

Article

Always Caring: The Gendered Realities of Spousal Home Care for Older Adults in the Community

Kelly Glubb-Smith ^{1,*}, Molly Crawford ² and Patricia Hanlen ³

¹ Social Work Programme, Division of Education, School of Education, University of Waikato, Hamilton 3240, New Zealand

² Division of Arts, Law, Psychology and Social Sciences, School of Psychology, University of Waikato, Hamilton 3240, New Zealand; mollycrawford21@gmail.com

³ Independent Researcher, Tauranga 3110, New Zealand; trishhanlen@xtra.co.nz

* Correspondence: kelly.glubb-smith@waikato.ac.nz

Abstract

The choice to age in a familiar home environment within the community without relying on residential services can prolong independence, provided care services are customised to the specific needs of the household. However, this model of care provision frequently conceals the hidden costs for women who are often the spousal carer. The navigation of care needs of a spouse when aged 65+ often contains challenges linked to accessing quality community care and respite. These challenges are further compounded by the impact of personal health realities that come with ageing. To explore the support needs of older adults choosing to remain in their own homes, qualitative semi-structured interviews took place with 26 individuals aged 65 and above. This article concentrates on a specific subset of the research using constructivist grounded theory to examine the caregiving realities of six women and one man. A significant finding was that these predominantly female carers often felt unsupported, fatigued, and time-poor, largely attributable to the scale of care needed. Formal care support was particularly valued when it prioritised relationships over task-oriented care. A key recommendation to enable couples to remain living at home and avoid residential care is that more support for spousal (informal) carers is required.

Keywords: ageing-in-place; gender; carer fatigue; community action; formal and informal support; home-based care; participatory social work research; Aotearoa New Zealand

1. Introduction

Drawing on the perspectives of six women and one man aged 65 and over, this article explores what it means to care for a spouse facing a life-limiting illness. A social-ecological lens is used to examine how individual, relational, community, and wider structural factors impact them as they care for their spouses. Approximately 480,000 people in Aotearoa New Zealand are informally caring for another person who is ill or disabled on a regular basis [1]. Twenty percent of these carers are aged 65 years and older [2], but evidence suggests that due to Census undercounting, the number of carers in this age range is higher [3]. There is a scarcity of research on the experiences and needs of older adults who are spousal carers in Aotearoa New Zealand [4].

From 1994 to 2020, the population of individuals aged 65 and over doubled in Aotearoa New Zealand and is forecasted to double again by 2063 [5]. Internationally, similar projections are occurring with the United Nations [6] perceiving population ageing as a defining global trend of this era. Global life expectancy trends have improved through advances



Academic Editors: Gregor Wolbring and Lisa Jean Moore

Received: 6 September 2025

Revised: 18 December 2025

Accepted: 6 February 2026

Published: 11 February 2026

Copyright: © 2026 by the authors.

Licensee MDPI, Basel, Switzerland.

This article is an open access article distributed under the terms and conditions of the [Creative Commons Attribution \(CC BY\)](https://creativecommons.org/licenses/by/4.0/) license.

in public health that have lowered mortality rates, alongside structural ageing linked to declining birth rates [7–9]. In the 1990s, OECD countries agreed to an ‘ageing-in-place’ policy designed to increase care service provision at home for the ‘frail aged’ [10] and reduce institutional care to advance opportunities for adults to age in their own communities [11].

The World Health Organisation [12] defines ageing in place as the “ability to live in one’s own home and community safely, independently and comfortably, regardless of age, income or capacity” (p.vi). In Aotearoa New Zealand, health policies aspire to promote the ability for people to age at home [13,14]. The ability to age in place provides older people with a feeling of security, a sense of attachment, and connection to both homes and communities [15–17]. This article reports on a subsection of qualitative findings related to the realities of seven spousal carers over the age of 65; the wider research project concentrated on the support needs of older adults when ageing in place. For information on the findings of the wider research project, see the Glubb-Smith and Hanlen [18] report into the home care needs of older people in the Western Bay of Plenty.

This research was conducted in a region of Aotearoa New Zealand that covers a range of rural settlements, towns, and a major urban area with a higher-than-average proportion of people aged 65 years and older. This community-based research project was instigated by the Home Care Advocacy Group (HCAG) in partnership with the Social Work Programme at the University of Waikato. In recognition of the challenges faced by older adults living independently, the HCAG was founded in 2023 to advocate for their health and wellbeing within the community. The HCAG contains representatives of regional organisations that have a national spread. The HCAG is facilitated by Age Concern, Tauranga, and is supported by Tauranga Rural Women (RWNZ), Grey Power Western Bay of Plenty (GPW BoP), and National Council of Women Tauranga (NCW).

The HCAG initiated this research due to their concerns about a lack of research into the needs of older adults in the community within Aotearoa New Zealand. The momentum to instigate this research project was also aligned with their belief that planning and action are needed to ensure a sustainable stream of skilled workers to provide care for people living in the community. The HCAG asserted in local media at the outset of the research that health, iwi [tribal], and social service providers need innovative decision-making about funding models for local communities and ways to improve and increase services to older and more vulnerable people in their homes [19].

Literature Review

Globally, older adults are particularly susceptible to social exclusion, health challenges, poverty, and insecure incomes [20]. In Aotearoa New Zealand, the primary care sector faces significant challenges due to rising multimorbidity in a growing older adult population and persistent difficulties in mitigating the adverse impact of social, economic, and cultural health inequities [21,22]. Understanding the impact of intersectional identities in ageing alongside the narratives embedded in discourses of ‘healthy ageing’ helps illuminate how inequities can be exacerbated with age [23]. Pinto et al. [24] conducted research into multiple factors of disadvantage in older adults in Aotearoa New Zealand. They found that 54% of older adults in Aotearoa New Zealand had good social connections, were financially secure, and occupied liveable housing, while 33% of older adults experienced vulnerability, and 13% experienced multiple disadvantages due to a lack of social connections or vulnerability in domains such as health, housing, and finances. Multiple factors of disadvantage make it harder for older caregivers to be resilient and experience ‘healthy ageing’ [25], and the Pinto et al. [24] data indicated that, compared to men, women were more prone to encountering overlapping disadvantages.

Despite being the predominant group of spousal carers, older women's perspectives are frequently absent from the literature. This review underscores the importance of examining how identity, financial insecurity, health risks, and social isolation shape their caregiving experiences. As a demographic category, older women constitute a diverse and varied group, exhibiting considerable variation across socio-cultural, economic, and health-related dimensions. Their experiences are further differentiated by sexual orientation, relationship configurations, and identity expressions. The results of an Aotearoa New Zealand Financial Capability Survey conducted by the Retirement Commission concluded that widowhood negatively affects women's financial wellbeing, with widowed women showing the greatest gender gap in retirement resilience, while, in contrast, widowed men fare better financially than married men [26].

Women who pause their careers for child-rearing face triple financial penalties: loss of income, missed retirement contributions, and reduced earnings upon re-entry [27]. Just as women are financially disadvantaged through time out of paid work due to unpaid care responsibilities prior to retirement, the gender impact of unpaid care work continues after retirement, with an overall impact of a disproportionate number of older women living in poverty in Aotearoa New Zealand compared to older men [28]. Further to this, evidence suggests that when considering the intersection of age and gender, older women who assume substantial spousal caregiving responsibilities face heightened health risks [29,30].

Societal expectations that link caregiving with feminine traits place additional strain on women; if policymakers and educators place more emphasis on challenging traditional gender roles, this may help reduce this burden [31]. Even with efforts to challenge gender roles, the caregiving burden largely remains with women, who typically outlive their male spouse by an average of $3\frac{1}{2}$ to 4 years [32]. Gendered pension gaps due to time out of paid work because of childcare responsibilities, combined with women living longer, result in increased pressure to care for their male partners while they may be ageing in constrained financial circumstances [33].

Issues impacting the care that people receive in their homes are complex and embedded in structures that require a systems-level solution. The availability of health and care services for older adults is shaped by socioeconomic, geographical, technological, and community factors, as well as supply and demand issues that necessitate cooperation among local and central governments, healthcare providers, non-governmental organisations, communities, families, and older individuals [34]. The care needs of older adults differ greatly, necessitating personalised approaches to address specific care situations [18]. Deteriorations in health and wellbeing due to ageing can involve frequent readjustments to adapt to changing physical, material, and social demands [35]. When care needs increase, transitioning to residential care can be experienced as a traumatic loss that can impact overall wellbeing [36,37]. The reluctance of many older adults to enter residential care services, even as their personal care support needs increase, underscores some of the complexities of care provisions for older adults.

The difficulties affecting home care services in Aotearoa New Zealand are consistent with pressures observed in many OECD countries [38–40]. The aged-care sector is struggling to remain resilient due to increasing demand for home and community support services, inadequate funding levels, workforce shortages, and service delivery inequities [41]. With an ageing population, the pressures on carers, families, whānau [family/extended family], communities, and health services are predicted to continue to intensify, necessitating innovative strategies to provide effective health and social support services [42]. Given that female family caregivers experience higher adverse psychosocial and health outcomes, more research is needed to effectively target resources in accordance with gendered needs [43].

In this research, the terms ‘informal care’ and ‘formal care’ are used to differentiate between paid care and care that is provided primarily by spouses, family, whānau, and neighbours. Informal care is therefore the unpaid care that someone provides, normally with no financial payment involved (but other exchanges may be made), while formal care is primarily the care support that is paid for. Spousal carers often take on the duty of care, but in doing so, they are required to learn a new range of practical and emotional skills [44]. Numerous studies reveal that care demands rise for those supporting older adults towards the end of their lives, and informal carers frequently lack the support they need [45]. Research into the health needs of older adult carers is still relatively scarce, especially when compared to research on younger carers [46].

When residential care is required, informal carers report experiencing mixed feelings primarily related to guilt, grief, failure, loss of control, and relief at their inability to continue caring for their family member at home [47,48]. Residential care that removes people from their family units and communities can result in the absence of companionship and support that this older generation provides. This is particularly important for Māori, where elders are positioned as guardians who have an important role in whānau/family group decision-making [49]. Comparable statements regarding the role of elders in Pacific communities across Aotearoa New Zealand can also be expressed [50]. In this study, we explored the gendered impact of spousal caregiving on older adults.

2. Methodology and Methods

In Aotearoa New Zealand, there is a scarcity of research findings based on older adults’ perspectives and experiences of ageing in place [4]. This participatory research reflects a wider push for greater involvement by older individuals in funding discussions that shape their communities [51,52]. The HCAG members are all women over the age of 65 years who are representatives from predominantly women’s organisations. Consistent with the United Nations Decade of Healthy Ageing Action Plan [53] devised in 2020, the HCAG developed this research initiative to enhance the health and wellbeing of their peers. In addition to the authors, a group of three female academics over the age of 65 years assisted with the individual interviews and an early aspect of the data analysis. A University of Waikato Summer Research Scholar assisted with two of the research interviews, data analysis, and coding.

The knowledge base of social work underpins this qualitative feminist inquiry [54], as the two principal researchers are social work academics, one of whom is retired. This research utilised a constructivist grounded theory design to advance a critical inquiry into the structural conditions, contextual circumstances, and subjective realities of older adults ageing in place [18,55]. The research team’s lived experience of ageing in the community of study added depth to the research analysis.

2.1. Methods

This study explored the lived realities and perspectives of two groups of participants within a specific geographical region: older adults aged 65 years and older adults who wish to age in place at home in the community, and the care professionals and needs assessors who assist them [18]. A non-probability purposive and snowball sampling method was utilised in both research phases to locate participants in the designated geographical region [18,56,57]. Utilising two distinct phases of data collection provided deeper insights into the needs and experiences of older adults in the region studied. The integration of multiple data sets with literature enables a broader perspective on how participants interact with wider societal and political structures [55]

2.2. Participant Selection and Data Collection

The first research phase involved semi-structured face-to-face interviews with twenty-six people aged 65 years and over regarding the factors that enable them to stay in their own homes as they age. Participant selection criteria were based on participants' age (65+) and whether they were living at 'home' in the community, with their preference being to age in place, rather than a residential facility [18]. The participants also needed to reside within the geographical region of study. "Home" as a construction can have multiple meanings beyond that of a physical house, and the emphasis within the research was on what support would be needed to enable people to avoid residential care [19]. No restriction was put on what defined a "home", but the participants were predominantly homeowners.

To locate participants for the interviews, the researchers collaborated with community centres and social service managers across the region of interest. Acting as independent third parties, these managers circulated participant information sheets detailing the research to older adults who met the participant selection criteria [18]. This approach helped to cultivate a wide range of participants to reflect the diversity within the population of the study.

The semi-structured interviews were primarily individual interviews and were completed in the participants' own homes or at a local community services centre convenient to them. The participants were encouraged to have family or support people present during the interview if they wished, and this enabled three couples to be interviewed together. The interviews comprised 10 key questions developed with reference to literature on ageing and the social determinants of good health. These interview questions focused on support needs, coping strategies, and the impact of receiving or providing others with assistance in order to remain 'at home'. The interviews reported on in this research were conducted in the second half of 2023 and early 2024. The second phase of the research utilised a Qualtrics (Provo, UT) online survey to gather qualitative and quantitative data from care service professionals and needs assessors for older adults. The survey was conducted to garner industry perspectives about how aged-care services can be made more responsive to community needs. The Qualtrics surveys began after the face-to-face interviews commenced, which was strategically done to allow for some of the early phase 1 data analysis to inform the refinement of the survey before it was released.

This article reports on aspects of the research that illuminate the voices of seven of the twenty-six participants interviewed who had significant carer responsibilities. The decision to focus on the realities of carers was due to the concerns held by the research team around the extreme pressures that this age group was under in caring for their loved ones. Participant demographics for the 6 female and one male participant are summarised in Table 1.

Out of the seven caregiving participants interviewed, one participant cared for her dying spouse and then her son, with the help of hospice nurses. One of the seven participated in the interview process alongside their spouse. These participant carers were not a homogeneous group as there was a wide range of health, wellbeing and socio-economic circumstances that impacted upon their ability to care for their spouse or family member. Six of the seven carers were living in homes they owned. Being a homeowner in Aotearoa New Zealand has been associated with higher long-term quality of life and can support healthier ageing [58]. However, at the time of the interviews, only two of the participants were actively caring; all seven participants reflected on the struggles they had caring as older adults.

Table 1. Participant demographics.

Demographic	Categories	Participants
<i>Age Range</i>	65–69	2
	70–74	2
	75–79	2
	80–84	1
<i>Living Situation</i>	Homeowner	6
	Other	1
<i>Care Recipient Gender</i>	Male	6
	Female	1
<i>Care Recipient Diagnoses</i>	Dementia	3
	Parkinson's	2
	Cancer	1
	Other	1

These seven cared-for individuals had a range of life-limiting illnesses; one of the spousal carers did not disclose the nature of the spouse's illness in the participant interview. The care recipients' diagnoses mirrored wider trends in Aotearoa New Zealand, as Alzheimer's disease is the most common neurodegenerative disease, followed by Parkinson's disease [59]. The increasing aged population in Aotearoa New Zealand, combined with the increase in life expectancy over the past few decades, means that the prevalence of these neurodegenerative diseases is predicted to continue to rise [59,60].

2.3. Ethics

The research received ethical approval by the Division of Arts, Law, Psychology and Social Sciences Human Research Ethics Committee at the University of Waikato, approval number FS203-37. Every individual who dealt with data signed a confidentiality agreement. Written informed consent to participate in the research was gained from all participants. To protect participants' identities, pseudonyms were allocated to interview participants, and a numerical code was allocated to the Qualtrics survey participants.

2.4. Transcribing, Analysing and Coding

The recordings from the phase one interviews were transcribed using Otter.ai (Mountain View, CA, USA) and coded in batches via NVivo Denver, CO) [61]. The data were iteratively analysed using a constructivist grounded theory design [62]. The first four interviews were coded by five members of the research team separately, before meeting to compare coding, to generate confidence in the movement from initial to focused coding [62]. Reflexive team discussions about social positioning, combined with visual mapping of categories and memo writing, supported the movement from initial to focused coding across both research phases.

2.5. Limitations

The findings are shaped by a limited number of participants who volunteered to share their experiences. Community-based research is embedded in a distinct set of contextual factors [63]. Even though this research was undertaken in a set geographical region, the wider political and policy influences reported on are relevant to carer support services in other regions of the country and beyond.

3. Findings and Discussion

The findings of this research highlight the challenges that those wanting to ‘age in place’ are faced with while informally caring for a spouse with a life-limiting illness. The thoughts and experiences of the seven participants who are informal carers are illuminated in conceptual categories presented in this section of the article. Information drawn from principal analytic categories has been further refined to specifically examine the experiences of the informal carers and correlated against existing literature. The categories covered relate to the carers’ feelings of being overwhelmed, alone, isolated, invisible, and unsupported. The findings accentuate the importance of flexible and responsive care support that recognises that a gendered duty of care is occurring as the informal carers’ own health needs are deteriorating.

3.1. *Overwhelmed by Complexity and Volume of Care*

The study identified that most of the carers interviewed provided care without enough physical and emotional support to sustain them in their role as carers. The participants spoke candidly about the toll that caring took on them. For instance, after caring for her husband with dementia for many years, Ruby stated the following: “I was absolutely worn out”, acknowledging that her family worried that she was at risk of dying before him due to carer exhaustion. Despite her family’s concern, Ruby reiterated that “I didn’t realise how worn out I was” and stated that once her husband had died, “It took a good little while for me to come to again, after looking after [him] and doing everything for him”. As Alice said of her husband, who had recently passed, “He needed an awful lot to be able to stay at home that society didn’t provide”.

The informal carers who were physically well, able to drive and navigate the health system, were at an advantage over those who suffered from their own ill health. Carers struggled with transport to the many medical appointments required, or in some instances had difficulties utilising the internet for online requirements. In the wider study, the participants viewed access to personal transport as a key factor in helping older adults remain in their homes [18]. Due to mobility issues and the frequency of medical appointments, locating a car park close enough to the entrance of medical facilities was a significant concern commented on by some of the carers.

Alongside the workload of attending frequent medical appointments, the participants reflected on the tasks involved with overseeing formal care provisions. Alice stated that she “...felt I had to do a lot of the coordination of care”. The role of overall care coordination was perceived by the informal caregivers to be a particularly relentless task. “When it comes to my health and my husband’s health, I’m an advocate for him. So, I need to be able to stand up right for it” (Shannon) [18] (p. 56).

Caregivers are often untrained and under-supported while assuming roles as case-managers, patient advocates, and paramedics [1,64]. This study’s findings indicate that carers who were receiving formal support to assist with their in-home care needs were appreciative of the help but felt that it was a struggle to get any assistance. When talking about the care her husband currently receives to shower every second day, Olivia commented that “It makes a lot of difference” to their quality of life. Unfortunately, the participants could easily find aspects of the formal care provided that needed to be improved to further support the wellbeing of the person being cared for. An example of improvements needed involves a participant stating that her husband would have been able to remain at home with her if the paid care was focused on building trust and engagement rather than just a brisk task-focused approach to care. Some illustrations of the complexity of care that lead to carers feeling overwhelmed are provided below, in relation to a lack of recognition of

care needs, the risk of violence, and the physical and mental toll experienced by carers due to sleep deprivation.

3.1.1. Carers Managing Alternative Realities

The interviews with carers demonstrated frequent experiences that denied their reality as carers or placed them in risky situations due to the cared-for person not having a clear awareness of their actions. Two examples of this are presented below, one relates to a spouse with dementia feeling more capable than he is, and the other involves a husband's nighttime hallucinations.

The first example of the cared-for person's altered reality is drawn from an interview where the informal carer and cared-for person were both present. The participant who had dementia stated the following: "I feel like I am quite capable of looking after myself". His wife's reality, as the informal carer, was quite different. She stated that despite his denial of needing care, two carers were providing support, and she was also receiving counselling to assist with the carer-related stress [18]. Her husband's denial of his carer support needs was a point of conflict between them. This lack of awareness is problematic when needs assessments take place, and the carer's reality is not heard separately.

In the second example, the lack of awareness was brought on through Olivia's husband sleeping deeply and having violent dreams.

When I first woke up with his hands around my neck, I never thought I would get them off. And from time to time, he's had a violent dream, and I've just managed to wake him up (Olivia). [18] (p. 48)

Olivia was clear that these violent dreams were brought on by Parkinson's disease, and the issues of incontinence were associated with this. "I usually get up to him because he's a bit wobbly and get him to the bathroom. And that can be anywhere between four and 10 times a night" (Olivia). The fatigue that is a result of the interrupted sleep, on top of the strain that the caregivers are under from all the other aspects of caring, can compromise their health [65]. This constant fatigue and emotional drain often become accepted as just a 'part of life' by carers. The stress of caregiving is often internalised by caregivers as a personal shortcoming, reinforced by gendered ideals that discourage them from reaching out for help [31,66].

3.1.2. Sleep Deprivation

Incontinence is associated with ageing and age-related illnesses; it creates a significant burden associated with washing, cleaning, and emotional strain for the carer [67]. Frequent cleaning is necessary when spills, misplaced toilet attempts, or nighttime incontinence occur, leaving carers responsible for additional laundry and nighttime bed linen changes. A crucial aspect of home care support is providing nighttime assistance with toileting or respite care, ensuring that the carer (typically the wife) can rest and recharge. Alice spoke in her interview about how trying it was to constantly have interrupted sleep "...so it would be six times a night to give him assistance because he was never able to lie in bed and use a bottle". She reflected on how "he would stand a while, but sit before finishing peeing", so "that meant the sheets were wet, which meant having to change the sheets" [18] (p. 49). Alice then expanded on this information by saying,

...then we did get [name of service] home care in. I had to pay for them to come and stay, but at \$200 a night, I could only afford that two or three times, but it would just give me a night where I could have a sleep all night through... And he used to have nightmares, so sometimes he would leap up against the cot sides... To have someone there at night would have been magic... About 8

o'clock at night, we started to go to bed, but it would take him a couple of hours to get organised to go to bed. It was bloody tough, I have to say (Alice). [18] (p. 50)

The lengths that these carers go to keep their spouse at home can be unimaginable, often driven by their care and connection with one another [68]. The participants tended to frame their spousal care as their duty and responsibility. This statement from Ana reflects the complex and emotionally challenging nature of providing care for a person with a debilitating illness, as her spouse had dementia: "There are times when I do get frustrated and think he is ready to go into a home" (Ana). Residential care was seen as a last resort, something that may be called on when the participants felt that they could no longer cope. "The other option is he goes into care, and I'm home on my own, and I don't want that" (Olivia) [18] (p. 38).

Carers expressed a notable reluctance to admit an inability to cope, despite the range of conflicting emotions expressed as they managed the physical and emotional challenges of caring. Approaching the carer role with pragmatism involves acknowledgment of the progressive nature of many illnesses. Consequently, caregivers actively seek practical solutions to the challenges driven by the goal to keep their spouse living at home, which they perceive as being in the best interest of their wellbeing.

3.2. *Alone, Isolated, and Unsupported*

The semi-structured interviews with the seven participants captured some of the everyday realities, restrictions, and isolation they experienced while ensuring that their spouses' care needs were being met. In this account, the participant expresses the moment she recognised that her husband's illness meant that she could no longer go outside due to his need for constant supervision:

She and I were working out in the garden, and I came in to see if he was okay. And he wasn't okay at all. And he was trying to go down the hallway to go to the toilet. And very indignant because he was going to do that by himself. And so, you even got to a stage where you couldn't go outside and do the gardening (Alice). [18] (p. 59)

Gardening was a source of pleasure for many of the participants in the wider research project [18]. For some of the spousal carers, the ability to have time out in the garden was no longer readily available to them due to the demands of caring.

Feeling alone, isolated, and unsupported was a recurrent theme when the participants reflected on their experiences of caring, and these feelings were primarily linked to the restrictions placed upon them due to the realities of caring as an older adult. Below are a series of quotes from the participants that communicate some of their salient feelings about being isolated, unable to go out, experiencing a lack of family support, and a loss of friends. A participant in the wider research project, Erina, is also quoted below. She is in her eighth decade and is an active volunteer in her local community centre. Erina did not identify as a spousal carer, but her dedication to caring for older adults in her community makes her observation more poignant and has therefore been included. The final quote from Ruby illustrates an ideal, as apparent in her satisfaction with having family support close by; for Ruby, her time as a carer has passed.

"The only true time in your life you're isolated is when you're old and alone... when you're old, you can become shut in (Erina)". [18] (p. 53)

"One lives in [nearby city] and the other one lives here. I get absolutely no support. I'm doing this all by myself (Ana).

I'm scared to open the paper some days. Who is gone now (Olivia). [18] (p. 53)

I'm on my own, and I like it that way. I have 18 Mokos [grandchildren], and I always had the Mokos staying with me going to school [laughs], so it is nice to be on my own (Ruby). [18] (p. 54)

The quotes from the informal carers about the realities of life as older adults were rich and varied. Many of the participants did not receive support from their families. Those who had family involved in their lives and were no longer burdened with the responsibility of caring appeared to be significantly happier despite their grief. The findings indicate that the informal carers can be very isolated due to a lack of family presence and dwindling friendship support.

Some of the carer providers surveyed were able to provide care services that specifically targeted issues of loneliness and isolation through care professional visitings or kaumatua (older people) activity programmes. Survey Participant 12 stated, "Our visiting service provides companionship to people over 65 who are lonely/socially isolated and would like a regular weekly visit from a friendly volunteer" [18] (p.54). Other care providers surveyed were unable to fund such services, despite acknowledging how vital these types of services were. For instance, "more socialisation/day programme opportunities for those unable to access outside activities" (Participant 3) [18] (p. 54) was central to providing better support for people to remain at home. These participants were often too busy caring, leaving them lacking the time to find someone to talk about their situation, and subsequently experienced loneliness. This sense of social isolation increased their sense of being unable to cope with the day-to-day realities of caring.

3.2.1. Social Invisibility

The participants expressed that public understanding of the effects of caregiving for a spouse as an older adult was very limited, emphasising that many people fail to grasp the reality of what it is like to care for someone over the age of 65 years. They also spoke of a future in which the illness would only get worse.

A societal lack of understanding about the realities of caring later in life often served to increase the participants' sense of marginalisation and alienation.

I still think Alzheimer's is a grieving journey. Yes, it's from the moment of diagnosis, you know where it's going to end up. It's not about 'if' it's 'when' that happens. But it's both a blessing and a curse. It's a blessing in that you've got time with each other even though this person that's been such an active cheering person has all disappeared (Shannon). [18] (p. 47)

For most of the informal carers who participated in this research, community contacts were very important. People who understood the illness or had family members with a similar diagnosis were highly valued. As one participant said: "your whole social life really involved people who were affected by Parkinson's because they could understand" which may be a comfort when there is "the frightening world that you navigate" [18] (p. 51).

Given the challenges of spousal care as an older adult, there is a need to tangibly recognise the social and emotional needs of these carers and provide accessible carer support [69]. The participants who were informal carers reflected on feelings of being invisible and suffering in silence. The frustration expressed by the participants about the lack of access to relevant care assistance and respite was a significant theme that was linked to feelings of social isolation and even societal abandonment. As an example, one of the spousal carers interviewed recounted a situation where she had been refused post-op care by a needs assessor because she was deemed to be able-bodied. This refusal of short-term care during her recovery from surgery had a direct impact on her ability to attend to the needs of her spouse, who was dependent on her to provide day-to-day care. Many of the participants spoke about the pressure on them to stay well so that they could maintain their

duties as carers. Having access to emergency respite care would assist informal carers to attend to their own medical needs and would therefore be less likely to burn out and feel unable to cope.

The interviews with these seven informal carers also helped illustrate the way in which these participants navigated their caregiving identity in accordance with the complex interplay of cultural, familial, and societal norms. The significant work done by carers attending to family members is under-appreciated, unpaid work that is not counted in the gross domestic product of an economy, despite health and social services being reliant on the work that familial carers do [70,71]. The New Zealand Institute of Economic Research [72] calculates that the amount of unpaid work done by people 65 years and older to support others in their community will increase significantly and that there will be cost savings due to the unpaid work done by older adults, reducing the need for publicly funded work.

The participants' narratives illuminated their sense of isolation that they experienced as carers, and it was evident that they felt an absence of trust and solidarity in their interactions with healthcare providers and their wider community [73]. It is well-known that social isolation and loneliness are risk factors for poor mental and physical health [74].

What would have been perfect would be if there could have been respite care in the home at an affordable price and for a month... just to give me a month off (Alice).

As caring for a spouse or family member is seen as a social expectation [75], there is a lack of support surrounding the carers and not enough services to provide them with a chance to have a break from this full-time role [64]. This role can take a big toll on the mental and physical health of the carer, with some caregivers being called "the hidden patient," as it is not uncommon for them to develop symptoms due to the stress of the role they are in [65]. This role is crucial to managing the care of a person who is unwell and is not acknowledged enough in policy, as active informal carers work alongside primary healthcare providers [76]. Informal carers are currently bridging the gaps in current formal healthcare and social services [1,76] and are not recognised enough for it.

3.2.2. Respite Services

The findings indicate that respite care outside of the home is not always practical or agreed to by the person requiring care; furthermore, it is often not available when needed. Further, many of the informal carers did not want their loved ones to go into respite care. Despite this reluctance, the need for more carer respite services was a central finding of the participant survey completed by the needs assessors and care providers, and these findings are consistent with the most recent [77] State of Caring Report by Carers NZ and the Carers Alliance.

Thirty-eight percent of the care professionals surveyed in this research project indicated that the service they worked for provides some form of carer respite. In response to the survey question 'What would enable people over the age of 65 years to be better supported to remain at home?'. Several participants emphasised the importance of services targeting respite for carers. As Participant 9 noted, the community care sector needs "to provide better in-home respite options for full-time carers to reduce carer stress" [18] (p. 39). Participant 6 asserted that there is a need for "greater availability of day programme/care and respite care to support spouses/other full-time carers". [18] (p. 39). There was an expressed need for funding for home-based daytime respite care:

Sometimes, day programmes aren't suitable, and it is difficult for carers to attend to their own needs safely. Carer support needs to be more appropriately funded, as it is only a contribution to the cost. Residential respite should be offered within

the home. Carers to be available up until say about 9 PM, not everyone wants to go to bed at 5 pm (Participant 4). [18] (p. 39)

3.3. Pragmatic Response to Duty of Care

It is evident from the voices of the women interviewed that in their everyday care, they focused on achieving positive outcomes for their spouses. They were pragmatic in their ability to adapt; at times, they reconciled themselves to their sense of being overwhelmed and could speak to knowledge of systemic issues underpinning their situation. For example,

“What happens if you do not know what the system is? And maybe that was my detriment, thinking that I had to do it myself. . . Did anybody sit down with you early in the piece and sort of, kind of, put [it to] you to fully understand the next phases? (Alice).

Women’s unpaid caregiving sustains healthcare systems worldwide, often in a manner that is under-acknowledged, not quantified, or compensated [78]. For this group of participants, six of the seven spousal carers were women caring 24 h per day, with little respite. This statement speaks to the unpaid work that these carers did as spouses

Again, really everything. If he’s poorly, I get him food. I cook; I clean. I drive if he’s been in for a colonoscopy, that sort of thing. Then I drive him there, bring him back. Everything a wife does. Really. Too numerous to list (Beatrice). [18] (p. 36)

Women live longer, and their rights as older adults continue to be compromised; further attention to the gendered experiences of women throughout their lifespan is needed [79]. The survey responses from needs assessors and care professionals often reflected worries about the escalating need and complexity of care, with many noting that one of their primary challenges is their “inability to provide services when it is clearly needed” (Participant 8). Meeting the care needs of older adults depends on collective efforts and a strong dedication to equitable, inclusive practices at all levels [34].

3.3.1. Needs Assessments for Unpaid Carers

The unspoken consequence of gender norms positions aged women as caregivers and assumes that they will take on this role despite having to shoulder the burdens that come along with it [80]. This role is significantly more difficult when there is a lack of support from the current systems in place in Aotearoa New Zealand. If healthcare systems continue to rely on unpaid carers, more should be done to support them [67,81].

One of the things I did ask for was, “could I have someone to do the vacuuming?” And I was declined because I’m an “able-bodied woman.” And I kept thinking it was not just that, if somebody could do the vacuum cleaning, I could look after [him]. But I had to do both (Alice). [18] (p. 37)

When applying for formal care in Aotearoa New Zealand, an unwell person will have their needs assessed to understand how they can be supported to live as independently as possible. This is helpful as it can alleviate some stress on the informal carer who lives in the same household. However, informal carers in this study did not have their own needs assessed. They were trying to balance their own life while meeting the needs of their partner, whom they care for, and on top of that, shouldering all the household responsibilities, such as cleaning. Needs assessments could be more effective if they looked at the needs of the household rather than just the needs of the unwell person [77].

It was evident that the spousal carers delayed attending to their own health needs due to their caring responsibilities. Alpass et al. [82] highlighted similar findings, demonstrating that despite the crucial role older caregivers play for individuals and society, their personal health and wellbeing frequently decline.

The participant interviews emphasise the struggles that carers had with the structure and supply of formal care provisions, and a nationwide call centre for informal carers would greatly assist with accessing care support [83]. The participants spoke about how hard it was to reach out for meaningful assistance, and this was linked to an expressed sense of invisibility in their roles as carers. The consequences of being unable to access meaningful help and the overlooked role of older people providing care in the community had significant effects on their physical and mental health. The participants' responses demonstrated the pragmatic mindset that they had as informal carers, while also serving to underscore the necessity of responsive support systems for informal carers.

3.3.2. Care Across Genders

The research findings illustrate how common it is for spousal carers to become socially isolated, with their independence so limited that they have few personal joys left, unless family or service providers can offer quality respite. Dealing with issues such as night-time incontinence adds to this burden, due to the amount of cleaning required alongside disrupted sleep. This work done by the informal caregivers was often gendered and under-recognised by the state; however, spousal caregiving is not always the remit of women. Amid the predominantly female narratives of spousal caregiving, the inclusion of the male participants' voices offers an important counterpoint. In the male participant's interview, it was evident that, like the female participants, he was alone, isolated, and unsupported when caring for his wife, who is now deceased. This statement speaks to his duty of care for his spouse during her final months:

Just a husband that loved his wife and didn't want anybody else to be doing for her that I could do (John). [18] (p. 51)

Although this article conceptualises caring as a gendered activity, the lived realities of individuals, as demonstrated by the male spousal carer in this study, highlight the vulnerability inherent in caregiving regardless of gender. All these challenges, coupled with the lack of external support, emphasise the urgent need for better support and resources for these informal spousal carers.

4. Conclusions

The findings suggest that the care requirements of older adults are diverse, and care provisions should be tailored to individualised needs with the realisation that these needs will evolve and most likely worsen. The study found that the decision to stay within the community without relying on hospital or residential aged services can prolong independence in a familiar home environment, if care services are customised to the specific needs of the household. The study identified that informal carers, who were primarily women, also face their own social, financial, and health realities, which impact their ability to care, and that these needs are often devalued and disregarded.

The care of a spouse over the age of 65 is a challenging life circumstance for many women, as frailties related to aging often get worse. The often-invisible work of women providing home-based care for their spouses was a salient impact of choosing to age in place in the community. At the extreme end of caring, for some, it poses a risk of physical and mental harm as their partner's cognition or capacity for impulse control decreases with their medical condition. For others, caring for a spouse can result in loneliness through social isolation, lack of mental stimulation, and concern for their own physical, mental, social, and financial wellbeing. Some of the participant caregivers had to balance their own wellbeing needs with those of their spouses, often in isolation from significant community and familial supports. Providing social work services from primary health clinics and community centres would improve the ability of spousal carers to access help before they

reach breaking point. To further prevent carer burnout, access to home-based carer respite is needed for people who are housebound, and expanding the availability of overnight residential care respite beds would assist in providing carer relief.

The participants in this study wanted to continue in their role as carers for a variety of overlapping reasons, such as financial, marital commitment, duty, love, and companionship. Policy development to enhance the support available to informal carers, who are predominantly older women, should also include formal recognition of their contributions and personal needs. These initiatives require the support of advocacy and changes in societal expectations, which collectively have the potential to positively influence and improve the quality of life for older individuals regardless of gender. The question must be asked: if women refused to care, then how would the ageing-in-place policy stand up?

Author Contributions: All authors have made a substantial contribution to the conception and design, or analysis and interpretation of data, and the drafting of this article. Conceptualisation, K.G.-S., M.C. and P.H.; Validation, K.G.-S., M.C. and P.H.; Formal Analysis, K.G.-S., M.C. and P.H.; Investigation, K.G.-S., M.C. and P.H.; Data Curation, K.G.-S., M.C. and P.H.; Writing—Original Draft Preparation, K.G.-S., M.C. and P.H.; Methodology, K.G.-S. and P.H.; Supervision, K.G.-S. and P.H.; Software, K.G.-S. and M.C.; Writing—Review and Editing, K.G.-S. and M.C.; Project Administration, K.G.-S.; Resources, K.G.-S.; Validation, K.G.-S. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Division of Arts, Law, Psychology and Social Sciences Human Research Ethics Committee at the University of Waikato (Approval number FS203-27 and date of approval 31 July 2023).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The original contributions presented in this study are included in the article. Further inquiries can be directed to the corresponding author.

Acknowledgments: We wish to thank the members of the Home Care Advocacy Group for instigating this research and their support of the research project as it unfolded. Thanks to Bev Edlin, Barbara Whyte, and Lesley Lyons-McAdam for their valued assistance with the participant interviews and their contribution to the early development of the research categories. Thanks to Bronwen Cowie, whose helpful suggestions contributed to reshaping aspects of this article. We also wish to acknowledge the support of the 2023 University of Waikato Undergraduate Summer Research Scholarship, which provided an internship to assist with transcription processes, data analysis, and a review of literature.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

OECD	Organisation for Economic Co-operation and Development
HCAG	Home Care Advocacy Group
RWNZ	Tauranga Rural Women
GPW BOP	Grey Power Western Bay of Plenty
NCW	National Council of Women Tauranga

References

1. Abey-Nesbit, R.; Doren, S.; Ahn, S.; Iheme, L.; Peel, N.M.; Declercq, A.; Hirdes, J.; Allore, H.; Jamieson, H.A. Factors associated with caregiver distress among home care clients in New Zealand: Evidence based on data from interRAI Home Care assessment. *Australas. J. Ageing* **2022**, *41*, 237–246. [CrossRef]
2. Ministry of Social Development. *Who are Carers?* Ministry of Social Development: Wellington, New Zealand, 2019. Available online: <https://www.msdd.govt.nz/documents/what-we-can-do/community/carers/who-are-carers.pdf> (accessed on 8 January 2024).
3. Heyes, R.; Grimmond, D. *The Economic Contribution and Sacrifices of Unpaid Family, Whānau and Aiga Carers in New Zealand*; Informetrics: Wellington, New Zealand, 2022. Available online: <https://digitalnz.org/records/49973290> (accessed on 8 January 2024).
4. Rose, K.; Kozłowski, D.; Horstmannshof, L. Experiences of Ageing in Place in Australia and New Zealand: A Scoping Review. *J. Community Appl. Soc. Psychol.* **2023**, *33*, 623–645. [CrossRef]
5. Stats NZ. *National Population Projections: 2022 (Base)–2073*; Stats NZ: Wellington, New Zealand, 2022. Available online: <https://www.stats.govt.nz/information-releases/national-population-projections-2022base2073> (accessed on 8 January 2024).
6. United Nations, Department of Economic and Social Affairs. *World Social Report 2023: Leaving No One Behind in an Ageing World*; United Nations: New York, NY, USA, 2023. Available online: <https://desapublications.un.org/publications/world-social-report-2023-leaving-no-one-behind-ageing-world> (accessed on 8 January 2024).
7. Jackson, N. *The Demographic Forces Shaping New Zealand's Future*; National Institute of Demographic and Economic Analysis, University of Waikato: Hamilton, New Zealand, 2011. Available online: https://ndhadeliver.natlib.govt.nz/delivery/DeliveryManagerServlet?dps_pid=IE9409024 (accessed on 8 January 2024).
8. St John, S.; Dale, M.; Aston, T. A New Approach to Funding the Costs of New Zealand's Ageing Population. *N. Z. Popul. Rev.* **2012**, *38*, 55–76.
9. World Health Organization, Regional Office for South-East Asia. *South-East Asia Regional Strategy on Health Ageing: 2024–2030*; World Health Organization: New Delhi, India, 2025. Available online: <https://www.who.int/publications/i/item/9789290220244> (accessed on 1 September 2025).
10. OECD. *New Orientations for Social Policy*; Organisation for Economic Co-operation and Development: Paris, France, 1992. Available online: [https://one.oecd.org/document/SG/PRESS\(92\)94/en/pdf](https://one.oecd.org/document/SG/PRESS(92)94/en/pdf) (accessed on 8 January 2024).
11. Davey, J. “Aging in Place”: The Views of Older Homeowners on Maintenance, Renovation and Adaptation. *Soc. Policy J. N. Z.* **2006**, *27*, 128–141.
12. World Health Organization. *Integrated Care for Older People (ICOPE): Guidance for Person-Centred Assessment and Pathways in Primary Care*, 2nd ed.; World Health Organization: Geneva, Switzerland, 2024. Available online: <https://iris.who.int/handle/10665/380175> (accessed on 1 September 2025).
13. Associate Minister of Health. *Healthy Ageing Strategy*; Ministry of Health: Wellington, New Zealand, 2016. Available online: <https://www.health.govt.nz/publications/healthy-ageing-strategy> (accessed on 8 January 2024).
14. Office for Seniors. *Better Later Life—He Oranga Kaumātua: 2019 to 2034*; Office for Seniors: Wellington, New Zealand, 2021. Available online: <https://www.officeforseniors.govt.nz/better-later-life-strategy> (accessed on 1 September 2025).
15. Napier, S.; Neville, S.; Adams, J. Ageing in Place in a Rural Town in Aotearoa New Zealand: A Deweyan Transactional Perspective. *J. Rural Stud.* **2024**, *111*, 103413. [CrossRef]
16. Wiles, J.L.; Leibing, A.; Guberman, N.; Reeve, J.; Allen, R.E.S. The Meaning of ‘Aging in Place’ to Older People. *Gerontologist* **2012**, *52*, 357–366. [CrossRef] [PubMed]
17. Ratnayake, M.; Lukas, S.; Brathwaite, S.; Neave, J.; Henry, H. Aging in Place: Are We Prepared? *Del. J. Public Health* **2022**, *8*, 28–31. [CrossRef]
18. Glubb-Smith, K.; Hanlen, T. *Home Care Needs of Older People: Western Bay of Plenty District*; Home Care Advocacy Group: Tauranga, New Zealand, 2024. [CrossRef]
19. New Group to Advocate for WBOP's Elderly. In *SunLive*; Sun Media Publication: Tauranga, New Zealand, 2023. Available online: <https://www.sunlive.co.nz/news/321822-new-group-to-advocate-wbops-elderly.html> (accessed on 8 January 2024).
20. Cox, C. The Sustainable Development Goals and Aging: Implications for Social Work. *J. Hum. Rights Soc. Work* **2020**, *5*, 39–47. [CrossRef]
21. Askerud, A.; Jaye, C.; McKinlay, E.; Doolan-Noble, F. What Is the Answer to the Challenge of Multimorbidity in New Zealand? *J. Prim. Health Care* **2020**, *12*, 118–121. [CrossRef]
22. Came, H.; O'Sullivan, D.; Kidd, J.; McCreanor, T. The Waitangi Tribunal's WAI 2575 Report: Implications for Decolonizing Health Systems. *Health Hum. Rights* **2020**, *22*, 209–220. [PubMed]
23. Langmann, E.; Weßel, M. Leaving No One Behind: Successful Ageing at the Intersection of Ageism and Ableism. *Philos. Ethics Humanit. Med.* **2023**, *18*, 22. [CrossRef]
24. Pinto, S.A.; Mok, P.; Warn, V. *Older People Experiencing Vulnerability and Multiple Disadvantage: A Report on the Needs of Older People (65+) in Health, Housing, Finance, Social Connections, and Access*; Social Wellbeing Agency: Wellington, New

- Zealand, 2023. Available online: <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/older-people-experiencing-vulnerability-and-multiple-disadvantage-in-new-zealand/older-people-experiencing-vulnerability-and-multiple-disadvantage-in-new-zealand.html> (accessed on 1 September 2025).
25. Pavarini, S.C.I.; Neri, A.L.; Brigola, A.G.; Ottaviani, A.C.; Souza, É.N.; Rossetti, E.S.; Terassi, M.; Oliveira, N.A.; Luchesi, B.M. Elderly Caregivers Living in Urban, Rural, and High Social Vulnerability Contexts. *Rev. Esc. Enferm. USP* **2017**, *51*, e03254. [CrossRef] [PubMed]
 26. Gamble, J. *New Zealand Financial Capability: Focus on Women*; Te Ara Ahunga Ora Retirement Commission: Wellington, New Zealand, 2022. Available online: <https://assets.retirement.govt.nz/public/Uploads/Deep-dive-on-womens-financial-capability.pdf> (accessed on 1 September 2025).
 27. Groom, M. Beyond the Pay Gap: The Retirement Disadvantage of Being Female. *Policy Q.* **2018**, *14*, 64–67. [CrossRef]
 28. Huang, Y.; Curtin, J. *A Review of Gender Differences in Retirement Income*; Public Policy Institute, University of Auckland: Auckland, New Zealand, 2019. [CrossRef]
 29. Lavela, S.L.; Ather, N. Psychological Health in Older Adult Spousal Caregivers of Older Adults. *Chronic Illn.* **2010**, *6*, 67–80. [CrossRef]
 30. Bom, J.; Bakx, P.; Schut, F.; van Doorslaer, E. The impact of informal caregiving for older adults on the health of various types of caregivers: A systematic review. *Gerontologist* **2018**, *59*, e629–e642. [CrossRef] [PubMed]
 31. Zygouri, I.; Cowdell, F.; Ploumis, A.; Gouva, M.; Mantzoukas, S. Gendered Experiences of Providing Informal Care for Older People: A Systematic Review and Thematic Synthesis. *BMC Health Serv. Res.* **2021**, *21*, 730. [CrossRef]
 32. Health New Zealand. *Life Expectancy in Aotearoa New Zealand: An Analysis of Socioeconomic, Geographic, Sex and Ethnic Variation from 2001 to 2022*; Health New Zealand: Wellington, New Zealand, 2024. Available online: <https://www.tewhatauora.govt.nz/assets/Uploads/Technical-Report-Life-Expectancy-Nov-2024-printable.pdf> (accessed on 16 October 2025).
 33. Dale, C.; St John, S. Women and Retirement in a Post COVID-19 World. In *University of Auckland Retirement Policy and Research Centre*; Elsevier: Amsterdam, The Netherlands, 2021. Available online: <https://ssrn.com/abstract=3869286> (accessed on 16 January 2024).
 34. Cabañero-García, E.; Martínez-Lacoba, R.; Pardo-García, I.; Amo-Saus, E. Barriers to Health, Social and Long-Term Care Access Among Older Adults: A Systematic Review of Reviews. *Int. J. Equity Health* **2025**, *24*, 72. [CrossRef] [PubMed]
 35. Coleman, T.; Kearns, R.A.; Wiles, J. Older Adults' Experiences of Home Maintenance Issues and Opportunities to Maintain Ageing in Place. *Hous. Stud.* **2016**, *31*, 964–983. [CrossRef]
 36. McKenna, D.M.; Staniforth, B. Older People Moving to Residential Care in Aotearoa New Zealand: Considerations for Social Work at Practice and Policy Levels. *Aotearoa N. Z. Soc. Work* **2017**, *29*, 28–40. [CrossRef]
 37. Panthi, M. Adaptation to Residential Care: Voices from New Zealand. *OBM Geriatr.* **2023**, *7*, 259. [CrossRef]
 38. Hall, A.; Davey, V.; McGarrigle, L.; Astbury, J.; Lazo Green, K.; Ahmed, N.; Williams, O.; Beyer, F.; Hanratty, B.; Price, D. *The Meaning of “Quality” of Homecare for Older People: A Scoping Review*; NIHR Policy Research Unit Older People and Frailty, University of Manchester: Manchester, UK, 2024. Available online: <https://documents.manchester.ac.uk/display.aspx?DocID=74963> (accessed on 1 September 2025).
 39. Hodgkin, S.; Savy, P.; Clune, S.; Mahoney, A.-M. Navigating the Marketisation of Community Aged Care Services in Rural Australia. *Int. J. Care Caring* **2020**, *4*, 377–393. [CrossRef]
 40. Scourfield, P. The Hidden, Human Costs of the UK's Failing “Market” for Home Care. *Crit. Radic. Soc. Work* **2024**, *12*, 414–422. [CrossRef]
 41. Moore, D.; Loan, J.; Rohani, M.; Trill, R.; Manning, N.; Yee, D. *A Review of Aged Care Funding and Service Models*; Te Whatu Ora—Health New Zealand: Wellington, New Zealand, 2024. Available online: https://hcha.org.nz/assets/Uploads/FINAL_A-review-of-aged-care-funding-and-service-models_strategic-assessment.pdf (accessed on 1 September 2025).
 42. Parr-Brownlie, L.C.; Waters, D.L.; Neville, S.; Neha, T.; Muramatsu, N. Aging in New Zealand: Ka Haere ki te Ao Pakeketanga. *Gerontologist* **2020**, *60*, 812–820. [CrossRef]
 43. Bueno, M.V.; Chase, J.-A.D. Gender Differences in Adverse Psychosocial Outcomes among Family Caregivers: A Systematic Review. *West. J. Nurs. Res.* **2022**, *45*, 78–92. [CrossRef]
 44. Morgan, T.; Bharmal, A.; Duschinsky, R.; Barclay, S. Experiences of Oldest-Old Carers Whose Partner Is Approaching End-of-Life: A Systematic Review and Narrative Synthesis. *PLoS ONE* **2020**, *15*, e0232401. [CrossRef]
 45. Wiles, J.; Moeke-Maxwell, T.; Williams, L.; Black, S.; Trussardi, G.; Gott, M. Caregivers for People at End of Life in Advanced Age: Knowing, Doing and Negotiating Care. *Age Ageing* **2018**, *47*, 887–895. [CrossRef]
 46. Fernández-Carro, C.; Faus-Bertomeu, A.; Rodríguez-Blazquez, C.; Forjaz, M.J.; Bernal-Alonso, A.; Ayala, A. The Impact of Caregiving on Older Caregivers' Health: A Scoping Review. *Ageing Int.* **2025**, *50*, 34. [CrossRef]
 47. Jacobson, J.; Gomersall, J.S.; Campbell, J.; Hughes, M. Carers' Experiences When the Person for Whom They Have Been Caring Enters a Residential Aged Care Facility Permanently: A Systematic Review. *JBI Evid. Synth.* **2015**, *13*, 241–317.

48. Larkey, F.A.; Hughes, M.; Nancarrow, S. The Experience of Entering Residential Aged Care: The Views of Residents, Family Members and Staff—An Appreciative Inquiry. *Australas. J. Ageing* **2024**, *43*, 52–60. [CrossRef] [PubMed]
49. Mead, H.M. *Tikanga Māori: Living by Māori Values*; Huia Publishers: Wellington, New Zealand, 2016.
50. Sa'uLilo, L. *Culturally Healthy Urban Design Among Pacific Elders for Good Health Outcomes: A Brief Literature Review*; Ageing Well and Healthier Lives National Science Challenges: Auckland, New Zealand, 2021. Available online: <https://www.futurestreets.org.nz/culturally-healthy-urban-design-among-pacific-elders-a-literature-review> (accessed on 23 January 2024).
51. Beks, H.; Clayden, S.; West, E.; King, O.; Alston, L.; Williams, S.; Sayner, A.; Huggins, C.; McNamara, K.; Gaffy, E.; et al. *Translating Policy into Practice by Engaging Older Persons and Their Carers as Co-Researchers*; Deeble Institute for Health Policy Research, Australian Healthcare and Hospitals Association: Canberra, Australia, 2024. Available online: <https://deliver.westernalliance.org.au/2024/03/how-can-the-australian-health-care-system-be-more-responsive-to-the-needs-of-older-persons-and-their-carers-heres-how> (accessed on 1 September 2025).
52. Bindels, J.; Baur, V.; Cox, K.; Heijting, S.; Abma, T. Older People as Co-Researchers: A Collaborative Journey. *Ageing Soc.* **2014**, *34*, 951–973. [CrossRef]
53. World Health Organization. *United Nations Decade of Healthy Ageing: Plan of Action*; World Health Organization: Geneva, Switzerland, 2020. Available online: <https://cdn.who.int/media/docs/default-source/decade-of-healthy-ageing/decade-proposal-final-apr2020-en.pdf> (accessed on 25 January 2024).
54. Healy, K. *Social Work Theories in Context: Creating Frameworks for Practice*, 3rd ed.; Bloomsbury Publishing: London, UK, 2022.
55. Charmaz, K. "With Constructivist Grounded Theory You Can't Hide": Social Justice Research and Critical Inquiry in the Public Sphere. *Qual. Inq.* **2020**, *26*, 165–176. [CrossRef]
56. Patton, M.Q. *Qualitative Research and Evaluation Methods*, 3rd ed.; Sage Publications: Thousand Oaks, CA, USA, 2002.
57. Davies, M.; Hughes, N. *Doing a Successful Research Project: Using Qualitative or Quantitative Methods*, 2nd ed.; Bloomsbury Publishing: London, UK, 2014.
58. Stephens, C.; Birchall, M.; Thompson, J. *Diversity in Housing Experiences and Their Correlates for New Zealand Adults Aged 75+ and 65–74 Years*; Report for the Commission for Financial Capability; Health and Ageing Research Team, Massey University: Wellington, New Zealand, 2021. Available online: https://www.massey.ac.nz/documents/1089/CFFC_Report_June_2021.pdf (accessed on 18 January 2024).
59. MacAskill, M.R.; Pitcher, T.L.; Melzer, T.R.; Myall, D.J.; Horne, K.-L.; Shoorangiz, R.; Almuqbel, M.M.; Livingston, L.; Grenfell, S.; Pascoe, M.J.; et al. The New Zealand Parkinson's Progression Programme. *J. R. Soc. N. Z.* **2023**, *53*, 466–488. [CrossRef]
60. Tippet, L.J.; Cawston, E.E.; Morgan, C.A.; Melzer, T.R.; Brickell, K.L.; Ilse, C.; Cheung, G.; Kirk, I.J.; Roberts, R.P.; Govender, J.; et al. Dementia Prevention Research Clinic: A Longitudinal Study Investigating Factors Influencing the Development of Alzheimer's Disease in Aotearoa, New Zealand. *J. R. Soc. N. Z.* **2023**, *53*, 489–510. [CrossRef]
61. Bazeley, P.; Jackson, K. *Qualitative Data Analysis with NVivo*; Sage Publishing: Thousand Oaks, CA, USA, 2013.
62. Charmaz, K. *Constructing Grounded Theory*, 2nd ed.; Sage Publications: London, UK, 2014.
63. Fouché, C. *Practice Research Partnerships in Social Work: Making a Difference*; Policy Press: Bristol, UK, 2015.
64. Wiles, J. Informal Caregivers' Experiences of Formal Support in a Changing Context. *Health Soc. Care Community* **2003**, *11*, 189–207. [CrossRef] [PubMed]
65. De Fazio, P.; Ciambone, P.; Cerminara, G.; Barbuto, E.; Bruni, A.; Gentile, P.; Talarico, A.; Lacava, R.; Gareri, P.; Segura-García, C. Depressive Symptoms in Caregivers of Patients with Dementia: Demographic Variables and Burden. *Clin. Interv. Aging* **2015**, *10*, 1085–1090. [CrossRef] [PubMed]
66. Eriksson, H.; Sandberg, J.; Hellström, I. Experiences of Long-Term Home Care as an Informal Caregiver to a Spouse: Gendered Meanings in Everyday Life for Female Carers. *Int. J. Older People Nurs.* **2013**, *8*, 159–165. [CrossRef]
67. Gibson, R.; Abey-Nesbit, R.; Gander, P.; Parsons, M. Exploring Older Care Recipients' Sleep Status as a Predictor for Informal Carer Distress: Evidence from New Zealand's interRAI Home Care Assessment Data. *BMJ Open* **2023**, *13*, e073524. [CrossRef]
68. Rea, H.; Kenealy, T.; Sheridan, N.; Gorman, D. Invisible Care: Do We Need a Code of Rights to Protect Family and Informal Carers? *N. Z. Med. J.* **2010**, *123*, 5–6.
69. Macdonald, M.; Martin-Misener, R.; Weeks, L.; Helwig, M.; Moody, E.; MacLean, H. Experiences and Perceptions of Spousal/Partner Caregivers Providing Care for Community-Dwelling Adults with Dementia: A Qualitative Systematic Review. *JBMEvid. Synth.* **2020**, *18*, 647–703. [CrossRef]
70. Burholt, V.; Balmer, D.; Frey, R.; Meha, P.; Parsons, J.; Roberts, M.; Simpson, M.L.; Wiles, J.; Gregorzewski, M.; Percival, T.; et al. Health Equity and Wellbeing Among Older People's Caregivers in New Zealand During COVID-19: Protocol for a Qualitative Study. *PLoS ONE* **2022**, *17*, e0271114. [CrossRef] [PubMed]
71. Waring, M. *Still Counting: Wellbeing, Women's Work and Policy-Making*; Bridget Williams Books: Wellington, New Zealand, 2018.

72. New Zealand Institute of Economic Research. *Business of Ageing, 2023 Update: A Report for the Office for Seniors*; NZIER: Wellington, New Zealand, 2024. Available online: https://www.officeforseniors.govt.nz/assets/Uploads/7000OFS_Business-of-Ageing-update-2023_3.pdf (accessed on 1 September 2025).
73. Tronto, J. There Is an Alternative: Homines Curans and the Limits of Neoliberalism. *Int. J. Care Caring* **2017**, *1*, 27–43. [[CrossRef](#)]
74. Courtin, E.; Knapp, M. Social Isolation, Loneliness and Health in Old Age: A Scoping Review. *Health Soc. Care Community* **2017**, *25*, 799–812. [[CrossRef](#)]
75. Ministry of Social Development. *The New Zealand Carers' Strategy*; Ministry of Social Development: Wellington, New Zealand, 2023. Available online: <https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/policy-development/carers-strategy> (accessed on 29 January 2024).
76. Wong-Cornall, C.; Parsons, J.; Sheridan, N.; Kenealy, T.; Peckham, A. Extending “Continuity of Care” to Include the Contribution of Family Carers. *Int. J. Integr. Care* **2017**, *17*, 11. [[CrossRef](#)] [[PubMed](#)]
77. Synergia. *The State of Caring in Aotearoa: A Report for Carers NZ and the Carers Alliance*; Carers NZ: Auckland, New Zealand, 2022. Available online: <https://carers.net.nz/state-of-caring-survey-2024> (accessed on 1 September 2025).
78. Davies, S.E.; Harman, S.; Manjoo, R.; Tanyag, M.; Wenham, C. Why It Must Be a Feminist Global Health Agenda. *Lancet* **2019**, *393*, 601–603. [[CrossRef](#)]
79. Came, H.; Matheson, A.; Kidd, J. Smashing the Patriarchy to Address Gender Health Inequities: Past, Present and Future Perspectives from Aotearoa (New Zealand). *Glob. Public Health* **2022**, *17*, 1540–1550. [[CrossRef](#)]
80. Williams, L.A.; Giddings, L.S.; Bellamy, G.; Gott, M. “Because It’s the Wife Who Has to Look After the Man”: A Descriptive Qualitative Study of Older Women and the Intersection of Gender and the Provision of Family Caregiving at the End of Life. *Palliat. Med.* **2017**, *31*, 223–230. [[CrossRef](#)]
81. Swain, N. Distress in Informal Carers of the Elderly in New Zealand. *N. Z. Med. J.* **2018**, *131*, 60–66.
82. Alpass, F.; Pond, R.; Stephens, C.; Stevenson, B.; Keeling, S.; Towers, A. The Influence of Ethnicity and Gender on Caregiver Health in Older New Zealanders. *J. Gerontol. Ser. B* **2013**, *68*, 783–793. [[CrossRef](#)] [[PubMed](#)]
83. Barnard, T.; Uekusa, S.; Stephens, C.; Alpass, F. “Call-it-in”: Addressing older informal caregivers’ support needs during the COVID-19 pandemic in Aotearoa New Zealand. *N. Z. Med. J.* **2025**, *138*, 24–35. [[CrossRef](#)] [[PubMed](#)]

Disclaimer/Publisher’s Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.