Exploring Health, Ageing and Care for Short-Term Canadian International Retirement Migrants Living Seasonally in Yuma, Arizona: A Case Study

by

John Pickering

B.A., McMaster University, 2004

Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy

in the
Department of Geography
Faculty of Environment

© John Pickering 2021
SIMON FRASER UNIVERSITY
Summer 2021

Copyright in this work is held by the author. Please ensure that any reproduction
or re-use is done in accordance with the relevant national copyright legislation.

Declaration of Committee

Name:	**John Pickering**
Degree:	**Doctor of Philosophy**
Title:	**Exploring Health, Ageing and Care for Short-Term Canadian International Retirement Migrants Living Seasonally in Yuma, Arizona: A Case Study**
Committee:	**Chair: May Farrales** Assistant Professor, Geography
	Valorie A. Crooks Supervisor Professor, Geography
	Jeremy Snyder Committee Member Professor, Health Sciences
	Andrew Sixsmith Committee Member Professor, Gerontology
	Parin Dossa Examiner Professor, Sociology and Anthropology
	Neil Hanlon External Examiner Professor, Geography University of Northern British Columbia

Ethics Statement

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

a. human research ethics approval from the Simon Fraser University Office of Research Ethics

or

b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University

or has conducted the research

c. as a co-investigator, collaborator, or research assistant in a research project approved in advance.

A copy of the approval letter has been filed with the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library
Burnaby, British Columbia, Canada

Update Spring 2016

Abstract

Short-term international retirement migration is a voluntary lifestyle where people around the age of retirement relocate from areas, typically those with cold winters, to areas with warmer and drier conditions during the winter months. This seasonal pattern of migration is common in many Global North countries, including Canada, the United States, the United Kingdom and many northern European countries. In this dissertation, I use qualitative methods informed by case study methodology to explore the lived experiences of Canadian short-term international retirement migrants managing their health while living in Yuma, Arizona. I specifically present four analyses. The first is a scoping review that synthesizes the literature about motivations for participating in international retirement migration. The second analysis presents the findings of focus groups conducted with health care providers and administrators at the main hospital in Yuma. It explores the opportunities and challenges of treating Canadian international retirement migrants. The third analysis thematically explores interviews conducted with older Canadians while in Yuma regarding how they plan to manage their health while abroad. Finally, an analysis of dyad interviews conducted with caregiver-care recipient partners explores the practice of informal caregiving among Canadian international retirement migrants while abroad and the supports used by caregivers. Overall, these analyses show how international retirement migration presents both opportunities and challenges for older Canadians, and that they serve to underscore the heterogeneity of this diverse group of travelers who have different understandings of risk as it relates to managing health while abroad. Further research is needed to explore other popular sites for retirement migration to further contextualise the experience of older Canadians living seasonally in the Southern United States and beyond.

Keywords: retirement migration; Canada; Arizona; health; United States; ageing

Dedication

This is dedicated to my infinitely patient family.

Thank you, Bryony, Tayvian, Kira and Natasha.

Acknowledgements

As is the case with any journey, there are often too many people to thank and give credit to. I apologise for anyone I have left off this list.

First and foremost, I need to acknowledge my supervisor and main source of guidance, Dr. Valorie Crooks, who worked tirelessly on my behalf to teach ‘an old dog new tricks.’ I will be forever grateful for the chance you took on this ‘old dog’ and the wisdom you have imparted onto me.

Thank you to my entire committee, Jeremy Snyder and Andrew Sixsmith, for all of their efforts towards this end.

I was also fortunate to work with so many fantastic scholars in the geography department at SFU whom I worked with on a variety of projects, courses and committees. I took so much from my fellow grad students, and I hope I was able to give some back during our time together. A special acknowledgement goes to my officemate, Sam.

A few special thanks are deserved by my following mentors who helped immeasurably along the way: Bill Ollier, Tony Gatrell and Paul Kingsbury.

Finally, my parents need to be acknowledged as an amazing source of support. Thank you for providing me with such privilege in my life and the ability to explore so many opportunities.

Table of Contents

Declaration of Committee ii
Ethics Statement iii
Abstract iv
Dedication v
Acknowledgements vi
Table of Contents vii
List of Tables x
List of Figures xi

Chapter 1. Introduction 1
1.1. Situating the Research: Health Geography 2
1.2. Situating the Research: Geographical Gerontology 4
1.3. Retirement Migration literature and the Geographies of Health and Ageing 7
1.4. Dissertation rationale and structure 9
1.5. Research Objectives 12
1.5.1. Case Study Methodology 12
1.6. Dissertation structure overview 13
1.6.1. Chapter 3: What is known about the factors motivating short-term international retirement migration? 14
1.6.2. Chapter 5: Opportunities and challenges in providing health care for International Retirement Migrants: a qualitative case study of Canadians travelling to Yuma, Arizona 15
1.6.3. Chapter 7: "If you have a pain, get on a plane": Qualitatively exploring how short-term Canadian international retirement migrants prepare to manage their health while abroad 16
1.6.4. Chapter 9: Transnational support systems for Canadian spousal caregivers living seasonally in the United States 16
1.7. Positionality and researcher reflexivity 17
1.8. What's to come 19

Chapter 2. The grey line dividing failure and success 20

Chapter 3. What is known about the factors motivating short-term international retirement migration? A scoping review 22
3.1. Abstract 22
3.2. Introduction 23
3.3. Methods 25
3.4. Findings 29
3.4.1. The Destination 32
3.4.2. The People 33
3.4.3. The Cost 34
3.4.4. The Movement 35
3.5. Discussion 36

3.5.1. Scoping review limitations 40
3.6. Conclusion..... 41

Chapter 4. Reflecting on the importance of gatekeepers (or collaborators) 42

Chapter 5. Opportunities and Challenges in Providing Health Care for International Retirement Migrants: A qualitative case study of Canadians travelling to Yuma, Arizona..... 44
5.1. Abstract 44
5.2. Background 46
5.3. Methods 48
5.3.1. Recruitment..... 49
5.3.2. Data Collection..... 50
5.3.3. Analysis 50
5.4. Results 51
5.4.1. Practice environment 52
5.4.2. Transnational Environment 54
5.4.3. Community environment 55
5.5. Discussion 56
5.6. Conclusion..... 61

Chapter 6. Embracing resourcefulness in qualitative fieldwork 63

Chapter 7. "If you have a pain, get on a plane": Qualitatively exploring how Canadian international retirement migrants prepare to manage their health while abroad 65
7.1. Abstract 65
7.2. Introduction..... 67
7.3. Methods 69
7.3.1. Recruitment..... 70
7.3.2. Data Collection..... 70
7.3.3. Analysis 71
7.4. Results 71
7.4.1. Becoming thoroughly prepared 72
7.4.2. Being preparation-adverse 74
7.4.3. Preparing by becoming informed yet not taking action 75
7.4.4. Becoming haphazardly prepared..... 76
7.5. Discussion 77
7.6. Conclusion..... 81

Chapter 8. Understanding Dyads and Researcher Reflexivity 83

Chapter 9. Relational, Community-based, and Practical: Support systems used by Canadian Spousal Caregivers in the United States 85
9.1. Abstract 85
9.2. Introduction..... 86

9.3. Methods ... 88
9.4. Findings ... 91
9.4.1. Relational support ... 92
9.4.2. Community-based support ... 93
9.4.3. Practical support ... 94
9.5. Discussion ... 95
9.6. Conclusion ... 97

Chapter 10. Conclusion ... 99
10.1. Chapter Overview ... 99
10.2. Revisiting research the objectives ... 100
10.2.1. Objective 1: Determine why older persons choose to live outside their home country seasonally ... 100
10.2.2. Objective 2: Understand the Impacts of Short-term Canadian International Retirement Migration on health care providers and care provision in Yuma ... 102
10.2.3. Objective 3: Explore How Transnational Aspects of Retirement Migration Shape Care Practices and How Canadian Retirement Migrants Manage Their Health in Yuma ... 104
10.3. Cross-cutting themes across all analyses ... 105
10.4. Future research directions ... 107
10.5. Concluding thoughts ... 108

References ... 110

List of Tables

Table 3.1. Preliminary Scoping Review Keyword Search Strategy 26
Table 3.2. Refined Scoping Review Keyword Search Strategy 27
Table 3.3. Academic Databases Searched, IRM Scoping Review 28
Table 3.4. Summary of themes and findings 37
Table 5.1. Synthesis of the Opportunities and Challenges in Providing Health Care to Canadian International Retirement Migrants in Yuma, Arizona 57
Table 7.1. Synthesis of Canadian international retirement migrants' preparatory strategies for managing their health while abroad 78

List of Figures

Figure 1.1 Geographies of Ageing (Skinner et al., 2015) 5
Figure 3.1 Scoping review process and results 31

Chapter 1.
Introduction

In late October, just after the Canadian Thanksgiving holiday, a great annual migration typically takes place. The cold artic winds descend and the jet stream begins to dip southward causing the temperature to drop in the evenings. Depending on where one lives in Canada, the first weather forecasts for snow may be announced. This is the time when migratory birds begin their long, annual journeys south to avoid the impending cold winters. This annual migration of birds and its implications for health and health care are the focus of my dissertation, although not of the avian variety; instead, I focus on human *snowbirds*. The moniker 'snowbirds' is used to refer to the annual movement, or migration, of older Canadians to warmer climates abroad during the winter months. These snowbirds are 'seasonal or short-term international retirement migrants', which I shorten herein to 'retirement migrants.' Thousands of older Canadians around the age of retirement and beyond choose to live seasonally in relatively warm, dry destinations during the winter months for a number of reasons, some of which I explore in this dissertation.

My research focuses on older Canadians who live seasonally in Yuma, Arizona in the southwestern United States (US). Southern Arizona, including Yuma, shares the upper Sonoran Desert with northern Mexico and enjoys a climate that remains warm and dry throughout the year, including the winter months. Drawn by the weather and returning for the social connections, Canadian retirement migrants can experience an active lifestyle unhampered by the mobility and isolation challenges that can be brought about at home during the winter months in Canada (e.g., Longino & Taplin, 1994; Radcliff et al., 2005). Older Canadians living seasonally in the US can also face numerous challenges to take part in this lifestyle, such as maintaining two residences, travelling long distances, and navigating a foreign income tax system (e.g., Coates et al., 2002; Longino et al., 1991; Longino and Taplin 1994; Marshall, et al. 1989). Some of the most significant challenges relate to health management and health care access, which are the focus of my research objectives.

In this dissertation, I present a case study of the interrelationships between place, ageing, and health as they are experienced by older Canadians who choose to live as retirement migrants. Specifically, I explore the wider motivations behind this transnational lifestyle (Chapter 3), as well as place-specific experiences of health management by Canadian short-term international retirement migrants in Yuma, Arizona (Chapters 5, 7, 9). This includes perspectives from both Canadian retirement migrants and destination-based health care professionals. My research is situated at the intersection of health geography and geographic gerontology, and it explores how health mobilities, movements across borders, and health care resources influence lived experiences with the goal of providing a deeper understanding of why older people choose to take part in this practice and the complicated health-related negotiations needed to successfully navigate such a lifestyle. When taken together, the four analyses presented in this dissertation serve to challenge our understanding of the aging process as it relates to migration and health. The remainder of this introductory chapter situates my research within the fields of health geography and geographical gerontology and also introduces both retirement migration and the destination of Yuma, Arizona. The final sub-sections detail my research objectives, dissertation structure, and specific analyses.

1.1. Situating the Research: Health Geography

Health geography is the primary disciplinary lens that has informed my research, with a primary focus on embodied connections between place and health. Interest in the connections between place and health have a long history with famous historical examples including Hippocrates' *Airs, Waters and Places* in 400 BC, as well as John Snow's work on the 1854 cholera epidemic in London. Since its formal inception with Kearns' (1993) seminal paper *Place and Health: towards a reformed medical geography*, health geographers have engaged with numerous theoretical models, multi-disciplinary connections, and approaches. Thus, health geography is a sub-discipline of human geography with deep connections with other sub-disciplines and fields of research. For example, in some areas of the sub-discipline, engagement with social critical theory has become a hallmark of health geography (Brown 1997; Craddock, 2001; Dyck, 1999; Philo 1997); while in other areas, non-biomedical definitions of health are explored through a social determinants of health framework (Marmot et al., 2008; Crooks et al.,

2018). While theoretical and conceptual considerations push the boundaries of health geography, qualitative research provides significant contributions by uncovering the lived experiences relating to the interconnections of health and place (Andrews, 2002; Baxter and Eyles, 1997). My dissertation is empirical in nature and contributes to this tradition in health geography. In the remainder this section I focus on the role of care in health geographic inquiry and detail connections to the 'mobilities turn' in the social sciences more broadly.

Qualitative approaches in health geography span a wide range of methods with a variety of participant groups (Baxter and Jack, 2008). Here, I rely on exploratory case study methodology (Yin, 2014) to inform my research design. The use of case study methodology typically uses multiple data sources and methods to uncover a variety of voices or viewpoints and the application of collaborative approaches; all of which add nuance and rigour to the understandings of a study, process or phenomenon (Evers and Van Staa, 2010). In the context of this dissertation, I have drawn on a long history within health geography of focusing on the places where phenomena actually take place, particularly in understandings of care and care landscapes (Conradson, 2003). Scholars interested in this research explore the social meanings and significance of how external forces shape (Andrews et al., 2012) and are shaped by (Bowlby, 2012) specific sites of care, including the interconnected relationships and lived experiences occurring within them. My dissertation combines a health geographic lens and exploratory case study methodology to probe care practices in a transnational context, both formal and informal, to gain insight into how retirement migration shapes the lived experiences of mobile older Canadians.

Care shapes, and is shaped by, the places in which it occurs. This highlights the agency of the care process. The ways in which care is understood is also fluid. For example, care is both formal and informal, the latter of which represents a significant portion of all care provided to persons over the age of 65 (Pickard et al., 2000). Evidence of this split can be observed in the decades of policy shifts and budget reductions within the Canadian health care system that have led to an increasing dependency on informal caregivers, often family members, to fill the care gaps created by the defunded providers in the formal health care sector (Fast et al., 1999). Health geographers have considerably explored a wide range of community-based care spaces, including shelter volunteers (Conradson, 2003; Johnsen et al, 2005), connections between work and care

(Tucker, 2010), and care provided in the home (Milligan, 2005, 2010). Formal care in institutional settings continues to be a strong focus, with sites including clinics, hospitals, pharmacies and care homes (e.g., Johnsen et al., 2005b; Evans et al., 2009; Kearns et al., 2003; Thompson and Bidwell, 2015). My dissertation builds on these understandings of care to, in part, consider the interactions between formal and informal care processes through an exploration of transnational lifestyles and practice.

Health geographers have been greatly influenced by the larger 'mobilities turn' in the social sciences. Mobilities studies challenge a static view of phenomena, which previously focused on *where* things are happening, to imagine a more nuanced understanding of the movements, or flows, between places and spaces (Gatrell, 2011). This static view of place is rooted in historical scholarship that precedes the shift from medical geography to the contemporary geographies of health. Medical geographers have long been interested in disease ecology and disease epidemiology, while health geographers can be viewed as having a long-standing interest in health services provision and access (Gatrell, 2011). However, both medical and health geography studies tend to conceptualise space and place as a contained entity, as if they were processes occurring within a vessel. Transnational processes often lie outside the scope of these studies, particularly those focused on ageing populations. Some exceptions to this are the few studies conducted outside of health geography that consider the seasonal flows of retirement migrants to specific places and the potential disruptions that may cause relating to destination-based health care services (Longino et al., 1991, Northcott and Petriuk, 2011). However, little is known about the perceptions and experiences of international retirement migrants who access health care across borders. Addressing this knowledge gap is a core goal of my dissertation research, specifically in how older Canadians become prepared to deal with, or choose to avoid using, the US health care system while living abroad.

1.2. Situating the Research: Geographical Gerontology

The geographies associated with ageing and ageing bodies themselves are not new, however the threat, perceived or otherwise, ageing poses to global societies is one of the great challenges of our time (e.g., Lutz et al., 2008; Sander et al., 2015; Vojković

et al., 2014). The need to understand how ageing occurs in places carries significant meaning as the challenges and opportunities associated with population ageing has the potential to affect us all. Geographical gerontology, like health geography, is heavily influenced by the various aforementioned ‘turns’ across the social sciences, and perhaps most significantly by the ‘spatial turn’ (Warf and Aris, 2008; Withers, 2009). Initial explorations in geographical gerontology (e.g., Andrews and Phillips, 2005; Andrews et al., 2007, 2009; Andrews, Evans, Wiles, 2013; Cutchin, 2009) began in response to calls for human geographers and social gerontologists to coalesce their research. One area of exploration within geographical gerontology has been the mobilities of older populations, which is depicted in the overlapping area of the Venn diagram in Figure 1. The connections between gerontology and geography synthesized in Figure 1 explore the nexus of ageing, health, and mobility; all of which have informed the research pursued in my dissertation.

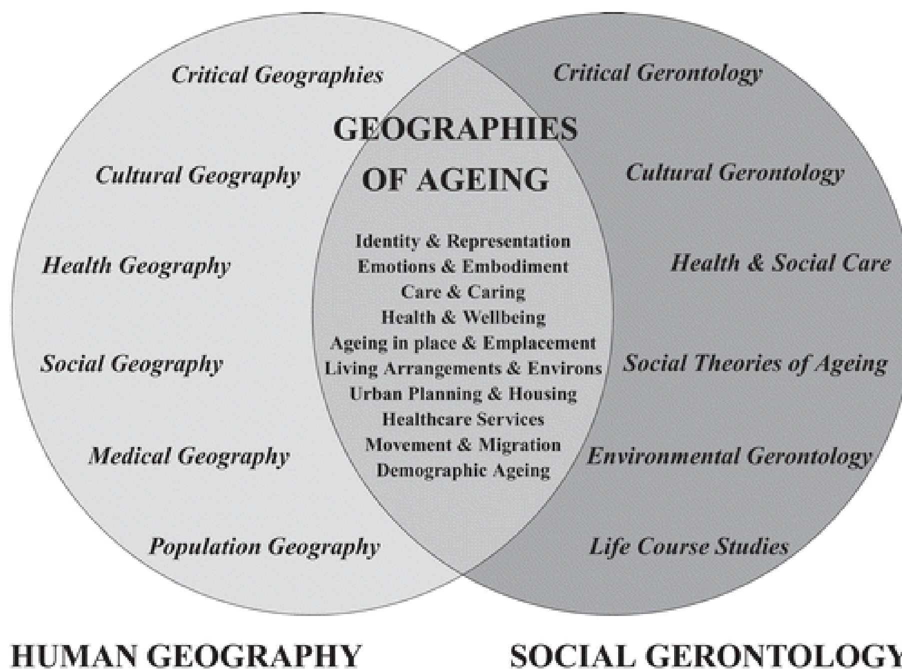

Figure 1.1 Geographies of Ageing (Skinner et al., 2015)

Within the fields of social gerontology and geographical gerontology there have been a propensity to conceptualise place and space as being static (Andrews et al., 2013). Researchers seeking to reimagine this fixed notion of space and place have been influenced further by the ‘relational turn,’ which calls for a more nuanced and dynamic

account of ageing and embodied person-place experiences (Andrews et al., 2013; Skinner et al., 2015). The history to this change lies in Rowles' early phenomenological approach to the human experience of place for older persons, in both urban (Rowles 1978) and rural (Rowles 1981) settings. Rowles would go on to identify an active and malleable relationship between person and place, including transformational changes in the meanings and significance of places due to the ageing process (2008). Further empirical work by Cutchin, Marshall and Aldrich (2010) found those engaging in 'daily activities of living' often resulted in a positive perception of a new place or home, specifically in the context of retirement communities. The entanglements of social relations and place in the lives of older persons form a complex, ongoing negotiation of person-place experiences. Analyses within my dissertation acknowledge these negotiations as important elements affecting older Canadian retirement migrants and their reliance on informal care networks within their broader communities and social networks.

The paradigmatic shift toward health mobilities has been used by geographical gerontologists to (re)consider the social implications of movements and flows of people. Cresswell (2006) considers the embodied experience of movement and the social aspects of meaning and power in the ways they affect health and well-being associated with people and places. Cresswell goes on to identify a modern world with ever expanding mobilities and interconnected activities that celebrate such movements while giving new meanings to previously ignored spaces and places (2006). Through the application of this nuanced understanding of movement, my dissertation provides a new perspective on the impacts of the seasonal flow of retirement migrants from Canada to the US. This place-making effect is visible in the creation of 'snowbird parks' or '55+ lifestyle communities,' which are terms commonly applied to the gated residential communities many snowbirds choose to live in. Geographical gerontology has a history of engaging in 'ageing community' literature (e.g., Egolf et al., 1992; Wolf and Bruhn, 1998); however, these studies often focus on how communities change as the population ages, which carry implications for the continuation of identified phenomena. Retirement migration communities differ as they are purpose-built and designed to encourage close social ties and mid-20th century charm, which results in circa 1950s suburban and/or rural idylls (Huber & O'Reilly, 2004; O'Reilly, 2007). Retirement migrants often live in extremely close proximity to other retired migrants, which adds a

layer of complexity and cohesion to social relations (Bradley, 2011; Casado-Díaz, 2009; Casado-Díaz, Casado-Díaz & Casado-Díaz, 2014). This has the effect of expanding one's support networks through the normalisation of close connections to neighbours and the communities that provide various forms of support in times of need. The social and health mobilities of retirement migration have far reaching effects that need to be considered in order to understand the implications of this retirement migration phenomenon, including health and health care. I explore these herein.

1.3. Retirement Migration literature and the Geographies of Health and Ageing

Studies on retirement migration involve a wide array of foci including ageing (e.g., Hall & Hardill, 2016; Oliver, 2012; Williams et al., 1997), migration (e.g., Gustafson, 2002; King et al., 1998; Warnes, 2009), and health (e.g., Innes, 2008; Northcott & Petriuk, 2011; Rodríguez et al., 2004), which are all core components of my dissertation. In this section I provide an overview of the retirement migration literature, highlight the differences in retirement migration practice between North America and other parts of the world, and draw together connections between health and retirement migration influencing this dissertation.

Retirement migration is a practice that explicitly connects ageing and geography. The movement of people within and beyond national borders has implications for industry, businesses, government policy and various related stakeholders; all of which create opportunities and challenges in the various destinations popular with retirement migrants (e.g., Brown et al., 2008; Huete & Mantecon, 2012). However, retirement migration is also a blanket term used to capture a highly dynamic phenomenon. For example, important differences exist regarding how this mobility plays out between Europe and North America due to the social and political differences between countries in each region. European migration often involves longer and semi-permanent stays abroad, although not exclusively, which requires a careful negotiation of the agreements between European nations (e.g., Ackers and Dwyer, 2004), now directed by the European Union (E.U.) Charter of Fundamental Rights from 2012. Interestingly, one might draw comparisons between Americans who relocate to Southern US states at the

time of retirement and long-term moves or intra-migration within the E.U. However, the differences between American states are not as significant as those between the nations that make up the E.U., which can include language and currency differences as well as differing policy climates and health and social care provisions (O'Reilly, 2007). Unlike older Americans who relocate within the US for the winter, in my research I focus on Canadians who relocate to the US for longer periods and thus cross international borders and require the navigation of foreign policies, social norms, and economic climates.

A second division in the retirement migration literature involves the data sources used in research. The 1980s and 90s saw a strong uptick in retirement migration research, both domestically within the US and internationally and much of this research relied on quantitative data through surveys (e.g., Longino et al., 1991; Longino and Taplin, 1994; Marshall et al., 1989). While such quantitative insights are useful, the lack of population-level tracking of retirement migration within the US and between the US and Canada limited researchers' abilities to assess the generalizability of survey findings. Perhaps in response to this, and as part of a qualitative turn in the social sciences more broadly, qualitative studies focusing on the lived experiences of retirement migrants became popular in 2000s and continue to this day, both in the European and North American contexts. These rich qualitative insights have led researchers to explore the motivations and decision-making processes of older persons as they navigate challenges and barriers, particularly as mobile retirement migrants (e.g., Hummert and Morgan, 2001; Oliver, 2011; O'Reilly & Benson, 2009; Sergeant & Ekerdt, 2008). In turn, this has led to deeper connections with social critical theories, as presented in studies exploring transnationalism within the context of retirement migration (e.g., Gustafson 2001, 2008). My dissertation research continues this qualitative focus while exploring significant knowledge gaps about health care use and health management in particular.

Some existing research has explored the challenges and barriers to health service access experienced by retirement migrants. In the North American context, this can be observed in studies focusing on US citizens in Mexico planning trips home to use the US health system for serious or specialized health issues (Lardiés-Bosque, 2016) and Canadians navigating the private health care system in the US (McHugh and Mings, 1994). In such research, the context of the host and sending communities for retirement

migrants is important for understanding issues shaping access and experiences of health service use. This highlights an important connection to my research probing transnational lifestyles and the ways in which people engage with formal and informal health care while living outside of their home country.

Retirement migration as a lifestyle has the potential to disrupt the person-place experience, as well as the social and residential choices commonly associated with aging. In fact, many older persons seek to enhance their existing social networks when choosing to relocate while simultaneously nurturing their existing home-based social networks to lessen such disruption (Davies and Hoath, 2016). For example, Desrosiers-Lauzon (2009) further described retirement migration communities in Florida as suppliers of the "Florida dream," an idea meant to capture the attractiveness of a community tailormade for older persons and one that would promote social networking and cohesion within. This powerful socio-spatial experience is at the core of the seasonal transnational movement that creates an appealing lifestyle many retirement migrants choose to revisit annually. The pull factor of social relations associated with retirement migration are an important contextual aspect to the research I explore in this dissertation and in some instances are explicitly considered in particular analyses.

1.4. Dissertation rationale and structure

Yuma, Arizona is a former cowboy town at the intersection of Mexico, Arizona, and California and has a long history of outsiders coming to stay or settle. It is important to add context to the city of Yuma and its inhabitants. Yuma lies at the domestic border with California and Nevada to the West, Utah to the North and New Mexico to the East; in addition to the international border with Mexico to the south. Several transnational mobilities further shape the social construction of Yuma, including, but not limited to, health worker seasonal migration, daily flows of Mexican migrant agricultural workers, off-shore medical schools residents at the Yuma Regional Medical Center, tourists, individuals accessing dental and pharmaceutical options across the border in Los, Algodones Mexico, and unregulated border migrations (e.g., illegal immigrants to the US over the Mexico border). This creates a complex population within Yuma with a variety of ethnicities living permanently in Yuma (i.e., African American, Asian, Caucasian,

Hispanic/Latinxs) as well as in-flows of a variety of ethnicities from the transnational migratory flows. During my research in the field, I made several observations, including workers of lower paid or menial jobs, which were overwhelmingly represented by people of colour. This may indicate the existence of significant issues of racism and discrimination, oft associated with the US and particularly the southern states (REFS). While I looked to interview people from all walks of life, ethnic background, socio-economic status and lived experience; this was extremely difficult. Ultimately, for Chapters 7 and 9 we only interviewed Caucasian participants who identified themselves as Cis gendered, except for 3 interviewees who identified as LGBTQIA+. I can only speculate as to the reasons for this and why so many people I observed living in the 55+ lifestyle communities were almost entirely Caucasian. It is possible that screening methods, such as required membership in housing associations, limit the ability of other ethnicities to gain access to these communities; or, the predominance of Caucasian residents may be unappealing or uninviting for other ethnicities.

Several scholars have studied this area in the past, including recent literature probing medical tourism activities originating in Yuma and continuing across the border into Los Algodones, Mexico (e.g., Adams, et al. 2017, 2018). The availability of discount dental work is also complimented by a robust discount pharmaceutical industry in Los Algodones, which supports older persons spending the winter in Yuma who may have neglected to fill their prescriptions and/or require quick and affordable access to various medicines (e.g., Adams et al., 2018; Oberle & Arreola, 2004). For all intents and purposes, Yuma represents a figurative and literal oasis in the desert as it is completely surrounded by rough desert terrain and is situated at a significant distance from other larger urban centres. For example, Quartzite is one of several small villages or towns located in the area surrounding Yuma and is a famous destination for retirement migrants looking to 'boondock' out in the open desert fields. 'Boondocking' is a term used to describe people parking a recreational vehicle (RV) or motorhome on empty land with no water or sewer hook-ups and living inexpensively, or free, during their seasonal stays. I was able visit these areas and conduct observational fieldwork during my visits to Yuma and credit these sites for providing me with a deeper and more nuanced understanding of the various ways in which people choose to live as retirement migrants. While all retirement migrants are untracked, untraced and unregulated, the boondocking RV seasonal migrants are most assuredly the least documented. Yuma is

also home to many gated RV parks, or snowbird parks within its municipal jurisdiction which offer amenities to those who rent RV parking pads for the winter months.

Yuma provides various services to attract retirement migrants. Golf courses abound, often located close to, or even within, the gated communities many retirement migrants choose to live in. Residential parks for snowbirds vary greatly in several ways, including size, cost, available amenities, location and ambiance. Other shops and services, such as large, clean and bright supermarkets, are also located in close proximity to residential parks and license plates in the parking lots reveal vehicles from Canada and the northern US frequenting these establishments. Throughout my fieldwork visits to Yuma, which included tours of gated RV parks, drives through boondocking areas, and extended observations of shops and services, I observed license plates from every province or territory in Canada except for Nunavut, which speaks to the effort of some Canadian international retirement migrants to successfully navigate the long journey south to Yuma.

The Yuma Regional Medical Center is the core of Yuma's health care landscape. It is a large, state-of-the-art medical centre offering a wide variety of services for a relatively small and isolated area in the middle of the upper Sonoran Desert. The Yuma Regional Medical Center is the only hospital in Yuma and the surrounding area and the various related primary, secondary and tertiary health care options under the Center's jurisdiction can be observed in the areas immediately surrounding the medical center. Additionally, a separate and specialised oncology clinic which is part of the Center provides active and recovery treatment for cancer patients and engages in oncological research. The nearest medical centers to compare with the size and capabilities of the Yuma Regional Medical Center are located over 250kms away by car in San Diego, California; Las Vegas, Nevada; and/or Phoenix, Arizona. These destination-specific factors create a unique and important landscape for retirement migration and informs my selection of Yuma as a research site. My dissertation research is based in Yuma, Arizona as a case study and is enhanced by both the geographical isolation of its physical location and its popularity among Canadian international retirement migrants.

1.5. Research Objectives

This dissertation counters notions that older people live sedentary, isolated lives and supports calls for health and ageing researchers to reimagine the myriad of ways people choose to age. Yuma, Arizona represents a unique opportunity as a site for my dissertation research due to its single formal medical center and extensive history as a popular destination for retirement migrants, both domestic and international. Despite the common knowledge surrounding Yuma as a popular retirement destination, little is known about how health and aging are experienced by retirement migrants who live there each winter. This is equally true for domestic migrants from the northern US states as it is for the significant population of older Canadians who share the destination seasonally. The analytic chapters within my dissertation include a review of studies related to retirement migration (Chapter 2 – scoping review) and respond to the knowledge gaps stemming from the review (Chapters 4, 6, 8) regarding ageing, care and health experiences in transnational settings that I explore within the context of Canadians wintering in Yuma. Specifically, this dissertation is informed by the following objectives, which are: 1) to synthesize why some older persons, including Canadians, choose to live outside their home country seasonally; 2) to understand the impacts Canadian retirement migration on health care providers and care provision in Yuma; and 3) to explore how transnational aspects of retirement migration shape care practices and how Canadian retirement migrants manage their health in Yuma. Specific question guides and examples of recruitment fliers have been included in a final section within this dissertation (see Chapter 11, Appendix). Together, these objectives aim to develop a rich exploration of international retirement migration in Yuma, Arizona in relation to transnational ageing and health through four distinct analyses.

1.5.1. Case Study Methodology

Case study methodology is adopted for this dissertation and has guided my approach to the primary data analyses presented in Chapters 5, 7, and 9. Qualitative methodology has a long-standing history in social sciences and human geography research (Hardwick, 2016), and is a useful approach for understanding and studying a complex social phenomenon as it occurs (Baxter and Jack, 2008). Retirement migration

is both spatially and temporally bound, and in my opinion, it represents an excellent topic for a case study approach, which has been a staple of geographical inquiry for well over a century. Case study methodology emphasises a rich and in-depth exploration from multiple perspectives (Hardwick, 2009; Simons, 2009; Thomas and Myers, 2015). The effectiveness of the evaluation of data pertaining to the case is best obtained through the use of multiple methods and analyses, as this helps to add and improve rigour in a qualitative study (Wolfram Cox and Hassard, 2010). My dissertation has been created from these principles and relies on multiple forms of data collection and analysis methods (i.e., scoping review, facility tours, focus groups, and semi-structured interviews) to understand the case. Schell (1992) asserts that there are three types of case study: exploratory, descriptive and explanatory (1992). The use of case study in this dissertation is primarily exploratory because I aim to contribute knowledge to a topic about which little is known. The nuanced data provided from both the qualitative data sets and researcher observational data in this dissertation have identified further areas of study, which is indicative of exploratory case study approaches (Schell, 1992).

The approach adopted for this dissertation is particularly appropriate given the primary objective of exploratory case studies is to study a phenomenon within the context of which it occurs, both spatially and temporally (Elger, 2010; Yin, 2014). This case study specifically explores how the processes of retirement migration, health, aging and the location of Yuma are inexorably intertwined and how this has shaped both place and process. Following Yin's approach to exploratory case studies (2014), my dissertation research provides significant insight into the process of retirement migration while using earlier aspects of the research to guide and shape later ones. Ogawa and Malen (1991) argue the use of exploratory case study method as an appropriate tool to enhance rigour in studies which rely on multivocal viewpoints, which is captured in the three analyses utilising primary data in this dissertation.

1.6. Dissertation structure overview

The structure of this dissertation is styled according to the paper-based model and is comprised of four distinct analyses involving four data sets and three research methods. Chapters 3, 5, 7 and 9 are stand-alone articles, with three already published in

academic journals and one submitted in June 2021. Between each stand-alone paper, I provide a short bridging chapter to situate the reader to each analysis and reflect on my own involvement in the research process. These bridging chapters (chapters 2, 4, 6 and 8) provide a transition between the separate data sets informing the analyses. In the remainder of this section, I will provide overviews of the analytic chapters.

1.6.1. Chapter 3: What is known about the factors motivating short-term international retirement migration?

This scoping review article follows the Arksey & O'Malley (2005) scoping review model and was published in the *Journal of Population Ageing* in 2019. Scoping reviews are a type of knowledge, or evidence, synthesis that are similar to systematic reviews. However, scoping reviews have a different function than other reviews as they do not seek to judge the quality of the research under review (Levac et al., 2010). Instead, scoping reviews are used to scope out what is known about a specific topic or focus of study and to identify knowledge gaps in existing literature (Arksey and O'Malley, 2005; Levac, et al., 2010; Munn et al., 2018). This paper provides an extensive overview of retirement migration literature in addition to determining the key motivations for seasonal retirement migrants: the destination, the people, the costs and the movement. Further, this analysis provides the only structured review to date on short-term retirement migration and offers a typology for future researchers to follow.

This chapter offers a thematic framework to conceptualize the factors that influence aspects of decision-making for seasonal retirement migrants, including decisions around whether or not to participate in this lifestyle and choosing a destination. The destination aspect of the study received the most consideration, with most articles citing climate as the key motivator. However, other aspects, such as the cost, highlight the financial complexities of managing a transnational lifestyle and the related implications for decision-making. Ultimately it is an intricate and nuanced combination of personal preference, experience and abilities that dictate where people live seasonally – whether it is in a landscaped house in Florida or an RV in the Arizona desert.

1.6.2. Chapter 5: Opportunities and challenges in providing health care for International Retirement Migrants: a qualitative case study of Canadians travelling to Yuma, Arizona

This exploratory qualitative article is based on focus group interviews with medical professionals in Yuma, Arizona conducted in May 2017 and was published in the journal *Tropical Diseases, Travel Medicine and Vaccines* in 2020. The scoping review (Chapter 3) findings revealed a lack of health care professionals' opinions and voices in existing research on retirement migration. In response to this knowledge gap, we held focus groups with three different health professional groups at Yuma Regional Medical Center to explore experiences of treating Canadian snowbirds. This provided unique insight into the inner workings and operations of the medical center relating to the treatment of older Canadians. This analysis identifies both opportunities and challenges in three separate environments: practice, transnational, and community. For example, the treatment of an older Canadian population creates complexities and challenges (e.g., billing and follow-up care), as well as opportunities (e.g., transnational physician-to-physician connections, additional revenue). Older Canadians are identified as being important clients in the greater Yuma region by participants in all focus group interviews.

This article challenges some of the long-standing views assuming Canadian international retirement migrants cause a burden on health care provision in their chosen destination, or that they avoid accessing health care while abroad (Betancourt, Green and Carillo, 2000; Longino et al., 1991; Longino and Taplin, 1994; Marshall et al., 1989). This paper has implications for many stakeholders involved in the transnational practice of retirement migration, but further research is needed to determine if the findings are specific to Yuma or indicative of a larger trend. We call for researchers and policy makers to work to create and enhance mechanisms to enhance continuity of care across borders and facilitate better communication between home and destination-based health care professionals.

1.6.3. Chapter 7: "If you have a pain, get on a plane": Qualitatively exploring how short-term Canadian international retirement migrants prepare to manage their health while abroad

This analysis draws on the results of semi-structured interviews with 19 older Canadians living in Yuma, Arizona conducted in January 2018 and is published in *Tropical Diseases, Travel Medicine and Vaccines* in April 2021. The interviews probed how Canadians planned to manage their health while abroad. The specific topics explored during the interviews drew from the findings of Chapter 5. The semi-structured interviews provided a rich data set and informed an analysis that characterizes the different preparatory strategies Canadian retirement migrants use to manage their health while abroad.

Four distinct preparatory strategies emerged through thematic analysis to form a typology summarising how Canadian international retirement migrants prepare to manage their health while abroad. Specific preparatory actions included filling prescriptions before departure and travelling with a list of current medicines and health issues. The breadth of strategies captured in the typology in part show how Canadian retirement migrants manage the complexities of travel health insurance planning, which was reported to lack transparency and cause a variety of negative outcomes. The typology presented in this analysis is of use to health care providers in popular retirement migrant destinations to appreciate differences among this patient population, which is often characterized as being relatively homogenous (i.e., race, socio-economic status, etc.).

1.6.4. Chapter 9: Transnational support systems for Canadian spousal caregivers living seasonally in the United States

This article shares the findings of semi-structured dyadic interviews of older Canadians living seasonally in Yuma, Arizona. The interviews were all conducted with married spouses who interviewed together in January 2019, where in each partnership one person has defined care needs and the other provides informal care. This article has been submitted *Health and Social Care in the Community* in June 2021. The interviews also form the basis of a second analysis led by my supervisor, Dr. Valorie Crooks,

published in the book *Carework and Medical Travel, Exploring the Emotional Dimensions of Caring on the Move* (Crooks & Pickering, 2021). That distinct analysis uses vignettes from five dyad interviews to broadly explore dimensions of continuity of care, caregiver identity, transnational support networks, care routines, and beneficial interventions as they relate to this form of transnational informal care. The analysis incorporated in my dissertation more deeply explores the specific issue of transnational support networks for informal caregivers while engaging with the full dataset of dyad interviews.

Informal care resources in retirement migration destinations are particularly important due to the unavailability of geographically close family members. This is important because close family commonly provide the primary support to informal spousal caregivers in domestic settings (Bouldin & Andersen, 2014; Chow 2004; Grossman & Webb, 2016; Oliver, 2011; Smith, 1998). Similarities in socio-economic status, culture, and social cohesion create an unusually close bond for older persons in retirement migrant communities that can create strong interpersonal connections (Casado-Díaz, 2009; Casado-Díaz, Casado-Díaz & Casado-Díaz, 2014), and as this analysis shows these bonds offer important support for informal care practices. We identify three support systems transnational spousal carers rely on in Yuma, Arizona during their seasonal stays: relational, community, and practical. This exploratory study of informal caregiving in the transnational context of international retirement migration is the first to give insight into this practice and in it we call for further research so that this care practice can be supported in meaningful ways.

1.7. Positionality and researcher reflexivity

I have strived to implement researcher reflexivity throughout the process of fieldwork and producing this dissertation as a whole. I understand researcher reflexivity as a self-awareness that one's own biases exist in all cases and influence almost every decision a researcher might make in a project on a variety of levels (Corlett and Mavin, 2018; Finlay and Gough, 2008). This self-awareness places the researcher at the heart of the project and removes the concept of 'objectivity.' Researcher reflexivity has become an important element of the qualitative research tradition (Corlett and Mavin,

2018) and the inherent subjectivity of the researcher has grown to be conceptualised as an opportunity, as opposed to a problem (Finlay and Gough, 2008). In many ways, biases are often changing, and I believe that some of mine have changed throughout the course of this research, such as how my own privileged ethnic and social status allowed me to access gated communities with ease, conduct surveillance of vehicles on private property (for the purpose of recruitment), and access to the homes of vulnerable older interview participants with little to no assurance of my institutional affiliation or trustworthiness.

My positionality has benefited and challenged me during this process. It is important to begin with the fact I identify as a privileged, cis-gendered, white male who has benefitted from social, political, economic, and other social structures that have been designed to benefit those who share my positioning. This privilege has provided me with many opportunities not available to a great majority of people in the world, both at home and abroad. Due to my positioning, I have enjoyed an ease of access to sites in which I conducted my research, including the aforementioned gated communities with their own security patrols, as well as hospitals that have guarded entrances. Older persons were willing to invite me to their homes to conduct interviews and others were willing to meet with little information beyond the study details, my claimed connection to Simon Fraser University, and photos of myself people could access online. During the evenings after days conducting interviews, I often imagined how differently the interview process might have unfurled if my social positioning was different. While there is no definitive answer beyond conjecture, I suspect the challenges and barriers would have been significant in comparison.

Three analyses within this dissertation research were directly supported through the presence of an on-site collaborator at the Yuma Regional Medical Center. This allowed for an ease of access to people with first-hand knowledge and experience dealing with Canadian international retirement migrants as patients. Three separate research trips to Yuma and an initial scoping trip to south Florida, three of which were with my supervisor, were fully funded by my supervisor's grants from the Canadian Institutes of Health Research added researcher observational perspectives and enabled investigator triangulation throughout this process. This has effectively added voices and perspectives to my own researcher reflexivity, specifically with issues relating to gendered experiences and understandings beyond my own. All of the methods and

research processes have also been heavily influenced by what I know, or what I think I know, about older Canadians. This is further shaped by personal connections to Canadian international retirement migrants, including my own and my friends' parents, that I have used to become informed beyond scholarly sources. This interconnected web of beliefs and experiences have all shaped the directions this project has taken. While I have remained aware the role I have played throughout the entirety of this project, it is crucial that I expose the underlying forces I owe for the successes and ease of this project.

1.8. What's to come

In the chapters that follow, I present the four separate studies which comprise this dissertation. The analyses appear in the formatting style they were written for their respective publication venues (i.e., Chapters 3, 5, 7 and 9). Each analytic chapter responds to specific research objectives, and I highlight the connections across these analyses in the concluding chapter of the dissertation. I have also added short bridging chapters before each analytic chapter to help situate the study in the larger context of the dissertation (i.e., Chapters 2, 4, 6 and 8) and to reflect on the challenges I faced in my academic journey. Furthermore, the implications of this research as a whole will be clearly connected to other studies focusing on ageing, health and place.

Chapter 2.
The grey line dividing failure and success

The following chapter presents the results from a scoping review conducted in 2017. Scoping reviews represent a logical starting point for an exploratory project, such as this dissertation, primarily due to their usefulness in providing an overview of the literature on a specific topic and in assisting researchers in determining knowledge gaps (Arksey and O'Malley, 2005). To gain insight into the scope of the literature I conducted three reviews simultaneously with broad focus on retirement migration, health care use abroad and how destinations are chosen. As a junior, and relatively inexperienced, academic researcher I failed to grasp the need to conduct more than one review. However, I trusted my supervisor's recommended approach and diligently conducted searches to create the content for the three guiding questions. In retrospect, this was an important lesson and one that would take time to fully comprehend.

My attempt at conducting three scoping reviews of health use abroad and how retirement migrants choose destinations failed. These reviews failed, quite honestly, due to a lack of peer-reviewed, published literature on retirement migration. Less than 20 articles for both of the failed reviews were determined to be viable to be included in the review. This lack of solid evidence eliminated the ability to answer the scoping review questions with any degree of confidence. Given the significant social issues with which researchers, practitioners, clinicians and policymakers tackle in other health related fields of inquiry, there is likely a tendency to simply move on and leave the failed studies behind. However, Van Maanen (1988) highlights just how common it is for researchers to experience study failures and how this is rarely admitted or communicated publicly, particularly in medicine and social science (Cameron, 2007). The potential benefits these studies hold for both the researcher and future researchers has been further outlined by more recent research (Gregory, 2019).

From the failed review studies came the reassessment of the successes. In this case, the review of factors motivating older persons to become retirement migrants resulted in a viable study, and one which would serve to situate and contextualise the psycho-social forces which shape the lived experiences of retirement migration. Thus, as

a jumping off point for my dissertation, this knowledge helped to inform my own understandings of why people became retirement migrants and why any risks to health might be overlooked in the pursuit of living a transnational lifestyle. Chapter 3 was integral to future studies and is the only review published on retirement migration my collaborators and I are aware of.

While the lessons I experienced were harsh, they were equally formative and informative. I have learned to view research as a process, or as a 'means to and end' as opposed to 'an end' in and of itself. This is not intended to be a *clichéd* account of my research failures, but instead to highlight the fact I learned the value of failed studies. Although these scoping reviews were 'failed' due to a lack of peer-reviewed literature I was able to learn from these studies and simultaneously benefit from the knowledge that my research was novel and necessary. The value of this also opens the possibilities of research directions primarily due to the fact that so little is known about the lived experiences of retirement migration, which allows for an exploratory case study methodological approach to inform my future research directions and specifically the analytic chapters in this dissertation (chapters 5, 7, and 9). The following chapter is the successful scoping review on the factors motivating retirement migration, published in the journal Population Ageing in 2019.

Chapter 3. What is known about the factors motivating short-term international retirement migration? A scoping review[1]

3.1. Abstract

It is known that older persons from many countries often enjoy living abroad for weeks or months of the year, often to avoid periods of harsh weather at home. However, there has been little attempt to synthesize existing knowledge of this practice, often called retirement migration. Scoping reviews are a widely accepted form of research synthesis. In this article we present the findings of a scoping review that asks: what is known about the factors motivating short-term international retirement migration? Using the guidance of a reference librarian, we searched 17 databases to identify pertinent academic articles. We read 110 articles in full, following an initial abstract review stage, ultimately including 44 in the review. The included articles primarily reported on studies that explored the lived experiences of short-term international retirement migrants and that were qualitative in nature. Four synthesis themes summarize existing knowledge about the factors that motivate this transnational mobility: (1) the destination (e.g., climate, natural and cultural environment); (2) the people (e.g., social networks, language); (3) the cost (e.g., cost of living abroad, affordability of health care and housing); and (4) the movement (e.g., ease of travel, visa and residency requirements). Research to date mainly explores short-term international retirement migrant destinations in affluent countries or destinations chosen by seasonal migrants from relatively wealthy Global North nations. Based on these findings we identify several pressing research gaps and directions for future research.

[1] Pickering, J., Crooks, V. A., Snyder, J., & Morgan, J. (2019). What is known about the factors motivating short-term international retirement migration? A scoping review. *Journal of Population Ageing*, *12*(3), 379-395. *Reproduced with permission from Springer Nature*.

3.2. Introduction

Short-term international retirement migration (IRM) is a residential strategy (Rodriguez et al. 2004) that is voluntary in nature, and it is often influenced by an individual's previous experience as a tourist and enabled by their privileged socio-economic status (King et al. 2000; O'Reilly 2000). Short-term international retirement migrants (IRMs) are typically individuals who temporarily or seasonally relocate to countries with warmer, and often drier (Gustafson 2001), climates during what corresponds to the winter or rainy months of their home country (King et al. 1998). In fact, IRMs are sometimes referred to as ‘snowbirds’ because they go away for some or all of the winter months, just as many migrating bird populations do. For IRMs, the goal of this short-term migration is frequently to improve quality of life by spending time in a more favorable environment (La Parra and Mateo 2008). Parallel migrations exist, which include permanent IRM that occurs when older persons permanently relocate abroad (Longino and Marshall 1990, Williams, et al. 1997) and short- or long-term retirement migration that is not international and thus involves relocating within one’s home country (Cribier 1987). For the sake of clarity, from here on when we refer to IRM or IRMs we are referring explicitly to those involved in short-term relocation abroad and maintain a principal residence in their home country unless stated otherwise. It is also important to note that some articles included in the review did not explicitly focus on short-term IRM, however they met our criteria of having explored short-term IRM and were deemed to be worthy of inclusion.

The practice of outbound IRM is well established in many ‘Global North’ countries and it is fueled by increased longevity and decreases in the mandatory retirement age in certain countries and professions (Williams et al. 2000). Additional processes, such as trade liberalization, have led to expanded travel options for individuals with the economic means to go abroad and lessened many international travel barriers, thereby creating an unprecedented ease of travel (Breuer 2005; Coates et al. 2002; Desrosiers-Lauzon 2009; Innes 2008). This has undoubtedly influenced the ability of some IRMs to travel abroad as well as expanded the range of potential destinations. Some local, regional, and national governments have opted to court IRMs and have invested infrastructure, promotional, and other resources into developing desirable IRM destinations (Desrosiers-Lauzon 2009; Warnes and Patterson 1998; Zhang et al. 2012). Seminal

research on short-term and permanent IRM was primarily interested in southern European destinations such as the Costa del Sol (Spain), the Algarve (Portugal), Tuscany (Italy), France, Cyprus and Malta (King et al. 2017). In North America, they include destination communities in Florida, Arizona, Texas, California and Hawaii in the United States (U.S.) (Northcott and Petriuk 2011); and Lake Chapala, the Baja, and northern state line cities in Mexico (Lizárraga 2010). In Oceania, Southeast Asia, and Northern Australia the nations of Bali, Indonesia, Singapore and Thailand are world-renowned IRM destinations (Zhang 2012; Davies and Hoath 2016). Recent years have seen an expansion of the global scope of IRM destinations into the Caribbean (Rodríguez-Rodríguez 2016), Central and Latin America (Hayes 2014), and Turkey (Balkir and Südas 2014).

Research into short-term IRM began in 1954 with Hoyt's investigation of elderly people traveling during winter from the northern U.S. and Canada to trailer parks in southern Florida. Subsequent research, much of it conducted by social scientists, has shown that this privileged group of older people is relatively healthy - at least able enough to travel (Longino et al. 1991) - financially comfortable (Warnes et al. 1999), eager to maintain or regain their independence, and typically free of familial commitments (Innes 2008). The earliest studies focused on IRM destinations (e.g., Hoyt 1954), while later ones began to examine the places IRMs were originating from and the impacts of this practice for their home countries (e.g., Croucher 2012). Research in this field has not been dominated by a single discipline and is highly interdisciplinary, wherein concepts or ideas from multiple domains are drawn together in single studies that are often conducted collaboratively. Following more than 60 years of interdisciplinary research, there is a clear and well-understood knowledge of where IRMs are travelling to and from, as well as many of the challenges this population deals with (e.g., transnational real estate purchases) and the privilege they hold. Despite this, there are certainly still significant knowledge gaps.

Despite the relatively robust literature that exists about short-term IRM, spanning more than six decades of research, there have been few attempts at structured reviews of this knowledge. Meanwhile, we know that such reviews are very useful for synthesizing research trends and identifying key knowledge gaps in a systematic way and that they can support the uptake of research into policy and applied realms (O'Brien et al. 2010). Scoping reviews are a form of knowledge synthesis that aim to identify the

key themes or concepts informing a particular area of research and summarize the main types of evidence and sources available (Arksey and O'Malley 2005; Davis et al. 2009; O'Brien et al. 2010). They are structured around a specific synthesis question and a multi-step iterative process is used to organize the review. Here, we use the scoping review method to ask: what is known about the factors motivating short-term IRM? Our synthesis interest is thus centered on those who travel across international borders, rather than retirement migrants who simply live elsewhere in their home countries for periods of time and stay abroad for a matter of weeks or months, rather than permanently relocate. Thus, the findings of this review are not intended to speak to the motivations of IRMs who travel within their own countries or who permanently relocate abroad. In the section that follows we provide details on our scoping review design, after which we examine the four themes identified in the existing published IRM literature that contribute to understanding the current state of knowledge regarding our synthesis question.

3.3. Methods

Scoping reviews are an ideal knowledge synthesis method to use when: existing studies on the topic have employed a range of analysis techniques or data collection methods; prior syntheses on the topic have not been completed; and/or a quality assessment of the included studies is not necessary (Arksey and O'Malley 2005). The topic of focus here meets all three criteria, which is why we have employed the scoping review method to ask: what is known about the factors motivating short-term IRM? Our approach was derived using the scoping review method characterized by Arksey and O'Malley (2005). It involves several procedural steps, which we detail below. Our scoping review began in September 2016 and the final list of sources for inclusion was identified in December 2016 with full article review having been completed in March 2017.

Steps 1 & 2 - Identifying the question and relevant literature

We began by searching for existing reviews on IRM to determine synthesis gaps relevant to our interest in motivating factors. We determined that no existing syntheses existed, so we then worked to refine our synthesis question. Following this, we devised a keyword search strategy that builds off this question. Specific keywords were identified

through discussions with a reference librarian and hand searching of titles and abstracts of recent IRM studies. Shown in Table 1, the preliminary strategy identified keywords focused on three categories: what (which listed some of the motivating factors identified in our initial steps), who, and why. After preliminary search attempts it was determined that this list of terms was too large and had too many permutations and computations to be effective. Table 2 shows the refined terms used in the final stage of the search process. Terms that further focused the search on *human* populations (as opposed to migratory animals or moss), and that limited erroneous results, were also identified and included at this stage. We defined our scope to examine articles exploring IRMs who engage in seasonal or short-term migration in acknowledgement that permanent relocation or relocation that is non-international is likely driven by distinct motivations and thus requires separate consideration.

Table 3.1. Preliminary Scoping Review Keyword Search Strategy

Focus	What	Who	Why
Retirement migration	Health	Traveler	Decision making
	Healthcare	Tourist	Attitudes
	Insurance	Retiree	Decisions
	Hospital	Migrant	Motivations
	Cost	Snowbird	Safety
	Planning	Holidaymaker	Travel
	Home	Vacationer	Vacation
	Communication	Pensioner	Adventure
	Illness	Patient	Affordability
	Community		Cost
	Contact		Savings
	Savings		Family
	Pension		Friends
			Networks

Table 3.2. Refined Scoping Review Keyword Search Strategy

Focus	What	Who	Why
Retir* migrat*	Health*	'Seasonal migrat*'	Decision*
	Healthcar*	'Elderly migrat*'	Motivat*
	Insuranc*	Snowbird*	Travel*
	Illnes*		Cost*

Boolean terms added to all searches: (-"seasonal worker"), (-mycology)

Step 3 – Searching the literature

We consulted with a reference librarian to devise a strategy to search the English-language, peer-reviewed literature published in scholarly journals. Combinations of keyword terms from Table 3.2 were searched in 16 academic databases as well as Google Scholar, summarized in Table 3.3. The keywords across the three categories were searched using Boolean operators to maximize the combinations and permutations of the terms. Different combinations yielded different results, and some combinations resulted in irrelevant and/or unmanageable results due to volume. When this occurred, we narrowed the results by adding additional keyword terms or removing keyword terms that yielded the broadest results.

The reference librarian identified the Web of Science database as an ideal starting point for our search. This first database search was used to identify exclusion terms. Certain terms, such as 'seasonal worker' and 'mycology' were determined to consistently yield unwanted results. They were removed from subsequent searches by adding (-mycology) and (-'seasonal workers'). The 'what' terms in Table 2 were included as the librarian suggested they would help the searches focus on IRMs and not migratory animals. Through test searches it was determined that this strategy would be unlikely to exclude potentially usable articles, and it did indeed result in a greater focus on humans in the identified literature. Identical search queries were then used in subsequent database searches and were focused to include options within the 'who' category. When combinations of terms yielded results in excess of 200 articles, additional terms were added to focus the results. The sources were limited to peer-reviewed, published articles, which required hand-searching for removal of books,

conference papers and reports. Search results were organized and stored using Endnote reference management software.

Table 3.3. Academic Databases Searched, IRM Scoping Review

Database	Temporal Period Covered (dd/mm/yyyy)
Academic Search Premier	01/01/1975 - 20/09/2016
Ageline	01/01/1978 - 10/09/2016
Alternative Press index	01/01/1991 - 27/09/2016
Alt HealthWatch	01/01/1997 - 20/09/2016
Biomed Central	open start date - 20/09/2016
Business Source Complete	open start date - 27/09/2016
Canada Research Index	01/01/1982 - 21/09/2016
CPI.Q	01/01/1988 - 21/09/2016
Geobase	01/01/1980 - 21/09/2016
Global Health	open start date - 03/10/2016
Google Scholar	open start date - 18/09/2016
Medline	01/01/1966 - 20/10/2016
PAIS International	open start date - 03/10/2016
PsycINFO	01/01/1967 - 20/09/2016
PubMed	01/01/1966 - 18/09/2016
Sociological Abstracts	01/01/1963 - 20/09/2016
Web of Science	01/01/1898 - 17/09/2016

Step 4 – Charting the data

Following removal of duplicate sources, our first step in data charting was to independently review titles and abstracts to identify articles to read in full. Following this, we met to reach consensus on those that should be read in full for potential inclusion in the scoping review. At the title/abstract review stage sources were typically removed due to: (1) a lack of focus on the synthesis question (e.g., short-term, international

movement), (2) the material not being a peer-reviewed published article, and/or (3) the source not having been published in English.

Articles identified for full review were gathered through institutional journal subscriptions or inter-library loan. Two team members were assigned to read each article to determine if it should be included in the review, a decision that was based on whether or not it had content relevant to the synthesis question, as well as to extract the relevant data. We independently reviewed articles in batches of ten, meeting after each batch to reach consensus on inclusion/exclusion and the scope of the extracted data. There were few initial disagreements amongst team members related to inclusion or exclusion of the sources. All decisions on inclusion/exclusion were achieved through consensus and never required a third reader to be assigned. The main reasons for exclusion at this stage were a lack of clear focus on international migration (versus domestic relocation) or on a retired or older population. We also hand-searched the reference lists of included articles to identify other sources that should go through a second round of title and abstract review.

Step 5 - Collating, summarizing and reporting the results

The review process was charted on a secure, online spreadsheet editable by all team members. We independently recorded bibliographic details and extracted data (if relevant) for each reviewed article. Following completion of the review phase, extracted data were reviewed independently by each team member to identify themes that organized findings relevant to the synthesis question. We then held multiple meetings to identify important themes and define their scope and scale. As we show in the next section, four such synthesis themes were identified.

3.4. Findings

Figure 1 summarizes our scoping review search process and outcomes. Forty-four articles were ultimately included in the review. Though we did not assess study quality as this is not a standard part of the scoping review method, it is worth noting that most of the reviewed studies were qualitative in nature and employed interview or survey methods. As there is no reliable population-level tracking of IRM, quantitative studies

included in the review were minimal due to lack of data (Casado-Diaz 2006). The reviewed articles explored mobilities between different world regions, but primarily examined northern Europeans traveling to southern Europe (n=22) or Canadians and Americans travelling to the southern U.S., Mexico and Central America (n=19). From the included articles, we identified four crosscutting synthesis themes that relate to our inquiry question regarding the factors that motivate short-term IRM: (1) the destination, (2) the people, (3) the cost, and (4) the movement. While we acknowledge interrelationships between these themes, in this section we discuss each separately.

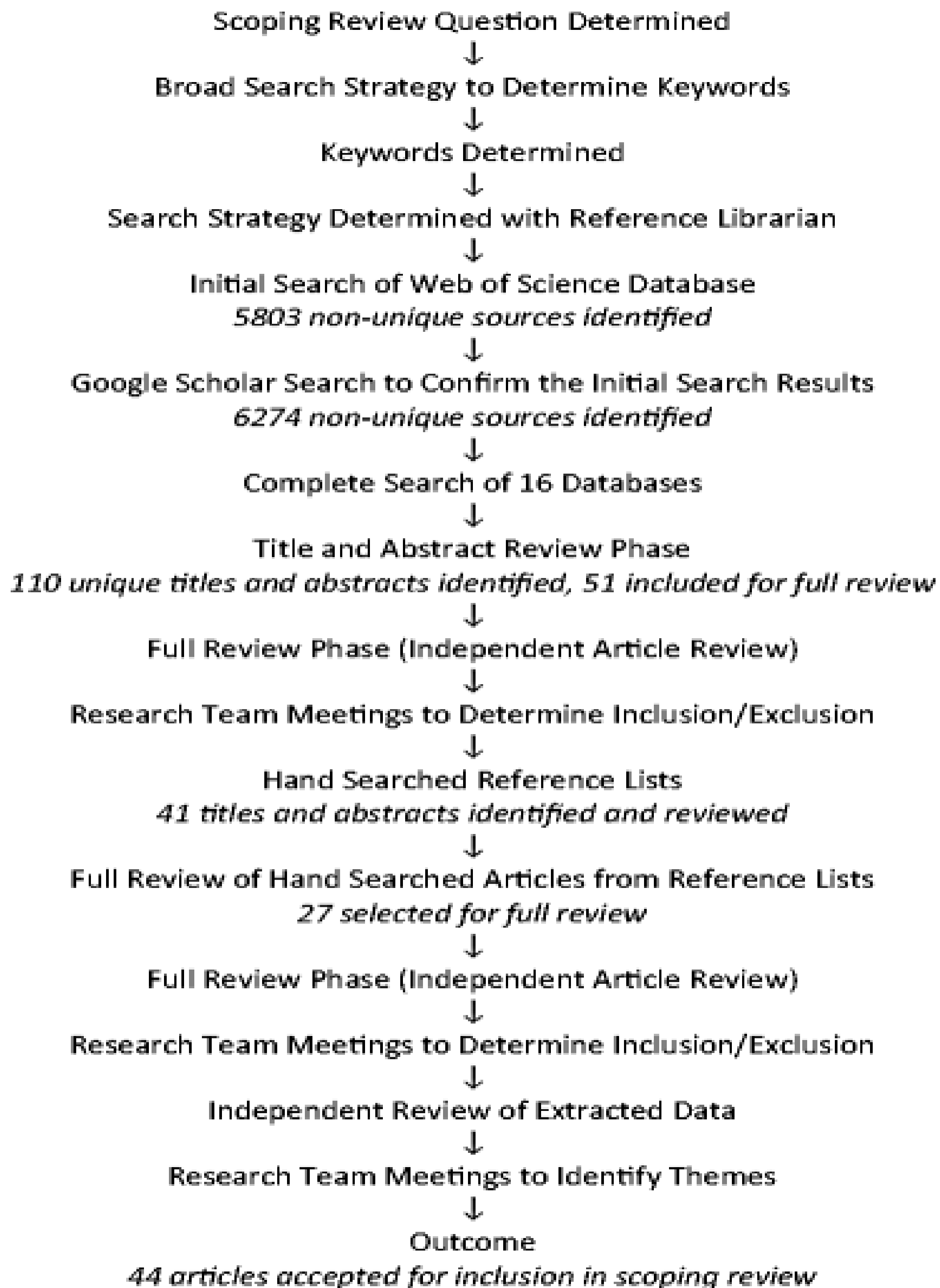

Figure 3.1 Scoping review process and results

3.4.1. The Destination

Destination climate is a well understood aspect of IRM and it was discussed as a highly influential motivator for individuals considering participating in this mobility (Ackers and Dwyer 2004; Breuer 2005; Croucher 2012; Desrosiers-Lauzon 2009; Dwyer 2000; Hayes 2015; Howard 2008, Innes 2008; King et al. 2017; Lardiés-Bosque 2016a, 2016b; Legido-Quigley and McKee 2012; Lizarraga et al. 2015; Longino and Crown 1990, Longino et al. 1991, 1994). The destination climate can attract IRMs due to the comfortable warm regions, while climate also serves as a push factor from the cold regions (Croucher 2012; Daciuk et al. 1990; Howard 2008; Sunil et al. 2007). In general terms, the climate at popular IRM destinations was described as warm and dry. Exposure to warmer climates was also cited as a potential health benefit, this being a widely held belief by many IRMs that motivates them to travel abroad (Coates et al. 2002; Dwyer 2000; Gustafson 2001, 2008; Huber and O'Reilly 2004; O'Reilly 2000; Rodriguez et al. 1998, 2004; Sunil et al. 2007; Warnes et al. 1999). A final element related to climate was the 'push' from home due to harsh and inclement weather (Croucher 2012; Daciuk et al. 1990; Desrosiers-Lauzon 2009; O'Reilly 2000; Sunil et al. 2007). This cold or wet climate was said to create an indoor focused lifestyle. This was due in part to the potentially hazardous conditions outside during colder months, such as icy walkways (Daciuk and Marshall 1990), which can serve to strengthen the appeal of travelling abroad.

Beyond climate, engagement in the cultural (Amin and Ingman 2010; Casado-diaz 2006; Coates et al. 2002; Howard 2008; Hayes 2014, 2015; Lardiés-Bosque 2016a; Lizárraga 2010; Moro 2006; Otero and Melton 1997; Rodríguez et al. 2004; Sunil et al. 2007; Williams and Patterson 1998), natural (Croucher 2012; Innes 2008; Lizárraga 2010; Rodríguez et al 1998, 2004; Sunil et al. 2007), and amenity (Casado-diaz 2006; Innes 2008; Lardiés-Bosque 2016b; Longino et al. 1991; Schafran and Monkkonen 2011; Northcott and Petruik 2011; Oliver 2010; Sunil et al. 2007; Zhang 2012) features of the destination were discussed as other prime motivators for participating in IRM. Rodriguez (2004), for example, points to the powerful attraction of these factors in relation to Spain, namely its natural beauty, culture, and climate, as the defining reasons for its popularity among IRMs. Among the cultural appeals of IRM destinations, many IRMs have specifically pointed to the attraction of participating in a 'slower pace of life' experienced elsewhere (Casado-Diaz 2006; Davies and Hoath 2016; Innes 2008; Hayes

2015; King et al. 2017; Oliver 2010; Rodríguez et al. 2004; Sunil et al. 2007; Warnes et al. 1999) and a desire to remove themselves from the fast pace of life in their home communities. Other studies have documented retirees' desire to experience cultures different from their own (Coates et al. 2002) and how this affects the decision-making processes for IRMs. Studies also reveal an attraction to relaxed cultures, particularly in Spain (Oliver 2010), Malta (Innes 2008), and Mexico (Sunil et al. 2007). Amenity rich destinations are another powerful attracting element for IRMs. Northcutt and Petriuk (2011) reported that amenity focused migration is an increasing phenomenon among IRMs.

3.4.2. The People

Enhancing one's social network of people of a similar age and with a similar lifestyle through IRM was a motivating factor explicitly discussed in several of the included articles (Croucher 2012; Davies and Hoath 2016; Huber and O'Reilly 2004; Innes 2008; Lardiés-Bosque 2016a and 2016b; Legido-Quigley and McKee 2012; Longino and Crown 1990, Longino et al. 1991; Marshall and Tucker 1990; O'Reilly 2000; Oliver 2010; Sunil et al. 2007; Tucker et al. 1988; Warnes et al. 1999). The attractiveness of gaining 'readymade' social networks in destination communities increases with age (Viallon 2012). Oliver (2010) observes that IRM allows individuals to forge new friendships and also to reinvent themselves socially (Howard 2008; O'Reilly 2000). This allows many IRMs to create a more socially focused lifestyle, which Sunil et al. (2007) reported as providing increased morale and a better quality of life. Gustafsson identified these qualities as being both a way to exercise one's adventurous spirit (2001) as well as an escape from reality (2002). Other studies illustrated 'friendly' cultures and positive attitudes towards foreigners, such as in Thailand (Howard 2008) and Mexico (Lardiés-Bosque 2016a), as enabling social networks to extend outside the IRM community. These social networks were also expressed within the 'quality of life' dialogue that surrounds IRM that featured in many articles included in this review (Casado-diaz 2006; Hayes 2014, 2015; King et al. 2017; Lardiés-Bosque 2016b; Legido-Quigley and McKee 2012; Lizarraga et al. 2015; Otero and Melton 1997; Sunil et al. 2007).

Some reviewed studies made a connection between language and popular IRM destinations, where the potential for linguistic accessibility can motivate some to engage

in this transnational practice. Some specifically stressed the need for English-language services to be offered by those living in the destination country and community (O'Reilly 2000; Warnes et al. 1991), especially in Mexico and Spain. IRMs are able to "partake of exotic landscapes and customs without sacrificing the familiar comforts of home, including their native tongue" (Croucher 2012:3) through the creation of linguistic enclave communities. Although language familiarity among people in the destination seems to be preferred by many IRMs, the same is not true for culture. The desire to experience the 'exotic' is a powerful motivating factor for many IRMs, and it is seen that the "search for landscapes, cultures and lifestyles that fit a kind of idealized middle-class myth" (Dwyer 2000:7) is a powerful motivating factor for the decision to temporarily retire abroad. Being surrounded by unfamiliar people and cultural practices in the destination is often balanced by living in close proximity to fellow expats from the same country, sometimes in gated IRM communities. This is especially true for British expats in Spain (O'Reilly 2000), U.S. citizens in Mexico (Sunil et. al. 2007), Canadians wintering in Florida (Marshall and Tucker 1990; Tucker et al. 1988) as well as those from Sweden spending time in Spain (Gustafson 2001, 2002, 2008).

3.4.3. The Cost

Cost factors motivating the decision to temporarily retire abroad, especially the lower costs of living abroad, were reported in cases of U.S. citizens wintering in Mexico (Amin and Ingman 2010; Hayes 2015; Lardiés-Bosque 2016a, 2016b; Morales 2010; Lizarraga et al. 2015; Schafran and Monkkonen 2011; Sunil et al. 2007) and Ecuador (Hayes 2014); Canadians wintering in the southern U.S. (Longino and Crown 1990, Longino et al. 1991), Ecuador (Hayes 2014), and Mexico (Coates et al. 2002); British wintering in Portugal (Williams and Patterson 1998), Malta (Innes 2008), and Spain (O'Reilly 2000; Oliver 2010; Rodríguez et al. 1998, 2004; Warnes et al. 1999); Global North retirees wintering in Thailand (Howard 2008); Australians wintering in Bali (Davies and Hoath 2016); and Northern Europeans, especially those from Sweden, wintering in southern Europe (Casado-Diaz 2006; Dwyer 2000; Gustafson 2008; Lizarraga et al. 2015; Moro 2006; Rodríguez et al. 2004). As was explained, "Tailoring a package of financial and social resources… is an important element in their migration decisions and movements. Many retirement migrants are resourceful in negotiating and re-negotiating

the most advantageous welfare 'deal'" (Acker and Dwyer 2004:471). Important 'financial resources' or costs include housing, pharmaceuticals and health care, food, transportation within, as well as to and from, the destination along with those associated with social and cultural amenities.

The draws of purchasing seemingly affordable housing and health care abroad were repeatedly discussed as specific financial motivators for engagement in IRM. This attraction was typically based on the differences in currency values and relative prices between home and abroad. For example, some Americans in Mexico (Croucher 2012), Canadians in Mexico (Coates et al. 2002), Northern Europeans in Spain (Moro 2006; Dwyer 2000, Casado-Diaz 2006), Australians in Bali (Davies and Hoath 2016), and British citizens staying in Malta (Hoggart and Buller 1995) were all said to have been motivated to purchase houses in the destination due to affordability. In some cases, people were able to purchase a house in a size or style that would have been unaffordable to them at home (Lardiés-Bosque 2016a). The same is true with regard to health care affordability in some destinations (Ackers and Dwyer 2004; Amin and Ingman 2010; Croucher 2012; Dwyer 2000; Innes 2008; Lardiés-Bosque 2016b; Otero and Melton 1997; Sunil et al. 2007). For example, Sunil et al. (2007) reported on the attraction of low-cost health care in Mexico, and this was echoed by Schafran and Monkkonen (2011), who cited affordable health care as the most popular reason why some IRMs chose Mexico as their preferred destination. Zhang (2012) cited the inexpensive price of health care in Thailand, especially for live-in caregivers, as having motivated Japanese to become IRMs. Similarly, Innes (2008) found British citizens were attracted to the inexpensive specialized health care in Malta.

3.4.4. The Movement

Many reviewed sources observed that the movement of people via IRM has been heavily influenced by the contemporary ease of travel enjoyed between many countries. Travel connections and connection improvements (Coates et al. 2002) are being made every year allowing new IRM destinations, such as Ecuador, to flourish (Hayes 2014), which can motivate IRMs to explore lesser established destinations. Specific examples of migration patterns that have grown due to perceived ease of travel included German

IRMs in the Canary Islands (Breuer 2005), Northern European Union IRMs in Spain (Casado-Diaz 2006; Rodriguez et al. 2004), British IRMs in Malta (Innes 2008), and U.S. IRMs in Mexico (Amin and Ingman 2010; Lardiés-Bosque R. 2016a, 2016b). While ease of travel was cited as a key motivator and related to the cost factors discussed in the previous sub-section, travel costs also factored into the decisions of individuals to become IRMs as they facilitate movement (Amin and Ingman 2010; Breuer 2005; Desrosiers-Lauzon 2009). Coates et al. (2002) found that the improved highways connecting the U.S. with Mexico, as well as the highway improvements in Mexico, motivated many American retirees to consider this destination due to the reduced travel costs and increased ease of driving.

An important factor related to movement commented on by included sources was the effect of the visa and residency requirements on IRM destinations and IRMs, in that this can serve to motivate or even prohibit movement. Zhang (2012) observed that accommodating visa requirements between Japan and Thailand led to Thailand becoming a preferred destination for Japanese IRMs. Meanwhile, numerous articles referred to residency laws and requirements, including municipal residency laws (Dwyer 2000; Hall and Hardill 2016; LaParra and Mateo 2008; Moro 2006) and tax legislation that dictates length of stay prior to needing to pay federal taxes, which shape IRMs' length of stay and even choice of destination (Gustafson 2008; Williams et al. 1997; Zhang 2012). Several articles examining the case of Canadian IRMs pointed out that Canadians are required to be in their home country for a specific number of days each year to maintain public health system access at home (Coates et al. 2002; Longino and Marshall 1990; Marshall and Tucker 1990; Northcott and Petriuk 2011; Tucker et al. 1988). This reality can serve to motivate outbound IRMs as it does allow for the potential of an extended stay abroad for IRM purposes, but it also strongly directs the length of stay. Those motivated to consider IRM may thus need to navigate residency requirements both at home and abroad.

3.5. Discussion

In this scoping review we have asked: what is known about the factors motivating short-term IRM? Following an extensive review of the English-language scholarly

literature, we included 44 articles in this review that offer existing research insights that assist with answering this important question. After reviewing the relevant articles, we summarized these insights using four themes: the destination, the people, the cost, and the movement. Table 4 presents a synthesis of the thematically organized review findings. Factors central to each of these themes ultimately serve to broadly motivate older persons' interest in short-term IRM, and sometimes even the selection of a specific destination country or community. For example, exposure to warmer climates (relative to home) and the opportunity to partake in new natural and cultural amenities are aspects of the destination that can and do motivate people to engage in IRM. We also acknowledge that there are interrelationships between the themes we have used to summarize the review findings. For example, while cost is a stand-alone theme, we also noted that the cost of travel and fluctuations in flight cost are factors that affect the movement of IRMs as travel affordability specifically can serve as a motivation for being part of this transnational practice.

Table 3.4. Summary of themes and findings

Theme Identified	*Key Motivating Factor*	*Example of Specific Motivation*
The Destination	Climate	Exposure to warmer climates in the winter months and their potential health promoting aspects
	Natural and cultural amenities	Spending time in amenity-focused destinations that cater to IRMs
The People	Improving/gaining social networks	Gaining new social networks through participating in IRM
	Language	Having people in the destination who are familiar with one's home language
	Culture	The potential for participating in new cultural practices
	Presence of fellow expats	Being able to spend time with those from one's home country in IRM communities abroad
The Cost	Cost of living	Manageable cost of living in the destination (which may be lower than costs at home)

	Affordability	Affordable real estate and health care when compared to home markets
The Movement	Ease of travel	New road networks that make travel by vehicle possible
	Visa and residency requirements	Lowering barriers to entry can facilitate staying abroad for long periods

This scoping review has synthesized the factors that motivate people to engage in IRM. When taken together, many of the motivating factors we have identified can be thought of as push or pull factors. Push (factors that prompt someone to leave a place) and pull (factors that draw someone to a place) factors are a common way of framing issues pertaining to mobility and movement (Amin and Ingman 2010; Croucher 2012; Davies and Hoath 2016; Hayes 2015; Innes 2008; Schafran and Monkkonen 2011; O'Reilly 2000) and were explicitly referenced in several of the articles included in this scoping review. In the context of IRM, for example, many included sources explored how IRMs are not only pulled to warm and dry climates, but were also pushed from cold, harsh climates at home to mild, dry ones in the destinations (Croucher 2012). Some IRMs are also pushed by high costs of living at home to low costs of living for short periods abroad, and particularly in the context of health care (Amin and Ingman 2010) and home ownership markets (Davies and Hoath 2016). Another push and pull factor pertains to movement, in that IRMs are often pushed away from considering destinations that are difficult to get to or have complex residency regulations, and are pulled to those that promote ease of travel (Breuer 2005). As we have shown in the findings section, both push and pull factors have a relationship to each of the four themes that synthesize existing research that examines what motivates retirees to engage in IRM.

We identified forty-four articles to be included into this review. In articles that presented the findings of primary research (as opposed to conceptual contributions), most were reporting on studies that were qualitative in nature. They frequently relied on interviews (e.g., Acker and Dwyer 2004; Breuer 2005; Dwyer 2000) and surveys (e.g., Davies and Hoath 2016; Longino et al. 1991; Marshall et al. 1989; Tucker et al. 1988) to understand various dimensions of the IRM experience. The experiential insights offered

by these studies provided a wealth of information relevant to the current scoping review. Future studies may benefit from adopting qualitative methods other than interviews and surveys, such as using personal diaries, mapping exercises, or focus groups in order to expand our knowledge about the factors motivating IRM by drawing on more diversely generated insights. We also acknowledge the importance of comparative studies being undertaken in the future, especially those comparatively exploring the motivations of IRMs living in different home countries or regions. Further to this, as noted by Casado-Diaz (2006:1323), there is a “lack of accurate official records” when it comes to the practice of IRM, including records establishing who travels abroad for this purpose and where they go. King et al. (2000) have also explicitly acknowledged the lack of systematically gathered population-level datasets that can yield important and meaningful insights about IRM and the factors that motivate older persons to engage in this transnational mobility. In the coming years, researchers seeking to make advances in understanding the factors that motivate IRM will need to identify novel ways of quantitatively assessing this practice and even push for more population-level tracking and monitoring by larger groups (e.g., travel health insurance providers, real estate boards, visa offices).

Scoping reviews function to help identify knowledge gaps in the literature (Arksey and O’Malley 2005), and several key gaps emerged as a result of the current review. For example, it became evident that the destinations in which most IRM research has been undertaken are popular among residents of Global North countries (e.g., Mexico, Spain, southern Europe, and the southern U.S.). Meanwhile there are indeed outflows of IRMs from Global South nations to other Global South countries or to the Global North. For example, some Caribbean retirees spend the hottest and/or wettest months in Canada or the U.S. While several sources acknowledged that short-term IRM exists outside of flows from the Global North to the Global South (Bozic 2006), these flows were not examined by the studies included in the current review and are thus ripe for future investigation. The motivations behind these IRMs’ travel may be quite distinct from those captured in the current review, and thus warrant research attention. This review also revealed a significant focus on IRMs from Canada, the U.S., Britain, Germany, and northern Europe in the existing literature. While the importance of retirees from these nations in propelling this transnational practice forward cannot be denied, there is relative silence about older persons from countries that take up a large share of the

world's aging population, such as India, China, and Russia. Again, motivations for participating in IRM by retirees in these countries may be unique relative to those captured in the existing research. Finally, most of the existing studies that provide insight into the factors motivating IRM do little to distinguish between IRMs, such as those who go abroad on their own versus those travelling with a spouse or friends, those with high levels of mobility versus those with impairments that affect movement, or those with cultural or gender identities other than what is held by most versus those who identify with majority populations in the destination community or country. Research that examines such differences, and even their intersections, can aid in achieving a more nuanced understanding of the factors synthesized in Table 4. Such insights would be incredibly valuable for policymakers in destination countries that are looking to develop or expand their IRM sectors, among other groups. Building on the point we raised above, all research directions identified here can benefit from both quantitative and qualitative insights and we encourage the use of a broader range of qualitative methods and the identification of new sources of quantitative data.

3.5.1. Scoping review limitations

The most significant limitation to this study is the omission of sources that were not written in English. Scoping reviews require parameters, and language is a commonly used one. We thus acknowledge that there may be robust scholarly discussions of IRM in other languages that are not captured in the current review. Another limitation is that there is no language convention with regard to the term(s) used to characterize the practice of IRM. As such, we acknowledge that our review will not have captured articles that described short-term IRM using words other than those found in our keywords. We believe this potential limitation was mitigated in part due to our *post hoc* review phase that involved hand searching the reference sections of fully reviewed sources, which is a point raised by Arksey and O'Malley (2005) when they introduced the scoping review protocol we followed.

3.6. Conclusion

Here we have presented the findings of a scoping review that set out to ask: what is known about the factors motivating short-term IRM? We found that many published articles provide insights relevant to answering this question despite the fact that no studies set out as their purpose to identify specific factors motivating this transnational mobility. Findings shared from the 44 articles included in this review point to four broad themes of motivating factors that have been touched upon in the existing literature: (1) the destination, (2) the people, (3) the finances, and (4) the movement. We believe this thematic framework is a useful way to conceptualize the factors that influence many aspects of decision-making regarding IRM, including decisions around whether to participate in this mobility, identifying the desired destination, and choosing whether to purchase or rent accommodations while abroad.

It is perhaps not surprising that the climate of the destination was cited as a primary motivator of IRM; however, this review reveals that climate is only one of a range of factors that work together to motivate retirees to spend periods of time abroad. This review also shows that IRMs can become connected to destinations by the social relationships formed, the financial benefits they offer, and the cultural and natural amenities in place. These connections motivate participation in IRM. Overall, this scoping review has systematically identified several important insights about existing knowledge of IRM and the factors that motivate older persons to participate in this mobility, while also pointing to pressing knowledge gaps that can only be addressed through future research.

Chapter 4.
Reflecting on the importance of gatekeepers (or collaborators)

Chapter 5 focuses on Yuma Regional Medical Center (YRMC) health care professionals' experiences of treating Canadian international retirement migrants. We specifically draw on their observations and experiences regarding the challenges and opportunities in providing care for a large, seasonal population of older Canadians. These experiences were captured through three separate focus groups conducted at YRMC with nurses, physicians, and administrators. The Greater Yuma regional health system is dominated by a single provider, the YRMC, which situates professionals working at its hospital as the *de facto* authority on if and how Canadians access health care in Yuma and the implications of that access.

The scoping review analysis in Chapter 3 contained several long-standing articles that depicted Canadians as reticent to access health care while in the United States (US). Canadian international retirement migrants were also not considered to be a drain on local or regional health care resources (e.g., Marshall et al., 1989; Longino et al., 1991; Longino and Taplin, 1994). However, the analysis presented in Chapter 5 demonstrates this is not always the case, with YRMC's hospital reporting on average 1200 visits by Canadian patients annually. In fact, Canadians accessing health care in Yuma, Arizona was depicted as a common occurrence, and thus not surprisingly the focus group participants identified Canadians as important clientele for the YRMC.

Health care professionals are valuable sources of information and often hold positions that can offer unique perspectives on both the provision of care and the characteristics of those accessing health care in a specific location (e.g., Kaner, et al., 1998; Li, et al., 2018; VanGeest, et al., 2007). The analysis in Chapter 5 relies exclusively on health care professionals as the only data source. Research has demonstrated how challenging it is to work with health care providers and administrators as participants for a number of reasons, including the challenges of trust-building with this highly educated group as well as time constraints (e.g., Broyles, et al., 2011; Levinson, et al., 1998; Li, et al. 2018). I was concerned about tackling this challenge,

and especially from a distance. However, I experienced none of these recruitment challenges during this study, which operated smoothly and without incident. As an unexperienced researcher at the time, I was oblivious to the fortunate situation I had the opportunity to capitalize on.

The ease of recruitment for the analysis presented in Chapter 5 was greatly enhanced and supported by the presence of an on-site collaborator, Dr. Trudie Milner who holds a senior leadership position YRMC. Dr. Milner had agreed to serve as a collaborator on the Canadian Institutes of Health Research-funded study that funded the analysis. While my collaborators and I created the focus group guide and recruitment materials, Dr. Milner took care of distributing the recruitment materials and her assistant scheduled the focus group times and rooms. Dr. Milner was effectively a gatekeeper to the three participant groups we sought to hear from in this study, and her participation as a collaborator greatly enhanced the ease of data collection. She also remained active as a collaborator, providing feedback during data analysis and writing and ultimately serving as a co-author (note that she never had access to the non-anonymized transcripts or the lists of focus group participants). Dr. Milner's involvement highlights the importance of establishing personal and professional links with gatekeepers who are positioned to facilitate field research and to help ensure the optimal results of a study and the value of situating gatekeepers as collaborators.

Chapter 5 has greatly influenced my approach to conducting future fieldwork as a health care researcher by highlighting the valuable role of a situated champion, stakeholder, or gatekeeper. While Dr. Milner facilitated and improved our research outcomes in this particular study, it is clear to me how the role of a gatekeeper could save a study from failure, or how the lack of a gatekeeper could prevent a potentially successful study from achieving its goals. My perception of this potential support has changed significantly from the onset of this study and will become a cornerstone of my approach to future research projects.

Chapter 5.
Opportunities and Challenges in Providing Health Care for International Retirement Migrants: A qualitative case study of Canadians travelling to Yuma, Arizona[2]

5.1. Abstract

Background

Increasing numbers of older individuals opt to spend extended time abroad each year for lifestyle, health, and financial reasons. This practice is known as international retirement migration, and it is particularly popular among retirees in Global North countries such as Canada. Despite the popularity of international retirement migration, very little is known about how and why health care is accessed while abroad, nor the opportunities and challenges posed for destination hospitals. In this article we focus on addressing the latter knowledge gap.

Methods

This qualitative case study is focused on the only hospital in Yuma, Arizona – a popular destination for Canadian retirement migrants in the United States. We conducted focus groups with workers at this hospital to explore their experiences of treating this transnational patient group. Twenty-seven people participated in three, 90-minute focus groups: twelve nurses, six physicians, and nine administrators. Thematic analysis of the focus group transcripts was conducted using a triangulated approach.

---

[2] Pickering, J., Crooks, V. A., Snyder, J., & Milner, T. (2020). Opportunities and challenges in providing health care for International Retirement Migrants: a qualitative case study of Canadians travelling to Yuma, Arizona. *Tropical Diseases, Travel Medicine and Vaccines*, *6*, 1-10.

Results

Participants identified three care environments: practice, transnational, and community. Each environment presents specific opportunities and challenges pertaining to treating Canadian retirement migrants. Important opportunities include the creation of a strong and diverse seasonal workforce in the hospital, new transnational paths of communication and information sharing for physicians and health administrators, and informal care networks that support formal health care services within and beyond the hospital. These opportunities are balanced out by billing, practical, administrative, and lifestyle-related challenges which add complexity to treating this group of transnational patients.

Conclusion

Canadians represent a significant group of patients treated in Yuma, Arizona. This is contrary to long-standing, existing research that depicts older Canadians as being reluctant to access care while in the United States. Significant overlaps exist between the opportunities and challenges in the practice, transnational and community environments. More research is needed to better understand if these findings are similar to other destinations popular with Canadian international retirement migrants or if they are unique to Yuma, Arizona.

5.2. Background

International retirement migration is a voluntary residential strategy (Rodriguez, Fernández-Mayoralas and Rojo, 2004) that occurs when older people around the age of retirement or thereafter – and typically living in Global North countries – relocate abroad (King, Warnes and Williams, 2000; O'Reilly, 2000). This relocation can happen on a short-term or permanent basis. In this article we are focused on short-term international retirement migration by older Canadians to the United States (US). Short-term international retirement migrants, or 'snowbirds' as they are sometimes popularly referred to in North America, are typically attracted to the warm, dry environments offered by popular destinations during what corresponds with the winter months in their home country. Retired Canadians are among those who take part in such international retirement migration. Estimates range from around 500,000 to more than one million Canadian snowbirds annually traveling to the US during the winter (Coates, Healy and Morrison, 2002; Desrosiers-Lauzon, 2009), with some sources suggesting that these numbers grow by 2-3% annually (Jerkovic and Kealey, 2018; Trade commissioner, Government of Canada, 2018). These are likely to be underestimates due to the lack of population-level quantifiable data and governmental oversight in both in- and out-migratory patterns of international retirement migrants (King, Warnes and Williams, 2000; O'Reilly, 2000). Previous research indicates the influx of older Canadian retirement migrants in the US is primarily to popular destinations in the southern states (e.g., Florida, Texas, Arizona, California). This seasonal migration of older Canadians can have many benefits for local economies, and recently proposed residency laws in the US are aimed at allowing Canadians to stay longer than six months and contribute more to the local economy (Tasker, 2017). While this increased seasonal demand is most clearly beneficial to the goods and service sectors and commercial retail outlets of destination economies, it is also felt in allied sectors such as real estate and health care (Coates, Healy and Morrison, 2002; Longino et al., 1991).

It is widely acknowledged that most international retirement migrants are in their sixties and beyond (Hall and Hardill, 2016; Northcott and Petriuk, 2011). This age group also corresponds with the stage in the life-course when people are likely to be managing one or more chronic health conditions (e.g., diabetes, arthritis), have a cancer diagnosis (or multiple diagnoses), and/or experience acute health episodes (e.g., heart attack,

stroke) (Vogelli et al., 2007; Ward, Schiller and Goodman, 2012; Wolff, Starfield and Anderson, 2002). It is thus likely that at least some international retirement migrants will need to access health care abroad to manage chronic and/or acute episodes, in addition to treating injuries. Meanwhile, only a few studies have set out to explore how international retirement migrants manage their health while abroad by accessing health care in destination communities (Ackers and Dwyer, 2004; Dwyer, 2000; Innes, 2008; Marshall et al., 1989; Rodriguez, Fernández-Mayoralas and Rojo, 2004). The financial accessibility of health care in destinations is also widely cited as a factor that pulls international retirement migrants to particular places (Croucher, 2012; Howard, 2008); though, again, research has not followed through with examining the lived experience of such access.

Although Canadian citizens and permanent residents have access to necessary health care with no out-of-pocket payment at the point of care, as provided under the Canada Health Act, this access does not extend to when they need to access care while travelling abroad (Ontario Health Insurance Program, 2017). Older Canadians who wish to have health insurance coverage while abroad, including in the US, do so by purchasing private travel health insurance policies. Existing research suggests that older Canadian international retirement migrants perceive the cost of health care in the US to be high and report they may prefer to take measures to avoid accessing care while abroad (Longino et al., 1991; Marshall et al., 1989). This includes behaviours such as filling prescriptions before departure and/or seeing regular care providers upon return home. While this limited existing research is useful for understanding some important aspects of the experiences of older Canadian retirement migrants accessing health care while in the US, these dated - yet influential - studies offer no insight into this issue from the perspectives of health care providers. We address this knowledge gap in the current analysis.

In this exploratory qualitative study, we examine the challenges and opportunities surrounding Canadian retirement migrants' use of and access to hospital-based health care while in the US from a unique perspective: that of health care providers and administrators in the destination. Specifically, we report on the results of focus groups conducted with workers at a regional medical centre in the Southern Arizona city of Yuma. Yuma was selected for this case study due to its popularity as a destination for Canadian snowbirds and also because the city has only one hospital and there are no

nearby cities, which means that workers at this facility have regular contact with older Canadian retirement migrants. We conducted focus groups with three groups of workers at this hospital. Using thematic analysis of the focus group results, we explore the opportunities and challenges presented by providing hospital-based care to this mobile, transnational, and aging patient group. We analytically organize these opportunities and challenges according to the unique environments within which they emerge. We use the term 'environments' to refer to important, yet distinct, domains of engagement encountered throughout the course of Canadian retirement migrants being treated in the hospital setting as in- or out-patients while living seasonally in Yuma, Arizona.

5.3. Methods

The purpose of this qualitative case study was to capture the experiential insights of destination-based health care providers delivering care to older Canadians while abroad in the context of international retirement migration. To address this purpose, we conducted focus groups with three health care provider groups working at a specific hospital: nurses, physicians, and administrators. Focus groups are an effective qualitative tool that can produce rich data through both the sharing of experiential insights by individual participants and the interaction between participants (Then, Rankin and Ali, 2014). We specifically sought to generate new ideas through an organic group discussion, which made focus groups and appropriate choice over interviews (Breen, 2006; Morgan 1996).

All participants were working at the sole hospital facility in Yuma, Arizona at the time of the study. This hospital has just over 400 beds, 2200 staff, and in recent years has seen approximately 1400 Canadian patient visits or admissions per year. Yuma is located in Southern Arizona, adjacent to the US-Mexico border. With no other hospitals within reasonable driving distance, it is likely that the Yuma Regional Medical Centre sees most (if not all) of the Canadian retirement migrants in the area in need of medical care. The city has a population of just over 100,000 and receives a sizeable number of Canadian retirees who travel abroad for extended stays each winter, with estimates of 80,000 to 100,000 additional residents during these months (US Census Bureau, 2018). For these reasons, it was selected for our case study. Consistent with case study methodology (Flyvberg, 2006; Yin 2017), we drew on multiple sources of information to understand important contextual aspects of Yuma as a destination for older Canadians.

This included taking tours of health and social care sites in the city, reviewing publicly available information in online discussion boards and websites about Yuma as a destination community for Canadians, and observing facets of everyday life in Yuma more broadly during fieldwork (including infrastructure targeting seniors). This wider contextual information informed both data collection and analysis.

5.3.1. Recruitment

We sought to recruit up to 12 participants for each of three focus groups: one held with nurses, one with physicians, and one with administrators (e.g., directors, billing and staff coordinators, insurance liaisons). Our goal was to have 8-10 people participate in each focus group, which is consistent with the established norm that 6 to 12 participants per group is ideal in order to facilitate conversation and interaction while remaining manageable (Then, Rankin and Ali, 2014; Morgan 1996). We recruited up to 12 participants per group to accommodate for some people not attending on the day. Following approval for this study from Simon Fraser University's Office of Research Ethics, our on-site collaborator circulated an invitation to participate to people in relevant departments at the hospital. The e-mail invitation contained information about the study purpose, proposed focus group dates, contact information for the lead investigators, and details on how to express interest in participating. It was also explained the focus group would be conversational in nature and thus participants need not have specific types of expertise with or established viewpoints on treating Canadian patients. Given the significant number of Canadian retirement migrants who seek treatment at the hospital each year we were confident all participants would have adequate knowledge of this patient group. Those interested in participating were asked to follow-up with the lead investigator by e-mail to confirm eligibility (i.e., they were a staff member at the hospital in one of the three target groups) and sign up to participate. This strategy also ensured our on-site collaborator would not know the identities of who did (or did not) participate in the focus groups in order to maintain anonymity. In keeping with current approaches to reporting on qualitative research, we do not include participant details with quotes (Breen, 2006; Saunders, Kitzinger and Kitzinger, 2015). This assists with minimizing the risk of identification associated with all participants working for the same employer and the lack of other medical centres in the region.

5.3.2. Data Collection

All focus groups were held on weekdays in May 2017 and were scheduled to run for 1.5 hours each. Two were held in the morning, where we provided breakfast, and the third was held in the early evening, where we provided a light dinner. All focus groups were conducted in meeting rooms at the hospital, to least inconvenience the participants. Two investigators attended each focus group, taking turns between serving as moderator and note taker.

Following review and completion of consent forms, the focus groups began with a round of introductions as well as an overview of the study purpose. From there the conversation was guided by five broad questions that were developed by our investigative team following extensive review of the literature and multiple conversations with our on-site collaborator. These broad questions probed: familiarity with treating Canadian international retirement migrants and the types of care they often seek; impacts of the seasonal 'snowbird' population on health services locally and in the hospital specifically; understandings of why Canadian patients may opt for care in one facility over another while abroad; the practical realities of treating seasonal Canadian international retirement migrants; and ways to facilitate continuity of care in the context of transnational care provision. Most of the broad questions had sub-probes to stimulate discussion. After each focus group the note taker and moderator met with the on-site collaborator to have a debriefing conversation (identifying important issues emerging from the conversation, determining if changes needed to be made to the guide in subsequent focus groups, etc.).

5.3.3. Analysis

Two digital recorders were used to record the discussion in each focus group (with one serving as a back-up). Following completion of the focus groups, the recordings were transcribed verbatim. Transcripts were independently reviewed by all investigators in preparation for coding and thematic analysis. Thematic analysis is a systematic, qualitative data analysis analytic technique in which researchers identify meaningful patterns that constitute themes amongst the collected data (Braun et al., 2018; Javadi and Zarea, 2016). Following independent transcript review, a meeting was held to identify emergent themes through contrasting specific issues discussed by

participants against the existing literature and the contextual insights gathered for this qualitative case study through our on-site fieldwork. Through this process we identified three ‘environments’ offering distinct opportunities and challenges for treating Canadian international retirement migrant patients in the hospital setting as being a meaningful analytic focus. These environments serve as the focus of the current analysis. We use the term environments to refer to important, yet distinct, domains of engagement throughout the course of these Canadian patients being treated while abroad.

Enabled by the size of the dataset, thematic coding was conducted by hand in a word processing program with organizational and analytic codes being identified and confirmed by the team. After hand coding was complete, the lead investigator shared coded extracts for each of the three environments to seek confirmation from the team regarding their interpretation, including their scope and scale. In the section that follows we include extracts in the form of verbatim quotes in order to enable the participants to ‘speak’ to the issues at hand. The inclusion of these quotes, in addition to our use of investigator triangulation at multiple points and establishment of an audit trail by keeping a record of important decisions, contribute to the rigour of this analysis (Mays and Pope, 1995; Seale and Silverman, 1990).

5.4. Results

A total of 27 people participated in the three focus groups, twelve nurses, six physicians, and nine administrators. Participants, almost 75% (n=20) of whom were women, had worked in the hospital for an average of 18.6 years. All had deep experience treating, overseeing the care of, and/or developing administrative protocols for older Canadian patients. Participants indicated there were no seemingly common treatments accessed by this transnational patient group, whether as in- or out-patients. Instead, it was noted Canadians presented for both chronic and acute care in most hospital units. It was also explained that in some cases Canadians called well ahead of their arrival in Yuma to schedule treatments to facilitate care continuity (e.g., diabetes management, cancer therapies). Participants also widely agreed it was very common to see admissions of Canadians through emergency in the winter months. These admissions, in some cases, were due to pharmaceutical interactions with sun, heat,

and/or alcohol. It was recognized Canadian retirement migrants, as well as retirement migrants coming from elsewhere in the US, were an important patient group for the hospital. In fact, the participants shared how the facility increased staff, opened extra beds, and provided additional services (including some that are community-based) during the winter months when the population of Yuma almost doubled with the influx of older retirees.

We asked participants to comment on the practical realities of treating older Canadian retirement migrants, many of which were framed as either opportunities or challenges for the hospital, clinicians, wider community, and/or patients. Through the process of thematic analysis, it became clear that distinct opportunities and challenges emerged in different types of environments encountered in the care trajectory. In the remainder of this section, we explore three specific environments: the practice environment, the transnational environment, and the community environment. By 'practice environment' we are referring to the spaces and activities that centre on caring for older Canadians within the hospital, including facilitating care continuity. The transnational environment pertains to the administrative, information exchange, and other processes that necessitate involvement of health care and insurance providers and spaces at home in Canada, and abroad in Yuma. Regarding the community environment, we conceptualize it to be the larger setting within which the hospital is located that shapes the everyday lives of both patients and those working at this hospital.

5.4.1. Practice environment

Within the practice environment, the opportunities for treating a sizeable Canadian retirement migrant patient load focus primarily on health human resources staffing and training. For example, participants noted that the presence of these patients assists with creating and maintaining a vibrant working environment as they keep staff busy with people in need of care. This demand facilitates staff retention among those with an interest in geriatric medicine, serves as the basis for placing medical residents at the hospital, and necessitates bringing in seasonal health human resources that expand treatment opportunities. The need to hire seasonal staff on a yearly basis has led to the

development of a strong pool of returning seasonal health human resources. *"I would say at least 70 to 75% of our seasonal employees have been coming back for at least five years, if not more…they're up to date on every change that we've done*." Participants referred to returning health workers' familiarity with treating Canadian international retirement migrants as a benefit of having seasonal employees, in that they are well prepared to understand the nuances of dealing with this mobile patient group (e.g., knowing to ask about both local and Canadian care networks upon admission). Having returning workers also lessened the seasonal training and orientation burden on administrators and other hospital staff, which was beneficial as such resources could be directed elsewhere.

The seasonal influx of older Canadian patients into the practice environment brings with it billing and practical complexities that pose challenges. A significant one is the need to navigate Canadian travel medicine insurance policies. Participants reported stress both for hospital staff and Canadian patients while waiting for insurance approvals, some of which needed to come from Canadian insurers that insurance and billing staff were unfamiliar with. Another complexity pertains to the lack of continuity of care for these Canadian patients who return home at the end of the travel season. This negatively affects the abilities of all staff, whether administrative or clinical, to provide necessary follow-up. At the same time, this has prompted some health workers to identify opportunities for enhancing continuity in this particular transnational care context. For example, some participants spoke about calling Canadian patients' regular care providers directly as a strategy for enhancing informational continuity, though this was often difficult due to time zone and administrative differences. An interesting administrative challenge in the clinical environment is that it is not always easy to determine who is a Canadian patient. The reason for this is that many Canadians have permanent or long-term residences where they stay in Yuma, and upon admission to the hospital they often report these local addresses. *"And I think that we struggle at times because of how they provide information, unit number or lot number or, they might consider [this as] their year-round residency, but, you know, in the summertime they go somewhere else. I struggle just getting correct addresses."* This was cited as a challenge because it may delay reaching out to international travel health insurers.

5.4.2. Transnational Environment

The transnational environment provides opportunities to enhance communication networks between international retirement migrants, physicians in Yuma, and clinicians based in Canada. This includes some physicians taking the time to call care providers at home in order to discuss post-discharge treatment protocols and understand opportunities for continued care at home in a health system that participants were mostly unfamiliar with. In instances where patients were managing cancer transnationally: *"So, communication from Canada to us…oncology is a lot more open to people moving, because we'll get people [who] come down with ports and we'll get orders to do lab work every month while they're here."* Participants specifically cited the hospital's community outreach programs as being crucial to improving communication networks and mitigating issues pertaining to the lack of continuity of care experienced by Canadians and other seasonal residents. For example, a free screening program has attracted a sizeable number of Canadian patients. *"Our database shows a little over 6,000 active members within the program…and out of that almost 2,000 of our members are Canadians."* Participants indicated the outreach programs are not only utilised to help educate the local population, but also act as an effective means to introduce older Canadians to local health care services, address concerns they have about their lack of familiarity with US-based health care, and to register in the hospital's database *prior* to requiring admission. Participants also described efforts to proactively educate Canadian international retirement migrants about the importance of traveling abroad with medical records in these outreach efforts.

The transnational environment creates significant administrative challenges for health professionals. These challenges are related to interactions with international health insurance providers and the lack of familiarity with the home health care systems of older Canadian patients. Participants expressed frustration over the time spent waiting for insurance provider clearance and described it as a significant source of stress for both patients and health workers in a context where many older Canadians are already concerned about their abilities to return home or afford care in the US. *"You get frustrated because your hands are tied. You've got to wait before you can actually give them the care that they need."* This frustration can become amplified: *"And they'll [Canadian patient] have like, the note when you open up the chart. It'll be like right, you know, in one of the main places where you see, it'll say 'need pre-authorization for*

whatever, call if you have questions'." There was also widespread acknowledgement that hospital workers' lack of familiarity with Canadian health care systems and Canadian patients' opportunities for care at home added complexity to the transnational environment. This lack of familiarity left some physicians and administrators unclear as to how to best advocate for their Canadian patients when interacting with international travel health insurance providers (e.g., in justifying why returning home or treatment in Yuma was best). It was also reported that no standard process exists for informing providers in Yuma about patient outcomes once they had returned to Canada. *"What happens to the patients when they go back, then? Are they treated exactly as they would be treated here, or what?"* This lack of 'closure' left some health workers with anxiety and stress related to the uncertainty associated with regularly treating transnational patients.

5.4.3. Community environment

The increased seasonal older population in Yuma provides opportunities for the hospital and its staff within the wider community environment by bolstering the number of hospital volunteers, facilitating the development of informal care networks, as well as creating and spreading a culture of care. As one participant explained, Canadian retirement migrants *"get a sense of community, at least with the hospital. So, there's a lot of them participating [volunteering] and they actually feel that they're part of…this community. So, I think that's really helpful*." These Canadian volunteers assist with support and navigation, providing information and in-hospital transportation, among other things, and participants explained they are a vital part of the network that connects the hospital to the community. The 'retirement migrant culture' that some older Canadians are part of in Yuma extends to the development of informal care networks that support patients within and beyond the hospital. "*Yeah, the culture is ... they take good care of each other, they're a good support group for each other.*" These informal care networks lessen the burden on the hospital staff in that they ease transitions back into the community. *"You can see it in the hospital…the snowbirds visit the snowbirds. I mean they have a really tight culture, and they've been seeing the same people from all over the country and Canada, and they all meet at the same park every year..."* It was explained that while older Canadians create strong informal care infrastructure and

support for one another, this is particularly true for those who live in the same residential parks.

The community environment presents some challenges for the hospital and its staff associated with lifestyle factors observed among some Canadian international retirement migrants. For example, it was widely discussed that the party atmosphere that surrounds international retirement migration results in significant numbers of injuries due to alcohol consumption. *"They [snowbirds] have fun. They trip and fall, end up in radiology again, yeah. The margaritas…the margaritas do it every time!"* Physicians also discussed a general lack of education about safe sex among older patients and how this has resulted in growing rates of sexually transmitted infections being reported. Canadian retirees also undertake other high-risk activities that can cause further stress on the hospital and its staff. For example, Canadian snowbirds routinely travel from Yuma to Los Algodones, Mexico (a short trip by car or bus) to purchase affordable dental care, pharmaceuticals, and other treatments. *"The ones that go to…Mexico to get…alternative treatments that you cannot get here. And then you're like, 'don't do it!' And you see them in the ER [emergency room] or in the hospital when they have an exacerbation of whatever."* Complications resulting from these community-based practices place significant pressure on hospital staffing plans during the busy winter months, thereby posing as a challenge for the hospital that emerges from the community environment.

5.5. Discussion

Despite some long standing and highly cited existing research that suggests Canadian retirement migrants have little uptake of health care while in the US (e.g., Betancourt, Green and Carillo, 2000; Longino et al., 1991; Longino and Taplin, 1994; Marshall et al., 1989), this analysis has shown that in Yuma, Arizona Canadians are indeed a significant patient group. In fact, many focus group participants viewed older Canadian patients to be a growing revenue stream. By consulting directly with health care providers and administrators at the only hospital in this city and the surrounding region, our results summarized in Table 1 show particular opportunities and challenges emerge in specific care environments when treating or connecting with this transnational patient population. Important opportunities include the creation of a strong and diverse

seasonal workforce in the hospital, new transnational paths of communication and information sharing for physicians and health administrators, and informal care networks that support formal health care services within and beyond the hospital. These opportunities are balanced out by billing, practical, administrative, and lifestyle-related challenges which add complexity to treating this group of transnational patients. We characterized the opportunities and challenges that exist for the hospital, physicians, patients, larger community and other groups across three distinct environments of care: the practice environment, the transnational environment, and the community environment. Although we discussed these environments separately in the results section, it is important to acknowledge they are interrelated and opportunities or challenges that emerge in one may be seen another way in a different environment. We begin this section by exploring some of these intersections, after which we identify some pressing new research directions.

Table 5.1. Synthesis of the Opportunities and Challenges in Providing Health Care to Canadian International Retirement Migrants in Yuma, Arizona

	Scope of this Environment	Example of a Challenge Created in this Environment	Example of an Opportunity Created in this Environment
Practice Environment	The spaces and activities that centre on caring for Canadian international retirement migrants within the hospital	Providing needed follow-up care and facilitating care continuity for Canadian patients who will return home at the end of the season	Hiring and retaining hospital staff to meet the seasonal influx in demand for services
Transnational Environment	The administrative, information exchange, and other processes that involve both health care or travel health insurance providers at home (in Canada) and abroad (in Yuma)	Navigating lack of familiarity with Canadian health care system and Canadian patients' health care opportunities at home	Educating Canadian international retirement migrants about the importance of travelling abroad with medical records
Community Environment	The larger setting within which the hospital is located that shapes the everyday lives of patients and hospital workers	Caring for Canadian retirement migrant patients who have undertaken risky activities associated with 'party atmosphere' in snowbird communities	Creating a culture of care that extends beyond the hospital and into the community (e.g., building a hospital volunteer program that includes Canadians)

The opportunities and challenges identified in this thematic analysis intersect across the three environments of care explored. One such intersection lies with the billing, practical, and administrative challenges identified within the practice and transnational environments. Participants' lack of knowledge of the Canadian health care system and lack of established relationships with some Canadian travel health insurance providers underlie these distinct challenges. For example, participants in all focus groups spoke openly about their confusion with the Canadian health care system, which was identified as a major source of stress associated with treating Canadian patients. This lack of knowledge created several challenges in the practice and transnational environments. It was not uncommon for participants to discuss frustration with their perception that the 'Canadian health care system' can require a patient to return home for care; meanwhile, it is actually private travel health insurance providers that make the decisions participants spoke of and not the 'Canadian health care system' they implicated. Consistent with our study, existing research highlights the complexity of crossing health systems and the challenges this can pose while abroad. For example, there is a long-standing and sizeable body of research that explores the cross-cultural complexity emerging from accessing health care transnationally (Hofstede, 1980; Selmer, 2007; Suphanchaimat et al., 2015; Hennebry, McLaughlin and Preibisch, 2016; Wang and Kwak, 2015). Given the cultural familiarity between Canada and the US (Selmer, 2007; Suphanchaimat et al., 2015), it is not surprising that this well-established challenge did not emerge as an important discussion point among participants. However, other research has shown how a lack of familiarity with patients' home health care systems can generate misunderstandings and other challenges in the context of transnational care. For example, research on medical tourism has shown that patients may not understand differences in the roles that health workers in destination hospitals take on relative to what they are familiar with in their home systems, which can create confusion (Crooks et al., 2016; Solomon, 2011). Further to this, in the context of caring for ill and injured vacationers, interviews with health care providers in a popular vacation destination in Mexico point to how misunderstandings based on stereotypes regarding practice competency can affect patients' decisions regarding receiving treatment for injuries sustained on holiday while abroad (Hoffman, Crooks and Snyder, 2018).

The continuity and dependability of the 'snowbird season' provides overlapping opportunities in the practice and community environments, which serves as the basis for

another important intersection in our thematic findings. Because the seasonal population influx in Yuma can be relied upon, although specific numbers may vary annually, the hospital was able to meaningfully expand its seasonal operations to include additional health workers and community outreach activities that benefitted all retirement migrants, including those from Canada. While a number of existing studies have touted the economic benefits to local communities that host Canadian retirees who winter in the US (Betancourt, Green and Carillo, 2000; Longino et al., 1991; Longino and Taplin, 1994; Marshall et al., 1989), the current analysis provides unique insight into how the operations of a specific hospital benefits from this transnational mobility. These benefits result in creating opportunities in the practice and community environments that form the basis of the transnational care received by older Canadians in Yuma, which included community outreach initiatives with significant uptake. These benefits also facilitate the development of distinct types of continuity. For example, the clinicians, nurses and physicians operating in the practice environment benefitted from the return of some of the same seasonal health professionals yearly, while the community environment provided experienced retirement migrant volunteers for the hospital. According to participants, the combination of these two opportunities created a positive working environment and enhanced the work culture of the hospital during snowbird season. Existing research shows this advantage exists in other industries that rely on seasonal workers, such as the tourism sector. Similar references to opportunities associated with developing a sense of community that positively integrates seasonal workers emerge from the tourism sector, as do those pertaining to the additional opportunities generated by cost savings for the employers of hiring seasonal workers (McCole, 2015; Anderson, 2018).

Interestingly, participants characterized the community environment in both positive and negative ways. For example, it was explained that some Canadian retirement migrants chose to become volunteers for the hospital, who create micro-communities of care within this facility and assist Canadian patients and others with transitioning back into the community after discharge. These individuals were highly valued, and their presence created important opportunities both for the hospital and its patients. Their presence in the hospital was also thought to reflect the tight-knit nature of retiree communities and the strong and positive social focus of the international retirement migration lifestyle (e.g., Campbell, 2015). Meanwhile, participants in all focus

groups identified the wider community to be one that poses some lifestyle-associated health risks for older Canadians. The intersection of alcohol overconsumption, risky sexual practices, and/or opting to purchase dental care or pharmaceuticals in Mexico with the increased health risks associated with aging resulted in some Canadian patients placing particular demands on the hospital and health workers. While we acknowledge the participants have interacted with only a fraction of the Canadian retirees who winter in Yuma, their characterization of the health risks associated with the community environment counter wide-held understandings of older people leading quiet, safe, risk-adverse lives (Albert and Duffy, 2012; Rolison et al., 2013). These findings provide important insight into why some Canadian retirement migrants need to access health care while in the US and highlights the importance of the wider outreach activities the case study hospital undertakes with all retirement migrants in the community environment.

To the best of our knowledge, this analysis provides the first insights offered by health care providers and administrators of the challenges and opportunities associated with treating international retirement migrants in the hospital setting. It is thus not surprising that many directions for future research build from the results, and here we highlight four. First, very little is known about if and how international retirement migrants' home health care providers are affected by this transnational practice. What are their experiences of supporting these patients before they go abroad and after they have returned? Have they interacted with health workers in the destination for any reason? Do they share the concerns about care and informational continuity raised by the focus group participants in this study? Exploring such questions has the potential to deepen the insights gleaned in the current study. Second, given the sizeable number of Canadians who participate in international retirement migration and the country's rapidly aging population (Hoffman, Crooks and Snyder, 2018), it is an opportune time to explore models and mechanisms for enhancing care continuity for those who participate in this transnational practice. Doing so has the potential to respond to some of the challenges identified by the focus group participants. Are there ways to facilitate information sharing and collaboration between health care providers/facilities at home and abroad that are cost-effective and maintain privacy? What are the potential risks and benefits associated with doing so, and what degree of involvement should private travel health firms have? Capturing reliable demographic data about Canadian international retirement migrants

who use health care while abroad will also assist with enhancing these analyses and targeting interventions that support continuity of care. Third, conducting similar research with health care providers and administrators in other international retirement migrant destinations and with different transnational patient populations will assist in identifying which findings from the current analysis are transferrable to other contexts. Finally, while we noted references of visits from friends and family to older Canadians in the hospital, the current study was focused on formal caregiving and did not explore informal caregiving in the international retirement migration context. Do unpaid, informal caregivers such as friends and family members encounter similar types of opportunities and challenges to those cited by the formal caregivers consulted in this study? Can informal caregivers play a role in mitigating or eliminating some of the challenges documented in this analysis and enhancing some of the opportunities? These are questions worth of exploration given the significant role informal caregivers play in managing health and wellbeing among older populations (Lee and Mason, 2014; Naganathan et al., 2016; van Groenou and De Boer, 2016; Van Houtven and Norton, 2004).

5.6. Conclusion

In this exploratory qualitative analysis, we presented the findings of focus groups conducted with health care providers and administrators working at a regional hospital in Yuma, Arizona regarding their experiences of treating older Canadian retirement migrants who winter in this destination. Through thematic analysis we identified specific opportunities and challenges posed by treating this transnational patient population that transect three distinct environments encountered in the hospital-based care trajectory: the practice environment, the transnational environment, and the community environment. The findings point to challenges associated with obtaining approvals for care from travel health insurance providers, lack of familiarity with Canadian patients' home health care systems, informational continuity, and the risky behaviours associated with the international retirement migration lifestyle that bring some patients to the hospital. There are, however, opportunities associated with this transnational population including seasonal increases in staffing, community outreach by the hospital, the creation of new forms of communication, and an influx of Canadian hospital volunteers

during ‘snowbird season’ who can assist with reintegration into the community after discharge. While additional research is needed in order to deepen our understanding of these findings and their implications, the experiences reported in this study work to counter the notion that older Canadians who stay seasonally in the US have little interaction with local health systems while abroad.

Chapter 6.
Embracing resourcefulness in qualitative fieldwork

Chapter 7 presents the findings from semi-structured interviews I conducted with older Canadians living seasonally in Yuma, Arizona. This analysis contributes to the case study presented throughout this dissertation. In Chapter 7, our analysis probes the health management planning experiences of Canadian international retirement migrants prior to going abroad and presents a typology of health management strategies. The analysis captures the vulnerabilities of many Canadians who, while aware of the risks inherent staying abroad for extended periods, are unable, ineligible, or unwilling to engage in preparatory practices to support their health prior to travel, much less engage in a coherent strategy to mitigate negative health outcomes. Chapter 7 serves to reinforce an important message that threads throughout my dissertation, which is that Canadian international retirement migrants are surprisingly less homogeneous than often depicted in existing studies and the retirement migration literature. These differences are important to acknowledge and carries implications for both policy and future research, and I revisit this issue in Chapter 10.

The data collected for analysis in Chapter 7 was obtained through semi-structured interviews with older Canadians living seasonally in Yuma. The interviews were to be conducted face-to-face during a fieldwork visit to Yuma in January 2018 for two weeks. As Yuma is a seasonal home to thousands of older Canadians, we agreed that it would be feasible to recruit once I was on-site given that my attempts to network with people via social media prior to arrival proved unfruitful. Once I arrived in Yuma, I had to immediately figure out pathways to successful recruitment, which proved to be more challenging than expected as it was almost impossible for me to distinguish between seasonal Canadians, domestic American retirement migrants and older residents of Yuma in public settings.

Informed by researcher observations *in-situ*, Canadian license plates on vehicles emerged as a readily available item that could help me identify Canadians staying seasonally in Yuma. I quickly created a postcard that described the study and invited people to follow up with me if interested in scheduling an interview that I could leave on

the driver side window of vehicles with Canadian license plates. My plan was to drive around supermarket, liquor store, shopping centre and restaurant parking lots looking for vehicles I could place the postcard on. These were all locations I had already observed numerous vehicles with Canadian license plates being parked. This recruitment strategy was a clear turning point in data collection because within a few days of placing postcards on vehicles I had received a number of e-mails from prospective participants. The strategy was so successful that I also used it to assist with recruitment for the analysis presented in Chapter 9.

In the course of undertaking data collection for the analysis shared in Chapter 7, I learned the importance of being resourceful. Data collection for the analysis in Chapter 5 was smooth and productive due to the support of our on-site collaborator who greatly facilitated recruitment. For the interviews presented in Chapter 7 there was no similarly situated gatekeeper to ease recruitment. In conducting this data collection, I learned how necessary it is to adapt to the challenges presented and quickly identify ways to work around them to push data collection forward, which is an incredibly time-sensitive task when undertaking international fieldwork for a pre-determined and specific time period. While I am certainly not alone in this type of experience, my solution of using postcards placed on dashboards is not something I have seen in any existing research with international retirement migrants. Ultimately, pioneering this postcard recruitment approach saved the data collection step and allowed for the rich analysis into how older Canadians prepared to manage their health during their long stays abroad.

Chapter 7.
"If you have a pain, get on a plane": Qualitatively exploring how Canadian international retirement migrants prepare to manage their health while abroad[3]

7.1. Abstract

Purpose: Every year, tens of thousands of older Canadians travel abroad during the winter months to enjoy warmer destinations that offer social and recreational opportunities. How do these Canadians prepare to manage their health while abroad? In this analysis we explore this question by developing a typology of preparatory strategies. **Methods**: Semi-structured interviews were conducted with 19 older Canadians living seasonally in Yuma, Arizona (United States). Interviews were transcribed verbatim and thematically analysed to form the basis of a typology of preparatory strategies. **Results**: Four distinct preparatory strategies form the typology that summarizes how Canadian international retirement migrants prepare to manage their health while abroad. First, some participants became thoroughly prepared by gathering information from multiple sources and undertaking specific preparatory activities (e.g., visiting a travel medicine clinic, purchasing travel health insurance, bringing prescription refills). Second, some participants were preparation-adverse and relied on their abilities to address health needs and crises in-the-moment. Third, some participants became well informed about things they could do in advance to protect their health while abroad (e.g., purchasing travel health insurance) but opted not to undertake preparatory actions. A final group of participants prepared haphazardly. **Conclusion**: This typology can assist health care providers in international retirement migrant destinations to appreciate differences

[3] Pickering, J., Crooks, V. A., Snyder, J., & Milner, T. (2021). "If you have a pain, get on a plane": qualitatively exploring how short-term Canadian international retirement migrants prepare to manage their health while abroad. *Tropical Diseases, Travel Medicine and Vaccines*, *7*(1), 1-10.

among this patient population that is often characterized as being relatively homogenous. More research is needed to determine if these preparatory strategies are common in other mobile populations and if they are found in other destinations popular with international retirement migrants.

7.2. Introduction

Although research exists regarding strategic health behaviours and decisions among international travellers (e.g., Dwyer 2000; Lardiés-Bosque 2016a; Longino, et al. 1991; Northcott and Petruik 2011; Tucker, et al. 1988), there has been little consideration of these issues among short-term or seasonal international retirement migrants. These migrants are older persons, typically over the age of 60, who travel abroad for the winter season or for short periods in order to enjoy the benefits of destinations with warmer climates that provide social, recreational, and even health-promoting opportunities (King, et al. 2000; O'Reilly 2000; Rodriguez, et al. 2004). International retirement migration is a widespread global practice, and Canadians are among those who participate in this transnational mobility. The seasonal aspect of this phenomenon is distinct from tourism and studies focusing on migrants looking to relocate long-term or permanently. In this paper we focus on the seasonal migration of older persons, known as 'snowbirds' in North America, who choose to return to the same destination to live for the winter months.

Marshall et al. (1989) identified some personal health management strategies undertaken by older Canadians living seasonally in Florida (United States [US]), which include pre-filling prescriptions prior to departure, purchasing travel health insurance, and maintaining a schedule of health check-ups with their family doctor prior to going abroad. Generally, however, little is known about the individual-level decision-making and action-taking choices these older Canadian travellers make in order to prepare to manage their health while abroad. Meanwhile, it is important that we be attentive to such preparatory practices given that research has shown it is common for international retirement migrants to be managing multiple chronic health conditions and that they are also at an age where the risk of acute health events (e.g., stroke, heart attack) is pronounced (Gudmundsson, et al. 2016; Vogeli, et al. 2007; Ward, et al. 2014; Wolff, et al. 2002).

The Canadian experience of seasonal migration presents its own challenges that likely shape if and how these seasonal travellers prepare to manage their health while abroad. This is particularly noticeable in issues surrounding paying for and accessing health care elsewhere, as well as in related stressors such as accessing health records

while abroad. For example, seasonal international retirement migrants from Canada to the US must ensure they spend more than six months of the year in their Canadian home province or territory to maintain their public health care health coverage. Simultaneously, the same Canadians need to manage a complex, multi-year averaging of time spent in the US to avoid requirements to pay US income tax on worldwide earnings (Coates, et al. 2002; Internal Revenue Service 2020). At home, Canadians have access to universal health care that is provided with no fee at the point-of-service for medically necessary care and is funded publicly through taxation. This universal access, however, is not portable to other countries when Canadians are travelling abroad (Canada Health Act 1985; Sethna and Doull 2012). Canadian travellers who want to have health insurance coverage while abroad need to privately purchase travel health insurance (Hunter and McCarthy 2017; Marshall, et al. 1989). While the insurance industry is federally regulated in Canada, there are significant differences in cost and coverage between companies (Allingham 2013). This variation creates a complex and convoluted network of providers that Canadian international retirement migrants must navigate if they want to purchase a travel health plan. There is no legal requirement to have private health insurance while abroad and so there are many Canadians – including international retirement migrants – who opt not to purchase coverage (Canadian Life and Health Insurance Association n.d.). This study acknowledges personal choice and preference is often shaped by constraints, which may be socio-economic, resource-based or related to competencies. For example, digital poverty, or a lack of computer and digital communications technology proficiency, has a positive correlation with age (Barrantes, 2007, 2010) and affects the ability of some individuals to conduct online searches and results in a lack of knowledge. Instead, this paper explores the lived experiences of Canadian seasonal international retirement migrants who provided an account of their preparation, or lack thereof, to live abroad for several months each year.

How can we characterize the preparatory strategy or strategies that older Canadians employ prior to going abroad as international retirement migrants to manage a health need or crisis? To answer this question, we developed a qualitative study based on semi-structured interviews with Canadian retirement migrants living seasonally in Yuma, Arizona. Due to its warm and dry climate, Yuma is a popular destination for both domestic and international retirement migrants in the US (Pickering, et al. 2020). The US

Census Bureau (2018) estimated the city's year-round population to be just over 100,000. It is estimated that the population of Yuma approximately doubles during the winter months with an additional 80,000 to 100,000 seasonal residents, many thousands of whom are Canadian retirees. We explore how Canadian international retirement migrants in this destination prepared to manage their health while abroad, including the steps they took while still in Canada to do so and any planning undertaken to access health care while in the US. Through thematic analysis of the interview findings, we identify a typology of preparatory strategies, noting four distinct approaches to preparation. We detail these strategies and then move to situate our findings within the context of the challenges surrounding the seasonal migration of older Canadians and the existing travel health and medicine literatures. This analysis is not only a contribution to the growing literature on short-term and seasonal international retirement migration (see Pickering, et al. 2019 for an overview), but the typology is an important informational tool that can be used by health care providers and administrators in destinations to understand some important differences among this seemingly relatively homogenous patient group (Canadian Life and Health Insurance Association n.d.; Ontario Blue Cross n.d.).

7.3. Methods

A qualitative case study approach was used to capture the experiences of Canadian international retirement migrants wintering in Yuma, Arizona as they reflected on their experiences of managing health in a transnational context. Consistent with case study methodology (Flyvberg 2006; Yin 2017) and building on our previous studies in Yuma (Pickering et al, 2019), we drew on multiple sources of information to understand important contextual aspects of this city as a destination for Canadian retirees. In addition to conducting face-to-face interviews, our activities included touring health and social care sites in the city, reviewing publicly available information, and observing aspects of everyday life in Yuma during our fieldwork. Our observations involved on-site interactions with facilities that older persons frequent, as well as infrastructures targeting seniors. While this analysis is focused on the findings specific to the interviews, this wider observational information was integral to the manner in which both data collection and analysis was conceptualised.

7.3.1. Recruitment

Following approval from our institutional research ethics board, participant recruitment began. Given the exploratory nature of this study, our goal was to recruit up to 20 Canadian international retirement migrants living seasonally in Yuma as participants for one-on-one interviews. After some requests to do so, we agreed to allowing some small group interviews to occur for participants who preferred to be interviewed with a partner or friend. After piloting a number of recruitment strategies (e.g., social media postings, advertisements on community billboards), one strategy proved most successful. Specifically, this involved placing a postcard with study details and contact information on the windows of vehicles with Canadian license plates. Prospective participants who responded to the invitation by email were sent a follow-up email which included a letter of invitation containing study details, its purpose, proposed interview dates, and information on how to participate. Interested participants were asked to reply to the lead investigator by e-mail to confirm eligibility (i.e., a Canadian living seasonally in Yuma over the age of 60) prior to scheduling the interview.

7.3.2. Data Collection

All interviews were held in January 2018 and ran for approximately 90 minutes. All interviews were conducted by a single member of the research team, recorded digitally and later transcribed verbatim. Recording started after a review of the study details and completion of a signed consent form. A semi-structured interview guide was used to guide the conversations. This guide was created following a review of relevant literature and through a process of confirmation among the investigators. Questions in the guide probed:

- Yuma as a destination for Canadian international retirement migrants
- Personal health
- Health care-related preparation prior to departing Canada
- Experiences with accessing health care while in Yuma

- Informational continuity of care (i.e., health records, prescription lists)

Consistent with a semi-structured approach, participants were invited to touch on topics of discussion not raised in the interview guide that they thought were relevant to the discussion. Upon completion of the interviews, participants were given a US$10 gift card to a local coffee shop to acknowledge their valuable contributions to the study.

7.3.3. Analysis

In preparation for coding and thematic analysis, verbatim interview transcripts were independently reviewed by all investigators. After the independent reviews, team meetings were arranged to identify emergent themes by contrasting the issues discussed by participants against the existing literature and the contextual insights gleaned from first-hand observations while in Yuma. Through this analytic process we arrived at developing a typology that characterizes the ways in which Canadian international retirement migrants approach preparing to manage their health while abroad. The typology characterizes four distinct, nuanced strategies used for such preparation. After developing this typology as an analytic framework, a coding structure was created that captured themes central to each preparation strategy. Coding was done by hand within a word processor. Coded extracts were shared with the investigators to seek confirmation on interpretation of the codes and the overall typology. The use of investigator triangulation throughout the analytic process, the establishment of an audit trail by keeping a record of important decisions, and the inclusion of direct quotes in the following section to build trustworthiness are all factors that contribute to the rigour of this analysis (e.g., Baxter and Eyles 1997; Houghton, et al. 2013; Tobin and Begley 2004).

7.4. Results

We interviewed 19 Canadian international retirement migrants wintering in Yuma, Arizona, most of whom were women (n=12). The majority of participants had spent multiple winter seasons in Yuma, and some had visited other popular retirement migrant

destinations in the US and Mexico. Participants ranged in age from 63 to 86 and had travelled from several Canadian provinces, including: British Columbia (n=8), Alberta (n=6), Manitoba (n=2), Saskatchewan (n=2), and Yukon (n=1). While most considered themselves to be in good health overall, many had experienced health exacerbations while abroad ranging from developing influenza to requiring hospitalization and ultimately repatriation due to diverticulitis. Participants drew on their deep lived experiences of this transnational practice during the interviews to reflect on how they managed their health while abroad and their plans for doing so prior to departing for Yuma. These plans included actions such as preparing to access health care before departure from and upon return home to Canada, accessing health care while in Yuma, filling prescriptions in advance or planning for renewals while abroad, purchasing travel health insurance, making copies of health records, and undertaking other similar activities that may facilitate care continuity and health management in this transnational context.

Through independent and triangulated transcript review and thematic analysis we identified four distinct preparatory strategies that together form a typology of how Canadian international retirement migrants planned for managing their health while abroad. First, there were those who chose to become thoroughly prepared for a range of potential outcomes by undertaking extensive, and often well-informed, research and preparatory activities. Second, some participants were highly preparation-adverse and opted to not prepare at all for the possibility of needing to access health care or have to take on any active health management while abroad. A third group characterized themselves as well informed, and as a result of what they had learned had opted to not undertake any preparatory actions that required financial investment (e.g., purchasing travel health insurance). Finally, a fourth group prepared in a haphazard way, often acting on information and advice that was obtained in a non-systematic way. In the remainder of this section, we expand on these four distinct preparatory strategies, drawing on verbatim quotes from participants to support interpretation.

7.4.1. Becoming thoroughly prepared

Participants who characterized themselves as thoroughly prepared for a range of potential health and health care access outcomes while abroad relied upon extensive

information gathering prior to, and during, their time away. In particular, they typically spent numerous hours researching different options for travel health insurance, often obtaining multiple quotes and speaking with a range of brokers. For example, as one participant explained "…*we had Manulife recommended to us [by friends] and we thought, 'well it's a big company.' So, we checked them out and decided to try it out and they were absolutely great*." Word-of-mouth was an important way to learn about travel health insurance plans for those wanting to prepare for their time abroad in such a way. Another participant described changing travel health insurance providers "…*after we'd heard so many complaints on [provider] about rejecting [health] claims*" from other retirement migrants. Others' experiential knowledge also informed many participants' decisions regarding where to access prescriptions while abroad. For example, participants received advice on whether or not buying pharmaceuticals across the border in Mexico (a very short drive from Yuma) was thought to be a safe option, or whether or not prescriptions should be filled in Canada before departing for the US. Participants' own histories as international retirement migrants also shaped the preparatory activities they undertook. For example, while in Canada prescriptions cannot often be written for longer than a two- or three-month supply of a drug, some participants had identified creative solutions: *"I need six months [worth of prescriptions] … So, I called the doctor [before departure], and said, 'I want you to double the dosage.' She said, 'I'll give you prescription for twice a day' and I just take it once."*

The preparatory planning of thoroughly prepared participants extended into the period after returning to Canada from Yuma. *"Your annual physical, you get 'em done as soon as you go home, you get all the doctor stuff out of the way when you get home, because you need six months clear when you return."* Signaled by this quote, many travel health insurance providers required a period of many months with no major health episodes or new prescriptions in order to issue policies for future travel. Thoroughly prepared travellers thus planned in advance to receive their annual physical exam from their family physicians shortly after returning home from Yuma so that they would have the health history record needed to purchase a travel medicine policy for the next winter season. From when to get their flu shot to when to start calling potential travel medicine insurers, and everything in between, we learned that many thoroughly prepared participants diarized specific preparatory activities so that they could create a sound plan for managing their health while abroad and act in the event they needed to access

health care while in Yuma. These planned and diarized activities also extended to health-related events including attending free screenings and educational workshops, known as the Silver Care program, offered by the Yuma Regional Medical Center.

7.4.2. Being preparation-adverse

Those who were preparation-adverse actively avoided preparing for the potential of having to manage health-related issues while living abroad for the winter. Although there were a variety of reasons given for why some participants were preparation-adverse, they all focused on a desire to not have to plan for some of the complexities of transnational living prior to arriving in Yuma. In some instances, participants lacked technological skills and were not confident in their abilities to get details from websites and apps, which they explained were key informational platforms for preparatory strategies (e.g., cost comparing travel health policies, reading information in online forums, looking up details of health service availability in Yuma). Instead, they opted to not seek out information or prepare for eventualities. In other instances, some of those who were preparation-adverse firmly believed that if they developed an acute or exacerbated chronic health condition, they would be stable enough to return home without needing to access care in Yuma. As one participant explained: *"My goal is to just try to stay healthy down here and not need any healthcare, because really I'd rather deal with it at home."* Others still had a firm belief that if they needed prescriptions refilled, had an emergency situation develop that required going to the hospital, or required some other form of medical intervention they would be able to easily make arrangements to do so while in Yuma without preparing in advance.

Unlike their more prepared counterparts, preparation-adverse participants did not spend time researching or purchasing travel health insurance prior to arriving in Yuma, nor did they worry about having checkups or physicals with their physicians at home prior to travel or upon return to Canada. These choices were often presented in a manner that suggested participants were resigned to the fact that travel health insurance would either be too costly, or that they would be ineligible. *"Some of us [Canadian international retirement migrants] do come without it [travel health insurance] … If you've got all kinds of health issues, it's gonna cost you more and they just figure they'll go take the chance."* For those for whom travel health insurance was too costly, the belief was:

“If you have a pain, get on a plane.” Interestingly, many preparation-adverse participants discussed the importance of using their social networks as a buffer against the potential negative consequences of their lack of preparation. For example, some believed that they could rely on other members of their residential communities in Yuma to offer recommendations for where to purchase pharmaceuticals, advise them on regulatory matters regarding accessing emergency medical care without travel health insurance, and the like.

7.4.3. Preparing by becoming informed yet not taking action

Unlike those who were thoroughly prepared to manage their health while in Yuma for the winter, there was another group of participants who had become well informed about a range of health matters but had chosen not to undertake any specific preparatory actions. Participants who undertook this strategy were generally knowledgeable about things such as travel health insurance, when and where to get prescription refills, and health care facilities in Yuma, but did not use this knowledge to guide any preparatory actions. Such research led many of those who opted not to purchase a policy to find the application process to be complex and criteria for approval to be restrictive, which is why this particular preparatory action was not adopted. As one participant explained: “*They [insurance providers] do that [make the approval process complex] on purpose so they can screw you later*” in terms of the lack of clarity regarding which pre-existing conditions may lead to non-coverage in the case of medical treatment while abroad. Phrases such as “*scam*” and “*cartel*” when describing what they had learned about the travel insurance sector and policy options. Participants in this group shared a commonly held belief that unfortunate events would happen to other people, but not themselves, and used such beliefs to inform decisions regarding not purchasing travel health insurance.

The tendency to become informed, yet avoid taking action, was motivated by a strong sense of self-reliance. This strategy resulted in these participants’ conscious decisions to avoid taking actions that others, and especially those who were thoroughly prepared, identified as beneficial. For example, despite knowing the benefits of regular visits with their doctor after returning home, many simply chose not to: *“No we don’t [visit our doctor after returning home]. Why would we? Our meds aren’t going to change.”*

Another element of self-reliance was these participants' common believe that they were "*in good enough health"* to take the risk of opting not to purchase travel medicine insurance for their time in Yuma, despite having done some research into the options available.

7.4.4. Becoming haphazardly prepared

A haphazard preparatory strategy was employed by participants who did not take a systematic or comprehensive approach to informing their decisions regarding which preparatory activities to undertake, or who undertook preparatory actions without becoming extensively informed. Much of their information gathering was done in situ through talking with friends and neighbours while already abroad. As one participant explained: *"I mean I think that's how snowbirds operate a bit. It's, it's so much as word of mouth."* While thoroughly prepared participants also cited the importance of experiential knowledge as an information gathering and knowledge building tool, those who prepared haphazardly relied on it as their primary source and so only received information that others chose to share. Because much information was gathered once having arrived in the destination, in many cases critical preparatory steps were missed. For example, some participants discussed carrying copies of recent medical records with them to Yuma, but not a full list of their prescriptions. In another instance, a participant had a complete list of their medications, but only learned of the advantages of having their annual physical exam with their family doctor upon return to Canada through word-of-mouth.

As with most other participants who had purchased travel health insurance, those who prepared haphazardly typically hoped they would not need to use their policies. *"We're kinda desperate not to use it [travel health insurance]. We pay all this money for it in case you're in a car accident or have something major."* There were also those who opted not to purchase travel health insurance at all. Many haphazardly prepared individuals reported learning through their social networks about the seemingly affordable pharmaceuticals and medical care available just across the border in Los Algodones, Mexico. They viewed it as a reliable alternative to using travel health insurance policies:

We don't have extended health care; we don't even have a pension. We, neither one of us, all we have is our [national contributory pension] and, well she gets [national old age security pension]. I don't get that yet. And so, we don't have pensions, we don't have extended health plan, so we do go to [Los] Algodones.

By relying heavily on others in their residential communities for health-related information in lieu of doing their own information gathering, in many ways these participants were also listening to others' risk assessments regarding accessing care and purchasing pharmaceuticals in Los Algodones.

7.5. Discussion

Each year a significant number of retired Canadians travel abroad to live seasonally in warmer climates. Our analysis of interviews with Canadians who travel to a specific destination in the US has identified four distinct preparatory strategies employed by these migrants to manage their health while living abroad seasonally. Each strategy is comprised of two common components, which are: (1) information gathering, and (2) preparatory actions. Table 1 provides a synthesis of these strategies and identifies specific examples of information gathering and preparatory actions. It is important to note that there are some intersections or points of commonality between strategies. For example, "thoroughly prepared" and "haphazardly prepared" strategies both produce knowledgeable individuals who also undertake a number of preparatory actions. Information sources and specific actions vary between these two groups, though. Thoroughly prepared individuals incorporate the experiential knowledge of others into their overall body of knowledge, while those who haphazardly prepare rely on it almost exclusively. This is an important distinction that ultimately has a profound impact on the knowledge systems international retirement migrants draw on to make (seemingly) informed decisions and put knowledge into action. In the remainder of this section, we consider the findings in light of the existing knowledge base, identify their implications for health services providers who care for international retirement migrants while abroad, and consider directions for future research.

Table 7.1. Synthesis of Canadian international retirement migrants' preparatory strategies for managing their health while abroad

	Scope of the Strategy	Examples of information gathering strategies	Examples of preparatory actions taken
Thoroughly Prepared	an international retirement migrant who carefully plans how they will manage their health abroad and undertakes preparatory actions based on this plan	undertakes multiple strategic searches for travel health insurance information; researches health-related events for the winter season	schedules full annual medical examination upon return to Canada; travels with pre-filled prescriptions for the duration of the stay in the US
Preparation Adverse	an international retirement migrant who undertakes little-to-no advanced planning and intends to act reactionarily to any health events or issues that emerge while abroad	receives word-of-mouth details about health management both home and abroad	plans to call on friends and acquaintances to provide financial support needed; plans to fly or drive home if health complications arise
Prepared with Info but not Action	an international retirement migrant who consults multiple information sources, considers the types of health management issues they may encounter while abroad, and then opts not to prepare in advance	researches travel health insurance options	does not take preparatory actions
Haphazardly Prepared	an international retirement migrant who is generally knowledgeable about health management, but has knowledge gaps and a non-systematic approach to gathering information that may result in taking risks	relies on incomplete information shared by friends and acquaintances	looks for affordable prescription refills while abroad; plans to avoid making travel health insurance claims

Existing research demonstrates that it is common for many types of travellers to be unprepared to manage potential health events while abroad (Savage, et al. 2018; Tate, et al. 2006), and some evidence has emerged depicting older travellers to be less prepared than younger ones (Del Prete, et al. 2019). These issues are echoed in this study, which has shown there are Canadian international retirement migrants who are similarly unprepared. These failings in preparation, that have also been documented elsewhere, include non-existent or inadequate travel health insurance coverage (Daciuk & Marshall 1990; Grace & Penny 2004), poor prescription medication management

(Gudmundsson, et al. 2016; Winslade, et al. 2020), incomplete documentation of past medical history (Leggat & Fischer, 2006), as well as limited knowledge of sources to connect with if problems do occur (MacPherson, et al. 2007). In the context of the current study, these gaps in preparation are very concerning given that migrants' ages may very well amplify the associated risks. More specifically, Canadian international retirement migrants have comparatively higher risks of experiencing negative health events while abroad than the average traveller due to their age, which corresponds to an elevated risk of numerous health complications (Gudmundsson, et al. 2016; Vogelli, et al. 2007; Ward, et al. 2014). As expected, many participants were aware of these risks and opted to become well-prepared and informed in an effort to mitigate negative outcomes. However, our findings also show that knowledge of risks does not always translate into undertaking preparatory actions. Evidence of inaction heightens the importance of public health practitioners and physicians providing travel health education to international retirement migrants (Bascom, et al. 2015; Cegolon, et al. 2017). Our findings underscore the need for travel medicine interventions that target international retirement migrants to ensure they can make informed decisions regarding how best to manage their health while abroad (Aw, et al. 2014). The Canadian Committee to Advise on Tropical Medicine and Travel could, for example, begin to identify best practices to support the development of interventions such as informational tools (Bui, et al. 2018).

Much of the existing literature on short-term and seasonal international retirement migration suggests these travellers share socio-economic similarities (Botterill, 2017; King et al., 1998), particularly given that they all require the financial means to travel and live abroad for extended periods and maintain separate domiciles. While looking at a more granular aspect of the international retirement migration experience in the context of the current study, we found important differences emerged among retired Canadians who traveled to Arizona for the winter. Specifically, differences became clear in how the interview participants prepared for, and perceived, potential health risks in relation to accessing health care and managing their health in a transnational context. For those who aim to improve the travel health awareness and literacy of international retirement migrants, these differences point to the fact that multiple types of interventions (e.g., informational tools, conversations with family physicians, travel health insurance purchase navigational aids) are likely needed to target all four of the traveller types identified in our analysis in order to address their

associated concerns and comfort with advanced preparation. This is consistent with the approach advocated for by Suh and Flaherty (2019), who suggest that older travellers benefit from tailored approaches to improving their travel medicine awareness and overall travel health. Many of our interview participants demonstrated particular distrust of, and a poor understanding of, the travel health insurance industry. Other research has documented similar concerns about insurance providers and lack of preparatory practices among individuals travelling regularly for business purposes, migrant farm workers, immigrant travellers visiting friends and relatives (e.g., Khan et al., 2016; Savage et al. 2018). Identifying ways to assist Canadian international retirement migrants with making *informed* decisions about travel health insurance options is a clear need that emerges from the current study. Our finding that Canadian international retirement migrants are not a homogenous group when it comes to preparing to manage their health while abroad is also an important learning point for members of the travel insurance industry, in addition to health care providers in destinations who may assume that Canadian travellers have mostly participated in similar preparatory activities around insurance acquisition or prescription renewals (Hoffman et al., 2018; Pickering et al., 2020).

The findings shared in the previous section hold a number of implications for further research, four of which we highlight here. First, little is known about the economic resources and income of the interviewees, and how this shapes the way that they prepare their health care arrangements. Research in other forms of retirement migration study the impacts of class inequalities on retirement migrants' diverse experiences (e.g., Oliver and O'Reilly, 2010; Olwig, 2007). These studies could help explain differences in the development in popular destinations and the individual-level decision making processes. Second, as was apparent from these interviews, widespread distrust towards the travel health insurance industry among Canadian international retirement migrants exists. Unfortunately, there is a paucity of research focused on most dimensions of travel health insurance, including trust-building with and decision-making by older travellers. We view this as an area worthy of further research consideration so that this information can assist with identifying ways to support informed decision-making not just about travel health insurance, but about all facets of travel medicine by international retirement migrants. Third, similar research undertaken in other US and international destinations popular with Canadian international retirement migrants will assist with shedding light on

whether or not any destination-specific factors shape the preparatory actions or information gathering strategies undertaken by Canadian international retirement migrants to manage their health while abroad. Finally, a number of individuals other than the traveller themselves are involved in supporting the ways in which Canadian international retirement migrants prepare for managing their health while abroad through information gathering and key actions. Among those mentioned in the findings are Canadian family physicians and pharmacists. It would be very useful to undertake research that captures the professional perspectives held by these groups regarding the opportunities and challenges they encounter in supporting these patients in their travel plans as well as their insights on ways to support informed decision-making that can secure the best health outcomes.

7.6. Conclusion

This exploratory, qualitative analysis found Canadian seasonal international retirement migrants engage in a variety of preparatory practices to manage their health during their time spent living abroad. Specifically, we identified four distinct preparatory strategies composed of both approaches to information gathering and preparatory actions undertaken. First, some participants became thoroughly prepared through gathering information from multiple sources and undertaking various preparatory activities (e.g., researching material online, purchasing travel health insurance, obtaining prescriptions for the duration of stay). Second, some participants were preparation-adverse and chose reactionary strategies to manage emerging health issues. Third, some participants became well informed in advance to protect their health while abroad, such as purchasing travel health insurance, but opted to avoid undertaking preparatory actions. A final group of participants prepared haphazardly. These findings support lessening reliance on one-size-fits-all approaches to health care intervention strategies (e.g., medical outreach programs, free health screenings, etc.) and informational campaigns for Canadian international retirement migrants.

Growing research attention is being given to aging, reflecting the upward trends in population aging in the Global North in particular (e.g., Ogura and Jakovljevic 2018;

Walker 2016). Much of this research is fixed-in-place or centres on mobility limitations or immobility, which is evident in studies on aging-in-place (e.g., Hwang, et al. 2011; Wang 2018), home care (e.g., Coyte and McKeever 2016; Genet, et al. 2011), and assistive transportation (e.g., Maus, et al. 2016; Silverstein and Turk 2016). In the current study, we shifted this narrative by having focused on a transnational mobility practiced by some older Canadians and others internationally, thereby focusing on older people as living mobile lives. International retirement migrants need to manage tax and health system requirements both at home and abroad, which may require carefully navigating complex requirements (Miller 2014). As this analysis showed, they must also make decisions regarding how they will manage their health while abroad that can involve seeking out information and undertaking preparatory actions while at home and away. Aging can be a mobile practice and studies such as the current one can help to identify the policy and practical implications of older people's transnational engagements, which are thus an important complement to work that frames aging as relatively fixed-in-place or localized.

Chapter 8.
Understanding Dyads and Researcher Reflexivity

The following chapter explores informal care provided by spouses, which is often referred to as spousal care in existing literature, in a transnational context. Specifically, Chapter 9 examines spousal care between Canadian international retirement migrants living seasonally in Yuma, Arizona and the support systems they rely on to provide informal care. The findings in Chapter 9 are the result of dyadic interviews with spouses who had experienced health complications while living in Yuma, Arizona during the winter months. Spouses identified as either the primary care giver or receiver and detailed their experiences of providing or receiving informal care from their partners. Caregiving and receiving are personal, interactive experiences which validates the use of dyadic interviews to capture both voices in order to gain insight into the collective experience of the couple (Perry & O'Connor, 2002). Several pitfalls for researchers are identified in the literature including connecting with one member of the dyad on an emotional level, giving preference to the account of one participant over the other and the potential of being requested to choose one side over the other (Forbat & Henderson, 2003; Morrow, 2005; Ummel & Achille, 2016). To ensure rigour and to limit these potential issues we chose to have one interviewer (the primary author) for all interviews.

Interviewing participants in dyadic fashion creates both opportunities and challenges. I observed spouses supporting each other during the interviews, particularly in providing key details or reminding their partners of the order in which events occurred. This was helpful in these interviews because one spouse identified as the primary caregiver while the other identified as the care receiver. These situations are often stressful, and it can be difficult to remember specific details. There was also a notable level of comfortability when sharing personal health experiences with their life partner sitting beside them. However, a variety of challenges emerged during this process that needed to be managed. While spouses could support each other by adding details or their version of the timeline of events, it also created a clouded account of what actually transpired when they disagreed with one another. This was further exacerbated in situations where one spouse's voice was particularly dominant. In fact, the dominant

voice often looked to control the direction of the responses which I then had to navigate in my role as interviewer.

After each dyad interview was completed, I jotted notes on specific challenges of each interview to use as a guide for refining my process before the next interview. I also discussed these challenges with my supervisor, who had accompanied me on this fieldwork. Through this process of note taking and holding debriefing conversations, I realized how I could use my interview style to overcome some of the challenges I was experiencing. For example, one strategy I implemented was to revisit important points raised earlier in the interview to ensure that my understanding was consistent with what the participants were reporting. This strategy helped to enhance consistency in interpretation, especially when there were elements of fuzziness between the participants' accounts. Managing a dominant voice in interviews is not new or novel to my situation, but it required tact to manage. I learned that I needed to open space in the discussions for less vocal participants, often doing so by explicitly inviting them to speak to their experience.

Throughout my dissertation research I had the opportunity to undertake focus group, one-on-one, and dyad interviews. Having the opportunity to use three styles of interview throughout this research greatly built my data collection skills. Interviewing is, of course, much more than asking questions and recording responses. In the case of dyadic interviews, Kaplan (2001) suggests the interviewer must be engaged in the interview process by constantly observing the nuances of the interactions between the participants. Kaplan suggests caregiving partners' perceptions of their own role are complex and a deeper understanding is necessary to contextualise their experiences of caring and couple-hood. Reflecting on how to improve my skills with dyad interviewing while in the field undertaking interviews greatly enhanced this process.

Chapter 9. Relational, Community-based, and Practical: Support systems used by Canadian Spousal Caregivers in the United States[4]

9.1. Abstract

Every year tens of thousands of older Canadians travel to the southern United States (US) to live there seasonally during the winter months to enjoy a warmer climate – a practice known as international retirement migration. Several factors facilitate participation in this transnational mobility, including having the financial resources needed to live abroad. For those managing chronic or acute health conditions, traveling with a caregiver (typically a spouse) is another important facilitator. In this qualitative analysis we explore the transnational systems of support that Canadian international retirement migrant spousal caregivers draw upon to enable them to provide care while in the US. We report on the findings of ten semi-structured dyad interviews (n=20 participants) conducted with Canadian international retirement migrants living seasonally in Yuma, Arizona. The dyads consisted of spouses, one of whom had defined care needs and the other of whom provided informal care. Through thematic analysis of these interviews, we identified three types of transnational support systems that spousal caregivers draw on: relational, community-based, and practical. While aspects of these support systems have been documented in other informal caregiving studies, this analysis demonstrates their copresence in the transnational caregiving context associated with international retirement migration. Overall, this analysis highlights the benefits of close social relations enjoyed by international retirement migrants providing informal care to mitigate the lack of access to their established support networks at home.

---

[4] Pickering, J., Crooks, V. A., Snyder, J., & Milner, T. (2022). "Relational, Community-Based, and Practical: Support systems used by Canadian spousal caregivers living seasonally in the United States. *Health and Social Care in the Community,* 00:1– 9. Copyright ©.

9.2. Introduction

Canadians, as with residents of most other Global North countries, have seen improvements in health status and health outcomes for decades that have resulted in increased life expectancy (de Bruin et al., 2018; Sherman, Forsberg, Karp, and Törnkvist, 2012). Coupled with lower birth rates, this trend has led to rapid population aging and, in turn, increasing demand for both formal and informal health care (Jacobs et al., 2017; Navaie-Waliser, Spriggs, and Feldman, 2002). In Canada, shifting demand for health care resources has been further heightened by continued health care restructuring that has resulted in a growing dependence on informal care (Birch and Gafni, 2005). By informal care, we are referring to the unpaid care provided by family members, friends, and others to support care recipients' health and wellbeing (Coumoundouros, Ould Brahim, Lambert, and McCusker, 2019; Triantafillou et al., 2010). This care can be hands-on in nature, or can involve providing emotional, financial, and other forms of support for activities of daily living (Monin et al., 2019; Triantafillou et al., 2010). Research has consistently identified family members as the main providers of informal care, with the majority of such care being provided by spouses (Grossman and Webb, 2016; Bouldin and Andersen, 2014). This informal care provided between spouses, or "spousal care" (Health Canada, 2002; Monin et al., 2019), is the most common form of informal care given to care recipients over the age of 60 (Coumoundouros, Ould Brahim, Lambert, and McCusker, 2019; Coyte and McKeever, 2016).

Informal care provided by spousal caregivers can directly affect the health of the care recipient (Rauer, Sabey, and Jensen, 2014). Common care responsibilities often focus on undertaking household tasks in addition to arranging care logistics, managing prescriptions, and interacting with health care professionals (Monin et al., 2019). Spousal caregivers are also known to be important emotional support resources for their partners (Berger et al., 2019; Donnellan, Bennett, and Soulsby, 2015). The practice of providing care is not without risk and can threaten spousal caregivers' own health or lead to the onset of caregiver burden (Health Canada, 2002). Having access to a range of meaningful supports can assist with limiting the negative impacts of providing care on spousal caregivers' own health and wellbeing (Portier et al., 2018). Existing studies indicate that nearby family members are the most common sources of support for

spousal caregivers (Grossman and Webb, 2016; Vlachantoni and Palmer, 2019). For example, they can assist with household management, transportation, emotional support, and companionship and thereby lessen the care responsibilities of the spousal caregiver (Van Groenou and De Boer, 2016). Health workers can also provide support to informal caregivers, though research has documented that formal health care systems typically provide limited support to spousal caregivers (O'Reilly, Rosato, Maguire, and Wright, 2015).

In 2015, the World Health Organization (WHO) published a report on ageing and health which included a call to fundamentally change the way we view ageing in relation to increasing mobility in later life. Our research responds to this call by exploring a transnational mobility undertaken by some older people worldwide, including Canadians. Many older Canadians choose to travel and live outside Canada for several months at a time to escape the cold winter at home in favor of warmer, drier winter climates elsewhere (Rodríguez, Fernández-Mayoralas, and Rojo, 2004; Pickering, Crooks, Snyder, and Milner, 2019). This practice is formally known as *international* retirement migration (Pickering and Crooks, 2019), with these migrants popularly referred to as 'snowbirds', and people choosing to participate in this mobility are typically over the age of 60 (King, Fielding, and Black, 1997; O'Reilly, 2000). Although retirement migrants bring economic benefit to cities and towns they choose to live in, it is common for them to live in closed-access housing communities that have on-site amenities (van den Hoonaard, 2002; Trolander, 2011). Despite the active lifestyles of most retired migrants (Lahti, Laaksonen, Lahelma, and Rahkonen, 2011), older persons by the age of 60 are at risk of health complications and many are managing multiple chronic illnesses (Gudmundsson, et al. 2016; Vogeli, et al. 2007). It is quite common for international retirement migrants to travel abroad with their spouses or partners (Longino and Marshall, 1990), which opens the opportunity for spousal care to be used as a health management strategy among those who have care needs. Meanwhile, we know very little about the practice of informal caregiving among international retirement migrants, including the resources that spousal caregivers draw on to assist them with providing such care while being abroad and away from their established support networks at home. We address this knowledge gap in the current analysis that is focused on spousal caregiving among Canadian international retirement migrants while wintering in the United States (US).

Despite the lack of reliable statistics, various estimations suggest that up to a million older Canadians live seasonally in the US every year for a period of weeks to months (Coates, Healy and Morrison, 2002; Desrosiers-Lauzon, 2009), which includes popular destinations in the US states of Florida, Arizona, and California. Here we identify the formal (i.e., structures or systems already in place) and informal (i.e., self-initiated) supports Canadian spousal caregivers utilize to assist them in providing care in the transnational context of international retirement migration, while living away from established family and health care support networks at home that are typically drawn on for support (Colombo, Llena-Nozal, Mercier, and Tjadens, 2011; Maly, Umezawa, Leake, and Silliman 2005). Specifically, we report on the findings of ten semi-structured caregiver-care recipient spousal dyad interviews (n=20 participants) conducted with Canadians wintering in Yuma, Arizona. Through thematic analysis we identify three distinct support systems that these spousal caregivers draw upon to support them in providing care in a transnational context. This analysis serves as a novel contribution to our understanding of spousal care in transnational contexts, which has been explored in research on transnational health care use (Casey, Crooks, Snyder, and Turner, 2013; Crooks, Casey, and Whitmore, 2016; Whitmore, Crooks, and Snyder, 2015) and transnational relocation (Baldassar, 2014; Horton and Stewart, 2012; Masselot, 2011).

9.3. Methods

This analysis contributes to a multi-method qualitative case study that aimed to explore the health management and health care access experiences of older Canadian international retirement migrants living seasonally in Yuma, Arizona. The lived experiences of these older Canadians who live in Yuma for weeks or months of the winter are the common unit of analysis throughout the multi-method case study (see also Pickering, Crooks, Snyder and Milner, 2020, 2021). Case studies have a long history in qualitative research (Flyvbjerg, 2006; Starman, 2013) and are useful when focusing on a phenomenon within the context in which it occurs (Crowe et al., 2011). The warm and dry climate in Yuma is particularly conducive to the lifestyle of retirement migrants during the winter months in North America. The popularity of Yuma as a destination is evident in the numerous “55+ lifestyle” communities and recreational vehicle resorts in the greater Yuma area, and online marketing sites attracting older Canadians to Yuma (e.g.,

snowbirdadvisor.ca; suncruisermedia.com). While our case study included focus groups with local health care workers (Pickering, Crooks, Snyder, and Milner, 2020) and extensive observational fieldwork over the course of multiple visits to Yuma (Pickering, Crooks, Snyder, and Milner, 2021), here we specifically examine in-depth semi-structured dyad interviews conducted with Canadian spousal partners who lived as seasonal international retirement migrants in Yuma. Our research team consists of three researchers with expertise in health care and transnational movements, two of whom have parents who participate in international retirement migration, and a knowledge end-user who holds a senior leadership position at the main hospital in Yuma.

Following ethics approval from our home institution, semi-structured interviews were conducted in Yuma in January 2019. Each interview was conducted with both spouses present and all interviews were conducted face-to-face and recorded digitally. Given the exploratory nature of the study, while also recognizing the practical challenges of conducting dyad interviews (i.e., finding times that work for all three people), we sought to recruit 20 participants for a total of ten dyad interviews during our 1.5-week fieldwork session. Recruitment happened via study announcements posted in Facebook groups for Canadians in Yuma and postcards with study details being placed by us on the windshields of vehicles with Canadian license plates parked in high-traffic areas (e.g., supermarkets, liquor stores, fast food restaurants, and shopping centers). People who expressed an interest in participating were sent a follow-up email containing detailed study information. Potential participants were asked to confirm their eligibility, which was that they were residents of Canada, over the age of 60, living seasonally in the Yuma area, and that one person in the couple had defined health needs while the other provided ongoing informal care. Subsequent correspondence enabled participants to determine a convenient time and place for the interview. Participants were provided with a gift card of $20 USD for a popular café to acknowledge their contributions to the study.

Interviews were conducted using a semi-structured guide that probed issues of health management, care practices, support networks, and general experiences as international retirement migrants at a location of the participants' choosing. Given the exploratory nature of this study, a semi-structured approach was used so that participants could also discuss topics they deemed important but were not addressed in our questions (Brinkman, 2013; Edwards and Holland, 2013). Dyadic interviews require

an approach independent of other interviewing techniques. We thus utilized the Morgan, Ataie, Carder, and Hoffman (2013) guide to dyadic interviewing, which highlights the necessity to avoid conceptualising such conversations as small focus groups despite the similarities surrounding the inability to guarantee confidentiality and anonymity between participants. Interviews lasted between an hour and 1.5 hours, almost all of which took place at participants' seasonal residences.

All interviews were transcribed verbatim. Following transcription, team members independently reviewed sample dyad interview transcripts to identify emergent themes as a first step in thematic analysis (Braun and Clarke, 2006). Thematic analysis is a useful method to highlight the differences and similarities in the exploration of the perspectives of different participants (Nowell, Norris, White, and Moules, 2017). Through triangulated discussion and consensus building we identified three meta-themes that characterized the transnational support systems relied on by spousal caregivers in international retirement migration: relational, community-based, and practical. These meta-themes were then used to structure a coding scheme developed through a process of investigator triangulation and implemented by the lead author (e.g., Fereday and Muir-Cochrane, 2006). Following this, the lead author used QSR NVivo to code the transcripts and extracted excerpts related to each meta-theme to confirm their scope and scale through investigator triangulation. Conversational clusters were coded to ensure both caregiver and care recipient voices were captured and could be extracted around a common point of discussion. Upon completion of coding and interpretive confirmation, we compared these themes to existing literature on informal caregiving, transnational care, and international retirement migration to identify contextual aspects that are salient to the case study – which is an important step in thematic analysis (Shenton, 2004; Tuckett, 2005). Overall, we built rigour into data collection and analysis by using investigator triangulation to enhance confirmability; enhancing dependability by maintaining an audit trail by keeping notes about key decisions during data collection and analysis; and, strengthening credibility through undertaking multiple on-site visits throughout the case study and our ongoing collaboration with a knowledge end-user (Shenton, 2004).

9.4. Findings

We interviewed Canadian international retirement migrant spouses living seasonally in Yuma, Arizona in dyadic interviews (n=10 interviews, 20 participants). All participants had experience living seasonally in Yuma for multiple winters and had travelled from several home Canadian provinces, including British Columbia (n=5), Alberta (n=3), Manitoba (n=1), Saskatchewan (n=1). In all instances one member of the spousal partnerships had experienced chronic illness exacerbations or acute illness while in Yuma, and in some cases, this involved the informal caregiver managing serious complications or hospitalizations while abroad in addition to ongoing, routine care. Consistent with the informal caregiving literature (e.g., Davidson, Abshire, Paull, and Szanton, 2018; Milligan and Morbey, 2013; Tatangelo, McCabe, Macleod, and You, 2018), in most cases the spousal carers we spoke with did not recognize their own need for support, nor did they consider themselves to be a caregiver and they attributed the care work they had undertaken to their role as spouse. In all instances, the care participants provided was transnational as care needs were present while in Yuma and at home in Canada, including during the journey between the two.

Through thematic analysis we identified three support systems Canadian international retirement migrant spousal caregivers use to manage care responsibilities while living seasonally in Yuma. First, local friend networks formed relational supports that were identified as important sources of support and provided practical assistance in a variety of ways including transportation, meals, check-ins, and emotional support. Second, the communities' participants lived in often had formal structures in place to support informal caregivers that included spaces for support groups to organize, locations to host information and outreach materials, and meal sharing initiatives. Finally, participants referred to practical supports that assisted them with providing informal care to be critical, such as websites that offered care resources and advice along with the availability of medical supplies or mobility aids that were available to those with the necessary resources (e.g., computer, health insurance plan, personal finances). In the remainder of this section, we detail these supports and how they were used in the transnational context of international retirement migration, supported by verbatim quotes from participants.

9.4.1. Relational support

Relational support systems were comprised of friends and others in participants' social networks in Yuma who offered support to the primary caregiver. Typically, these people were identified as close friends and/or close neighbors by participants and their assistance was viewed as a core source of support and respite for the caregiver. Relational support providers were viewed as integral sources of mental and emotional support for caregivers, including through the provision of ongoing "*check-ins*" (Dyad 1) about needed assistance. Participants indicated the importance of both personal and virtual check-ins by relational support providers, which helped to lessen feelings of isolation brought on by providing informal care for their partner while away from their very established support networks at home. Some participants reported previously having supported other informal care providers in their communities: *"When [our neighbours] were going through that thing, we helped them off and on. The old couple who were next to us, he had a fall, so we would check in on them"* (Dyad 8). They appreciated being able to rely on the same types of relational support that they had provided for others in their own caregiving contexts.

In some instances, caregiving partners explained that members of relational support networks stepped in to provide assistance in undertaking roles that would typically be played by their spouse while at home. For example, one caregiver who did not drive while in the US had a neighbour who is in their support network arrange to drive them to a major airport several hours away to take an unexpected flight home. The importance of having this type of local support was also explained by another participant when referring to having food dropped off at their home: "…*we have several friends in here that are good friends that you could just call on them and say, … 'We will be home late, could you drop some food off for us?' And they'd be there in a minute"* (Dyad 4). This was referred to as providing "*peace of mind*" (Dyad 8) by allowing caregivers to focus on providing care and caring for themselves as much as possible while allowing members of relational support networks to take on some of the tasks of everyday life. These examples helped to highlight the ease and closeness of social relations in these close-knit communities. Participants widely regarded these types of supportive relationships to be part of the "*social contract*" (Dyad 5) in place in residential parks for international retirement migrants.

9.4.2. Community-based support

Residential communities were a crucial source of support for spousal caregivers in several ways. Prominently placed bulletin boards were observed at several residential parks visited throughout the case study research, and participants indicated that activities such as informational events and support groups were commonly advertised on these boards. One participant noted that the support groups offered both mutual assistance and co-learning, "*I noticed on their board they had ads for support groups, a pulmonary group, and it looked like anybody who wanted to could just come to those sessions and they were for education*" (Dyad 10). The most common support groups were for spousal caregivers of partners with chronic conditions. One participant explained that "*There's another group…that deals with dementia*" (Dyad 1) support while another also reporting another "…*support group for stroke victims. There's a group that gets together"* (Dyad 3).

In addition to organized support groups, a number of participants explained that retired health workers served as important community-based resources to support informal caregivers and others with health-related needs. "*There are caregivers [retired nurses and physicians] in the community that may not be part of an organization, but they are there*" (Dyad 2). This quote serves to underscore that these local residents were viewed as an important community resource, and in some instances, they were central to rolling out volunteer-led public health clinics and supports. Although informal by nature, participants referred to these community members as providing key supports for addressing medical complications that not all spousal caregivers were equipped to deal with. For example, "*People can come in and once a week get your blood pressure checked. Get your sugar checked*," (Dyad 7) and "…*there's a blood pressure clinic here every week. So, you can go have your blood pressure checked every week. And if it's out of whack, they'll recommend that you go to a walk-in clinic*" (Dyad 6). These community-based support systems helped spousal caregivers manage time-consuming and challenging personal care requirements associated with heart disease and diabetes in particular. Another community-based initiative that some participants reported to be supportive was meal sharing programs that allowed caregivers in need of respite and

others who were “*unable to prepare their own meals*” (Dyad 8) to arrange to have a few meals dropped off at their trailer or house.

9.4.3. Practical support

Participants emphasized the importance of having access to the medical supplies, prescriptions, mobility aids and other items needed to support the health and wellbeing of the care recipient. This required having the financial resources to cover such expenses in addition to other living costs, for example maintaining a residence in Canada and Yuma. In this regard, participants reported that an important strategy was to determine where it was best to purchase supplies, whether at home or while in the US, and to research this carefully. In many cases “*they [caregivers] come [to Yuma] with the equipment. …Somebody’s given them that at home, or they’ve purchased it on their own. And they come with it*” (Dyad 6). Participants also explained that it was important to have a plan to deal with complications or symptom exacerbations if they arose, whether it was to purchase costly travel medical insurance and have treatments provided while in Yuma or return to Canada. Such planning was important “*because we might have to leave really quick*” (Dyad 9) to return home if significant medical intervention was needed, and so this type of very practical logistical planning was an important activity that caregivers undertook and often required reviewing websites for detailed information.

International retirement migrants often needed to manage complex systems, including foreign-based income tax and differences in accessing health care between the US and Canada. Participants indicated that finding practical supports to assist them with navigating these differences minimized informational burden placed on caregivers and enabled them to provide more focused spousal care. One such support was purchasing a membership with the Canadian Snowbird Association, which released newsletters and hosted networking events in many popular US destinations for older Canadians. As one participant explained: *“I think, the tip I would give [other caregivers] I think, is the Canada Snowbird Association which is readily available to help snowbirds”* (Dyad 10). Participants also advised that wider community supports were also available to assist caregivers in practical ways that could also lessen dependence on support people in their communities. As one explained, they recommend that caregivers “*reach*

out for services that are already available… [such as] Meals on Wheels" (Dyad 2) or similar in-home services. Other participants reported the use of fee-based services to assist with daily living activities, where spousal caregivers purchase assistance from a fee-for-service organization "*for an hour a day to make meals and to clean up the kitchen*." (Dyad 1). In each instance, these types of practical supports enabled informal caregivers to draw on others' expertise to assist them with daily life while in Yuma which, in turn, allowed more dedicated time to provide spousal care.

9.5. Discussion

Our analysis of dyadic interviews with Canadian international retirement migrants living seasonally in the US identifies three specific support networks for spousal caregivers who provide informal care to their partners, namely relational, community-based, and practical supports. In addition to being focused on providing care for the care recipient spouse, each support system consisted of actions or practices that supported caring for the caregiver's mental/emotional health (e.g., check-ins from community members and ongoing responsibilities (e.g., meal preparation). Although the previous section considers each support system separately, they have important intersections. For example, relational supports for informal caregivers provided by friends and neighbors intersected with community support systems when those neighbours attended the same support group or on-site health clinic. Similarly, the availability of practical support resources is often reinforced through community support systems. For example, meal service providers may be invited into the retirement migrant communities, which facilitates the ability of residents to take advantage of these practical supports. This brings services closer to caregivers who need to remain close to a partner. In the remainder of this section, we consider the findings in relationship to existing literature, identify their implications for transnational spousal support, and outline directions for future research.

Existing informal care literature identifies support systems as crucial to the health and wellbeing of caregivers and care recipients alike (e.g., Antonucci, Birditt, Sherman, and Trinh, 2011; Berger et al., 2019; Plöthner et al., 2019), and thus it is not surprising that such systems were identified as important for supporting informal caregiving in the

transnational context of international retirement migration. Cash, Hodgkin, and Warburton (2013) previously identified the importance of multi-faceted support networks for spousal caregivers, which includes familial, non-familial, community, and personal support networks. This type of multi-faceted approach was heavily mirrored among participants in this study, with one important exception: familial networks. The transnational nature of international retirement migration took participants away from available family support networks at home, which left them looking to members of their lifestyle communities for support. Although the findings presented here have some parallels to those of other studies focused on caregiving in a transnational context, such as in the context of medical care sought abroad (e.g., Casey, Crooks, Snyder, and Turner, 2013) and expatriates working abroad long-term (e.g., Wasielewski, 2015), there are important contextual differences related to international retirement migration that participants' comments highlighted. More specifically, due to their age, Canadian international retirement migrants are more likely to be managing multiple chronic and/or acute health conditions and thus symptom exacerbations while abroad than other travelers (Gudmundsson et al., 2016). Participants of this study were quite aware of this and as such it is not surprising that caregivers and care recipients alike discussed supports such as fully understanding travel health insurance policies and planning for potential of needing to return home unexpectedly early to access medical care as practical supports.

Research surrounding spousal care specifically, and informal care more generally, has long established the importance of support systems for spousal caregivers (Pratt and Kethley, 1988; Sauer and Coward, 1985). With few exceptions, this research typically conceptualizes caregivers-care recipients to be fixed in place and support systems to be proximal. A study of 'elderly migration' in Australia underscores the power of communication technologies to assist informal caregivers (Wilding and Baldassar, 2018) in relation to longer term or semi-permanent relocations. While participants in the current study used platforms such as Skype, FaceTime, and Facebook to remain connected to their family support systems at home, they did not view these people to be integral to their networks of support while in the US seasonally. While physical and social isolation are common experiences among caregivers (e.g., Dickens, Richards, Greaves, and Campbell, 2011; Hajek, Kretzler, and König, 2021; Steptoe, Shankar, Demakakos, and Wardle, 2013), older Canadian caregivers in the

current study used neighbourly connections in their tight-knit residential communities to assist with offsetting such isolation. This finding supports the importance of integrating some of the social principles of age-friendly community design in popular destinations for retirement migrants and their relevance for supporting informal care practices (see, for example, Fänge, Oswald, and Clemson, (2012).

The findings of this study raise numerous questions for further research, three of which we highlight here. First, various challenges in the provision of spousal care in the transnational context of international retirement migration were reported. However, little is known about the specific care practices undertaken by people living abroad but not permanently living outside of their home country. Further research on other transnational mobilities would assist with identifying support systems that are specific to particular types of movements, destinations, and durations, which would be useful to travel medicine practitioners in particular. Second, undertaking similar studies in other popular destinations for Canadian international retirement migration would assist in understanding how destination-specific factors contribute to spousal care and informal care in transnational environments. Finally, conducting interviews with stakeholders and health care professionals would provide an additional account of the role and significance of spousal care for Canadian international retirement migrants. Nurses and physicians may have insight into effective strategies that spousal caregivers could utilize, as has already been documented in relation to the care that international retirement migrant patients seek while abroad (Pickering, Crooks, Snyder, and Milner, 2020). The perspectives gathered from such professionals can assist with creating informal caregiver support resources and tools that could be disseminated by groups such as the Canadian Snowbird Association.

9.6. Conclusion

This analysis qualitatively explored the care support system of Canadian international retirement migrant spousal caregivers in a transnational environment. We identified three separate support systems that offer a range of supports to older caregiver-care recipient dyads participating in these transnational lifestyles. The first support system involved the destination-based friends and close neighbours who provided assistance that in many ways provided caregivers with some moments of respite, such as check-ins and transportation or logistical assistance. Second, the closed

communities in which participants lived abroad seasonally had many support options tailored to this setting, including volunteer-led support group spaces and informal health clinics. Finally, these older informal caregivers relied on practical support systems, such as having access to needed medical supplies and informational resources. While these support systems have been documented in other research, the current study shows their co-presence in the context of this transnational context.

This study has explored a highly mobile older population living abroad seasonally. Given the relative absence of robust population-level research on international retirement migrants (Pickering, Crooks, Snyder, and Milner, 2019), qualitative studies, such as this one, are important as they can contextualise the lived experiences of this group of older travelers. Existing studies on spousal and informal care typically focus on the lived experiences of older persons in a static setting, including studies focused on the home as a place of care (e.g., Egdell, 2013; Glass, 2016), aging-in-place (e.g., Fritz and Dermody, 2019; Peek et al., 2014), as well as the isolation experienced by older persons (e.g., Hajek, Kretzler, and König, 2021; Steptoe, Shankar, Demakakos, and Wardle, 2013). The current study not only serves to build on emerging qualitative research on international retirement migration (e.g., Barbosa, Santos, and Santos, 2020; Bender, Hollstein, and Schweppe, 2018; Hayes, 2021; King, Cela, Morettini, and Fokkema 2019), but also serves as an important acknowledgement that some care practices involve mobility and movement and that this is true in relation to the seasonal movement of older retirees. It behooves us to understand such informal care dynamics in order to create resources that can best meet caregivers' and care recipients' needs alike given that the health and wellbeing of both are so greatly affected by the practice of giving care.

Chapter 10.
Conclusion

10.1. Chapter Overview

Short-term international retirement migration involves older individuals, around the age of retirement, leaving their home country in the winter months to live seasonally in a warmer and drier location. This voluntary lifestyle requires careful negotiation of a number of factors, primarily due to the average age of these individuals and associated health risks. The popularity of this lifestyle is difficult to quantify given the fact this population is largely untracked, untraced and unregulated. For this reason, many recent academic publications focus on qualitative accounts of the lived experience of retirement migrants (e.g., King et al., 2021).

My thesis responds to knowledge gaps identified in Chapters 2 and 3 and employs an exploratory case study methodology (Yin, 2014, 2017) to examine the lived experiences of Canadian short-term international retirement migrants living seasonally in Yuma, Arizona. This case study is organized around four separate analyses, each of which uses a unique dataset. First, a scoping review of the relevant literature was conducted in order to understand what is and is not known about what motivates older people to participate in international retirement migration. Second, qualitative focus groups were conducted with destination-based health care professionals at the only regional medical center in Yuma, Arizona to explore the opportunities and challenges of treating a large, seasonal Canadian population. Third, semi-structured interviews with Canadian short-term international retirement migrants in Yuma, Arizona were conducted to explore the preparatory practices and strategies employed to mitigate and manage health issues while living abroad for several months each year. Finally, dyadic interviews with Canadian spouses In Yuma explored the support systems Canadian short-term international retirement migrants rely on when acting as informal care providers in a transnational setting.

The totality of this research provides a novel exploration of a popular destination for Canadian short-term international retirement migrants and opens avenues for future researchers to further explore these varied healthcare mobilities. The remainder of this

concluding chapter will revisit my research objectives identified in Chapter 1, restate the relevant findings from my analyses, and demonstrate connections to existing literature which ground this dissertation. Each research objective is discussed separately, however several points of crossover occur and they are not mutually exclusive. I conclude with cross cutting themes across the analytic chapters, directions for future research and a summary of the strengths of this dissertation.

10.2. Revisiting research the objectives

In this section, I will review the research objectives as stated in the introductory chapter and examine them within the context of the analytical chapters in this dissertation (i.e., Chapters 3, 5, 7, 9), which are to:

1) determine why older persons, including Canadians, choose to live outside their home country seasonally;

2) understand the impacts Canadian retirement migration on health care providers and care provision in Yuma; and,

explore how transnational aspects of retirement migration shape care practices and how Canadian retirement migrants manage their health in Yuma.

10.2.1. Objective 1: Determine why older persons choose to live outside their home country seasonally

This objective specifically targeted the design of Chapter 3, which explored the factors motivating a transnational lifestyle choice and why this mobility is popular with older persons in many countries. To achieve this, we employed a scoping review evidence synthesis approach in accordance with Arksey and O'Malley's (2004) framework. Our specific approach focused on identifying the key factors, or characteristics, influencing individual level decision-making within the current state of research on retirement migration (Munn et al, 2018).

To address this objective, we reviewed existing studies to determine what is known about the factors motivating people to choose a retirement migration lifestyle. We identified 4 factors: (i) the destination, (ii) the people, (iii) the cost, and (iv) the movement. *The destination* was identified as the most common factor motivating older persons to choose a retirement migration lifestyle. Popular retirement destinations exist across the globe, but tend to share some destination-specific factors, such as climate, and include famous destinations such as the Mediterranean (e.g., King et al, 2017; Innes, 2008; Rodriguez et al., 2004), southern US states (e.g., Katz, 2019; Longino et al., 1990, 1991), Central America (e.g., Hayes, 2021; Morrissey, 2018; Sloane & Silbersack, 2020), and Mexico and the Caribbean (e.g., Amin et al, 2010; Coates et al., 2002). While climate is highly cited and defined as the primary motivating factor in existing literature on retirement migration, it is important to recognise how it is often presented in studies in combination with other factors. *The people* in the destination also served to enhance personal social networks (Croucher 2012; Davies and Hoath 2016). These social connections are further capitalised on through the pursuit of a "middle-class idyll" in the purposeful design of the popular residential communities many retirement migrants live in (Dwyer 2000). *The cost* associated with this lifestyle also creates a push-pull dynamic where some people choose this lifestyle to live in a more affordable manner and to stretch their retirement pensions. This cost savings is associated with destinations such as Mexico or Central America. Finally, *the movement* itself influences the decision to choose a transnational lifestyle. This might include socio-political factors such as the reduction in barriers to acquiring visas between two countries. In the context of older Canadians travelling to the US seasonally, participants in Chapters 7 and 9 referred to the attraction of the American interstate road system and how the ease of navigation created a "*trip within a trip*."

Chapter 3 presents a nuanced understanding of the differences amongst factors motivating retirement migrant lifestyles and destination choices. To become a retirement migrant, one must navigate a host of challenges and barriers and, as evidenced in Chapter 3, the decision-making process is both complex and multivariant. This scoping review offers novel insights into retirement migration, three of which I will highlight here. First, this review offers the first such structured knowledge synthesis of the state of the art in the field of retirement migration. Secondly, our analysis of the existing literature suggests little is known about what motivates retirement migration choices and

decisions. This lack of studies was further reinforced by our experience with failed review studies focused on health and how retirement migrants become informed (see Chapter 2). Finally, the contextualised account of these factors becomes further muddied depending on a range of personal attributes. The most significant of which lie in the division of retirement migrants as young-old (i.e., newly retired, 60 – 70 years of age, etc.) and old-old (i.e., 75+ years of age). Existing studies corroborate this account that younger retirement migrants have increasingly greater technological skills due to exposure (i.e., at work), which will likely influence their ability to navigate factors and become better informed in the decision-making progress around participating in this mobility (Buse, 2010; Paccagnella, 2016).

10.2.2. Objective 2: Understand the Impacts of Short-term Canadian International Retirement Migration on health care providers and care provision in Yuma

This objective was addressed in Chapter 5 and informed by the exploratory case study methodological approach (Schell, 1992; Yin, 2014, 2017). Focus groups are an effective qualitative tool because they encourage the sharing of experiential insights by participants about a familiar context, and so they were the method employed to address this objective. In the remainder of this section, I will synthesise the findings from Chapter 5 and conclude by offering insight into the significance of responding to this research objective and the novel aspects which emerged.

The analysis in Chapter 5 identified 3 'environments' where the presence of older Canadian short-term retirement migrants created both opportunities and challenges to the provision of health care services and the practice of care in Yuma during the winter months. Within the 'practice environment,' the cyclical nature of seasonal retirement migration practice allowed the medical center to plan accordingly for the population increase. This allowed for the investment in wings of the hospital which were mothballed and unused during the summer months, and returning seasonal staff (i.e., nurses) who did not require training and orientation. Challenges within this environment primarily centred around managing foreign-based Canadian travel health insurance companies, which brought uncertainty to care provision. The 'transnational environment' captured

the specific elements between Canada and the US that either promoted or impinged health are provision. These aspects were often described as communications between physicians and health care institutions, which were both opportunities and challenges to the provision of care. The 'community environment' explored elements relating to the retirement migration community itself, including both older people and their interpersonal relationships, as well as community aspects of their living environments which includes both Canadians and non-Canadians. The community of retirement migrants added value to care provision at the medical center through volunteer work, but also encouraged risky lifestyle choices relating to consumption of alcohol and unsafe sexual practices. While some of these findings were expected, overall the findings have important implications for the provision of care in a US destination popular with Canadian retirement migrants.

This analysis identified important and novel issues. First, the focus group interviews with the medical center administrators identified Canadians as important clientele who are actively pursued by the medical centre, which is understandable but heretofore had not been formally acknowledged. This knowledge helps to contexualise the significance of the seasonal Canadian population in Yuma, and specifically the importance health care administrators at the Yuma Regional Medical Center place on attracting Canadian international retirement migrants as clientele. Second, health care professionals at the medical center demonstrated a distinct lack of knowledge relating to the Canadian health care system. This knowledge deficit created confusion in the treatment of older Canadians, particularly around repatriation for medical care. Physicians also expressed experiencing negative psycho-social effects due to being unable to follow-up on patient outcomes after a patient is repatriated to Canada. Finally, Chapter 5 highlights the medical center's challenges with the Canadian travel health insurance system, with many problems and challenges exacerbated by the lack of knowledge relating to Canadian health care. These same concerns were echoed from the Canadian patient perspective explored in Chapter 7. In Chapter 5, physicians and nurses expressed frustration with the protocols of informing the travel health care providers before they could proceed with care provision. Similarly, participants in Chapter 7 described feeling abandoned by their service providers during this time. Taken together, these novel elements highlight the complexities surrounding the

management of a transnational lifestyle and the specific challenges of managing health issues across borders for both providers and patients.

10.2.3. Objective 3: Explore How Transnational Aspects of Retirement Migration Shape Care Practices and How Canadian Retirement Migrants Manage Their Health in Yuma

Chapters 7 and 9 respond to this research objective and utilised semi-structured interviews as the primary data collection method. While Chapter 7 relied primarily on one-on-one interviews, Chapter 9 reported on the findings of dyadic interviews. Both of these data collection techniques are well established, and semi-structured interviews allow researchers to explore various themes as topics as they emerge during the course of the interview (e.g., Kallio et al., 2016; Polit and Beck, 2010). In the remainder of this subsection, I will synthesise the findings from Chapters 7 and 9 before concluding with the novel and important aspects of these two studies in response to this research objective.

This research objective captures the challenges international retirement migrants experience when seeking to managing their health across international borders. Two analyses support this by demonstrating the challenges in preparation strategies for health management (Chapter 7) and providing informal care for one's spouse while living outside of Canada (Chapter 9). Chapter 7 offers a typology of different preparation strategies participants described during the interviews. We identified four separate preparatory strategies employed by short-term Canadian international retirement migrants: (i) thoroughly prepared, (ii) haphazardly prepared, (iii) prepared with info but not with action, and (iv) preparation adverse. This analysis highlights the need for health care professionals to interact with older patients using multiple lines of inquiry to understand how they have prepared to manage their health during long stays abroad. Chapter 9 explores the transnational-specific supports available to Canadian international retirement migrants providing informal spousal care to their partners. We highlighted three key supports, which are relational, community-based, and practical. We argued that a variety and interconnected set of place-specific factors are relied on by international retirement migrants for support while providing care and to mitigate the lack

of geographically close familial support typically relied upon at home. Overall, providing informal care in this transnational context created a dynamic that normalises the reliance on destination-based aspects, particularly relationships in the destination (i.e., friends, neighbours), to fill the care gap and undertake a greater share of the care burden.

The transnational aspects of retirement migration have agency, which can shape and affect care practices. This can be understood in three distinct ways, including through the culture of care, landscape of care, and understandings of caregiver roles in Yuma, Arizona. First, the culture of care within retirement migrant communities is significant. Spouses reported caring for their partners, which was unsurprising; however, they also reported how the communities they lived in acted collectively as a support resource (Chapter 7 and 9). The transnational-specific support structures were further bolstered by observations of informal care between retirement migrants by health care professionals at the regional medical center (Chapter 5). This knowledge adds a different perspective to the current discourse of spousal and informal care. Second, the landscape of care for retirement migrants is complicated and heavily influenced by a variety of factors, including the Canadian travel health insurance industry (Chapter 7), which impacts the ability of health care professionals to provide quality and timely care (Chapter 5). It is currently unknown if this impacts the decision-making process of older Canadians to access formal health care services, or if it increases the burden of those providing informal care. Finally, many participants voiced a lack of understanding of caregiving roles and demonstrated that while they were aware of the potential need to provide informal care, they felt unprepared to do so adequately (Chapter 9). This is a concerning discovery and suggests that more can be done within Canada to better inform individuals who intend to live outside Canada for significant portions of time each year while providing informal care. This has implications for policy makers, as well as health care professionals and those in supporting positions, such as pharmacists.

10.3. Cross-cutting themes across all analyses

The most significant theme that runs across all the analytic chapters lies in showing the power and draw of social connections for short-term international retirement migrants. While the power of social ties was not the focus of any analytics, the

importance of social connections can be seen in every analysis. While Chapter 3 explored why people choose to *become* retirement migrants, the strength and centrality of the social networks identified throughout my dissertation highlight why people choose to *remain* retirement migrants season after season. New residents are quickly introduced to existing members, permanent or temporary, and become connected to the larger network of retired migrants living in the retirement migration residential communities. Chapter 9 showed how this process is a means to building care resources in the community, but it also acts as a process to embed new members and retain them in the community. In Chapter 7, the analysis surrounding the 'community environment' similarly depicts how social ties are further reinforced in times of need, such as during health complications, hospitalisations and bereavements for lost community members. Many Canadian international retirement migrants I spoke with in Yuma joked that while they travelled for the weather, they stayed for the people. I believe that the substantial pull of social ties is one of the most significant, yet poorly understood, factor motivating the decision-making process of retirement migrants. I hope my dissertation research inspires future researchers to continue this exploration.

A second cross cutting theme revolves around the concept of labelling and representational approaches by scholars exploring international retirement migration. Retirement migrants are often depicted as a homogeneous group with a range of shared characteristics, including health and socio-economic status. However, this dissertation examines international retirement migrants on a granular level and highlights the significant differences amongst them, including in preparatory strategies for managing health while abroad. For example, some participants in Chapter 7 explained they had been "*priced out*" of travel health insurance due to negative health history and age, while some participants in Chapters 7 and 9 also offered second-hand accounts of friends and neighbours who were unable to afford health coverage insurance. International retirement migrants have been identified as being relatively privileged, if only based on the significant time and financial resources necessary to maintain two separate residences (Croucher, 2012). Several points in the analytic chapters highlight this. In Chapter 3, we indicate that this socio-economic privilege is not ubiquitous, and differences can be observed for retirement migrants originating from various places. In Chapter 5, health care professionals recognised the reticence of some Canadian retirement migrants accessing health care in the US due to cost concerns. Chapter 7

highlights similar concerns as Chapter 5, but from the patient perspective. Chapter 7 also identifies a sub-population of Canadian retirement migrants who cannot afford travel health insurance and embark on a risky health management strategy of hoping for the best outcome in lieu of a formal preparation strategy. Finally, Chapter 9 identifies retirement migrants who rely on community support for meals as a form of cost savings. These specific findings highlight important differences among Canadian international retirement migrants.

10.4. Future research directions

Future research should consider the perceptions and experiences of Canadian international. retirement migrants who live seasonally in retirement destinations beyond Arizona. Conducting similar research elsewhere would allow for a comparison with the research in this dissertation, while research in other popular destinations might expose place-based differences yet to be discovered. Such research should explore the perceptions of destination-based health care professionals in addition to the lived experiences of short-term Canadian international retirement migrants. Connections to perceptions surrounding care and health care access would provide further context into the meanings ascribed to such services and the importance they have in the decision-making process of retirement migrants. Little is known about the differences between popular retirement destinations and the importance this holds for retirement migrants and their use of and access to health care.

Participants in Chapters 7 and 9 shared conflicting accounts of the Canadian travel health insurance system, including concerns relating to transparency, trustworthiness, and dependability. Some participants highlighted these concerns as a justification for avoiding using travel health insurance providers, which may place them at greater risk to navigate health issues which may arise while living outside of Canada. This issue is further affected by accounts of risky behaviour in retirement migrants, where evidence of over-consumption of alcohol and unsafe sexual practices with multiple partners exists in retirement migrant communities. These and other risks carry implications for uninsured individuals, destination-based health care professionals and the Canadian health care system which may be required to treat repatriated individuals

on short notice. Future researchers should explore use travel health insurance usage amongst populations of older Canadians, related concerns are and how the system could be reimagined through policy adjustments to create a more transparent and responsive system which would inspire trust and confidence.

My dissertation has revealed issues pertaining to the lack of understanding and tracking of older Canadians outside Canada seasonally. For example, little is known about the origin provinces of Canadian retirement migrants. This knowledge would provide a more nuanced understanding of where people originate and why certain areas hold stronger attractions for Canadians. Furthermore, the the n-coronavirus and restrictions of border crossings has opened serious questions relating to the need of federal agencies to know where Canadians are and where they have been. In the event of a future pandemic or other disaster, policy can be more responsive to the needs of older Canadians abroad seasonally if we know more about their flows and destinations.

10.5. Concluding thoughts

My research provides novel insight into the highly mobile lifestyles of some of older Canadians, and highlights concerns related to the destination-based effects of transnational lifestyles and global health care mobilities. I have drawn on existing literature regarding connections between ageing, health and place; transnationalism and transnational lifestyles; and the agency of international retirement migration in place-making. By highlighting the untracked, untraced and unregulated nature of retirement migration and the need for empirical, qualitative studies, this dissertation adds nuance to our understanding of how older persons manage their health and choose to live in later life. The analyses suggest great complexities lie in connections between health, ageing and place which have yet to explored and the knowledge gaps defined within should serve as a road map for future research.

I believe a significant success of this research is its ability to highlight the complexities of aging and how some people choose to act differently than what common depictions of older age present. These complexities hold significant value for destination-based health care professionals and those within Canada. In the current context of the

global n-coronavirus pandemic, the need to understand the movements of persons has become increasingly crucial for policymakers and future policy decisions (Lee et al., 2021). Expanding our knowledge of the migratory patterns in and out of Canada is essential and this dissertation adds a particular perspective to that discourse and body of literature through connections to health, ageing and place.

References

Ackers, L., & Dwyer, P. J. (2004). Fixed laws, fluid lives: the citizenship status of post-retirement migrants in the European Union. *Ageing and Society*, 24(3), 451-475.

Adams, K., Snyder, J., Crooks, V. A., & Berry, N. S. (2017). "Stay cool, sell stuff cheap, and smile": Examining how reputational management of dental tourism reinforces structural oppression in Los Algodones, Mexico. *Social Science & Medicine*, 190, 157-164.

Adams, K., Snyder, J., Crooks, V. A., & Berry, N. S. (2018). A critical examination of empowerment discourse in medical tourism: the case of the dental tourism industry in Los Algodones, Mexico. *Globalization and health*, 14(1), 70.

Agree, E. M., & Glaser, K. (2009). Demography of informal caregiving. In Uhlenberg, P. (ed.), *International handbook of population aging* (pp. 647–668). Dordrecht: Springer. Doi: 10.1007/978-1-4020-8356-3_29

Albert, S. M., & Duffy, J. (2012). Differences in risk aversion between young and older adults. *Neuroscience and neuroeconomics*, *2012*(1).

Allingham, J. D. (2013). Travel medical insurance. *Canadian Family Physician*, 59(8), 819-822.

Amin, I., & Ingman, S. R. (2010). Retiring in a foreign land: how do the American retirees deal with health care issues in Mexico. *Journal of Aging and Emerging Economies*, *2*(2), 22-35.

Anderson, E. (2018). Belonging, temporariness and seasonal labour: Working holidaymakers' experiences in Regional Australia. In *Work and identity* (pp. 117-131). Palgrave Macmillan, Cham.

Andrews, G. J. (2002). Towards a more place-sensitive nursing research: an invitation to medical and health geography. *Nursing inquiry*, *9*(4), 221-238.

Andrews, G. J., & Phillips, D. R. (Eds.). (2004). Ageing and place (Vol. 9). Routledge.

Andrews, G. J., Cutchin, M., McCracken, K., Phillips, D. R., & Wiles, J. (2007). Geographical gerontology: The constitution of a discipline. *Social Science & Medicine*, 65(1), 151-168.

Andrews, G. J., Milligan, C., Phillips, D. R., & Skinner, M. W. (2009). Geographical gerontology: mapping a disciplinary intersection. *Geography Compass*, 3(5), 1641-1659.

Andrews, G.J., Evans, J., Dunn, J.R. and Masuda, J.R., (2012). Arguments in health geography: on sub-disciplinary progress, observation, translation. *Geography Compass*, 6(6), pp.351–383.

Andrews, G. J., Evans, J., & Wiles, J. L. (2013). Re-spacing and re-placing gerontology: relationality and affect. *Ageing & Society*, 33(8), 1339-1373.

Antonucci, T. C., Birditt, K. S., Sherman, C. W., & Trinh, S. (2011). Stability and change in the intergenerational family: A convoy approach. *Ageing and Society*, *31*(7), 1084–1106. Doi:10.1017/S0144686X1000098X

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International journal of social research methodology*, 8(1), 19-32.

Aw, B., Boraston, S., Botten, D., Cherniwchan, D., Fazal, H., Kelton, T., ... & Stowe, B. (2014). Travel medicine: What's involved? When to refer? *Canadian Family Physician*, *60*(12), 1091-1103.

Baldassar, L., Baldock, C. V., & Wilding, R. (2007). Aged care across borders: transnational migration, families and long-distance care. L.: Palgrave MacMillan.

Baldassar, L. (2014). Too sick to move: Distant 'crisis' care in transnational families. *International Review of Sociology*, 24(3), 391-405.

Balkir, C., & Südas, I. (2014). Guests and hosts: European retirees in coastal Turkey. *Insight Turkey*, *16*(4), 123.

Barbosa, B., Santos, C. A., & Santos, M. (2020). Tourists with migrants' eyes: the mediating role of tourism in international retirement migration. *Journal of Tourism and Cultural Change*, 1-15.

Barrantes, R. (2007). Analysis of ICT demand: what is digital poverty and how to measure it? *Digital Poverty: Latin American and Caribbean Perspectives*, 29-53.

Barrantes, R. (2010). Digital poverty: An analytical framework. In 17th Biennial Conference of the International Telecommunications Society.

Bascom, C. S., Rosenthal, M. M., & Houle, S. K. (2015). Are pharmacists ready for a greater role in travel health? An evaluation of the knowledge and confidence in providing travel health advice of pharmacists practicing in a community pharmacy chain in Alberta, Canada. *Journal of Travel Medicine*, *22*(2), 99-104.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report*, 13(4), 544-559.

Baxter, J., & Eyles, J. (1997). Evaluating qualitative research in social geography: establishing 'rigour' in interview analysis. *Transactions of the Institute of British geographers*, *22*(4), 505-525.

Bender, D., Hollstein, T., & Schweppe, C. (2018). International retirement migration revisited: From amenity seeking to precarity migration?. *Transnational Social Review*, *8*(1), 98-102.

Benson, M., & O'reilly, K. (2009). Migration and the search for a better way of life: a critical exploration of lifestyle migration. *The sociological review*, *57*(4), 608-625.

Berger, S., Chen, T., Eldridge, J., Thomas, C. A., Habermann, B., & Tickle-Degnen, L. (2019). The self-management balancing act of spousal care partners in the case of Parkinson's disease. *Disability and Rehabilitation*, *41*(8), 887–895. Doi:10.1080/09638288.2017.1413427

Betancourt J, Green A, Carillo J.E. (2000). The challenges of cross-cultural healthcare-diversity, ethics, and the medical encounter. In Bioethics Forum (Vol. 16, pp. 27-32). Midwest Bioethics center.

Birch, S., & Gafni, A. (2005). Achievements and challenges of medicare in Canada: Are we there yet? Are we on course?. *International Journal of Health Services*, 35(3), 443-463. Doi.org/10.2190/rwa1-c3pb-0ky4-hbut

Bloch, A., & Hirsch, S. (2018). Inter-generational transnationalism: the impact of refugee backgrounds on second generation. *Comparative migration studies*, *6*(1), 1-18.

Bouldin, E. D., & Andresen, E. (2014). Caregiving across the United States: caregivers of persons with Alzheimer's disease or dementia in 8 states and the District of Columbia. Data from the 2009 & 2010 Behavioral Risk Factor Surveillance System. *As of February 26, 2014*.

Bowlby, S., (2012). Recognising the time—space dimensions of care: Caringscapes and carescapes. *Environment and Planning A*, 44(9), pp.2101–2118.

Božić, S. (2006). The achievement and potential of international retirement migration research: The need for disciplinary exchange. *Journal of Ethnic and Migration Studies*, *32*(8), 1415-1427.

Bradley, D. E. (2011). Litwak and Longino's developmental model of later-life migration: Evidence from the American Community Survey, 2005–2007. *Journal of Applied Gerontology*, *30*(2), 141-158.

Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 77–101. doi:10.1191/1478088706qp063oa

Breen, R. L. (2006). A practical guide to focus-group research. *Journal of geography in higher education*, *30*(3), 463-475.

Breuer, T. (2005). Retirement migration or rather second-home tourism? German Senior Citizens on the Canary Islands. Dedicated to Jürgen Bähr on his 65th birthday. *Die Erde: Zeitschrift der Gesellschaft für Erdkunde,* 136(3): 313-333.

Brinkmann, S. (2013). *Qualitative interviewing*. Oxford: Oxford University Press.

Brown, M. P. (1997). Replacing citizenship: AIDS activism and radical democracy. Guilford Press.

Brown, D. L., Glasgow, N., Kulcsar, L. J., Bolender, B. C., & Arguillas, M. J. (2008). Community challenges and opportunities associated with retirement in-migration. In Brown, D. L., & Glasgow, N. (Eds) *Rural retirement migration* (pp. 141-177). Springer, Dordrecht.

Broyles, L. M., Rodriguez, K. L., Price, P. A., Bayliss, N. K., & Sevick, M. A. (2011). Overcoming barriers to the recruitment of nurses as participants in health care research. *Qualitative Health Research*, *21*(12), 1705-1718.

Bui, Y. G., Kuhn, S. M., Sow, M., McCarthy, A. E., Geduld, J., & Milord, F. (2018). The changing landscape of travel health services in Canada. *Journal of Travel Medicine*, *25*(1), tay032.

Buse, C. E. (2010). E-scaping the ageing body? Computer technologies and embodiment in later life. *Ageing and Society*, *30*(6), 987.

Cameron, M. (2007). When research goes pear-shaped: Report and reflections on a failed study of exercise and manual therapies for rheumatoid arthritis. *Complementary health practice review*, *12*(1), 63-77.

Campbell, N. (2015). Designing for social needs to support aging in place within continuing care retirement communities. *Journal of Housing and the Built Environment*, *30*(4), 645-665.

Canada Health Act, Revised Statutes of Canada (1985, c. C-6) Retrieved from: https://laws-lois.justice.gc.ca/eng/acts/c-6/page-3.html#h-151633

Canadian Life and Health Insurance Association. (n.d.) *A Guide to Travel Insurance.* Retrieved from: http://clhia.uberflip.com/i/199455-a-guide-to-travel-health-insurance/0?

Canzler, W., Kaufmann, V., & Kesselring, S. (Eds.). (2008). Tracing mobilities: Towards a cosmopolitan perspective. Ashgate Publishing, Ltd.

Carduff, E., Finucane, A., Kendall, M., Jarvis, A., Harrison, N., Greenacre, J., & Murray, S. A. (2014). Understanding the barriers to identifying carers of people with advanced illness in primary care: triangulating three data sources. *BMC Family Practice*, *15*(1), 1-10.

Casado-Díaz, M., Kaiser, C., Warnes, A. M., & Casado-Diaz, M. A. (2004). Northern European retired residents in nine southern European areas: characteristics, motivations and adjustment. Ageing and society, 24(3).

Casado-Díaz, M. A. (2006). Retiring to Spain: an analysis of differences among North European nationals. *Journal of ethnic and migration studies*, *32*(8), 1321-1339.

Casado-Diaz, M.A. (2009) 'Social capital in the sun: bonding and bridging social capital among British retirees', in Benson, M.C. and O'Reilly, K. (eds) Lifestyle Migration: Expectations, Aspirations and Experiences. Aldershot: Ashgate.

Casado-Díaz, M. A., Casado-Díaz, A. B., & Casado-Díaz, J. M. (2014). Linking tourism, retirement migration and social capital. *Tourism Geographies*, *16*(1), 124-140.

Casey, V., Crooks, V. A., Snyder, J., & Turner, L. (2013). Knowledge brokers, companions, and navigators: A qualitative examination of informal caregivers' roles in medical tourism. *International Journal for Equity in Health*, *12*(1), 94. Doi:10.1186/1475-9276-12-94

Cash, B., Hodgkin, S., & Warburton, J. (2013). Till death us do part? A critical analysis of obligation and choice for spousal caregivers. *Journal of Gerontological Social Work*, 56(8), 657-674. Doi: 10.1080/01634372.2013.823472

Cegolon, L., Heymann, W. C., Lange, J. H., & Xodo, C. (2017). Travel health education. *Journal of travel medicine*, *24*(5), 1-4.

Chow, N. (2004). Asian value and aged care. *Geriatrics & gerontology international*, *4*, S21-S25.

Ciobanu, R. O., Fokkema, T., & Nedelcu, M. (2017). Ageing as a migrant: Vulnerabilities, agency and policy implications. *Journal of Ethnic and Migration Studies*, 43(2), 164-181.

Ciobanu, R. O., Nedelcu, M., Ammann, E. S., & van Holten, K. (2020). Intersections between ageing and migration: current trends and challenges. *Swiss Journal of Sociology*, 46(2), 187-197.

Coates, K. S., Healy, R., & Morrison, W. R. (2002). Tracking the snowbirds: Seasonal migration from Canada to the USA and Mexico. *American Review of Canadian Studies*, 32(3), 433-450.

Colombo, F., Llena-Nozal, A., Mercier, J., Tjadens, F. (2011). Help wanted? providing and paying for long-term care. (Vol. 2011). Paris: OECD publishing.

Conradson, D., (2003). Spaces of care in the city: the place of a community drop-in centre. *Social & Cultural Geography*, 4(4), pp.507–525.

Corbin, J., & Morse, J. M. (2003). The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive topics. *Qualitative inquiry*, 9(3), 335-354.Doi: 10.1177/1077800403009003001

Corlett, S., & Mavin, S. (2018). Reflexivity and researcher positionality. The SAGE handbook of qualitative business and management research methods, 377-399.

Coumoundouros, C., Ould Brahim, L., Lambert, S. D., & McCusker, J. (2019). The direct and indirect financial costs of informal cancer care: A scoping review. *Health and Social Care in the Community*, *27*(5), e622–e636. Doi:10.1111/hsc.12808

Coyte, P. C., & McKeever, P. (2001). Home care in Canada: Passing the buck. *Canadian Journal of Nursing Research = Revue Canadienne de Recherche en Sciences Infirmieres*, *33*(2), 11–25. Doi: 10.1093/oso/9780198805366.003.0004

Coyte, P. C., & McKeever, P. (2016). Home care in Canada: Passing the buck. *Canadian Journal of Nursing Research Archive*, 33(2).

Craddock, S. (2001). Engendered/endangered: women, tuberculosis, and the project of citizenship. *Journal of Historical Geography*, 27(3), 338-354.

Cresswell, T. (2006). On the move: Mobility in the modern western world. Taylor & Francis.

Cribier, F. (1987). Retiring to the seaside: A housing perspective. *Housing Studies*, 2(1), 42-56.

Crooks, V. A., Casey, V., Whitmore, R., Johnston, R., & Snyder, J. (2015). 'They go the extra mile, the extra ten miles...': examining Canadian medical tourists' interactions with health care workers abroad. In Handbook on Medical Tourism and Patient Mobility. Edward Elgar Publishing.

Crooks, V. A., Casey, V., & Whitmore, R. (2016). Informal caregiving on the move. In Fenton, N. E., & Baxter, J. (Eds.). Practicing qualitative methods in health geographies (pp. 244-256). Routledge.

Crooks, V.A., Andrews, G.J., & Pearce, J. (Eds.). (2018). Routledge Handbook of Health Geography (1st ed.). Routledge. https://doi.org/10.4324/9781315104584

Crooks, V.A., J. Pickering (2021) "Informal Caregiving in a Transnational Context: The case of Canadian international retirement migrants in the United States." In. C. Vindrola (ed.) Carework and Medical Travel, Exploring the Emotional Dimensions of Caring on the Move. UK: Lexington Books.

Croucher, S. (2012). Privileged mobility in an age of globality. *Societies*, 2(1), 1-13.

Cutchin, M. P. (2009). Geographical Gerontology: New Contributions and Spaces for Development. *The Gerontologist*, 49(3), 440-444.

Cutchin, M. P., Marshall, V. W., & Aldrich, R. M. (2010). Moving to a continuing care retirement community: Occupations in the therapeutic landscape process. *Journal of cross-cultural gerontology*, 25(2), 117-132.

Daciuk, J. F., & Marshall, V. W. (1990). Health concerns as a deterrent to seasonal migration of elderly Canadians. *Social Indicators Research*, 22(2), 181-197.

Davidson, P. M., Abshire, M. A., Paull, G., & Szanton, S. L. (2018). Family caregivers: Important but often poorly understood. *Journal of Clinical Nursing*, *27*(23-24), 4242-4244..

Davies, A., & Hoath, A. (2016). The Migration of Australians to Bali, Indonesia: More than Retirees and Surfers. *Geographical Research*, 54(1), 35-51.

Davis, K., Drey, N., Gould, D. (2009). What are scoping studies? A review of the nursing literature. *International Journal of Nursing Studies*, 46, 1386-1400.

De Bruin, S., Lette, M., Stoop, A., Zonneveld, N., Reynolds, J., Masana, L., . . . Baan, C. (2018). Improving integrated care for older people living at home in Europe: Findings and experiences from the SUSTAIN project. *International Journal of Integrated Car*e, 18(s2). Doi:10.5334/ijic.s2066

Del Prete, V., Mateo-Urdiales, A., Bueno-Cavanillas, A., & Ferrara, P. (2019). Malaria prevention in the older traveller: a systematic review. *Journal of Travel Medicine*, 26(7), taz067.

Desrosiers-Lauzon, G. (2008). Southern seduction: Canadian and American snowbirds in Florida since 1945 (Doctoral dissertation, University of Ottawa (Canada)).

Desrosiers-Lauzon, G. (2009). Canadian snowbirds as migrants. *Canadian Issues*, 27.

Desrosiers-Lauzon, G. (2011). Florida's snowbirds: Spectacle, mobility, and community since 1945. *McGill-Queen's Press-MQUP*.

Dickens, A. P., Richards, S. H., Greaves, C. J., & Campbell, J. L. (2011). Interventions targeting social isolation in older people: A systematic review. *BMC Public Health*, 11(1), 647. Doi:10.1186/1471-2458-11-647

Donnellan, W. J., Bennett, K. M., & Soulsby, L. K. (2015). What are the factors that facilitate or hinder resilience in older spousal dementia caregivers? A qualitative study. *Aging and Mental Health*, 19(10), 932–939. Doi:10.1080/13607863.2014.977771

Dwyer, P. (2000). Movements to some purpose? An exploration of international retirement migration in the European Union. *Education and Ageing*, 15(3), 353-377.

Dyck, I. (1999). Body troubles: women, the workplace and negotiations of a disabled identity. *Mind and body spaces: Geographies of illness, impairment and disability*, 119-137.

Dyck, I., & Kearns, R. A. (2006). Structuration theory: agency, structure and everyday life. *Approaches to human geography*, 86-97.

Edwards, R., & Holland, J. (2013). What is qualitative interviewing? London: A&C Black.

Egdell, V. (2013). Who cares? Managing obligation and responsibility across the changing landscapes of informal dementia care. *Ageing and Society*, 33(5), 888–907. Doi:10.1017/S0144686X12000311

Egolf, B., Lasker, J., Wolf, S., & Potvin, L. (1992). The Roseto effect: a 50-year comparison of mortality rates. *American journal of public health*, 82(8), 1089-1092.

Elger, T. (2010). Contextualisation. In: Mills, A.J., Durepos, G. and Wiebe, E., (eds.) Encyclopedia of Case Study Research. SAGE Publications, Inc., Thousand Oaks, CA, pp.232–234.

European Union Charter of Fundamental Rights. (2012). Retrieved from: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:12012P/TXT

Evans, J.D., Crooks, V.A. and Kingsbury, P.T., (2009). Theoretical injections: on the therapeutic aesthetics of medical spaces. *Social Science & Medicine*, 69(5), pp.716–721.

Evers, J.C. and Van Staa, A., (2010). Qualitative Analysis in Case Study. In: Mills, A.J., Durepos, G. and Wiebe, E., (eds.) *Encyclopedia of Case Study Research*. SAGE Publications, Inc., Thousand Oaks, CA.

Fänge, A. M., Oswald, F., & Clemson, L. (2012). Aging in Place in Late Life: Theory, Methodology, and Intervention. *Journal of Aging Research*, *2012*, 660-661.

Fast, J. E., Williamson, D. L., & Keating, N. C. (1999). The hidden costs of informal elder care. *Journal of Family and Economic Issues*, *20*(3), 301-326.

Fausset, C. B., Kelly, A. J., Rogers, W. A., & Fisk, A. D. (2011). Challenges to aging in place: Understanding home maintenance difficulties. *Journal of Housing for the Elderly*, 25(2), 125-141.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), 80–92. Doi:10.1177/160940690600500107

Finlay, J., Franke, T., McKay, H., & Sims-Gould, J. (2015). Therapeutic landscapes and wellbeing in later life: Impacts of blue and green spaces for older adults. *Health & place*, *34*, 97-106.

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative inquiry*, *12*(2), 219-245.

Fritz, R. L., & Dermody, G. (2019). A nurse-driven method for developing artificial intelligence in “smart” homes for aging-in-place. *Nursing Outlook*, *67*(2), 140–153. Doi:10.1016/j.outlook.2018.11.004

Forbat, L., & Henderson, J. (2003). “Stuck in the Middle with You”: The Ethics and Process of Qualitative Research th Two People in an Intimate Relationship. *Qualitative Health Research*, *13*(10), 1453-1462.

Gatrell, A. C. (2011). Mobilities and health. Ashgate Publishing, Ltd.

Genet, N., Boerma, W.G., Kringos, D.S., Bouman, A., Francke, A.L., Fagerström, C., Melchiorre, M.G., Greco, C. and Devillé, W. (2011). Home care in Europe: a systematic literature review. *BMC health services research*, 11(1), 207.

Gesler, W. M. (1992). Therapeutic landscapes: medical issues in light of the new cultural geography. *Social science & medicine*, 34(7), 735-746.

Gesler, W. M. (1993). Therapeutic landscapes: theory and a case study of Epidauros, Greece. *Environment and Planning D: Society and Space*, 11(2), 171-189.

Giddens, A. (1981). A contemporary critique of historical materialism (Vol. 1). Univ of California Press.

Giner-Monfort, J., & Huete, R. (2020). Uncertain sunset lives: British migrants facing Brexit in Spain. *European Urban and Regional Studies*, 0969776420972148.

Glass, A. P. (2016). Family caregiving and the site of care: Four narratives about end-of-life care for individuals with dementia. *Journal of Social Work in End-of-Life and Palliative Care*, *12*(1–2), 23–46. Doi:10.1080/15524256.2016.1156605

Golant, S. M. (1984). The geographic literature on aging and old age: An introduction. Urban Geography, 5(3), 262-272.

Grace, R. F., & Penny, D. (2004). Travel insurance and medical evacuation: view from the far side. *Medical journal of Australia*, *180*(1), 32-35.

Grace, B. L. (2019). Family from afar? Transnationalism and refugee extended families after resettlement. *Journal of Refugee Studies*, *32*(1), 125-143.

Gray, D. (2008). The Canadian Snowbird Guide: Everything You Need to Know about Living Part-Time in the USA and Mexico. John Wiley & Sons.

Gregory, K. (2019). Lessons of a failed study: Lone research, media analysis, and the limitations of bracketing. *International Journal of Qualitative Methods*, *18*, 1609406919842450.

Griffith, D. A. (2013). Establishing qualitative geographic sample size in the presence of spatial autocorrelation. *Annals of the Association of American Geographers*, 103(5), 1107-1122.Doi: 10.1080/00045608.2013.776884

Grossman, B. R., & Webb, C. E. (2016). Family support in late life: A review of the literature on aging, disability, and family caregiving. *Journal of Family Social Work*, 19(4), 348-395.

Gudmundsson, A., Stevenson, J. M., Petrovic, M., Somers, A., Onder, G., Callens, S., & van der Cammen, T. J. (2016). Challenges and risks for older travellers with multimorbidity: Focus on pharmacotherapy. *European Geriatric Medicine*, *7*(5), 407-410.

Gustafson, P. (2001). Retirement migration and transnational lifestyles. *Ageing and Society*, 21, 371.

Gustafson, P. (2002). Tourism and seasonal retirement migration. *Annals of Tourism research*, 29(4), 899-918.

Gustafson, P. (2008). Transnationalism in retirement migration: the case of North European retirees in Spain. Ethnic and Racial studies, 31(3), 451-475.

Gustafson, P., & Laksfoss Cardozo, A. E. (2017). Language use and social inclusion in international retirement migration. *Social Inclusion*, 5(4), 69-77.

Hajek, A., Kretzler, B., & König, H. H. (2021). Informal caregiving for adults, loneliness and social isolation: a study protocol for a systematic review. *BMJ open*, *11*(5), e044902.

Hall, K., & Hardill, I. (2016). Retirement migration, the ‘other’ story: caring for frail elderly British citizens in Spain. *Ageing & Society*, *36*(3), 562-585

Hardill, I. (2009). Introduction: geographies of aging. *The Professional Geographer*, 61(1), 1-3.

Hardwick, S. W. (2016). Case study approach. International Encyclopedia of Geography: People, the Earth, *Environment and Technology: People, the Earth, Environment and Technology*, 1-6.

Harper, S., & Laws, G. (1995). Rethinking the geography of ageing. *Progress in Human Geography*, 19(2), 199-221.

Hayes, M. (2014). ‘We gained a lot over what we would have had’: The geographic arbitrage of North American lifestyle migrants to Cuenca, Ecuador. *Journal of Ethnic and Migration Studies*, *40*(12), 1953-1971.

Hayes, M. (2015). Moving South: The Economic Motives and Structural Context of North America’s Emigrants in Cuenca, Ecuador. *Mobilities*, 10(2), 267-284.

Hayes, M., & Pérez-Gañán, R. (2017). North–South migrations and the asymmetric expulsions of late capitalism: Global inequality, arbitrage, and new dynamics of North–South transnationalism. *Migration Studies*, *5*(1), 116-135.

Hayes, M. (2021). 'Sometimes you gotta get out of your comfort zone': retirement migration and active ageing in Cuenca, Ecuador. *Ageing & Society*, *41*(6), 1221-1239.

Health Canada. (2002). *National profile of family caregivers in Canada −2002* [final report]. Retrieved from https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/home-continuing-care/national-profile-family-caregivers-canada-2002-final-report.html

Hennebry, J., McLaughlin, J., & Preibisch, K. (2016). Out of the loop:(In) access to health care for migrant workers in Canada. *Journal of international Migration and Integration*, *17*(2), 521-538.

Hoffman, L., Crooks, V. A., & Snyder, J. (2017). Pills in paradise: Exploring international lifestyle and retirement migrants' perceptions of the pharmaceutical sector on Cozumel Island, Mexico. *Health & Place*, 47, 139-146.

Hoffman, L., Crooks, V. A., & Snyder, J. (2018). A challenging entanglement: health care providers' perspectives on caring for ill and injured tourists on Cozumel Island, Mexico. *International journal of qualitative studies on health and well-being*, *13*(1), 1479583.

Hofstede, G., & Hofstede, G. H. (1984). *Culture's consequences: International differences in work-related values* (Vol. 5). sage.

Hoggart, K., & Buller, H. (1995). Retired British homeowners in rural France. *Ageing & Society*, *15*(3), 325-353.

Horn, V., Schweppe, C., & Um, S. G. (2013). Transnational aging—A young field of research. *Transnational Social Review*, 3(1), 7-10.

Horn, V., & Schweppe, C. (2017). Transnational aging: toward a transnational perspective in old age research. *European Journal of Ageing*, *14*(4), 335-339..

Horsfall, D., Leonard, R., Rosenberg, J. P., & Noonan, K. (2017). Home as a place of caring and wellbeing? A qualitative study of informal carers and caring networks lived experiences of providing in-home end-of-life care. *Health & place*, 46, 58-64.

Horton, S., & Stewart, A. (2012). Reasons for self-medication and perceptions of risk among Mexican migrant farm workers. *Journal of immigrant and minority health*, 14(4), 664-672.

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse researcher*, 20(4).

Howard, R.W. (2008). Western retirees in Thailand: motives, experiences, wellbeing, assimilation and future needs. *Ageing and society*, 28(02), 145-163.

Hoyt, G. C. (1954). The life of the retired in a trailer park. *American Journal of Sociology*, 59(4), 361-370.

Huber, A. and O'Reilly, K. (2004). The construction of Heimat under conditions of individualised modernity: Swiss and British elderly migrants in Spain. *Ageing & Society*, 24(3), 327-351.

Huete, R., & Mantecón, A. (2012). Residential tourism or lifestyle migration: Social problems linked to the non-definition of the situation. *Controversies in tourism*, 160-173.

Hunninghake, D. B., Darby, C. A., & Probstfield, J. L. (1987). Recruitment experience in clinical trials: literature summary and annotated bibliography. *Controlled clinical trials*, 8(4), 6-30.

Hunter, A., & McCarthy, A. (2017). Travel Health Considerations. In: Arya, A. N. (Ed.). (2017). Preparing for international health experiences: a practical guide. CRC Press.

Hwang, E., Cummings, L., Sixsmith, A., & Sixsmith, J. (2011). Impacts of home modifications on aging-in-place. *Journal of Housing for the Elderly*, 25(3), 246-257.

Innes, A. (2008). Growing older in Malta: experiences of British retirees. *International Journal of Ageing and Later Life*, 3(2), 7-42.

Internal Revenue Service. (2020) Taxation of Non-resident Aliens. Retrieved from: https://www.irs.gov/individuals/international-taxpayers/taxation-of-nonresident-aliens

Jacobs, J., Neilson, J., Stanfors, M., Alto, P., & Maria, C. A. (2017). Caregiving Time Costs and Tradeoffs with Paid Work and Leisure: Evidence for Sweden, the UK and Canada. *Lund Papers in Economic Demography*, (2017: 5).

Javadi, M., & Zarea, K. (2016). Understanding thematic analysis and its pitfall. *Journal of client care*, 1(1), 33-39.

Jerkovic, J, Kealey, M. (2018). Report on the Feasibility of Cross-Border Healthcare for Canadians in Surprise, February 6. Available from: https://www.surpriseaz.gov/DocumentCenter/View/39743/2018-Cross-Border-Healthcare-Feasibility-Report?bidId=

Johnsen, S., Cloke, P. and May, J., (2005a). Day centres for homeless people: spaces of care or fear? *Social & Cultural Geography*, 6(6), pp.787–811.

Johnsen, S., Cloke, P. and May, J., (2005b). Transitory spaces of care: serving homeless people on the street. *Health & Place*, 11(4), pp.323–336.

Jones, K., & Moon, G. (1987). Health, disease and society: an introduction to medical geography continued. Routledge & Kegan Paul Ltd.

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of advanced nursing*, *72*(12), 2954-2965.

Kaner, E. F., Haighton, C. A., & McAvoy, B. R. (1998). 'So much post, so busy with practice--so, no time!': a telephone survey of general practitioners' reasons for not participating in postal questionnaire surveys. *British Journal of General Practice*, 48(428), 1067-1069.

Kaplan, L. (2001). A couplehood typology for spouses of institutionalized persons with Alzheimer's disease: Perceptions of “We”– “I”. *Family Relations*, 50(1), 87-98.

Katz, S. (2019). Spaces of age, snowbirds, and the gerontology of mobility: The elderscapes of Charlotte County, Florida. In *Cultural Aging* (pp. 202-232). University of Toronto Press.

Kearns, R. A. (1993). Place and health: towards a reformed medical geography. *The Professional Geographer*, 45(2), 139-147.

Kearns, R. A. (1994). Putting health and health care into place: an invitation accepted and declined. *The Professional Geographer*, 46(1), 111-115.

Kearns, R., & Moon, G. (2002). From medical to health geography: novelty, place and theory after a decade of change. *Progress in Human Geography*, 26(5), 605-625.

Kearns, R.A., Barnett, J.R. and Newman, D., (2003). Placing private health care: reading Ascot hospital in the landscape of contemporary Auckland. *Social Science & Medicine*, 56(11), pp.2303–2315.

Kearns, R., & Collins, D. (2010). Health geography. A companion to health and medical geography, 15-32.

Kellerman, A. (1987). Structuration theory and attempts at integration in human geography. *The professional geographer*, 39(3), 267-274.

Kemper, P. (1992). The use of formal and informal home care by the disabled elderly. *Health services research*, 27(4), 421.

Khan, N. M., Jentes, E. S., Brown, C., Han, P., Rao, S. R., Kozarsky, P., Hagmann, S.H., LaRocque, R.C., Ryan, E.T. and Global TravEpiNet Consortium. (2016). Pre-travel medical preparation of business and occupational travelers: an analysis of the global TravEpiNet consortium, 2009 to 2012. *Journal of Occupational and Environmental Medicine*, 58(1), 76.

Kiamie, D., & DeSalvo, R. (1989). Theodor Adorno, Rebel without a Cause: A Marxian Critique of Critical Thought. *Rethinking Marxism*, 2:3, 162-166, DOI: 10.1080/08935698908657880

King, R., Fielding, A., & Black, R. (1997). The international migration turnaround in Southern Europe. *Southern Europe and the new immigrations*, 1-25. Doi:10.1002/9781118867365.ch4

King, R., Warnes, A. M., & Williams, A. M. (1998). International retirement migration in Europe. *International journal of population geography*, 4(2), 91-111.

King, R., Warnes, T., & Williams, A. (2000). Sunset lives: British retirement migration to the Mediterranean. Berg.

King, R., Lulle, A., Sampaio, D. and Vullnetari, J., (2017). Unpacking the ageing–migration nexus and challenging the vulnerability trope. *Journal of Ethnic and Migration Studies*, 43(2), 182-198.

King, R., Cela, E., Morettini, G., & Fokkema, T. (2019). The Marche: Italy's new frontier for international retirement migration. *Population, Space and Place*, *25*(5), e2241.

King, R., Cela, E., & Fokkema, T. (2021). New frontiers in international retirement migration. *Ageing & Society*, 41(6), 1205-1220.

Kojima, G. (2018). Frailty as a predictor of nursing home placement among community-dwelling older adults: A systematic review and meta-analysis. *Journal of Geriatric Physical Therapy*, 41(1), 42–48. Doi:10.1519/JPT.0000000000000097

Koser, K. (2007). Refugees, transnationalism and the state. *Journal of Ethnic and Migration Studies*, 33(2), 233-254.

Lamsal, M. (2012). The structuration approach of Anthony Giddens. *Himalayan Journal of Sociology and Anthropology*, 5, 111-122.

La Parra, D., & Mateo, M.A. (2008). Health status and access to health care of British nationals living on the Costa Blanca, Spain. Ageing & Society, 28(1), 85-102.Lardiés-Bosque, R. (2016). Geographical mobility among retired US migrants living in the Northwestern region of Mexico bordering California, *US. Bulletin of Geography. Socio-economic Series*, (32), 105-116.

Lahti, J., Laaksonen, M., Lahelma, E., & Rahkonen, O. (2011). Changes in leisure-time physical activity after transition to retirement: a follow-up study. International Journal of Behavioral Nutrition and Physical Activity, 8(1), 36.

Lardiés-Bosque, R. (2016a). Geographical mobility among retired US migrants living in the Northwestern region of Mexico bordering California, *US. Bulletin of Geography. Socio-economic Series*, 32(32), 105-116.

Lardiés-Bosque, R., et al. (2016b). Retirement migration and transnationalism in northern Mexico. *Journal of Ethnic and Migration Studies*, 42(5), 816-833.

Lee, K., Grépin, K. A., Worsnop, C., Marion, S., Piper, J., & Song, M. (2021). Managing Borders During Public Health Emergencies of International Concern: A Proposed Typology of Cross-border Health Measures.

Lee, R., & Mason, A. (2014). Is low fertility really a problem? Population aging, dependency, and consumption. *Science*, 346(6206), 229-234.

Lee, S., & Smith, C. A. (2012). Criteria for quantitative and qualitative data integration: mixed-methods research methodology. *CIN: Computers, Informatics, Nursing*, *30*(5), 251-256.

Leggat, P. A., & Fischer, P. R. (2006). Accidents and repatriation. *Travel Medicine and Infectious Disease*, *4*(3-4), 135-146.

Leggett, A. N., Sonnega, A. J., & Lohman, M. C. (2019). Till death do us part: Intersecting health and spousal dementia caregiving on caregiver mortality. *Journal of Aging and Health*, 0898264319860975. Doi:10.1177/0898264319860975

Legido-Quigley, H. & McKee, M. (2012). Health and social fields in the context of lifestyle migration. *Health & Place*, 18(6), 1209-1216.

Levinson, W., Dull, V. T., Roter, D. L., Chaumeton, N., & Frankel, R. M. (1998). Recruiting physicians for office-based research. *Medical care*, 934-937.

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: advancing the methodology. *Implementation science*, 5(1), 69.

Li, A., Cronin, S., Bai, Y. Q., Walker, K., Ammi, M., Hogg, W., ... & Wodchis, W. P. (2018). Assessing the representativeness of physician and patient respondents to a primary care survey using administrative data. *BMC family practice*, *19*(1), 1-10.

Liu, L. W., & McDaniel, S. A. (2015). Family caregiving for immigrant seniors living with heart disease and stroke: Chinese Canadian perspective. *Health Care for Women International*, *36*(12), 1327–1345. Doi:10.1080/07399332.2015.1038346

Lizarraga, O., Mantecón, A., & Huete, R. (2015). Transnationality and Social Integration within Lifestyle Migration. A comparative study of two cases in Mexico and Spain. *Journal of Latin American Geography*, *14*(1), 139-159.

Longino, C. F., & Marshall, V. W. (1990). North American research on seasonal migration. *Ageing & Society*, *10*(2), 229-235.

Longino, C.F. & Crown, W.H. (1990). Retirement migration and interstate income transfers. *The Gerontologist*, 30(6), 784-789.

Longino Jr, C. F., Marshall, V. W., Mullins, L. C., & Tucker, R. D. (1991). On the nesting of snowbirds: A question about seasonal and permanent migrants. *Journal of Applied Gerontology*, 10(2), 157-168

Longino, C. F., & Taplin, I. M. (1994). How does the mobility of the elderly affect health care delivery in the USA? *Aging Clinical and Experimental Research*, 6(6), 399-409.

Luborsky, M. R., Lysack, C. L., & Van Nuil, J. (2011). Refashioning one's place in time: Stories of household downsizing in later life. *Journal of Aging Studies*, 25(3), 243-252.

Lutz, W., Sanderson, W., & Scherbov, S. (2008). The coming acceleration of global population ageing. *Nature*, *451*(7179), 716-719.

MacPherson, D. W., Gushulak, B. D., & Sandhu, J. (2007). Death and international travel—the Canadian experience: 1996 to 2004. *Journal of Travel Medicine*, *14*(2), 77-84.

Maly, R. C., Umezawa, Y., Leake, B., & Silliman, R. A. (2005). Mental health outcomes in older women with breast cancer: impact of perceived family support and adjustment. Psycho-Oncology: *Journal of the Psychological, Social and Behavioral Dimensions of Cancer*, 14(7), 535-545.

Marmot, M., Friel, S., Bell, R., Houweling, T. A., Taylor, S., & Commission on Social Determinants of Health. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. *The lancet*, *372*(9650), 1661-1669.

Marshall, B., Cardon, P., Poddar, A., & Fontenot, R. (2013). Does sample size matter in qualitative research?: A review of qualitative interviews in IS research. *Journal of computer information systems*, 54(1), 11-22. Doi:10.1080/08874417.2013.11645667

Marshall, V.W., Longino Jr C.F., Tucker R., & Mullins L. (1989). Health care utilization of Canadian snowbirds: An example of strategic planning. *Journal of Aging and Health*. May;1(2):150-68.

Martin, H. W., Hoppe, S. K., Larson, C. L., & Leon, R. L. (1987). Texas snowbirds: Seasonal migrants to the Rio Grande valley. *Research on Aging*, 9(1), 134-147.

Masselot, A. (2011). Highly skilled migrants and transnational care practices: Balancing work, life and crisis over large geographical distances. *Canterbury L. Rev.*, *17*, 299.

Maus, M., Lindeman, D. A., & Satariano, W. A. (2016). Wayfinding, mobility, and technology for an aging society. In *Community wayfinding: Pathways to understanding* (pp. 153-167). Springer, Cham.

Mayer, J. D., & Meade, M. S. (1994). A reformed medical geography reconsidered. *The Professional Geographer*, 46(1), 103-106.

Mays, N., & Pope, C. (1995). Qualitative research: rigour and qualitative research. *Bmj*, *311*(6997), 109-112.

McCole, D. (2015). Seasonal employees: The link between sense of community and retention. *Journal of Travel Research*, *54*(2), 193-205.

Meade, M. S. (2014). Medical geography. The Wiley Blackwell Encyclopedia of Health, *Illness, Behavior, and Society*, 1375-1381.

Miller, M. J. (2014). Snowbirds Flying Blind: Beware the US Residence Trap. *Can. Tax J.*, 62, 547.

Milligan, C., (2005). From home to 'home': situating emotions within the caregiving experience. *Environment and Planning A*, 37(12), pp.2105–2120.

Milligan, C. and Wiles, J., (2010). Landscapes of care. *Progress in Human Geography*, 34(6), pp.736–754.

Milligan C., Morbey H. (2013) Older Men Who Care: Understanding Their Support and Support Needs, Lancaster University. Lancaster University Centre for Ageing Research. Available online at: https://eprints.lancs.ac.uk/id/eprint/68443/1/Older_men_who_care_report_2013Final.pdf (accessed April 14, 2021).

Milligan, C., & Morbey, H. (2016). Care, coping and identity: Older men's experiences of spousal care-giving. *Journal of Aging Studies*, *38*, 105–114. Doi:10.1016/j.jaging.2016.05.002

Monin, J. K., Levy, B., Doyle, M., Schulz, R., & Kershaw, T. (2019). The impact of both spousal caregivers' and care recipients' health on relationship satisfaction in the Caregiver Health Effects Study. *Journal of Health Psychology*, *24*(12), 1744–1755. Doi:10.1177/1359105317699682

Morales, O. L. (2010). The US citizens retirement migration to Los Cabos, Mexico. Profile and social effects. *Recreation and Society in Africa, Asia and Latin America*, 1(1).

Morgan, D. L. (1996). Focus groups. *Annual review of sociology*, *22*(1), 129-152.

Moro, D. (2006). *International Retirement Migration: Legal Framework in European Union*. Warwick University, Dept. of Economics.

Morrissey, M. (2018). Imaginaries of North American lifestyle migrants in Costa Rica. *Population, Space and Place*, *24*(8), e2168.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of counseling psychology*, *52*(2), 250.

Moskal, M. (2011). Transnationalism and the role of family and children in intra-European labour migration. *European Societies*, *13*(1), 29-50.

Munn, Z., Peters, M. D., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC medical research methodology*, 18(1), 143.

Naganathan, G., Kuluski, K., Gill, A., Jaakkimainen, L., Upshur, R., & Wodchis, W. P. (2016). Perceived value of support for older adults coping with multi-morbidity: patient, informal caregiver and family physician perspectives. *Ageing & Society*, *36*(9), 1891-1914.

Navaie-Waliser, M., Spriggs, A., & Feldman, P. H. (2002). Informal caregiving: differential experiences by gender. Medical care, 1249-1259.

Northcott, H. C., & Petruik, C. R. (2011). The geographic mobility of elderly Canadians. Canadian Journal on Aging/La Revue canadienne du vieillissement, 30(3), 311-322.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International journal of qualitative methods*, *16*(1), 1609406917733847.

O'Brien Kelly K, Colquhoun Heather, & Levac Danielle. (2010). Scoping studies: Advancing the methodology. *Implementation Science, 5*(1), 69-77.

O'Reilly, D., Rosato, M., Maguire, A., & Wright, D. (2015). Caregiving reduces mortality risk for most caregivers: A census-based record linkage study. *International Journal of Epidemiology*, *44*(6), 1959–1969. Doi:10.1093/ije/dyv172

O'Reilly, K., (2000). New Europe / Old Boundaries: British migrants in Spain. *Journal of Social Welfare and Family Law*, 22 (4), 477-491.

O’Reilly, K. (2007). The rural idyll, residential tourism, and the spirit of lifestyle migration. In *Association of Social Anthropologist Conference, London: London Metropolitan University. Retrieved October* (Vol. 28, p. 2009).

O'Reilly, K., & Benson, M. (2009). Lifestyle migration: escaping to the good life? © Ashgate.

O’Reilly, K., & Benson, M. (2015). Lifestyle migration. Routledge handbook of cultural gerontology, 420-427.

Oberle, A. P., & Arreola, D. D. (2004). Mexican medical border towns: a case study of Algodones, Baja California. *Journal of Borderlands Studies*, *19*(2), 27-44.

Ogawa, R. T., & Malen, B. (1991). Towards rigor in reviews of multivocal literatures: Applying the exploratory case study method. *Review of educational research*, *61*(3), 265-286.

Ogura, S., & Jakovljevic, M. M. (2018). Global population aging-health care, social and economic consequences. *Frontiers in public health*, 6, 335.

Oliver, C., & O'Reilly, K. (2010). A Bourdieusian analysis of class and migration: Habitus and the individualizing process. *Sociology*, 44(1), 49-66.

Oliver, C. (2011). Pastures new or old? *Migration, narrative and change*. Anthropologica, 67-77.

Oliver, C. (2012). Retirement migration: Paradoxes of ageing. Routledge.

Olwig, K. F. (2007). Privileged Travelers?: Migration Narratives in Families of Middle-Class Caribbean Background. In Going First Class? (pp. 87-102). Berghahn Books.

Ontario Blue Cross. (n.d.) Not your traditional Snowbirds: Canadian snowbirds are travelling internationally. Retrieved from: https://on.bluecross.ca/images/docs/whitepapers/not_your_traditional_snowbirds-on-en.pdf

Ontario Health Insurance Program. OHIP coverage while outside Canada. 2017, April 21. Available from: https://www.ontario.ca/page/ohip-coverage-while-outside-canada#section-1

Otero, Y. & Melton, L. (1997). US retired persons in Mexico. *The American Behavioral Scientist*, 40(7), 914-922.

Paccagnella, M. (2016). Age, Ageing and Skills: Results from the Survey of Adult Skills. OECD Education Working Papers, No. 132. *OECD Publishing*.

Pajnik, M., & Bajt, V. (2012). Migrant women's transnationalism: family patterns and policies. *International Migration*, 50(5), 153-168.

Peek, S. T., Wouters, E. J., Van Hoof, J., Luijkx, K. G., Boeije, H. R., & Vrijhoef, H. J. (2014). Factors influencing acceptance of technology for aging in place: A systematic review. *International Journal of Medical Informatics*, 83(4), 235–248. Doi:10.1016/j.ijmedinf.2014.01.004

Perry, J., & O'Connor, D. (2002). Preserving personhood: (Re) membering the spouse with dementia. *Family Relations*, 51(1), 55-62.

Philo, C. (2007). A vitally human medical geography? Introducing Georges Canguilhem to geographers. *New Zealand Geographer*, 63(2), 82-96.

Phizacklea, A. (2003). Transnationalism, gender and global workers. In Crossing borders and shifting boundaries (pp. 79-100). VS Verlag für Sozialwissenschaften, Wiesbaden.

Pickard, L., Wittenberg, R., Comas-Herrera, A., Davies, B., & Darton, R. (2000). Relying on informal care in the new century? Informal care for elderly people in England to 2031. *Ageing and society*, 20(6), 745-772.

Pickering, J., Crooks, V. A., Snyder, J., & Morgan, J. (2019). What is known about the factors motivating short-term international retirement migration? A scoping review. *Journal of Population Ageing*, 12(3), 379-395. *Reproduced with permission from Springer Nature*.

Pickering, J., Crooks, V. A., Snyder, J., & Milner, T. (2020). Opportunities and challenges in providing health care for International Retirement Migrants: a qualitative case study of Canadians travelling to Yuma, Arizona. *Tropical Diseases, Travel Medicine and Vaccines*, 6:9.

Pickering, J., Crooks, V. A., Snyder, J., & Milner, T. (2021). "If you have a pain, get on a plane": qualitatively exploring how short-term Canadian international retirement migrants prepare to manage their health while abroad. *Tropical Diseases, Travel Medicine and Vaccines*, 7(1), 1-10.

Ploeg, J., Matthew-Maich, N., Fraser, K., Dufour, S., McAiney, C., Kaasalainen, S., Markle-Reid, M., Upshur, R., Cleghorn, L. and Emili, A. (2017). Managing multiple chronic conditions in the community: a Canadian qualitative study of the experiences of older adults, family caregivers and healthcare providers. *BMC geriatrics*, 17(1), 40. Doi:10.1186/s12877-017-0431-6

Plöthner, M., Schmidt, K., De Jong, L., Zeidler, J., & Damm, K. (2019). Needs and preferences of informal caregivers regarding outpatient care for the elderly: A systematic literature review. *BMC Geriatrics*, 19(1), 82. Doi:10.1186/s12877-019-1068-4

Polit D.S. & Beck C.T. (2010) Essentials of Nursing Research. Appraising Evidence for Nursing Practice, 7th edn. Lippincott-Raven Publishers, Philadelphia.

Potier, F., Degryse, J. M., Bihin, B., Debacq-Chainiaux, F., Charlet-Renard, C., Martens, H., & de Saint-Hubert, M. (2018). Health and frailty among older spousal caregivers: an observational cohort study in Belgium. *BMC geriatrics*, 18(1), 291. Doi:10.1186/s12877-018-0980-3

Pratt, C. C., & Kethley, A. J. (1988). Aging and family caregiving in the future: Implications for education and policy. *Educational Gerontology*, 14(6), 567–576. Doi:10.1080/0380127880140608

Preloran, H. M., Browner, C. H., & Lieber, E. (2001). Strategies for motivating Latino couples' participation in qualitative health research and their effects on sample construction. *American Journal of Public Health*, 91(11), 1832-1841.

Radcliff, T. A., Dobalian, A., & Duncan, R. P. (2005). A comparison of seasonal resident and year-round resident hospitalizations in Florida. Florida Public Health Review, 2, 63-72.

Rauer, A. J., Sabey, A., & Jensen, J. F. (2014). Growing old together: Compassionate love and health in older adulthood. *Journal of Social and Personal Relationships*, 31(5), 677-696.

Richmond, C., Elliott, S. J., Matthews, R., & Elliott, B. (2005). The political ecology of health: perceptions of environment, economy, health and well-being among 'Namgis First Nation. *Health & place*, 11(4), 349-365.

Robinson, C. A., Bottorff, J. L., Pesut, B., Oliffe, J. L., & Tomlinson, J. (2014). The male face of caregiving: A scoping review of men caring for a person with dementia. *American journal of men's health*, 8(5), 409-426.

Rodríguez, V., Fernández-Mayoralas, G., & Rojo, F. (1998). European retirees on the Costa del Sol: a cross-national comparison. *International Journal of Population Geography*, 4, 183-200.

Rodríguez, V., Fernández-Mayoralas, G., & Rojo, F. (2004). International retirement migration: Retired Europeans living on the Costa del Sol, Spain. *Population Review*, 43(1), 1-36

Rodríguez-Rodríguez, V. (2016). Aging, Mobility and Migration in Latin America. In Environmental Gerontology in Europe and Latin America (pp. 73-91). Springer International Publishing.

Rolison, J. J., Hanoch, Y., Wood, S., & Liu, P. J. (2014). Risk-taking differences across the adult life span: a question of age and domain. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 69(6), 870-880.

Rowles, G. D. (1978). Prisoners of space?: Exploring the geographical experience of older people. Westview Press.

Rowles, G. D. (1981). The surveillance zone as meaningful space for the aged. *The Gerontologist*, 21(3), 304-311.

Rowles, G. D. (1986). The geography of ageing and the aged: toward an integrated perspective. *Progress in Human Geography*, 10(4), 511-539.

Rowles, G. D. (2008). Place in occupational science: A life course perspective on the role of environmental context in the quest for meaning. *Journal of Occupational Science*, 15(3), 127-135.

Sampaio, D., King, R., & Walsh, K. (2018). Geographies of the ageing–migration nexus: An introduction. Area, 50(4), 440-443.

Sander, M., Oxlund, B., Jespersen, A., Krasnik, A., Mortensen, E. L., Westendorp, R. G. J., & Rasmussen, L. J. (2015). The challenges of human population ageing. *Age and ageing*, 44(2), 185-187.

Sauer, W. J., & Coward, R. T. (1985). The role of social support networks in the care of the elderly. In W. J. Sauer & R. T. Coward (Eds.), Social support networks and the care of the elderly (pp. 3–20). New York: Springer. Doi:10.1300/j010v12n04_08

Saunders, B., Kitzinger, J., & Kitzinger, C. (2015). Anonymising interview data: Challenges and compromise in practice. *Qualitative Research*, *15*(5), 616-632.

Savage, R. D., Rosella, L. C., Crowcroft, N. S., Arneja, J., de Villa, E., Horn, M., Khan, K. and Varia, M. (2018). How can we keep immigrant travelers healthy? Health challenges experienced by Canadian South Asian travelers visiting friends and relatives. *Qualitative Health Research*, *28*(4), 610-623.

Schafran, A. and P. Monkkonen (2011). Beyond Chapala and Cancún: Grappling with the impact of American migration to Mexico. *Migraciones internacionales*, 6(2): 221-256.

Schell, C. (1992). The value of the case study as a research strategy. Manchester Business School, 2, 1-15

Seale, C., & Silverman, D. (1997). Ensuring rigour in qualitative research. *The European journal of public health*, *7*(4), 379-384.

Selmer, J. (2007). Which is easier, adjusting to a similar or to a dissimilar culture? American business expatriates in Canada and Germany. *International Journal of Cross-Cultural Management*, *7*(2), 185-201.

Sergeant, J. F., & Ekerdt, D. J. (2008). Motives for residential mobility in later life: post-move perspectives of elders and family members. *The International Journal of Aging and Human Development*, *66*(2), 131-154.

Sheller, M. (2014). Sociology after the mobilities turn. *The Routledge handbook of mobilities*, 45-54.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, *22*(2), 63-75.

Sherman, H., Forsberg, C., Karp, A., & Törnkvist, L. (2012). The 75-year-old persons' self-reported health conditions: A knowledge base in the field of preventive home visits. *Journal of Clinical Nursing*, *21*(21–22), 3170–3182. Doi:10.1111/j.1365-2702.2012.04314.x

Silverstein, N. M., & Turk, K. (2016). Students explore supportive transportation needs of older adults. *Gerontology & geriatrics education*, 37(4), 381-401.

Simpson, P. M., Siguaw, J. A., & Sheng, X. (2016). Tourists' life satisfaction at home and away: A tale of two cities. *Journal of Travel Research*, *55*(2), 161-175.

Skinner, M. W., Cloutier, D., & Andrews, G. J. (2015). Geographies of ageing: Progress and possibilities after two decades of change. *Progress in Human Geography*, 39(6), 776-799.

Sloane, P. D., & Silbersack, J. (2020). Real estate, housing, and the impact of retirement migration in Cuenca, Ecuador and San Miguel de Allende, Mexico. In *Retirement migration from the US to Latin American colonial cities* (pp. 41-65). Springer, Cham.

Smith, G. C. (1998). Residential separation and patterns of interaction between elderly parents and their adult children. *Progress in Human Geography*, *22*(3), 368-384.

Solomon, H. (2011). Affective journeys: the emotional structuring of medical tourism in India. *Anthropology and Medicine*, *18*(1), 105-118.

Starman, A. B. (2013). The case study as a type of qualitative research. *Journal of Contemporary Educational Studies/ Sodobna Pedagogika*, *64*(1).

Stebbins, R. A. (2001). *Exploratory Reserach in the Social Sciences.* Thousand Oaks: Sage.

Steptoe, A., Shankar, A., Demakakos, P., & Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences of the United States of America*, *110*(15), 5797–5801. Doi:10.1073/pnas.1219686110

Stones, R. (2005). Structuration theory. Macmillan International Higher Education.

Suh, K. N., & Flaherty, G. T. (2019). The older traveler. In *Travel Medicine* (pp. 247-253). Elsevier.

Sunil, T. S., Rojas, V., & Bradley, D. E. (2007). United States' international retirement migration: the reasons for retiring to the environs of Lake Chapala, Mexico. *Ageing & Society*, *27*(4), 489-510.

Suphanchaimat, R., Kantamaturapoj, K., Putthasri, W., & Prakongsai, P. (2015). Challenges in the provision of healthcare services for migrants: a systematic review through providers' lens. *BMC health services research*, *15*(1), 1-14.

Szanton, S. L., Leff, B., Wolff, J. L., Roberts, L., & Gitlin, L. N. (2016). Home-based care program reduces disability and promotes aging in place. *Health Affairs*, 35(9), 1558-1563.

Tasker, J.P. (2017). Snowbirds could soon stay 8 months in U.S. despite push to tighten border | CBC News, March 07. Available from: https://www.cbc.ca/news/politics/canadian-snowbirds-8-months-1.4011788

Tatangelo, G., McCabe, M., Macleod, A., & You, E. (2018). "I just don't focus on my needs." The unmet health needs of partner and offspring caregivers of people with dementia: A qualitative study. *International Journal of Nursing Studies*, *77*, 8-14.

Tate, J., Freeman, H., Mein, J., & Maguire, G. (2006). Grey nomads: health and health preparation of older travellers in remote Australia. *Australian Family Physician*, *35*(1-2), 70.

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. *The Sage handbook of qualitative research in psychology*, 17-37.

Then KL, Rankin JA, Ali E. Focus group research: what is it and how can itbe used?. Can J Cardiovasc Nurs. 2014;24(1).

Thompson, L. and Bidwell, S., (2015). Space, time, and emotion in the community pharmacy. *Health & Place*, 34, pp.251–256.

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of advanced nursing*, 48(4), 388-396.

Trade commissioner, Government of Canada (2018). Canada-Florida Economic Impact Study: Canada is Florida's most important economic partner. Available from: https://www.tradecommissioner.gc.ca/united-states-of-america-etats-unis-amerique/market-facts-faits-sur-le-marche/0002354.aspx?lang=eng#h2-5

Triantafillou, J., Naiditch, M., Repkova, K., Stiehr, K., Carretero, S., Emilsson, T., Di Santo, P., Bednarik, R., Brichtova, L., Ceruzzi, F. and Cordero, L. (2010). Informal care in the long-term care system. *European Overview Paper*, 223037, 1-67.

Tucker, R. D., Marshall, V. W., Longino, C. F., & Mullins, L. C. (1988). Older Anglophone Canadian snowbirds in Florida: A descriptive profile. *Canadian Journal on Aging*, *7*(3), 218-232.

Tucker, I. (2010). Everyday spaces of mental distress: the spatial habituation of home. *Environment and Planning D: Society and Space*, 28(3), pp.526–538.

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary nurse*, *19*(1-2), 75-87.

Ugalde, A., Krishnasamy, M., & Schofield, P. (2012). Role recognition and changes to self-identity in family caregivers of people with advanced cancer: a qualitative study. *Supportive Care in Cancer*, *20*(6), 1175-1181.

Ummel, D., & Achille, M. (2016). How not to let secrets out when conducting qualitative research with dyads. *Qualitative Health Research*, *26*(6), 807-815.

US Census Bureau (2018). Yuma county quick facts report. Retrieved September 22, 2018, from: https://www.census.gov/quickfacts/fact/table/yumacountyarizona/PST045217

van den Hoonaard, D. K. (2002). Life on the margins of a Florida retirement community: The experience of snowbirds, newcomers, and widowed persons. *Research on Aging*, 24(1), 50-66.

VanGeest, J. B., Johnson, T. P., & Welch, V. L. (2007). Methodologies for improving response rates in surveys of physicians: a systematic review. *Evaluation & the health professions*, *30*(4), 303-321.

van Groenou, M. I. B., & De Boer, A. (2016). Providing informal care in a changing society. *European Journal of Ageing*, 13(3), 271-279.

Van Hear, N. (2014). Refugees, diasporas and transnationalism. *The Oxford handbook of refugee and forced migration studies*, 176-187.

van Houtven, C. H., & Norton, E. C. (2004). Informal care and health care use of older adults. *Journal of health economics*, *23*(6), 1159-1180.

van Noorloos, F., & Steel, G. (2016). Lifestyle migration and socio-spatial segregation in the urban(izing) landscapes of Cuenca (Ecuador) and Guanacaste (Costa Rica). *Habitat International*, 54, 50-57.

Vertovec, S. (1999). Conceiving and researching transnationalism. *Ethnic and racial studies*, *22*(2), 447-462.

Vertovec, S. (2001). Transnationalism and identity. *Journal of Ethnic and Migration studies*, *27*(4), 573-582.

Vertovec, S. (2004). Migrant transnationalism and modes of transformation 1. *International migration review*, *38*(3), 970-1001.

Viallon, P. (2012). Retired snowbirds. *Annals of Tourism Research*, *39*(4), 2073-2091.

Vlachantoni A., Fuglsang Palmer M. (2019) Gender and Caring in Later Life. In: Gu D., Dupre M. (eds) Encyclopedia of Gerontology and Population Aging. Springer, Cham. Doi:10.1007/978-3-319-69892-2_156-1

Vogeli, C., Shields, A. E., Lee, T. A., Gibson, T. B., Marder, W. D., Weiss, K. B., & Blumenthal, D. (2007). Multiple chronic conditions: prevalence, health consequences, and implications for quality, care management, and costs. *Journal of General Internal Medicine*, *22*(3), 391-395.

Vojković, G., Magdalenić, I., & Živanović, Z. (2014). Population ageing and its impact on labour force in the Southeast Europe countries. *Zbornik Matice srpske za drustvene nauke*, (148), 701-713.

Walden, G. R. (Ed.). (2012). *Focus group research*. SAGE Publications.

Walker, A. (2016). Population ageing from a global and theoretical perspective: European lessons on active ageing. In Age-Friendly Cities and Communities in International Comparison (pp. 47-64). Springer, Cham.

Wang, L., & Kwak, M. J. (2015). Immigration, barriers to healthcare and transnational ties: A case study of South Korean immigrants in Toronto, Canada. *Social Science & Medicine*, *133*, 340-348.

Wang, J. (2018). Mobile and connected health technologies for older adults aging in place. *Journal of gerontological nursing*, 44(6), 3-5.

Ward, B. W., Schiller, J. S., & Goodman, R. A. (2014). Peer reviewed: multiple chronic conditions among us adults: a 2012 update. *Preventing Chronic Disease*, *11*.

Warf, B., & Arias, S. (Eds.). (2008). The spatial turn: Interdisciplinary perspectives. Routledge.

Warnes, A. M. (1990). Geographical questions in gerontology: needed directions for research. *Progress in Human Geography*, 14(1), 24-56.

Warnes, A. M., & Patterson, G. (1998). British retirees in Malta: components of the cross-national relationship. *Population, Space and Place*, *4*(2), 113-133.

Warnes, A. M., King, R., Williams, A. M., & Patterson, G. (1999). The well-being of British expatriate retirees in southern Europe. *Ageing & Society*, *19*(6), 717-740.

Warnes, A. M., Friedrich, K., Kellaher, L., & Torres, S. (2004). The diversity and welfare of older migrants in Europe. *Ageing and society*, 24(3), 307-326.

Warnes, A. M., & Williams, A. (2006). Older migrants in Europe: a new focus for migration studies. Journal of ethnic and migration studies, 32(8), 1257-1281.

Warnes, T. A. (2009). International retirement migration. In International handbook of population aging (pp. 341-363). Springer, Dordrecht.

Wasielewski, P. L. (2015). The magic of Oaxaca: An emotional geography of age, gender and nation. *Symbolic Interaction*, *38*(4), 557–574. Doi:10.1002/symb.186

Whitmore, R., Crooks, V. A., & Snyder, J. (2015). Ethics of care in medical tourism: Informal caregivers' narratives of responsibility, vulnerability and mutuality. *Health & Place*, *35*, 113-118.

Williams, A. M., King, R., & Warnes, T. (1997). A place in the sun: International retirement migration from northern to southern Europe. *European urban and regional studies*, 4(2), 115-134.

Williams, A. M., & Patterson, G. (1998). An empire lost but a province gained: a cohort analysis of British international retirement in the Algarve. *International journal of population geography*, *4*, 135-156.

Williams, A. M., King, R., Warnes, A., & Patterson, G. (2000). Tourism and international retirement migration: new forms of an old relationship in southern Europe. *Tourism Geographies*, *2*(1), 28-49.

Williams, A.P., Lum, J.M., Deber, R., Montgomery, R., Kuluski, K., Peckham, A., Watkins, J., Williams, A., Ying, A. and Zhu, L. (2009). Aging at home: integrating community-based care for older persons. *Healthcare Papers*, 10(1), 8-21.

Winslade, Nancy E, Stowe, Brian N, & Aw, Brian J. (2020). Ensuring the quality of pre-travel prescribing. *Journal of Travel Medicine*, 27(4), 1-3.

Withers, C. W. (2009). Place and the" Spatial Turn" in Geography and in History. Journal of the History of Ideas, 70(4), 637-658.

Wolf, S., & Bruhn, J. G. (1993). The power of clan: The influence of human relationships on heart disease. Transaction Publishers.

Wolff, J. L., Starfield, B., & Anderson, G. (2002). Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Archives of Internal Medicine*, *162*(20), 2269-2276.

World Health Organisation. (1946). Constitution of the world health organisation. In International Health Conference, New York. Geneva: WHO.

Yin, R. K. (2014). Case study research design and methods (5th ed.). Thousand Oaks, CA: Sage.

Yin, R. K. (2017). *Case study research and applications: Design and methods (6th ed.)*. Sage publications.

Zhang, Y., et al. (2012). The emerging transnational ‘retirement industry’ in Southeast Asia. *International Journal of Sociology and Social Policy*, 32(11/12), 708-719

Zubair, M., & Norris, M. (2015). Perspectives on ageing, later life and ethnicity: ageing research in ethnic minority contexts. *Ageing & Society*, 35(5), 897-916.

Chapter 11. Appendix

11.1. Question Guides

11.1.1. Focus Group Interviews Guide May 2017

Focus Group Guide

Welcome, introductions, and meeting overview (10 minutes)

Prompts:

Tell us your name and a little bit about yourself (round the table)

Overview of meeting goals and structure, our definition of Snowbirds and background to the project

Brief explanation of what we know about snowbirds and other IRMs and how these specific groups are statistically managing chronic health issues and outline the importance of understanding how they manage their health over borders and for extended periods of time

Open discussion (20 minutes)

Guiding question: What seasonal impact on health services in Yuma do you experience and is there a defined snowbird season within the health services industry?

Prompts:

Are these impacts positive or negative in nature? Please give some examples, both positive and negative.

What are some of the positive impacts of increased health services demands on an area such as Yuma during and after the snowbird season?

What are some of the negative impacts of increased health services demands on an area such as Yuma during and after the snowbird season?

Open discussion (20 minutes)

Guiding question: Do you know of Canadians seeking care at your institution?

Prompts:

Are these return patients?

Are there concerns about Canadian snowbirds following instructions, or advice from physicians?

Do many snowbirds satisfy primary health care needs through the hospital emergency services?

(YES> Does this create a drain or add unnecessary pressure to the emergency services?)

(NO> What are the other points of entry into primary health service contact that snowbirds use in Yuma?)

Open discussion (20 minutes)

Guiding question: What types of specific problems affect snowbirds? Do they arrive with more acute conditions due to putting off seeking medical services?

Prompts:

Are snowbirds typically seeking care for chronic or acute problems?

What conditions are snowbirds typically dealing with?

Open discussion (20 minutes)

Guiding question: Why do Canadians end up in the hospital?

Are they educational programs for snowbirds or Canadians?

Is there any cross-border contact: physician to physician, or hospital to hospital?

Open discussion (20 minutes)

Guiding question: What could be done to enhance cross border care, in your professional opinion?

Improvised questions and following tangents related to their knowledge.

Ending/Wrap up question (10minutes): Based on what we have discussed tonight, what do you think are the most pressing or important points that have been raised about IRMs that are living away from their home countries for extended periods of time (i.e.. 6 months less a day)?

Summary and concluding comments (last 5 minutes)

Note: Total meeting time will be 120 minutes. The meeting will be catered and has been arranged onsite with ample parking. All attendees will be provided with small gift (valued around CAN $5) to acknowledge their contributions.

11.1.2. Preparatory Interview Guide, January 2018

Welcome, introductions, and meeting overview (10 minutes)

Do you, or do you know of Canadian snowbirds, who have experience accessing health services here in Yuma, Arizona? If so, in what ways?

What issues are unique to snowbirds in your experience or opinion?

What are some of the most common treatments these Canadian snowbirds seek?

From a seasonal or retirement migrant perspective, what are some of the barriers to accessing health care?

As you probably know, continuity of care is a key indicator of quality health care delivery. Patients who experience continuity of care are more likely to have better health outcomes and to manage chronic conditions, including those common among the aging population (e.g., diabetes).

Do you carry any medical records or information with you? Have you heard of others carrying medical records with them?

Do you have detailed information on what medications you are using and have used in the past?

Do you use any other methods to track health related information while you are in Yuma?

What specific ways do you know snowbirds deal with this issue? Do you have any recommendations for other snowbirds?

Did you receive and recommendations from other snowbirds?

Please identify ways health care service providers could make it easier to access health care services by people from other countries, especially Canadian snowbirds?

Do you attend any hospital driven outreach programs for people aged 55+ while you are in Yuma, Arizona? Were these programs useful? Are there any programs that you would want to see provided?

Did you inform your doctor in Canada prior to traveling to Yuma? Why or why not?

Have you, or do you know of any snowbirds, that seek out medical treatments while in Yuma?

Please share any stories that you have direct knowledge of that involve Canadians accessing health care in Yuma, Arizona.

11.1.3. Informal Caregiver Interview Guide, January 2019

- _Welcome and introductions. (5 minutes)

Do you currently care for a Canadian IRM?

Is this_Canadian_IRM_a_friend, spouse_or_family_member?

Do you receive any compensation_for_providing_care?

What are the most significant challenges you face as an informal care provider?

What is the condition of the person you provide care for?

Have they been diagnosed with a chronic condition? Acute condition?

- If so, what is the condition?

- If not, do you suspect they may have a chronic condition, such as dementia, that has not been diagnosed yet?

Do you have support from others (neighbours, friends, etc.) while you are living seasonally in Yuma, Arizona?

Does the hospital in Yuma, or other medical facilities or groups, provide support for informal caregivers? (i.e., through outreach programs, etc.)

- What support would specifically assist you in caring for others?

Do you carry medical information with you for the person you care for? If so, what documents?

- Did someone, or some source, recommend you do this?

Did you receive any recommendations from other informal caregivers of snowbirds?

- What advice would you offer to other care providers?

Did you rely on any outside sources of information for support, such as the snowbirds.org website?

Do you and the person you provide care for attend any hospital driven outreach programs for people aged 55+ while you are in Yuma, Arizona?

- If so, were these programs useful? If not, would you be interested in such programs?

- Are there any programs or supports that you would want to see provided for the informal caregivers?

Did the person you care for inform their doctor in Canada prior to traveling to Yuma? Why or why not?

11.1.4. Recruitment Flier/Postcard

When:
January 8-20, 2019

Contact us at:
medtoursfu.ca

We are looking to interview unpaid caregivers of Canadian 'snowbirds' in Yuma, Arizona.

John Pickering

Simon Fraser University
Burnaby, BC, Canada