

# ‘Pathways to choice’ of care setting

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## ABSTRACT

This article aims to encourage critical reflection about the limitations of the rational choice approach as an explanatory insight to understanding older people’s choice-making about their health or social care requirements. It develops an interpretive framework examining how older people engage in the process of choice-making when selecting a care option. Choice-making is conceptualised as a temporal, processual phenomenon, influenced by others, and characterised by an individual’s behavioural responses to changing circumstance and lifecourse events. Data are from qualitative interviews with 29 older adults whose choice of care option involved moving to an extra-care setting in Wales (United Kingdom). Transcripts were coded using in-case and constant-comparison approaches, and analysis was undertaken using concepts of *engagement* and *temporality* as elements of the choice-making process. Using an inductive approach, a typology of six different ‘pathways to choice’ of care setting was identified; these findings suggest that choosing a care option in later life is a diverse, interactive and time-bound social phenomenon, inadequately captured by the rational choice approach where it is understood more as an individualised, linear and logical process. Recognising that choice-making evolves through time as part of a process shaped by others means service providers will be better positioned to offer opportunities for more preventative-focused interventions which empower older consumers to make planned and informed choices about care options.

**KEY WORDS**—choice, consumer-directed care, rational choice, extra-care, care options.

## Introduction

Over recent decades, a rational choice approach has influenced the development of health and social care provisions through an emphasis on personalisation and self-managed care (Department of Health 2016a, 2016b; National Health Service England 2016). At the micro-level of human behaviour, this approach assumes that ‘decision-makers (*in this case older people*) have logically consistent goals (whatever they are) and, given these goals,

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choose the best available option' (Gächter 2013: xxxviii 33). Set in the broader parameters of decision-making theory (Elster 1986; Harper, Randall and Sharrock 2015; March 1994; Wittek, Snijders and Nee 2013), when applied to individual consumption – a person's choice of care option, for example – a rational choice approach implies that an individual will be a purposive and reasoned consumer with clearly defined preferences, fully aware of all possible constraints and outcomes regarding their decisions, and empowered to make informed choices about their care requirements, amidst an array of options. It also suggests that individuals will make choices independently of others, based on self-interest, or considering others only for instrumental reasons (Gächter 2013).

In practice in the current context of social care provisions, this approach has helped to cast older people as independent consumers in the public eye. Increasing emphasis has been placed on facilitating 'consumer choice' (Tilly, Wiener and Cuellar 2000), accompanied by an approach to decision-making (Eichler and Pfau-Effinger 2010; Greve 2010; Jordan 2006; Taylor-Gooby 2008) which assumes older individuals will be self-directed and empowered consumers (Andersson and Kvist 2014; Carder and Hernandez 2004; Yeandle, Kröger and Cass 2012), able to exercise choice about the services and support they require (Kunkel and Nelson 2005), selecting them from a broad range of care commodities (Clarke *et al.* 2007), accessible through personalised care packages (Fine 2013; Lymbery 2010; Wiener, Anderson and Khatutsky 2007). This ethos of consumer choice has also spread to residential decision-making, as different models of supported living options begin to proliferate (Brecht, Fein and Hollinger-Smith 2009; Welsh Government 2017).

The aim of this article is to encourage critical reflection about these core assumptions, with a view to highlighting some of the limitations of the rational choice approach as a basis for understanding older people's choice-making about their health or social care requirements. The article addresses this aim by developing an exploratory, interpretive framework which examines the different ways in which older people engage in the choice-making process when it comes to selecting a care option in a particular setting. The term *care option* here refers to situations where older people who have been assessed as eligible for social care services, and depending on their type of need, have been given the option to: remain in their private, home setting and receive local authority care services *in situ*; relocate to an *extra-care* or assisted living facility<sup>1</sup> and benefit from its supportive environment; or relocate to a *residential care-home* setting providing more specialist, but not intensive nursing care support.<sup>2</sup>

Central to the interpretive framework is the idea that there is merit in distinguishing an older person's choice – defined as the degree to which they

*engage* in and exercise agency over the selection of a care option – as part of a broader temporal process evolving across different time-frames, and which may be shaped by individual design, but also by others – family, friends, service providers or health workers, for example. Choice-making is therefore conceptualised here as a *temporal* phenomenon, evolving as part of a broader decision-making process influenced by others, and characterised by an individual's behavioural responses to changing circumstance and lifecourse events across time.

Considering individual choice-making in this way as a complex social phenomenon, involving decision processes, time-frames and significant others, is important if we are to provide opportunities for more timely, preventative-focused service interventions which maximise opportunities for older people to make planned and informed choices. It also encourages critical reflection about the risks for policy and practice, of providing an oversimplified view of older people as a homogenous care consumer audience, endowed with similar aptitudes or intentions for exercising independent, informed and empowered choice-making, in preference for one which recognises the potential for a greater diversity, and complexity of preferences and needs. The article therefore explores the question: does older people's choice of care option reflect a more complex and diverse social phenomenon than a rational choice perspective might otherwise suggest? Specifically, this question is explored through analysis of narratives gathered from older people living in Wales (United Kingdom) who had chosen to relocate to an extra-care setting, and were asked to comment on the circumstances which led them to adopt this care option.

After outlining why a rational choice approach can be said to have certain limitations as a basis for understanding later-life health and social care choice-making, the article then adopts an inductive approach to this phenomenon by developing an interpretive framework where choice is conceptualised as part of a complex decision-making process, and is shaped by time as well as human interaction. Qualitative narratives are used to elaborate the parameters of the framework and results are provided in the form of a typology of 'pathways to choice'.

The theoretical framework used to interpret results draws on the concept of autonomy, notably as it has been elaborated by Collopy (1988, 1995) and others (Hillcoat-Nallétamby 2014) in relation to older people's lives in different care settings. This body of work offers a useful approach for considering the degree to which study participants have really engaged or been implicated in the choice-making process. Pro-active coping theory (Aspinwall and Taylor 1997), more recently applied to the phenomenon of later-life residential decision-making (Pope and Kang 2010), also offers an interesting interpretive perspective for considering how participants

have developed responses to potentially stressful changes to life circumstances, such as the prospect of relocation from their own home to a new care setting.

*Limits to the rational choice approach for understanding later-life choice-making*

There are at least three limitations to the rational choice approach when it comes to understanding health and social care choices in later life. First, it understates the possibility that choice may be compromised in circumstances of *vulnerability* or *frailty*. Choosing a residential care option, for example, can be conditioned by levels of frailty (Fernandez-Carro 2016); and a willingness or capacity to engage in making choices shaped by the speed with which health conditions evolve (Wang and Nolan 2016). An individual's ability to exercise choice in situations such as palliative care may be compromised in the absence of clear clinical or service guidelines (Drought and Koenig 2002; Kite and Tate 2005), or stymied for older people living in the community if their physical environment, social support or material resources are not malleable enough to accommodate their preferences (Rolls *et al.* 2011). For those with dementia, exercising choice can be challenging if they are marginalised from decision-making and unable to follow through on their preferences (Smebye, Kirkevold and Engedal 2012; Tyrrell, Genin and Myslinski 2006), or if denied opportunities to shape service outcomes as they see fit (Bamford and Bruce 2000). The complexities of making choices in contexts of frailty are also evident during transitions from hospital to home (Walker, Johns and Halliday 2015), where some evidence suggests that services have not always been successful in ensuring they meet clients' personal choices for post-discharge care (Andrews, Manthorpe and Watson 2004), or in promoting their involvement in establishing service preferences (Benten and Spalding 2008).

Second, the rational choice approach focuses on the individual consumer, thus sidestepping the importance of *other actors* in shaping choice-making. An older person's engagement in choosing a care option or setting, for example (Wada 2016), can be influenced by interactions with broader networks of family, friends, and service or medical staff (Eichler and Pfau-Effinger 2010; Fernandez-Carro 2016; Groger 1994; Shawler, Rowles and High 2001). Equally, some evidence shows that making choices in tandem with others can enhance a sense of empowerment, particularly if they can be shared or delegated (Sciegaj, Capitman and Kyriacou 2004; Sixsmith 1986). Also implicit in the idea of rational, individual choice-making is the goal of personal independence, but insights provided from

work on the concepts of autonomy (Collopy 1988, 1995; Hillcoat-Nallétamby 2014) and interdependencies (Rabiee 2013; Shakespeare 2000) suggest that older people will often overtly recognise their need for others in helping them to achieve personal goals, proactively seeking support when exercising choice or decision-making.

Third, this approach does not help us view choice as integral to decision-making, an important distinction to make when developing interventions to facilitate informed and pro-active planning in anticipation of changing health and care needs; this means recognising that choice is not a static or one-off phenomenon, but can be embedded in decision-making processes operating across different *temporal* frameworks. This temporality is already evidenced, for example, when older people progressively renegotiate their engagement in making choices as they adjust across time to a residential transition (Ayalon and Greed 2016; Shawler, Rowles and High 2001); experience changing cognitive capacities (Mitoku and Shimanouchi 2014); express feelings of ambivalence about relocation (Löfqvist *et al.* 2013); or have fluctuating expectations about the likelihood of further moves (Sergeant, Ekerdt and Chapin 2010). Some choices will reflect anticipated change, others will be more spontaneous, conditioned by immediate circumstance (Pope and Kang 2010; Wilson 1997); and in the post-move phase, choice can be subject to re-evaluations about the permanency of relocation, suitability of a living environment (Sergeant and Ekerdt 2008) or the ability to exercise choice once *in situ* (Tracy and DeYoung 2004).

In sum, the premise of this article is that when applied to the phenomenon of individual choice-making in later life, the rational choice approach has several shortcomings which limit its relevance as an explanatory framework; it disregards situations of vulnerability or frailty, understates the confluence of complex human interactions in shaping an older person's ability to engage in choice-making, neglects temporal dimensions, and does not systematically view choice as integral to broader processes of decision-making.

## Methods

### *Study context*

The article draws on data collected from those living in the extra-care setting, as part of a larger study undertaken in Wales (Burholt *et al.* 2011) designed to fill a knowledge gap about the care and service needs of three groups of older individuals who were either receiving care at home in the community, in an extra-care facility or in a residential care-home

setting. All study participants could be considered care ‘consumers’, as they were given the option to receive care services at home or, depending on level of need, to relocate to one of the other two settings. The study involved collection of quantitative and qualitative data, this article drawing on the latter.

### *Sampling, participant recruitment and data collection*

The study population was identified using a purposive sampling technique and was drawn from one rural and one urban county in North and South Wales, respectively, both with extra-care and residential care schemes. Selection of county was not based on characteristics such as bed capacity, as Wales is a small country and anonymity may have otherwise been compromised. A publicly available specialist database of all registered extra-care and residential home schemes was used to identify schemes in the two counties, and their managers were contacted and visited to outline the study and seek approval to carry out interviews with clients. In total, five schemes refused to participate. Once managers had approved the study, information packs and consent forms were sent to all residents. Older people living at home in the community setting receiving care through local authority social services were contacted through care service teams, with care team managers distributing information packs and consent forms to clients through case workers operating in the community, who then facilitated participant recruitment during pre-scheduled home visits. Consent forms were returned directly to the research project team if people agreed to participate.

Final recruitment figures gave a total sample of 183 individuals aged 60–98 (extra-care = 58; residential care = 66; community dwellers = 59), and the research team completed questionnaires during face-to-face interviews with all of them. Due to cost and time constraints, in-depth, face-to-face qualitative interviews were completed with a randomly selected sub-sample of 91 of the initial 183 participants, selected from the three care settings (extra-care  $N = 29$ ; residential  $N = 29$ ; community  $N = 33$ ). For the total sample ( $N = 183$ ), their mean age was 80.3 years, with about one-quarter male (Table 1). A majority were widowed, although marital status varied significantly across the three settings ( $\chi^2 = 20.11$ , degrees of freedom = 5,  $p < 0.005$ ), a difference which can be accounted for because 56 per cent of all married participants were residing at home in the community, 62 per cent of all divorced participants were living in a residential home and 41 per cent of all widowed participants were living in extra-care (Burholt *et al.* 2011). The sub-sample randomly selected for the qualitative interviews ( $N = 91$ ) reflects a similar picture, with those in a married relationship more likely to be living at home in the community (Table 1, numbers in italics).

TABLE 1. *Socio-demographic characteristics of study participants by care setting: total and sub-samples*

	Residential		Extra-care		Community		Total	
	Total sample	Sub-sample	Total sample	Sub-sample	Total sample	Sub-sample	Total sample	Sub-sample
N	66	29	58	29	59	33	183	91
	<i>Percentages</i>							
Male	23	24	29	21	29	30	27	25
Female	77	76	71	79	71	70	73	75
Marital status:**								
Married	9	14	12	17	30	36	17	23
Single	17		12		16		15	
Divorced	25	86	7	83	11	64	15	77
Widowed	49		68		44		53	
Single/divorced/widowed								
Mean age (SD)	82.3 (8.4)	82.0 (7.5)	79.2 (9.8)	81.5 (8.3)	79.0 (9.3)	79.0 (8.9)	80.3 (9.2)	80.8 (9.0)
Mean MMSE (SD)***	19.0 (5.8)		24.5 (4.1)		25.6 (4.2)		22.8 (5.6)	

Notes: SD: standard deviation. Mini-Mental State Examination (MMSE) score ranges: severe (<9), moderate (10–20), mild (21–24).

Source: Adapted from Burholt *et al.* (2011: 15, table 1; 28, table 4).

Significance levels: \*\*  $p < 0.005$ , \*\*\*  $p < 0.001$ .

Quantitative data were collected using a questionnaire comprising nine sections to record validated measures of health-related quality of life, nutrition, activities of daily living, depression/mood, self-reported physical health and cognitive frailty (Mini-Mental State Examination (MMSE); Folstein, Folstein and McHugh 1975), health, satisfaction with life and social networks. Measures of physical ability (timed *get up and go* and grip strength) were also introduced during the interview (for details, see Burholt *et al.* 2011). Qualitative data were collected during face-to-face interviews using a semi-structured guide; sessions were recorded during interviews held in participants' homes or private spaces in the other two settings; these captured participants' subjective experiences and perceptions on core topics about health care, social activities, support networks, perceptions of frailty and disability, and motives and choices for moving where relevant.

The study received University ethics approval and included protocols and training specifications for care team managers and case workers involved in recruitment. Interviewers and care managers received a one-day training course offered by the research team on issues relating to recruitment, confidentiality, consent, safety and maximising participant engagement. As recall of past events was an important aspect of qualitative interviews, training included the use of prompts to help participants relate narratives to specific events (*e.g.* death of a spouse, a fall at home) or chronological sequences (*e.g.* 'How long have you lived here?'; Have your care package or needs changed over time?). Quality and rigour of the data collection process was monitored throughout the fieldwork period through regular team meetings.

#### *'Pathways to choice' of care setting: choice of sub-sample, data analysis, coding and typology*

There are two reasons why this article focuses on narratives from participants in the extra-care setting. Previous analysis of the quantitative data using the MMSE, which is designed to screen for cognitive impairment and includes questions for a dimension on recall, showed significant differences between care settings, but on average, scores for extra-care participants did not indicate cognitive frailty (see Table 1; mean = 24.5, standard deviation = 4.1). This suggests that participants' accounts of their choice-making process were not adversely affected by poor recall. Furthermore, unlike those living at home in the community, these participants will have experienced relocation as part of the decision-making process.

#### *Data analysis*

If a participant's choice of care option had involved relocation they were asked specific questions about the motives and triggers which had prompted



their choice ('What was it that made you decide to come into extra-care/residential care?'; 'Why was it you chose this particular place?'; 'Were the facilities a contributing factor as to why you chose to come here?'; 'How satisfied are you with the choice that you made?'). These responses provided a narrative framework (Patton 2015) for participants to recollect their choice-making trajectories as part of a broader decision-making process evolving across different time periods (Sergeant, Ekerdt and Chapin 2010).

An analytical framework was developed to inform exploration of the qualitative transcripts and subsequent coding process. Analysis focused on the concepts of *engagement* and *temporality* to characterise the process of choice-making (see Figure 1).

The notion of *engagement* reflects the participants' degree of involvement in making choices about the extra-care option, including the role of others in this process; it was elaborated by drawing on work demonstrating the role of different actors (e.g. family, medical or nursing staff) in shaping or exercising control over an older person's relative engagement in the process of choosing, deciding and receiving care in different settings (Eichler and Pfau-Effinger 2010; Rowles and High 1996). The qualitative study of Reed *et al.* (2003) about older people's experiences of relocation between different care-home settings which identified different categories reflecting participant representation of their involvement in relocation decisions (e.g. *preference*, *strategic*, *reluctant* and *passive* relocations) also informed the analysis.

Drawing on *a priori* classifications identified in extant literature about residential behaviour and decision-making (Baumker *et al.* 2012; Shawler, Rowles and High 2001), the concept of *temporality* was elaborated based on the timing and sequencing of single events (e.g. partner dies) identified by participants as triggers for changes to their life circumstances prior to relocation to the extra-care setting. Pro-active coping theory, which examines how individuals prepare in advance for stressful life events such as long-term care needs (Aspinwall and Taylor 1997; Ouwehand, de Ridder and Bensing 2007; Pope and Kang 2010), has also been useful in distinguishing differences in behaviour in terms of *pro-active* (e.g. visiting facilities with a view to moving), *re-active* (e.g. to a given incident such as sudden illness) or *passive* (e.g. reactions based on the influence of a third party) reactions.

### Data coding

A coding framework was developed to capture these concepts, and applied by the author for each transcript starting with a line-by-line, in-case

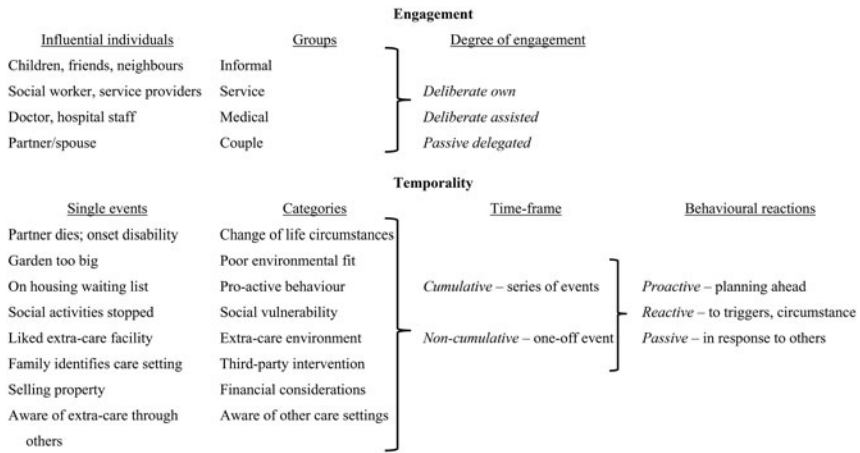


Figure 1. Analytical framework: *engagement* and *temporality*.

approach followed by a process of constant comparison (Strauss and Corbin 1998). NVivo qualitative software was also used, with coding of free (*e.g. sister*) and a series of tree (*e.g. constellation of informal actors*) nodes, and use of the coding stripe function to identify different combinations of the coded categories for the elements of *temporality* and *engagement* within transcripts (Leech and Onwuegbuzie 2011). A quarter of the transcripts were also coded independently by one other researcher and the transcripts were compared to ensure interpretive convergence (Patton 2015). To ensure anonymity, pseudonyms and identity numbers are used for presentation of results.

For *engagement* (see Figure 1, reading from left to right), coding was in two stages. First codes were ascribed to individuals whom participants mentioned had influenced their choices prior to moving to extra-care; these were then grouped as informal (*e.g. neighbours*), service-based (*e.g. social worker*) or medical (*e.g. general practitioner*) actors, with an additional category of ‘couple’ identified to capture dyadic choice-making for those with a partner. The categories provided the basis for higher-order coding, and each participant’s degree of *engagement* in choice-making was coded as either ‘deliberate own/couple’ (overtly recognised choice as their own or that of couple only), ‘deliberate assisted’ (overtly sought third-party support or willingly accepted unsolicited interventions) or ‘passive delegated’ (overt recognition of unsolicited interventions by third party).

For *temporality*, coding first involved identifying single trigger events, and then grouping them into categories (*e.g. partner dies becomes change of*

life circumstances); these were then identified in each transcript in relation to the time-frame used explicitly or implicitly by participants to describe their pre-location experiences, and recoded as part of a *cumulative* (a series of events) or *non-cumulative* (a one-off event) process. In a final phase of coding, participants' behavioural reactions to the process of choice-making was distinguished as *proactive* (taking concerted measures to plan ahead), *reactive* (responding to an event or circumstance) or *passive* (reacting in response to a third-party intervention).

The typology of different 'pathways to choice' (Figure 2) emerged as part of an inductive process once coding was completed for each transcript, and the different combinations of the elements of *engagement* and *temporality* identified within, and then across, all transcripts.

## Results

### *Interpretive framework: participant engagement and temporal context*

The interpretive framework (Figure 2) represents both the different elements of *engagement* and *temporality* identified in the narratives, and their combinations within them (Types of pathway). Taking each element separately, findings show that each participant's degree of *engagement* in choice-making varies significantly. Some have made their own choice, exercising individual agency and purposive intent independently of others (*choice deliberate own*), or within the confines of the couple (*choice deliberate couple*); conversely, some, as either individuals or couples, have clearly identified themselves as choosers and deciders, but have also willingly accepted interventions from others, with positive and empowering effects (*choice deliberate own (couple)/assisted*); and a third group have spoken of the unsolicited intervention of others, acknowledging their submission to these as a disempowering influence (*choice passive delegated*).

For the temporal context in which choice operates, interpretation of each transcript shows that it has crystallised across different time-frames as part of broader decision-making processes; some participants have made choices quickly in response to one-off events (*non-cumulative*), others only once a sequence of events have occurred (*cumulative*). They have also reacted differently to these events as *pro-active*, and/or *re-active* or *passive* choice-makers.

### *Typology*

The different combinations of the elements of *engagement* and *temporality* enabled the identification of six different types of 'pathway' which had characterised participants' choice-making journeys.

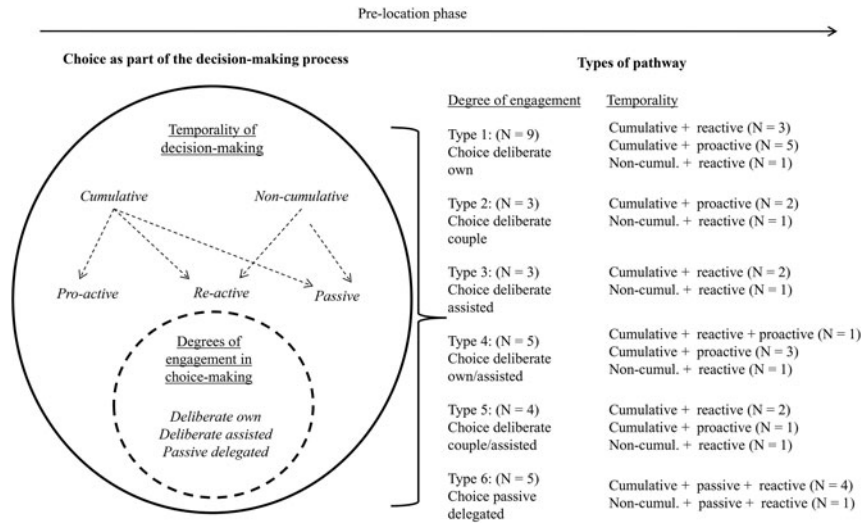


Figure 2. Interpretive framework and typology: ‘pathways to choice’ of care setting.  
*Note.* non-cumul: non-cumulative.

Overall, 12 had embarked on a pathway without the intervention of a third party other than a partner (Figure 2: degree of *engagement* Types 1 and 2); another 12 had been willingly influenced by a third party (Types 3, 4 and 5) and five had succumbed passively to others (Type 6).

There was, however, much greater variation within these six pathways in terms of the temporal context in which participants’ choices evolved and crystallised, with each pathway encompassing two or three different decision-making processes and reactions; *e.g.* whilst 12 had made their own choices (Type 1), some had done so as a result of experiencing a history of cumulative events to which they responded *reactively* or *pro-actively*, whilst others amongst this group had set themselves in motion quickly but only in reaction to an external event. Others were *passive* actors, responding in reaction to a third party, either because of a one-off event or through a more complex history over time (*e.g.* Type 6).

In sum, the typology serves to demonstrate that participants’ choice pathways are both complex and diverse, but with more variation in terms of their temporal context than the nature of their engagement.

The final section provides detailed examples and analysis of the different ‘pathways’ identified, using thick interview extracts.

## Pathways to choice

### Type 1

For this first pathway, participants had engaged in making their own choice of care setting, without the intervention of others.

*Deliberate own, cumulative and reactive.* Mrs H-P, aged 84, is a widow and has a son and daughter. Prior to moving to extra-care, her life circumstances had changed progressively with time – she had experienced ill-health and widowhood which precipitated an initial relocation, and subsequent shrinking social networks which engendered a sense of loneliness and isolation:

Mrs H-P: I went to see my friend Nancy [in an extra-care setting] and I couldn't get over it. And I really love it here.

Interviewer: Why did you move from your own home to here?

Mrs H-P: I have got and I'm a diabetic ... we used to have a farm ... when my husband was alive and when he died I moved to Blackwood and I bought a house and it was all lovely for a few years. Then gradually my friends were dying, one moved away ... and we always used to go out on a Saturday, the four of us ... to a pub, and have a meal and have a good old chat. That's all stopped ... And all the things I was in finished. I was in WI [Women's Institute], that packed in. I was in Arthritis Care ... that packed in. I was in CRUSE, you know for bereavement ... that packed in – everything. Gradually we were all getting older and we didn't like going out in the nights. And then I was sat in the house then for quite a long time ... well I missed all that.

When asked about her reasons for being satisfied with her life in the extra-care setting, Mrs H-B responds:

I came in November the 15th and that week there was concerts. They'd come from Blackwood Operatic and there was a choir ... And then the children came they had from the schools. I said 'Oh this is lovely.' And what I couldn't get over was how caring the carers are that come round ... I've never known nothing like it. I took to it straight away. And quite a few people said 'Well we think you've been here years.' And I'd only been here about two months. Because I wanted to come here see, I think that's what it is. And I really like it here.

Mrs H-B's pathway was shaped by an accumulation of events, her choice of care option precipitated by, and in reaction to, an unanticipated visit to the care setting. The choice was clearly her own, as illustrated by her enthusiasm about her life in extra-care.

*Deliberate own, cumulative and pro-active.* Ms. R, divorced, aged 85, had fallen whilst living alone in a flat, and although she initially gave this as her primary reason for contemplating a move, she also hints at her wish to remain independent of her daughter:

I'd had a number of very bad falls ... I was in a flat. My daughter had to take care of me when I fell you see and let's face it when you get older and I think your children are a bit apprehensive about it as well ... sometimes there's a bit of a battle going on when I tell them I'm all right.

However, she had been anticipating the need to choose a care setting for some time:

I'd been in touch with Clwydil and Alynon [residential homes] before because I wanted a place for the elderly ... but I wasn't successful. So I put my name down for this place before it was due to be opened and then somebody came to interview me.

She had deliberated her choice of care setting with financial concerns in mind:

What they were offering here well, I thought I'd be better off, and then I thought that I had to look at the financial situation of it all and I told them I wouldn't consider anything above a certain amount.

From a temporal perspective, Ms. R engaged in a cumulative, but also proactive decision-making process through her search for a supported living environment, punctuated by a series of falls, all of which crystallised over time, to end with her decision to move to extra-care. Her choice was deliberate and her own, with no evidence of third-party interactions or interventions to influence this.

*Deliberate own, non-cumulative and reactive.* Mrs T, widowed, aged 84, responded to an impromptu invitation to visit an extra-care facility; this triggered her rapid decision to move there, and she immediately undertook the sale of her home. Her choice was deliberate, and throughout her narrative of the relocation process, she did not indicate any evidence of previous planning, nor intervention of others in her relocation trajectory:

Well we [friend] got an invitation, I don't know why but we did ... [so] we decided we'd come. So I took all the papers home with me and spent all the evening reading and I thought to myself, 'I'd be better off there than I am here' you know. So the next day we came back and said that I wanted to come here and called the house people Peter Large [housing agents] and that was it. It only took me – well it was over Christmas so it was about ten days I think to sell.

### *Type 2*

The second pathway identified from the narratives included those whose choice and decision-making had evolved within the context of the couple dyad.

*Deliberate couple, cumulative and proactive.* Mrs J-R, aged 78, was married and living with her husband. The couple had no children. She had had

health problems over a period of time and their previous house required maintenance which the couple recognised would become increasingly challenging with time. Prior to moving, they were also dependent on being able to drive to access local services:

We lived in a bungalow out of town and I'd had quite a lot of illness. We got quite a bit of garden fencing and goodness knows what. And we thought 'Oh blooming heck, it's going to be a hard job.' I had by-pass surgery so I was out of action for quite a long time. Also with living out of the town we were using the car all the time. So anyway we saw these advertised because I'd always said 'I'm never living in a flat'.

Against this backdrop of events, and with a view to their future needs, the couple visited the extra-care facility and immediately took the decision to relocate:

So we came and went to the launch, and that summed it all up, and decided then and there that we'd come. And basically ... I mean they're lovely flats.

The couple's choice of care setting was deliberate and their own, their decision-making having evolved in response to long-term changes to life and health circumstances, the choice of care setting reflecting anticipation of changes to come.

*Deliberate couple, non-cumulative and reactive.* A widow, Mr Q's narrative encompasses the time when his wife was still alive. The couple had visited an extra-care setting, prompted by a neighbour who had made them aware of the facility:

We were in the council bungalow and we hadn't thought any further than that. Apart from what you always think ... 'I suppose I'll be in a nursing home sometime.' We had no intention of thinking about anything but my neighbour across the road ... his son was one of the architects for this place. They came to see us one day and told me just what it is all about and to come up and have a look. Well I arranged to come up and have a look round. Literally fell in love with the place straight away, my wife and I.

From a temporal perspective, the couple's choice of care setting was clearly purposive and their own, and embedded in a non-cumulative and reactive decision-making process, a visit to the care setting acting as the trigger for their rapid residential relocation.

### *Type 3*

For those on this pathway, their choice had been assisted by others, but was nonetheless their own.

*Deliberate assisted, cumulative and reactive.* Ms J had been living with her mother, and both had experienced a series of health-related events:

We were down in Doliogh and I was in and out of hospital like a yoyo and Mother was alive then. So the social worker said to us ‘This is the place to be’ because there were carers to look after Mother you see ... We [with social worker] came, and I had a look at it first. And it looked very good I liked it. And about five or six months after I got up here I got TB [tuberculosis], and had to go into hospital, so it’s a good job we were here because there was somebody to look after Mother.

Ms J’s choice of care setting was deliberate and her own, but nonetheless assisted by, and in reaction to, her social worker’s interventions. From a temporal perspective, it had been part of a cumulative decision-making process, shaped by health problems and crystallised by a visit to the extra-care facility.

*Deliberate assisted, non-cumulative and reactive.* Mrs Z, aged 87 and widowed, moved to extra-care following hospitalisation:

- Mrs Z: I was in hospital for 15 months, I only used to live across the road. There was a place going here so we took it, my daughters and I.  
 Interviewer: So it was a discussion between yourself and your daughters?  
 Mrs Z: Yeah.  
 Interviewer: And what was the main reason for you coming here then?  
 Mrs Z: Because I knew the area.  
 Interviewer: And what was the main reason for you coming into an extra-care scheme rather than going back to your old home?  
 Mrs Z: Well, they [medical staff] thought that I wouldn’t cope, and I couldn’t cope actually.

Mrs Z’s choice of care setting was her own, but with her daughters facilitating the relocation process and medical staff influencing her decision not to return home. Her choice was also influenced by familiarity with the local community and was taken rapidly, as part of a temporal context shaped by her reaction to a one-off event, hospitalisation.

#### *Type 4*

Along this journey, participants’ choice-making was the product of self-determination, coupled with assistance from others.

*Deliberate own/assisted, cumulative, reactive and proactive.* Mrs S, aged 83, was widowed with no children. When asked why she had decided to come to extra-care, she demonstrates awareness of her social and financial vulnerability as someone with no children and limited financial resources. She had also experienced a series of falls and other health problems:

I came here because I was living in the bungalow, I had no children, my weekly income coming in is limited, I don’t get a pension in my own right. My husband’s pension was very low ... I fell in the garden ... I got over that and I thought ‘You



silly thing Mary, you are losing yourself falling in the garden' ... and then it happened again and I put it down to rushing to answer the doorbell.

Mrs S's niece played a decisive role in her choice of care setting and decision to relocate:

Just after that I had septic toenail, and the doctor came up and also my niece visited. She said 'Aunty Mary I don't know what you are struggling here for, why don't you see if you can get into Cefn Glas?' Well I applied, there was no room. So I carried on and then she came again and she got in touch with the local authorities and they said that there was a one-bedroom apartment if I would like to take it. They came over to see me and I thought 'Well I am not going to hesitate this time', so I put the bungalow up for sale with my niece's help, I didn't put anything up ... she went to see a solicitor, everything.

Mrs S's relocation to extra-care was in fact the result of a much longer history of trying to find alternative accommodation; prior to being widowed, the couple had proactively sought to find a supported care setting, without success:

My husband and I had been visiting one or two local authority homes. I went into one and quite frankly I wanted to come out straight away ... Then we went to see another place which wasn't too bad really ... but I'm afraid at that moment I didn't like it.

In this instance, the choice of care setting has been deliberate, albeit in reaction to, and aided by the intervention of a family member, which has crystallised a latent intention to move, against a context of progressive and cumulative changes to physical wellbeing. As a temporal phenomenon, it was nonetheless part of a more complex decision-making process where seemingly immediate decisions nonetheless reflect longer-term efforts to relocate.

*Deliberate own/assisted, cumulative and pro-active.* Mrs R-A, aged 85, widowed, had a son. Recognising the impact that driving cessation and widowhood had had on her life at home, she made a deliberate decision to seek alternative accommodation, and sought support from her son to carry through on her decision:

I was living in a house in Glan Conwy and ... I stopped driving. I'd passed 80 and I felt the time had come when I shouldn't be driving any longer. But I wasn't on a bus route and I was out of the village ... and I became isolated. And I stayed on for a bit after my husband died ... And then I decided I'd need to move and so my ... I've got a son living in Abergele, and he said 'Well we'll have a look round. Where would you like to live?' 'I thought I'd like to live on Rhys-on-Sea ... And what he [son] was particularly keen on was that I had ... there was around-the-clock care. And so we came and had a look here and we both liked it and we said 'Are there any apartments for sale?' And as it happened there was. And this was one of them that we viewed. And this was the one that I preferred of the three we saw.

Mrs R-A's choice of care setting reflected a personal preference for a seaside location, albeit tempered by her son's concern for there to be care support in place, with her final choice reflecting mutual agreement. Her pathway therefore combines elements of individual and mutual choice, set against a decision-making process, which although initiated by Mrs R-A, was nonetheless shaped by support from a family member. Events had a cumulative effect but were taken as the basis for reasoned and proactive, rather than precipitated decision-making.

*Deliberate own/assisted, non-cumulative and reactive.* Mrs H, a widow aged 75, experienced a severe and unprecedented diabetic attack whilst with her family, and this incident triggered change, with family members advising she could no longer live alone:

We'd all gone out for a meal all the family – my 75th birthday ... and I had a very big hypo [hypoglycaemic episode]. I'd never had one like that in my life. I just went completely out, about three-quarters of an hour. They all helped me you know ... but they said: 'You can't stay on your own now'.

Mrs H's daughter subsequently suggested her mother visit an extra-care facility she had identified and helped her in this process:

My daughter had seen these flats ... And she said 'Why don't you just try it Mum. Just go and have a look.' And we looked at about four or five flats. I deliberately chose this one because it gives me a bit of exercise walking up and down the corridor when I'm going to lunch and things like that. The family helped me move in.

Mrs H's engagement in the choice of care setting was mediated and empowered by family members, notably her daughter, although she made a deliberate choice in selecting the particular flat she wanted. Her choice was set in a temporal context of rapid and reactive behaviour, triggered by a discrete event.

### *Type 5*

For participants on this pathway, choice-making was the product of negotiation at the level of the couple, combined with assistance from others.

*Deliberate couple/assisted, cumulative and reactive.* Mrs S-N was 61 and married. The couple's decision to move was shaped by longstanding illness, third-party intervention, the poor environmental-fit of their own home and lack of alternative accommodation, as they had previously been placed on a waiting list for specialist accommodation, but this had fallen through:

We were living in a very, very small bungalow about the size of this lounge and kitchen combined and in that there was a living room and a bedroom. My husband who is a wheelchair user couldn't get in and out of any of the doors because they were too narrow ... In a way, we thought that we were going to be staying in the little bungalow until we both died. Then the social worker said: 'Have you thought of the new extra-care apartments on the Prom?' My immediate reaction was: 'I don't want to live in the West End.' And she said, 'Well come and have a look anyway.' Brian was quite happy to come and have a look. I was sort of 'mmmhh'. But as soon as you walk in and you see what's on offer, you sort of think 'Wow, this is not the West End of Rhioch!' So it was just a case of come in, have a look round – 'Do we want to move here? Yes, do we ever!'

In this instance, the couple's engagement in choosing the care setting had been facilitated by others, but crystallised as a deliberate choice of their own; it was part of a cumulative process, although their move was finally unanticipated and reactive – to the social worker's intervention and visit to the facility.

*Deliberate couple/assisted, cumulative and pro-active.* When interviewed, Mrs I, aged 86, was widowed, but her choice of care setting had initially been made whilst her husband was alive. Both had had multiple health problems over a period of time and Mr I had been admitted to a care home when his wife was ill and unable to cope at home:

My husband was alive then and he'd been in and out of hospital, he had a stroke, he had Menières' disease ... he was getting chest infections. In the end he couldn't walk. So we were in a three-bedroom house, and I had to go into hospital to have a big operation, so it meant I had to get him into respite care. While I was in hospital he contracted a chest infection. So during that time he came out of hospital and they put him in a care home. Social services came to see me while I was in hospital and they said, 'Well you're alright to go home, but your husband, no because you can't manage him', which I couldn't ... so he had to stay in a care home.

Prior to these problems, the couple had already anticipated the need to move into supported accommodation:

They came to see us [social services] and they said that these places (extra-care) were being built and would we like our name to go on the list ... And my husband said, 'Well we'll think about it.' So my husband and I thought about it, he said, 'Well it's not a bad idea love, you never know when we might need help.' So I said, 'Oh fair enough' so when they rung up I said, 'Yes put our name on the list.' Well our name was on the list for six years ... they came to see me whilst my husband was in care and they said, 'What do you think about a flat out here?' So I thought, 'Well it's not a bad idea.' so I said, 'Yes.' So we came out and had a look at the flats. And we sat down talking in the lounge, with the carers. And they said, 'You know your husband can come here with you.' Of course that clinched it didn't it.

This couple's story illustrates a complex decision-making process which had evolved over a long period of time, influenced by the cumulative effect of

progressive and sudden illness and the lack of appropriate specialist housing available when required. They had engaged pro-actively in this process, having previously anticipated a need to move. Finally, their deliberate choice of care setting evolved into an individual one for Mrs I, and was assisted by social services and care providers.

*Deliberate couple/assisted, non-cumulative and reactive.* Mr C, aged 70, was living in extra-care with his wife and they had a son and daughter. When asked how they had made the decision to move to extra-care, Mr C explains:

Family, as I said, I've got a son and a daughter who live in the area ... And they said it would suit us and suit them because they could keep an eye on us nearer without them travelling 60 miles every while, so it suited them. And I'm glad we made the move because I find it very convenient. You walk across our garden go through the far gate and you're in the town ... so we've got Tesco and we've got Somerfield [supermarket] just down the road.

For this couple, their children had played a decisive role in the choice of care setting, although their story does not suggest that they had engaged in this choice unwillingly. From a temporal perspective, during interview the couple had not alluded to any events or circumstances leading to their decision to move; their choice was therefore the result of a non-cumulative and reactive process.

### *Type 6*

For participants who had embarked on this pathway, their engagement in choice-making had been marginal, and subject to the disempowering influence of others.

*Passive delegated, cumulative, passive and reactive.* Following consecutive illnesses, Mr L, aged 88, underwent a series of moves from home, involving admission to residential and hospital settings, before moving to the extra-care setting:

They cleared that up [ulcerated leg] and then, I was in Newtown nursing home ... they put me there and I couldn't stop in there forever because the rooms were upstairs and although there was a lift to take me up, I was scared stiff of that ... Then they decided they would put me in ... it's a religious place. Then one morning ... I thought cor my leg's cold, and from my foot, all up to there, it was absolutely white like marble. The doctor gave me some tablets and then I ended up in hospital. He [consultant] came and had a look and said, 'Well I'm afraid we can't do anything with that. We're going to have to amputate.'

The actual decision to move Mr L into extra-care was taken by medical staff during his stay in hospital:

They did the operation and I was in there for weeks and weeks and they were trying to find somewhere for me to go. Mr Harris came round and said 'Look, you're not to worry, you will stay here until I have found somewhere that I think is suitable for you.' Well I didn't have any expectations. Because I had no choice, I thought to myself 'I'll just go where they push me.'

Mr L's story portrays a passive and disempowered actor both in terms of the choice of care setting and the decision-making process in which it emerged, instead delegating his authority to medical staff.

*Passive delegated, non-cumulative, passive and reactive.* Mrs B, aged 79, was at first quite hostile to the idea of visiting an extra-care facility, the initial decision to move her from her own home having been initiated by family members:

My son and his wife, they were very concerned about me. They said that I wasn't looking after myself. I wasn't eating carefully enough. Ian [son] wrote to me and he said 'Come to the Open Day' and I said 'No I didn't want to come here.' And they said 'Well why?' ... But anyway time went on about six weeks, and Ian said to me 'Mum I'm worried about you, you're not responding to a lot of conversation lately and you seem to be losing the art of speech.' So I said, 'Well I can't see what the joy is ... if I'm going to have a flat of my own, I'll be isolated again won't I?' So he said, 'Not really because there's lots of things happening there that will keep you on your toes.' So I came.

Despite her initial resistance, she eventually conceded to her son's wishes:

He [son] wrote again and said this flat went vacant. And so they said 'Come and have a look at the flat.' So I came and had a look at the flat and I thought 'Well it's not as much to do as the three-bedroom house down there.' So I said 'Okay.'

For Mrs B, the decision-making process occurred over a short period of time, in reaction to the initiatives and instance of her son. Her choice of care setting was passive as she did not play any active part in selecting the particular care environment, and her initial unwillingness to move there was finally subjugated to her family's wishes.

## **Discussion**

This article has elaborated an interpretive framework of the pathways that older people have embarked upon in choosing a care option by relocating to an extra-care setting. The broader aim has been to encourage critical reflection about the limitations of the rational choice approach in explaining individual preferences for health and social care provisions, and to challenge the assumption of a linear, homogenous choice-making process in favour of one which reflects the heterogeneity of these journeys as part of

complex and temporally defined ‘pathways’. The typology which has emerged has provided some clear responses to the question posed at the outset. Choosing a care option is a complex and diverse, rather than linear and uni-dimensional social phenomenon. These variations spring from the different ways in which participants have engaged in making choices purposively by themselves or with a partner, by sharing them with others, or as passive, and at times even coerced, actors. More complicated are the time-frames within which these processes have evolved, and the different reactions participants have had to the events shaping their choices. When combined, these elements of *temporality* and *engagement* enable us to generate a rich picture of the diversity of pathways involved in choosing a care setting in later life.

The narratives provided by older participants tell a story about how their *engagement* on these ‘pathways’ has been in response to specific events – well-recognised ‘push–pull’ factors such as bereavement or home maintenance, or a lack of suitably adapted accommodation to match and ‘fit’ changing physical, social and cognitive circumstances. In line with a rational choice approach, some participants do appear to have acted as atomistic agents, exercising choice purposively, wilfully and independently of others. But findings go beyond these explanations to demonstrate how participants’ ‘pathways’ have also evolved under the influence of others who have shaped opportunities for them to exercise autonomy about how, when and which choices they make about a future care setting.

A premise of the rational choice approach is that individuals are driven in their preferences by self-interest (Wittek, Snijders and Nee 2013), although critics (Gächter 2013) have argued for a rationality of social preferences where outcomes of social interactions can be based on consideration of others. Mrs I and Ms J’s stories illustrate this well in the adult child–parent and couple dyad context, and align with residential decision-making research (Sergeant and Ekerdt 2008) which demonstrates that individual agency to choose according to personal preference is modulated through social interactions with and consideration for others. This article also shows the differential effect these social interactions can have in modulating individual *engagement* and empowering individuals to make choices (Groger 1994; Johnson, Popejoy and Radina 2010; Reed *et al.* 2003). Mrs H, for example, was empowered by her daughter’s interventions, but Mr L’s ability to choose his care setting was seriously eroded by medical staff, and in Mrs B’s case, her autonomy was subjugated to match her son’s preferences. Delegation of choice-making in this instance cannot, as suggested by Collopy (1988: 12), ‘be recognised as a valid form of autonomy’ which positions older people as ‘agents and active participants ... as authorizers of the circumstances and processes of care’.

These individuals have also influenced participants' level of engagement in exercising *decisional* (making decisions without external coercion or restraint) and *executorial* (freedom to act on decisions and carry out personal choices) autonomy (Collopy 1988, 1995). Although Mrs S-N and spouse were prompted into action by a social worker, this intervention nonetheless empowered them to exercise *decisional* autonomy; and Mrs H was able to execute her decision to move, through practical help from her family. As suggested by pro-active coping theory, in some instances these individuals have acted as buffers in situations of stress (Aspinwall and Taylor 1997), as facilitators of 'effective choice' (Brown and King 2005) or 'choice editors', channelling information and aiding appraisal processes (Glendinning 2008). Mr Q's neighbours effectively acted as vectors of information, indirectly empowering the couple to make an informed choice. In Mrs S's case, her niece's intervention enabled her to delegate the practical aspects of the sale of her property as part of the relocation process to extra-care.

In sum, findings suggest that atomistic agency in choice-making does not always operate to the exclusion of transactional relations between the older care consumer and others. Regardless of which end of the autonomy spectrum we situate choice, other people can shape an individual's engagement in this process by empowering them, or conversely, by imposing bounded choices (Mulder 1996). In this regard, Collopy's (1988: 10) general contention that 'an autonomous person is not a lone, isolated, atomistic agent making decisions without ties to other people, social institutions and traditions of thought and action' holds true.

From a temporal perspective, these exploratory findings show that participants have made choices, and reacted differently to events and triggers along the way, as part of broader decision-making processes evolving over varying time-frames. Some 'pathways' involve complex temporalities, reflecting the interplay of cumulative events, interspersed with reactive and/or pro-active behaviour, others passivity, as Mr L's narrative illustrates. Findings on the reactive temporalities align with Collopy's (1988) concept of *immediate* autonomy (freedom in a specific, limited sphere of choice and behaviour), the pro-active temporalities with his *long-range* autonomy (future freedom) and with Reed *et al.*'s (2003) *strategic*, and Speare and Meyer's (1988) *anticipatory* moves, where relocation represents overt attempts to respond to actual or anticipated change. Mrs T, for example, had taken anticipatory action by selling her home and moving to extra-care, her future care needs in mind. Conversely, as pro-active coping theory also suggests, some individuals will not prepare in advance for stressful life events, but will react only once they have occurred (Ouweland, de Ridder and Bensing 2006), whilst others will engage in pro-active coping

strategies in advance of change with the intent of preventing or modifying a stressful event once it occurs (Aspinwall and Taylor 1997). Applying this theory to later-life residential decision-making, Pope and Kang (2010) distinguished moving as a response to an imminent need for relocation, albeit in the absence of crisis. More fundamentally, where participants' reactions have been *reactive* or *passive*, arguably full rationality has not been in operation (Gachter 2013), and is better explained through the notion of *bounded* or *weak rationality*, where individuals do not possess, or are unable to process necessary information to maximise their decision-making (Wittek, Snijders and Nee 2013).

The framework elaborated in this article has therefore highlighted the relevance of introducing a temporal, processual element to gerontological research focusing on choice-making about care options, particularly when they involve a transition and relocation to another living environment, as is the case with extra-care. This aligns with recent research emphasising the temporal nature of residential decision-making. For example, Granbom *et al.* (2014) have elaborated the concept of *residential reasoning* on the basis that thoughts about ageing in place and relocation are inter-linked and evolve across time, notably in anticipation of increased vulnerability in the fourth age (Koss and Ekerdt 2016). Cutchin's (2001, 2003) concept of *place integration* recognises that ageing in place in the context of relocation to an assisted living environment, will be a process which reflects the older person's personal history, a sense of place, as well as uncertainty about the future. This body of work has yet to make the link between individual choice-making and relocation, but it does suggest the need for more dynamic frameworks which see these phenomena as interlinked.

The significance of these findings in relation to the current policy and service ethos of promoting consumer choice for social and health care in the UK are two-fold. First, they add weight to the work of other scholars who argue for more critical reflection about the complex processes, circumstances and actors shaping older people's choices and decision-making as consumers of health and social care (Means 2012; Moffatt *et al.* 2012; Ottmann, Allen and Feldman 2013; Rabiee and Glendinning 2014). Second, they suggest that the individualistic reasoning underpinning the rational choice approach can be questioned, to accommodate a more nuanced one which recognises the co-existence of interdependency, autonomy and individual agency as part of the choice-making phenomenon. Some of the pathways identified demonstrate participants' ability to delegate, share and/or accept assistance with choice-making. This contrasts with the contemporary policy emphasis on the individual and on promoting independence, and points to the importance of recognising that interactions with others will, in some instances, temper individual agency when it



comes to exercising consumer choice, albeit for 'better or for worse'. Furthermore, findings suggest that choice-making needs to be conceptualised as more than a one-off event or part of a logically sequenced set of events, but as integral to diverse and often complex, time-bound decision-making processes; arguably more so in later life than in other phases of the lifecourse, if changes to the stabilising effect of adequate social networks, economic and personal health resources happen unexpectedly, or if anticipated, lead to pro-active planning over time.

For practice, there are three things the article highlights. First, by recognising choice-making as a time-bound phenomenon, there will be key intervention points appearing on these pathways – widowhood, registering on a housing list, falls – which, if recorded, can act as pointers for more personalised interventions in the form of targeted information, advice and practical support to facilitate consumer choice. Second, focusing service delivery on older citizens as individuals can provide a distorted, and potentially ineffective lens through which to assess preference with regard to choice of care option. Mapping out the networks of actors who shape older people's choices and intervene at crucial moments in this process – as part of a personal care plan, for example – could provide a more effective platform from which to identify individual service requirements in line with consumer preferences. Lastly, findings also reflect the old adage 'seeing is believing'; for several participants, their final choice of extra-care setting and decision to move there were based on exposure to the care setting through visits to residents, invitations to open days, recommendations from a third party or chance encounters. In situations where there is a mismatch between a person and their living environment, but attachment to place dominates choice-making, and potentially stymies thoughts about relocation, then contact with those who have made the transition to a care setting such as an extra-care facility may be a further mechanism through which to shape the process, in both empowering and forward-looking ways, by providing insights, information and peer learning opportunities. Here, service providers themselves could play a more active role in facilitating choice by investing further in opportunities to 'open up' such settings to the wider community.

## **Conclusion**

This article has contributed to critical theorising by offering an exploratory interpretive framework which challenges the rational choice approach by recognising individual choice-making about later-life care options as a dynamic, interactive and time-bound social phenomenon. In sum, and in answer to the question the article set out to examine, these exploratory

findings definitely suggest that older people's choice of care option does reflect a more complex and diverse social phenomenon than a rational choice perspective might otherwise suggest.

Findings should be considered in light of certain shortcomings; factors shaping the supply of alternative care settings have not been considered; older participants' recollections of events and circumstance leading to their transition to different care settings may be incomplete; and the 'pathways to choice' framework and its component typology will require further validation with participants who have made choices about other care options. To empower older consumers as choice makers, intervention strategies must recognise and accommodate the influence of others, and facilitate pro-active planning for future care requirements by acknowledging time as a crucial factor.

### Acknowledgements

Data are from the project 'Extra-care: Meeting the Needs of Fit or Frail Older People?' completed at Swansea University, UK. The author was a co-applicant and project research team member. This work was supported by the Welsh Assembly Government, Social Care Research Award, Wales, UK (RFSC07-3-012). Financial sponsors played no role in the design, execution, analysis or interpretation of data or writing of the study. All aspects of the article (including scientific development, data analysis and writing) have been undertaken by the sole author. The article does not represent any conflict of interest.

### NOTES

- 1 In the UK context, extra-care facilities are usually purpose-built housing schemes offering self-contained, private living accommodation, with access to communal facilities and services, with low-level care and support from staff present 24 hours a day, and the option of purchasing additional person-centred services such as domestic or personal care help.
- 2 Residential care homes in the UK are normally communal facilities, with individual or shared rooms, and which meet residents' cognitive, physical and medical needs, although not intense nursing care requirements.

### References

- Andersson, K. and Kvist, E. 2014. The neoliberal turn and the marketization of care: the transformation of eldercare in Sweden. *European Journal of Women's Studies*, **22**, 3, 274–87.
- Andrews, J.-A., Manthorpe, J. and Watson, R. 2004. Involving older people in intermediate care. *Journal of Advanced Nursing*, **46**, 3, 303–10.
- Aspinwall, L. G. and Taylor, S. E. 1997. A stitch in time: self-regulation and proactive coping. *Psychological Bulletin*, **121**, 3, 417–36.

- Ayalon, L. and Greed, O. 2016. A typology of new residents' adjustment to continuing care retirement communities. *The Gerontologist*, **56**, 4, 641–50.
- Bamford, C. and Bruce, E. 2000. Defining the outcomes of community care: the perspectives of older people with dementia and their carers. *Ageing & Society*, **20**, 5, 543–70.
- Baumker, T., Callaghan, L., Darton, R., Holder, J., Netten, A. and Towers, A.-M. 2012. Deciding to move into extra care housing: residents' views. *Ageing & Society*, **32**, 7, 1215–45.
- Benten, J. and Spalding, N. 2008. Intermediate care: what are service users' experiences of rehabilitation? *Quality in Ageing and Older Adults*, **9**, 3, 4–14.
- Brecht, S. B., Fein, S. and Hollinger-Smith, L. 2009. Preparing for the future: trends in continuing care retirement communities. *Senior Housing and Care Journal*, **16**, 1, 47–62.
- Brown, T. and King, P. 2005. The power to choose: effective choice and housing policy. *European Journal of Housing Policy*, **5**, 1, 59–75.
- Burholt, V., Nash, P., Doheny, S., Dobbs, C., Phillips, C., Phillips, J., Marston, H., Hillcoat-Nallétamby, S., Evans, S. and O'Mahoney, S. 2011. *Extracare: Meeting the Needs of Fit or Frail Older People?* Centre for Innovative Ageing, Swansea University, Swansea, UK.
- Carder, P. C. and Hernandez, M. 2004. Consumer discourse in assisted living. *Journals of Gerontology: Psychological Sciences and Social Sciences*, **59B**, 2, S58–67.
- Clarke, J., Newman, J., Smith, N., Vidler, E. and Westmarland, L. 2007. *Creating Citizen-consumers. Changing Publics and Changing Public Services*. Sage, London.
- Collopy, B. J. 1988. Autonomy in long term care: some crucial distinctions. *The Gerontologist*, **28**, supplement, 10–17.
- Collopy, B. J. 1995. Power, paternalism and the ambiguities of autonomy. In Gamroth, L. M., Semradek, J. and Torquist, E. M. (eds), *Enhancing Autonomy in Long-term Care. Concepts and Strategies*. Springer, New York, 3–14.
- Cutchin, M. P. 2001. Deweyan integration: moving beyond place attachment in elderly migration theory. *International Journal of Aging and Human Development*, **52**, 1, 29–44.
- Cutchin, M. P. 2003. The process of mediated aging-in-place: a theoretically and empirically based model. *Social Science & Medicine*, **57**, 6, 1077–90.
- Department of Health 2016a. *Factsheet 4: Personalising Care and Support Planning* (updated). Available online at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/268681/Factsheet\\_4\\_update.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268681/Factsheet_4_update.pdf) [Accessed 23 February 2017].
- Department of Health 2016b. *Guidance. Adult Social Care Market Shaping*. Available online at <https://www.gov.uk/government/publications/adult-social-care-market-shaping/adult-social-care-market-shaping> [Accessed 23 February 2017].
- Drought, T. S. and Koenig, B. A. 2002. 'Choice' in end-of-life decision making: researching fact or fiction? *The Gerontologist*, **42**, supplement 3, 114–28.
- Eichler, M. and Pfau-Effinger, B. 2010. The 'consumer principle' in the care of elderly people: free choice and actual choice in the German welfare state. In Greve, B. (ed.), *Choice. Challenges and Perspectives for the European Welfare States*. Wiley Blackwell, Chichester, UK, 78–93.
- Elster, J. (ed.) 1986. *Rational Choice*. Blackwell, Oxford.
- Fernandez-Carro, C. 2016. Ageing at home, co-residence or institutionalisation? Preferred care and residential arrangements of older adults in Spain. *Ageing & Society*, **36**, 3, 586–612.
- Fine, M. D. 2013. Individualising care. The transformation of personal support in old age. *Ageing & Society*, **33**, 3, 421–36.

- Folstein, M. F., Folstein, S. E. and McHugh, P. R. 1975. 'Mini-mental state'. A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, **12**, 3, 189–98.
- Gächter, S. 2013. Rationality, social preferences and strategic decision-making from a behavioral economics perspective. In Wittek, R., Snijders, T. and Nee, V. (eds), *Handbook of Rational Choice Social Research*. Stanford Social Sciences, Palo Alto, California, 33–71.
- Glendinning, C. 2008. Increasing choice and control for older and disabled people: a critical review of new developments in England. *Social Policy & Administration*, **42**, 5, 451–69.
- Granbom, M., Himmelsbach, I., Haak, M., Lofqvist, C., Oswald, F. and Iwarsson, S. 2014. Residential normalcy and environmental experiences of very old people: changes in residential reasoning over time. *Journal of Aging Studies*, **29**, 6, 9–19.
- Greve, B. (ed.) 2010. *Choice: Challenges and Perspectives for the European Welfare States*. Wiley-Blackwell, London.
- Groger, L. 1994. Decision as process: a conceptual model of black elders' nursing home placement. *Journal of Aging Studies*, **8**, 1, 77–94.
- Harper, R., Randall, D. and Sharrock, W. 2015. *Choice. The Sciences of Reason in the 21st Century: A Critical Assessment*. Polity Press, London.
- Hillcoat-Nallétamby, S. 2014. The meaning of independence for older people in different residential settings. *Journals of Gerontology: Psychological Sciences and Social Sciences*, **69B**, 3, 419–30.
- Johnson, R., Popejoy, L. L. and Radina, M. E. 2010. Older adults' participation in nursing home placement decisions. *Clinical Nursing Research*, **19**, 4, 358–75.
- Jordan, B. 2006. Public services and the service economy: individualism and the choice agenda. *Journal of Social Policy*, **35**, 1, 143–62.
- Kite, S. and Tate, T. 2005. Choice and palliative care: what do we mean? *Palliative Medicine*, **19**, 4, 267–69.
- Koss, C. and Ekerdt, D. J. 2016. Residential reasoning and the tug of the Fourth Age. *The Gerontologist*. Published online: 13 February 2016. doi <https://doi.org/10.1093/geront/gnwo10> [Accessed 30 August 2017].
- Kunkel, S. R. and Nelson, I. M. 2005. Consumer direction: changing the landscape of long-term care. *Public Policy & Aging Report*, **15**, 4, 13–16.
- Leech, N. L. and Onwuegbuzie, A. J. 2011. Beyond constant comparison qualitative data analysis: using NVivo. *School Psychology Quarterly*, **26**, 1, 70–84.
- Löfqvist, C., Granbom, M., Himmelsbach, I., Iwarsson, S., Oswald, F. and Haak, M. 2013. Voices on relocation and aging in place in very old age – a complex and ambivalent matter. *The Gerontologist*, **53**, 6, 919–27.
- Lymbery, M. 2010. A new vision for adult social care? Continuities and change in the care of older people. *Critical Social Policy*, **30**, 1, 5–27.
- March, J. G. 1994. *Primer on Decision Making. How Decisions Happen*. The Free Press, New York.
- Means, R. 2012. A brave new world of personalized care? Historical perspectives on social care and older people in England. *Social Policy & Administration*, **46**, 3, 302–20.
- Mitoku, K. and Shimanouchi, S. 2014. The decision-making and communication capacities of older adults with dementia: a population-based study. *The Open Nursing Journal*, **8**, 17–24.
- Moffatt, S., Higgs, P., Rummery, K. and Jones, I. R. 2012. Choice, consumerism and devolution: growing old in the welfare state(s) of Scotland, Wales and England. *Ageing & Society*, **32**, 5, 725–46.

- Mulder, C. 1996. Housing choice. *Netherlands Journal of Housing and the Built Environment*, **11**, 3, 209–32.
- National Health Service England 2016. *Personalised Care and Support Planning Handbook: The Journey to Person-centred Care. Core Information*. Care and Support Planning Working Group and Coalition for Collaborative Care, Leeds, UK. Available online at <https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf> [Accessed 23 February 2017].
- Ottmann, G., Allen, J. and Feldman, P. 2013. A systematic narrative review of consumer-directed care for older people: implications for model development. *Health & Social Care in the Community*, **21**, 6, 563–81.
- Ouwehand, C., de Ridder, D. T. D. and Bensing, J. M. 2007. A review of successful aging models: proposing proactive coping as an important additional strategy. *Clinical Psychology Review*, **27**, 8, 873–84.
- Patton, M. Q. 2015. *Qualitative Research & Evaluation Methods*. Fourth edition, Sage, London.
- Pope, N. D. and Kang, B. 2010. Residential relocation in later life: a comparison of proactive and reactive moves. *Journal of Housing for the Elderly*, **24**, 2, 193–207.
- Rabiee, P. 2013. Exploring the relationships between choice and independence: experiences of disabled and older people. *British Journal of Social Work*, **43**, 5, 872–88.
- Rabiee, P. and Glendinning, C. 2014. Choice and control for older people using home care services: how far have council-managed personal budgets helped? *Quality in Ageing and Older Adults*, **15**, 4, 219–10.
- Reed, J., Cook, G., Sullivan, A. and BurrIDGE, C. 2003. Making a move: care-home residents' experiences of relocation. *Ageing & Society*, **23**, 2, 225–41.
- Rolls, L., Seymour, J. E., Froggatt, K. A. and Hanratty, B. 2011. Older people living alone at the end of life in the UK: research and policy challenges. *Palliative Medicine*, **25**, 6, 650–7.
- Rowles, G. D. and High, D. M. 1996. Individualizing care: family roles in nursing home decision making. *Journal of Gerontological Nursing*, **22**, 3, 20–5.
- Sciegaj, M., Capitman, J. A. and Kyriacou, C. K. 2004. Consumer-directed community care: race/ethnicity and individual differences in preferences for control. *The Gerontologist*, **44**, 4, 489–99.
- Sergeant, J. F. and Ekerdt, D. J. 2008. Motives for residential mobility in later life: post-move perspectives of elders and family members. *International Journal of Aging & Human Development*, **66**, 2, 131–54.
- Sergeant, J. F., Ekerdt, D. J. and Chapin, R. K. 2010. Older adults' expectations to move: do they predict actual community-based or nursing facility moves within 2 years? *Journal of Aging and Health*, **22**, 7, 1029–53.
- Shakespeare, T. 2000. The social relations of care. In Lewis, G., Gewirtz, S. and Clarke, J. (eds), *Rethinking Social Policy*. Sage, London, 52–65.
- Shawler, C., Rowles, G. D. and High, D. M. 2001. Analysis of key decision-making incidents in the life of a nursing home resident. *The Gerontologist*, **41**, 5, 612–22.
- Sixsmith, A. J. 1986. Independence and home in later life. In Phillipson, C., Benard, M. and Strang, P. (eds), *Dependency and Interdependency in Old Age: Theoretical Perspective and Policy Alternatives*. Croom Helm, London, 338–347.
- Smebye, K. L., Kirkevoid, M. and Engedal, K. 2012. How do persons with dementia participate in decision making related to health and daily care? A multi-case study. *BMC Health Services Research*, **12**, 241.
- Speare, A. and Meyer, J. W. 1988. Types of elderly residential mobility and their determinants. *Journal of Gerontology*, **43**, 3, S74–81.

- Strauss, A. and Corbin, J. 1998. *Basics of Qualitative Research Techniques and Procedures for Developing Grounded Theory*. Second edition, Sage, London.
- Taylor-Gooby, P. 2008. Choice and values: individualised rational action and social goals. *Journal of Social Policy*, **37**, 2, 167–85.
- Tilly, J., Wiener, J. M. and Cuellar, A. E. 2000. Consumer-directed home- and community-based services programs in 5 countries: policy issues for older people and government. *Generations*, **24**, 3, 74–83.
- Tracy, J. P. and DeYoung, S. 2004. Moving to an assisted living facility: exploring the transitional experience of elderly individuals. *Journal of Gerontological Nursing*, **30**, 10, 26–33.
- Tyrrell, J., Genin, N. and Myslinski, M. 2006. Freedom of choice and decision-making in health and social care: views of older patients with early-stage dementia and their carers. *Dementia*, **5**, 4, 479–502.
- Wada, Y. 2016. Older people's exercising of choice in long-term care: a comparative analysis of England and Japan. *Ageing & Society*, **36**, 6, 1185–210.
- Walker, R., Johns, J. and Halliday, D. 2015. How older people cope with frailty within the context of transition care in Australia: implications for improving service delivery. *Health & Social Care in the Community*, **23**, 2, 216–24.
- Wang, Y. and Nolan, M. 2016. Older people and decision-making following acute stroke in China: 'hiding' as a barrier to active involvement. *Ageing & Society*, **36**, 7, 1526–54.
- Welsh Government 2017. *Our Housing AGEenda: Meeting the Aspirations of Older People in Wales. A Report by the Expert Group on Housing an Ageing Population in Wales*. Available online at <http://gov.wales/topics/housing-and-regeneration/housing-supply/expert-group-on-housing-an-ageing-population/?lang=en> [Accessed 23 February 2017].
- Wiener, J. M., Anderson, W. L. and Khatutsky, G. 2007. Are consumer-directed home care beneficiaries satisfied? Evidence from Washington State. *The Gerontologist*, **47**, 6, 763–74.
- Wilson, S. A. 1997. The transition to nursing home life: a comparison of planned and unplanned admissions. *Journal of Advanced Nursing*, **26**, 5, 864–71.
- Wittek, R., Snijders, T. and Nee, V. (eds) 2013. *Handbook of Rational Choice Social Research*. Stanford Social Sciences, Palo Alto, California.
- Yeandle, S., Kröger, T. and Cass, B. 2012. Voice and choice for users and carers? Developments in patterns of care for older people in Australia, England and Finland. *Journal of European Social Policy*, **22**, 4, 432–45.

Accepted 27 July 2017; first published online 14 September 2017

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