009). In order to mitigate the problem of deductive disclosure in this study, a summary profile of the research participants was developed using coded participants' identification rather than their actual names and socio-demographic variables. The summary profile is presented in Table 5.2.

Table 5.2: Profiling of research participants

| Participant ID | Sex | Age | Marital status | Current employment | Main Source (s) of income | Educational background |
|----------------|-----|-----|----------------|--------------------|---------------------------|------------------------|
| AR10 | M | 78 | married | retired | pension + remittance | degree |
| AR21 | M | 70 | married | retired | pension + investment | degree |
| AR1 | F | 60 | married | paid work | Salary | diploma |
| AR4 | F | 61 | married | paid work | Salary | secondary |
| AR12 | F | 60 | married | paid work | Salary | secondary |
| AR15 | F | 61 | divorced | self employed | retail business | tertiary |
| AR2 | M | 67 | married | paid work | own business | tertiary |
| AR3 | M | 63 | married | paid work | Salary | tertiary |
| AR5 | M | 60 | married | paid work | Salary | tertiary |
| AR6 | M | 63 | married | self employed | own business | tertiary |

| Participant ID | Sex | Age | Marital status | Current employment | Main Source (s) of income | Educational background |
|----------------|-----|-----|----------------|--------------------|---------------------------|------------------------|
| AR13 | M | 67 | married | retired | Pension | tertiary |
| AR7 | F | 60 | widowed | paid work | Salary | secondary |
| AR18 | F | 60 | married | paid work | Salary | diploma |
| AR9 | M | 60 | married | paid work | Salary | tertiary |
| AR20 | F | 67 | widowed | retired | Pension | tertiary |
| GR15 | M | 73 | married | retired | Pension | tertiary |
| GR1 | F | 61 | married | retired | pension + resistance | diploma |
| GR9 | F | 61 | married | self employed | own business | diploma |
| GR17 | F | 68 | widowed | retired | Pension | diploma |
| GR2 | M | 70 | married | retired | pension +investment | tertiary |
| GR11 | M | 66 | married | self-employed | pension+ business | tertiary |
| GR19 | M | 66 | married | retired | Pension | tertiary |
| GR4 | F | 65 | married | retired | pension +investment | tertiary |
| GR12 | F | 64 | married | retired | Pension | tertiary |
| GR3 | M | 61 | married | retired | Pension | tertiary |
| GR6 | M | 72 | married | retired | pension + remittance | tertiary |
| GR7 | M | 73 | married | retired | pension + remittance | tertiary |
| GR10 | F | 68 | married | retired | pension + remittance | diploma |
| GR14 | M | 70 | married | retired | pension + investment | tertiary |
| GR23 | F | 70 | widowed | retired | pension + inheritance | tertiary |

The data reduction process in IPA

The second analytical process involved interpretive phenomenological analysis, relating to understanding the meaning of active ageing based on the lived experiences of older people. The first stage of the analytical process involved phenomenological reduction (Lawthom and Tindall (2011), which required deducing the general meaning of the phenomenon (active ageing) from participants without any pre-determined structure of thought. The need to suspend one's presuppositions is referred to as bracketing or phenomenological reduction (Lawthom & Tindall, 2011). Table 5.3 provides a sample of the analytical data

process. Table 5.4 is a code book showing a summary of all the words, phrases or sentences emerging from the data (codes), which constituted the ***units of the general meaning*** of active ageing for particular older people. Table 5.5 also shows the emerging codes for factors that contribute to quality of life during old age.

Table 5.3: Sample extract of the IPA process

| | |
|---|---|
| Interviewer: What does active ageing mean to you based on your everyday life experiences? | |
| Original transcripts | Emerging issues/code (Sampled) |
| Selected responses: | |
| "It means getting yourself busy so that you don't feel bored, especially in the company of other people. Loneliness is a problem here, so you need people at this age" (AR) | Being busy, the company of other people |
| "You see, if you are old, like me yet you can do all the things young people do, and you don't depend on anyone to help you, that is active ageing" (AR-6) | Independence |
| "Well, active ageing is being busy always with people around you, you know, you can't live alone at this age!" (GR1-Ghana) | Being busy, company of other people |
| "It means you are not bed ridden, and that you can go about doing what you want. In this country, you cannot be idle, you must be active, by doing something. If you are not employed, you must find a hobby to keep you active" (AGR7) | Good health, independence, activity/work |
| "hmmm, it depends on, when I was 70, I had the children around so they helped me since I couldn't do things by myself, I am 80 now, and I wish at this age, I could do things without being assisted" (GR-10) | Health, independence |
| "By sixty-five, my grandchildren came, so I stopped the evangelism work for the church. Now, I stay home and take care of the little ones because one is five and other is three. They keep me busy. In the church, I am active in children ministry" (GR14-Ghana) | Activity, family life, community service |
| My spouse is here, and the children, together with my grandchildren, are always around. I interact with them always, and this keeps me happy and healthy. When I can talk with people often and get to visit friends and also participate in activities of the community, I am active ageing (GR-3) | Presence of children, grandchildren, Meet and interact with people Feeling happy |

Table 5.4: Codebook on IPA for experiential meaning of active ageing

| Emerging codes | Code Frequency | | | | | | | | | | | | | | | | | | | | | | | | | | | Total Freq | | | |
|--|----------------|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----------|----|----|----|----|----|----|----|-----|-----|-----|-----|---------------|-----|-----|-----|
| Meaning of active active ageing based on lived experiences | Ghana | | | | | | | | | | | | | | | Australia | | | | | | | | | | | | | | | |
| | R1 | R2 | R3 | R4 | R6 | R7 | R9 | R10 | R11 | R12 | R14 | R15 | R17 | R19 | R23 | R1 | R2 | R3 | R4 | R5 | R6 | R7 | R9 | R10 | R12 | R13 | R15 | | R18 | R20 | R21 |
| Happiness at old age | | | | * | | | | | | | * | | | | | * | * | | | | | | | | | | | | | | 4 |
| Always busy with people around | * | | | | | * | | | * | | | * | | | | | * | * | | | * | | | | | | | * | | | 8 |
| Be able to do something for yourself | | | * | | | | * | | | | * | | | | | | | | | | | | | | | * | | | | | 4 |
| Being able to engage with friends and family | | | | | | | | | | | | * | | * | * | | | | | * | | * | | * | | | | | * | | 7 |
| Do things to occupy yourself. | | * | | | * | | * | | | | * | | | | * | * | | | | | | * | | * | | | | | | | 8 |
| Do things you want to do without been assisted | * | | | | | | | | | * | | | | | | | | | | | * | | | | | | | | * | | 4 |
| Doing some work even volunteering or paid at old age | | | | | | | * | | | | | | | | * | | | | * | | | * | * | | | | | | * | | 6 |
| Exercise | | | | | | * | | | | | * | | | | | * | | | * | * | | | | | | * | | | * | | 7 |
| You are fine, and not so may diseases | | | | | | | | | * | | | | * | | | | * | | | | | | | | | | * | | | | 4 |
| Having grandchildren and getting busy with them | * | | | * | | * | | * | | | * | | | * | * | | | * | | | | | * | | | * | | | | | 10 |
| Having power and strength to do anything of your own | | | * | | | | | | | * | | | | | | | | | * | | | | * | | | | * | | | | 5 |
| Having the ability to be active in community life | | | * | | | * | | * | | | | | * | * | * | | | | | | | | * | | * | | | | * | | 9 |
| Having the opportunity to eat good and healthy food | | | | | | * | | | | | | | | | | | * | | | | * | | | | | | * | | | | 4 |
| Never get sick | | | * | | | | | | | | | | * | | | | | | * | | | | | * | | | | | | | 4 |
| Involved in something | * | | | | | | | | | | | | | | | | | | | | | | | | | | * | | | | 2 |
| Is genetic issue | | * | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 |
| It means you are not bed ridden | | | | | * | | | | | | | | | | | | | | | | * | | | | * | | | | | | 3 |
| Keeping your relationships | * | | | * | | | * | * | | | | * | | | * | | | * | | | | | | | | | | * | | | 8 |
| Living with God | | | * | | | | | | * | | | | | * | | | | | | | * | | * | | | | | | | | 5 |
| Make your heart active | | | | | | | | | | | | | | | | | | | | | | | | | | | * | | | | 1 |
| Mind does not tell me I am old | | | | | | | | | | | | | | * | * | | | | | | | | | | | | | | | | 2 |
| Not thinking or worrying too much | | | | | | * | | | | | | | | | | | | | | | | | | | | | | | | | 1 |
| Ability to walk around without difficulty | | * | | | * | | | | * | | | | | | | | | | | | | | | | | | * | | | | 4 |
| Entertainment with friend and family | * | | | | | | | | | | | * | | | * | | | * | | | | | * | * | | | | | * | | 7 |

Table 5.5: Code book on pathways and factors contributing quality of life during old age

| Emerging codes | Code Frequency | | | | | | | | | | | | | | | | | | | | | | | | | Total Freq | | | | | |
|--|----------------|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----------|-----|----|----|----|----|----|----|----|----|-----|-----|---------------|-----|-----|-----|-----|-----|
| Pathways through which experiential active ageing occurs | Ghana | | | | | | | | | | | | | Australia | | | | | | | | | | | | | | | | | |
| | R1 | R2 | R3 | R4 | R6 | R7 | R9 | R10 | R11 | R12 | R14 | R15 | R17 | R19 | R23 | R1 | R2 | R3 | R4 | R5 | R6 | R7 | R9 | R10 | R12 | | R13 | R15 | R18 | R20 | R21 |
| Income size | * | * | | * | * | | * | * | | | | | * | | * | | * | | * | | * | * | * | * | * | | * | * | * | | 18 |
| Income source | * | | * | | | * | * | | | * | | * | | | * | | | | | * | | | | | | | | | | | 8 |
| My education | | | | | * | | | | * | | | | | | | * | | | | | * | | * | | * | | | | | * | 7 |
| Work | | | | | | | | | * | | | | | | | | | * | | | | | * | | * | | | * | | | 5 |
| Investment | * | | | | | | | | | | | | * | | | | | | | * | | | | | | | * | | | | 4 |
| Looking after children | * | | * | | | * | | | | | | * | | * | | | | | | | * | | * | | | | | | | * | 5 |
| marriage | * | | * | | | | * | | * | * | | * | | | * | | | * | | | | | | * | | | * | | * | | 11 |
| T ravel | | | | | | * | | | | | | * | | * | | | | | | | | | | | | | | * | | | 4 |
| Our family | | | | | * | | | | * | | | | | | | | | | | | | | | * | | * | | | | | 4 |
| Free education | * | * | | | | | * | | | * | | | | | | | | | | * | | | | | | | | | | | 4 |
| Social unrest leading to migration | | | | | | | | | | | | | | | | | | * | | | | | | | | | | | * | | 2 |
| Having the ability to be active in community life | | | * | | | | | | | | | | | | * | | | | | | | | | | | | | | | | |
| Many friends | | | | | * | | | | | | | | | * | | | | * | | | | * | | | | | | | * | | 5 |
| Busy life | * | | | | | | | | | | * | | | | | | | * | | | | | | * | | | | | | | 4 |
| Involved in something | | * | | | | * | | | | | | | | | | | | | | | | | | | | | | | | | 2 |
| Laws an Policies | | | | | | | | | | * | | | * | | * | | | | | | | | | | * | | * | * | | * | 7 |
| Presence of Social Services | * | | | | | | | | | | | | | | | | * | | | | * | | * | | * | | | * | * | * | 8 |

Cluster analysis of codes for relevant meaning of active ageing

[I]t is not the real content of human subjectivity that is the focus of a hermeneutic inquiry but, rather, what the individual's narratives imply about what he or she experiences every day. (Lopez & Willis, 2004, p. 729)

In line with Lopez and Willis (2004), the researcher took the position that the units of general meaning of active ageing as generated above are not sufficient to relate the experiential meaning to the current literature and theory of active ageing because phenomenological study requires going beyond the descriptive data of active ageing as indicated by respondents. As noted by Lopez and Willis (2004), it is imperative to relate the implications of individual narrations of experience to a wider body of knowledge. This process is what Ricoeur (1970) cited in King et al. (2008) referred to as 'bringing out the meaning of experience'. However, Lawthom and Tindall (2011) argued that this process must honour the context of the narratives of the participants and be consistent with the parameters of the study. It should be noted that the clustering of codes into themes was done based on similarity in the semantic meaning of the concepts and their relevance to the life course approach and other theories of ageing. A cluster analysis in Nvivo was used in this instance using coding similarity. Table 5.6 shows the different clustered meanings (themes) relevant to the study's theory and the research question, which were arrived at based on the units of general meaning provided by research participants. Each of these themes is discussed later.

Table 5.6: Clustered codes for relevant meaning

| Theoretical Theme | Cluster of words/phrases/sentences | Code Frequency | Code Total |
|--------------------|---|----------------|------------|
| Social Interaction | Being able to engage with friends and family | 7 | 49 |
| | Having grandchildren and getting busy with them | 10 | |
| | Ability to be active in community life | 9 | |
| | keeping your relationships active | 8 | |
| | always busy with people around | 8 | |
| | Entertainment with friends and family | 7 | |
| Activity | Always busy.... | 8 | 29 |
| | Doing things to occupy yourself | 8 | |
| | Involved in something.... | 2 | |
| | Ability to walk around without difficulty | 4 | |
| | Ability to be exercise | 7 | |
| Physical health | Never sick | 4 | 16 |
| | Not bedridden | 3 | |
| | Fine and not so many diseases | 4 | |
| | Having the opportunity to eat good and healthy food | 4 | |
| | My genetic makeup as I see from my lineage | 1 | |
| Independence | Be able to do things for yourself | 4 | 13 |
| | Do things you want to do without being assisted | 4 | |
| | Having power and strength to do anything on your own | 5 | |
| Happiness | Happy during old age | 4 | 6 |
| | Not thinking or worrying, just happy | 1 | |
| | My mind does not tell me I am old; I am just excited | 1 | |
| Work/Employment | Doing some work, even if volunteering or paid | 6 | 6 |
| Spirituality | Living with God or being part of a church | 5 | 5 |
| Public safety | Feeling safe around others and able to move about in public | 3 | 3 |

5.6.2 Comparative Case Analysis

The third level of analysis was a comparative case analysis using the analytical tools of process tracing and typological theory analysis. It should be

emphasised that in addition to understanding the lay meaning of active ageing based on the expressions of older people, there was the need also to examine i) how the experiential meaning differed or were similar in the two policy settings; and ii) the causal pathways through which research participants attained different qualities of life. The process tracing approach and how it was used to examine the causal pathway of quality of life is discussed below.

In theory, *process tracing* as an analytical tool in this study was underpinned by the life course perspective of ageing, which assumes that later life experiences are, to a large extent, dependent on events within the life transition from birth to death (Browne et al., 2009; Riley, Foner, & Riley Jr, 1999). Process tracing is also grounded in the understanding of causal mechanisms as consisting of real or systematic observations that may or may not produce regular patterns of behaviour (Maxwell, 2004).

As stated previously, the comparative case analysis in this study relied on the process tracing approach in the first instance. According to Mahoney (2012), process tracing has emerged as a useful analytical tool for examining causal linkages that are valid within the case being investigated. Mahoney (2012) further argued that process tracing requires a mode of reasoning in which the analyst derives a logical conclusion from a set of premises. The premises include "facts" from the case and one or more pre-existing generalisations that can be applied to these facts" (p.14). The key principles for establishing whether an event has resulted in another event in process tracing include: i) *the principle of necessary and sufficient condition* (i.e. where a factor or a cause is both necessary and sufficient to produce the outcome) ii) *the straw in the wind* (i.e. supporting an explanation with caution. it may be in or out) and iii) *the smoking gun* (i.e. that is when the cause demonstrates a sufficient condition to produce the outcome) (A. Bennett & Checkel, 2015; George & Bennett, 2005; Mahoney, 2012). In the current analysis, the smoking gun test was more appropriate than the others. Thus, the causal statements made in the analysis as will be presented in Chapter Eight relied on the smoking gun principle to affirm the arguments. The process tracing approach was supported by the use of NVivo software to organise the qualitative data into

appropriate categories and themes and to capture memory points during the coding process. Table 5.4 provides information on the coding frame for the case analysis. In addition, where possible, direct statements of respondents that addressed pertinent issues were captured and presented as part of the analysis.

To strengthen the analysis further, a typological theory was constructed to classify different types of quality of life based on the expressed lived experiences of older people and to examine how each of the types of quality of life was attained. Doty and Glick (1994) and Bailey (1994) argued that typologies are useful analytic tools for theory building which can further be subjected to rigorous empirical testing using the quantitative models. Typology involves the creation of a types based on theoretically informed distinctions of explanatory variables through which cases are expected to cluster (George & Bennett, 2005).

Relative to this study, the two central dimensions of quality of life (level of social interaction and level of social service provision) (see Chapter Two) were used to construct a four-quadrant typology of quality of life based on the recommendations of Bailey (1994) that developing typologies requires conceptualization along at least two dimensions of the variable of interest.

Constructing the typology

In creating the matrix, all the indicators of the dimensions were scaled from zero to two (0= low, 1 = medium and 2= high). The matrix produced four quadrants referred to as attribute spaces (Kluge, 2000). For social interactions, the central indicators were social capital, activity and income or assets. For the level of service provision, the indicators were health and health care, social protection, and other allied services such as subsidies in public service utilisation and private support services.

The experiential stories of participants on these indicators were scored based on the intensity of the issues from their story. Thus the analysis was based on the explicit statements of research participants. The average score for each dimension was determined for each participant. The average score per participant per dimension was used to determine the participant's position on the matrix; no

participant could belong to more than one category at a time, as shown in Table 5.7 below.

Table 5.7: A process of creating a typology of active ageing using dimensions and indicators

| Dimension | Indicators | Scale (0=Low, 1= Medium, 2 =High) | Score |
|---------------------|-----------------------|--|--|
| Social Interactions | Social capital | Low =0= Extremely limited social capital or no apparent functional social capital | Average score per respondent on social interaction |
| | | Medium =1= Some aspects of functional social capital either on the external or internal sides present | |
| | | High = 2= Fully functional social capital with both external and internal sources well utilised | |
| | Continuous Activity | Low = 0=Extremely limited activity or no apparent activity | |
| | | Medium =1= Some level of activity either physical, social or economic | |
| | | High = 2=Full range of combination of activities including physical, social & eco | |
| | Income or assets | Low = 0= very low income or no asset | |
| | | Medium =1= Evidence of some appreciable level of assets | |
| | | High = 2= Evidence of High levels of assets | |
| | Health and Healthcare | Low = 0 = Non-availability and or limited access to healthcare services during ill health | |
| | | Medium =1= Limited availability of health services but opportunities for access when in ill health | |
| | | High =2= Full availability of diversified health services and range of opportunities for access to adequate healthcare when sick | |

| Dimension | Indicators | Scale (0=Low, 1= Medium, 2 =High) | Score |
|--------------------|----------------------------|---|--|
| Essential Services | Social Protection/Security | Low=0= No opportunities for social protection including contributory pensions, old age pensions and other relevant social welfare systems | Average score per respondent on Essential Services |
| | | Medium =1= Some functional social protection available but limited access or general insufficient | |
| | | High =2= Fully functional social protection system including sufficient pensions, old age pensions etc. | |
| | Subsidised public service | Low =0= No known functional subsidies of public services | |
| | | Medium =1= Some subsidies available but hardly accessible | |
| | | High=2= Sufficient opportunities for subsidised public services | |
| | Private support services | Low=0= No experience of private support services such as not for profit organisations or faith-based institutions | |
| | | Medium =1= Some limited opportunities for private support services | |
| | | High =2= High presence and experiences with private social support services | |

5.7 Ethics and ethics clearance

This study adhered to ethical standards of research practice. For purposes of maintaining research participants' confidentiality, gaining informed consent and maintaining privacy, the researcher followed ethical procedures. As a result, the researcher sought appropriate ethics approval of the Human Ethics Committee of the Edith Cowan University. An information letters about the research project was provided to each participant (See Appendix 4). Interested participants then signed letters of informed consent (see Appendix 3) before the interviews commenced. Furthermore, participants were assured of confidentiality and their rights to

withdraw their consent at any time if they became uncomfortable with the interview without any reprisals.

For privacy, the data was stored in lockable filing cabinets and on password-protected computers and hard drives. Critical confidential data will be shredded and deleted from the hard drives at the end of the research. The researcher was solely responsible for the data collection so no field assistants were used. The professional transcriber was not supplied with any identifying information. In order to achieve privacy and confidentiality during the transcription, the voice files were made anonymous and given unique codes known only to the researcher before being handed over for transcription. Moreover, the thesis has de-identified all participants in the study.

CHAPTER SIX: UNDERSTANDING ACTIVE AGEING THROUGH THE EXPERIENCE OF OLDER PEOPLE

6. Introduction

Apparently, a great deal had been written about old age, but most of the authors who dealt with it were lads and lasses, as it seemed to me, in their late fifties or early sixties. They knew the literature, but not the life. Some of them had brought together statistics or pored over medical reports, while others had tracked down the aged with camera and tape recorder; what they didn't and couldn't know was how it feels to be old. I knew, close as I was to my 80th birthday, and I decided that there was still room for an honest personal report (Cowley, 1982, p. ix)

According to the Cowley's statement above, one of the most authentic ways of understanding issues of ageing is allowing older people to tell their own stories. Unfortunately, it is not plausible for every older person to write about their own feelings and experiences as Cowley did. As a result, this chapter presents and discusses the findings from the study of reported experiences of the 30 research participants, and the meanings they ascribed to active ageing. The findings and the discussions aim to represent what these older people considered as most important for the promotion of their quality of life. The chapter also analyses the conceptual fit between the experiential meaning of active ageing and the World Health Organisation's (WHO) active ageing model.

6.1. Meaning of active ageing: An interpretive phenomenological analysis

In the analysis of the data for the 30 in-depth interviews, the IPA process discussed in Chapter Five, led to a finding of a total of eight experiential meanings of active ageing that emerged. The importance research participants accorded each theme was measured by the total number of references they made to particular themes (frequency of the codes). A total of 25 codes on the research participants' particularised active ageing experience, represented by words, phrases or whole sentences emerged from the IPA coding process. Table 6.1 shows the list of the primary codes that emerged from the IPA process and their frequencies in the data.

According to Pietkiewicz and Smith (2014), an important aspect of IPA is the clustering of emerging codes into theoretical themes. As a result, the 25 codes, which emerged from the data were clustered into eight themes based on code similarity and their relevance to theory (Pietkiewicz & Smith, 2014; Pringle et al., 2011). Figure 6.1 shows the emergent themes and their relevance to quality of life, which is based on the themes' proportional representation in the total code distribution. Table 6.1 and Figure 6.1 represent the overall finding from participants in both Ghana and Australia (as a single unit).

Table 6.1: Emerging codes and the meaning of experiential active ageing

| Emergent theme | Emergent codes | Code Frequency | Code reference total |
|-----------------------|---|-----------------------|-----------------------------|
| Social Interaction | Being able to engage with friends and family | 7 | 49 |
| | Having grandchildren and getting busy with them | 10 | |
| | Ability to be active in community life | 9 | |
| | Keeping your relationships active | 8 | |
| | Always busy with people around | 8 | |
| | Entertainment with friends and family | 7 | |
| | | | |
| Activity | Always busy.... | 8 | 29 |
| | Doing things to occupy yourself | 8 | |
| | Involved in something.... | 2 | |
| | Ability to walk around without difficulty | 4 | |
| | Ability to be exercise | 7 | |
| Physical health | Never sick | 4 | 16 |
| | It means not bedridden | 3 | |
| | Fine and not so many diseases | 4 | |
| | Having the opportunity to eat good and healthy food | 4 | |
| | My genetic makeup as I see from my lineage | 1 | |
| | | | |

| Emergent theme | Emergent codes | Code Frequency | Code reference total |
|-----------------|---|----------------|----------------------|
| Independence | Be able to do things for yourself | 4 | 13 |
| | Do things you want to do without being assisted | 4 | |
| | Having power and strength to do anything on your own | 5 | |
| | | | |
| Happiness | Happy at old age | 4 | 6 |
| | Not thinking or worrying, just happy | 1 | |
| | My mind does not tell me I am old; I am just excited | 1 | |
| Work/Employment | Doing some work, even if volunteering or paid | 6 | 6 |
| Spirituality | Living with God or being part of a church | 5 | 5 |
| Public safety | Feeling safe around others and able to move about in public | 3 | 3 |

Overall, Figure 6.1 shows that the most important meaning of experiential active ageing for research participants in Ghana and Australia was ‘social interaction,’ which represented 38 per cent of the total codes for the meaning of active ageing. This was followed by activity (23%), physical health (13%), independence (10%), happiness (5%), work and employment (5%), spirituality (4%) and public safety (2%). The next section discusses each of the themes and its relevance to the quality of life in old age as reported by the research participants and from the literature.

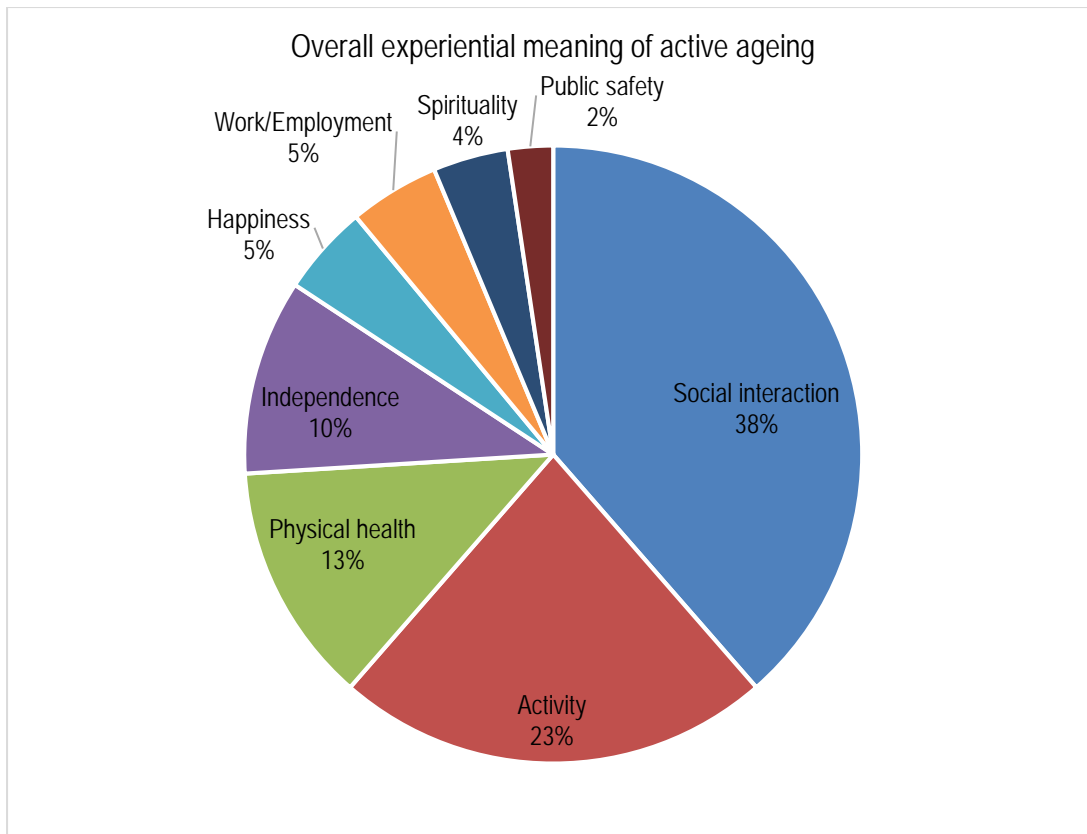


Figure 6.1: Overall experiential meaning of active ageing

6.2 Discussion

6.2.1 Social Interaction

The concept of 'social interaction' emerged as the most important component of experiential active ageing for older Ghanaians living in Ghana and Australian. Social interaction as interpreted in the data was demonstrated by the research participants' references to engaging with friends and family, keeping and maintaining strong family connections, having an interactive community life, being busy with other people around, and having moments of fun. Some participants stated the importance of social interaction to their quality of life as follows:

The most important thing for me as far as active ageing is concerned is having all my family members and friends around, providing support when I need, and keeping me company. By age 65, I had my grandchildren, so I am home taking care of the little ones. One is 5 years and other is 3 years. The children keep me busy as we sing, play and study. In the church, I am active with the Children's Ministry as well. I belong to a number of associations and groups in the community and we meet quite often to discuss issues about our lives (GR14-Ghana).

I must say I am lucky to have my wife, my children and my grandchildren all around. I meet the children always, and we interact. The children also support my wife and me in many ways. Their presence alone, keeps me quite active and healthy. I also attend our Ghanaian Association meetings here. It's good. It keeps me informed about developments back home, and we engage in other social events. In the church too, I am active. I think the western culture and the Australian culture here makes older people feel a bit neglected, very lonely and makes things difficult for a lot of older people who do not have families, and no one seems to take a serious interest in them (AR13-Australia).

Active ageing? For me, it's about making time to relax with friends and family, having entertainment over barbeque after all your hard work and service. It's about friendship and enjoyment at old age. (AR12, Australia)

My husband and I have four adult children who are all married and have their children. They take turns to visit us. They are so bonded to us that almost all the time they are here. We don't have need for anything because they provide. After all, we looked after them well so it's their turn to look after us, hahaha [Laughs]. (GR12, Ghana)

Two of my nieces come around to take care of my needs. I provide the money, and they do anything I want. Other family members and friends also come around on visits. They know that whenever they come, there is always something to eat or take home. My children are not here, but the house is busy. [Interjected with a follow-up question]. Well, I don't think they would have come if I didn't have money and these properties [pointing at houses, land, and an orchard]. (GR23, Ghana).

Overall, the central issues in the extracts above are family relationships and cohesion, opportunities to talk with someone, physical presence of people, and membership of associations such as a church or the extent of social networking, friendship and play. The researcher interpreted and categorised these issues under the theme 'social interaction' drawing on leads in the literature.

The finding that social interaction is an important component in active ageing has been discussed in the literature and in contemporary arguments about promoting quality of life at old age (Bowling & Stafford, 2007; Derksen et al., 2015; Grundy et al., 2007; World Health Organization, 2008). Fundamentally, social interaction is rooted in the principles of social functioning. It is seen as the overall

interpersonal interaction of an individual (Berkman & Glass, 2000). Abbott and Pachucki (2016) and Algar et al. (2016) claimed that social interactions and integration are of immense significance to the physical and mental health of older people. Pillemer et al. (2016) also observed that social interaction takes the form of continuous engagement in economic or income generating activities, community volunteerism, relationship with peers and family members and establishing new social networks. Furthermore, Liao and Brunner (2016) noted that early life social relations have implications for quality of life at old age. Some of these dimensions of social relations include having a confiding support, extensive network of friends and, quite importantly, “having a partner” (Liao & Brunner, 2016, p. 160).

Some researchers have argued that social interaction compensates for some of the health difficulties associated with old age (Derksen et al., 2015; Seeman et al., 2001). For example, although there are no known curative treatments for dementia, scientists believe that social interaction significantly improves quality of life for older people living with dementia (Abbott & Pachucki, 2016; Algar et al., 2016; Liao & Brunner, 2016). In their work on the meaning of active ageing among older Australians, Buys and Miller (2006) stressed that older Australians made references to social interaction (participation) as being critical for their well-being.

Social interaction was prominent in the work of Rowe and Kahn (1987) who introduced the concept of active engagement with life in their model on successful ageing. In this regard, social interaction relates to how an individual functions in society relative to both kinship and non-kinship ties. Other researchers have also established that social isolation and a lack of social interaction may expose older people to challenges in managing chronic illnesses and disabilities (Abbott & Pachucki, 2016; Huxhold et al., 2014; McHugh Power et al., 2016). To counter the shrinking nature of social networks at old age in some parts of the world, scientists and social policy actors have developed robotic tools and telecare systems (Coradeschi et al., 2013; Mort, Roberts, & Callén, 2013). For example, the ‘*GiraffPlus*’ has been developed to improve social interaction and monitoring through a robotic telepresence in parts of Europe (Coradeschi et al., 2013).

Huxhold et al. (2014) argued that social interaction reinforces the relevance of social bonds, obligatory and reciprocal relationships at old age, and recommended the building and maintenance of friend-based social networks, such as through volunteering at old age, and joining associations and participating in community life. These measures have implications for promoting sound mental health, physical health, happiness and future quality of life (Huxhold et al., 2014; Menkin et al., 2016).

6.2.2 *Activity*

Activity at old age emerged as the second important theme in the data pertaining to the research participants' experiential meaning of active ageing. As a theme, 'activity' was drawn from the research participants' references to having the ability to keep busy, do things, and undertake some physical exercise such as regular walking. However, in many respects, activity was described in conjunction with social interaction. Activity at old age was captured in the following extracts of interview responses about active ageing:

At my age, I keep myself very busy, meeting people and doing things together with them. I do a lot of evangelism, moving from house to house and preaching to people about Jesus Christ. Sometimes, I take a walk with some friends and run around with the grandchildren whenever they visit. I am engaged in all kinds of activities I can find, and I feel good about it. This is active ageing. (GR12-Ghana)

I am naturally a very busy person. I am happy taking care of grandchildren. Also, I am always doing one thing or the other. I attend meetings, group exercise with friends, church activities and anything that can keep me active. (AR4-Australia)

Active ageing means being able to exercise regularly such as using the gym and walking. It also means watching your eating habits, and your lifestyle and so on. I always make sure I do these things, and you can see how I still look good at this age. (AR2-Australia)

The interview extracts above suggest that social and physical activity were significant for the research participants. Social activity appeared to be often related to activities performed with other people, which may also include physical activity. Some of the physical activities cited in the data included undertaking regular

exercise, walking and doing things to move parts of the body, and attending a gymnasium.

The relationship between activity and ageing has been widely discussed in the literature. For example, Diggs (2008) argued that implicitly there is a positive relationship between activity and life satisfaction at old age. Furthermore, Westerterp (2000) and Hamer, Lavoie, and Bacon (2014) found that regular activity and exercise maintained muscle function and reduced the risk of disability and mortality common at old age. Similarly, G. R. Andrews (2001) found that regular physical activity reduces incidence of coronary heart disease, hypertension, depression and anxiety.

It is evident from the literature that many of the past theoretical positions on activity and ageing centred on physical activity such as regular exercise (Heikkinen & Ageing, 1998). However, the type of activity referred to by the research participants went beyond physical exercise to include communal social activity; that is activities performed with other people. The case of GR12 above is an exemplar. The respondent emphasised how being “engaged in all kinds of activities” had a social value reward of happiness (Menec, 2003). This is consistent with Rowe and Kahn’s (1997) observation that active engagement is an integral part of successful ageing and relates to productive activity whether paid or voluntary with a social value and the maintenance of interpersonal relationships.

As indicated previously, the relationship between activity and ageing was studied by Rowe and Kahn (1997), who referred to activity in relation to work and productivity. However, the data from this study showed that activity at old age referred mostly to activities with social value and did not necessarily seem to refer to activity undertaken for economic gain. As noted by Menec (2003), different activities have their different benefits: some activities provide physical benefits for general health; some are underpinned by social values; and others offer an opportunity for solitary reflection on life. As important as these activities might be, within the context of active ageing, activities that provide social value have been described as having more-enduring advantages than the rest (Bullington, 2006; Choi et al., 2016). Choi et al. (2016) argued that among older Koreans, social activities

such as religious activities, friendship organisations, leisure/culture clubs, family/school reunions, and volunteer work positively correlated with quality of life at old age. Similarly, Greaves and Farbus (2006) argued that social activities among older people positively impacted upon their health and quality of life.

In a nutshell, the data has shown that activity which can be for physical, social or financial benefits remains important to the quality of life at old age. However, based on the interview data, activity with social value was more commonly referred to as contributing to quality of life at old age. Whilst the literature undeniably shows that physical activity and its effect on older people's wellbeing is also important, a considerable number of respondents made statements that showed that they mostly valued being involved in social activities at old age.

6.2.3 Physical health

Physical health was the third important theme that emerged from the data. A total of six coded items with an aggregate frequency of 16, were clustered to constitute the theme. Physical health represents 13 per cent of the total code distribution. The main issues interpreted as 'physical health' included research respondents' references to the absence of disease, good food and nutrition, and opportunities for healthcare during sickness. References to health in the data were reflected in the following transcript extracts:

If you're not always sick and you are fine in your body without so many diseases, then you are actively ageing. People do not believe me when I say I am 64 years old. I am still fit because I maintain my health by taking good care of myself and I eat well. I always have regular check-ups, and I have not been sick in a long time. It's all about good health, and we have the system here to provide the best care anyone can think. (AR2- Australia)

Sometimes, I think, it [active ageing] depends on your genetic make-up; some old people are unyielding 'til they die, maybe at 100. I am currently 70, but I still feel good and strong. It runs in the family. My father was quite old and strong before he died, and my grandfather. (GR2- Ghana)

Even though I don't feel too well in my body, I have some joint pains and its quick difficult to walk, I am a very happy person because I can still talk with other people around. That's what matters to me. (GR4-Ghana)

From the extracts above, the concept of health was associated mainly with the absence or presence of diseases. However, health is a relative concept, relying on the individual defining it according to the time, culture, social class, age and to some extent gender (Morrison, 2008). Nonetheless, there is general consensus in the literature that health should be defined broadly to comprise physical, psychological, emotional and social wellbeing (Morrison, 2008; Suzman, Beard, Boerma, & Chatterji, 2015; World Health Organization, 2002). However, many people, including some participants in this study, restrict their view of 'health' to the mere absence of disease, while others (such as respondent GR 4) associate being healthy with 'happiness', despite having poor physical health. Similar findings were made by Grundy et al. (2007) who found that even in poor physical health, people can still live happy lives if they are in a socially supportive environment.

The issue on health and ageing remains one of the most discussed aspects of active ageing in the literature because the active ageing concept itself is based on determinants of health (Steptoe, Deaton, & Stone, 2015; World Health Organization, 2002). It is known that people older than 60 years are at risk of chronic neuro-degenerative diseases and other lifestyle-associated chronic disease conditions (Biritwum, Mensah, Yawson, & Minicuci, 2013; Lloyd-Sherlock et al., 2012; Suzman et al., 2015). Furthermore, it has been established that there are various health complications associated with ageing, and that ageing often involves a period of enduring chronic conditions, disability, dementia and cognitive impairment and psychosocial conditions (Ellen et al., 2017; Gagliardi et al., 2016). Also, ageing comes with an increased risk among the adult population of diabetes, obesity, cardiovascular conditions, arteriosclerosis, oral health problems, cancer, and osteoporosis (Briggs et al., 2016; Ighodaro et al., 2017; Scannapieco & Cantos, 2016). John R Beard et al. (2016) also argued that the incidence of severe disability among older people has been increasing in the last 30 years. Indeed, the global disease burden for older people has also increased rapidly in the last ten years

(Gagliardi et al., 2016). Dementia, for example, is endemic and has become a public health issue. Dementia is predicted to further increase in the coming years (Gagliardi et al., 2016, p. 5).

In effect, physical health is an important element of our understanding of experiential active ageing. However, its contribution to the overall meaning of active ageing depends on the presence of other people, such as family members (Lipsedge, 2015; Park & Folkman, 1997; Sobo, 2016).

6.2.4 Independence

The notion of independence as a component of active ageing featured in the data. A total of 3 codes with 13 references were clustered to constitute the theme 'independence', as shown in Table 6.1. Some of the codes clustered to mean independence included research participants' reference to being able *to do* things for themselves without being assisted. Regarding its proportion, as seen in Figure 6.1, independence accounted for 10 per cent of the entire code references used in describing active ageing. In general terms, the research participants argued that whereas being in the company of others was important, ageing actively also involved being able to do some things unassisted. Participants who shared this view did not want undue interferences from others. Some of the direct statements from participants about 'independence' in the data follow:

You see, if you are of my age and you can do all the things young people do without depending on anyone to help you, that is active ageing. I am on my own, and I can do things my way. It's about being free to do what you want to do. (AR6 - Australia)

I think that I should be able to do some basic things for myself without being always helped. I don't want to be an object of pity with everyone thinking that I am incapable. I might need help, but I have to make the decision. (GR7-Ghana)

To me active ageing is to have your free will and independence even at old age. It means to have your money and decide how to use it. I am in charge of my life, and I take control of it. (AR18-Australia)

The concept of independence was listed in the United Nations Principle for Older Persons (1991). Independence and autonomy are known to be valued in later

life experiences, according to Gale, Cooper, and Sayer (2015). The WHO defined independence as the “ability to perform functions related to daily living – that is, the capacity of living independently in the community with no or little help from others” (WHO, 2002 p.13). There is an understanding that ageing comes with some level of frailty which naturally implies a degree of dependence for older people at old age (Gale et al., 2015). However, Cunningham, Paterson, Himann, and Rechnitzer (1993) argued that although the capacity of older people to undertake normal daily activities reduces with ageing, this does not always preclude them from functional daily living independent of other people. Therefore, to determine the quality of life of an individual at old age, there is the need to examine the person’s functional ability in undertaking customary tasks without depending on others for assistance. Plath (2008) asserted that as much as independence is important, and there is a plethora of its usage in policies all over the world, it is a complex concept and must be applied cautiously.

Betti, Bettio, Georgiadis, and Tinios (2015) have presented another important dimension to independence. The authors argued that the issue of economic independence, especially for older women, is central to their quality of life while they are ageing. Betti et al. (2015) found that many older women depended financially largely on their ageing husbands and hardly had any access to income or other economic assets, including pensions. However, of course, this is not the case for women everywhere, especially in this study where female participants demonstrated an appreciable level of financial independence. For example, GR17 noted:

I receive my regular pensions, which is quite small, but I have four grocery shops dotted around the city. I make lots of money from that each month. I also have houses that I rented out, and my children also regularly remit me. I don’t have a need for money.
(GR-17)

The extract from GR17 above and similar statements from many other females represented in this study showed some level of financial independence. Thus, a central issue for most participants in relation to independence was about

being able to make decisions on managing their financial resources, which is important for quality ageing of older people, irrespective of their gender.

6.2.5 Happiness

The concept of happiness also emerged as an important dimension of experiential, active ageing. Table 6.1 shows that three main codes from 6 direct references have been clustered to constitute happiness. The codes include: *“happy at old age” “not worrying, just happy” “mind does not tell me I am old, just excited”*. Happiness represented 5 per cent of total codes referenced in the study, as shown in Figure 6.1. Here are some of the quotes in the data that refer to happiness:

I am very active, maybe that is why my mind does not tell me I am old. I think active ageing is all about making yourself happy at all times. (AR1- Australia)

For me, active ageing has to do with being happy and relaxed in your old age. I normally do things that make me happy, a place to laugh and talk with people. I don't want to stress myself at this age, just taking it easy and making myself and other happy. I am happy, and that is what matters. (GR4-Ghana)

I have some joint pains, and it's difficult to walk about, but I am a very happy person. (GR11, Ghana)

The topic of happiness and ageing has been examined by Jopp and Rott (2006). They acknowledged that happiness is a relevant factor in determining the well-being of people at old age. Their contention is that in spite of having cognitive and physical restrictions at old age, the strength of subjective well-being concepts such as happiness “are preserved and changes are very small” (Jopp & Rott, p. 277). Likewise, Olshansky, Carnes, and Butler (2003) indicated that the human body is wired to weaken, but the psychological state of being happy has an enduring strength. This presupposes that, regardless of whether an older person is in good physical health or not, the psychological state of happiness remains an important aspect of active ageing.

The notion of happiness being integral to active ageing confirms the works of Chen et al. (2015) and Bowling and Dieppe (2005). Similarly, Nyström, Eriksson Sörman, and Nilsson (2014) found that the quality of life at old age to some extent was dependent on the psychological state of happiness, rather than on cognitive

functioning and health. In their study on whether cognitive function was essential for quality ageing, Nyström et al. (2014) reported that there was no significant relationship. In line with this, a respondent in the present study reported that:

For me, I am very active, maybe that is why my mind does not tell me I am old. It is all about making yourself happy at all times.
(AR1-Australia).

Clearly, the role of the mind in opening up to the negative realities of ageing was offset by the respondent's state of happiness. Acknowledging that ageing comes with some unfortunate conditions, including physical ailment, depression, cognitive impairment and general social vulnerability, Mishra (2014) asserted that the ageing process could be reversed or repaired by inducing happiness through laughter therapy. Her experiment with older people in India demonstrated how laughter contributed significantly to happiness and also affected the subjective wellbeing of older people. Thus, the psychological state of happiness and its maintenance is critical for ageing actively.

6.2.6 Work and employment

Opportunity for work and employment, whether paid or voluntary, at old age, was also a component of experiential, active ageing in the data. Only one code from 6 references constituted this theme and represented just about five per cent of the total code frequency in the data. Research participants in this category associated engagement in work with active ageing. Below are examples of statements used in describing work and employment as components of active ageing:

To be active in old age means to be able to involve yourself in something. When I retired after 60, I was contracted again to work as a public relations officer for our subsidiary organisation. I worked as a consultant also for some of our allied partners. These opportunities kept me active. Maybe I was lucky, unlike others who hardly get these working privileges after retirement. (GR2-Ghana)

Another participant described that work is one option amongst many for participating in the community:

Active ageing is about more active participation whether in the workforce, unpaid workforce or some community-related activities and also being able to travel the world and engage with other people. I mean once you retire, one would like to be active in the community, play a role, which is essential to the community, such as helping in educating younger people and other community services. I also love to travel a lot to meet people. (AR-8, Australia)

In theory, the opportunity to work at old age has occupied many of the debates about active ageing over the years (Börsch-Supan et al., 2013; Boudiny, 2013). The central argument has been that the economic participation of older people keeps them healthy. The 'participation' pillar of the WHO's model of active ageing emphasised the need for work and employment of older people after retirement. Also, among many European countries, the core of active ageing has been to promote employment for older people (European Union, 2012). However, while studies have demonstrated that a significant number of older people are willing to work beyond the retirement age, they face several barriers, including ableism and ageism stemming from employer apathy and lack of coordinated policy on economic participation of older people (Georgiou, 2015).

6.2.7 Spirituality

Another important feature of the meaning of experiential active ageing in the data related to spirituality. A single code of 5 references constituted this theme. Some older people associated active ageing experiences with their deep involvement in religious activities, describing a belief that their ability to remain strong, healthy and happy hinged on their service to God. One respondent said this about the issue of spirituality and ageing:

Talking about active ageing, it is all about your relationship with God or your creator. Old age and good health are gifts from God, and when you have a good relationship with God, He will bless you with everything including an active, happy life at old age. I am always in church, and I participate in every program. It is God who gives active functional life. (GR-23, Ghana)

The extract above is indicative of how important spirituality is for some participants. Indeed, spirituality and ageing have been researched previously. For example, (Cohen & Koenig, 2003; Seedsman & Feldman, 2002) found a connection

between spirituality and active ageing. Spirituality, as explained by Moberg (1983) in Jewell (1999), referred to the affirmation of life about a divine being (God), the self, community and the environment that nurtured and celebrated wholeness. Jewell (1999) considered spirituality as an intangible, yet vital aspect needed to provide quality of life to people, especially older people.

6.2.8 Public safety

Public safety was also found to be an important feature in the research participants' understanding of experiential active ageing. The theme of public safety was noted only by three participants in Australia, representing only two per cent of the total code frequency. The single code use for this theme was *'feeling safe and able to move about in public'*. A research participant in Australia noted:

Sometimes, active ageing can also mean living in a safe community without being afraid. Here, at times, these boys can enter an old person's house and steal from him or her. I have not directly experienced that but my neighbour did. Some older people even die in the room without anybody around. It's not safe to be alone. (AR3, Australia)

Public safety refers to conditions that protect people from physical and emotional harm. The WHO's broad determinants of active ageing recognised the need for a friendly and supportive environment, safe houses, and an absence of violence and abuse of older people. Safety for older people also means protection from all kinds of abuse and neglect. (Constança et al., 2012).

6.3 The conceptual fit between research participants' experiential active ageing and the WHO model of active ageing.

This section examines the conceptual and theoretical fit between the WHO active ageing model and the experiential meaning of the term by the research participants. According to Bowling and Stafford (2007), the lay meaning of concepts is useful for validating policy models such as active ageing. Figure 6.2 shows that the WHO's active ageing model has three pillars —health, participation and security; and a total of eight distinct dimensions of experiential active ageing, each having different levels of significance to quality of life at old age.

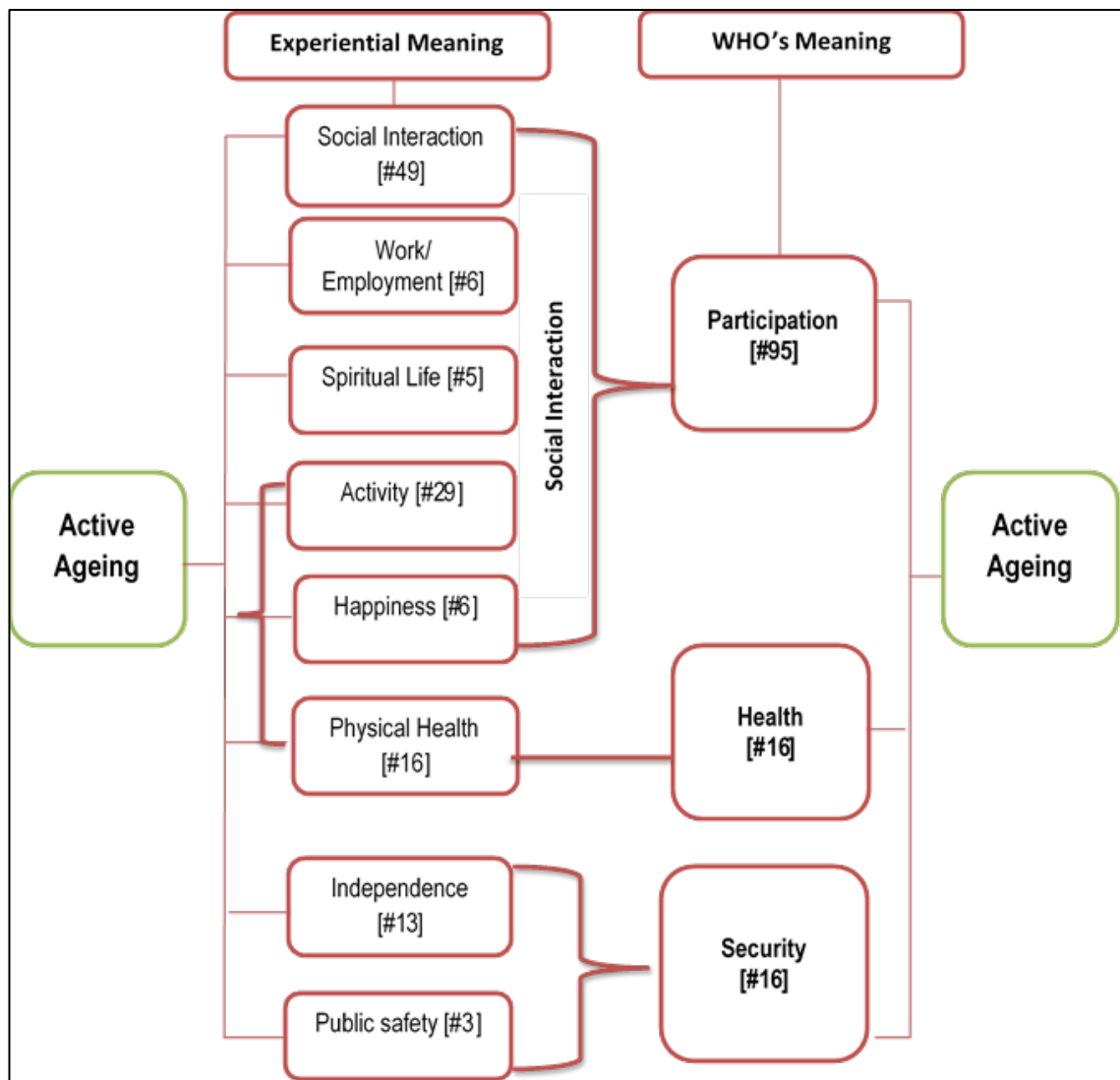


Figure 6.2: Experiential meaning compared with WHO's active ageing model

Source: Based on data from this study

The evidence from the data presented in this chapter shows significant variations between the participants' experiential meaning (on the left) and the WHO model's meaning of active ageing (on the right). As stated above, participants' perceptions of their active ageing emphasised 'social interaction' in relation to quality of life at old age, whereas the WHO's model prioritises health promotion and prevention (Barrett & McGoldrick, 2013; Rechel et al., 2013). There is, however, a similarity between participants' notion of social interaction and the WHO's participation pillar. Figure 6.3 shows that 'participation' in the WHO model is the most significant pillar, represented by 75 per cent of the participants' total codes reported in the interviews.

Conceptually, participation is different from social interaction, hence, the use of participation in the WHO model presents a probable theoretical challenge. Participation in itself presents an opportunity to undermine some very important actionable attribute of active ageing such as social interaction. In practice, participation should rather be seen as a function of social interaction. Carpentier (2011) argued that the concept of participation is a political idea, which is not the same as access and interaction. 'Participation' further suggests power differences without mutual interest. As noted by Agarwal (2001) participation is a contested ideological concept, with several competing meanings and applications; when not applied appropriately, the term participation may result in vested interest and perpetuation of an imbalanced power structure, implying that there are those who have the power to invite others to participate and those who must be invited. The imbalanced power structure associated with the notion of participation is what can make the active ageing concept coercive and counterproductive as noted by Walker (2002) and also by Minkler and Holstein (2008).

Furthermore, the notion of participation ignores the possible health differences among older people and emphasises the specificity of economic participation rather than the generality of social interaction. This may explain why some national (e.g. Australia) and regional level (e.g. European Union) policy actions on ageing and active ageing have largely focused on health promotion, physical activity and economic participation (Boudiny, 2013; European Union, 2012). Walker (2002) observed, that active ageing emphasised employment, health, pension, retirement, and citizenship. Viewed this way, according to Katz and Calasanti (2014), active ageing may be falling into the trap of being mere marketing rhetoric. Governments' emphasis on health prevention and promotion and economic participation of older people (Barrett & McGoldrick, 2013; Rechel et al., 2013) could undermine the promotion of social interaction which, according to the reported experiences of older people in this study, was the most important feature of experiential meaning of active ageing.

Based on the data presented above, the researcher argues that social interaction captures a broader range of issues on ageing than 'participation'. Social

interaction involves maximising opportunities of community living, relationship with peers and family members, and establishing new social networks Pillemer et al. (2016). McMurray (2007) claimed that social interaction results in independence, happiness good health and overall quality of life.

In view of the arguments above, embedding social interaction in WHO's 'participation' pillar would mean curtailing its ability to shape social actions towards older people. The risk of focusing on participation at the national policy levels is that it may be misconstrued to mean the mere inclusion of older people in the policy processes on ageing, without commitments to take actions that promote social interaction. Inclusion in the policy process, may also be politically restrictive, which cannot be equated to social interaction.

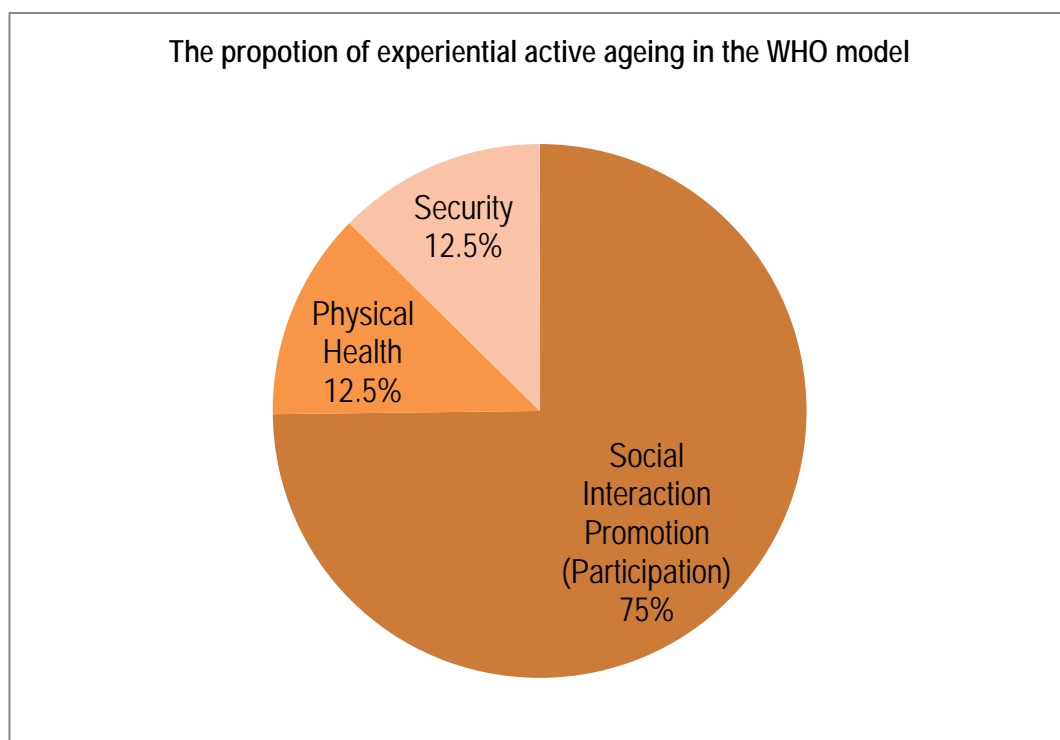


Figure 6.3: The proportion of experiential active ageing in the WHO model.

Source: Based on data from the present study

6.4 Summary

This chapter examined the concept of active ageing based on the reported lived experiences of 30 older people in Ghana and Australia and the conceptual fit between the experiential meaning of active ageing of the research participants

involved in this study and the original model proposed by the WHO. Overall, experiential active ageing was seen as a complex and multi-dimensional phenomenon, with 'social interaction' emerging as the most important element in the research participants' active ageing experiences. Social interaction for the research participants meant having families and friends around, continuous activity with social relevance, and being engaged in community activities. Obviously, there is some correspondence between social interaction and the 'participation' pillar of the WHO model, but it is difficult to fathom how much. The data has shown that national level policy actions in Ghana and Australia must seek social interaction for older people at both macro and micro levels. This should include promoting activities that yield social satisfaction, happiness and those that strengthen family bonds, community support structures and intergenerational solidarity without neglecting the complementary roles of health, income supports and safety of older people. Theoretically, the WHO concept of active ageing needs to be reconsidered in the light of the contextual realities of and lived experiences older people in different settings, and should not be regarded as a one-size-fit- all model, as it appears to be currently.

CHAPTER SEVEN: POLICY CONTEXTS AND EXPERIENTIAL ACTIVE AGEING: A COMPARATIVE CASE STUDY

7. Introduction

The previous chapter described the meaning of experiential active ageing through an IPA process for a sample of 30 older people, and established the conceptual fit between their experiential meaning and the WHO Model. This chapter presents a comparative case study of how Ghana and Australia's respective policy contexts influenced the experiential meaning of active ageing of the research participants. There are two main sections to the chapter. The first section focuses on the differences and similarities in the experiential meaning of active ageing between participants in Ghana and Australia. It is assumed that the variation observed in the two participant groups' experiences of active ageing is partly due to the different contexts in which they lived. The second section is a discussion of the relevance of context in participants' experiences of active ageing.

7.1 Comparing the experiential meaning of active ageing of participants in Ghana and Australia

This section presents the differences and similarities in the experiences and meaning of active ageing in the sample from Ghana (n=15) and Australia (n=15). Figures 7.1 and 7.2 show that the themes that emerged from the data were mostly the same in the two research localities, except for 'public safety', which was reported by only participants in Australia. The themes common to all participants (n=30), as previously reported in Chapter Six, comprised: social interaction, activity, physical health, independence, happiness, work/employment and spirituality.

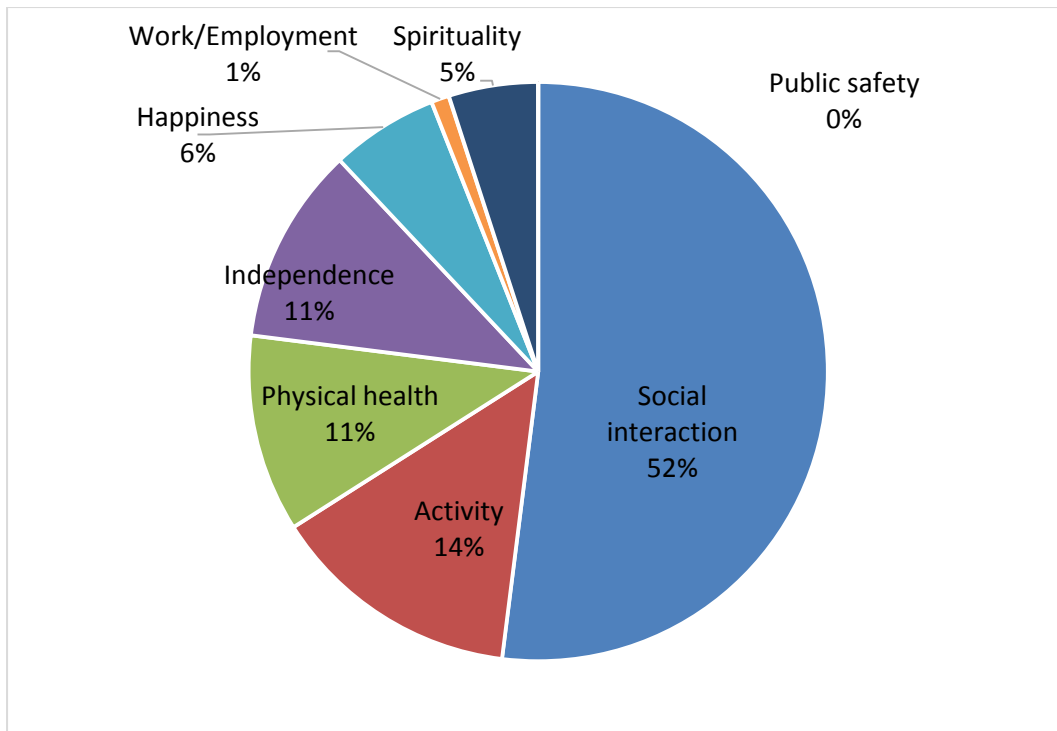


Figure 7.1: Experiential active ageing in Ghana (n=15)
 Source: Based on data from this study

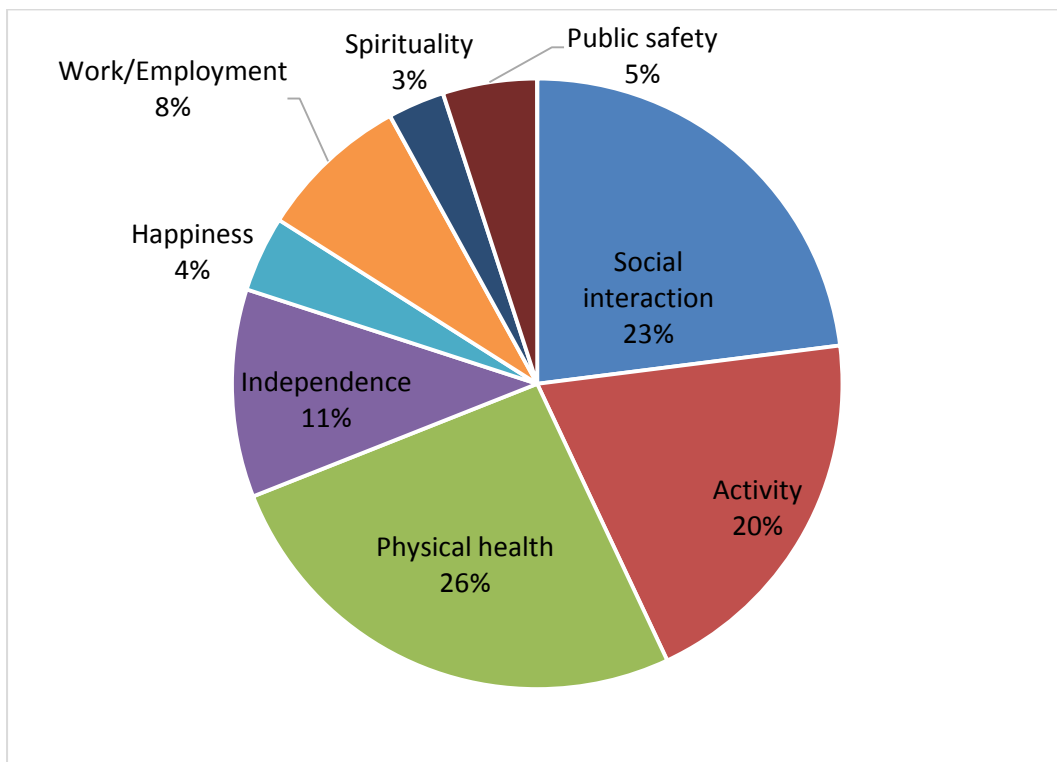


Figure 7.2: Experiential active ageing in Australia (N=15)
 Source: Based on data from this study

However, despite the similarity in the themes, as noted above; there were distinct differences in the level of importance accorded to some theme by the two sets of participants. An account of each of the themes, and how and why it differed between Ghana and Australia follows.

Social interaction

In Chapter Six, at aggregate level (n=30), social interaction was the most important experience of active ageing for research participants in both Australia and Ghana. However, as Figures 7.1 and 7.2 show, the proportional representation of social interaction was higher in Ghana (52%) than in Australia (23%). This indicates that in terms of lived experiences of ageing, participants in Ghana were likely to have had greater access to and utilisation of social interaction opportunities than their counterparts in Australia. The higher social interaction experiences for research participants in Ghana suggested that they relied more on their families and other non-kin relations for companionship than their fellows in Australia. The following extracts from the interviews with two selected participants show these differences. The respondent from Ghana remarked:

I had a mild stroke two years ago, and life has not been very easy, but somehow, I am always happy and strong because of my children and my wife. They have been a great source of support to me. I can walk about today because they gave me the strength to walk. Besides, my younger brothers, whom I looked after, have been very supportive financially. Do you see the woman there? [Pointing to a middle-aged woman about 15 metres away] She is also my sister. She came to visit. When you see me lively, happy and active today, it is because they made it possible. (GR19-Ghana)

The research participant in Australia stated:

It's not been easy since I lost my husband about four years ago. As you see me now, I look much older than I should be because I had to do so much alone since the loss. We had two children but they are all busy with their lives and hardly come around. The younger boy is single, he doesn't want to marry, but the older boy is married to a woman who doesn't even want to see me because I opposed their marriage. The younger boy occasionally comes to see me, but he is always with friends. I am not in any active employment except some voluntary works for my church. I am not too worried, though; I have all kinds of support service such as a

good pension, healthcare, and the Senior's Card. It's helpful. But I feel lonely sometimes and wish I am gone back to Ghana. The health care system is so good for me so that I will hang in here.
(AR20-Australia)

The first extract above shows that the participant (GR19) from Ghana was not in a good physical health, having suffered a mild stroke; however, the respondent indicated that the presence and assistance of his family kept him interactive, which according to the participant, meant a “lively, happy and active” life at old age. This narrative, which emphasised the support of families, friend and communities, was common for participants in Ghana. However, in the case of the Australian respondent (AR20) (the second extract), there was very little contact and interaction with the children, and with the loss of the husband, the participant “feels lonely sometimes”. Despite having access to good public services, this respondent clearly felt isolated, and expressed disappointment at not having her children and family around her and partly regretted not going back to Ghana.

The reason for the differences between participants in Ghana and Australia was the different interactive social environments. First, it is important to note that compared to participant GR19, participant AR 20 was widowed, so she was lonely. Participant AR20 also opposed her son’s marriage, so she had alienated him and his wife as a couple. In this instance, the entire nuclear family system for this participant was broken down. Participant GR19 on the other hand had the wife and children and the extended family to provide support, which is a reflection of the Ghanaian traditional values and its enduring kinship and non-kinship support system accentuate family and communal living rather than individual activities (Darteh et al., 2016; Goody, 2005; Nukunya, 2003). However, the sustainability of family support for ageing in Ghana has been questioned (van der Geest, 2016). Brown (2015) and Apt (2013) have warned that vigilance is needed to protect and strengthen the reciprocal family support system such as deepening family life education in the educational curriculum, even though the National Ageing Policy of Ghana has made explicit the need for such provision (Government of Ghana, 2010).

Relative to Australia, researchers have recognised the significance of social ties in enhancing the quality of life at old age (Byles et al., 2016; Gow & Mortensen,

2016; Warburton, Cowan, & Bathgate, 2013), but the data from this study indicate that friends contributed more to the quality of life for most older people than children and relatives (Giles, Glonek, Luszcz, & Andrews, 2005). The views of respondents such as AR 20 above typify the lack of filial piety, where children do not have a strong emotional and obligatory attachment to their parents. Other researchers have also found increasing social isolation among the elderly in Australia (Bartlett, Warburton, Lui, Peach, & Carroll, 2013; Beer et al., 2016).

Physical health

The data in this study also showed differences in the level of emphasis on health as an experience of active ageing between Ghana and Australia. In Australia, participants' experiences of good health and healthcare were spoken about more frequently than social interaction and activity although the differences were not significant. Physical health, which constituted 26 per cent of participants' codes in Australia referred to their enjoyment of physical health and to having access to good health services. However, in Ghana, physical health came third in order of importance, representing only 11 per cent of total code references. Physical health in both contexts was referred to in the sense of the absence of diseases and access to healthcare when sick. On the experiences of physical health, a participant in Australia stated:

If you're not always sick and you are fine in your body without so many diseases, then you are actively ageing. People do not believe me when I say I am 64 years old. I am still fit because I maintain my health by taking good care of myself and I eat well. I always have regular check-ups, and I have not been sick in a long time. It's all about good health, and we have the system here to provide the best care anyone can think of. (AR2- Australia)

Similar experiences of concerns for health ran through the interview responses of Australian participants. This explains why 'health' had relatively high frequency of reported experiences of active ageing in the Australian data. Tellingly, the Australian policy system on ageing emphasises healthcare. For example, from the 1985 Aged Care Reforms strategy through to the 1997 Aged Care Act and the 2012 Living Longer, Living Better Aged Care Reforms, the critical issue of concern for Australia had been the issue of providing quality healthcare for people at old

age (Commonwealth of Australia, 2015a). Almost every reform within the ageing sector in Australia made significant provision for healthcare. The focus on health in ageing policy and deliberation in Australia is consistent with the WHO's active ageing framework, which focuses on health promotion and disease prevention (World Health Organization, 2002).

Activity

Closely associated with the significance of health among participants in Australia was physical and social activity, which was the third most important issue in Australia, and second in Ghana. However, the proportion of emphasis in Australia (20%) was higher than the proportion in Ghana (14%). The physical activity in this context referred to the ability to walk about, undertake planned exercises, and attendance at gymnasiums. For example, a respondent in Australian indicated that:

Active ageing means being able to exercise regularly, watching your eating, and your lifestyle and so on. I always make sure I do these things, and you can see how I still look good at this age.
(AR2-Australia)

Social activity, on the other hand, referred to activities that were done for social benefits. Social activity may include physical activity but in the context of other people. For example, the following respondents in Australia noted:

I am naturally a very busy person. At my age, I am happy taking care of grandchildren. Also, I am always doing one thing or the other. I attend meetings, group exercises with friends, church activities and anything that can keep me active. I am therefore actively ageing. (AR4-Australia)

I mean once you retire, one would like to be active in the community, play a role which is essential to the community, such as helping in the education area or doing community work to help, doing volunteer programs and then going on walks with people. I do these always. (AR-8, Australia).

The greater importance attached to physical activity by Australian respondents could be partly attributed to the policy environment in Australia, which encourages physical activity. For example, the *Australian Physical Activity and Sedentary Behaviour Guidelines* provided by the Department of Health recommends several physical activities for older Australians (W. Brown, Moorhead,

& Marshall, 2015). The recommendations made explicit the need for all older Australians, 65 years and above, to undertake regular physical activity such as 150 to 300 minutes per week of moderate to intense exercise, including 40 minutes of weight bearing exercise, so as to maintain or improve their health conditions.

Researchers have found that various health ailments, including cancers, are associated with lack of physical exercise among Australians (Bezzina, Brown, Mao, & Ramsay, 2016; Gebel et al., 2015; Nguyen, Bauman, & Ding, 2016; Olsen et al., 2015). In their study of older people in Australia, Barnett, Smith, Lord, Williams, and Baumand (2003) asserted that weekly physical exercise with ancillary home exercises contributed to improving the balance of older people and reduced their risk of falls. Similar observations were made by van Uffelen (2015) about the benefits of physical exercise for older people.

Work and employment

Another theme that emerged in the data and worthy of comparison between the research participants relates to work and employment at old age. Several participants reported that the ability to participate in work or employment, whether paid or unpaid, was essential. At least, 8 per cent of total codes from participants in Australia mentioned this. In Ghana, however, the notion of work and employment at old age was barely mentioned (1%). This variance is expected partly because, among Australian participants, ten (10) were under 65 years of age and so were still actively working in the formal sector. The Australian policy environment encourages participation in work even after the retirement age (Gebel et al., 2015).

Under the Australian policy guidelines for the employment of matured age workers, the Commonwealth Government has provided a guide to businesses for employing mature-aged workers (Commonwealth of Australia, 2011). In Ghana, the retirement age is 60 years, and all participants except two were actively working in the formal sector on a post-retirement contract. However, many of the participants in Ghana were also involved in unpaid family and community work, which they mentioned largely as social activity. For example, a participant in Ghana noted:

Being the Chairman of the landlord's association in this community, I do preside over meetings, and do so many other things for the community without a fee. In addition, my children come to live their children with me occasionally without paying for my services. These activities keep me active and I enjoy doing them. (GR15-Ghana).

Independence

The data also pointed to an interesting similarity between the views of research respondents in Ghana and Australia on independence as a component of active ageing. The theme of independence represented 11 per cent of total codes used by participants in both countries. Independence, referred to the participant's ability to perform tasks without being assisted. The following statements in the data reflected this notion:

You see if you are my age and you can do all the things young people do without depending on anyone to help you that is active ageing. I am on my own, and I can do things my way. It's about being free to do what you want to do. (AR6 Australia)

I think that I should be able to do some basic things for myself without being always helped. I don't want to be an object of pity with everyone thinking that I am incapable. I might need help, but I have to make the decision. (GR7-Ghana)

The congruence on the views of participants in Ghana and Australia on 'independence' suggests that having liberty and the dignity to perform tasks themselves is important to older people. In the UK, Stenner, McFarquhar, and Bowling (2011) found that independence was critical for participants in explaining the meaning of active ageing. The notion of independence also applies to the idea of autonomy and free will at old age (Stenner et al., 2011). For older Ghanaians in Australia and Ghana involved in this study, the loss of independence was considered to be a loss of active ageing. In view of this, in many parts of the world, there are programs to restore (reablement strategies) the functional abilities of older people to make them independent (Aspinal, Glasby, Rostgaard, Tuntland, & Westendorp, 2016; Lewin et al., 2014; Senior et al., 2014; Tuntland, Aaslund, Espehaug, Førland, & Kjekken, 2015).

It is clear from the analysis above that there were contextual differences in the ways research participants experienced and defined active ageing. However, most of the differences were in the level of priority given to the emerging themes for the quality of life at old age. This means that context specific and targeted policy for ageing is important. In the next section of the chapter, the researcher provides a theoretical justification for the consideration of context in the adoption and application of international policy proposals to country contexts.

7.2 Context and experiences of active ageing

A clear difference between the Australian and the Ghanaian contexts in the experiential meaning of active ageing was that in Australia there was a stronger emphasis on health promotion and prevention, physical activity, and employment or work as reflected in government policies. In Ghana, on the other hand, the meaning of active ageing was more focused on social interaction and social activity. A possible reason for the relative differences in the experiential meaning of active ageing between Ghana and Australia was the nature of the respective political economies and social contexts, as discussed in Chapter Four. In Australia, for example, the social policy environment, has been largely driven by either neo-liberal or neo-socialist ideologies, which have placed a premium on productivity to offset future threats of rapid population ageing to the economy (Fine, 2014; Pakulski, 2016). Warburton (2014) argued that since 2002, the Australian political and economic landscapes for policies on ageing has shifted from concentrating on frailty and illness to more productive notions of ageing. Thus, the policy emphasis has been on people taking more responsibility for their ageing, productivity, participation and provision (Pakulski, 2016).

The Intergenerational Reports of Australia have also been a key driver of policy action on ageing. These reports have painted unfavourable pictures of population ageing and its implications for the Australian economy and future generations (Biggs & Kimberley, 2013; Pakulski, 2016). The reports have encouraged austerity measures such as cutting down on government-funded programs, and promoting self-reliance at old age (Fine, 2014). Thus, there has been a policy shift towards promoting privatisation and the reliance on the market to

drive social processes, including welfare at an old age, while reducing the public provision of welfare (Fine, 2014; Pakulski, 2016). As argued above, the policy environment partly shapes how older people conceptualise and experience active ageing by: i) taking advantage of the opportunities provided by structural forces such as government policies (Elder Jr et al., 2003) and ii) navigating around the constraints placed on them by agency in order to create an ageing pathway for themselves (Bengtson et al., 2012; Elder Jr et al., 2003; Estes, 2001).

The Ghanaian political economy context for ageing is unclear on the ideological path because the policy environment appears to oscillate between neo-liberal and social democratic considerations (Agyepong & Adjei, 2008). To this end, the policy environment for ageing in Ghana does not provide a clear direction for government decisions, actions and experiences of ageing; hence, notions of ageing remains in the hands of older people. This partly explains why older people in Ghana value social interaction as reflected in their reliance on family, kinship and non-kinship supports systems (Coe, 2016; Darteh et al., 2016).

A critical component of the life course approach to ageing, as discussed in Chapter Two, shows the manner in which society is arranged and governed (Bengtson & Allen, 2009; Bengtson et al., 2012). As noted by Estes (2001), structural factors and processes, such as political decisions (e.g. a government's policy on employment of older people) contribute significantly to people's experiences of ageing. Walker (2006) argued that the relationship between social structure, age, and the individual and socio-economic status is complex and dynamic. Political and economic processes, which are normally driven by ideology, shape how social policies are created. Over time, social policies either create opportunities for quality of life or constrain the quality of life at old age (Baldwin et al., 1993; Fry, 2005). Therefore, in examining ageing experiences, this research has underscored the need for researchers to look beyond the individual level factors to focus on broader social policy environments within which ageing occurs.

7.3 Summary

The analysis of data presented in this chapter has revealed notable differences in the experiences and description of active ageing between

participants in Australia and Ghana. However, the differences were mainly about the level of importance of the emergent themes to the quality of life of research participants. The differences showed context-specific variations in the participants' active ageing experiences. Despite this, the emergent themes were generally similar, with 'independence' being a cross-cutting theme.

In a nutshell, improving policy makers' understanding of the socio-political and economic settings within which ageing occurs will present a range of opportunities for older people. For example, it is assumed that people make choices and take advantage of opportunities that are created through social policies to maximise their quality of life in later life (Hoffmann, 2016; Marshall & Mueller, 2002). Again, the extent to which older people have taken advantage of public services, such as education, employment, and how they made choices regarding health care service was invariably influenced by opportunities or constraints created by social structural arrangements (Hoffmann, 2016; Marshall & Mueller, 2002).

An understanding of the policy context is also important because knowledge of the context within which lived experience occurs can provide a guide for future policy directions towards ageing and quality of life at old age. Clearly, policy actions and decisions for older people are driven by the interests, and motivations of agencies including state and non-state actors. While some actors perceive ageing as an opportunity to maximise and customise business products for older people to consume (Coughlin, 2010; Panagos, 2003; Ring, 2002), others perceive ageing as a threat to the economic sustainability of nations (David E Bloom et al., 2010; Bosworth et al., 2004; Panagos, 2003; Productivity Commission, 2005). Those with an altruistic bent consider welfare provision for the aged as a human right for which nation states must take responsibility, but who bears the cost remains unresolved (Kulik et al., 2014; Walker & Maltby, 2012; World Health Organization, 2015). As discussed in Chapter Four, the policy context of ageing is also reflected in the argument that ageing issues in the last two decades have been shaped largely by four central forces: commodification, medicalisation, privatisation and rationalisation (Estes, 2001). In effect, the way people live and experience ageing is,

to some extent, affected by decisions and policies of governments, most of which are driven by political expediencies.

CHAPTER EIGHT: QUALITY OF LIFE AND EXPERIENTIAL ACTIVE AGEING

8. Introduction

This chapter presents and discusses the topic of *quality of life* in relation to the participants' reported experiences. Process tracing and typological theory were used to analyse the data. There are two parts to this chapter. The first part is the creation of a typology (i.e. classification into types) of quality of life of research participants. The typology was created using the dimensions of the concept of 'quality of life' as presented in Chapter Two. The typology resulted in the creation of four different types of quality of life among the research participants. A comparison of the typology between research participants in Ghana and Australia is also presented. The second part is a presentation and a discussion of the causal pathways through which some of the research participants attained the highest form of quality of life. In addition, selected individual cases were used to typify the causal pathways through which different factors contribute to quality of life. As explained below, the process tracing approach was used to analyse the data from reported experiences; and is situated within the life course approach to ageing (see Chapter Two for details). The chapter concludes with a synthesised discussion of common themes (factors) that contributed to the quality of life of research participants.

8.1 Developing a typological theory of quality of life for older people

Before the presentation and discussion of findings relating to the typology of quality of life, it is important to recap the logic and process of creating the typology (details of this are given in Chapter Five). Ageing experiences are different for different people at different times. Given the level of variation, it is important to create a theoretical matrix that clusters experiences into mutually exclusive groups or types. The clustering of experiences is useful, allowing policy makers to address issues for each theoretical type. Developing theoretical types that are mutually exclusive requires an appropriate analytical tool, which is systematic and transparent. In this instance, a typological theory approach was used (A. Bennett,

2013b; Cornelissen, 2016; Fiss, 2011). Typology has been known over the years as an important analytic tool for theory building (Bennett, 2013b; Doty & Glick, 1994).

Bailey (1994) and (Bennett, 2013a; George & Bennett, 2005) have argued that theory-based typologies can effectively be converted into hypothesis and subjected to rigorous empirical testing using quantitative models. Doty & Glick (1994), asserted that typologies are a set of conceptually derived ideal types, which show the relationship between the features of the central concepts under investigation, and which are believed to produce relevant outcomes of the study, and finally, Cornelissen (2017) contended that typologies are inter-related specifications of dimensions aimed at fleshing out new constructs and causal interactions.

In the construction of a typology, Bailey (1994) and Kluge (2000) asserted that applying typological analysis to any research requires conceptualisation along at least two dimensions. In this study, as previously discussed in Chapter Two, there were two dimensions of quality of life, which also emerged from the reported experiences of the research participants. These were; social interaction and service provision. Social interaction refers to a range of micro level opportunities, including i) the level of social capital, family supports and other social networks (Cramm et al., 2013; Gray, 2009; Heaney & Israel, 2008; Silverstein, Gans, & Yang, 2006); ii) the nature of and range of activity including formal and informal activities, or social, activities (Adams et al., 2011; Duclos, 2013; Phoenix & Griffin, 2015; Vidovićová, 2005); and iii) income or assets (Van der Geest, 1997). The dimension of service provision, on the other hand, includes key macro level policies and programmes that have implications for the quality of life for people at old age. It also entails issues of access and utilisation of such services (Lloyd-Sherlock, 2004). Some of the services considered in this study are healthcare services (Udayshankar & Parameaswari, 2014), social security, old-age pensions and other social assistance programmes such as discounted use of public services and utilities (International Labour Organization, 2014; Social Security Administration, 2013) and other macro level opportunities that enhance quality of life at old age.

In creating the typology for this study, a two-by-two matrix was used to represent the two dimensions of social interaction and service provision, as discussed previously: The vertical (y-axis) 'level of social interaction'; and the horizontal (x-axis) 'level of access to service provisions'.

8.1.1 Typology of quality of life of research participants

This section presents and discusses the different types of quality of life, which were based on reported lived experiences of research participants. The first part of the typology focused on data from the 30 participants in the study. Figure 8.1 reveals four types of quality of life, based on the interplay between the level of participants' social interaction and the level of their access to essential services provision. The first category comprises participants who experienced a high level of social interaction together with high levels of access to essential services. In all, 12 out of 30 participants fell into this category. The second category comprised participants who experienced a high level of social interaction but had limited access to essential services. There were a total of eight (8) in this category. The third category consisted of participants who had a high-level of access to essential services but experienced a low level of social interaction. There were 10 out of 30 participants in this category. The fourth category would have consisted of participants who had limited access to essential service and at the same time experienced limited social interaction. However, no participants in the current study fitted into this category — which might be due to the nature of the sample; as explained under the limitations of the study in Chapter Nine. The details of these findings are shown in Figure 8.1 below.

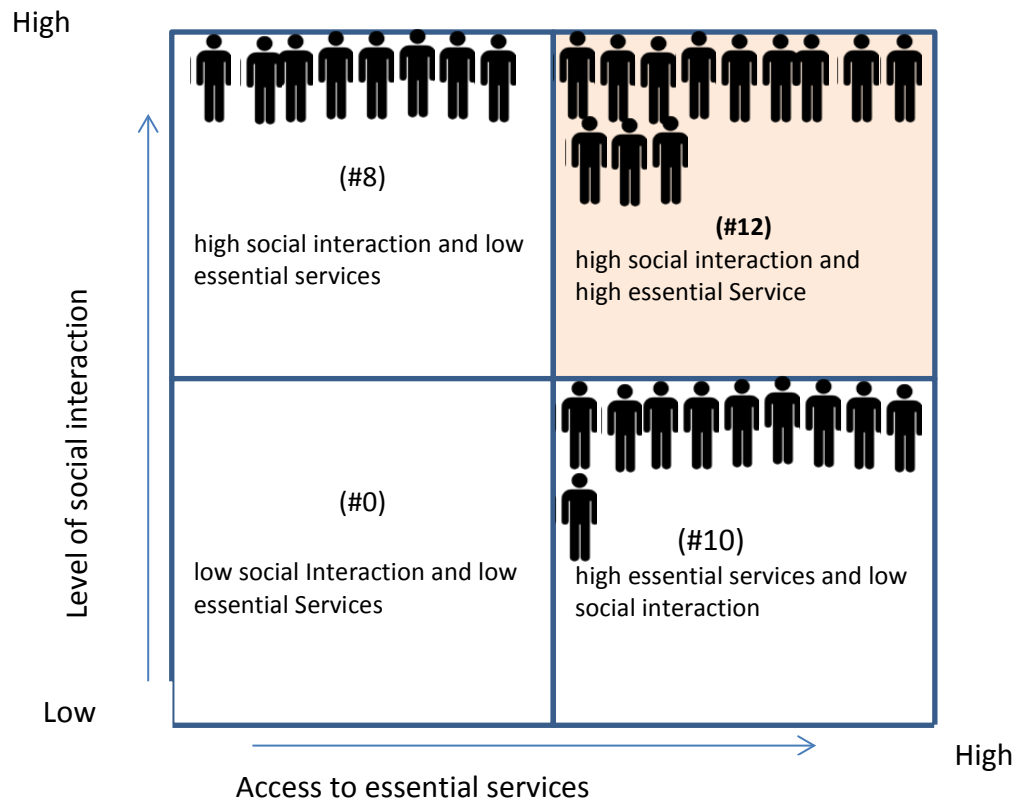


Figure 8.1: Typology of quality of life (n=30)

According to (Bennett, 2013a), the theoretical labelling of categories is an important aspect of creating typologies. Kluge (2000) referred to this as a characterisation of constructed types. In making the classifications theoretically relevant, labels are provided to distinguish each type from the other. Figure 8.2 shows that the first category that was named the '*optimum agers*'. These were respondents with high levels of social interaction and high levels of access to essential services provision. Based on the data from the reported experiences and also from the literature (Villar, 2012), the optimum ageing category is the desired state of quality of life of older people. The second category, '*the happy poor agers*', included those who had high levels of social interaction but had limited access to essential services. The '*disconnected agers*' made up the third category. This cluster comprised those with low levels of social interaction but had high level of access to essential services. The fourth and last category of active agers, the '*destitute agers*', was made up of respondents who had both limited social interaction and access to essential services. This group is not available in this current study. Next, each of the

theoretical types and their relevance to the overall body of knowledge on active ageing and quality of life of older people will be explained in more detail.

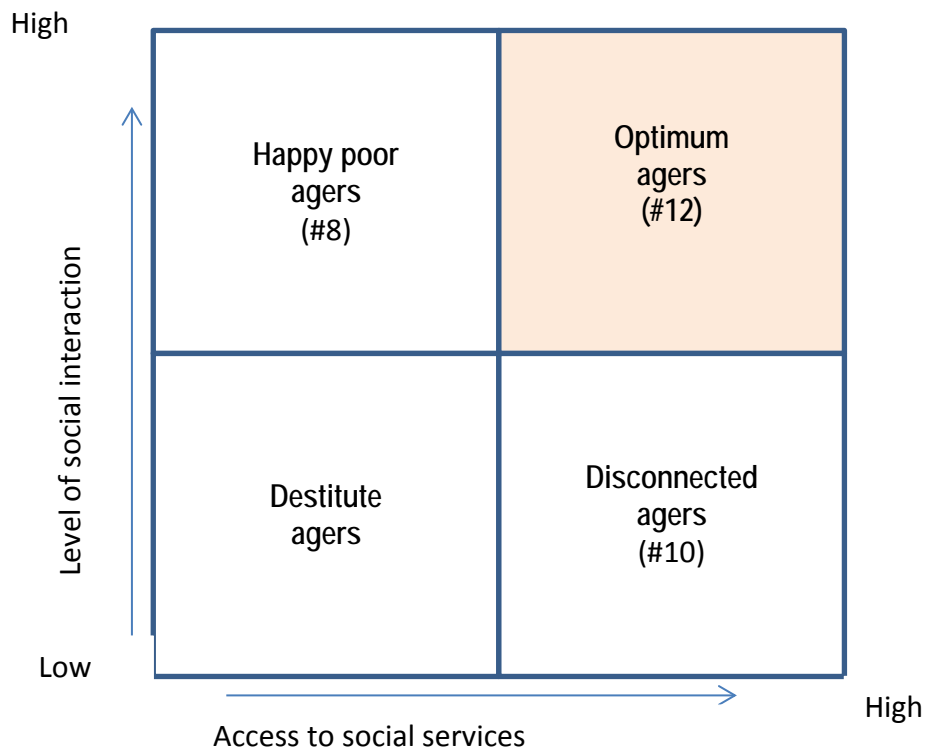


Figure 8.2: Typological of quality of life (All Participants, n=30)

Optimum agers

The optimum agers category represented about 40 per cent of all participants in the study (#12 out of 30). These were older people who experienced a high level of social interaction and high level of access to essential services. Being categorised with a high level of social interaction means that they self-reported having ample kinship and non-kinship ties. Typically, they showed active engagement with the community and other avenues of social networking. Being categorised with a high level of access to essential service means that participants regularly accessed essential public service opportunities such as health check-ups without any difficulty. Other services such as social security pensions and other non-contributory based transfers were available and affordable to them.

In demonstrating a state of optimum ageing, an Australian based participant said:

Life is good at this age; my partner and I are doing quite well. Our children are all grown now and are all married except the last-born who is currently in the University. All the children come around occasionally with our three grandchildren. We have time for ourselves, and we are enjoying our investments. The pensions are not much, but we have other sources of income. The children provide us with great support. We are busy with church activities and all kinds of programs around us. We are never worried about our health because we have good facilities here with valuable government support. There are other services for seniors here. My partner and I are just happy together. (AR-21- Australia)

A respondent in Ghana noted similarly that:

I lost my husband quite early, but I have three grown up children who are doing very well with their lives. They provide so much needed support at all times. I am busy taking care of their children. You see those two [pointing at two children playing], they are my grandchildren. It feels like I am back to my youthful days because of them. I am also the leader of the Women's Ministry of my local church. My siblings and other family members are always here and this house is full of people at all times. It is great having people around you at this age. I don't have much health problems, the hospitals are there, and once you have money, you can get the care you need. I have the national health insurance as a pensioner, but my children often pay my bills when I need them to. (GR-17, Ghana)

The above extracts from reported lived experiences are indicative of a state of optimum active ageing where participants demonstrated complete satisfaction of their quality of life which centred on their level of social interaction, and their level of access to essential services, particularly, health, pensions and other subsidised public services. The two sample extracts above also demonstrate that there were variations in individual life stories for people who are classified within the same attribute space. This is a reminder that older people are not an entirely homogeneous group with identical needs.

The concept of optimum or optimal ageing is not fully discussed in contemporary literature on ageing. However, Felsted and Wright (2014) proposed the concept of optimal ageing as the culmination of all the recommended elements of ageing including, physical, psychological and social aspects of ageing. Also, Villar (2012) observed that the presence of optimum levels of subjective well-being and

life satisfaction in old age is a desirable destination, even more so when there are objective measures of optimum life satisfaction. In the preamble to the Constitution of the World Health Organisation, it is stated “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 2006, p. 1). Accordingly, some arguments in the literature on health issues make use of the concept of optimum health, in line with the ideals of the provisions of the Constitution of the World Health Organisation (Daly, 2013; Mather, 1963; Sweeney & Witmer, 1991). By inference, optimum ageing should also be conceptualised as a high level of life satisfaction at old age measured by social, physical, mental and economic well-being. Such an understanding is necessary for policy makers to create the needed environment for people to experience a high degree of life satisfaction in old age. In achieving this condition, it will be useful to consider promoting opportunities that will enhance social interaction in old age. At the same time, it will be helpful to ensure the provision of adequate essential services for older people. The combination of plentiful social interaction and essential service provision would likely result in a state of optimum ageing.

Happy poor agers

The second category of quality of life at old age identified in the data was the ‘happy-poor agers’. As indicated above, this category consisted of older people who had high levels of social interaction but had limited access to essential services. Many of these participants indicated having lives filled with families, friends and an engaging community life. They were also involved in a range of physical, social and economic activities. Some of them indicated having assets, which they drew on to enhance their social interaction (Van der Geest, 1997). These participants claimed to be living very happy lives, but indicated having difficulties with accessing quality healthcare when they needed it most.

The issue of access to health services for participants related to either their lack of money to pay for the required medical attention, or the lack of specialised services available to deal with their old age health issues. Some participants indicated having limited pensions that hardly met their subsistence needs. Also,

some of the respondents in this category were not receiving subsidised or discounted government services such as transports, utility bills and other allied services. In spite of the limited essential public services for older people in this category, they demonstrated a considerable state of social interaction, and they appeared happy with their lives. For example, a participant in Ghana noted:

I am doing so well with my life now. I have all the support I need from my children and other family members. I am a member of some groups in the community here. I am the chairman of the Landlords Association in this area, and I am always busy on one issue or the other. The only problem I have is the healthcare system. When you go to the hospital, you are told the National Health Insurance does not cover your drugs, so you have to pay out of pocket. It is a bit difficult because my pension is only eight hundred (¢800) a month [approximately \$UD200 per month] and this is one of the highest around. If not for the children who support me occasionally, how can I buy my drugs? (GR3, Ghana).

The paradox of happy-poor people and their quality of life at old age is discussed in the literature (Cramm et al., 2013; Gabriel & Bowling, 2004; Vestergaard et al., 2015). Gabriel and Bowling (2004), for example, observed that some of the most important factors for quality of life in old age included having good social relationships and other social support systems. It also included maintaining a healthy level of social activity, and role retention in society. (Vestergaard et al., 2015) argued that even where there is mental and cognitive decline, many older people can be happy and the source of this happiness is generally traceable to the individual's high level of social interaction. The implication of this "happy poor ager" type of quality of life is that even though these participants have a high level of social interaction and are happy, they are aware that they have fallen short of the ideals of optimum ageing. People in this category would require increased levels of essential public service provision to qualify for the optimum ageing category. The experiences of research participants in this category suggest that the social policy environment for ageing in their respective contexts was defective. This point is explained further under section 8.1.2 of this chapter on Ghana and also in Chapter Four.

Disconnected agers

The third category of quality of life is labelled the 'disconnected agers'. This category represented 33 per cent of the total number of participants. As indicated previously, this category comprised participants who demonstrated a high level of access to essential services but had a limited level of social interaction. The experiences of participants in this category centred on the extent to which they relied on essential public service provision for their welfare. However, these participants were experiencing isolation and loneliness. In demonstrating the state of disconnectedness, a participant noted:

I like this place [referring to Australia] very much because every care I need with my health is provided. We have an excellent healthcare system, and there are all kinds of drugs. The health professionals are dedicated and friendly. Also, you get a discount service if you have the Senior's Card when you buy any drug. With my Seniors' Card, I have a discount on almost all services. We also have this community group that occasionally comes to help us. However, I wish I were in Ghana as well, where all the family would be around. Sometimes, I feel lonely here without family and friends. Everyone is busy with their lives and no one seems to care. (AR15, Australia)

Social disconnection and social isolation in old age has gained prominence in contemporary discussions on ageing, more so in some places than in others (Haslam, Cruwys, Haslam, & Jetten, 2015; Neville, Russell, Adams, & Jackson, 2016; Waite, Iveniuk, & Laumann, 2014). As explained by Cornwell and Waite (2009), social disconnection is a function of the lack of contact with other people. It is determined by situational factors such as the absence of small social networks, infrequent social interaction, and lack of participation in social activities and groups. Closely related to the concept of social isolation is loneliness. Nicholson (2012) and Grenade and Boldy (2008) found that social isolation and loneliness were prevalent among older people Australians and that these experiences are as a result of older people having unsatisfying kinds of relationships.

Toepoel (2013) asserted that social isolation is an indicator of poor social integration. Its prevalence is dependent on the quality and quantity of social relations available to the individual, and social relations have implications for

creating access to resources. Overall, social isolation is seen as occurring due to a lack of social ties. In Australia, for example, (Keough, 2015) claimed that loneliness had become the greatest concern for older people living at home. Similarly, in a study among the Dutch elderly, Toepoel (2013) found that there was growing evidence of social isolation and loneliness, and the only tangible correlates of social connectedness were friends in leisure activities, partners in cultural activities, community voluntary works, children and other family relations.

As mentioned above, the other outcome of social disconnection is loneliness. According to Grenade and Boldy (2008), loneliness, is a perceived negative emotion resulting from isolation. Loneliness in old age has significant implications for quality of life. The feeling of loneliness, however, varies markedly among older people and is often influenced by gender, family networks, ethnicity, neighbourhood designs, being widowed, and childlessness (Creecy, Berg, & Wright, 1985; Grenade & Boldy, 2008; Nzabona, Ntozi, & Rutaremwa, 2016).

As stated above, 'disconnected agers' would require government policy actions to move them into the optimum active ageing attribute space. Menec (2016) argued that isolation and loneliness, though not health problems, present significant health risks for older people, and that policies and programs that promote social interaction are important for older people in this category. Similarly, Pettigrew, Donovan, Boldy, and Newton (2014) suggested that there should be policy provisions for a broad range of group activities, in combination with a targeted approach for those most at risk of social isolation. Toepoel (2013) further proposed that leisure activities such as holidays, sports, cultural activities, voluntary work, and reading clubs are critical predictors of social connectedness. Unfortunately, activities such as watching television, spending time in front of the computer and listening to the radio can increase the chances of isolation. In effect, it requires a policy imperative to maximise opportunities for social interaction for older people found within the category of disconnected active agers.

Destitute agers

The last theoretical category of quality of life constructed during the study's analysis and re-theorising phase was the destitute agers group. Although, no

participant in this study fitted into this category, the topic is worth discussing. Destitute agers, broadly speaking, were older people who had limited or no access to essential public services and also had limited levels of social interaction. Many of the past studies on destitution focused on the economic or material dimensions of poverty, for example; although, Sharp, Devereux, and Amare (2003) acknowledged the multidimensional nature of destitution. This study contends that Sharp et al.'s conceptualisation falls short of what destitution should be, especially for older people. They stated:

Destitution is a state of extreme poverty that results from the pursuit of 'unsustainable livelihoods', meaning that a series of livelihood shocks and/or negative trends or processes erode the asset base of already poor and vulnerable households until they are no longer able to meet their minimum subsistence needs, they lack access to the key productive assets needed to escape from poverty, and they become dependent on public and/or private transfers. (Sharp et al., 2003, p. 6).

This kind of conceptualisation of destitution ignores the relevance of social capital and other indicators of social interaction for older people. This conceptual difficulty notwithstanding, it is important to state that even though destitute agers are not represented in this study, the relevance of this term to some older people's real circumstances cannot be denied. A much broader sample of people from different backgrounds would validate this construct of older people, and is relevant to current debates on the plight of older people in many parts of the world (Bhat & Dhruvarajan, 2001; Fajemilehin, Ayandiran, & Salami, 2007; Hossain, 2013).

8.1.2 Comparative analysis of typologies of active ageing in Ghana and Australia

The section provides a comparative analysis of different types of quality of life depicted among the research participants in Ghana and Australia. Figures 8.3 and 8.4 show the variations in the intensity of the various types of active ageing among respondents in Ghana and Australia. Among participants in Ghana, for example, the majority of the respondents (8 out of 15), representing 53 per cent, were within the attribute space of 'happy poor active agers'.

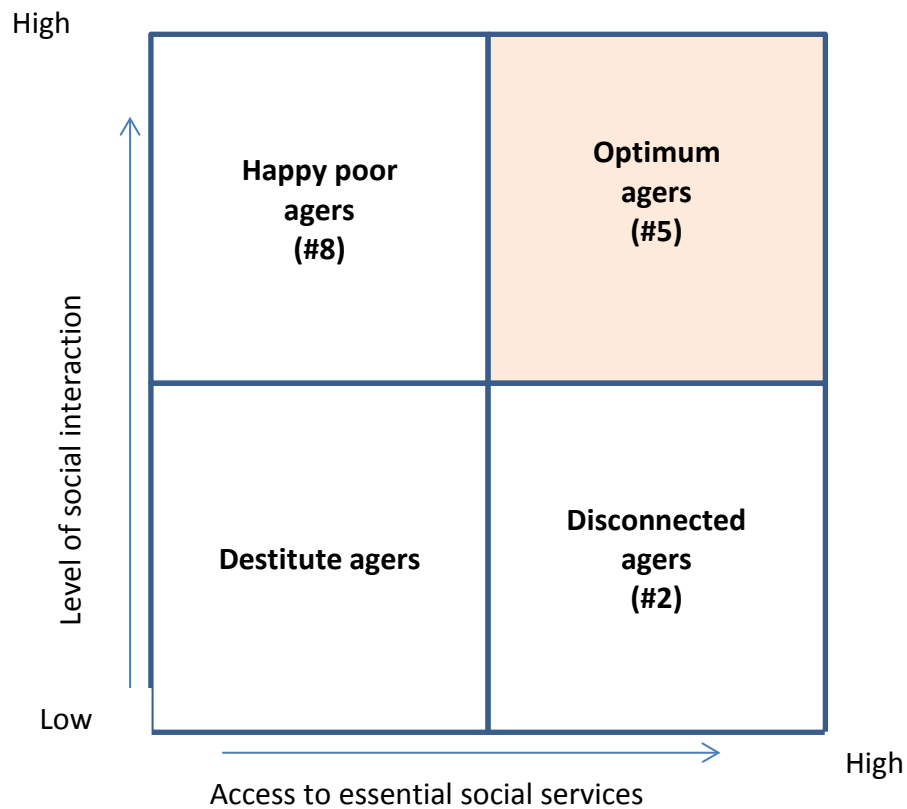


Figure 8.3: Typology of quality of life of participants in Ghana (n=15)

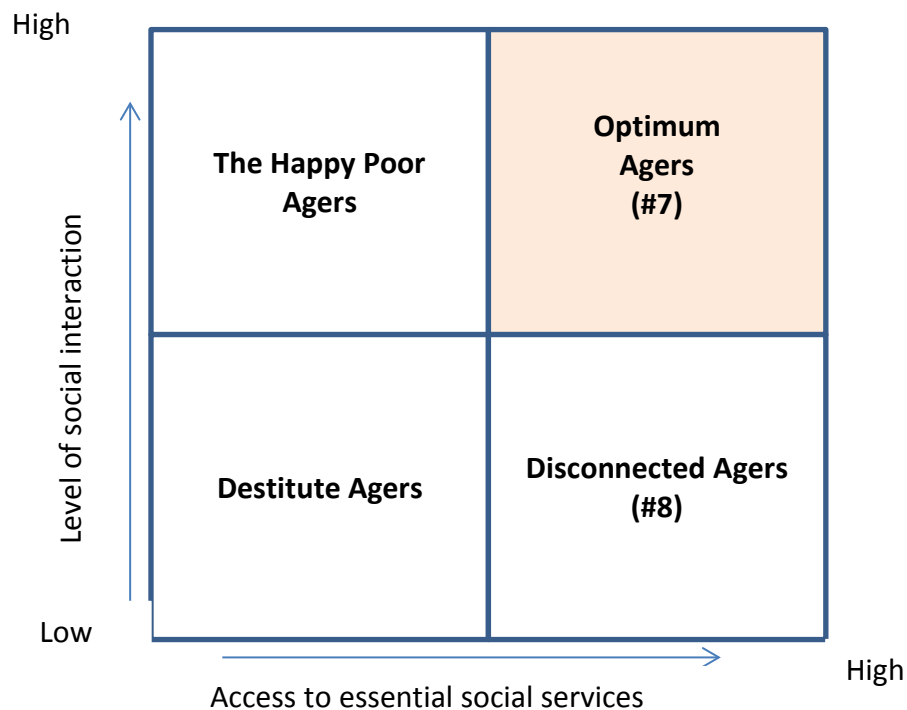


Figure 8.4: Typology of quality of life of participants in Australia (n=15)

As noted previously, these 'happy poor' older people demonstrated high levels of functional social interaction, and low levels of access to essential services. Comparatively, there were no participants in Australia within this category. The implication of this finding is that levels of social interaction were relatively higher for participants in Ghana than in Australia. According to Oppong (2006) and Doh, Afranie, and Bortei-Dorku Aryeetey (2014), such a finding is expected among Ghanaian participants because, even though the traditional kinship network system has dissipated somewhat, it remains the most viable option for providing support to older people in Ghana. Coe (2016) observed that Ghana's kinship support for the elderly extends to other non-kin relations, which then provides an extensive support base for the elderly. In Australia, the level of social ties and connection is somewhat weaker (Victoria State Government, 2016).

As indicated above, the proportion of disconnected active agers in Ghana was lower than in Australia. This finding confirms the fact that the level of social isolation or disconnectedness in Australia was higher than in Ghana. Studies in Australia, for example, have shown that there are increasing experiences of loneliness and isolation (Giles et al., 2005; Victoria State Government, 2016). On the other hand, it has been found by some researchers (Casey et al., 2003; Chomik & Piggott, 2012) that essential service provisions for the aged in Australia are better than in many OECD countries or other developing economies such as Ghana. In effect, even though the data showed Australian participants experienced a disconnection from social ties, they enjoyed better essential service provision. That notwithstanding, the data revealed that social isolation, especially for older migrants, is a critical social policy issue in Australia that needs to be addressed.

Finally, there were a few more 'optimum agers' in Australia than in Ghana, but the difference between seven and five was not very significant. These people had the recommended mix of social interaction and access to essential services. Further analysis of the data showed that participants who identified with experiences of social interaction in Australia were individuals who had maintained social contacts with families back home and who had their partners, children, grandchildren and great-grandchildren around them in Australia. Moreover, some

of these respondents were actively engaged in employment in Australia at the time of data collection. Others were associated with external social capital bodies such as belonging to a church or an association such as the Association of Ghanaian Community in Australia, the Organisation of African Unions in Australia and other allied social networks.

8.2 Causal pathway analysis of quality of life

This section presents analysis and discussion of findings relating to the causal pathway through which the most important theoretical type of experiential active ageing occurred. In regard, the most critical theoretical interest for this study is the 'optimum ageing' category. Gerring (2010) argued that when investigating human behaviour or a social phenomenon, it is important to know what has happened and, more importantly, why and how they have happened, to develop an appropriate policy intervention to address weaknesses or build on strengths. Given this, the policy imperatives of understanding the causal pathways (Bryman, 2015; Gerring, 2013) through which each type of active ageing occurs is crucial for this study. The notion of causality is complex and controversial (Sobel, 2000); however, as suggested by Sloman (2005), there are a variety of ways in which to establish a causal mechanism through which an event has occurred. One such useful approach to causal analysis in qualitative research is 'process tracing' (A. Bennett & Checkel, 2014; Mahoney, 2012).

As an analytic tool, process tracing began in the field of cognitive psychology. It refers to techniques for analysing the intermediate steps in cognitive mental processes to better understand human decision-making (Bennett & Checkel, 2015). Process tracing is very popular among political scientists, and it is also very useful for understanding relevant social policy issues, such as ageing. According to Mahoney (2012), process tracing is a useful tool for analysing causal processes that are valid within the case being examined. Logically, process tracing requires a mode of reasoning in which the analyst derives a conclusion from a set of premises (Collier, 2011; Mahoney, 2012). In this study, process tracing was used to evidence of processes, sequences, and conjunctures of events within selected cases. (Bennett & Checkel, 2015, p. 7). In determining the validity of causal inferences or

claims made in this study, the smoking gun test (i.e. the evidence is unique and sufficient to confirm that the event has occurred and has led to an outcome) (Bennett & Checkel, 2015; Collier, 2011; George & Bennett, 2005; Mahoney, 2012).

The process tracing approach used in this study was underpinned by the life course perspective on ageing, which assumes that current circumstances are shaped by past events, from birth to the present time (see Chapter Two). The critical question for this section is: Why did some research participants experience optimum ageing while others did not? In conducting this analysis, it was not possible to develop an aggregate story line for all individual cases within each of the four theoretical types of quality of life due to the large volume of qualitative data obtained. As a compromise, the process tracing was conducted on selected individual cases within the optimum ageing category only.

8.2.1 Understanding the causal pathway to optimum ageing

The causal process of attaining optimum active ageing is complex and varies significantly from person to person. One participant each was selected from Australia and Ghana and was used to illustrate the causal pathways through which each of these individuals attained optimum ageing. In addition to this, the central issues that ran through all the experiences of optimum ageing were used to develop a composite causal pathway that is to some extent representative of all participants within the optimum active ageing category.

Case One: The story of Felix (AR-10)

My name is Felix [not real name]. I was born in Ghana in December 1938. I am the fourth of seven children. My parents were wonderful people, who took great interest in our daily lives. We lived in Accra most of the time, but we originally came from the Central Region of Ghana. My parents were very enthusiastic about our education, so they took me and my other siblings to school. I remember my first day at school. I also remember that education was free so we did not have to pay [paused to think], that was the time of Governor Allan Burns.

I enrolled at the University of Ghana in 1964. At that time, University education was free so we did not worry about tuition fees. At the University, I made many friends, and after completing my study, one of my friends recommended me for a position at

the Ministry of Agriculture. From then on, I started earning a good income, so I could marry. I married my wife at age 30 and we have been together since then. We had three children. She was just 21 years when we married. Working with the Ministry of Agriculture was fun. I registered for my social security and made contributions. I also saved lots of money at the time because my parents taught me the habit of saving. To be a graduate in the early 1970s in Ghana was a great prestige, so we were well paid. There was instability in Ghana in the 1970s and after the 1979 coupe d'état, which led to the military take-over of government, I became afraid for my life, so I decided to migrate. Ghana was completely unsafe at the time for many people working within the government ministries. As a result, I withdrew my savings and, with the support of a friend, I migrated to Australia in late 1979 with my wife. In Australia, I had the opportunity to further my education to Masters and a PhD levels and I got an appointment to teach in an Australia University. Teaching at the university in Australia created valuable opportunities for me. I made more friends and later became a member of a prominent church in Australia. I looked after my children and they have all completed University. I also invested in real estate in Australia and Ghana. All along, I kept close ties with my family back in Ghana. I am retired now and I receive a good superannuation. I also enjoy other social services for older people in Australia. I have the Senior's Card and I get discounts on most services. I am currently 78 years with some joint pains and a few health issues here and there, but I am feeling hearty, happy and independent because my wife, my children and my grandchildren keep the home alive. The children are also very supportive too. It's great to be old, so I think.

Felix's life story is presented in Figure 8.5 below; and followed by an analytical discussion of the story.

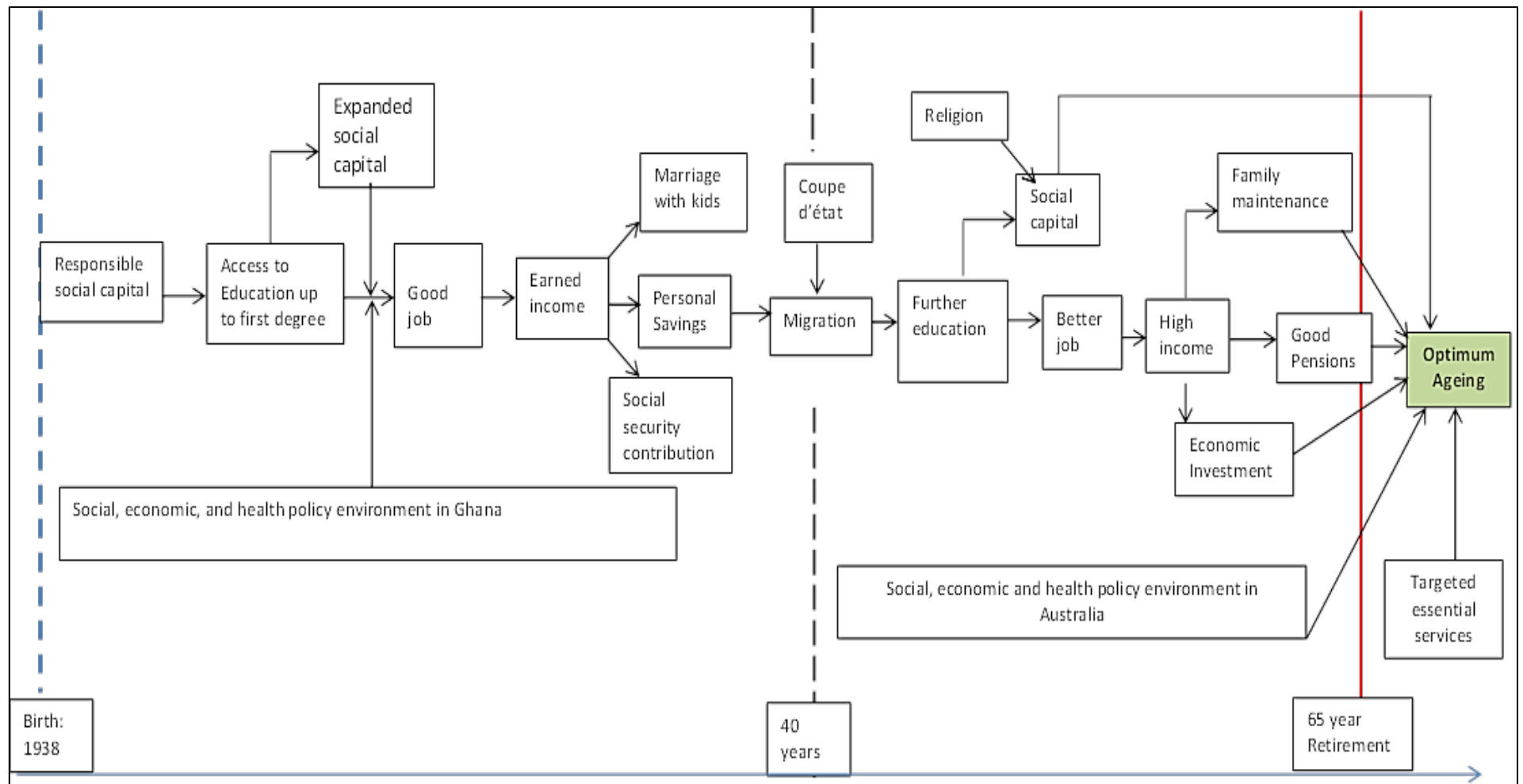


Figure 8.5: Pathway to optimum ageing (Case AR-10- Mr Felix).

Source: Developed by author

Case one: Analysis

The causal pathway to optimum ageing, as shown in Figure 8.5 in Felix's case, indicates that the starting point for Felix was a fortuitous social capital (parents and family), which created opportunities and encouragement for Felix to access education. It is noted that Felix's access to education was also dependent on the prevailing educational policies, which made education free and compulsory. While engaged in university education, Felix expanded his social capital by making friends. One of his friends assisted him to secure his first job with the Ministry of Agriculture. It is important to note that Felix's social capital from school was necessary but not sufficient for attaining the job; he needed his degree, the social contact and the job availability. However, Felix's good job was a necessary and sufficient condition for him to earn income. Because he earned income, he was able to comfortably marry, start a family (expanding social capital), and save part of his income while contributing to social security.

Furthermore, the 1979 *coup d'état* in Ghana was a necessary cause for his migration but not sufficient. His financial savings complemented the situation, created by the political unrest, enabling him and his family to migrate' with the help of another friend. Migration to Australia enhanced Felix's human, social and economic capitals, stemming from a relative better social policy environment in the country. At 78, Felix uses multiple sources of support including his social capital and networks, his pensions and investments, activity within his church, and the essential services provided for older people in Australia.

Within the life course perspective, it can be argued that the current status of quality of life of Felix is directly connected to the series of events that characterised his life from birth and the social policy environment within which he grew. The life course perspective, as noted earlier, is guided by five basic principles including linked lives, historical time and place, life span development, social context and the role of agency or personal initiatives. Felix's narrative can be seen through these principles. For example, Felix benefitted from the principle of linked lives – bonds of kinship or community and throughout his life he maintained the creation of such linked lives – social capital. The historical, political and social context within which he grew and attended school also contributed to his human capital development – agency (personal initiatives). Felix, decision to migrate to Australia,

which led to greater expansion in economic and social resources are clear examples of how choices of the past affect current life circumstances.

Case two: The story Vero (GR,17)

My name is Vero [Not real name], a Ghanaian, and I live in Accra, Ghana. I was born in 1948. I lost my parents just before I completed my middle school education. As a result, I assumed responsibility for my three younger siblings because I was the first-born. The situation compelled me to marry at an early age, after which I gave birth to three children. I started petty trading, selling groceries to support the family income. Through my support, my siblings attended University and other tertiary institutions. All of them secured various jobs. My husband valued formal education so much so he supported me to further my education by training as a teacher. I enrolled in a teacher-training college and did what was called post-middle teacher training education. While in school, my siblings took over and looked after my three children. When I completed the training in 1982 at the age of 34, I taught in several schools as a primary class teacher. I was also registered under the national social security scheme (SSNIT). After a while, I took a loan from the bank to expand my grocery business as a second job, while raising my children. My husband was very supportive. The business grew into a whole supermarket with stores in different locations of the city [Accra]. I made lots of money at the time. In 2003, at the age of 55, I lost my husband through a motor accident, and received a life insurance compensation, which I invested in different projects.

After the death of my husband, I became very committed to my local church and took on a leadership position. At the moment, I earn income from multiple sources, including a state retirement pension, my grocery shops, other business I have and remittances from my children. I am keeping some of my grandchildren so their parents always bring money and food. I am also busy, supervising my grocery shops and actively engaged in church's activities. I do not worry about health issues because even though I have a national health insurance, I hardly use that because my children have also registered me for a private health insurance scheme, which provides a better service than the national one. I do not have any serious health issue and I live a satisfactory life. At 68, I spend lots of time with the grandchildren and occasionally travel to visit some of my siblings abroad. A greater part of

my day is also devoted to church activities and other community services, including a Non-Governmental Organisation (NGO) that I set up in memory of my husband.

Vero's story is presented in Figure 8.6 and an analytical discussion follows after the Figure.

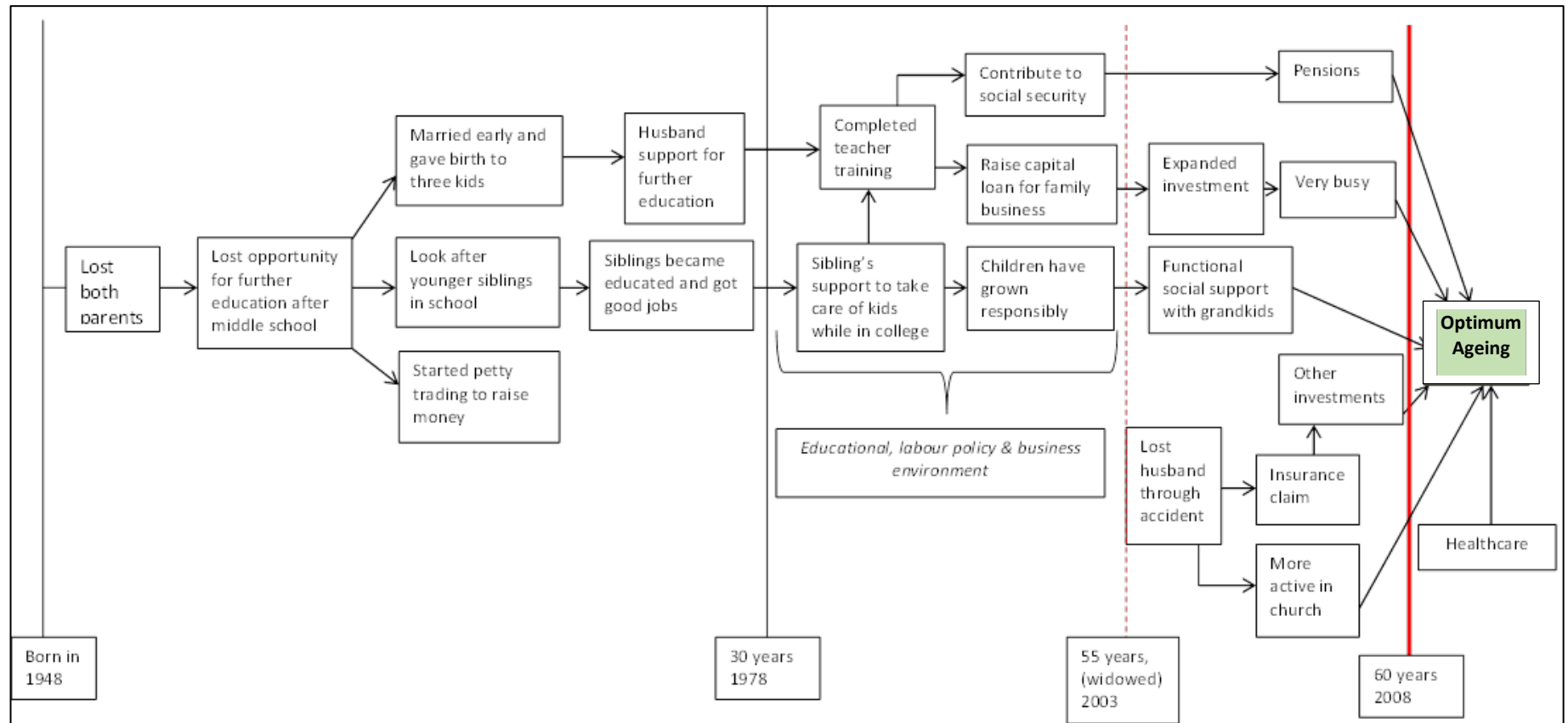


Figure 8.6: Pathway to optimum Ageing (Case GR-17- Vero)

Source: Developed by author

Case two: Analysis

As shown in Figure 8.6, Vero's pathway to active ageing was complex, with several connecting events and life circumstances. To begin with, Vero had a rough start in life when her parents died early. As a result, she lost the opportunity for extensive childhood education. Due to her inability to attend school, Vero got married early, started a groceries business, and looked after her younger siblings. At this point, under the principle of linked lives, Vero laid the foundation for a bonded family life, which explained the volume of social interaction available to Vero at old age. Vero's husband supported her to obtain formal education, which was possible because, the social policy environment created such an opportunity but Vero's personal initiative and choices were critical. Vero built her social networks, especially within her family. Through reciprocal arrangement, the siblings looked after her children while she attended teacher-training college, and this allowed her to acquire a professional teacher's certificate. Because Vero became a teacher, she contributed to the social security scheme, raised more money and was able to look after the children. Vero took a loan to expand her groceries business, while working as a teacher. At the time of data collection Vero had retired, but was still managing her groceries business, which kept her busy. Along the line, Vero lost her husband, but used the life insurance compensation she received to expand her business. Vero received pension benefits because of her contribution to the scheme when she was a teacher. She now has time to look after her children, and the children have grown into responsible adults. Vero stated that she now lives a very satisfactory life.

8.2.2 *Synthesising the causal path theory of optimum active ageing*

Based on the process tracing of the two case studies above, and synthesis of the stories of all participants who fell within the category of optimum ageing, it is imperative to acknowledge the common contributory factors towards optimum active ageing. As shown in the causal diagram 8.7, there are two direct conjunctural causes of optimum active ageing operating within the context of the life course perspective of ageing (Bengtson et al., 2012). A conjunctural cause occurs when multiple factors interact simultaneously to produce an effect (Aus, 2009; Gerring,

2010). In this study, two factors interacted simultaneously to produce optimum active ageing, namely: i) the level of functional social interaction; and ii) the availability or access to essential services, such as health care and social protection at old age.

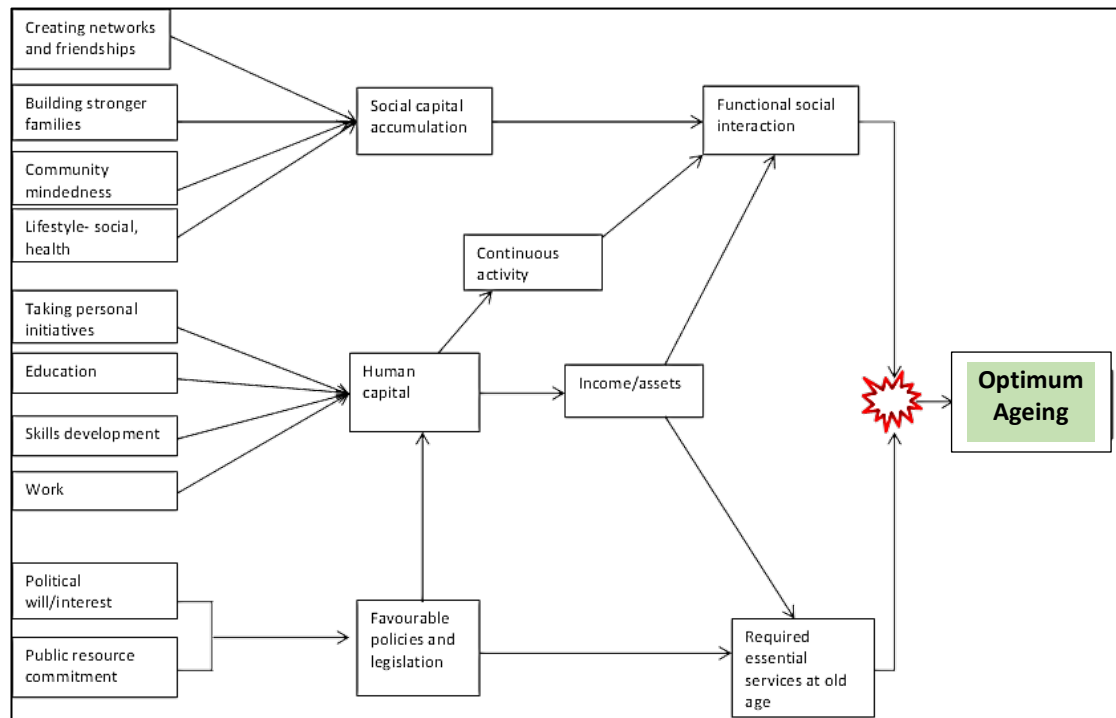


Figure 8.7: A synthesis of causal pathway of optimum active ageing

Source: Author

From Figure 8.7 above, the immediate causes of optimum active ageing were social interaction and access to essential services in old age, which have been discussed previously in the chapter. Consistent with the life course approach, the causal pathway shows that both social interaction and availability of essential services for older people have several antecedent causes. For example, social interaction was generated by three antecedent factors during the life course: the accumulation of social capital, continuous activity, and the availability of income, which maintained and sustained social interaction. Social capital accumulation was also influenced by other background casual factors, such as the creation of friendships and networks, building and having strong families and active engagement with community activities. There is also the issue of overall social and health lifestyle of the individual.

In addition to the social capital pathway, the analysis also found that an older person's ability to continue with activity, mainly economic activity was dependent on the individual's resourcefulness and level and nature of her/his human capital accumulations during the life course. The human capital in this instance is the volume of knowledge and skills acquired by the individual, coupled with personal actions. Vero's case was a typical example where her continued engagement in a grocery business—even at old age— was due to the knowledge and skills (and capital) she had acquired throughout her life course. Theoretically, it is assumed that ageing depreciates the human capital of individuals and nations (Day & Dowrick, 2004; Fougère & Mérette, 1999; Wei, 2007). Therefore, employers are hesitant to employ older people (Georgiou, 2015; Taylor & Walker, 1994). However, at the individual level, accumulated skills and knowledge at old age can remain valuable (Georgiou, 2015). Some older people in this study have remained highly functional, undertaking paid and unpaid work akin to their skill areas. For example, a 70-year-old male participant in this study was an accountant before retirement. He now works as an accountant for his local church on a voluntary basis. He indicated having much fulfillment from this work, and he does not feel retired. There is sufficient evidence in many past studies that work, whether paid or unpaid, and other forms of activities, provide some level of satisfaction for older people (Adams et al., 2011; Chambre, 1984; Stenholm et al., 2015).

Furthermore, the analysis shows that the income of older people contributes to the nature and strength of their social capital. As argued by Van der Geest (1997), money is used to maintain social bonds at old age. Older people with some assets and or income were more likely to gain independence and enhanced social interaction through helping people in need, who in turn could provide help to others. This finding is similar to those made by Adams et al. (2011) who found that when the effects of the quality of the social relationship are controlled in a regression analysis, income does not produce well-being at old age. In the view of the researcher, even though money can be used to buy love, it cannot buy happiness or optimum ageing however money can act through different mechanisms to have an effect during old age.

Moreover, having money at old age contributes to the extent to which the individuals get access to services. The data show that essential services such as healthcare for older people attract payment no matter how subsidised the cost might be (Heinrich et al., 2010; Macha et al., 2012; Xu et al., 2003). Consequently, older people who have a comfortable level of financial resources are better able to pay for specialised services when needed (De Nardi et al., 2009). In the case of Ghana, for example, even though almost all respondents indicated enrolling in the National Insurance Health Scheme (NHIS), the scheme does not cover the cost of some essential drugs and some health services, which mean people have to pay for these services (Parmar et al., 2014).

In terms of the causal pathway for essential services, the evidence indicates that the current state of essential services provision is a result of the prevailing policy and legislative atmosphere. The policy environment as discussed in Chapter Four was largely shaped by political will and the interest and commitment of public funds towards such services (Boudiny, 2013; Hyman, 2014; Prince et al., 2015).

To some extent, it can be argued in this study that the utilisation of some of the essential services at an old age such as paying hospital bills or buying drugs was influenced by the availability of income (Prince et al., 2015). Clearly, whereas income appears to be important at old age, it does not have a direct causal effect on optimum ageing unless there are people to help in order to attain the desired effect (Wagnild, 2003).

Overall, it is argued in this study that optimum active ageing is a product of a life course event where actions of the past directly influence current circumstances. Optimum active ageing is a conjunctural cause from social interaction, on the one hand, and access to essential services on the other hand. Social interaction has been defined as the level of social capital accrued by the individual over time, including continuous activity and the availability of income or asset to maintain social capital. Social interaction also involves the creation of strong families, which have implications for strengthening reciprocal ties and the maintenance of quality of life in old age. As argued by Adams et al. (2011), social relationships (social interaction) are the primary predictor of well-being at old age. Adams et al. (2011)

further assert that the social relationship contributes more to the well-being than any of the other factors (Adams et al., 2011; Darteh et al., 2016).

8.3 Summary

The analysis of data in this chapter shows that acquiring, creating and maintaining a high level of social interaction, together with the development of knowledge, useful skills and personal initiatives in a favourable social, economic and health policy environment, are likely to lead to optimum ageing. Regarding policy implication, it is important for nations to take steps to strengthen family systems in the first place, and to create opportunities for individuals to deepen social networking and communal living. It may also be useful to create opportunities for continuous activity within the social interaction milieu. Finally, since optimum ageing is a life course event, it is imperative for social policies to facilitate sound human capital development, which has implications for income such as pensions and the creation of assets that are needed to fuel social interaction. Specific essential services, such as health care and social protection, are valuable public services that provide protection for older people.

CHAPTER NINE: CONCLUSION

9. Introduction

This thesis explored the meaning of active ageing from the lived experiences of a sample of older Ghanaians living in Ghana and Australia, and compared these experiences theoretically and conceptually with the model of active ageing developed by the World Health Organisation (WHO). Drawing on data collected from 30 older Ghanaians, comprising 15 who were living in Ghana and 15 who were living in Australia, the study also investigated the manner in which the research participants' active ageing experiences varied according to their different socio-cultural and political contexts. Furthermore, the study examined different forms of quality of life based on the reported experiences of research participants, and the factors that contribute to the highest quality of life. This analysis showed how life course events contribute to variations in the quality of life at old age. The theoretical basis for this study was the life course approach to ageing, which presumes that later life events and circumstances (quality of life) are largely shaped by events of life from the time of birth. These events and circumstances are influenced by the overall social structure and an individual's characteristics through time and space. This theoretical consideration led to the choice of an interpretive phenomenological analysis in combination with comparative case study research as the methodological approaches for the study.

This study examined the WHO's active ageing framework, which guides policies and practices associated with global demographic ageing. On the one hand, the study has found that the WHO's active ageing model is broad, and has resulted in a lack of consensus in the literature on what is the most important factor for promoting a high quality of life at old age. For example, while some researchers emphasised the need to promote health and physical activity, others have argued in favour of economic participation of older people. On the other hand, the WHO (2002) acknowledged that the active ageing model is an extension of the determinants of health, suggesting an obvious prioritisation of health issues. An

important contribution of this thesis relates to the need for active ageing stakeholders to contextualise the WHO's active ageing model based on the perspectives and experiences of older people within their respective socio-cultural and political contexts.

9.1 The meaning of active ageing

The first research question sought to examine the meaning of active ageing for the research participants, based on their reflections of their lived experiences. From the reported lived experiences, eight notions of active ageing were identified: social interaction, activity, health, independence, work and employment, spirituality, happiness, and public safety. For the two sampled groups overall, social interaction emerged as the most significant experiential meaning of active ageing. The research participants conceptualised social interaction variously as i) the availability and use of social networks, which include kinship and non-kinship support at old age; ii) opportunities for continuous social activity, with or without economic benefits; and iii) the availability of income for the maintenance of social interaction. The importance of social interaction for the quality of life of older people has been recognised by other researchers. For example, researchers have asserted that social interaction facilitates the promotion of mental and physical health (Abbott & Pachucki, 2016; Algar et al., 2016) and longevity (Holt-Lunstad et al. (2010). Social interaction also results in the overall wellbeing of older people, including their happiness (Huxhold et al., 2014). This emphasis on promoting social interaction as a critical component of active ageing corresponds with McMurray (2007) socio-ecological model of community health and wellness. McMurray asserted that quality of life for older people comes from family and community social engagement practices, which create reciprocal relationships and interests and eventually contribute to health, happiness, interdependence and overall quality of life.

9.2 The fit between the experiential meaning of active ageing and the WHO model

The second research question for the study sought to examine the conceptual and theoretical fit between the WHO's active ageing model and the experiential meaning reported by the research participants. Overall, there were

marked variations between the two in terms of the key factors for the quality of life of older people. Whereas the experiential meaning of the participants' active ageing was keyed primarily to social interaction, especially for those living in Ghana, the WHO's model prioritised health promotion and prevention (Barrett & McGoldrick, 2013). Social interaction is subsumed under the participation pillar of the WHO's model; which makes it less important than other factors. As a consequence of the WHO's order of priorities, some policy actions on active ageing at the national level (e.g. countries in Europe) and regional level (e.g. the European Union) have ignored social interaction and largely focused on health promotion, physical activity and economic participation (Boudiny, 2013; European Union, 2012). This has meant that considerations for social interaction in these policies, such as the promotion of community and family life, are treated as subsidiary interventions.

9.3 Context and lived experiences of active ageing

The third research question focused on the extent to which different socio-cultural, political and economic environments influence the experiences and meaning of active ageing. This investigation was necessary because, within the life course approach to ageing, it is assumed that contexts, including political, economic, social and cultural, play significant roles in constructing lives of people from birth to old age. The life course approach also assumes that the policy environment within which the older individual lives has an influence on their experiences of old age. The data from this study showed variations in the experiences and meaning of active ageing between research participants in Ghana and Australia. For example, whereas the participants in Ghana strongly emphasised social interaction in their lived experiences, the participants in Australia related their experiences more to issues of physical health and physical activity. The variation was partly traceable to the different policy and practice environments within which the participants lived, including laws, programmes and projects designed by their respective state and non-state actors to affect the wellbeing of older people. In Australia, there was evidence of sound health promotion policies

and programs; in Ghana however, such opportunities and facilities were limited, and there was more attention given in Ghana to family and community activities.

Furthermore, the present study has found that policies, to some extent, determined the nature of choices and decisions people made about opportunities and determined constraints imposed on them by the social structure. Through the life stories of the research participants, it was found that the meaning and experiences of active ageing reported reflected an accumulation of the effects of opportunities taken or not taken, choices made, and constraints imposed by the policy system from childhood to the time of this study. This finding confirms the life course theory that events of earlier life do affect later life experience (Bengtson, Elder, & Putney, 2012).

In addition to the above, even though context contributed to variations in the life experiences and meaning of active ageing, it was observed that the emergent themes were similar to a great extent, suggesting that there are fundamental issues for older people everywhere, although they may be accorded different levels of importance. For instance, the issues of social interaction, health, activity and independence were important cross-cutting themes for older people in both research localities. Several arguments have been made in previous studies about the relevance of these issues for promoting quality of life at old age (Seeman, Lusignolo, Albert & Berkman, 2001; Tseklevs, Escalante, Escalante, & Bingley, 2016). This implies that as nations develop policies for older people, cross-cutting issues need to be addressed. In the long run, it is acknowledged that the influence of the social policy environment —including culture, politics, economics, and religion — affects the way people live and experience ageing. Thus, country-specific social policy environments have an important bearing on the quality of life of people at old age. Policies create the broad-brush strokes within which people experience their quality of life at old age.

9.4 What factors contribute to differences in quality of life among research participants?

The final research question for this study focused on examining why differences exist in the experiences of the quality of life of research participants.

The first part of this analysis sought to classify research participants according to their experiences. The second part of the analysis focused on the causal pathways that led to their quality of life, based on the reported experiences of participants. The purpose of these two analyses was to pinpoint which aspects considered crucial for the promotion of a higher quality of life for older people irrespective of where they live.

The present study classified old people's quality of life into a typology based on the interplay between levels of social interaction and access to essential services. This classification method allowed four types of quality of life: 1) 'optimum agers', who had high levels of social interaction and high levels of access to essential services; 2) 'happy poor agers', who reported high levels of social interaction but limited access to essential services; 3) 'disconnected agers' who reported high levels of access to essential services but had a limited level of social interaction, and 4) 'destitute agers' who did not have access to essential services and also lacked adequate social interaction, but were not represented in the presented study's population sample.

It is noted from the study that the pathway to each of these types of active ageing was based on life course events from birth up to the time of the study. Importantly, optimum active ageing, the most desired quality of life at old age, was shaped mostly by original family circumstances, personal actions, and the wider social policy environment throughout the life course. In particular, it was evident that acquiring, creating and maintaining a functional social interaction, in addition to the development of useful skills and personal initiatives towards work within a favourable social, economic and health policy environment, were likely to lead to optimum ageing over the life course.

9.5 Policy implications and recommendations

Given that social interaction emerged from participants (especially those living in Ghana) as the most important meaning and experience of active ageing; national level policy makers may need to review current settings and consider giving more emphasis to enhancing social interaction at both macro and micro levels of society. This would include promoting activities that strengthen family

bonds, yield social satisfaction, and generate happiness. Furthermore, policy makers should consider strengthening community support structures and intergenerational solidarity to ensure mutual reciprocal commitment between generations and within communities.

In Australia, even though the experiences prioritised health, social interaction was equally significant. Policy makers in Australia may also need to promote opportunities that strengthen family bonds and reciprocity, especially in the aftermath of the Commonwealth Home Support Program (CHSP), which is promoting independent community living for older people. The CHSP encourages older people to stay in their homes and communities, and this will require a strong family and community support-base. For migrant older people, policies that provide opportunities for better social integration will be useful.

The need to promote social interaction for older people is acknowledged in the literature as being able to reduce health-care-associated cost at old age while, enhancing the functional abilities of older people to live independently and happily (McMurray, 2007; Tseklevs et al. 2015). Yet, despite this recognition of social interaction in enhancing the quality of life, policy actions have largely remained health-centred (Boudiny, 2013). That notwithstanding, the complementary roles of essential public services such as healthcare for older people, income support and social security at old age cannot be ignored.

The debate about the theoretical and conceptual fit of the active ageing model is ongoing. Some past researchers sought to validate the model but did not find any significant result (Paúl et al., 2012). The present study found eight components of experiential active ageing but there was not a close fit between them and the WHO's model. The eight components include: social interaction, activity, health, independence, work and employment, happiness, spirituality and safety. In terms of the implications of context for policy actions, international policy proposals such as the active ageing framework are imprecise on specific actions to be taken at national level to ensure the best form of quality of life at old age. In adapting such policy frameworks, it will be useful for policy makers and others providing services to old people to take into account contextual issues that are

specific to their people and develop models that fit their situations. For example, as stated by Walker (2002) and many others, the current state of the active ageing model appears to be more relevant to the highly developed nations than the developing ones, especially those in Africa. This implies that context-specific active ageing policy will be critical if the intention is to promote active ageing as the ideal policy for demographic ageing. That is, notwithstanding cross-cutting issues of social interaction, including family and community life will require prioritisation in policy actions for older people in specific settings as opposed to the universalisation of the WHO's active ageing model. The present study's findings are that issues of social interaction, including family and community life, have some special significance; they are subsumed under the pillars of participation and are the dominant issue raised by research participants.

Finally, in terms of exploring opportunities for promoting optimal active ageing, sound social policies that create opportunities for people to develop over the life course are essential for constructing the desired quality of life at old age. Policies that promote family life in addition to other policies on education, employment and health could be critical investments that can yield good returns for people at old age. State and non-state actors may need to consider creating policies that make significant investments in building capacities, creating favourable working lives for people so that they can make a commitment to family life and build social networks, create personal investments and make financial savings. Also, policies that promote personal responsibility for the future can be useful in encouraging people to take advantage of current opportunities and create better quality lives at old age.

9.6 Limitations and opportunities for future research

9.6.1 *Limitation of the study*

This study had some limitations. In the first instance, IPA studies normally have small sample sizes (e.g. 1 to 10 participants) to allow for detailed idiographic analysis (Pietkiewicz & Smith, 2014). The population sample in the present study comprising 30 participants was relatively high, making it difficult to handle the volume of qualitative data and perform a deeper idiographic analysis. However,

with the assistance of the Nvivo software, the difficulty was surmounted to a large extent, the researcher was able to capture views from all participants with supported case extracts from the data.

Another limitation occurred with validating the content with participants after transcription. This was not possible for all participants. For some, this was due to a problem of access and time constraint. However, in such situations, an independent validator was employed to match the transcriptions to the voice data. In addition, the findings of this study may not be generalised to older people everywhere due to the focused nature of the sample. Participants in the study were mainly composed of skilled professionals and middle class older people living in urban and sub-urban locations of Australia and Ghana. Participants were also high functioning older people participating, which might not show other issues that might be associated with ageing experiences. This presents an opportunity to broaden the scope of future research of this nature

9.6.2 Future research opportunities

The present study did not consider the gender dimension of experiences of active ageing because it was outside the scope of the study. A gender dimension could usefully be taken into account in future research on active ageing. In addition, the present study did not have participants within the fourth category of the final typology used — ‘destitute agers’. Therefore, future research should consider including samples from all categories of people, from a broader range of socio-economic strata with more varied life experiences, including rural and urban dwellers, and men and women.

Further, research on the issues of social interaction within communities and families will be an important step towards meeting the identified needs in the present study – this could include further localised studies on generational issues (i.e. i) To what extent can the younger generations both work to support an increasing older demographic and be personally available to meet the social interaction needs of the older generation? ii) What is the impact of family and community support in contexts of immigration – or where there are no younger

family members – and to what extent can government services or technology be used to alleviate any gaps?

Finally, a large-scale quantitative study could be conducted to test the statistical significance of the eight components of experiential active ageing to the quality of life of older people identified in this study. Such a research will enable policy makers or service providers to benefit from having tools developed to conduct needs assessments on different scales (national, local, per group), or individually; and so there is potential to use further research to efficiently identify and evaluate the significance of specific factors to those populations.

REFERENCES

- Abbey, C., Odonkor, E., & Boateng, D. (2014). A Beneficiary Assessment of Ghana's Cash Transfer Programme (LEAP) in May 2014. *Accra: African Development Program Ghana*.
- Abbott, K. M., & Pachucki, M. C. (2016). Associations between social network characteristics, cognitive function, and quality of life among residents in a dementia special care unit: A pilot study. *Dementia*, 1471301216630907.
- Abdulai, A. G. (2009). Political Context Study–Ghana. Leeds and Accra: Human Rights, Power and Civic Action Research Project.
- Abdulai, A. G., & Hickey, S. (2016). Rethinking the politics of development in Africa? How the 'political settlement' shapes resource allocation in Ghana. ESID Working Paper No. 38.
- Abel-Smith, B. (2016). 10 Age, Work and Social Security: The Policy. *Age, Work and Social Security*, 255.
- Abiola, O. Y. (2016). The Moderator Effect of Income and Social Status, Social Connectedness and Physical Activity on Healthy Ageing Amongst Older Adults in Ibadan Metropolis, Nigeria. *African Journal for the Psychological Studies of Social Issues*, 19(2), 135-149.
- Adams, J. M., & White, M. (2004). Biological ageing. *The European Journal of Public Health*, 14(3), 331-334.
- Adams, K. B., Leibbrandt, S., & Moon, H. (2011). A critical review of the literature on social and leisure activity and wellbeing in later life. *Ageing and Society*, 31(04), 683-712.
- Adedeji, J. L. (2001). The legacy of JJ Rawlings in Ghanaian politics, 1979–2000. *African Studies Quarterly*, 5(2), 1-27.
- Adinkrah, M. (2015). *Witchcraft, Witches, and Violence in Ghana*. Berghahn Books.
- Adusei-Asante, K., & Doh, D. (2016). The Two Sides of Free National Health Insurance Policies: Lessons from Daakye District, Ghana. *Rangsit Journal of Social Sciences and Humanities*, 3(2), 37-47.
- Ardayfio-Schandorf, E. (2006). The family in Ghana: Past and present perspectives. *African families at the turn of the 21st century*, 129.
- African Union, & HelpAge-International. (2002). *AU Policy Framework and Plan of Action on Ageing*. Nairobi Kenya: HelpAge International, Africa Regional Development Centre.
- Agarwal, B. (2001). Participatory exclusions, community forestry, and gender: An analysis for South Asia and a conceptual framework. *World development*, 29(10), 1623-1648.
- Ageing, W. H. O., & Unit, L. C. (2008). *WHO global report on falls prevention in older age*: World Health Organization.
- Agyemang, C., Attah-Adjepong, G., Owusu-Dabo, E., Aikins, A. D. G., Addo, J., Edusei, A., . . . Ogedegbe, G. (2013). Stroke in Ashanti region of Ghana. *Ghana medical journal*, 46(2), 12-17.
- Agyepong, I. A., & Adjei, S. (2008). Public social policy development and implementation: a case study of the Ghana National Health Insurance scheme. *Health policy and planning*, 23(2), 150-160.

- Aikins, A. d.-G., & Apt, N. A. (2016). Aging in Ghana: Setting Priorities for Research, Intervention and Policy. *Ghana Studies*, 19(1), 35-45.
- Aikins, A. d.-G., Kushitor, M., Sanuade, O., Dakey, S., Dovie, D., & Kwabena-Adade, J. (2016). Research On Aging in Ghana from the 1950s To 2016: A Bibliography and Commentary. *Ghana Studies*, 19(1), 173-189.
- Aikins, A. D.-G., & Marks, D. F. (2007). Health, disease and healthcare in Africa. *Journal of health psychology*, 12(3), 387-402.
- Ainsworth, B. E. (2016). Active Aging: From Cells to Environment. *Kinesiology Review*, 5(1), 1-3.
- Algar, K., Woods, R. T., & Windle, G. (2016). Measuring the quality of life and well-being of people with dementia: A review of observational measures. *Dementia*, 15(4), 832-857.
- Alidu, S., Dankyi, E., & Tsiboe-Darko, A. (2016). Aging Policies in Ghana: A Review of the Livelihood Empowerment against Poverty and the National Health Insurance Scheme. *Ghana Studies*, 19(1), 154-172.
- Andrews, G. R. (2001). Care of older people: Promoting health and function in an ageing population. *BMJ: British Medical Journal*, 322(7288), 728.
- Andrews, T. (2012). What is social constructionism. *Grounded theory review*, 11(1), 39-46.
- Apt, N.A (2013). Older people in rural Ghana: health and health seeking behaviours *Aging and Health in Africa* (pp. 103-119): Springer.
- Apt, N. A. (2012). Aging in Africa: Past experiences and strategic directions. *Ageing International*, 37(1), 93-103.
- Aryeetey, E., Harrigan, J., & Nissanke, M. (2000). *Economic reforms in Ghana: The miracle and the mirage*: Africa World Press.
- Arza, C. (2017). The expansion of economic protection for older adults in Latin America.
- Ashidam, B. N. A. (2011). *The problem of the cap 30 pension scheme in ghana*. Institute of Distance Learning, Kwame Nkrumah University of Science and Technology.
- Aspinal, F., Glasby, J., Rostgaard, T., Tuntland, H., & Westendorp, R. G. (2016). Reablement: supporting older people towards independence. *Age and Ageing*, afw094.
- Aus, J. P. (2009). Conjunctural causation in comparative case-oriented research. *Quality & Quantity*, 43(2), 173-183.
- Australian Bureau of Statistics. (2012). *Reflecting a Nation: Stories from the 2011 Census, 2012–2013*. Canberra Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/lookup/2071.0main+features752012-2013>.
- Australian Bureau of Statistics. (2014). Australian Demographic Statistics,. *September Quarter, 2013, Catalogue No. 3101.0, ABS*, (Canberra, various issues.).
- Australian Bureau of Statistics. (2016). *Australian Demographic Statistics, June 2016*. Canberra
- Australian Department of Immigration and Citizenship. (2011). Community Information Summary Ghana-born.
- Australian Government. (2015). Total Operational Places and Ratios by State and Territory - 30 June 2015.
- Baer, B., Bhushan, A., Taleb, H. A., Vasquez, J., & Thomas, R. (2016). The right to health of older people. *The Gerontologist*, 56(Suppl 2), S206-S217.

- Bahle, T. (2008). The State and Social Services in Britain, France and Germany since the 1980s: Reform and Growth in a Period of Welfare State Crisis. *European Societies*, 10(1), 25-47.
- Bailey, K. D. (1994). Typologies and taxonomies: an introduction to classification techniques (Vol. 102): Sage.
- Baldwin, N., Harris, J., & Kelly, D. (1993). Institutionalisation: why blame the institution? *Ageing and Society*, 13(01), 69-81.
- Baltes, P. B., & Baltes, M. M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. *Successful aging: Perspectives from the behavioral sciences*, 1(1), 1-34.
- Barnett, A., Smith, B., Lord, S. R., Williams, M., & Baumand, A. (2003). Community-based group exercise improves balance and reduces falls in at-risk older people: a randomised controlled trial. *Age and Ageing*, 32(4), 407-414.
- Barrett, G., & McGoldrick, C. (2013). Narratives of (in) active ageing in poor deprived areas of Liverpool, UK. *International Journal of Sociology and Social Policy*, 33(5/6), 347-366.
- Barrientos, A., & Lloyd-Sherlock, P. (2002). Non-contributory pensions and social protection. *Issues in Social Protection*.
- Barth, M. C. (2000). An aging workforce in an increasingly global world. *Journal of aging & social policy*, 11(2-3), 83-88.
- Bartlett, H., Warburton, J., Lui, C.-W., Peach, L., & Carroll, M. (2013). Preventing social isolation in later life: findings and insights from a pilot Queensland intervention study. *Ageing and Society*, 33(07), 1167-1189.
- Bartolini, S., Bilancini, E., & Sarracino, F. (2016). Social Capital Predicts Happiness Over Time. *Policies for Happiness*, 175.
- Bauman, A., Merom, D., Bull, F. C., Buchner, D. M., & Singh, M. A. F. (2016). Updating the evidence for physical activity: summative reviews of the epidemiological evidence, prevalence, and interventions to promote "Active Aging". *The Gerontologist*, 56(Suppl 2), S268-S280.
- Beard, J. R., Biggs, S., Bloom, D. E., Fried, L. P., Hogan, P., Kalache, A., & Olshansky, S. J. (2011). *Global Population Ageing: Peril or Promise*, . Retrieved from Geneva: World Economic Forum.:
- Beard, J. R., Officer, A., de Carvalho, I. A., Sadana, R., Pot, A. M., Michel, J.-P., . . . Mahanani, W. R. (2016). The World report on ageing and health: a policy framework for healthy ageing. *The lancet*, 387(10033), 2145-2154.
- Beer, A., Faulkner, D., Law, J., Lewin, G., Tinker, A., Buys, L., . . . Chessman, S. (2016). Regional variation in social isolation amongst older Australians. *Regional Studies, Regional Science*, 3(1), 170-184.
- Ben-Shlomo, Y., & Kuh, D. (2002). A life course approach to chronic disease epidemiology: conceptual models, empirical challenges and interdisciplinary perspectives: IEA.
- Bengtson, V. L., & Allen, K. R. (2009). The life course perspective applied to families over time *Sourcebook of family theories and methods* (pp. 469-504): Springer.
- Bengtson, V. L., & DeLiema, M. (2016). Theories of Aging and Social Gerontology: Explaining How Social Factors Influence Well-Being in Later Life. *Gerontology: Changes, Challenges, and Solutions [2 volumes]: Changes, Challenges, and Solutions*, 25.

- Bengtson, V. L., Elder Jr, G. H., & Putney, N. M. (2012). The life course perspective on ageing: Linked lives, timing, and history. *Adult lives: A life course perspective*, 9-17.
- Bengtson, V. L., Gans, D., Putney, N. M., & Silverstein, M. (2009). Theories about age and aging. *Handbook of theories of aging*, 2, 3-23.
- Bennett, A. (2013a). Causal mechanisms and typological theories in the study of civil conflict. *J. Checkel, T.(Ed.), Transnational Dynamics of Civil War*, 205-230.
- Bennett, A. (2013b). The mother of all isms: Causal mechanisms and structured pluralism in International Relations theory. *European Journal of International Relations*, 19(3), 459-481.
- Bennett, A., & Checkel, J. T. (2014). *Process tracing*: Cambridge University Press.
- Bennett, A., & Checkel, J. T. (2015). *Process Tracing: Process tracing: from philosophical roots to best practices* Cambridge University Press.
- Bennett, S., & Webb, R. (2006). *The politics of the Australian federal system*: Parliamentary Library.
- Berkman, L. F., & Glass, T. (2000). Social integration, social networks, social support, and health. *Social epidemiology*, 1, 137-173.
- Betti, G., Bettio, F., Georgiadis, T., & Tinios, P. (2015). *Unequal Ageing in Europe: Women's Independence and Pensions*: Springer.
- Bezzina, A., Brown, J., Mao, Y., & Ramsay, B. (2016). Health and physical activity among elderly Melbournians to develop urban design directions.
- Bhat, A. K., & Dhruvarajan, R. (2001). Ageing in India: drifting intergenerational relations, challenges and options. *Ageing and Society*, 21(05), 621-640.
- Bhuyan, S. S., Chandak, A., Gupta, N., Isharwal, S., LaGrange, C., Mahmood, A., & Gentry, D. (2017). Patient–provider communication about prostate cancer screening and treatment: new evidence from the Health Information National Trends Survey. *American journal of men's health*, 11(1), 134-146.
- Biggs, S., & Kimberley, H. (2013). Adult ageing and social policy: new risks to identity. *Social Policy and Society*, 12(02), 287-297.
- Biritwum, R., Mensah, G., Yawson, A., & Minicuci, N. (2013). Study on global AGEing and adult health (SAGE) Wave 1. *The Ghana National Report*. Geneva: World Health Organization.
- Black, B. P., Holditch-Davis, D., & Miles, M. S. (2009). Life course theory as a framework to examine becoming a mother of a medically fragile preterm infant. *Research in nursing & health*, 32(1), 38-49.
- Blom, J., den Elzen, W., van Houwelingen, A. H., Heijmans, M., Stijnen, T., Van den Hout, W., & Gussekloo, J. (2016). Effectiveness and cost-effectiveness of a proactive, goal-oriented, integrated care model in general practice for older people. A cluster randomised controlled trial: Integrated Systematic Care for older People—the ISCOPE study. *Age and Ageing*, 45(1), 30-41.
- Bloom, D. E., Canning, D., & Fink, G. (2010). Implications of population ageing for economic growth. *Oxford Review of Economic Policy*, 26(4), 583-612.
- Bloom, D. E., Jimenez, E., & Rosenberg, L. (2011). Social Protection of Older People. *PGDA Working Paper, No. 83*.

- Bonoli, G., & Shinkawa, T. (2005). 1. Population ageing and the logics of pension reform in Western Europe, East Asia and North America. *Ageing and pension reform around the world: evidence from eleven countries*, 1-23.
- Borowski, A., Encel, S., & Ozanne, E. (1997). *Ageing and social policy in Australia*: Cambridge University Press.
- Börsch-Supan, A., Brandt, M., Litwin, H., & Weber, G. (2013). Active ageing and solidarity between generations in Europe: First results from SHARE after the economic crisis: Walter de Gruyter.
- Bosworth, B., Bryant, R., & Burtless, G. (2004). The impact of aging on financial markets and the economy: A survey. *Available at SSRN 1147668*.
- Boudiny, K. (2013). 'Active ageing': From empty rhetoric to effective policy tool. *Ageing and Society*, 33(06), 1077-1098.
- Boudiny, K., & Mortelmans, D. (2011). A critical perspective: Towards a broader understanding of 'active ageing'. *Sensoria: A Journal of Mind, Brain & Culture*, 7(1), 8-14.
- Bousquet, J., Kuh, D., Bewick, M., Standberg, T., Farrell, J., Pengelly, R., . . . Bringer, J. (2015). Operational definition of Active and Healthy Ageing (AHA): A conceptual framework. *The journal of nutrition, health & aging*, 19(9), 955-960.
- Bowling, A. (2008). Enhancing later life: how older people perceive active ageing? *Aging and Mental Health*, 12(3), 293-301.
- Bowling, A., & Dieppe, P. (2005). What is successful ageing and who should define it? *Bmj*, 331(7531), 1548-1551.
- Bowling, A., & Iliffe, S. (2006). Which model of successful ageing should be used? Baseline findings from a British longitudinal survey of ageing. *Age and Ageing*, 35(6), 607-614.
- Bowling, A., See-Tai, S., Ebrahim, S., Gabriel, Z., & Solanki, P. (2005). Attributes of age-identity. *Ageing and Society*, 25(04), 479-500.
- Bowling, A., & Stafford, M. (2007). How do objective and subjective assessments of neighbourhood influence social and physical functioning in older age? Findings from a British survey of ageing. *Social science & medicine*, 64(12), 2533-2549.
- Briggs, A. M., Cross, M. J., Hoy, D. G., Sánchez-Riera, L., Blyth, F. M., Woolf, A. D., & March, L. (2016). Musculoskeletal health conditions represent a global threat to healthy aging: a report for the 2015 World Health Organization World Report on Ageing and Health. *The Gerontologist*, 56(Suppl 2), S243-S255.
- Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and health*, 21(1), 87-108.
- Brown, A. (2016). Federalism in australia revisited: Political history and culture as Forces for stasis and change. *Federalism and decentralization: perceptions for political and institutional reforms*, 235.
- Brown, C., & Lowis, M. J. (2003). Psychosocial development in the elderly: An investigation into Erikson's ninth stage. *Journal of Aging Studies*, 17(4), 415-426.
- Brown, L. A. (2015). Elderly caregiving in Ghana: An exploration of family caregivers' perceptions.

- Brown, W., Moorhead, G., & Marshall, A. (2015). Choose health: be active: a physical activity guide for older Australians. Commonwealth of Australia and the Repatriation Commission, Canberra.
- Browne, C. V., Mokuau, N., & Braun, K. L. (2009). Adversity and resiliency in the lives of Native Hawaiian elders. *Social Work, 54*(3), 253-261.
- Bryman, A. (2015). *Social research methods*: Oxford university press.
- Büla, C. (2016). Physical activity and cognitive function in older persons. *Schweizerische Zeitschrift für Sportmedizin & Sporttraumatologie, 64*(2).
- Bullington, J. (2006). Body and self: a phenomenological study on the ageing body and identity. *Medical humanities, 32*(1), 25-31.
- Burton, A. E., Shaw, R. L., & Gibson, J. M. (2015). Living together with age-related macular degeneration: An interpretative phenomenological analysis of sense-making within a dyadic relationship. *Journal of health psychology, 20*(10), 1285-1295.
- Buss, W., & Buss, E. (2015). Escaping the American Blot-A Comparative Look at Federalism in Australia and the United States through the Lens of Family Law. *Cornell Int'l LJ, 48*, 105.
- Butler, M. (2015). *Advanced Australia: The Politics of Ageing*: Melbourne Univ. Publishing.
- Buy, L., & Miller, E. (2006). The meaning of "active ageing" to older Australians: Exploring the relative importance of health, participation and security.
- Byles, J., Vo, K., Thomas, L., Mackenzie, L., & Kendig, H. (2016). Partner status and mental and physical health of independently living men aged 70 years and older. *Australasian journal on ageing*.
- Caliendo, M., & Kopeinig, S. (2008). Some practical guidance for the implementation of propensity score matching. *Journal of economic surveys, 22*(1), 31-72.
- Canadian Library Association. (2002). Canadian Guidelines on Library and Information Services for Older Adults.
- Carney, G. M. (2010). Citizenship and structured dependency: the implications of policy design for senior political power. *Ageing and Society, 30*(02), 229-251.
- Carpentier, N. (2011). The concept of participation: If they have access and interact, do they really participate? *CM-časopis za upravljanje komuniciranjem, 6*(21), 13-36.
- Casey, B., Oxley, H., Whitehouse, E. R., Antolin, P., Duval, R., & Leibfritz, W. (2003). Policies for an Ageing Society.
- Castles, F. G., & Uhr, J. (2005). Australia: Federal constraints and institutional innovations *Federalism and the Welfare State*: Cambridge University Press.
- Chambre, S. M. (1984). Is volunteering a substitute for role loss in old age? An empirical test of activity theory. *The Gerontologist, 24*(3), 292-298.
- Chaudhury, H., Campo, M., Michael, Y., & Mahmood, A. (2016). Neighbourhood environment and physical activity in older adults. *Social science & medicine, 149*, 104-113.
- Chen, W., Okumiya, K., Wada, T., Sakamoto, R., Imai, H., Ishimoto, Y., . . . Shih, H.-I. (2015). Social cohesion and health in old age: a study in southern Taiwan. *International Psychogeriatrics, 1*-9.
- Chestnov, O., Obermeyer, W., St John, J., Van Hilten, M., & Kulikov, A. (2014). Towards the world we want. *Bulletin of the World Health Organization, 92*(9), 623-623.

- Chippis, J., & Jarvis, M. A. (2016). Social capital and mental well-being of older people residing in a residential care facility in Durban, South Africa. *Aging & mental health*, 20(12), 1264-1270.
- Choi, Y., Lee, K. S., Shin, J., Kwon, J. A., & Park, E. C. (2016). Effects of a change in social activity on quality of life among middle-aged and elderly Koreans: Analysis of the Korean longitudinal study of aging (2006–2012). *Geriatrics & gerontology international*.
- Chomik, R., & Piggott, J. (2012). Pensions, Ageing and Retirement in Australia: Long-Term Projections and Policies. *Australian Economic Review*, 45(3), 350-361.
- Chong, A. M. L., & Liu, S. (2016). Receive or give? Contemporary views among middle-aged and older Chinese adults on filial piety and well-being in Hong Kong. *Asia Pacific Journal of Social Work and Development*, 26(1), 2-14.
- Clare, L., Rowlands, J., Bruce, E., Surr, C., & Downs, M. (2008). The experience of living with dementia in residential care: An interpretative phenomenological analysis. *The Gerontologist*, 48(6), 711-720.
- Clarke, A., & Warren, L. (2007). Hopes, fears and expectations about the future: what do older people's stories tell us about active ageing? *Ageing and Society*, 27(04), 465-488.
- Clausen, J. A. (1991). Adolescent competence and the life course, or why one social psychologist needed a concept of personality. *Social psychology quarterly*, 54(1), 4-14.
- Clausen, J. A. (1995). *American lives: Looking back at the children of the Great Depression*: Univ of California Press.
- Coe, C. (2017). Negotiating eldercare in Akuapem, Ghana: care-scripts and the role of non-kin. *Africa*, 87(1), 137-154.
- Cohen, A. B., & Koenig, H. G. (2003). Religion, religiosity and spirituality in the biopsychosocial model of health and ageing. *Ageing International*, 28(3), 215-241.
- Coile, C., Milligan, K., & Wise, D. A. (2016). Introduction to "Social Security Programs and Retirement Around the World: The Capacity to Work at Older Ages" *Social Security Programs and Retirement Around the World: The Capacity to Work at Older Ages*: University of Chicago Press.
- Coleman, W. (2016). *Only in Australia: The history, politics, and economics of Australian exceptionalism*: Oxford University Press.
- Coll-Planas, L., Nyqvist, F., Puig, T., Urrútia, G., Solà, I., & Monteserín, R. (2016). Social capital interventions targeting older people and their impact on health: a systematic review. *Journal of Epidemiology and Community Health*, jech-2016-208131.
- Commonwealth of Australia. (2002). *Intergenerational Report 2002-03*. Canberra
- Commonwealth of Australia. (2007). *Intergenerational Report: 2007*. Canberra
- Commonwealth of Australia. (2010). *Australia to 2050: Future Challenges*. The 2010 Intergenerational Report. Canberra.
- Commonwealth of Australia. (2011). *Investing in experience*.
- Commonwealth of Australia. (2014). *The People of Australia: Statistics from the 2011 Census*. Retrieved from <https://www.border.gov.au/ReportsandPublications/Documents/research/people-australia-2013-statistics.pdf>. On 20th November 2016

- Commonwealth of Australia. (2015a). 2015 Intergenerational Report: Australia in 2055. Canberra.
- Commonwealth of Australia. (2015b). *National Ageing and Aged Care Strategy For people from Culturally and Linguistically Diverse (CALD) backgrounds*. Canberra Retrieved from https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/07_2015/dss1582_aged_care_strategy_cald_a4_vaccessible.pdf.
- Connell, R., Fawcett, B., & Meagher, G. (2009). Neoliberalism, New Public Management and the human service professions Introduction to the Special Issue. *Journal of Sociology*, 45(4), 331-338.
- Constança, P., Ribeiro, O., & Teixeira, L. (2012). Active ageing: an empirical approach to the WHO model. *Current gerontology and geriatrics research*, 2012.
- Coradeschi, S., Cesta, A., Cortellessa, G., Coraci, L., Gonzalez, J., Karlsson, L., . . . Palumbo, F. (2013). *Giraffplus: Combining social interaction and long term monitoring for promoting independent living*. Paper presented at the 2013 6th International Conference on Human System Interactions (HSI).
- Corbin, J., & Strauss, A. (2014). Basics of qualitative research: Techniques and procedures for developing grounded theory: Sage publications.
- Cornelissen, J. (2016). Developing propositions, a process model or a typology? Addressing the challenges of writing theory without a boilerplate. *Academy of management review*, amr. 2016.0196.
- Cornelissen, J. (2017). Editor's Comments: Developing Propositions, a Process Model, or a Typology? Addressing the Challenges of Writing Theory Without a Boilerplate. *Academy of management review*, 42(1), 1-9.
- Cornwell, E. Y., & Waite, L. J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of health and social behavior*, 50(1), 31-48.
- Coughlin, J. F. (2010). Understanding the Janus face of technology and ageing: Implications for older consumers, business innovation and society. *International Journal of Emerging Technologies and Society*, 8(2), 62.
- Courtney, M., Minichiello, V., & Waite, H. (1997). Aged care in Australia: A critical review of the reforms. *Journal of Aging Studies*, 11(3), 229-250.
- Cousins, S. (2005). Contemporary Australia. *National Identity*, 1-7.
- Cowley, M. (1982). *The view from 80*: Penguin Books, 1982.
- Cramm, J. M., Van Dijk, H. M., & Nieboer, A. P. (2013). The importance of neighborhood social cohesion and social capital for the well being of older adults in the community. *The Gerontologist*, 53(1), 142-152.
- Creecy, R. F., Berg, W. E., & Wright, R. (1985). Loneliness among the elderly: A causal approach. *Journal of Gerontology*, 40(4), 487-493.
- Creedy, J., & Scobie, G. M. (2005). Population ageing and social expenditure in New Zealand. *Australian Economic Review*, 38(1), 19-39.
- Creswell, J. W. (2012). Qualitative inquiry and research design: Choosing among five approaches: Sage.
- Crosato, K. E., Ward-Griffin, C., Leipert, B., & Leipert, K. C. B. (2007). Aboriginal women caregivers of the elderly. *Rural and remote health*, 7(796).

- Cunningham, D. A., Paterson, D. H., Himann, J. E., & Rechnitzer, P. A. (1993). Determinants of independence in the elderly. *Canadian Journal of Applied Physiology*, 18(3), 243-254.
- Dajak, L., Mastilica, M., Orešković, S., & Vuletić, G. (2016). Health-related Quality of Life and Mental Health in the Process of Active and Passive Ageing. *Psychiatria Danubina*, 28(4), 404-408.
- Daley, J., McGannon, C., & Hunter, A. (2014). Budget pressures on Australian governments 2014. *Grattan Institute*, viewed, 21.
- Daly, M. (2013). Tips for Optimum Health & Weight.
- Danivas, V., Bharmal, M., Keenan, P., Jones, S., Karat, S. C., Kalyanaraman, K., . . . Krishna, M. (2016). An interpretative phenomenological analysis (IPA) of coercion towards community dwelling older adults with dementia: findings from Mysore studies of natal effects on ageing and health (MYNAH). *Social psychiatry and psychiatric epidemiology*, 51(12), 1659-1664.
- Dankl, K. (2017). Design age: Towards a participatory transformation of images of ageing. *Design Studies*, 48, 30-42.
- Darteh, E. K. M., Nantogmah, B., & Kumi-Kyereme, A. (2016). "If your parents help you grow your teeth; you help them lose theirs": Family Support for the Aged in Yamoransa, Ghana. *Journal of Social Sciences*, 7(2), 38-50.
- Davidson, P. M., Phillips, J. L., Dennison-Himmelfarb, C., Thompson, S. C., Lockett, T., & Currow, D. C. (2016). Providing palliative care for cardiovascular disease from a perspective of sociocultural diversity: a global view. *Current opinion in supportive and palliative care*, 10(1), 11-17.
- Davidson, S. (2016). *Going grey: The mediation of politics in an ageing society*: Routledge.
- Day, C., & Dowrick, S. (2004). Ageing economics: human capital, productivity and fertility. *Agenda: A Journal of Policy Analysis and Reform*, 3-20.
- de Jong Gierveld, J., van Tilburg, T., & Dykstra, P. (2016). Loneliness and Social Isolation Anita Vangelisti & Daniel Perlman (eds), *The Cambridge Handbook of Personal Relationships, second edition*, Cambridge University Press (forthcoming) (pp. 1-30).
- De Nardi, M., French, E., & Jones, J. B. (2010). Why do the elderly save? The role of medical expenses. *Journal of Political Economy*, 118(1), 39-75.
- Debrah, Y. A. (2002). Ghana. *Thunderbird International Business Review*, 44(4), 495-513.
- Dehejia, R. H., & Wahba, S. (2002). Propensity score-matching methods for nonexperimental causal studies. *Review of Economics and statistics*, 84(1), 151-161.
- Derksen, B., Duff, M., Weldon, K., Zhang, J., Zamba, K., Tranel, D., & Denburg, N. (2015). Older adults catch up to younger adults on a learning and memory task that involves collaborative social interaction. *Memory*, 23(4), 612-624.
- Devereux-Fitzgerald, A., Powell, R., Dewhurst, A., & French, D. P. (2016). The acceptability of physical activity interventions to older adults: A systematic review and meta-synthesis. *Social science & medicine*, 158, 14-23.
- Devereux, S. (2010). Building social protection systems in southern Africa. *Background paper for the European Report on Development*.
- Diggs, J. (2008). Activity theory of aging *Encyclopedia of aging and public health* (pp. 79-81): Springer.

- Dillaway, H. E., & Byrnes, M. (2009). Reconsidering successful aging: A call for renewed and expanded academic critiques and conceptualizations. *Journal of Applied Gerontology*.
- Disney, J. (2004). Social policy. The Howard Years, Melbourne, Black Inc.
- Dodge, R., Daly, A. P., Huyton, J., & Sanders, L. D. (2012). The challenge of defining wellbeing. *International Journal of Wellbeing*, 2(3).
- Doh, D., Afranie, S., & Bortei-Dorku Aryeetey, E. (2014). Expanding social protection opportunities for older people: The role of the traditional family and community structures. *Ghana Social Sciences Journal*, Vol. 11(1), 26-52
- Doty, D. H., & Glick, W. H. (1994). Typologies as a unique form of theory building: Toward improved understanding and modeling. *Academy of management review*, 19(2), 230-251.
- Drożdżak, Z., & Turek, K. (2016). Retirement and perceived social inferiority strongly link with health inequalities in older age: decomposition of a concentration index of poor health based on Polish cross-sectional data. *International journal for equity in health*, 15(1), 21.
- Duckett, S. (2015). Intergenerational report misses the point on health spending. *Australasian journal on ageing*, 34(4), 214-216.
- Duclos, M. (2013). physical Activity in Ageing. *Deutsche Zeitschrift für sportmedIZiN*, 64(6).
- Ebbinghaus, B. (2005). When Less is More Selection Problems in Large-N and Small-N Cross-National Comparisons. *International sociology*, 20(2), 133-152.
- Ehnes, J. (2012). Ageing and Financial (In) Security. *Global Population Ageing: Peril or Promise?*, 18.
- Elder Jr, G. H. (1985). Perspectives on the life course.
- Elder Jr, G. H. (1994). Time, human agency, and social change: Perspectives on the life course. *Social psychology quarterly*, 4-15.
- Elder Jr, G. H. (1998). The life course as developmental theory. *Child development*, 69(1), 1-12.
- Elder Jr, G. H., Johnson, M. K., & Crosnoe, R. (2003). The emergence and development of life course theory *Handbook of the life course* (pp. 3-19): Springer.
- Elder Jr, G. H., & Rockwell, R. C. (1979). The life-course and human development: An ecological perspective. *International Journal of Behavioral Development*, 2(1), 1-21.
- Ellen, M. E., Panisset, U., de Carvalho, I. A., Goodwin, J., & Beard, J. (2017). A Knowledge Translation Framework on Ageing and Health. *Health Policy*.
- Encel, S., Ozanne, E., Borowski, A., Encel, S., & Ozanne, E. (2007). The politics of ageing. *Longevity and social change in Australia*, 296-315.
- Engeli, I., & Allison, C. R. (2014). Comparative policy studies: conceptual and methodological challenges: Palgrave Macmillan.
- Estes, C. L. (2001). Social policy and aging: A critical perspective: Sage.
- Estes, C. L., & Mahakian, J. L. (2001). The political economy of productive aging. *Productive aging: Concepts and challenges*, 197-213.
- Estes, C. L., Swan, J. H., & Gerard, L. E. (1982). Dominant and competing paradigms in gerontology: Towards a political economy of ageing. *Ageing and Society*, 2(02), 151-164.
- European Union. (2012). Council Declaration on the European Year for Active Ageing and Solidarity between Generations (2012): The Way Forward. Retrieved from

- Eysenck, H. (1987). Personality and ageing: An exploratory analysis. *Journal of Social Behavior and Personality*, 3(1), 11.
- Fajemilehin, B. R., Ayandiran, E. O., & Salami, K. K. (2007). Elderly destitution in Ile-Ife community of Osun State, Nigeria. *International journal of nursing practice*, 13(3), 161-165.
- Felsted, K. F., & Wright, S. D. (2014). The Promise and Challenges of Post Ageing *Toward Post Ageing* (pp. 119-136): Springer.
- Ferri, C. P., Prince, M., Brayne, C., Brodaty, H., Fratiglioni, L., Ganguli, M., . . . Huang, Y. (2006). Global prevalence of dementia: a Delphi consensus study. *The lancet*, 366(9503), 2112-2117.
- Fine, M. (2014). Intergenerational perspectives on ageing, economics and globalisation. *Australasian journal on ageing*, 33(4), 220-225.
- Fiss, P. C. (2011). Building better causal theories: A fuzzy set approach to typologies in organization research. *Academy of Management Journal*, 54(2), 393-420.
- Foos, P. W., Clark, M. C., & Terrell, D. F. (2006). Adult age, gender, and race group differences in images of aging. *The Journal of genetic psychology*, 167(3), 309-325.
- Fosnot, C. T. (2013). Constructivism: Theory, perspectives, and practice: Teachers College Press.
- Foster, L., & Walker, A. (2014). Active and successful aging: A European policy perspective. *The Gerontologist*, gnu028.
- Fougère, M., & Mérette, M. (1999). Population ageing and economic growth in seven OECD countries. *Economic Modelling*, 16(3), 411-427.
- Fox, N. J. (2005). Cultures of ageing in Thailand and Australia.(What can an ageing body do?). *Sociology*, 39(3), 481-498.
- Frimpong, J. A. (2015). Social Support for the Aged: The Role of Private Care Homes in Accra. University of Ghana.
- Fry, C. L. (2005). Globalization and the experiences of aging. *Gerontology & geriatrics education*, 26(1), 9-22.
- Gabor, M. R. (2007). Types of non-probabilistic sampling used in marketing research.,„Snowball” sampling. *Management & Marketing*, 2(3).
- Gabriel, Z., & Bowling, A. (2004). Quality of life from the perspectives of older people. *Ageing and Society*, 24(05), 675-691.
- Gagliardi, C., Papa, R., Postacchini, D., & Giuli, C. (2016). Association between Cognitive Status and Physical Activity: Study Profile on Baseline Survey of the My Mind Project. *International Journal of Environmental Research and Public Health*, 13(6), 585.
- Gale, C. R., Cooper, C., & Sayer, A. A. (2015). Prevalence of frailty and disability: findings from the English Longitudinal Study of Ageing. *Age and Ageing*, 44(1), 162-165.
- Gardner, K. (2002). Age, narrative and migration: The life course and life histories of Bengali elders in London: Berg Publishers.
- Gebel, K., Ding, D., Chey, T., Stamatakis, E., Brown, W. J., & Bauman, A. E. (2015). Effect of moderate to vigorous physical activity on all-cause mortality in middle-aged and older Australians. *JAMA internal medicine*, 175(6), 970-977.
- George, A. L., & Bennett, A. (2005). Case studies and theory development in the social sciences: Mit Press.

- Georgiou, J. (2015). Exploring the benefits of attracting, recruiting and retaining mature age employees up to and beyond the traditional age of retirement: Perspectives from Western Australia.
- Gerring, J. (2007). The case study: what it is and what it does. In *The Oxford handbook of comparative politics*.
- Gerring, J. (2010). Causal mechanisms: Yes, but.... *Comparative Political Studies*, 43(11), 1499-1526.
- Gerring, J. (2013). *The Case Study What it is and What it Does* R. E. Goodin (Ed.) Retrieved from <http://www.oxfordhandbooks.com/10.1093/oxfordhb/9780199604456.001.0001/oxfordhb-9780199604456-e-051> doi:10.1093/oxfordhb/9780199604456.013.0051
- Ghana Statistical Service. (2013a). 2010 Population and Housing Census: National Analytical Report. Retrieved from Accra, Ghana: GSS.:
- Ghana Statistical Service. (2013b). The Elderly in Ghana: 2010 Housing and Population Census. Retrieved from
- Giddens, A. (2013). *The third way: The renewal of social democracy*: John Wiley & Sons.
- Giele, J. Z., & Elder, G. H. (1998). *Methods of life course research: Qualitative and quantitative approaches*: Sage.
- Giles, L. C., Glonek, G. F., Luszcz, M. A., & Andrews, G. R. (2005). Effect of social networks on 10 year survival in very old Australians: the Australian longitudinal study of aging. *Journal of Epidemiology and Community Health*, 59(7), 574-579.
- Ginn, J. (1993). Grey power: age-based organisations' response to structured inequalities. *Critical social policy*, 13(38), 23-47.
- Glaserfeld, E. v. (2005). Thirty years constructivism. *Constructivist Foundations*, 1(1), 9-12.
- Goldsmith, T. C. (2011). *Biological Aging Theory*.
- Goody, E. N. (2005). *Contexts of kinship: An essay in the family sociology of the Gonja of northern Ghana*: Cambridge University Press.
- Goss, S. C. (2010). Future Financial Status of the Social Security Program, The. *Soc. Sec. Bull.*, 70, 111.
- Government of Ghana. (1964). *Seven Year Development Plan- 1964 - 1970*. Ghana: National Planning Commission
- Government of Ghana. (2007). *Ghana Country Report on the Implementation of the Madrid International Plan of Action on Ageing*. Accra, Ghana: National Population Council Retrieved from https://s3.amazonaws.com/ndpc-static/CACHES/NEWS/2015/07/10/Implementation+MIPAA_Ghana+Report.pdf.
- Government of Ghana. (2010). *National Ageing Policy Framework*. Accra, Ghana: Ministry of Gender, Children and Social Protection.
- Government of Ghana. (2015). *Draft Ghana National Social Protection Policy*. Accra Ghana: Ministry of Gender, Children and Social Protection Retrieved from <http://www.mogcsp.gov.gh/policies/National%20Social%20Protection%20Policy.pdf>.
- Government of South Australia. (2009). *Health Service Framework for Older People 2009–2016: Improving Health & Wellbeing Together / South Australia*,
- Gow, A. J., & Mortensen, E. L. (2016). Social resources and cognitive ageing across 30 years: the Glostrup 1914 Cohort. *Age and Ageing*, 45(4), 480-486.

- Graeme Hugo. (2014). The Demographic Facts of Ageing in Australia. Retrieved from https://www.dss.gov.au/sites/default/files/documents/11_2014/002_the_demographic_facts_of_ageing_in_australia_-_revised_0.pdf website:
- Gray, A. (2009). The social capital of older people. *Ageing and Society*, 29(01), 5-31.
- Greaves, C. J., & Farbus, L. (2006). Effects of creative and social activity on the health and well-being of socially isolated older people: outcomes from a multi-method observational study. *The Journal of the Royal Society for the Promotion of Health*, 126(3), 134-142.
- Grebe, E. (2015). The Evolution of Social Protection Policy in Ghana's 'Fourth Republic': Contributory social insurance reform and limited social assistance for the 'extreme poor' under NPP and NDC governments, 2000-2014.
- Grenade, L., & Boldy, D. (2008). Social isolation and loneliness among older people: issues and future challenges in community and residential settings. *Australian Health Review*, 32(3), 468-478.
- Grischow, J., & Weiss, H. (2015). 9 Pan-Africanism, Socialism and the Future. The Struggle for the Long-Term in Transnational Science and Politics: Forging the Future, 218.
- Groot, C., Hooghiemstra, A., Raijmakers, P., van Berckel, B., Scheltens, P., Scherder, E., . . . Ossenkoppele, R. (2016). The effect of physical activity on cognitive function in patients with dementia: a meta-analysis of randomized control trials. *Ageing research reviews*, 25, 13-23.
- Grundy, E., Fletcher, A., Smith, S., & Lamping, D. (2007). *Successful Ageing and Social Interaction: A Policy Brief*: International Longevity Centre--UK.
- Halaweh, H., Svantesson, U., & Willén, C. (2016). Experiences of Habitual Physical Activity in Maintaining Roles and Functioning among Older Adults: A Qualitative Study. *Rehabilitation Research and Practice*, 2016.
- Halfon, N., & Hochstein, M. (2002). Life course health development: an integrated framework for developing health, policy, and research. *Milbank Quarterly*, 80(3), 433-479.
- Hall, J., & van Gool, K. (2016). Ageing, entitlement and funding health care. *POPULATION AGEING*, 261.
- Hamer, M., Lavoie, K. L., & Bacon, S. L. (2013). Taking up physical activity in later life and healthy ageing: the English longitudinal study of ageing. *British journal of sports medicine*, bjsports-2013-092993.
- Hamer, M., Lavoie, K. L., & Bacon, S. L. (2014). Taking up physical activity in later life and healthy ageing: the English longitudinal study of ageing. *Br J Sports Med*, 48(3), 239-243.
- Handayani, S. W., & Babajanian, B. (2012). Social protection for older persons: Social pensions in Asia.
- Hanson, O.-Y. (2014). Ghana'S Pension Reforms in Perspective: Can the Pension Benefits Provide a House a Real Need of the Retiree? *European Journal of Business and Management*. www.iiste.org, Vol.6, No.32, 2014.
- Harman, G. (2002). Producing PhD graduates in Australia for the knowledge economy. *Higher Education Research & Development*, 21(2), 179-190.

- Hashim, D., Boffetta, P., La Vecchia, C., Rota, M., Bertuccio, P., Malvezzi, M., & Negri, E. (2016). The global decrease in cancer mortality: trends and disparities. *Annals of Oncology*, 27(5), 926-933.
- Haslam, C., Cruwys, T., Haslam, S. A., & Jetten, J. (2015). Social connectedness and health. *Encyclopaedia of Geropsychology*, 46-41.
- Healy, J. (2002). The care of older people: Australia and the United Kingdom. *Social Policy & Administration*, 36(1), 1-19.
- Heaney, C. A., & Israel, B. A. (2008). Social networks and social support. *Health behavior and health education: Theory, research, and practice*, 4, 189-210.
- Hefferon, K. M., & Ollis, S. (2006). 'Just clicks': an interpretive phenomenological analysis of professional dancers' experience of flow. *Research in Dance Education*, 7(2), 141-159.
- Heikkinen, R.-L., & Ageing, W. (1998). The role of physical activity in healthy ageing.
- Heinrich, S., Rapp, K., Rissmann, U., Becker, C., & König, H.-H. (2010). Cost of falls in old age: a systematic review. *Osteoporosis international*, 21(6), 891-902.
- HelpAge-International. (2013). *Global Agewatch Index 2013*, . Retrieved from London, WC1A 9GB, UK:
- Hoffmann, R. (2016). *Causal Effects Between Socioeconomic Status and Health in a Life Course Perspective*. Paper presented at the Third ISA Forum of Sociology (July 10-14, 2016).
- Hofman, A., Breteler, M. M., van Duijn, C. M., Janssen, H. L., Krestin, G. P., Kuipers, E. J., . . . Vingerling, J. R. (2009). The Rotterdam Study: 2010 objectives and design update. *European journal of epidemiology*, 24(9), 553-572.
- Holstein, M. B., & Minkler, M. (2003). Self, society, and the "new gerontology". *The Gerontologist*, 43(6), 787-796.
- Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: a meta-analytic review. *PLoS Med*, 7(7), e1000316.
- Hong, S.-I., Hasche, L., & Bowland, S. (2009). Structural relationships between social activities and longitudinal trajectories of depression among older adults. *The Gerontologist*, 49(1), 1-11.
- Hossain, F. (2013). Needs of the Destitute Elderly of Bangladesh: A Sociological Inquiry. *Middle East Journal of Age & Ageing*, 10(5).
- Hsu, H.-C. (2007). Exploring elderly people's perspectives on successful ageing in Taiwan. *Ageing and Society*, 27(01), 87-102.
- Huinink, J., & Feldhaus, M. (2009). Family research from the life course perspective. *International sociology*, 24(3), 299-324.
- Huinink, J., & Kohli, M. (2014). A life-course approach to fertility. *Demographic research*, 30, 1293.
- Hutchison, T., Morrison, P., & Mikhailovich, K. (2006). A review of the literature on active ageing. *Canberra: Healthpact Research Centre for Health Promotion and Wellbeing*.
- Huxhold, O., Miche, M., & Schüz, B. (2014). Benefits of having friends in older ages: Differential effects of informal social activities on well-being in middle-aged and older adults. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 69(3), 366-375.

- Hwang, S.-J. (2016). Public pensions as the great equalizer? Decomposition of old-age income inequality in South Korea, 1998–2010. *Journal of aging & social policy*, 28(2), 81-97.
- Hyman, D. N. (2014). Public finance: A contemporary application of theory to policy: Cengage Learning.
- Ighodaro, E. T., Abner, E. L., Fardo, D. W., Lin, A.-L., Katsumata, Y., Schmitt, F. A., . . . Monsell, S. E. (2017). Risk factors and global cognitive status related to brain arteriolosclerosis in elderly individuals. *Journal of Cerebral Blood Flow & Metabolism*, 37(1), 201-216.
- International Labour Organization. (2014). Social protection for older persons : key policy trends and statistics Retrieved from Geneva:
- Jakubowicz, A. H. (2016). " Once upon a Time in... ethnocratic Australia: migration, refugees, diversity and contested discourses of inclusion". *Cosmopolitan Civil Societies: An Interdisciplinary Journal*, 8(3).
- Janssen, D., Jongen, W., & Schröder-Bäck, P. (2016). Exploring the impact of austerity-driven policy reforms on the quality of the long-term care provision for older people in Belgium and the Netherlands. *Journal of Aging Studies*, 38, 92-104.
- Jewell, A. (1999). *Spirituality and ageing*: Jessica Kingsley Publishers.
- Jiang, N., Lou, V. W., & Lu, N. (2016). Does social capital influence preferences for aging in place? Evidence from urban China. *Aging & mental health*, 1-7.
- Jones, D. S., & Greene, J. A. (2016). Is dementia in decline? Historical trends and future trajectories. *New England Journal of Medicine*, 374(6), 507-509.
- Jopp, D., & Rott, C. (2006). Adaptation in very old age: exploring the role of resources, beliefs, and attitudes for centenarians' happiness. *Psychology and aging*, 21(2), 266.
- Juwei, Z. (2016). Population Ageing, Change of Labor Market and Social Security for the Old Age--How to Perfect the Urban Employee Basic Pension Insurance.
- Kaiser, K. (2009). Protecting respondent confidentiality in qualitative research. *Qualitative Health Research*, 19(11), 1632-1641.
- Kankam, B. (2016). CITIZENSHIP EDUCATION IN GHANA: A TRADITIONAL AND MODERN PERSPECTIVE IN DEVELOPMENT.
- Katz, S. (2001). Growing older without aging? Positive aging, anti-ageism, and anti-aging. *Generations*, 25(4), 27.
- Katz, S., & Calasanti, T. (2014). Critical perspectives on successful aging: Does it “appeal more than it illuminates”? *The Gerontologist*, gnu027.
- Kaye, L. W., Butler, S. S., & Webster, N. M. (2003). Toward a productive ageing paradigm for geriatric practice. *Ageing International*, 28(2), 200-213.
- Kendig, H. (2017). Australian Developments in Ageing: Issues and History *Ageing in Australia* (pp. 13-27): Springer.
- Kendig, H., & Duckett, S. J. (2001). *Australian directions in aged care: The generation of policies for generations of older people*: Australian Health Policy Institute at the University of Sydney.
- Kendig, H., Elias, A.-M., Matwijiw, P., & Anstey, K. (2014). Developing age-friendly cities and communities in Australia. *Journal of aging and health*, 26(8), 1390-1414.

- Kendig, H., Loh, V., O'Loughlin, K., Byles, J., & Nazroo, J. Y. (2016). Pathways to well-being in later life: Socioeconomic and health determinants across the life course of Australian baby boomers. *Journal of Population Ageing*, 9(1-2), 49-67.
- Kendig, H., & Woods, M. (2015). Intergenerational Report 2015: A limited and political view of our future. *Australasian journal on ageing*, 34(4), 217-219.
- Keough, L. B. (2015). Social Wellbeing, Locality and Ageing: A Snapshot of the Social Lives of Older People in Rural Australia. Paper presented at the Refereed Proceedings of TASA 2015 Conference.
- Khemani, S. (2015). Buying votes versus supplying public services: Political incentives to under-invest in pro-poor policies. *Journal of Development Economics*, 117, 84-93.
- King, G., Keohane, R. O., & Verba, S. (1994). Scientific inference in qualitative research. *Princeton, NJ*.
- King, N., Finlay, L., Ashworth, P., Smith, J., Langdridge, D., & Butt, T. (2008). "Can't Really Trust That, So What Can I Trust?": A Polyvocal, Qualitative Analysis of the Psychology of Mistrust. *Qualitative research in psychology*, 5(2), 80-102.
- King, W. R. (2009). Knowledge management and organizational learning: Springer.
- Kluge, S. (2000). *Empirically grounded construction of types and typologies in qualitative social research*. Paper presented at the Forum Qualitative Sozialforschung/Forum: Qualitative Social Research.
- Kok, A. A., Aartsen, M. J., Deeg, D. J., & Huisman, M. (2016). Socioeconomic inequalities in a 16-year longitudinal measurement of successful ageing. *Journal of Epidemiology and Community Health*, jech-2015-206938.
- Kolodner, J. (2014). Selecting the best case for a case-based reasoner. *Proceedings of*, 11, 155-162.
- Komp, K., & Johansson, S. (2015). Population ageing in a lifecourse perspective: developing a conceptual framework. *Ageing and Society*, 1-24.
- Kpessa, M. W. (2010). Ideas, Institutions, and Welfare Program Typologies: An Analysis of Pensions and Old Age Income Protection Policies in Sub-Saharan Africa. *Poverty & Public Policy*, 2(1), 37-65.
- Kuh, D., Ben-Shlomo, Y., Lynch, J., Hallqvist, J., & Power, C. (2003). Life course epidemiology. *Journal of Epidemiology and Community Health*, 57(10), 778.
- Kuh, D., Cooper, R., Hardy, R., Richards, M., & Ben-Shlomo, Y. (2013). *A life course approach to healthy ageing*: OUP Oxford.
- Kuh, D., & Network, N. D. o. A. P. (2007). A life course approach to healthy aging, frailty, and capability. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 62(7), 717-721.
- Kulik, C. T., Ryan, S., Harper, S., & George, G. (2014). Aging populations and management. *Academy of Management Journal*, 57(4), 929-935.
- Kumado, K., & Gockel, A. F. (2003). Social security in Ghana.
- Kuyini, A. B. (2015). Social Welfare Policy in Ghana: Current Provisions, Reach, and Challenges. *Current Politics and Economics of Africa*, 8(3), 293.
- Kwankye, S. (2013). Growing old in Ghana: Health and economic implications. *Postgraduate Medical Journal of Ghana*, 2(2), 88-97.

- Kwok, J. Y. C., & Ku, B. H. B. (2016). Elderly people as “apocalyptic demography”? A study of the life stories of older people in Hong Kong born in the 1930s. *Journal of Aging Studies*, 36, 1-9.
- Larkin, M., Eatough, V., & Osborn, M. (2011). Interpretative phenomenological analysis and embodied, active, situated cognition. *Theory & Psychology*, 21(3), 318-337.
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative research in psychology*, 3(2), 102-120.
- Lavelle, A. D. (2010). The ties that unwind? Social democratic parties and unions in Australia and Britain. *Labour History: A Journal of Labour and Social History*(98), 55-75.
- Lavelle, A. D. (2015). Social democracy or neo-liberalism? The cases of Germany and Sweden.
- Lawthom, R., & Tindall, C. (2011). Phenomenology. Qualitative methods in psychology: A research guide. 2nd edition. Maidenhead: Open University Press/McGraw Hill.
- Lemon, B. W., Bengtson, V. L., & Peterson, J. A. (1972). An exploration of the activity theory of aging: Activity types and life satisfaction among in-movers to a retirement community. *Journal of Gerontology*, 27(4), 511-523.
- Lewin, G., Allan, J., Patterson, C., Knuiman, M., Boldy, D., & Hendrie, D. (2014). A comparison of the home-care and healthcare service use and costs of older Australians randomised to receive a restorative or a conventional home-care service. *Health & social care in the community*, 22(3), 328-336.
- Liao, J., & Brunner, E. J. (2016). Structural and functional measures of social relationships and quality of life among older adults: does chronic disease status matter? *Quality of Life Research*, 25(1), 153-164.
- Lijphart, A. (1971). Comparative politics and the comparative method. *American political science review*, 65(03), 682-693.
- Lipsedge, M. (2015). Psychiatry in Context: Experience, Meaning and Communities: RCP.
- Litwin, H., & Shiovitz-Ezra, S. (2006). The association between activity and wellbeing in later life: What really matters? *Ageing and Society*, 26(02), 225-242.
- Lloyd-Jones, D. M. (2017). General Population and Global Cardiovascular Risk Prediction. *Hypertension: A Companion to Braunwald's Heart Disease*, 1.
- Lloyd-Sherlock, P. (2004). Living longer: Ageing, development and social protection: Zed books.
- Lloyd-Sherlock, P., McKee, M., Ebrahim, S., Gorman, M., Greengross, S., Prince, M., . . . O'Neill, D. (2012). Population ageing and health. *The lancet*, 379(9823), 1295-1296.
- Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, 14(5), 726-735.
- Lor, P. (2011). Methodology in comparative studies. *Internafional and Comparafive Librarianship*.
- Luborsky, M. R., & Rubinstein, R. L. (1995). Sampling in qualitative research rationale, issues, and methods. *Research on Aging*, 17(1), 89-113.
- Lucumí, D. I., Gomez, L. F., Brownson, R. C., & Parra, D. C. (2015). Social capital, socioeconomic status, and health-related quality of life among older adults in bogota (Colombia). *Journal of aging and health*, 27(4), 730-750.

- Lynott, P., & Lynott, R. (2013). Disengagement-Critical Assessment Of Disengagement Theory.
- Macha, J., Harris, B., Garshong, B., Ataguba, J. E., Akazili, J., Kuwawenaruwa, A., & Borghi, J. (2012). Factors influencing the burden of health care financing and the distribution of health care benefits in Ghana, Tanzania and South Africa. *Health policy and planning*, 27(suppl 1), i46-i54.
- Macmillan, R., & Copher, R. (2005). Families in the life course: Interdependency of roles, role configurations, and pathways. *Journal of Marriage and Family*, 67(4), 858-879.
- Mahoney, J. (2003). Strategies of causal assessment in comparative historical analysis. *Comparative historical analysis in the social sciences*, 337-372.
- Mahoney, J. (2012). The logic of process tracing tests in the social sciences. *Sociological Methods & Research*, 0049124112437709.
- Majeed, T., Forder, P. M., Tavener, M., Vo, K., & Byles, J. (2017). Work after age 65: A prospective study of Australian men and women. *Australasian journal on ageing*.
- Manas, L. R., & Sinclair, A. J. (2017). Diabetes and functional limitation: The emergence of frailty and disability. *Diabetes in Old Age*, 213.
- Marcoen, A., Coleman, P. G., & O'Hanlon, A. (2007). Psychological ageing. *Ageing in society*, 38-67.
- Marquet, O., & Miralles-Guasch, C. (2015). Neighbourhood vitality and physical activity among the elderly: The role of walkable environments on active ageing in Barcelona, Spain. *Social science & medicine*, 135, 24-30.
- Marshall, V. W., & Mueller, M. M. (2002). Rethinking social policy for an aging workforce and society: Insights from the life course perspective: Canadian Policy Research Networks Ottawa.
- Martin, P., Kelly, N., Kahana, B., Kahana, E., Willcox, B. J., Willcox, D. C., & Poon, L. W. (2015). Defining successful aging: A tangible or elusive concept? *The Gerontologist*, 55(1), 14-25.
- Mather, J. M. (1963). Attainment of optimum health. *Canadian Medical Association journal*, 89(4), 175.
- Matthews, F., Stephan, B., Robinson, L., Jagger, C., Barnes, L., Arthur, A., . . . Collaboration, A. S. C. (2016). A two decade dementia incidence comparison from the Cognitive Function and Ageing Studies I and II. *Nature communications*, 7.
- Maxwell, J. A. (2004). Using qualitative methods for causal explanation. *Field methods*, 16(3), 243-264.
- Mba, C. J. (2010). Population ageing in Ghana: research gaps and the way forward. *Journal of aging research*, 2010.
- McClintock, M. K., Dale, W., Laumann, E. O., & Waite, L. (2016). Empirical redefinition of comprehensive health and well-being in the older adults of the United States. *Proceedings of the National Academy of Sciences*, 113(22), E3071-E3080.
- McDonald, P. (2016). Ageing in Australia: Population changes and responses. *POPULATION AGEING*, 65.
- McHugh Power, J., Tang, J., Lawlor, B., Kenny, R. A., & Kee, F. (2016). Mediators of the relationship between social activities and cognitive function among older Irish adults: results from the Irish longitudinal study on ageing. *Ageing & mental health*, 1-6.

- McIntosh, G., & Phillips, J. (2003). Caring for the elderly—an overview of aged care support and services in Australia. *ACT: Parliament of Australia e-brief, Parliamentary Library*. Retrieved March, 23, 2009.
- McMurray, A. M. (2007). *Community health and wellness: A socio-ecological approach*: Elsevier.
- Mendes, P. (2008). *Australia's welfare wars revisited: The players, the politics and the ideologies*: Unsw Press.
- Menec, V. H. (2003). The relation between everyday activities and successful aging: A 6-year longitudinal study. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 58(2), S74-S82.
- Menkin, J. A., Robles, T. F., Gruenewald, T. L., Tanner, E. K., & Seeman, T. E. (2016). Positive Expectations Regarding Aging Linked to More New Friends in Later Life. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, gbv118.
- Mills, C. W. (1959). *The promise*.
- Minkler, M. (1989). Gold in gray: reflections on business' discovery of the elderly market. *The Gerontologist*, 29(1), 17-23.
- Minkler, M., & Holstein, M. B. (2008). From civil rights to... civic engagement? Concerns of two older critical gerontologists about a “new social movement” and what it portends. *Journal of Aging Studies*, 22(2), 196-204.
- Mishra, S. (2014). *Healthy Ageing, Happiness, Quality of Life for Rural Marginalized People and E-Health*. Paper presented at the XVIII ISA World Congress of Sociology (July 13-19, 2014).
- Moffitt, T. E. (1993). Adolescence-limited and life-course-persistent antisocial behavior: a developmental taxonomy. *Psychological review*, 100(4), 674.
- Mohd, S., Senadjki, A., & Mansor, N. (2016). Living Arrangements of Elderly: Evidence from Household Income Expenditure Survey. *Journal of Population Ageing*, 1-20.
- Morel, N., Palier, B., & Palme, J. (2012). *Towards a social investment welfare state?: ideas, policies and challenges*: Policy Press.
- Morrison, V. (2008). Ageing and physical health. *Handbook of the Clinical Psychology of Ageing*.
- Morrow-Howell, N., Hinterlong, J., & Sherraden, M. (2001). *Productive aging: Concepts and challenges*: JHU Press.
- Mort, M., Roberts, C., & Callén, B. (2013). Ageing with telecare: care or coercion in austerity? *Sociology of health & illness*, 35(6), 799-812.
- Myles, J., & Pierson, P. (2001). The comparative political economy of pension reform. *The new politics of the welfare state*, 305, 322-323.
- Neville, S., Russell, J., Adams, J., & Jackson, D. (2016). Living in your own home and being socially connected at 95 years and beyond: a qualitative study. *Contemporary Nurse*, 52(2-3), 258-268.
- Nguyen, B., Bauman, A., & Ding, D. (2016). Incident Type 2 Diabetes in a Large Australian Cohort Study: Does Physical Activity or Sitting Time Alter the Risk Associated With Body Mass Index? *Journal of Physical Activity and Health*, 1-21.
- Nicholson, N. R. (2012). A review of social isolation: an important but underassessed condition in older adults. *The journal of primary prevention*, 33(2-3), 137-152.

- Nielsen, R. A. (2016). Case selection via matching. *Sociological Methods & Research*, 45(3), 569-597.
- Nies, M. A., Troutman-Jordan, M., Branche, D., Moore-Harrison, T., & Hohensee, C. (2013). Physical activity preferences for low-income sedentary urban African American older adults. *Journal of gerontological nursing*, 39(6), 20-29.
- Nolan, M. (2016). "Super" Debates within the Antipodes? Explaining Differing New Zealand and Australian Retirement Policies in the late Twentieth Century. *Australian Journal of Politics & History*, 62(3), 435-451.
- Nukunya, G. K. (2003). Tradition and change in Ghana: An introduction to sociology: Ghana Universities Press.
- Nyqvist, F., & Forsman, A. K. (2015). Social capital as a health resource in later life: the relevance of context (Vol. 11): Springer.
- Nyström, M., Eriksson Sörman, D., & Nilsson, L. (2014). *Is Cognitive Functioning Important for Quality in Ageing?* Paper presented at the Psychonomic Society's 55th Annual Meeting.
- Nzabona, A., Ntozi, J., & Rutaremwa, G. (2016). Loneliness among older persons in Uganda: examining social, economic and demographic risk factors. *Ageing and Society*, 36(04), 860-888.
- O'Connor, J. S., Orloff, A. S., & Shaver, S. (1999). States, markets, families: Gender, liberalism and social policy in Australia, Canada, Great Britain and the United States: Cambridge University Press.
- OECD. (2011). Pensions at a Glance. Retrieved from <http://www.oecd.org/berlin/47570029.pdf>
- Olsen, C. M., Wilson, L. F., Nagle, C. M., Kendall, B. J., Bain, C. J., Pandeya, N., . . . Whiteman, D. C. (2015). Cancers in Australia in 2010 attributable to insufficient physical activity. *Australian and New Zealand journal of public health*, 39(5), 458-463.
- Olshansky, S. J., Carnes, B. A., & Butler, R. N. (2003). If humans were built to last. *Scientific American*, 13, 94-100.
- Oppong, C. (2006). Familial roles and social transformations older men and women in sub-Saharan Africa. *Research on Aging*, 28(6), 654-668.
- Organization, W. H. (2007). *Global age-friendly cities: A guide*: World Health Organization.
- Organization, W. H. (2015). World report on ageing and health. *Geneva: World Health Organization*.
- Pakulski, J. (2016). Facing the challenges of an ageing society. *POPULATION AGEING*, 111.
- Paltasingh, T., & Tyagi, R. (2017). Situating Elderly Role in Family Decision-Making: Indian Scenario. *Indian Journal of*, 31(1), 43-57.
- Panagos, T. I. (2003). In search of the silver lining: Case analysis for mature market businesses. Massachusetts Institute of Technology.
- Park, C. L., & Folkman, S. (1997). Meaning in the context of stress and coping. *Review of general psychology*, 1(2), 115.
- Parmar, D., Williams, G., Dkhimi, F., Ndiaye, A., Asante, F. A., Arhinful, D. K., & Mladovsky, P. (2014). Enrolment of older people in social health protection programs in West Africa—Does social exclusion play a part? *Social science & medicine*, 119, 36-44.
- Paúl, C., Ribeiro, O., & Teixeira, L. (2012). Active ageing: an empirical approach to the WHO model. *Current gerontology and geriatrics research*, 2012.

- Per Capita Australia. (2014). *Blue Print for an Ageing Australia*. . Retrieved from
- Peterson, K. L., Jacobs, J. P., Allender, S., Alston, L. V., & Nichols, M. (2016). Characterising the extent of misreporting of high blood pressure, high cholesterol, and diabetes using the Australian Health Survey. *BMC public health*, 16(1), 695.
- Pettigrew, A. M., Woodman, R. W., & Cameron, K. S. (2001). Studying organizational change and development: Challenges for future research. *Academy of Management Journal*, 44(4), 697-713.
- Pettigrew, S., Donovan, R., Boldy, D., & Newton, R. (2014). Older people's perceived causes of and strategies for dealing with social isolation. *Aging & mental health*, 18(7), 914-920.
- Phillips, J. E., Ajrouch, K. J., & Hillcoat-Nallétamby, S. (2010). *Key concepts in social gerontology*: Sage.
- Phillipson, C. (2001). History and historical sociology: divergent paths in the study of ageing. *Ageing and Society*, 21(04), 507-522.
- Phoenix, C., & Griffin, M. (2015). Sport, Physical Activity and Ageing. *Routledge Handbook of Cultural Gerontology*, 329.
- Phoenix, C., & Tulle, E. (2017). Physical Activity and Ageing. In Piggin, J., Mansfield, L. & Weed, M. (Eds.) (In Press - 2017) *The Routledge Handbook of Physical Activity Policy and Practice*. Routledge.
- Pietkiewicz, I., & Smith, J. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal*, 20(1), 7-14.
- Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal*, 20(1), 7-14.
- Pillemer, K., Wells, N. M., Meador, R. H., Schultz, L., Henderson, C. R., & Cope, M. T. (2016). Engaging older adults in environmental volunteerism: The Retirees in Service to the Environment program. *The Gerontologist*, gnv693.
- Plath, D. (2008). Independence in old age: the route to social exclusion? *British Journal of Social Work*, 38(7), 1353-1369.
- Porcellato, L., Carmichael, F., Hulme, C., Ingham, B., & Prashar, A. (2010). Giving older workers a voice: constraints on the employment of older people in the North West of England. *Work, Employment and Society*, 24(1), 85-103.
- Price, S. J., McKenry, P. C., & Murphy, M. J. (2000). *Families Across Time. A Life Course Perspective* Los Angeles: roxbury.
- Prince, M., Wimo, A., Guerchet, M., Ali, G., Wu, Y., & Prina, M. (2015). World Alzheimer Report 2015. The global impact of dementia. An analysis of prevalence, incidence, cost & trends; Alzheimer's Disease International: London. *Available at: (Accessed February 17, 2016)*.
- Prince, M. J., Wu, F., Guo, Y., Robledo, L. M. G., O'Donnell, M., Sullivan, R., & Yusuf, S. (2015). The burden of disease in older people and implications for health policy and practice. *The lancet*, 385(9967), 549-562.
- Principi, A., Jensen, P. H., & Lamura, G. (2014). *Active ageing: Voluntary work by older people in Europe*: Policy Press.

- Pringle J, Drummond J, McLafferty E, & Hendry C (2011). Interpretative phenomenological analysis: a discussion and critique. *Nurse researcher*, 18(3), 20 -24.
- Productivity Commission. (2005). Economic implications of an ageing Australia. *SSRN Working Paper Series*.
- Productivity Commission. (2013). An Ageing Australia: Preparing for the Future. *Canberra: Commission Research Paper*, 43-45.
- Quadagno, J. (2013). Aging and the life course: An introduction to social gerontology: McGraw-Hill Higher Education.
- Quartey, P., Quartey, P., Kunawotor, M. E., Kunawotor, M. E., Danquah, M., & Danquah, M. (2016). Sources of retirement income among formal sector workers in Ghana. *African Journal of Economic and Management Studies*, 7(3), 366-378.
- Rada, C. (2016). Population Ageing and its Global Challenges. *Global Ageing in the Twenty-First Century: Challenges, Opportunities and Implications*, 159.
- Rechel, B., Grundy, E., Robine, J.-M., Cylus, J., Mackenbach, J. P., Knai, C., & McKee, M. (2013). Ageing in the European union. *The lancet*, 381(9874), 1312-1322.
- Reed, J., Cook, G., Childs, S., & Hall, A. (2003). Getting old is not for cowards: Comfortable, healthy ageing. *Joseph Rowntree Foundation, York, UK*.
- Reeves, A., McKee, M., Mackenbach, J., Whitehead, M., & Stuckler, D. (2017). Public pensions and unmet medical need among older people: cross-national analysis of 16 European countries, 2004–2010. *Journal of Epidemiology and Community Health*, 71(2), 174-180.
- Rehnberg, J., & Fritzell, J. (2016). The shape of the association between income and mortality in old age: A longitudinal Swedish national register study. *SSM-Population Health*, 2, 750-756.
- Reitzes, D. C., Mutran, E. J., & Verrill, L. A. (1995). Activities and Self-Esteem Continuing the Development of Activity Theory. *Research on Aging*, 17(3), 260-277.
- Rico-Uribe, L. A., Caballero, F. F., Olaya, B., Tobiasz-Adamczyk, B., Koskinen, S., Leonardi, M., Miret, M. (2016). Loneliness, social networks, and health: a cross-sectional study in three countries. *PLoS one*, 11(1), e0145264.
- Ricoeur, P. (1970). Freud and Philosophy; an Essay on Interpretation. Translated by Denis Savage.
- Riley, M. W., Foner, A., & Riley Jr, J. (1999). The aging and society paradigm. *Handbook of theories of aging*, 327-342.
- Ring, A. L. (2002). Using "anti-ageing" to market cosmetic surgery: just good business, or another wrinkle on the face of medical practice? *Medical journal of Australia*, 176(12), 597-600.
- Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative research in psychology*, 11(1), 25-41.
- Rofman, R., & Apella, I. (2016). Social Protection in a Demographic Transition. *Demographic Change in Uruguay*, 75.
- Rollins, A. (2014). Health care on the frontline of painful budget cuts. *Australian Medicine*, 26(9), 8.
- Rowe, J. W., & Kahn, R. L. (1987). Human aging: usual and successful. *Science*, 237(4811), 143-149.
- Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, 37(4), 433-440.

- Ryan, N. (2005). A decade of social policy under John Howard: social policy in Australia. *Policy & Politics*, 33(3), 451-460.
- Saldana, J. (2009). An introduction to codes and coding. *The coding manual for qualitative researchers*, 1-31.
- Sampson, R. J., & Laub, J. H. (1990). Crime and deviance over the life course: The salience of adult social bonds. *American sociological review*, 609-627.
- Scannapieco, F. A., & Cantos, A. (2016). Oral inflammation and infection, and chronic medical diseases: implications for the elderly. *Periodontology 2000*, 72(1), 153-175. doi:10.1111/prd.12129
- Seawright, J., & Gerring, J. (2008a). Case selection techniques in case study research a menu of qualitative and quantitative options. *Political Research Quarterly*, 61(2), 294-308.
- Seawright, J., & Gerring, J. (2008b). Case selection techniques in case study research: A menu of qualitative and quantitative options. *Political Research Quarterly*, 61(2), 294-308.
- Seedsman, T., & Feldman, S. (2002). 'Spirituality' and ageing well: thoughts on coping with loss and grief. *Education and ageing*, 17(2-3), 201-215.
- Seeman, T. E., Lusignolo, T. M., Albert, M., & Berkman, L. (2001). Social relationships, social support, and patterns of cognitive aging in healthy, high-functioning older adults: MacArthur studies of successful aging. *Health psychology*, 20(4), 243.
- Senior, H. E., Parsons, M., Kerse, N., Chen, M.-H., Jacobs, S., Vander Hoorn, S., & Anderson, C. S. (2014). Promoting independence in frail older people: a randomised controlled trial of a restorative care service in New Zealand. *Age and Ageing*, 43(3), 418-424.
- Shanahan, M. J., Elder Jr, G. H., & Miech, R. A. (1997). History and agency in men's lives: Pathways to achievement in cohort perspective. *Sociology of Education*, 54-67.
- Shann, E. (2016). *An Economic History of Australia*: Cambridge University Press.
- Sharp, K., Devereux, S., & Amare, Y. (2003). *Destitution in Ethiopia's Northeastern Highlands (Amhara National Regional State)*: Institute of Development Studies at the University of Sussex.
- Shaw, R. L., West, K., Hagger, B., & Holland, C. A. (2016). Living well to the end: A phenomenological analysis of life in extra care housing. *International journal of qualitative studies on health and well-being*, 11.
- Shinebourne, P. (2011). The theoretical underpinnings of interpretative phenomenological analysis (IPA). *Existential analysis*, 22(1), 16-32.
- Silverstein, M., Gans, D., & Yang, F. M. (2006). Intergenerational support to aging parents the role of norms and needs. *Journal of Family Issues*, 27(8), 1068-1084.
- Silverstein, M., & Parker, M. G. (2002). Leisure activities and quality of life among the oldest old in Sweden. *Research on Aging*, 24(5), 528-547.
- Simons, H. (2014). Case study research: In-depth understanding in context. *The oxford handbook of qualitative research*, 455.
- Sixsmith, J., Sixsmith, A., Fänge, A. M., Naumann, D., Kucsera, C., Tomsone, S., . . . Woolrych, R. (2014). Healthy ageing and home: The perspectives of very old people in five European countries. *Social science & medicine*, 106, 1-9.

- Skarupski, K. A., de Leon, C. F. M., Bienias, J. L., Scherr, P. A., Zack, M. M., Moriarty, D. G., & Evans, D. A. (2007). Black-white differences in health-related quality of life among older adults. *Quality of Life Research*, 16(2), 287-296.
- Sloman, S. (2005). Causal models: How people think about the world and its alternatives: Oxford University Press.
- Smith, J. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative research in psychology*, 1(1), 39-54.
- Smith, J., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory. *Method and Research London: Sage*.
- Smith, J., Flowers, P., Osborn, M., & Yardley, L. (1997). Interpretative phenomenological analysis and the psychology of health and illness. *Material discourses of health and illness*, 68-91.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology *Psychology and health*, 11(2), 261-271.
- Sobel, M. E. (2000). Causal inference in the social sciences. *Journal of the American Statistical Association*, 95(450), 647-651.
- Sobo, E. J. (2016). Culture and Meaning in Health Services Research: An Applied Approach: Routledge.
- Social Security Administration. (2013). *Social Security Programs Throughout the World: Asia and the Pacific* (Vol. 13): Government Printing Office.
- Solomon, Z., Helvitz, H., & Zerach, G. (2009). Subjective age, PTSD and physical health among war veterans. *Aging and Mental Health*, 13(3), 405-413.
- Southwell-Wright, W., Gowland, R., & Powell, L. (2016). Foundations and Approaches to the Study of Care in the Past. *Care in the Past: Archaeological and Interdisciplinary Perspectives*, 1.
- Stake, R. E. (1995). The art of case study research: Sage.
- Stake, R. E. (2013). *Multiple case study analysis*: Guilford Press.
- Stenholm, S., Koster, A., Valkeinen, H., Patel, K. V., Bandinelli, S., Guralnik, J. M., & Ferrucci, L. (2015). Association of physical activity history with physical function and mortality in old age. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, glv111.
- Stenner, P., McFarquhar, T., & Bowling, A. (2011). Older people and 'active ageing': Subjective aspects of ageing actively. *Journal of health psychology*, 16(3), 467-477.
- Steptoe, A., Deaton, A., & Stone, A. A. (2015). Subjective wellbeing, health, and ageing. *The lancet*, 385(9968), 640-648.
- Stowe, J. D., & Cooney, T. M. (2015). Examining Rowe and Kahn's concept of successful aging: Importance of taking a life course perspective. *The Gerontologist*, 55(1), 43-50.
- Streib, G. F., & Binstock, R. H. (1990). Aging and the social sciences: Changes in the field. *Handbook of aging and the social sciences*, 3, 1-16.
- Stuart-Hamilton, I. (2012). *The psychology of ageing: An introduction*: Jessica Kingsley Publishers.

- Sultan, S. M., & Schrofer, T. T. (2008). 5.4 Building Support to have Targeted Social Protection Interventions for the Poorest—The Case of Ghana. *Social Protection for the Poorest in Africa*, 300.
- Suzman, R., Beard, J. R., Boerma, T., & Chatterji, S. (2015). Health in an ageing world—what do we know? *The lancet*, 385(9967), 484-486.
- Sweeney, T. J., & Witmer, J. M. (1991). Beyond social interest: Striving toward optimum health and wellness. *Individual Psychology: Journal of Adlerian Theory, Research & Practice*.
- Tawiah, E. (2013). Population ageing in Ghana: a profile and emerging issues.
- Taylor, G. (2010). Federalism in Australia. *Vienna Online J. on Int'l Const. L.*, 4, 171.
- Taylor, P. E., & Walker, A. (1994). The ageing workforce: Employers' attitudes towards older people. *Work, employment & society*, 8(4), 569-591.
- Teune, H., & Przeworski, A. (1970). The logic of comparative social inquiry. *New York*.
- Toepoel, V. (2013). Ageing, leisure, and social connectedness: how could leisure help reduce social isolation of older people? *Social indicators research*, 113(1), 355-372.
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International journal for quality in health care*, 19(6), 349-357.
- Torre, L. A., Siegel, R. L., Ward, E. M., & Jemal, A. (2016). Global cancer incidence and mortality rates and trends—an update. *Cancer Epidemiology and Prevention Biomarkers*, 25(1), 16-27.
- Tuntland, H., Aaslund, M. K., Espehaug, B., Førland, O., & Kjekshus, I. (2015). Reablement in community-dwelling older adults: a randomised controlled trial. *BMC geriatrics*, 15(1), 145.
- Udayshankar, P., & Parameaswari, P. (2014). Healthy and Active Ageing. *World Applied Sciences Journal*, 30(7), 927-928.
- United-Nations. (2013). *World Population Ageing*. Retrieved from
- United Nations, D. o. E. a. S. A., Population Division. . (2015). *World Population Ageing 2015 (ST/ESA/SER.A/390)*. .
- United Nations Economic Commission for Europe. (2012). *Active Ageing. UNECE Policy Brief on Ageing No. 13*. Retrieved from
- Van der Geest, S. (1997a). Money and respect: The changing value of old age in rural Ghana. *Africa*, 67(04), 534-559.
- Van der Geest, S. (1997b). Between respect and reciprocity: Managing old age in rural Ghana. *Southern African Journal of Gerontology*, 6(2), 20-25.
- Van der Geest, S. (2016). Will families in Ghana continue to care for older people? Logic and contradiction in policy. *Ageing in SubSaharan Africa: Spaces and Practices of Care*, 21.
- Van der Geest, S. (2002). From wisdom to witchcraft: Ambivalence towards old age in rural Ghana. *Africa*, 72(3), 437-463.
- van der Steen, J. T., Radbruch, L., Hertogh, C. M., de Boer, M. E., Hughes, J. C., Larkin, P., . . . Firth, P. (2014). White paper defining optimal palliative care in older people with dementia: a Delphi study and recommendations from the European Association for Palliative Care. *Palliative medicine*, 28(3), 197-209.

- Van Malderen, L., De Vriendt, P., Mets, T., & Gorus, E. (2016). Active ageing in the nursing home: Could participatory action research provide the answer? *Action Research*, 1476750316636668.
- van Uffelen, J. (2015). Active and healthy ageing: The benefits of physical activity and exercise. *Sport Health*, 33(1), 36.
- Vandenbroucke, F., Hemerijck, A., & Palier, B. (2011). The EU needs a social investment pact. *Observatoire Social Européen Paper Series, Opinion Paper*, 5.
- Vestergaard, S., Thinggaard, M., Jeune, B., Vaupel, J. W., McGue, M., & Christensen, K. (2015). Physical and mental decline and yet rather happy? A study of Danes aged 45 and older. *Aging & mental health*, 19(5), 400-408.
- Victoria State Government. (2016). Ageing is everyone's business: A report on isolation and loneliness among senior Victorians. Retrieved from Melbourne: <http://www.seniorsonline.vic.gov.au/>
- Vidovićová, L. (2005). To be active or not to be active, that is the question: the preference model of activity in advanced age. *Ageing International*, 30(4), 343-362.
- Villar, F. (2012). Successful ageing and development: The contribution of generativity in older age. *Ageing and Society*, 32(07), 1087-1105.
- Wagnild, G. (2003). Resilience and successful aging: Comparison among low and high income older adults. *Journal of gerontological nursing*, 29(12), 42-49.
- Waite, L. J., Iveniuk, J., & Laumann, E. O. (2014). Social Connectedness at Older Ages and Implications for Health and Well-Being. *Interpersonal Relationships and Health: Social and Clinical Psychological Mechanisms*, 8.
- Walker, A. (1981). Towards a political economy of old age. *Ageing and Society*, 1(01), 73-94.
- Walker, A. (2002). A strategy for active ageing. *International social security review*, 55(1), 121-139.
- Walker, A. (2005). Towards an international political economy of ageing. *Ageing and Society*, 25, 815.
- Walker, A. (2006). Active ageing in employment: Its meaning and potential. *Asia-Pacific Review*, 13(1), 78-93.
- Walker, A., & Foster, L. (2013). Active ageing: Rhetoric, theory and practice. *The making of aging policy: Theory and practice in Europe*, 27-53.
- Walker, A., & Maltby, T. (2012). Active ageing: a strategic policy solution to demographic ageing in the European Union. *International Journal of Social Welfare*, 21(s1), S117-S130.
- Warburton, J. (2014). 24. ageing and social policy in australia. *International Handbook on Ageing and Public Policy*, 301.
- Warburton, J., Cowan, S., & Bathgate, T. (2013). Building social capital among rural, older Australians through information and communication technologies: A review article. *Australasian journal on ageing*, 32(1), 8-14.
- Wei, H. (2007). Measuring Australia's human capital development: The role of post-school education and the impact of population ageing. *Statistical Journal of the IAOS*, 24(3, 4), 183-191.
- Werfalli, M., Engel, M. E., Musekiwa, A., Kengne, A. P., & Levitt, N. S. (2016). The prevalence of type 2 diabetes among older people in Africa: a systematic review. *The lancet Diabetes & endocrinology*, 4(1), 72-84.

- Westerterp, K. R. (2000). Daily physical activity and ageing. *Current Opinion in Clinical Nutrition & Metabolic Care*, 3(6), 485-488.
- Westwood, S., & Daly, M. (2016). Social Care and Older People in Home and Community Contexts: A Review of Existing Research and Evidence.
- Whitbourne, S. K., & Whitbourne, S. B. (2010). *Adult development and aging: Biopsychosocial perspectives*: John Wiley & Sons.
- Whitbourne, S. K., & Willis, S. L. (2014). *The baby boomers grow up: Contemporary perspectives on midlife*: Psychology Press.
- Williams, J. (2009). Diabetes and the older adult: what care do they need and what do they receive. *Journal of Diabetes Nursing*, 13(8), 308-310.
- Wong, L., & Jun, T. (2006). Non-state care homes for older people as third sector organisations in China's transitional welfare economy. *Journal of Social Policy*, 35(02), 229-246.
- Wong, M. C., Goggins, W. B., Wang, H. H., Fung, F. D., Leung, C., Wong, S. Y., . . . Sung, J. J. (2016). Global incidence and mortality for prostate cancer: Analysis of temporal patterns and trends in 36 countries. *European urology*, 70(5), 862-874.
- World Health Organization. (2000). *The Implications for Training of Embracing a Life Course Approach to Health*. Retrieved from Geneva: World Health Organization:
- World Health Organization. (2002). Active ageing: A policy framework.
- Constitution of the World Health Organisation, (2006).
- World Health Organization. (2008). *WHO global report on falls prevention in older age*. (9241563532). World Health Organization.
- World Health Organization. (2012). *Dementia: a public health priority*. Geneva.
- World Health Organization. (2014). *Ghana country assessment report on ageing and health*. Retrieved from Geneva, Switzerland
- World Health Organization. (2015). World Report on Ageing and Health. (WHO/FWC/ALC/15.01).
- World Health Organization. (2016). Life expectancy at birth (Years), 2000 -2015. Retrieved 23rd February 2017, from WHO http://gamapserver.who.int/gho/interactive_charts/mbd/life_expectancy/atlas.html
- Wu, Y.-T., Fratiglioni, L., Matthews, F. E., Lobo, A., Breteler, M. M., Skoog, I., & Brayne, C. (2016). Dementia in western Europe: epidemiological evidence and implications for policy making. *The Lancet Neurology*, 15(1), 116-124.
- Xu, K., Evans, D. B., Kawabata, K., Zeramardini, R., Klavus, J., & Murray, C. J. (2003). Household catastrophic health expenditure: a multicountry analysis. *The lancet*, 362(9378), 111-117.
- Yang, Y. C., Boen, C., & Mullan Harris, K. (2015). Social relationships and hypertension in late life: evidence from a nationally representative longitudinal study of older adults. *Journal of aging and health*, 27(3), 403-431.
- Yin. (2013). Case study research: Design and methods: Sage publications.
- Yin, R. (2003). K.(2003). Case study research: Design and methods. *Sage Publications, Inc*, 5, 11.
- Yin, R. K. (2013). *Case study research: Design and methods*: Sage publications.
- Zacher, H. (2015). The Importance of a Precise Definition, Comprehensive Model, and Critical Discussion of Successful Aging at Work. *Work, Aging and Retirement*, wav020.

- Zaidi, A. (2012). Population ageing and financial and social sustainability challenges of pension systems in Europe: A cross-national perspective. *The Future of Multi-pillar Pensions. Cambridge University Press: Cambridge, UK.*
- Zaidi, A., & Rejniak, M. (2010). Fiscal policy and sustainability in view of crisis and population ageing in Central and Eastern European countries. *Policy Brief. European Centre. August.*

APPENDIX 1:

In-depth Interview Guides

Project title: Towards active ageing: A comparative study of older Ghanaians in Australia and Ghana

Part One

In-depth Qualitative Interview Guide for participants

1. What does active ageing mean to you based on your everyday life experiences?
2. Discuss your experience with active ageing. [Probing points: explore issues of health promotion, disease, health prevention; participation (economic, community and family) and security (economic-income income sufficiency, asserts; physical safety, housing and environmental safety)]
3. How does it feel like turning 60 years and over? Tell me all your experiences with the process up to this point [Probing points: What has changed, why have they changed? self-awareness of ageing, fears, threats, anxieties, opportunities]
4. Overall, discuss your satisfaction with the quality life of life in the ageing process so far. [Probing points: Are you active ageing? How and why?]
5. What do you think might be causing how you feel about your life at old age? Discuss please
6. What do you think has happened throughout your life which can explain your current level of satisfaction with life?

APPENDIX 2: Short Questionnaire

Socio-Demographic Background for matching participants

| Contact Details | | | |
|---|---|--|------|
| Full name of respondent | | | |
| Contact details | Phone: | | |
| | E-mail: | | |
| Current country of residence | | | |
| Socio-Demographic and Economic Background | | | |
| | | | Tick |
| Age | | | |
| | | | |
| Sex | Male | | |
| | Female | | |
| Nationality | 2=Ghanaian 1=Dual citizenship 0=Renounced | | |
| Ethno-linguistic origin | 1=Akan/Ewe/Ga 0=Others | | |
| Highest Education | 2=Tertiary | | |
| | 1=Secondary | | |
| | 0=Elementary/Basic | | |
| Professional background | 1=Skilled professional 0=None skilled causal | | |
| Currently working? | 1=Paid/ Non-paid work 0=No work | | |
| Average monthly income from all sources | 1=More than \$1000 0=Less than \$1000 | | |
| Residential location | 1=Urban 0=Rural | | |
| Ownership of place of residence | 1=Own/family residence 0=Not own residence | | |
| Religious inclination | 1=Christianity 0=Others | | |

APPENDIX 3:

Consent Form



INFORMED CONSENT FORM

Towards Active Ageing: A Comparative Study of Experiences of Older Ghanaians in Australia and Ghana

By signing this consent form, I _____ (please write your name) declare that the researcher has explained the study to me and/or I have read the Interview Participation Form and voluntarily decided to be interviewed. I am aware the interview will be one-on-one basis and will last not more than 30 minutes.

I understand that I will be required to answer a couple of questions from the researcher on active ageing. I also understand that my conversation with the researcher will be audio recorded. I understand that all my responses will be kept confidential and only shared among the research team. I understand all steps will be taken to ensure my anonymity. I am aware that this study is not compulsory and I can withdraw my consent anytime I wish without any penalty.

I understand that the research data gathered in this study may be published provided I am not personally identified in any way. I have been well informed that should I have any concern regarding the study, I can contact any member of the research team:

Daniel Doh
PhD Candidate
School of Psychology and Social
Sciences
Edith Cowan University,
Joondalup, WA

Tel: +61424391151 (Australia)
+233244890062 (Ghana)

Email: ddoh@our.ecu.edu.au
/ danydoh@yahoo.co.uk

Dr Peter Hancock
Senior Lecturer
School of Psychology and
Social Sciences
Edith Cowan University,
Joondalup, WA

Tel: (618) 63045804

Email: p.hancock@ecu.edu.au

Dr Kwadwo Adusei-Asante
Lecturer
School of Psychology and Social
Sciences
Edith Cowan University,
Joondalup, WA

Tel: (618) 0863042848

Email: k.adusei@ecu.edu.au

OR

Kim Gifkins

Research Ethics Officer, Joondalup Campus

Telephone: (+61 8) 6304 2170

Fax: (+61 8) 6304 5044

Signed/Thumb Print: _____ **Date:** _____ -

Mobile no. _____

Residential Address _____

Witnessed by Daniel Doh

APPENDIX 4:

Information Sheet



Information Sheet

Title of Project:

Towards Active Ageing: A Comparative Study of Experiences of Older Ghanaians in Australia and Ghana

This research project is being undertaken as part of the requirements of a PhD at Edith Cowan University.

Project Description

This study seeks to examine the meaning of the concept of active ageing from the lived experiences of older people. It also seeks to examine factors that influence quality of life in old age.

You are selected to participate in this project for either of the following two reasons:

- That you are a Ghanaian, 60 years and above and
- You reside in either Ghana or Australia

The project involves in-depth interviews with 50 older Ghanaians (25 each from Ghana and Australia). This face –to-face interview shall last for 45minutes. The interview process will also involve the administration of a short survey questionnaire. Out of the 50 initial participants, an appropriate number will be selected to be included in the final analysis based on the outcome of a matching exercise.

The project will also involve interviews with 10 key informants (5 each from Ghana and Australia) selected from Government Department with responsibilities on ageing or active ageing, leading civil society organisation on active ageing, a leading academic on active ageing. The duration of this interview is 45 minutes.

The following are the project staff:

Lead Investigator:

Daniel Doh
PhD Candidate
School of Psychology and
Social Sciences
Edith Cowan University,
Joondalup, WA

Tel: +61424391151
(Australia)
+233244890062 (Ghana)

Email: ddoh@our.ecu.edu.au
/ danydoh@yahoo.co.uk

Supervisor:

Dr Peter Hancock
Senior Lecturer
School of Psychology and
Social Sciences
Edith Cowan University,
Joondalup, WA

Tel: (618) 63045804

Email:
p.hancock@ecu.edu.au

Associate Supervisor:

Dr Kwadwo Adusei-Asante
Lecturer
School of Psychology and
Social Sciences
Edith Cowan University,
Joondalup, WA

Tel: (618) 0863042848

Email: k.adusei@ecu.edu.au

The information to be provided by participants will be used only for academic purposes. In order to ensure confidentiality for participants, only the core project staff listed above or to be recruited will have access to the non-identified information provided. Pseudonyms shall be used where necessary and voice recorded interviews will be erased immediately after transcription. The data will be kept with the lead supervisor who is a Senior Lecturer with the Faculty of Engineering and Social Sciences, Edith Cowan University. The information (transcripts) will be stored in electronic version and shall be held for a maximum of 5 years and thereafter destroyed. This shall be done by deletion and burning of the storage device such as a flash drive.

The results of the study will be disseminated through reports, conferences and journal article publications. Results of this project will not include any information that may identify any individual participant. On demand, participant will be provided with feedbacks regarding their specific results of the study.

Participation in this project is voluntary as such, no explanation or justification is required if a participant chooses not to participate. A decision not to participate will not disadvantage or involve any penalty for participants. Participants may withdraw their consent at any time in the project including withdrawal of information if such information has already been collected.

The project does not pose any known risk to participants or researchers. However, the appropriate risk assessment of this project has been undertaken. The project has also been approved by the Ethics Committee of Edith Cowan University, WA.

If you have any questions or require any further information about the research project, please contact:

Daniel Doh
PhD Candidate
School of Psychology and
Social Sciences
Edith Cowan University,
Joondalup, WA

Tel: +61424391151
(Australia)
+233244890062 (Ghana)
Email: ddoh@our.ecu.edu.au
/ danydoh@yahoo.co.uk

Dr Peter Hancock
Senior Lecturer
School of Psychology and
Social Sciences
Edith Cowan University,
Joondalup, WA

Tel: (618) 63045804
Email:
p.hancock@ecu.edu.au

Dr Kwadwo Adusei-Asante
Lecturer
School of Psychology and
Social Sciences
Edith Cowan University,
Joondalup, WA

Tel: (618) 0863042848
Email: k.adusei@ecu.edu.au

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact:

Research Ethics Officer
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Phone: (08) 6304 2170
Email: research.ethics@ecu.edu.au