Journal of Aging Studies 61 (2022) 101011

Contents lists available at ScienceDirect

Journal of Aging Studies

journal homepage: www.elsevier.com/locate/jaging

“I'm definitely not socially excluded!”- Perceptions of social exclusion among Australian government housing residents aged 80 and older who live alone

Naomi Paine [a,*], Melanie Lowe [b], Jerome Rachele [c], Gavin Turrell [d]

[a] *La Trobe University, John Richards Centre for Rural Ageing, Edwards Rd, Bendigo, VIC 3552, Australia*
[b] *The University of Melbourne, Melbourne, VIC, Australia*
[c] *Victorian University, Melbourne, VIC, Australia*
[d] *RMIT University, Melbourne, VIC, Australia*

ARTICLE INFO

Keywords:
Social exclusion
Life-course
Life span
Resilience
Oldest old
Critical gerontology
Live alone
Socioeconomically disadvantaged

ABSTRACT

The oldest old - those aged 80 years and over - are the fastest growing sector of the Australian population and are generally assumed to be at risk of social exclusion which impedes healthy aging. The voices of those thought to be vulnerable to social exclusion are seldom heard. Informed by a critical gerontology framework, socio-ecological model of health and life-course perspectives, this research involved semi-structured in-depth interviews with a purposive sample of 13 people aged 80 and older living alone in government housing, in a socio-economically disadvantaged neighborhood in Melbourne, Australia. Interview transcripts were analyzed using thematic analysis. The findings reveal a positive picture of survival despite hardship, supportive relationships, a sense of autonomy from living independently, and contributing to society. These findings challenge ageist assumptions, which equate advanced age with social exclusion.

Introduction

Australia, like many other developed countries, has an aging population (Australian Bureau of Statistics, 2018). The greatest proportional population growth is projected to be in the oldest age group; often referred to as the “oldest old” (Cherry et al., 2013; Cresswell-Smith et al., 2018). Criteria for oldest old vary, yet there is a view that these old people have outlived their life expectancy, with the most common stratifications being aged over 80 or 85 years (Kydd, Fleming, Paoletti, & Hvalič-Touzery, 2020). Although there is no agreed upon definition, social exclusion is often conceptualized as a dynamic process by which individuals, groups, and populations are prevented from realizing their rights and opportunities for health and wellbeing (Popay et al., 2008). A complex bi-directional link has been established between social exclusion and various health and wellbeing outcomes including morbidity, disability and depression (Cacioppo & Cacioppo, 2014; Leigh-Hunt et al., 2017), lower quality of life (Dahlberg & McKee, 2018), and unmet care needs (Kim & Kawachi, 2017).

As people age, it is assumed that there is an increased likelihood of experiencing exclusion (Callander, Schofield, & Shrestha, 2012; Sacker, Ross, MacLeod, Netuveli, & Windle, 2017), with fewer opportunities and pathways to alleviate exclusion among older people. This is attributed to limited financial capacity and social supports that “may also represent the outcome of disadvantages experienced earlier in the life-course”(-Scharf, Phillipson, & Smith, 2005b, p. 85). Age-related characteristics such as health-decline, death of partner and friends, and diminishing income following retirement, are likely to make the oldest old vulnerable to the impact of social exclusion (Jose & Cherayi, 2017; Macleod, Ross, Sacker, Netuveli, & Windle, 2017; Van Regenmortel et al., 2016).

In gerontology, the concept of social exclusion is perceived to be useful in understanding old-age related disadvantage (Scharf, Phillipson, Smith, & Kingston, 2002). The causes of older age social exclusion are often conceptualized as being multi-dimensional, influenced by material resources, social relationships, community participation, services and information, neighborhood and environment (Macleod et al., 2017; Scharf et al., 2005b; Walsh, Scharf, & Keating, 2017). It should be noted that critical analysis of the causes of social exclusion is distinct from the classification of older people as socially excluded. However, with limited exceptions (Richardson & Le Grand, 2002; Walsh, O'Shea, & Scharf, 2019), both the conceptualization and labelling of older age

* Corresponding author at: Australian Catholic University, 115 Victoria Parade, Fitzroy, VIC 3065, Australia.
E-mail address: n.paine@latrobe.edu.au (N. Paine).

https://doi.org/10.1016/j.jaging.2022.101011
Received 8 September 2021; Received in revised form 1 February 2022; Accepted 22 February 2022
Available online 5 April 2022
0890-4065/© 2022 Published by Elsevier Inc.

social exclusion has been predominately defined by experts, with the perception and definition of social exclusion provided by older people themselves being an underexplored area.

The socio-ecological model suggests that the health and behavior of individuals are shaped by macro (policies and culture), *meso* (intrapersonal and interpersonal relationships) and micro (biological and behavioural) factors (Whitehead & Dahlgren, 1991). The meso level encompasses intrapersonal factors such an individual's knowledge, awareness, attitudes, beliefs and perceptions; and interpersonal factors such as an individual's family, friends and health care (Bauman, Sallis, Dzewaltowski, & Owen, 2002; McLeroy, Bibeau, Steckler, & Glanz, 1988). We considered the socio-ecological model to be useful for conceptualizing the multiple factors that can inhibit or increase vulnerability to social exclusion. The complementary life-course perspective (Kuh, 2014) provides a lens to help understand the experiences of very old age and how earlier life experiences affect later health and wellbeing. According to founders of the life-course perspective, aging experiences are shaped by cohort and historical factors and are mostly concerned with individual choice and social norms (Elder Jr, 1975). However, it has been argued that the aging experience is also shaped by encounters with social and political structures (Biggs, Estes, & Phillipson, 2003). We considered that a life-course perspective that incorporates the political economy provides a useful critique of economic /structural disadvantage in later life, in keeping with our conceptualization of late life social exclusion.

Different age groups may feel unique types of social exclusion, highlighting the importance of exploring these perceptions across the life-course. Reflecting the potential influence of ageism, Warburton et al. (2013) argues that the oldest old may also feel especially excluded due to “social distancing as the public shun them” (p. 6). Informed by critical gerontology, which recommends that aging research critically appraise the socially constructed features of aging and their implications (Biggs, Lowenstein, & Hendricks, 2003), this paper considers the perspectives and experiences of marginalized older people (Biggs, Lowenstein, & Hendricks, 2003; Estes., 2001; Phillipson, 2013). A key assumption based on previous literature is that the oldest old are socially excluded by virtue of their age. However, qualitative inquiries exploring perceptions of social exclusion among the oldest old are scarce, with even less research focused on those considered vulnerable and/or living alone (Korkeila et al., 2001; Macleod et al., 2017).

The following research questions sought to address this research gap. A logical sequence of questioning may typically first investigate “the extent to which” the oldest old perceive themselves to be socially excluded before investigating the “how” and “why”. The questions were placed in the reverse order because we did not want to assume from the outset that the oldest old would perceive themselves to be socially excluded, nor close off any potential discussion points about positive identities in older life.

Q.1 What are the factors that exacerbate or protect against perceived social exclusion among oldest old who live alone in public housing in a disadvantaged neighborhood?

Q.2 To what extent do this group perceive themselves to be socially excluded?

Method

We purposively selected interview participants according to four main eligibility criteria: aged 80 or older, living in public (government-owned) housing, living in a disadvantaged area, and living alone. The study location was an inner suburb of Melbourne, with a high proportion of public housing units for single older people. The eligibility criteria for older person public housing in Victoria, Australia is based on age (e.g. over 55 years) and risk of homelessness, in particular having low income and few assets. The study locality was also characterized by a high proportion of socioeconomic disadvantage, as measured by the Australian Bureau of Statistics' Socioeconomic Index for Areas (e.g. ABS SEIFA index). Only 9% of Australia's suburbs have a SEIFA index lower than the study area (e.g. are more disadvantaged).

Thirteen people aged in their 80s or 90s were recruited. Eight of these were recruited through door knocking. Door knocking was deemed a suitable method to overcome barriers of research participation among this cohort: poor literacy and health, and scepticism about research (Liljas et al., 2017). One hundred and fifty homes were door-knocked. Approximately one-third elicited no response, and about half of those who opened the door were under the age of 80 and thus ineligible. Of those where contact was made, and the occupant was potentially eligible, three refused and three did not speak English. A further two displayed cognitive difficulties, which made them ineligible. A further six participants were recruited through facilitated community or social groups, where staff assisted with identifying potential participants. These facilitated groups, run by either the local council or local health centre, included an ethnic specific social support group, community garden group and senior citizens club. An English translator was engaged for one interview.

The interviews were conducted in either the participant's home, Neighborhood House or Community Health Centre, depending on the participants' preferences. In some instances, it was necessary for a second person (carer/relative/friend) to be present during the interview due to issues around authenticity of the researcher and disability status of the interview participant.

The socio-ecological model of health (Bauman et al., 2002; McLeroy et al., 1988) and life-course perspective (Phillipson, 2013) provided the structural and individual-level conceptualization of the factors that exacerbate or protect against perceived social exclusion. Subsequently, the semi-structured interview guide included questions on themes of perceived social support, community participation, neighborhood perceptions and life-course experiences, while allowing flexibility to explore additional topics raised by the participants. All interviews were audio-recorded with permission from the participants and were transcribed verbatim. We assigned pseudonyms to protect each interviewee's identity. Ethics clearance was granted for the interviews by the Human Research Ethics Committee at the Australian Catholic University.

Participants were interviewed using semi-structured, face-to-face interviews between March and May 2019. The average duration of the interview was 30 min. The socio-demographic characteristics of this sample are as follows: All lived alone. There were six men and seven women. The age of participants ranged from 81 to 95. On average, females were older (87 years) than their male counterparts (85 years). Regarding ethnic diversity, eight participants were born in Australia, two in other countries where English is the main language, and three in countries where English is not the main language. Participants typically had mobility restrictions (e.g. use of wheelchair or walker), sensory impairment (e.g. hearing and vision) or both. Indeed, only one participant appeared to have no mobility or sensory disability. Housing tenure consisted of public housing; nine lived in single older person units, two lived in mixed age public housing, and two had purchased their home from public housing. The duration of time lived in their current home or broader neighborhood ranged from 2 to 63 years. On average, female participants had been a resident of their current home/neighborhood longer than males.

The method of data analysis reflected the main phases of thematic analysis, informed by Braun & Clarke (2006). The initial stage of thematic analysis involved checks for accuracy of 143 pages of transcribed interviews and noting the overall impression of the interview. Where relevant, inflection and tone were noted to give meaning within the text. Interview transcripts were then uploaded into the software package, NVivo 12, for coding (QSR NVivo). Coding for categories, themes and sub-themes (e.g. barriers and enablers) were segmented according to the responses, to address the main research questions. To provide additional understanding, relationships between themes and deviant or divergent sub-themes were identified (Green & Thorogood, 2009). The coding was completed by the lead author, with broad themes discussed and agreed

upon by all authors.

Results

Exacerbating and protective factors for social exclusion

The findings revealed a complex, diverse and interrelated array of factors that impact on self-perception of social exclusion, and experience of contributing and protecting factors. The four themes that emerged are discussed in turn below: supportive relationships, connection to home, life-course survival and contributing to society (see Table 1).

Supportive relationships

Having an attentive and supportive family were important factors that contributed to protecting participants, both male and female, from feeling socially excluded. As illustrated by Keith, family inclusion was a source of great joy and was linked to acceptance of a limited social life.

> …you see my granddaughter works at the RSL [Returned Servicemen League], and every second week normally we go down there for a meal. My son and my grandson and his mates. Last time we went there was about 12 people on the table. Otherwise, I don't have a great social life …If I need to go somewhere, I know my son will take me there. You know that sort of thing. He lives around the corner with his wife, he spends a few days here….. It was my son's birthday the other week. They picked me up and take me and bring me back you know.

Participants placed a high social value on their ability to live on their own and independently in the community. Relatives, who predominately also lived in public housing in the same neighborhood, play an important role in helping them to remain living independently, which participants appreciated. Assistance provided by family included: paying of bills, shopping for groceries, cooking, and “doing a bit of washing”. Similar to Keith above, Ada shared:

> She got me transferred when this flat became vacant, so that she could look after me…. Yeah. Gets me pension, and she's in charge of the book and all that, and… yeah… Pays all the bills, and she knows what I need and all that and she just gets it, you know? Oh, I couldn't deal without her.

For those without strong family ties, the presence of other social ties, such as with neighbors, associates such as social group or club members, and carers, were equally important in reducing their perceptions of social exclusion.

The analysis also revealed factors that restricted the sense of supportive relationships. Death and illness of friends and family was a common theme, with many noting that they were the “last ones left”. Grieving for friends and family, especially their own children, continued to play a role in current feelings of sadness. When relatives lived far away, communication and visiting were restricted. Some participants desired to see more of these people, and it caused a sense of loneliness. Interview participants explained that the physical distance, expense and reliance on others were barriers to visiting relatives.

Participants' health status both reduced and increased feeling of supportive relationships. Poor mobility, eyesight and hearing, and chronic health conditions prevented them from getting out into the community or visiting people. For example, Clifford alluded to his health negatively impacting on his general quality of life and social interactions “…I have a problem with my heart. I am nearly dead 3 years ago. I take all this tablets. I not go outside. I am scared maybe getting sick”.

Deterioration in the health of friends or family members was also perceived as a restriction to social relationships. For instance, Sarah commented that visiting physically and/or mentally ill friends was awkward:

> You know what it's a very sad thing because most of my friends have passed away. I've got two very good friends that live in [name of suburb], yes I do see them…. I think we're going to their place. We don't get out a lot with them now because unfortunately her husband's got Parkinson's and they don't go out much.

On the other hand, poor health was sometimes a catalyst for greater levels of social interaction and care. Tom described his recent illness drawing more attention from shop staff: “They look out for me, because they knew I'd been sick, you know”.

Some participants described how they appreciated the respect, attention and care provided by community and health personnel, and how this contributed to them not feeling socially excluded. Beatrice talked about her recent positive stay in hospital:

> I shouldn't say bloody lovely but I do, I notice I'm saying bloody a lot lately. But no, the nurses and that, I can't say I've been ill-treated in the hospital, in fact I'm grown to like being there. I'm being waited on, when I've been in a long while, you know. And I get to know them and when I come home I think, oh I'll have to get my own meals, you know! No, I can't say a [bad] word about it.

Not all participants desired more company or more opportunities for group socialization. Some in fact were adamant that they did not want more company. Lack of time and opportunities to make friends across a person's life may contribute to reluctance to socialize, as highlighted in the following quote from Edith:

> No, see, I don't drink and most people drink… I've never had time to go into that group-y thing. See, because, again, you work and you

Table 1
Results of thematic analysis: barriers and enablers that impact on oldest old's perceptions of social exclusion.

Theme	Enablers that impact on oldest old's perceptions of social exclusion	Barriers that impact on oldest old's perceptions of social exclusion
1. Supportive Relationships	Reciprocal relationships - helping and being helped. Presence of supportive family and/or friends. Positive interaction with carers and health professionals. Deterioration in health increases care from others. Participation in organized social groups.	Disability and poor health limits opportunities to socialize and get out. Estranged family. Physical distance from family. Sick friends are awkward to visit. Gossip diminishes trust.
2. Connection to home	Perceived neighborhood cohesion (despite not knowing and undesirable neighbors). Perceived improvement in safety/prosperity. Stable, safe, comfortable home (relative to previous transitory/precarious housing).	
3. Life-course survival	Previous experience of exclusion (e.g. resilience and relativeness). Positive sense of self (e.g. independence, autonomy and rebellion). Feeling proud and lucky to be a survivor (also downwards comparison to others).	Not wanting to be dependent, not wanting to be a burden, or look incompetent. Not wanting to be associated with “old” people. Previous experience of life-course trauma (e.g. family separation, grief). Lifelong lack of opportunity and never learning to be socially competent.
4. Contributing to society	Intergenerational solidarity. Neighborhood cohesion.	

> rear your kids and then you rear your grandkids. There's no time for that.

This response is representative of other participants who suggested that prior life-course opportunities play an important role in this theme of sense of supportive relationships.

Connection to home

For most, the journey to living in single older person public housing reflected some form of social or economic hardship. Divorce, domestic abuse, financial difficulties and lifelong living in public housing were common trajectories. Most participants had no or very little input into decisions about where they were to be housed and very few had prior knowledge of the suburb or neighborhood they moved into. Despite this, the majority described a positive connection to their home that seemed to buffer feelings of social exclusion. The alternative view was from Edith who disliked the area she was housed in, yet valued helpful, but non-intrusive neighbors.

> … I didn't like this side of Melbourne when I came here. I was reared in [name of suburb], worked in [name of suburb], got married and lived in [name of suburb], and when I had nowhere to go they said, "That's where you are," and I cried for a week… That's the 1960s. I came here and brought my kids because they said, "There you go, that's your house and that's where you'll live." [Over time] I never liked it any better. Oh well, the boys [neighbors] look after me. They put out my bin. The boys! That one's in a wheelchair full-time and that one's in a wheelchair part-time. They look after me, make sure my bin's out…And he comes past in the morning and I know he checks because he stops out the front, yeah, check.

It was common for interview participants to not really know their neighbors. Many observed the social norm, or preference, to "keep to themselves" (Andrew). For some participants, factors such as "no one bothering them", and being "quiet" positively influenced their sense of home. For others, it was feeling "safe", and having people around "just like me". Feeling safe in their home was often relayed in the historical context of increasing neighborhood prosperity and safety. Long-term residents like Sarah explained that the area had improved greatly in recent years:

> We had a lot of undesirables around this area and of course, I think it's still got a bit of a stigma about it. It didn't have a good reputation because a lot of them were ex-prisoners, homeless. Yeah so it wasn't a good area. We were lucky because we're sort of up this end, it was more down that [name of streets] around that area that was bad…. Oh it's changed tremendously. They've all gone, there's still a few undesirable places as you would know, around. Here, I think, we're in a lovely little area.

Living alone was mostly regarded as an accepted, tolerable, and for some, a preferable experience. Men, more so than women, conveyed their gratitude of having a comfortable and secure home. The connection to home intersected with the theme life-course survival. The ability to afford the rent of public housing was an enabling factor in preventing a sense of social exclusion. Keith explains:

> Yes, this place is pretty cheap like, everyone complains, if you go outside it could be double. I could never do that, that's because that's what your pension is. It would take all your pension. I'm all right. A lot of people are really struggling, really struggling.

Life-course survival

Previous experiences of exclusion in some instances appeared to build resilience that protected against feelings of isolation in old age. The theme life-course survival reflected the oldest old's narrative of survival, resilience, courage and grit despite social and economic hardship throughout their long life. An alternative interpretation is that perhaps other issues in their lives made feelings of social exclusion relatively unimportant. In the following, Beatrice highlights how her experience of exclusion and life-course trauma contributed to her feeling a relative lack of isolation in her older age.

> I don't want to get into a broken marriage and all that… I've tried to forget. But now these days they do more for you if you've had a real bad marriage. It's come too late for me…So I have to accept that and get on with my life, make the best. And I feel peace in my mind. I've got no worries. Oh well, bills and that but I mean, no arguments and all that. I feel contented in my life.

Participants discussed their experiences of disadvantage throughout their lives. Long-term experience of public housing, disability, institutionalization (e.g. orphanage), divorce, domestic abuse or family separation were among the lived experiences of the participants. Mary relayed a sense of resilience and relativity that she carried with her into older age. Her response also highlights the intersections between life-course resilience, disability and public housing:

> Going back years and years ago, we were first in Camp Pell [slum rehousing program] …And, because there was no housing, so we were in army camps… I've lived in quite a lot of places, all through the ministry …But, prior to that when I was about four I got infantile paralysis…I was in the hospital for all those years…And mother and father split up, one of seven kids, and it was pretty tough on a girl back then. A lot tougher than what it is now… you've got to hold your head up high and partly ignore that. Feel the shame that you are crippled and people are making fun of you. But you don't be a lap dog for anyone. You should show that you're equal as good as them. It's just a bit of inner strength comes from somewhere.

This interview extract also illustrates the important historical context of the oldest old's lived experience and cohort experiences. The example includes references to previous social distinctions and cultural norms based on gender, religion, hardships during the depression, large numbers of siblings, and an experience of a childhood disease that can now be prevented through vaccination.

For Geoff, life-course factors influenced his mistrust and avoidance of social contact. He did not go out to any social groups or visit people. Geoff also implied that his drinking and behavior pushed people away. His daughter, Bree, who played a key role in facilitating the discussion, noted that living in an orphanage and the death of his wife, impacted greatly on her father's current self-exclusionary behavior:

> He was in an orphanage. Boys' Home and all that…So his life is different, so that was the way that he was brought up. And that's how he is today. ...And the reason why my dad's like this. Because he was a big family, and when he was little his mum died, his dad was a prick…So he doesn't really get close or trust people.

Notably, Geoff, Clifford, Edith and Mary, were all recruited via door-knocking and appeared on the surface to be the most isolated of the sample. For example, they reported seldom venturing outside their units, nor did they participate in any social groups. Yet these participants denied feeling excluded.

Participants reflected on their adaptations, expectations and attitudes to older age. Their narratives seemed to suggest that surviving to old age with all their "faculties" (both mental and physical), were important protective factors that influenced their lack of identification with social exclusion. Downwards comparisons of others worse-off than themselves, were frequently attributed to feelings of their achievement: "I mean I go to [name of shopping centre] sometimes and I see the poor ones there in wheelchairs and I think I don't know why I'm whinging, you know" (Beatrice).

A cultural preference to remain living in their own home for as long as possible was emphasized as desirable, as explained by Sarah.

> What's important for me is to stay well enough to stay in my own home. Well I used to go down to the nursing home and visit a friend of mine down there. Unfortunately, now she's got dementia and she doesn't really know us, so I don't go anymore. I think just to see them sitting around, it just doesn't, I don't know. I think it's very sad and I think it's better if you can stay in your own home and maintain yourself. I know there's going to go a time when I won't be able to stay here. I realize that.

The oldest old notion of feeling in control and rebelling against assumptions of frailty appeared to be fundamental to their sense of well-being and rejection of feeling socially excluded. Often relatives, especially their children, were portrayed as being overly protective. The example below highlights this tension.

> Yeah and then I have sneaked to [name of suburb]. I don't tell my son and I don't tell my nephew because they'll growl at me and say oh you shouldn't. But on a nice day I think no, I'm going to get the bus at the front, get out at the shop, have a little wander around, catch the bus home. And I feel good to get out on my own!… He [son] thinks I'm not capable. I'm not stupid. I pick my good days and I manage. (Beatrice).

Contributing to society

The theme contributing to society describes the myriad of ways oldest old contribute to family, friends, neighborhood and community. These contributions were often subtle. Analysis revealed that the oldest old play a part in creating a broader culture of social inclusion. Males more so than females, reported contributing to neighborhood cohesion with friendly gestures and providing practical assistance to neighbors. For Keith and Chris:

> I've got a neighbor who's not real educated she can't write and can't read, sometimes I go over and help her out with things. My neighbor you know, she buys a card and gets me to fill it out. I've got reasonable IQ, I wouldn't like to be like that you know.

> I try to help as much as I can. Some of them, they are in a wheelchair or they are not that active. I move a lot of things.

In contrast, females, like Beatrice and Mary, were more likely than males to discuss their provision of intergenerational emotional support:

> Well there's, all my mum and sister, they've all gone now and two of her sons and there's only one of her sons that's left and that's [name of nephew] but he's got schizophrenia and he's in a home. He can come and go but he has to have these tablets and I haven't seen him for [ages] but I ring him and every pension day I send him a little parcel.

> I've just got to hang on as long as I can for my kids… Well, to be there for any problem they might have that I can probably help them.

Perceptions of being socially excluded

When discussing barriers and enablers to social exclusion, it appeared that the oldest old were not socially included in the community as they seldom got out and about. Community participation seemed to be very narrow, with older women in particular describing themselves as being mostly housebound. For example, Edith commented, “I'm in here” and Beatrice said, “I don't get to the city anymore”. Most could not leave their house without assistance. However, this did not necessarily equate with perceiving themselves to be socially excluded in any explicit or definable way. Lost community connection was evident, but rarely lamented, and in some cases was a preference.

The manner of response suggested that social exclusion was not synonymous with absence of supportive relationships. Many participants remarked matter-of-factually that they had no visitors, yet denied social exclusion. In the following quote, Andrew implies that phone contact with family prevents him feeling socially excluded.

> Well I don't get no visitors. That doesn't worry me. My daughter hasn't been well so she can't drive a car, she's had an operation, so she'll be a few more weeks. But I ring her, I've got a disability mobile phone.

For those without family support, perceptions of non-exclusion related to their capacity to adapt and feelings of contentment with their current situation. This is demonstrated in the following interview with Edith who claimed she was not socially excluded:

> If I wanted to be included, I would be. I'm not a vegetable that sits here and does nothing. I like to see what goes on around in life. I read, and I watch, and I look, and I see what's around even though I'm in here.

A common thread running through the conversations was that being noticed, or having the capacity to be noticed or helped, was important in protecting against exclusion. For example, Edith, wore an emergency alarm bracelet around her wrist and Keith had a disability mobile phone, which contributed to feelings of security and reducing sense of isolation and loneliness.

> I can't remember what this thing around my wrist is called. I just press it and someone answers. It stops me from feeling isolated. I've accidently knocked it and a voice says “hello, are you all right?” That's when I know it's working (laughter). (Edith).

Despite what appears to be an absence of visitors, family and close friends, the sentiment of not feeling socially excluded was also shared by participants from culturally and linguistically diverse backgrounds. For example, the experience of going down to the shops and belonging to a social group was more important for Catherine than having no one to confide in. It should be noted that, unlike the majority of the oldest old in the sample, Catherine was able to get out of her house without assistance, and she alluded to feelings of pride in this ability.

Translator:	She doesn't feel excluded as in, she still gets out. She gets on the bus and goes to [name of] shopping centre and it'll take her half an hour or something to walk back. Just that she can't walk very far and she catches a cab home.
Catherine:	Me much stronger!
Translator:	She finds respect and people love her
Catherine:	Good friends in the club, me much happy – Catherine no come today - they notice me.
Interviewer:	Oh good, so they worry about you if you're not there?
Translator:	Even in the Australian group as she calls it, even they miss her, if she's not around they ask where she is.
Interviewer:	…When you have something personal you want talk to, you've got good friends to talk to?
Catherine:	Not much friends, not like me, no trust.
Translator:	She doesn't really have any problems, I don't like getting too close to people because I'll say this and she'll tell so and so and she'll tell so and so and she'll tell so and so and even I don't really say anything to my son.

Discussion

Through interviews with 13 participants aged over 80 who lived alone in a socioeconomically disadvantage neighborhood, this research explored experiences of social exclusion. This research fills a gap in the lack of research on social exclusion among this cohort. The finding that a large proportion of the qualitative sample did not perceive themselves to be socially excluded does challenge existing perceptions. Participants

blended personal, neighborhood and structural/macro factors within the four themes of supportive relationships, sense of home, life-course survival and contributing to society.

Supportive relationships

The qualitative narratives suggested that supportive relationships with family, neighbors, social groups, and community and health services, were important for fostering a sense of social inclusion. For this sample, close ties were valued, but in the absence of these ties, weak ties filled the void. A sense of support, even informal or indirect, seemed to give people the confidence that help would be provided if necessary and therefore minimized the risk of feeling socially excluded. For example, participants recollected friendly behavior with acquaintances. This finding concurs with previous research, showing amicable relationships are just as important as close family ties (Phillipson, Bernard, Phillips, & Ogg, 1998), especially among older adults who live alone (Carr, 2019; Djundeva, Dykstra, & Fokkema, 2019). Our findings imply that it is possible to still feel socially included despite living alone and having an absence of close, supportive relationships.

The analysis found positive and negative accounts of relationships, supporting a distinction between supportive (quality) over quantity of relationships. In particular, this study found that previous opportunities and personal hardship shape current and future willingness and behavior regarding forming new relationships. The influence of life-course in shaping opportunities for social interaction have been found in other studies (Ziegler, 2012).

Healthcare provided by community and healthcare organizations supported health and wellbeing and mitigated against feelings of social exclusion. Whilst almost all participants received formal care, the social aspect of care provision also seemed to have a positive effect on perceived levels of social inclusion. Most interview participants gave high praise for the health professionals they encountered. These findings are consistent with an earlier study which showed that healthcare staff play an instrumental role in maintaining a sense of self, especially in the context of bodily decline (Lloyd, Calnan, Cameron, Seymour, & Smith, 2014). It should be noted, however, that the level of protection provided by formal care depends on continuity and depth of positive, respectful relationships (Grenier & Guberman, 2009).

Good physical and mental health can help older people to maintain social relationships (Walsh et al., 2017). The participants provided nuanced accounts that further add to the understanding of the interchange between health and social exclusion. It was found that in some instances it was the poor health of their friends (rather than their own health) that created barriers to social inclusion. Furthermore, poor health sometimes provided opportunities for valued social inclusion with family, caregivers and other residents. These findings are discordant with some previous research (Portacolone, Perissinotto, Yeh, & Greysen, 2018), which suggests that poor personal health creates barriers to social inclusion.

The way participants talked about restrictions in supportive relationships implied that diminished social ties are normal and to be expected in old age, due mostly to outliving friends, family and partners. Lower expectations, and appreciation for the relationships one does have, were also intertwined with life-course experiences and psychological adaptations that protected them from feeling socially excluded.

Connection to home

The analysis provided evidence of community living as an important factor that influenced perceptions of social exclusion. Remaining at home in old age is generally considered a sign of independence, and therefore an important achievement. Feeling independent may enhance quality of life by increasing a perception of personal control (Plath, 2008) and foster a philosophical or spiritual perspective (Scharf, Phillipson, & Smith, 2005a). Social comparison was intertwined with a sense of home and autonomy. Social comparison refers to the process in which people evaluate their own abilities, attitudes and accomplishments in relation to others (Festinger, 1954). In many instances, the oldest old compared their present autonomy favorably relative to others, which is indicative of downwards social comparison. For example, they were proud of their accomplishments in relation to others they knew who were not able to live independently. Negative perceptions of residential aged care influenced this feeling, with many of the participants speaking of their preference to remain living in their own home as long as possible. Rejection of nursing homes appears to be a common theme influencing satisfaction in late life (Nosraty, Jylha, Raittila, & Lumme-Sandt, 2015; Stones & Gullifer, 2016).

Our findings further underscore the interplay of interpersonal factors with broader contextual and structural/macro influences. The participants seemed content with their neighborhood and limited social interactions, and were grateful for their Australian government benefits such as the age pension and public housing. Several of the sample were mindful that there were plenty of others with economic and housing difficulties “that had it much worse”. These finding resonate with literature that emphasizes the importance of neighborhood and communities in people's ability to age in place, in addition to having appropriate housing in which to grow old (Kalina, 2020; Wiles, Leibing, Guberman, Reeve, & Allen, 2012). Both the physical structure of a ‘house’ and the subjective feeling of being ‘at home’ were important protective factors for this sample of older public housing residents. However, it should be noted that there is limited opportunity for older public housing residents to modify their houses, nor move to other places.

Secure housing, for elders in public housing, contributed to feelings of wellbeing, and mitigated feelings of social exclusion among participants. This was particularly evident for men with a history of precarious or transient housing, which supports an Australian study of older men (aged 65 to 75) who reported that public housing provided a sense of personal safety and security (Morris, 2018). The importance of home cannot be underestimated: it meant that oldest old people's accommodation was guaranteed and affordable, and subsequently they had the capacity to lead a dignified and good life.

Public housing preserved in areas that become gentrified - as is currently occurring in our study area - is an important site for analysis. Without public housing, the older people are at risk of needing to relocate due to housing unaffordability. Thus, preservation of public housing is vital for residents continued sense of security and autonomy.

Participants' positive perception of public housing also intersects with their positive views of their changing neighborhood. In previous studies about gentrification, older people were found to often perceive change in their neighborhood somewhat negatively (Scharf et al., 2002), although also noting positive aspects of safety (Burns, Lavoie, & Rose, 2012). In other studies, gentrification appeared to make little difference (Prattley, Buffel, Marshall, & Nazroo, 2020). In this study, however, participants were pleased with the changes they saw in their neighborhood, especially regarding increased perceptions of safety. The historical context of their neighborhood, which was once associated with drunkards, prostitutes and people with mental illness, was an important relative marker. A few participants mentioned there are still areas where there are “undesirables” but this did not alter their overall positive impression of their neighborhood – despite it being ranked among the 10% most disadvantaged neighborhoods in Australia, and the top 3% of disadvantages areas in Melbourne. The surprising findings of a positive sense of neighborhood despite what would appear to be on the surface an undesirable place to grow old, confirms early research of the importance of subjective (i.e. in the mind) contextual evaluations of neighborhoods (Lagory, Ward, & Sherman, 1985) as well as older adults capacity to negotiate settings they appraise as less than ideal (Johnson, 2022). Other researchers have also noted a disconnect between what could be considered a hazardous neighborhood, and positive evaluations from their research participants, with contextual factors playing a

key part in the difference (Russell, Hill, & Basser, 1998).

Family carers, all of whom lived in public housing (which may indicate intergenerational disadvantage), were integral for social relationships. Family carers, usually their children, enabled their parents to remain living independently in the community. Some researchers suggest the upwards social mobility and material wealth characteristics of the post-industrial society have contributed to geographical fragmentation of the family (Buffel, Rémillard-Boilard, & Phillipson, 2015). The present study supported the possibility that intergenerational disadvantage may keep families close, strengthening family ties, and thus builds psychological wellbeing which may reduce perceptions of social exclusion.

Life-course survival

Life-course infers that prior experiences strongly affect present life (Dannefer & Settersten, 2010). It has been argued that unfavorable life-course factors predispose older people to various aspects of social exclusion (Grundy, 2016). Participants explained that their way of life, attitudes, and choices were heavily influenced by past events – for some reaching as far back as their childhood (e.g. childhood disability, homelessness and family separation). Opportunities to learn and practice social etiquette were also found to be shaped by the life-course and mirror similar findings to previous research on older adult social isolation (Machielse & Duyndam, 2020). The findings add to the evidence that expressions of grief and illness are long lasting, and not necessarily confined to recent events (Weldrick & Grenier, 2018). However, in contrast to previous literature, the participants also seemed to infer that their life-course contributed to a sense of gratitude and satisfaction with life. Life-course survival seemed to be reflected in their life stories, possibly preventing social exclusion.

Their sense of survival, and the related positive associations of resilience, may help explain why the oldest old participants did not recognize themselves as excluded. The participants attributed their capacity to adapt to changes and positive perceptions of current social inclusion (and non-identification with social exclusion), to their experiences over the life-course. For many, life-long skills and attitudes were developed in response to hardship, such as living through a period of war, economic depression, and personal family breakdown. Their ability to manage social and financial constraints experienced through life, resonates with other findings of resilience in the oldest old (Browne-Yung, Walker, & Luszcz, 2017; Kok, van Nes, Deeg, Widdershoven, & Huisman, 2018), and with prior studies of disadvantage (Van Regenmortel et al., 2019) and living alone (Djundeva et al., 2019; Samanta, 2021).

Contributing to society

Broader intergenerational solidarity and neighborhood cohesion were created and maintained by the oldest old participants in this study. In many cases the participants' contributions to society were linked with their wellbeing – and no doubt to the wellbeing of others. There were many accounts confirming the oldest old played an important role in maintaining neighborly connections. The thematic analysis revealed that informal social relationships with neighbors mitigated the feeling of being excluded from the neighborhood. These interview participants embodied the value of neighborliness, being a good neighbor. Neighborliness has been found to strengthen individual inclusion and neighborhood cohesion (De Donder, Smetcoren, van Der Vorst, Dierchkx, & Schols, 2019). By performing deeds such as checking in on neighbors, noticing if anyone needs any help, and assisting with everyday chores such as putting garbage bins out for collection, the participants demonstrated neighborhood cohesion.

In tough times, such as when experiencing personal relationship difficulties, it was the oldest old whose advice was sought. Provision of emotional support to younger family members in particular was common and, in some instances, attributed to participants' life satisfaction. Transmitting knowledge and experience to younger generations resonates with the concept of *generativity*, defined as: "the concern in establishing and guiding the next generation""(Erikson, 1950, p. 267) Previous studies have similarly found that wanting to support younger generations was a significant source of life satisfaction (Kok et al., 2018; Van Regenmortel et al., 2019).

Limited evidence of perceived social exclusion among oldest old from disadvantaged backgrounds

Many scholars observe that social exclusion is a disputed term (Peace, 2001; Walsh et al., 2017; Warburton et al., 2013). However, there is a general understanding that social exclusion refers to processes relating to social and economic disadvantage, and to categories of excluded people and places. Despite possessing attributes that are thought to contribute to being socially excluded, the study participants denied and defied social exclusion. They dissociated themselves from it, either by highlighting independence/autonomy or simply not identifying as being socially excluded. Similar themes of older people resisting a label, despite an objective classification are found in frailty research (Cluley, Martin, Radnor, & Banerjee, 2021; Grenier, 2007; Kaufman, 1994). It is plausible participants were 'positivity biased', preferring to view their past and present circumstances in a positive light (Carstensen & DeLiema, 2018).

Our findings offer a critique of deficit views of social exclusion. By classifying people as socially excluded based on assumptions of disadvantage (e.g. living alone, advanced age, living in public housing, living in socially economic disadvantaged neighborhoods) there is the potential to overlook positive aspects of older people's lived experience and their contributions to society. Furthermore, previous definitions that conceptualize social exclusion as separation from mainstream society (Walsh et al., 2017) are morally problematic. Inherent in the concept of "mainstream society" is the normalization of mainstream. Framed in this way, social exclusion takes on a punitive tone, implying that excluded people should be accountable and conform to the standards of mainstream society (Daly & Silver, 2008). Without questioning and challenging the above assumptions, social exclusion discourse may inherently strengthen negative ageist attitudes about the limited capacity of older people to engage with society.

Due to their age, the focus of this paper could be thought of as those living in the fourth age. However, the stereotypical imagery of frailty, dependence (Baltes & Smith, 2003) and lack of agency (Higgs & Gilleard, 2014) was not fully supported by our findings. Instead, it was common for the oldest old to perceive themselves as playing a role in fostering neighborhood cohesion, and supportive relationships especially among their family. Gerontological researchers have observed that older adults are central to their community and fulfill important roles for social interaction (Warburton & McLaughlin, 2005; Wilken, Walker, Sandberg, & Holcomb, 2002). These "little kindnesses" (Warburton & McLaughlin, 2005) are rarely acknowledged in social exclusion policy but are important to individual, family, and community functioning. Aligned with critical gerontological perspectives, this research adds to evidence that challenges the assumption that the oldest old have entered the "metaphorical black hole" (Gilleard & Higgs, 2010) of advanced age. We provide evidence of older people contributing to society, even when in a situation perceived as disadvantaged (e.g. advanced age, living alone in public housing).

Although our small study provides rare insights into perceptions of social exclusion among lone-dwelling oldest old from disadvantaged backgrounds, it has some limitations that can be considered for future research. Participant recruitment was limited to those deemed to be cognitively competent and living in the community, as opposed to residential aged care. Cognitively impaired and nursing home residents may be more vulnerable to social exclusion. The door knocking method may have introduced sampling bias as a consequence of who opened the

door, and who was home at that time. It is plausible that potentially eligible people were unable or unwilling to open the door. This may mean that the most vulnerable or socially reclusive participants were not included in the sample. Conversely it is plausible that a more socially active sample were excluded as they may have been out at the time of recruitment. Eligible oldest old who were not recruited may have had different experiences and perceptions of social exclusion from those who were interviewed. The purposive selection of participants from a particular neighborhood in metropolitan Melbourne, Australia may mean that finding would differ in other locations. Further investigation, with greater geographic and individual sociodemographic variation, may reveal different perceptions and interpretations of social exclusion and inclusion.

Moreover, direct and indirect questioning about social exclusion experiences during the interviews may have introduced social desirability bias (Dury et al., 2018), whereby participants denied social exclusion, feeling that it was the desirable response. However, the face-to-face interviews allowed the interviewer to take measures to probe and clarify participant responses as well as provide verbal support when they disclosed sensitive information.

Building on this study, future social exclusion research should aim to increase representation of the oldest old and explore life-course resilience - both of which are important for challenging current negative ageist stereotypes that equate old with exclusion.

From a critical perspective, social exclusion can be used as an analytic category to determine problematic social relationships and life events resulting from a lifetime of multiple and inter-connected aspects of disadvantage. Framing life-course from a political economy approach directs attention to how policy interventions might influence and transform life experiences (Grenier, 2012). Our findings articulate that perceptions of social exclusion may be offset through structural/macro prevention efforts, such as providing adequate and accessible health care in the community and in the home, pensions (welfare payments) and secure, affordable housing. Provision of older person public housing may be particularly integral to protecting disadvantaged older people from social exclusion. These structural determinants of social exclusion can be addressed by a broad range of national, state and local social policies, aimed at addressing disadvantage. In Victoria, for example, the Municipal Association of Victoria (MAV) support Local Councils to plan for *Positive Aging*. Polices include Age-Friendly Cities and Communities, Healthy and Active Aging, Elder Abuse Prevention, and Building Community Capacity around End of Life. These policies may help address agism and issues of marginalization from mainstream institutions, services, and amenities by focusing on the built and social environment.

Conclusion

A growing body of literature suggests that the oldest old, especially those from disadvantaged backgrounds, are at risk of poor health and wellbeing effects across the board. Yet the oldest old are underrepresented in social exclusion research. This article addresses a gap in existing knowledge and examines experiences and perceptions of social exclusion among the oldest old. The finding that the oldest old were not at great risk of social exclusion is discordant with previous studies that predict greater experiences of social isolation with advancing age. Reflections on the notion of social exclusion, and making assumptions about those most at risk, may contribute to cultural imagery of old age as a time of exclusion, decline and helplessness. The oldest old in our study did not see themselves in this light. A greater recognition of life-course survival, resilience and the unique ways the oldest old contribute to society provides a more nuanced reflection of experiences of health and wellbeing among those aged in their 80s and 90s across the socioeconomic spectrum.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Submission declaration and verification

The manuscript comprises original unpublished material and is not under consideration for publication elsewhere. The manuscript will not be submitted to another journal before a final editorial decision from the *Journal of Aging studies* is rendered. All authors accept the conditions laid down in the Submission Guidelines, each has made significant contributions to the paper and have read and approved the final version. None of the authors has any conflict of interest associated with the paper.

Declaration of Competing Interest

Non declared.

Acknowledgements

Not applicable.

References

Australian Bureau of Statistics. (2018). Population Projections, Australia, 2017 (base) - 2066. Retrieved 20 December from https://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/3222.0#:~:text=POPULATION%20SIZE%20AND%20GROWTH,49.2%20million%20people%20by%202066.

Baltes, P., & Smith, J. (2003). New frontiers in the future of aging: From successful aging of the young old to the dilemmas of the fourth age. *Gerontology, 49*(2), 123–135. https://doi.org/10.1159/000067946

Bauman, A. E., Sallis, J. F., Dzewaltowski, D. A., & Owen, N. (2002). Toward a better understanding of the influences on physical activity: The role of determinants, correlates, causal variables, mediators, moderators, and confounders. *American Journal of Preventive Medicine, 23*(2), 5–14.

Biggs, S., Estes, C., & Phillipson, C. (2003). *Social theory, social policy and ageing: A critical introduction: Critical perspectives*.

Biggs, S., Lowenstein, A., & Hendricks, J. (2003). *The need for theory : Critical approaches to social gerontology*. Baywood Pub. Co: Amityville, N.Y.

Braun, V., & Clarke, V. (2006). *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Browne-Yung, K., Walker, R. B., & Luszcz, M. A. (2017). An examination of resilience and coping in the oldest old using life narrative method. *Gerontologist, 57*(2), 282–291. https://doi.org/10.1093/geront/gnv137

Buffel, T., Rémillard-Boilard, S., & Phillipson, C. (2015). *Social isolation among older people in urban areas*.

Burns, V. F., Lavoie, J. P., & Rose, D. (2012). Revisiting the role of neighbourhood change in social exclusion and inclusion of older people. *Journal of Aging Research, 2012*, 1–12. https://doi.org/10.1155/2012/148287

Cacioppo, J. T., & Cacioppo, S. (2014). Social relationships and health: The toxic effects of perceived social isolation. *Social and Personality Psychology Compass, 8*(2), 58–72. https://doi.org/10.1111/spc3.12087

Callander, E. J., Schofield, D. J., & Shrestha, R. N. (2012). Multiple disadvantages among older citizens: What a multidimensional measure of poverty can show. *Journal of Aging & Social Policy, 24*(4), 368–383. https://doi.org/10.1080/08959420.2012.735177

Carr, D. (2019). Aging alone? International perspectives on social integration and isolation. *The Journals of Gerontology: Series B, 74*(8), 1391–1393.

Carstensen, L. L., & DeLiema, M. (2018). The positivity effect: A negativity bias in youth fades with age. *Current Opinion in Behavioral Sciences, 19*, 7–12. https://doi.org/10.1016/j.cobeha.2017.07.009

Cherry, K. E., Walker, E. J., Brown, J. S., Volaufova, J., LaMotte, L. R., Welsh, D. A., … Frisard, M. I. (2013). Social engagement and health in younger, older, and oldest-old adults in the Louisiana healthy aging study. *Journal of Applied Gerontology, 32*(1), 51–75. https://doi.org/10.1177/0733464811409034

Cluley, V., Martin, G., Radnor, Z., & Banerjee, J. (2021). Talking about frailty: The role of stigma and precarity in older peoples' constructions of frailty. *Journal of Aging Studies, 58*, Article 100951.

Cresswell-Smith, J., Amaddeo, F., Donisi, V., Forsman, A. K., Kalseth, J., Martin-Maria, N., … Walhbeck, K. (2018). Determinants of multidimensional mental wellbeing in the oldest old: A rapid review [journal article]. *Social Psychiatry and Psychiatric Epidemiology*. https://doi.org/10.1007/s00127-018-1633-8

Dahlberg, L., & McKee, K. J. (2018). Social exclusion and well-being among older adults in rural and urban areas. *Archives of Gerontology and Geriatrics, 79*, 176–184. https://doi.org/10.1016/j.archger.2018.08.007

Daly, M., & Silver, H. (2008). Social exclusion and social capital: A comparison and critique. *Renewal and Critique in Social Theory, 37*(6), 537–566. https://doi.org/10.1007/s11186-008-9062-4

Dannefer, D., & Settersten, R. A. (2010). The study of the life course: Implications for social gerontology. In *The SAGE handbook of social gerontology*.

De Donder, L., Smetcoren, A.-S., van Der Vorst, A., Dierchkx, E., & Schols, J. (2019). *Journal of Aging Studies, 49*, 66–73. https://doi.org/10.1016/j.jaging.2019.100787

Djundeva, M., Dykstra, P. A., & Fokkema, T. (2019). Is living alone "aging alone"? Solitary living, network types, and well-being. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences, 74*(8), 1406–1415.

Dury, S., Dierckx, E., van der Vorst, A., Van der Elst, M. L., Fret, B., Duppen, D., … De Donder, L. (2018). Detecting frail, older adults and identifying their strengths: Results of a mixed-methods study.(report). *BMC Public Health, 18*(1). https://doi.org/10.1186/s12889-018-5088-3

Elder, G. H., Jr. (1975). Age differentiation and the life course. *Annual Review of Sociology, 1*(1), 165–190.

Erikson, E. H. (1950). *Childhood and society*.

Estes.. (2001). *Social policy & aging: A critical perspective*. SAGE Publications, Inc.. https://doi.org/10.4135/9781452232676

Festinger, L. (1954). A theory of social comparison processes. *Human Relations, 7*(2), 117–140.

Gilleard, C., & Higgs, P. (2010). Aging without agency: Theorizing the fourth age. *Aging & Mental Health, 14*(2), 121–128. https://doi.org/10.1080/13607860903228762

Green, J., & Thorogood, N. (2009). *Qualitative methods for health research* (2nd ed.). London: Sage.

Grenier, A. (2007). Constructions of frailty in the English language, care practice and the lived experience. *Ageing and Society, 27*(3), 425–445.

Grenier, A. (2012). *Transitions and the lifecourse: Challenging the constructions of'growing old*. Policy Press.

Grenier, A., & Guberman, N. (2009). Creating and sustaining disadvantage: The relevance of a social exclusion framework. *Health & Social Care in the Community, 17*(2), 116–124. https://doi.org/10.1111/j.1365-2524.2007.00804.x

Grundy, E. (2016). Ageing and disadvantage. In H. Dean, & L. Platt (Eds.), *Social Advantage and Disadvantage*. https://doi.org/10.1093/acprof:oso/9780198737070.001.0001

Higgs, P., & Gilleard, C. (2014). Frailty, abjection and the 'othering'of the fourth age. *Health Sociology Review, 23*(1), 10–19.

Johnson, I. M. (2022). Aging in the downtown corridor: Mapping the neighborhood experiences of Seattle's unhoused adults over age 50. *Journal of Aging Studies, 60*, Article 100997. https://doi.org/10.1016/j.jaging.2021.100997

Jose, J., & Cherayi, S. (2017). Social exclusion of older persons: The role of socio-demographic characteristics. *Ageing International, 42*(4), 447–465. https://doi.org/10.1007/s12126-016-9255-5

Kalina, M. (2020). Narratives of home and neighbourhood within state-subsidised aged housing in Durban, South Africa. *Journal of Aging Studies, 54*, Article 100864. https://doi.org/10.1016/j.jaging.2020.100864

Kaufman, S. R. (1994). The social construction of frailty: An anthropological perspective. *Journal of Aging Studies, 8*(1), 45–58.

Kim, E. S., & Kawachi, I. (2017). Perceived neighborhood social cohesion and preventive healthcare use. *American Journal of Preventive Medicine, 53*(2), e35–e40. https://doi.org/10.1016/j.amepre.2017.01.007

Kok, A. A. L., van Nes, F., Deeg, D. J. H., Widdershoven, G., & Huisman, M. (2018). "Tough times have become good times": Resilience in older adults with a low socioeconomic position. *Gerontologist, 58*(5), 843–852. https://doi.org/10.1093/geront/gny007

Korkeila, K., Suominen, S., Ahvenainen, J., Ojanlatva, A., Rautava, P., Helenius, H., & Koskenvuo, M. (2001). Non-response and related factors in a nation-wide health survey. *European Journal of Epidemiology, 17*(11), 991–999. https://doi.org/10.1023/A:1020016922473

Kuh, D. (2014). *A life course approach to healthy ageing* (first edition.. ed.). New York, NY: Oxford University Press.

Kydd, A., Fleming, A., Paoletti, I., & Hvalič-Touzery, S. (2020). Exploring terms used for the oldest old in the gerontological literature. *Journal of Aging and Social Change, 10*(2).

Lagory, M., Ward, R., & Sherman, S. (1985). The ecology of aging: Neighborhood satisfaction in an older population. *The Sociological Quarterly, 26*(3), 405–418. https://doi.org/10.1111/j.1533-8525.1985.tb00235.x

Leigh-Hunt, N., Bagguley, D., Bash, K., Turner, V., Turnbull, S., Valtorta, N., & Caan, W. (2017). An overview of systematic reviews on the public health consequences of social isolation and loneliness. *Public Health, 152*, 157–171. https://doi.org/10.1016/j.puhe.2017.07.035

Liljas, A. E. M., Walters, K., Jovicic, A., Iliffe, S., Manthorpe, J., Goodman, C., & Kharicha, K. (2017). Strategies to improve engagement of 'hard to reach' older people in research on health promotion: A systematic review. *BMC Public Health, 17*(1), 349. https://doi.org/10.1186/s12889-017-4241-8

Lloyd, L., Calnan, M., Cameron, A., Seymour, J., & Smith, R. (2014). Identity in the fourth age: Perseverance, adaptation and maintaining dignity. *Ageing and Society, 34*(1), 1. https://doi.org/10.1017/S0144686X12000761

Machielse, A., & Duyndam, J. (2020). Strategies of socially isolated older adults: Mechanisms of emergence and persistence. *Journal of Aging Studies, 53*, Article 100852. https://doi.org/10.1016/j.jaging.2020.100852

Macleod, C. A., Ross, A., Sacker, A., Netuveli, G., & Windle, G. (2017). Re-thinking social exclusion in later life: A case for a new framework for measurement. *Ageing and Society*, 1–38. https://doi.org/10.1017/s0144686x17000794

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly, 15*(4), 351–377. https://doi.org/10.1177/109019818801500401

Morris, A. (2018). Housing tenure and the health of older Australians dependent on the age pension for their income. *Housing Studies, 33*(1), 77–95. https://doi.org/10.1080/02673037.2017.1344202

Nosraty, L., Jylha, M., Raittila, T., & Lumme-Sandt, K. (2015). Perceptions by the oldest old of successful aging, vitality 90+ study. *Journal of Aging Studies, 32*, 50–58. https://doi.org/10.1016/j.jaging.2015.01.002

Peace, R. (2001). Social exclusion: A concept in need of definition? *Social Policy Journal of New Zealand*, 17–36.

Phillipson, C. (2013). *Ageing*. Cambridge, U.K: Polity.

Phillipson, C., Bernard, M., Phillips, J., & Ogg, J. (1998). The family and community life of older people: Household composition and social networks in three urban areas. *Ageing and Society, 18*, 259–289.

Plath, D. (2008). Independence in old age: The route to social exclusion? *British Journal of Social Work, 38*(7), 1353–1369. https://doi.org/10.1093/bjsw/bcm045

Popay, J., Escorel, S., Hernández, M., Johnston, H., Mathieson, J., & Rispel, L. (2008). Understanding and tackling social exclusion. http://www.who.int/social_determinants/knowledge_networks/final_reports/sekn_final%20report_042008.pdf.

Portacolone, E., Perissinotto, C., Yeh, J. C., & Greysen, S. R. (2018). "I feel trapped": The tension between personal and structural factors of social isolation and the desire for social integration among older residents of a high-crime neighborhood. *Gerontologist, 58*(1), 79–88. https://doi.org/10.1093/geront/gnw268

Prattley, J., Buffel, T., Marshall, A., & Nazroo, J. (2020). Area effects on the level and development of social exclusion in later life. *Social Science & Medicine, 246*, Article 112722.

Regenmortel, V., De Donder, L., Dury, S., Smetcoren, A.-S., De Witte, N., & Verté, D. (2016). Social exclusion in later life: A systematic review of the literature [journal article]. *Journal of Population Ageing, 9*(4), 315–344. https://doi.org/10.1007/s12062-016-9145-3

Richardson, L., & Le Grand, J. (2002). Outsider and insider expertise: The response of residents of deprived neighbourhoods to an academic definition of social exclusion. *Social Policy and Administration, 36*(5), 496–515.

Russell, C., Hill, B., & Basser, M. (1998). Older people's lives in the inner city: Hazardous or rewarding? *Australian and New Zealand Journal of Public Health, 22*(1), 98–106. https://doi.org/10.1111/j.1467-842X.1998.tb01152.x

Sacker, A., Ross, A., MacLeod, C. A., Netuveli, G., & Windle, G. (2017). Health and social exclusion in older age: Evidence from understanding society, the UK household longitudinal study. *Journal of Epidemiology and Community Health, 71*(7), 681–690. https://doi.org/10.1136/jech-2016-208037

Samanta, T. (2021). Living solo at midlife: Can the pandemic de-stigmatize living alone in India? *Journal of Aging Studies, 56*, Article 100907. https://doi.org/10.1016/j.jaging.2020.100907

Scharf, T., Phillipson, C., & Smith, A. (2005a). Social exclusion and quality of life of excluded older people. *Working with Older People, 9*(3), 32–35. https://doi.org/10.1108/13663666200500049

Scharf, T., Phillipson, C., & Smith, A. (2005b). Social exclusion of older people in deprived urban communities of England. *European Journal of Ageing, 2*(2), 76–87. https://doi.org/10.1007/s10433-005-0025-6

Scharf, T., Phillipson, C., Smith, A., & Kingston, P. (2002). *Growing older in socially deprived areas*. Help the Aged.

Stones, D., & Gullifer, J. (2016). 'At home it's just so much easier to be yourself': Older adults perceptions of ageing in place. *Aging & Society, 36*(3), 449–481. https://doi.org/10.1017/S0144686X14001214

Van Regenmortel, S., Smetcoren, A. S., Marsillas, S., Lambotte, D., Fret, B., & De Donder, L. (2019). Exploring underexposed stories: The experienced lifecourse of financially excluded older adults. *Ageing and Society*. https://doi.org/10.1017/S0144686X19001235

Walsh, K., O'Shea, E., & Scharf, T. (2019). Rural old-age social exclusion: A conceptual framework on mediators of exclusion across the lifecourse. *Ageing and Society*, 1–27.

Walsh, K., Scharf, T., & Keating, N. (2017). Social exclusion of older persons: A scoping review and conceptual framework. *European Journal of Ageing, 14*(1), 81–98. https://doi.org/10.1007/s10433-016-0398-8

Warburton, J., & McLaughlin, D. (2005). Lots of little kindnesses: Valuing the role of older Australians as informal volunteers in the community. *Ageing and Society, 25*(5), 715–730. https://doi.org/10.1017/S0144686X05003648

Warburton, J., Ng, S. H., Shardlow, S. M., Warburton, J., Ng, S. H., & Shardlow, S. M. (2013). *Social inclusion in an ageing world: introduction to the special. 33(1)* pp. 1–15). https://doi.org/10.1017/S0144686X12000980

Weldrick, R., & Grenier, A. (2018). Social isolation in later life: Extending the conversation. *Canadian Journal on Aging, 37*(1), 76–83. https://doi.org/10.1017/S071498081700054X

Whitehead, M., & Dahlgren, G. (1991). What can be done about inequalities in health? *The Lancet, 338*(8774), 1059–1063. https://doi.org/10.1016/0140-6736(91)91911-D

Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. E. (2012). The meaning of "aging in place" to older people. *The Gerontologist, 52*(3), 357–366.

Wilken, C. S., Walker, K., Sandberg, J. G., & Holcomb, C. A. (2002). A qualitative analysis of factors related to late life independence as related by the old-old and viewed through the concept of locus of control. *Journal of Aging Studies, 16*(1), 73–86. https://doi.org/10.1016/S0890-4065(01)00035-4

Ziegler, F. (2012). "You have to engage with life, or life will go away": An intersectional life course analysis of older women's social participation in a disadvantaged urban area. *Geoforum, 43*(6), 1296–1305. https://doi.org/10.1016/j.geoforum.2012.03.013