Relocation of Elderly Women: Decision-Making Factors

by

Janet Porth

A thesis
presented to the University of Manitoba
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ABSTRACT

This descriptive study explored decision-making factors related to the relocation of elderly women into age-segregated Elderly Person's Housing (E.P.H.). The conceptual framework used was Dunn's (1961) health status and environmental theory of high-level wellness. The study assumed that relocation causes stress and decreases health status.

A stratified random sample of 30 elderly females, was drawn to proportionaly represent a two by three matrix of housing (public, non-profit, and profit) by age (young-old and old-old). The women, all of whom lived alone, had moved within the past year. The semi-structured interview guide incorporated quantitative questions from the Aging in Manitoba (1973, 1976, 1983) studies. The qualitative questions were designed by the researcher to elicit data regarding the respondents' preceived reasons for moving.

The respondents' reasons for moving fell into six categories; independence, finances, poor health, physical safety, companionship, and dissatisfaction. There were no significant differences as to whether a specific reason was mentioned or not mentioned by age and housing categories. However, there were differences in ranking of the reasons

across the groups. Maintaining independence and finances were mentioned most often.

Information gained from this study has interest for nursing and the health care system, specifically, health promotion and gerontology. Nursing implications and recommendations for further study were discussed.

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To my family who constantly organized and reorganized their lives around mine, I could not have done it without you. Thank you.

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INTRODUCTION

1.1 STATEMENT OF THE PROBLEM

The past two decades in North America have seen a marked increase in the development of segregated Elderly Person's Housing (E.P.H.). This trend toward high-rise accommodation in order to meet the needs of the elderly person is also evident in Manitoba, particularly in the city of Winnipeg. Further, a viable Home Care Program has been established in Manitoba over the past decade. This Program was developed to meet a broad range of health and social needs experienced by elderly persons. The Program was one application of an extensive research study under the auspices of the Manitoba Department of Health and Social Development (1973) entitled, Aging in Manitoba: A Study of the Elderly and of Resources Available to Meet Need, 1971. The Home Care Program has developed resources to meet the needs of elderly persons, enabling them to remain in their community residences. Inspite of the existence of this program, many elderly persons opt to alter their life style by moving out of neighbourhoods with established support networks to the strange and unknown environments of 'down town' high-rise apartment dwellings. Other elderly persons, already

residing in the 'core' areas of the city, find themselves pressured to relocate due to city redevelopment plans for their neighbourhood.

Community health professionals, working in the areas of health promotion and illness prevention, are not in contact with these elderly persons prior to their making this important decision. These professionals become frustrated when referals for 'care' needed by residents are received from the caretaker or manager of these complexes. B. Havens (personal communication, February 18, 1983) stated there is an increase in the utilization of health care services by elderly persons following relocation. The study suggested that within the first three months of the move, health service utilization increased by 15 percent; and that by six months following the move utilization had increased by 45 percent with a leveling out or gradual decrease in utilization seen the ninth month after the move. Residents requiring increased health services may be at risk of not being able to remain in the housing unit, necessitating another move with its attendant changes in life style and environment. The health professional silently wonders if the deterioration they are observing could have been prevented had the elderly individual remained in his/her established neighbourhood. Was the decision to alter the their life style made too quickly without thorough understanding of the ramifications of such a decision? Lange (1980) suggested

that voluntary relocation for the older person involved a greater adjustment in life style than for the young because the older person is also experiencing life changes associated with aging. Therefore, the elderly person requires assistance to manage successfully the changes that accompany the relocation.

In addition, the economic viability of building segregated, high rise apartments for elderly people needs to be questioned. The percentage of elderly persons within the total population will decrease slightly until 1996 and then sharply increase from the 1980's figure of 12 percent to 20 percent by the year 2031 as the post war baby-boom reaches age 65 years. This bulge in the elderly population is closely followed by a decreasing adult population which is evidenced now in decreasing school enrollment causing closure of many buildings. Will this phenomenon be repeated in vacant E.P.H.'s 60 or 70 years from now? Further, do the E.P.H. complexes run the risk, with their aging population, of becoming quasi-nursing homes? Moreover, do the neighbourhoods left vacant by the elderly become subject to deterioration and vandalism? Monies and programs providing the elderly person with assistance to maintain their home and neighbourhood may well be the solution of choice for housing needs.

The aim of this study is to isolate the decision-making criteria used by elderly persons who have recently

relocated into public, non-profit or profit/commercial age segregated living accommodation. A descriptive study using semi-structured interviews was conducted to ascertain the reasons for the elderly person's move at this particular time in their life cycle. As a consequence of identifying the decision-making criteria considered in relocation, this study adds knowledge to the health promotion field by providing additional information to health professionals who are assessing need and developing care plans for their elderly clients. Based on the information from this survey, it is evident that further research is needed to define indicators which would identify persons 'at risk' of making inappropriate decisions. After identifying persons at probable risk, resources within the Home Care Program and other health and social programs could be developed to meet the elderly person's immediate or long term needs, thereby enabling them to adapt to their new residence or to remain in the familiar environment of their own residence.

1.2 LITERATURE REVIEW

1.2.1 Historical Overview of Aging in Society

At the turn of the century and up to a few decades ago, (Shanas et al., 1968) the elderly were cared for in the community by their families, friends and neighbours. The United States Department of Health, Education and Welfare (1968) supported this notion, by stating that in non-

industrial societies the family was the primary source of security for the older person. Kinship was the predominant institution which provides for economic, political and religious functions. Access to resources was through the senior generations which assured a secure old age.

However, industrialization disrupted this reciprocal agreement of exchange. Kinship structures lost control of the economic function as specialization occurred. Goods and services were purchased outside the family structure. The United States document (1968) indicated industrial families were units for consuming goods and services, whereas non-industrial families were both consumption as well as production units.

This move to industrialization (Shanas et.al., 1968), with the family unit becoming a consumer of goods and services, placed more emphasis on independence within the family unit. Therefore, people in industrial societies tend to view being dependent as undesirable. This may place the elderly person in need of supportive services in a negative position.

> When increasing age, physical frailty, and associated problems necessitate the help of others, most older people find themselves in an impossible conflict. Many will deny they have problems or refuse to consider help. Others become hostile to those who can and will help. Some will simply withdraw in an attempt to buttress their self-esteem (U.S. Dept. H.E.W. 1968:158).

Furthermore, Tibbits (1977), Watson and Kivett (1976) and Silverston (1976) among others have indicated that the vast majority of elderly persons prefer to remain independent as long as they are capable of doing so. Industrial society has attempted to develop ways of preserving this independent lifestyle through support services and programs. By preserving independence, society assumes the health of its older citizens will be enhanced.

1.2.2 Development of the Manitoba Home Care Program

The need for the home care program in Manitoba was clearly identified by the Department of Health and Social Development. The study of the needs of the elderly in Manitoba and the resources available to meet those needs (Health & Social Development, 1973) indicated vast areas of concern for the elderly, such as poverty, isolation, lonliness, forced relocation, segregation, decreased health functioning, unemployment and forced dependence. The Thompson and Havens report noted:

> The proportion of older people is increasing and the rate of growth of this older age group is predicted to increase more rapidly than that of other age groups combined (Health & Social Development, 1973:1).

Subsequent to this report and the publishing of the Manitoba White Paper on Health Policy in 1972, a team composed of staff from the Department of Health and Social Development, the Health Services Commission, and the White

Paper group presented a report which outlined a model for the present Home Care Program. The program's aim is to provide care at home as a viable alternative to institutionalization. Further, the program is designed to maximize the individual's health status while simultaneously encouraging the independence of the recipient of services.

The program functions in the capacity of health promotion. Nickoley-Colquilt (1982) suggested that during the past decade approaches to the care of the elderly emphasized health promotion. In these programs the goal is to manage harmful conditions in the environment and strengthen the ability of people to cope with stress and change thereby reducing the incidence of health deviance. Health promotion approaches parallel preventive interventions which advocate intervening prior to the onset of disease or disfunction. Ford (1982) argued that an effective way to control escalating health care costs of services consumed by the elderly population is through programs of health promotion, since more healthful life styles and the exercise of greater personal responsibility for health will be less expensive than the present system. The assurance of a system of health care and human services available and accessible to the elderly individual when needed will go far toward improving their motivation to accept and participate in health promotion.

Health professionals must understand what conditions precipitate deterioration of health in order to effectively promote health. People react differently to illness, disability, and aging and so experience varying degrees and kinds of frustration. For those older persons who do relocate, the trauma of separation from home and family with resulting isolation can lead to illness. Studies such as the one done by the Canadian Health Program Branch (1973) indicated that institutionalization often leads to more rapid deterioration and subsequent misery for those persons concerned (Canada, 1973:57).

The Home Care Program in Manitoba operates on the premise that individuals progress toward and remain in a state of greater 'wellness' in the familiar environment of their own home. Shapiro (1979) stated:

> Community-based home care programs 1. Affirm the centrality and the continuity of the home, the family, and the community in the life of the individual. 2. Have the attitudes and work perspectives which promote the concept of health and 3. Exist within the same context as most health and social services (Shapiro, 1979:61).

Thus the experience of illness and/or aging should be less stress producing when support systems exist to inhibit deterioration and enhance functioning in the familiar surroundings of one's home.

A conjoint study by the Province of Manitoba and Health and Welfare Canada (1982) reported findings on the Manitoba Program in relation to costs. The report compared the cost

of home care to the cost of alternative institutional care. The findings revealed that care at home compared to institutional care was more cost effective. The Manitoba/Canada Study (1982) indicated:

> The propensity to need and to use home care services increases with age.....'Manitoba-type' Home Care Programs represent one means of reducing the costs of health care (Department of National Health & Welfare & Province of Manitoba, 1982:31).

When the post war baby-boom adult reaches their mid sixties by the year 2031, established programs like the Manitoba Home Care Program will represent an increasingly important aspect of economical health care delivery.

1.2.3 Growth of the Elderly Population

The numbers of elderly persons within the general population has been rapidly increasing over the past few decades as a result of improved infant, child, and young adult mortality and morbibity rates. Of interest to this survey are the future projections of the total elderly population aged 60 years and over within Canada. Stone and Fletcher (1981) forecast an increase in the elderly population resulting from the effects of the postwar baby-boom as illustrated in Figure 1. As the percentage of elderly persons within the total population continues to grow, there is a notable increase in the old-old population (75 years and older) within the elderly population. The trend observed in the national population figures is also reflected in the Manitoba population picture. However, B.

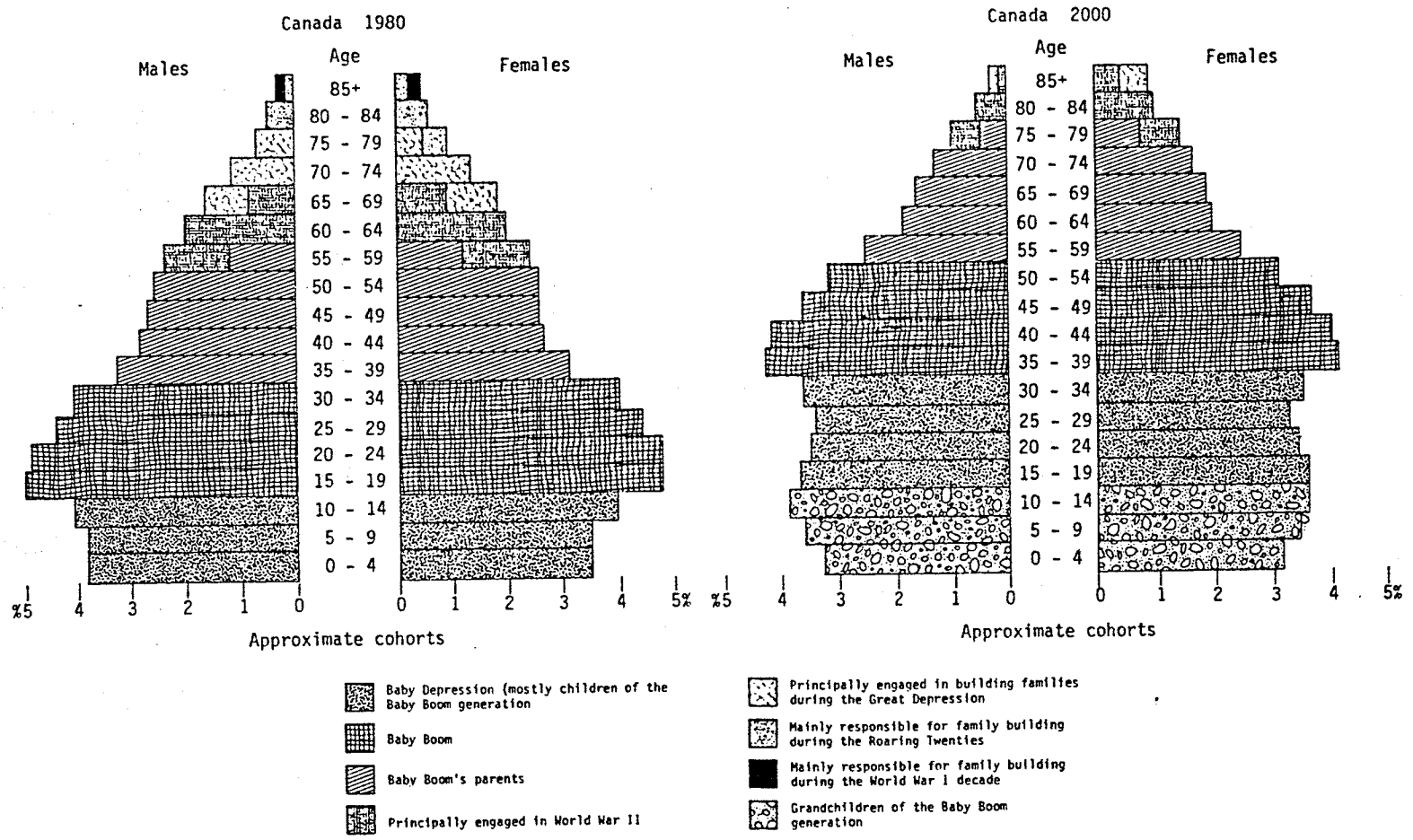

Figure 1: Canadian age pyramids by sex for 1980 & 2000

Havens (personal communication, February 18, 1983) indicated that in Manitoba this trend is being identified earlier, especially in the 75 year and over elderly population (see Figure 2). In other words, the population of Manitoba is aging faster than the Canadian population. The population trends outlined in Figure 1 and 2 serve to direct planners and policy makers as they plan programs to meet the needs indicated by changing demographic structures.

Fletcher and Stone (1982) forecasted a growing predominance of women in the older population. The statistics they cite from the 1976 census of Canada showed the Canadian population contained 1.1 million women aged 65 and older, 240 thousand of whom were 80 years of age and older. Statistics Canada projects a continued high growth rate in this segment of the population and that by the year 2001 there will be more than 2 million women aged 65 and older. However, added to this increased number of women in the older population is a drop in the ratio of male to female. Fletcher and Stone (1982) stated:

> projections assume that older females will continue to have higher survival rates than males, especially in the 75-and-over age group. We can expect that there will be 150 females to every 100 males aged 65 and over by 2001. Within the 75 and over age group, females are expected to outnumber males nearly two to one while, among the aged 80 and older, the projections envisage about 219 women to every 100 men by the year 2001 (Fletcher and Stone, 1982:12).

The result of this population shift will incur greater requirements for services in the areas of income

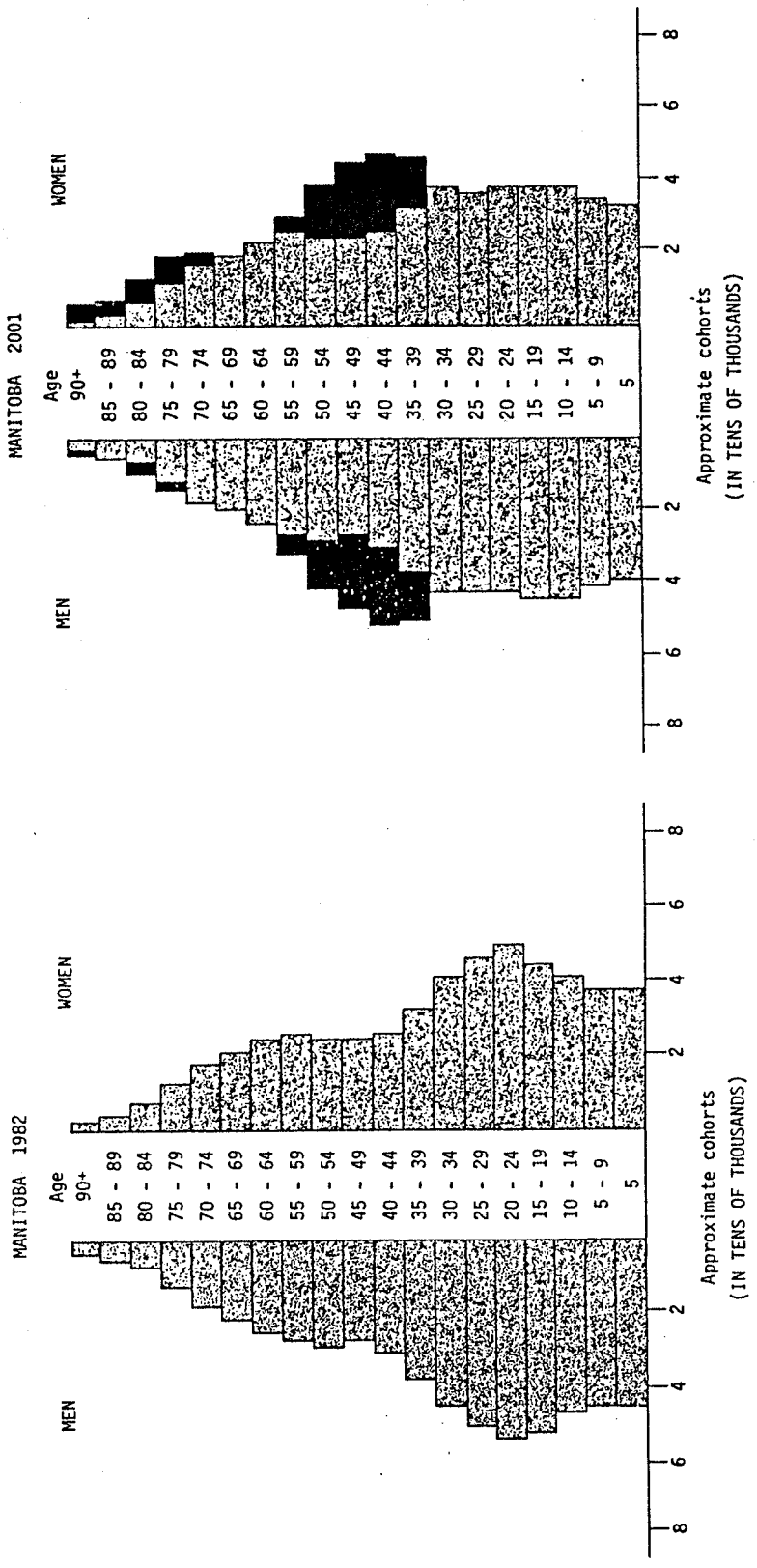

Figure 2: Manitoba age pyramids by sex for 1982 & 2001

maintenance, health care, housing and personal care. Statistics Canada projections in Figure 3 reflect the male/female population ratio for the year 1980 and projects the growth rates by sex for the years 2000, 2020 and 2040 for the population 60 years and over. Flecher and Stone (1982) suggested that not only will women swell the ranks of the 55 to 74 age group during the first two decades of the twenty-first century, but that after 2021 these women will be counted among the 75 and over age group. Therefore, these persons aged 75 and older may pose serious problems within the health care system as the possibility of decreasing health functioning and frailty compound isolation, loneliness and depression.

Table 1 represents a statistical compilation of the Manitoba population 65 years of age and older based on data compiled by the Statistics Branch, Manitoba Department of Health (1976) and the annual Manitoba Health Services Commission (M.H.S.C.) (1983) report. The information indicates an increase in the elderly population from 1976 to 1981 and 1983. Table 1 illustrates the elderly population per district offices within the Winnipeg Region and shows the increase within each district. A more rapid increase is noted in the suburbs of East Kildonan, West Kildonan and St. James as the population in these districts age. The percentage increase is noted for the Province as well as for the Winnipeg Region. For metro Winnipeg the increase from

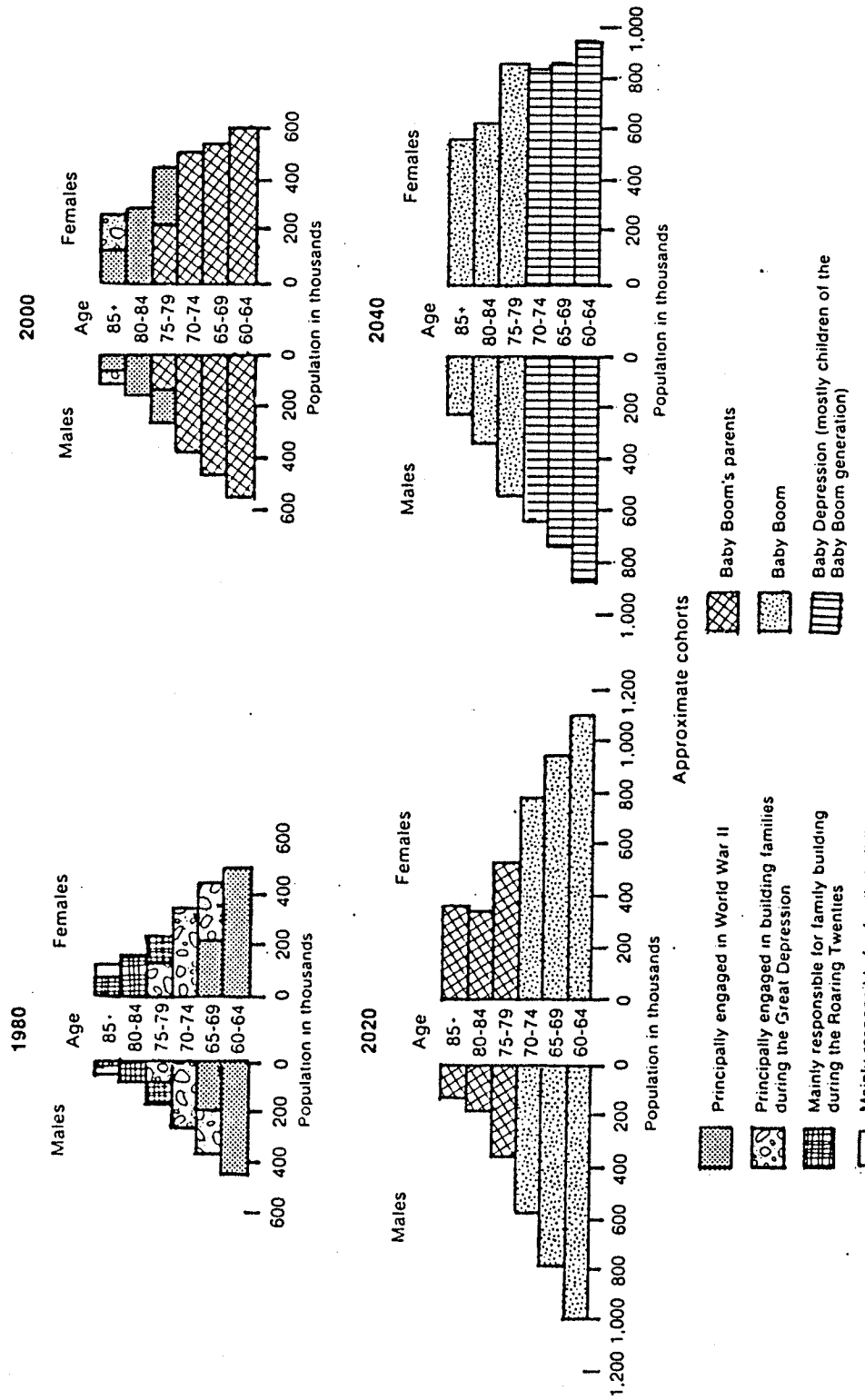

Figure 3: Canadian population aged 60 and over by sex for 1980, 2000, 2020, & 2040

1976 to 1981 is 13.8 percent and from 1976 to 1983 the increase is 19.5 percent. The Manitoba increase from 1976 to 1981 is 14.6 percent which is 0.8 percent higher than the metro Winnipeg increase for the same period. The provincial 1976 to 1983 increase is 17.9 percent or 2 percent lower

TABLE 1

Winnipeg Region - Population 65 years and over

		1976	1981	1983
Central -	Inner City	34,102	35,313	35,307
North East -	East Kildonan	4,445	6,095	6,596
	Transcona	1,446	1,741	1,856
	St. Pauls E.	172	244	223
North West -	West Kildonan	2,917	4,319	4,642
	St. Pauls W.	343	371	391
South -	Fort Garry	2,040	2,997	3,178
South East -	St. Boniface	4,280	5,103	5,203
	St. Vital	3,120	4,350	4,680
West -	St. James	5,593	7,309	7,760
Total Metro Winnipeg -		58,458	67,822	69,836

Percent increase from 1981 to 1983=+03.0%
Percent increase from 1976 to 1981=+13.8%
Percent increase from 1976 to 1983=+19.5%

Total Manitoba -	108,167	123,979	127,095

Percent increase from 1981 to 1983=+02.5%
Percent increase from 1976 to 1981=+14.6%
Percent increase from 1976 to 1983=+17.5%

than the metro Winnipeg increase.

However, of note and of interest to this study is the more rapid recent increase in the elderly population in Winnipeg as compared to the increase in the province as a whole. This increase in persons over age 65 years in metro Winnipeg from the years 1981 to 1983 is +0.5 percent higher than the increase in provincial population age 65 years and over. This may suggest that there is migration of elderly people from rural areas of the province into the city or that elderly persons in the City have stopped retirement migration out of the city or that the previously migrated retired people are moving back to Winnipeg.

1.2.4 Assumptions about Elderly Person's Housing

Over the last two decades a trend of increasing mobility among elderly persons (Wiseman, 1980) has been seen. This mobility may begin at the age of 65 years with retirement. Such mobility is evidenced by movement of persons/couples to holiday retirement, age-segregated villages. Bultena and Wood (1969) studied American retirement communities in Arizona, and found that 75 percent of the elderly respondents residing in regular communities held negative attitudes toward retirement communities. Their main criticism was the absence of younger persons in these places and the 'abnormality' in living patterns which this implied. Langino (1980), Marshall & Eteng (1970), and Wiseman (1980)

refer to this phenomenom as 'elderly migration'. Wiseman (1980) stated:

> the popular image of elderly migration is that some older people move for sun and fun into luxurious retirement communities while others relinquish a single-family home for an inner-city apartment (Wisemen, 1980:142).

With the slightly increasing longevity and the greatly increasing mobility rate of the nuclear family, many elderly couples/persons have opted to relocate from established suburban single-family dwelling to more compact apartments, located closer to shopping areas and transportation arteries. This study is directed to the latter group.

Yee and Van Arsdol (1977) described the life cycle as being delineated by a series of age-related events which they describe as normatively-defined events including births, marriages, changes in living arrangements and deaths. Their study indicated that residential mobility increases between marriage and birth of the first child, and decreases after birth of the last child. Yee and Van Arsdol (1977) concluded that family life cycle transition points likely delineate events that are followed by subsequent residential changes. Beaver (1979) supported this concept, indicating that 80 percent of the elderly movers experienced a major life disruption or precipitating event prior to their move. Wiseman (1980) identified triggering mechanisms to moves which are comprised of various 'push and pull' factors, such as the pull of amenities and the push of environmental stress.

Although there have been some studies in the United States and Canada regarding the relocation of the elderly (Havens, 1968; Golant, 1972), there is a gap in the reporting of the actual decision process that precedes the relocation. The literature does not indicate whether the relocated person actually had or wanted to have supports that would have enabled him/her to remain in their previous environment. Clifford, Heaton and Fuguitt (1981 & 1982) suggested the elderly are caught in a contemporary paradigm of aging as a developmental process in that the older persons have both a reluctance to and a capacity for change. Elderly persons may wish to maintain familiar and habitual patterns of living but may have to be flexible in order to make modifications in response to changes that occur in life.

Logically it can be anticipated that reasons for relocation would include reduced health status; a loss of physical functioning; retirement or death of spouse; reduction in income; death or relocation of other family members; reduction or loss of a support network; expropriation or loss of a former residence; or simply wishing to move closer to services or to family, friends or persons of similar ethnic background. However, any one of the losses indicated can produce stress and precipitate vulnerability to illness or decreased health status. Eckert (1979) stated that the effects of stress for the aged

individual may be more deleterious as a result of their reduced physical stamina, forced dependency and subsequent dissonance in values and loss of social ties and relationships. As well, O'Brien, Shichor and Decker (1982), Brody (1978), and Tinker (1980) indicated that the aged are fearful of being victimized because of their vulnerability. O'Brien, Shichor and Decker (1982) also pointed out that in actual fact the victimization of the aged is less than other age groups.

However, women (Chappell & Havens, 1980; Lally, Black, Thornock & Hawkins, 1979) are especially vulnerable because they suffer from the 'double jeopardy' or 'double whammy' of being old and female. Lally et al. (1979) studied older women in single rooms in Seattle and found a restricted social network, even though it was by choice due to the high value placed on independence, increased vulnerability to both diseases and mortality.

Historically, studies of the relocation phenomenon in North America has largely been influenced by Cummings and Henry's (1961) Disengagement Theory:

> aging is an inevitable mutual withdrawal or disengagement, resulting in decreased interaction between the aging person and others in the social system he belongs to (Cummings and Henry, 1961:14).

It followed that persons reaching the age of 65 years should detach themselves from the interdependence of society. Society should continue toward life and the elder

person should prepare for death. The move of the elderly population into segregated living arrangements effectively isolated them and decreased their social interaction with other age groups. On the other hand, present thinking has lead to the current theories of Activity and Continuity. Wiseman and Roseman (1979) discribe 'Continuity Theory' as:

> unlike disengagement [Continuity theory] postulates that a person wishes to maintain familiar and habitual patterns of living throughout life such as a nurturant family role or a productive work-oriented role (Wiseman and Roseman, 1979:326).

However Borup, Gallego and Hefferman (1979 & 1980) argue that the negative relocation effect described in many studies is a myth. There are no adverse consequences on older people either in terms of increasing the probability of mortality or in terms of negatively influencing health and levels of functioning causing a loss of independence.

Beaver (1979) studied voluntary entrants to new apartments. The study emphasized freedom of choice on the part of the mover as she believed that maximum participation in the decision-making process would enhance the elderly person's adjustment to the setting. Beaver (1979) stated:

> some elderly people may look forward to the move; others may be more apprehensive and ambivalent.....nevertheless, the individual must move on to the next step if he is to make a successful adjustment to relocation (Beaver, 1979:569).

Further, the findings of this study indicated the tendency of the older mover to consider few options when moving, therefore becoming at risk of making inappropriate decisions in regard to the relocation.

Other literature (Ferraro, 1981; Busse and Pfeiffer, 1979) supports the premise that informal neighbourhood support systems for the elderly are important and that one possible reason for relocation to Elderly Persons Housing (E.P.H.) is to increase the likelihood of this peer support system. Cantor (1979) documented the importance of the informal support system of neighbours and friends. Her study focused on the inner city neighbourhoods of New York City. She concluded that age per se was not a barrier to establishing meaningful relationships with those around, and in fact a larger number of persons living within the immediate vicinity may result in expanded social support networks comprised of friends and neighbours of varying ages. Her study indicated a high degree of reciprocity. There was an almost equal flow of services between the elderly and their on-the-average younger neighbours Cantor (1979) stated:

> because the lives of the elderly tend to be neighbourhood bound, socialization with those around assumes even greater importance, both as a way of utilizing time and as an outlet for tension reduction in daily life (Cantor, 1979:450).

However, other studies (Ehrlich, Ehrlich & Woehlke, 1982; Lawton, Nahemow & Tsong-Min-Yeh, 1980; Hodkinson, 1975 & Bell, 1976) found: that social interaction decreases over

time and that peers within the neighbourhood cannot be relied on for support in times of need or crisis.

Two Canadian studies have supported the importance of establishing neighbourhood ties for the elderly person. In a Toronto study (Andreae, 1976) people would not relocate to other parts of the city even though the move offered an improved living environment. Urban Studies, University of Winnipeg (1976) surveyed people with respect to housing in the inner city. They found that 28 percent would remain in their single detached homes, 20 percent would consider row-housing and 34 percent would consider a medium sized apartment block of no more than three stories. This study (University of Winnipeg, 1976) indicated that neighbourhood ties remained strong and stated: "age doesn't seem to diminish the desire to be where the action is" (University of Winnipeg, 1976:44). Moreover, a survey by Zamprelli (1976) of the then existing E.P.H.'s in Winnipeg found that the majority of residents were single or widowed women. Further, these women had suffered a decrease in functioning following their relocation and were dependent upon support services.

Brody (1978) compared an experimental group of tenants in community housing for the elderly to two control groups who applied for community housing. One group moved elsewhere and the other group failed to move. The study indicated the significant motivation for moving in all three groups was

the older person's fear of crime, loneliness and isolation, and deteriorated housing in their neighbourhood. However, the reluctance to move could not be overlooked. The study stated this reluctance stemmed from rootedness and emotional investment in home and neighbourhood, from low energy or disease processes not captured by the study's instruments, and from a greater tolerance for stress, or personality factors such as 'giving up' or lack of readiness for a new experience.

However, what of the future for the elderly persons? Golant (1975) foresaw an increase in elderly concentrations within metropolitan areas especially in the 'old-old' (age 75 and over) group, who will represent an increasing proportion of the total elderly population. They will be motivated to move because of varied housing and service opportunities that provide physical and psychological security. As well, he predicted an increase in age-integrated neighbourhoods containing persons in all stages of the life cycle.

Fletcher and Stone (1982) further stated the future older woman, who has managed her household for 50 years, will not wish to accept the loss of autonomy or drop in status or authority and therefore may opt to live alone, especially as living alone has become and will become more socially acceptable. The woman's movement has helped change popular opinion concerning the appropriate living arrangements of

women. Women are better equiped psychologically, physically and economically to continue living alone. Wiseman and Roseman (1979), and Tinker (1980) stated that more counselling is needed by the elderly about the advantages and disadvantages of moving. Counselling needs to be supported by research (Golant, 1975) into the areas of the decision-making process including the decision to move.

This issue was raised in a brief sponsored by the First Baptist Church (1981) in Brandon, Manitoba titled, Brandon Area Senior Citizen Housing Project. The brief asked why elderly persons were not assisted with government programming to remain in their established homes and neighbourhoods. The Church's survey found that when elderly people realized they might have to move, the thought of leaving their home was worrisome because their house represented a lifetime of memories. These memories were very important and somehow represented security to the elderly person in their senior years. When the time came to move, the elderly person was often thrust into an extremely different environment. Further, the brief suggested that contact with persons who are ill and who have little chance of recovery is depressing to the elderly. This type of atmosphere does nothing to improve their situation and they soon give in to their own depression. The survey postulates that a person who is unhappy and thinks they are ill may eventually become ill. Consequently, if people could be

kept in their own homes they would be happier and thus healthier. The Brandon survey (1981) stated:

> when a couple reach retirement age, in most cases their homes do not have a mortgage. Their yearly costs would include taxes, repairs, food, clothing, utilities, transportation and medical bills. In most cases, the couple or widow(er) has sufficient funds to take care of these costs. It would seem then that the cost to the government to initiate a program to help seniors stay in their own homes would be substantially less than if the government were to place these people in subsidized or non-profit housing (First Baptist Church, 1981:5).

Moreover, Tinker (1980); Havens (1980); and Goodspeed and Maychak (1982) indicated the need to develop community resources in health care services and in improving existent shelter or housing to provide more encouragement for those elderly trying to stay in the community and remain in their own homes.

1.3 CONCEPTUAL FRAMEWORK

The conceptual framework for this study stems from Dunn's theory of high-level wellness (Dunn, 1961) which conceptualizes man's health-illness status as resulting from his interaction with his environment. This perspective sees man as a part, product and determiner of his environment.

Health in this health-illness grid is defined by the World Health Organization (1946) as: "The complete state of physical, mental and social well-being, not merely the absence of disease or infirmity" (World Health Organization,

1946:1). Dunn's ecological conceptualization elaborated upon this definition of perceived health and illness as being influenced by one's environment. He viewed health and illness as a dynamic process. Dunn (1961) stated:

> High level wellness for the individual is defined as an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable. It requires that the individual maintain a continuum of balance and purposeful direction within the environment within which he is functioning (Dunn, 1961:10).

Sakalys (1973) elaborates on Dunn's theory further and describes man's health:

> As being determined by the interaction and integration of two ecological universes: the internal environment of man himself and the external environment in which he lives and to which he relates (Sakalys, 1973:7).

Therefore, a change in one part of the system produces changes in the other interrelated parts of the system. Moreover, it can be concluded that man's interactions with his environment has an effect on his health status.

Dunn's theory makes three basic assumptions. The first is that people move in a direction to progress to a consistently higher level of functioning. Secondly, there is always an open ended and expanding future which challenges the person to pursue his potential. Thirdly, there is intergration of the whole being of the person, including the body, mind and the spirit. Dunn (1961) theorizes health and illness as being on a graduated scale or 'health grid'. One axis of this grid is environmental

which is made up of physical, and socioeconomic components. The other or health axis ranges from death to peak wellness with the area in between ranging from various and relative states of wellness or illness. The grid can be divided into four quadrants.

1. Poor health in an unfavourable environment
2. Protected poor health in a favourable environment
3. Emergent high-level wellness in an unfavourable environment
4. High-level wellness in a favourable environment

The degree of wellness depends upon the favourableness of the environment and the health status as indicated in the schema of Dunn's (1961) Health Grid (see Figure 4). There must be a balance maintained between the internal environment of man himself and the external environment in which he lives and to which he relates.

For purposes of this study, the relocation of the elderly person into an urban age-segregated E.P.H. from his/her established residence is viewed on the environmental axis in the unfavourable quadrants. According to this theory then it follows that on the health axis the relocated elderly individual will be somewhere in the quadrant of poor health as compared to high-level wellness. Therefore, the move or change of residence, for the women in the sample caused stress as it would with any age group. However, the

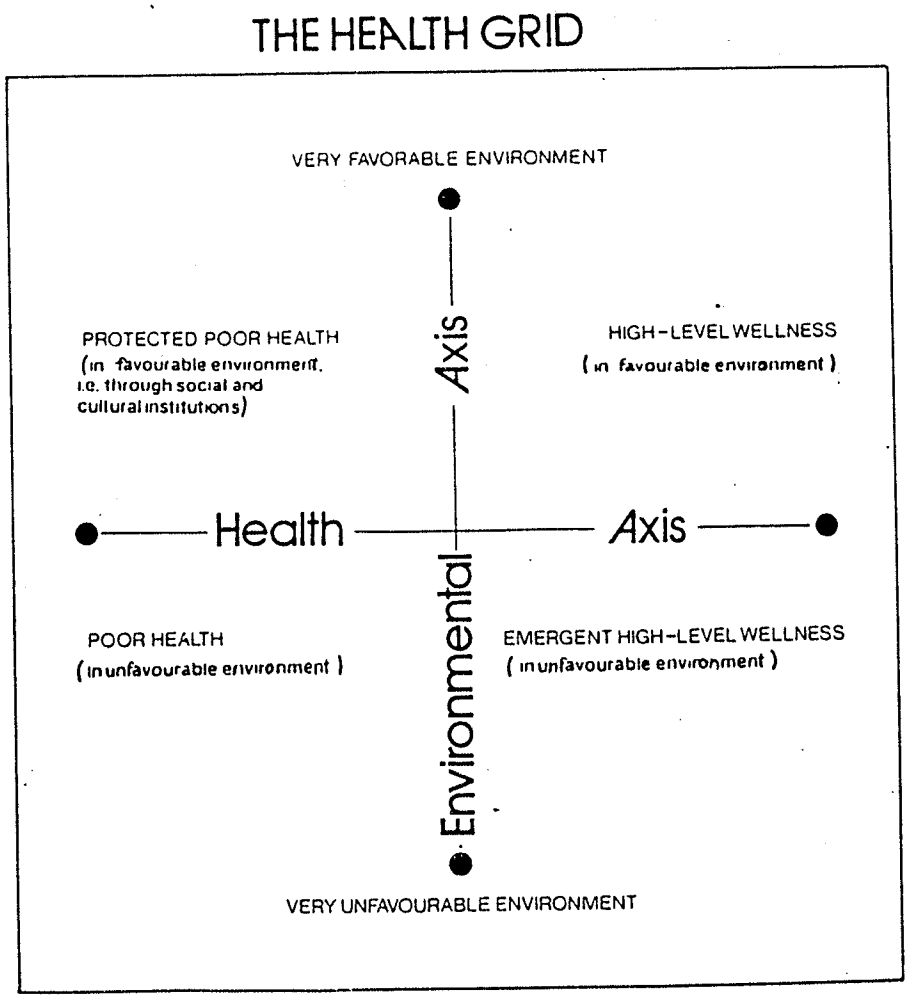

Figure 4: Dunn's (1961) health grid depicting degrees of wellness

additional stressors of having to come to terms with depleted resources, either financial or physical; the loss of a spouse or companion or other familiar person; or the perceived deterioration of health and inability to manage are factors which suggest that these women are in a vulnerable state or in an unfavourable position on the health grid.

The environmental axis of Dunn's Health Grid (Figure 4) is made up of physical and socio economic components and the individual's degree of wellness depends on the favourableness of the environment. Therefore, the study resident's new residences, the E.P.H. which has physical and socio economic components is on the environmental axis.

It follows that the resident's degree of wellness depends, in part, on the E.P.H. environment. The greater the stress or unfavourableness associated with the new residence, the more it will affect the wellness or health of the resident. In applying Dunn's Health Grid, sample members would fall at various points. However, because the move is recent, with the stressers associated with any change, the new residence will be viewed as falling below the centre of the environmental axis or in the unfavourable environment. How the individual adapts to the new residence will dictate whether the move will eventually be in a favourable environmental position, remain as is or move further down the unfavourable portion of the axis. For example, those people with physical disabilities which were additionally being stressed by their previous environment could be viewed in Dunn's schema in poor health in the unfavourable environment quadrant. However, as they adapt they could remain in the unfavourable environment, but move nearer to emergent high-level wellness or move up the environmental axis to the protected poor health in a favourable environment.

1.4 PURPOSE OF THE STUDY

Since support services are available to residents of Manitoba through the Home Care Program, and more recently through the support services to Seniors Projects, the purpose of this study is to isolate possible needs causing relocation that are not presently being met through the existing programs. Are unmet needs such as financing, decrease in health functioning, loss of support systems and increased vulnerability among the decision-making criteria affecting the elderly person's decision to relocate from their established living environment into segregated apartment type housing? This study addresses the following general research questions:

1. What was the precipitating decision-making factor causing the elderly person to relocate from their established home into an age-segregated urban dwelling?
2. Was the elderly person aware of programs/services in the community that may have altered his/her decision to relocate?
3. What services/programs would need to be developed in the community in order to prevent the elderly person from relocating?

1.5 ETHICAL CONSIDERATIONS

The sample consisted of elderly females who agreed to participate in the study. Subjects were sent a 'Letter of Introduction' (Appendix A) followed by a telephone call to confirm her agreement to participate in the study. At the time of the pre-arranged interview, the subjects were given a copy of the 'Prepared Statement for Requesting Subject Participation' (Appendix B). The subjects were requested to sign a consent form (Appendix C) and a copy was left with them. The subjects were informed that they could withdraw from the study at any time without fear of reprisal. Each subject was assigned a code number in order to protect the identity of the subjects and provide for confidentiality. Subjects who wished a copy of the results of the study indicated their desire in writing on the consent form. The subjects understood that any publications done by the researcher after the completion of the study would protect their anonymity.

Health questions, issues, and problems identified by the respondents were discussed following completion of the interview. No teaching or counselling was done by the researcher. If indicated, a referral to the Department of Health's local community office or the respondent's physician was suggested to the subject. Depending upon the degree of risk to the individual and with the subject's permission a telephone referral was completed by the researcher.

Approval to utilize the Manitoba Health Services Commission (M.H.S.C.) registration list for a sampling frame was obtained from the M.H.S.C. Access and Confidentiality Committee (Appendix D). The research proposal was presented to the Ethical Review Committee of the School of Nursing and approval to conduct the study was received prior to the collection of any data (Appendix E).

Chapter II

METHODS

2.1 INTRODUCTION

The cross-sectional survey was used to explore decision-making factors involved in relocation of the elderly into age segregated housing. The survey was chosen as the research method in order to describe and isolate the decision-making criteria used by elderly women who have relocated. The literature (Marshall & Eteng, 1970; Wiseman, 1980; Langino, 1980; & Gutman, 1983) has looked at migration and relocation of elderly persons but not at the actual decision-making factors immediately preceding the move. Further, Yee and Van Arsdol (1977) and Beaver (1979) indicated that prior to a move or relocation for the elderly individual, the person has most likely experienced a major life disruption. In addition, to not identifying the actual decision process, the literature does not indicate whether the relocated elderly person had or wanted to have supports that would have enabled him/her to remain in their previous residence and thus prevented the relocation. Therefore, given that this gap exists in the literature, this study will provide additional information to the field. A survey which included questions that would gather qualitative and

quantitative data for analysis was the best design to elicit the subject's perceptions and explore their decision-making process. Those elderly women who had recently relocated into Winnipeg Region E.P.H. units were interviewed using a structured interview guide. In order to explore possible age differences within the elderly population, the subjects were grouped into young-old (60 to 74 years) and old-old (75 years and older) categories. The interviews were conducted by the researcher within a year of the relocation. The interviews were tape-recorded.

2.2 ASSUMPTIONS

The assumption basic to this study is that elderly persons relocating from established/supportive community residences into age-segregated E.P.H. units may become less healthy following the move. Relocation of any kind causes an increase in stress and that increase in stress may be deleterious to an individual's health status and may result in the increased utilization of health services has been indicated by B. Havens (personal communication, February 18, 1983). Moreover, for the elderly person forced to relocate but not wanting to leave a household representing a lifetime of memories and security, the stress of relocation may be accentuated. This accentuated stress, coupled with the decreasing ability to adjust associated with aging (Clifford, Heaton & Fuguitt, 1981 & 1982), may precipitate

illness in the elderly person. Increased energy expended to cope with the new and perhaps hostile environment of the age-segregated E.P.H., may leave little reserve energy to combat an illness. Thus, the individual's increased vulnerability at the time of the move may hamper his/her ability to cope with or to overcome an illness.

2.3 DEFINITIONS

For the purposes of this study the following terms were defined:

1. Precipitating decision-making factor refers to the most crucial reason for relocating, as expressed by the elderly respondent.
2. Relocation means that the decision to change her residence was made by the elderly woman.
3. Elderly Person's Housing (E.P.H.) refers to apartment housing, either public, non-profit or profit, developed to provide special housing for people over the age of 55 years in the urban setting of Winnipeg.
4. Public housing refers to subsidized housing under the auspices of Winnipeg Regional Housing.
5. Non-profit housing refers to housing sponsored by a benevolent organization or group. Examples include the Mennonite Brethern, Lions Club and the Knights of Columbus.

6. Profit housing refers to housing developed by private enterprise for profit.
7. Elderly person refers to anyone 60 years of age and older at the time of the study.
8. Mixed housing refers to a community milieu or neighbourhood consisting of a mix of people of varying age groups.
9. Established/supportive community residence refers to an apartment or house in a rural or an urban area where the respondent has established a supportive network. This supportive network may be immediate family, significant others, or a neighbourhood where one has lived for ten or more years.
10. The young-old age category refers to persons 60 years to 74 years of age, while the old-old age category captures persons 75 years of age and older.

2.4 SAMPLE AND SETTING

A stratified random sample was drawn using a random table of numbers from the Manitoba Health Service Commission's (M.H.S.C.) computer registration lists. This listing, compiled bi-monthly, consisted of information on persons moving within the Province of Manitoba. The information compiled consisted of name, age, sex, previous address, and relocation address. Since Manitoba has a universal health care system, physicians and hospitals are reimbursed for

their services through this mechanism. The importance of possessing a valid M.H.S.C. card is recognized by recipients of the service. Therefore, people generally are prompt in notifying the M.H.S.C. of any change in their status, such as a change of address, in order to retain a valid card and number. This prompt reporting of changes in status by the consumer ensures the reliability of the M.H.S.C. listing (Roos, Roos, Cageorge & Nicol, 1982) as a sampling frame. Regular periodic updating checks of the registration list by M.H.S.C. indicate that approximately 90 percent of persons will provide the M.H.S.C. with their change of address within a short time after their relocation.

However, the small percentage of persons who do not voluntarily provide their change of status information to the M.H.S.C. are picked up in various ways at the point of utilizing the system for a service. Moreover, the utilization of health services increases with age and are further increased following a move (B. Havens, personal communication, February 18, 1983 & Gutman, 1980), making persons over the age of 60 years very cognizant of their need for a valid M.H.S.C. card. The realization of this need further assures prompt reporting of changes to the M.H.S.C.

The M.H.S.C. registration list or sampling frame was compared to the 1983 Directory of Senior Citizen Residences of Winnipeg compiled annually by the Age and Opportunity

Centre. This Directory lists all urban E.P.H.'s and categorizes them by public, non-profit and profit units. The comparison was completed to identify those elderly women who relocated to each of these types of accommodation. In total there are 82 E.P.H. complexes satisfying the definition of an age-segregated E.P.H.. Within these 82 E.P.H., there are 8,295 units including units for married and single persons. Further, the identified female names from the sampling frame were organized under the three headings indicated by the housing variable. Each housing variable was further stratified by two age groupings resulting in a two by three matrix (see Figure 5). Therefore, each housing type had two potential samples: a young-old age group consisting of women 60 years to 74 years; and the old-old age group consisting of women 75 years of age and older.

Relocation causing a change in occupancy was estimated, based on past M.H.S.C. data, to be approximately 30 to 40 persons per month. However, a four month period yielded 104 subjects appropriate for stratification. The women in each of the six cells were totalled and the sampling fraction calculated to obtain 30 subjects in the sample. The appropriate stratified sample calculation resulted in having 8 subjects in the young-old public housing category, 6 subjects in the old-old public housing category, 5 subjects in each of the young-old and old-old non-profit housing

HOUSING TYPE

AGE	PUBLIC	NON-PROFIT	PROFIT
	Young-Old (60 - 74 YEARS)	Young-Old (60 - 74 YEARS)	Young-Old (60 - 74 YEARS)
	Old-Old (75 YEARS PLUS)	Old-Old (75 YEARS PLUS)	Old-Old (75 YEARS PLUS)

Figure 5: Two by three matrix by housing type & age

categories and 3 subjects in each of the young-old and old-old profit housing categories (see Figure 6).

A table of random numbers was used to draw the subjects. Freund (1967) maintained that stratification of a sample, if executed, generally leads to a higher degree of precision and improves the ability to generalize to the whole population. Twice as many potential subjects were drawn per cell than required to allow for persons who were ruled out of the final sample due to prolonged absence from their residence, language problems or for those who refused to participate. The decision to pull twice as many names than needed based on the experience of the Aging in Manitoba (1973) study. It proved to be appropriate.

SAMPLE CELLS

PUBLIC 60-74 Years N=8	NON-PROFIT 60-74 years N=5	PROFIT 60-74 years N=3
PUBLIC 75 Years Plus N=6	NON-PROFIT 75 Years Plus N=5	PROFIT 75 Years Plus N=3

Figure 6: Sample population per cell by housing type & age

The sample consisted of female subjects only. Males were excluded because of their few numbers in this segment of the population. Female to male ratios widen (Fletcher & Stone, 1982) with increasing years and will continue to widen in future years leaving a predominant female society over the age of 80 years by the year 2001. A current survey of Manitoba E.P.H. residents by Y. Gold (personal communication, June 4, 1983) indicated only 27% of residents were males. For this study, the names on the list received for preparation of the sampling frame consisted of two-thirds female names compared to one-third male names.

Persons were excluded from the sample if there were problems interviewing due to confusion, illness, language barriers or if the subject was not available for interview due to migration (seasonal), hospitalization, or absence from their E.P.H. for an extended period of time. In total 53 persons were telephoned. Fifteen persons refused to participate and numerous attempts were made to contact the remaining five people without success.

The reasons given for refusal varied. Nine women stated they were too busy and did not want to be bothered or seemed insecure and did not want strangers in their homes. One woman felt participating in the study was an infringement on her time. Another stated she was involved in a complex divorce case and upon discussing the letter of introduction with her lawyer, they decided she should not participate. Four women felt their understanding of English was not sufficient to be able to participate.

Three persons were ruled out of the sample by the researcher at the interview stage. One individual was ruled out because of language difficulties; one because of the frequency of her moves over the last two years; and one because of the emotional stress associated with her move to the E.P.H..

2.5 THE METHOD OF MEASUREMENT

The instrument used in the study was a structured interview guide (Appendix F) developed by the investigator. This method was chosen over the mailed questionnaire because of its ability to generate qualitative data as well as quantitative information.

The interview remains one of the better methods available to researchers who desire to gather data related to the respondent's interpretation of his/her reactions to situations. This instrument allowed the researcher to analyze the data for emerging patterns across the sample. In addition, in a face to face interview, the researcher was able to further explain the study to potential subjects increasing the number of respondents willing to participate in the project. Polit and Hungler (1978) indicated that many people, such as the elderly, simply can not fill out questionnaires. Interviews can enhance the quality of the data through probing, and face to face interviews have the ability to produce additional data through observation. Polit and Hungler (1978) observed:

> the interviewer is in a position to observe or judge the respondents' level of understanding, degree of cooperativeness, social class, life-style, and so forth. These kinds of information can be most useful in interpreting the responses (Polit and Hungler, 1978:353).

Questions to be analyzed quantitatively were taken from the Aging in Manitoba (1973, 1976, 1983) studies with a

reliability range from .87 to .96. These studies involved interviews with a total of 12,182 elderly Manitoba residents. The questions for qualitative analysis were designed by the researcher. These data were subsequently grouped and classified by the researcher. The classifications were agreed upon by an independent judge with considerable experience and expertise in the field of gerontology. Prior to commencing the study, the interview guide was pretested on a convenience sample of similar elderly women. The pretest familiarized the interviewer with the interview guide and identified a few areas for clarification.

The interviews were conducted during the winter of 1983-84. The questions on the structured interview were grouped into four sections.

1. Personal characteristics
2. Present and previous living arrangements
3. Health status and ability to function
4. Identified needs and resources

Although the interview guide was categorized under four major headings, questions under each heading were both qualitative and quantitative in nature.

2.5.1 Personal Characteristics

This category of the interview guide was constructed by the researcher and consisted of 17 questions all taken from the Aging in Manitoba (1973, 1976, 1983) studies. The questions were desiged to elicit demographic information such as sex; marital status; family size; ethnicity; education and past/present occupation. This category provided a general overview of the study population as well as insight into the background of decision-making factors for relocation. For example, questions 12 through 15 asked about family members who may be seen as supportive and how often they were see by the respondent. If the family member was seen as often as was desired this would indicate the subject was living in a more favourable environment than if contact was perceived by the subject as less than desireable.

In the study, those persons who were legally married but whose spouse was absent and not living in the same accommodation were considered as separated. The married person with a spouse who was separated permanently, either through placement of the spouse in an institution or for similar reasons, would still be considered as married but were classified as being alone.

2.5.2 Living Arrangements

This section, constructed by the researcher, consisted of 15 questions. The first 10 questions were taken from the Aging in Manitoba (1973, 1976, 1983) studies. These questions were designed to capture the subject's past living arrangements; where they would like to live; their opinion of their new apartment and how it compared to their previous accommodation. For example, questions 1 and 3 asked what type of housing was previously lived in by the subject and was it close to their present apartment. Question 7 asked how satisfied the respondent was with aspects of their new housing. Qestions 11 through 15 were designed by the researcher to capture data relating to the resources available to the subjects in their new and old locations and the decision-making factors relative to their relocation. For example, question 11 asked the subjects to identify their major reasons for the move to E.P.H.. The questions asked regarding the present and past living arrangements determined the respondent's satisfaction or dissatisfaction with those living arrangements and what arrangements they would prefer. If the idividual was comparatively satisfied with their new living arrangement then the environment may be favourable and therefore, less stressful.

2.5.3 Health Status and Ability to Function

This category, constructed by the researcher, was comprised of 12 questions taken from the Aging in Manitoba (1973, 1976, 1983) studies. The questions were structured in order to gather information on the subject's current level of functioning; how they perceived their present health, both physical and emotional; and how they managed the routine activities of daily living which may have affected their decision to relocate. For example question 10 in this section elicited medical diagnoses and diseases known to the respondent. Questions such as 1, 5, 6, and 9 captured data on how the subject perceived her limitations and how she functioned in her activities of daily living. If the subject perceived herself as ill and unable to function, then her environment may be interpreted as unfavourable and increase the stress under which she lives.

2.5.4 Needs and Resources

This category, constructed by the researcher, had 10 questions of which 1 to 6 inclusive and number 10 were taken from the Aging in Manitoba (1973, 1976, 1983) studies. Questions 7, 8, and 9 were designed by the researcher. These questions asked about resources in the new neighbourhood which were known to the subjects and if the subject was using the resource, or would use the resource if it was needed. The remaining questions were related to the

resources of self, of family and of the community which were used by the subject as well as the resources that the respondent would like to have had available to her. For example, questions 5 and 6 asked who would help the respondent if assistance was needed and was the help now being received sufficient? The accessibility of resources to meet the individual's needs may have affected the decision to relocate and if resources were seen as being more available or, in fact, were more available, then the respondent's new environment would be seen in the favourable axis compared to her previous evironment.

2.6 INSTRUMENT VALIDITY AND RELIABILITY

The close ended questions in each of the four sections of the questionnaire were extrapolated from the Aging in Manitoba Study (1973) and subsequent follow-up studies in 1976 and 1983. A reliability range from .87 to .96 was reported for these studies. Therefore, it was not necessary to test for reliability with the pre-test group. The specific questions taken from the Aging in Manitoba (1973, 1976 & 1983) questionnaires were indicated in each of the four sections of the interview guide under the preceeding measurement section.

The content and construct validity of these questions is ensured in that they were previously used in three studies which involved interviews with a total of 12,182 elderly persons and the high reliability range reported.

The questions, as indicated previously, in the living arrangements section (numbers eleven through fifteen inclusive) and questions in the needs and resources section (numbers seven through nine inclusive), were open ended questions designed by the investigator to capture qualitative data. These qualitative data elicited factors related to the respondent's decision to relocate. A thorough review of the literature (Sherman, 1983; Janson & Ryder, 1983; Gober & Zonn, 1983; Krout, 1983 and Aday & Miles, 1982) revealed that factors such as fear, isolation, lack of resources, limited finances, recent widowhood and preceived poor health may be causes for the elderly to relocate. The open ended questions were formulated to elicit these factors.

2.7 PRE-TESTING

The pre-test determined the clarity of the instrument. Pre-testing provides an opportunity to detect gross inadequacies or unforseen problems before administering the instrument to individual subject's of the research. Because the majority of the questions were modified from the Aging in Manitoba (1973, 1976, 1983) studies, respondents were not anticipated to encounter major difficulties in answering the questions. The interview schedule was administered to a convenience sample of five elderly women, known to the researcher, who were similar in personal background to the study sample.

The time required to administer each of the pre-test interviews was recorded. The time for these interviews averaged forty minutes. Therefore, the schedule was not modified. Responses on the pre-test did not identify items for deletion or major modification. Some minor clarification in wording was noted.

Babbie (1975) indicated that in survey interviews the interviewer must communicate genuine interest in the respondent in order to put him/her at ease. He further stated this can be accomplished by the interviewer being familiar with the questionnaire so that the interview progresses smoothly. The pre-test provided the interviewer with the opportunity to acquire this familiarity.

2.8 PROCEDURE

The descriptive survey method used in this study explored many aspects associated with decisions by elderly females to move into E.P.H. units. A letter of introduction (Appendix A) requesting their participation explained the study and indicated that further information regarding the study could be obtained from the University of Manitoba or the researcher. Names and phone numbers were given. Three women called the University and two women called the researcher to seek further information. They subsequently participated in the study, although one of these individuals was ruled out by the researcher at a later time. The letter

of introduction stated the researcher would contact them by phone within two weeks of their receipt of the letter. The majority of persons waited for the researcher to contact them. Nearly all persons requested more information at the time of the phone call. Many volunteered information over the phone to the point that the researcher had to interrupt indicating she would visit them to complete the interview. This suggestion was well received and agreeable with the subjects. These women seemed lonely and were eager to talk with someone. Some of the women who had refused to participate in the study were, however, willing to provide information over the phone. It seemed that the in-home interview was objectionable, not the sharing of information. This may be due to feelings of vulnerablity and subsequent insecurity about letting a stranger into their home.

Many people asked how their name had been chosen. The researcher explained the M.H.S.C. registration listing and that permission was obtained to use the computer listing through the Access and Confidentiality Committee. The confidentiality of the individual was stressed. No one expressed any negative concerns and the women were apparently satisfied and felt comfortable with the explanation. An interview time was scheduled that was convenient to the subject and the researcher. Late mornings, afternoons and early evenings seemed appropriate. No one was visited on the weekend or after nine o'clock in

the evening. A small number of interviews needed to be rescheduled because of an unexpected time conflict for either the subject or the researcher. One visit was rescheduled because the tape recorder malfunctioned, and another because of a misunderstanding of the date. The rescheduled interviews were accepted in a positive manner. Subjects were given the opportunity to withdraw from the interview when the paraphrase (Appendix B) was explained and the consent form (Appendix C) was signed. A copy of the consent form was left. No one refused or withdrew at this time or during the interview except the three discontinued by the researcher because of language bariers, frequency of moves, and emotional stress.

The tape recorder was viewed with some skepticism at the onset of the interview by approximately one-half of the sample. However, it was soon forgotten as the interview progressed. Three women wished to expand upon a point raised by the questionnaire and did not wish their comments recorded. The recorder was, therefore, turned off at that point and started again with the next question on the interview guide. Many had never heard their voice on a tape recorder and asked the researcher to play back part of the interview. They were surprised at the sound of their voices.

No interview lasted more than one hour. The average length of time was approximately forty minutes. In the

lengthier interviews, the women tended to digress from the question to reminisce over something about which the question had reminded them. It was necessary for the researcher to refocus the conversation in order to continue the interview. All interviews, except for one, were conducted with only the subject present. However, most women had discussed the forthcoming interview with family or friends. The one exception was a sister who was at the apartment during the interview. She did not participate in the interview but did remain in the room.

2.9 DATA ANALYSIS

The structured interview was used to elicit decision-making criteria on relocation as well as reactions to the recent alterations in living environment. The interview also captured data that were subjective and retrospective in nature. No attempt was made to verify the information. The criteria or factors identified or perceived by the respondents were accepted by the investigator as the major criteria for making the decision to relocate.

Descriptive statistics which summarized the observations were used to examine differences in the responses of subjects across the categorical variables. The structured interview guide elicited mostly nominal data from the respondents to which univariate analysis such as frequency distributions were applied. The continuous variables such

as age and education were analyzed using means. Summaries of dispersion were also reported for those variables. The young-old category (age 60 to 74 years) was described and analyzed as were the old-old category (75 years and older) in the areas of personal characteristics, health functioning, living arrangements, and needs and resources. In addition, the age categories were examined within each housing type (public, non-profit, profit) in order to determine if there were any significant factors in the respondent's personal characteristics, health functioning, or knowledge of resources which may have influenced their choice of relocation facility. Relationships among age and the housing variable were examined using contingency tables and chi-square. These tables were examined using a two by two frame so that each reason as classified by the researcher could be analyzed. Each reason by category of age and housing type was either mentioned or not mentioned by the respondent. The data was then analyzed for any significant difference.

The data from the qualitative questions in each of the 30 interviews were analyzed to identify categories of decision-making factors and perceived resources. This type of qualitative analysis is referred to as content analysis. The tape-recorded interview data was transcribed to incident cards to facilitate analysis. The incidents were then sorted and categorized using a card file system. Repetitive

patterns identified in the analysis became categories and were given titles that summarized the common theme of a category which were subsequently given operational definitions. Schatzman and Strauss (1973) indicated that the most fundamental operation in the analysis of qualitative data is the discovering of significant classes of things or events and the properties that characterize them. The establishing of classes and linkages are mandatory to the task of analysis. Therefore, the goal of this analysis was to discover the factor(s) that precipitated the decision made by these elderly women to relocate.

A random selection of ten percent of the incident cards was used to establish reliability. These incident cards were judged by an independent judge; considered an expert in the field by virtue of her many years of working experience. The independent judge was asked to classify the incidents. The interrater reliability of the judge and the investigator in assigning incidents to the same classifications was 100 percent.

Although the questions under each heading of the interview guide directly related to one specific components, there was some inter-relatedness between questions of each component. Therefore, when analyzing the data this inter-relatedness was considered more relevant to the analysis than the previously related questionnaire headings. The

inter-related groupings of questions were then given new headings. These were:

1. Demographic data: Most of the questions eliciting demographic data were from the Personal Characteristics section of the interview guide. These were questions such as; age, employment, nationality, language, and education. The questions on income from the Needs and Resources section were added to this category for analysis.

2. Housing environment: Most of these questions in the reorganization of the data came from the Living Arrangements section of the guide such as: what was the previous housing arrangement; was it owned or rented; was it close by; and how long the respondent had lived there. Some questions on resources and services available to the respondent came from the Needs and Resources section.

3. Activities of daily living: Most of this data was from the Health Status and Ability to Function section of the questionnaire. There were questions eliciting information on the respondent's perceived health, their diet, how often they saw the doctor, and whether they spent time in bed due to illness. Other questions such as the help they were receiving

or were not receiving came from the Needs and Resources section.

4. Moving patterns: The questions impacting on this area came mostly from the Living Arrangements section of the guide. These were questions such as the open ended questions eliciting data about the reason for moving and the questions regarding the length of time the respondent had lived alone. The question regarding who and where the respondent would like to live came from the Health and Ability to Function section.

Therefore, the results and the discussion of the data analysis outlined in chapters three and four are organized according to these new headings.

Chapter III

RESULTS

3.1 DEMOGRAPHIC DATA

The demographic data on the 30 interview schedule provided the researcher with information about the elderly women in the sample. The demographic variables included the individual's age; marital status; length of time alone if widowed, divorced or separated; nationality of the individual other than Canadian; the language most often spoken; educational status; and past and present employment status. Other variables captured whether the elderly woman had been living with relatives such as children, grandchildren, siblings, parents or other relatives which included nieces, nephews or cousins. The characteristics of the sample were revealed by these demographic data.

3.1.1 Respondent's Age

The mean age of the subjects was 73.3 years with a range from 61 years to 87 years of age. However, 23.2% of the elderly women in the sample were 80 years of age and older. The Canadian Governmental Report on Aging (1982) estimated that only 13.5% of the population 60 years of age and older

is over 80 years of age, but the latter figure was based on a population study of both males and females. The higher percentage of older elderly women in this sample may also be a result of limiting the subjects to those women living in E.P.H.'s. As longevity for elderly women increases, perhaps the move to E.P.H. occurs at an older age. The 1981 census data (Canada, 1984) on elderly Canadian women reported that the older group of elderly women (aged 85 and over) has

TABLE 2

Respondents by Age Groupings

Age Group	Number	Percent
60 - 64	n=02	6.6%
65 - 69	n=07	23.3%
70 - 74	n=07	23.3%
Young-old (60 -74)	n=16	53.3%
75 - 79	n=07	23.3%
80 - 84	n=08	16.6%
85 plus	n=02	6.6%
Old-old (75 plus)	n=14	46.7%
Total Sample (60-85 plus)	n=30	100.0%

increased faster than the groups aged 65-74 and 75-84 years.

The study sample was grouped into two age categories as illustrated in Table 2. The two age categories of young-old (age 60-74 years) and the old-old (aged 75 years and older) totalled 30 sample members.

The sample was further categorized into housing types by

TABLE 3

Respondents by Housing & Age Categories

Housing type	Young-old	Old-old	Percent
Public	n=08	n=06	46.7%
Non-profit	n=05	n=05	33.3%
Profit	n=03	n=03	20.0%

the age categories as shown in Table 3. The proportion of individuals within the two by three matrix was planned to be congruent with the distribution found in the sampling frame. This distribution is represented by a 28.84% sample of the frame by category. As outlined in Tables 2 and 3, the highest proportion of elderly women in the sample were between the ages of 65 years and 79 years, with the highest percentage of the sample residing in public housing.

3.1.2 Marital Status and Years Alone

All members of the sample were living alone. The majority of persons, 21 or 70% were widowed. Five or 16.7% were divorced or separated, while 13.3% had never been married. Of those widowed, the mean years alone was 14.6 years. However, 10 or 47.6% of the widows had been widowed for 10 years or less, while 7 or 33.3% had been widowed for 5 years or less. Table 4 indicates the mean for the number of years alone for those women widowed, divorced or separated by housing type and age grouping.

Further, Table 4 illustrates that, in general, persons in the old-old age group have spent more years alone than persons in the young-old age group. This held true for the old-old age group in each housing category with the exception of the profit housing where young-old persons had been alone 2.7 years longer than old-old persons. Also of note in Table 4 is the dramatic difference in years alone between the young-old and old-old in non-profit housing. On the average, the old-old women in non-profit housing have been alone 13.4 years longer than young-old women in the same housing group. However, in total women in public housing have been alone the longest (17.5 years).

TABLE 4

Years spent alone by Respondents by Age and Housing Categories

Age groups	Number	Mean Years	S.D.
Young-old	16	11.2	11.3
Old-old	14	17.3	14.9
Housing Groups			
Non-profit	10	13.5	14.8
Profit	06	07.0	08.1
Public	14	17.5	13.3
Age & housing groups			
Young-old			
Non-profit	05	06.8	08.5
Profit	03	08.3	10.4
Public	08	15.1	12.9
Old-old			
Non-profit	05	20.2	17.6
Profit	03	05.6	07.3
Public	06	20.8	14.3

3.1.3 Ethnicity

Other than Canadian, the nationality most frequently mentioned (46.6%) was English. The Non-French European nationalities including German, Ukrainian and Mennonite were mentioned second (29.9%), followed by Scottish (10%), Irish (6.6%), Flemish (3.3%), and French (3.3%).

3.1.4 Education

The educational level of the sample was indicated by the number of years or grades completed in school. The range of years was zero to 17 years with a mean of 8.7 years. However, 11 or 35.6% of the women sampled had more than a junior-high (grade 9) education. In fact, three or 9.9% of the sample had post secondary education, with 6.6% having completed graduate work.

Table 5 indicates the mean levels of education by the age and housing groupings of the sample.

TABLE 5

Education of Respondents by Age and Housing Categories

Age groups	Numbers	Mean years	S.D.
Young-old	16	08.6	13.0
Old-old	14	08.7	04.7
Housing groups			
Non-profit	10	09.3	02.9
Profit	06	10.5	04.2
Public	14	07.5	04.1
Age & Housing groups			
Young-old			
Non-profit	05	08.8	01.3
Profit	03	10.0	05.5
Public	08	08.0	02.9
Old-old			
Non-profit	05	09.8	04.1
Profit	03	11.0	03.6
Public	06	06.8	05.5

The data in Table 5 revealed that both the young-old and old-old received similar years of education, 8.6 and 8.7 years respectively. However, there was a higher number of years of education for both young-old and old-old in profit housing, 10 and 11 years respectively, when compared with the average number of years of education for both the young-old and the old-old age groupings in public housing, 8.0 and 6.8 years respectively. Unexpectedly, in both profit and non-profit housing the old-old averaged one more year of education than their young-old counterparts.

3.1.5 Employment

Data regarding employment was elicited using two semi-structured questions. The largest proportion (73.4%) of the sample had worked outside their homes. However, 8 or 26.6% of the women in the sample had not been employed outside of their homes and indicated their employment as housewife. One lady stressed and wished her response to be recorded as 'housewife and mother' and to underscore mother.

If the woman had been employed outside of her home, the data were grouped into five classifications of employment. These were:

1. Unskilled labour for which no formal training was required, such as operating an elevator.

2. Care providing which included caring for children through a formal agency like Family Services of Winnipeg or being hired by a family to care for an ill of frail adult. In the latter, a formal contractual agreement was entered into.
3. Small business in which the respondent had been self employed, such as a florist.
4. Professional training for which a university degree was required, such as teaching.
5. Skilled labour for which formalized training was needed prior to employment, such as a typist or secretary.

Even though 73.4% of the total sample as illustrated in Table 6 had had gainful employment, 7 or 23.3% of the total sample were classified as unskilled workers. This represented 31.8% of those women employed. In addition, 4 or 13.3% of the total sample were employed in the care provider role. Combining those employed in unskilled jobs with those employed as a care provider revealed 50% of the 73.4% employed women had done work which required no previous training. The remaining 11 women who had been employed were distributed among the classifications of business (13.3%), professionals (13.3%), and skilled labour (10.0%).

When asked about present employment, 22 or 73.3% of the sample indicated they were not presently employed.

TABLE 6

Previous Employment of the Respondents

Type	Number	Percent
Unskilled	n=07	23.3%
Care Provider	n=04	13.3%
Business	n=04	13.3%
Professional	n=04	13.3%
Skilled	n=03	10.0%
Total outside home	n=22	73.4%
Housewife	n=08	26.6%
Total sample	n=30	100.0%

Volunteer work was considered as employment, and seven women or 23.3% were doing volunteer work which consisted mostly of providing child care to grandchildren. Two women were providing child care on a regular, full time basis so that both parents could work. One woman was considering employment in the near future. However, only 3 women or 10% of the sample indicated they needed more funds to live comfortably. Ninety percent of the sample responded that they had assets to fall back on. They could meet future needs, meet emergencies and buy little extras.

3.1.6 Families

Twenty-five women or 83.3% of the sample indicated they had children. The remaining 5 women or 16.7% did not have any living children, four women or 13.3% having never been married. The same percentages held for grandchildren. However, 26 or 86.7% of the sample stated they had siblings still alive while 4 or 13.3% did not. Only one woman had a living parent. However, everyone had other living relatives such as nieces, nephews and cousins.

3.1.7 Summary

The random sample of women living in E.P.H. was by design proportionately distributed between two age groupings, the young-old (aged 60 to 74 years) and the old-old (aged 75 years and older) and three housing types; public, non-profit and profit. The mean age of subjects was 73.9 years, and most lived in public housing. Most of the sample (86.7%) had been married, but all were now living alone. English was the predominant language spoken and the sample's mean years of schooling was 8.6 years. Nearly three-quarters (73.4%) of the women sampled had been gainfully employed outside their home. However, half (50.0%) of this group had no job training prior to their employment. All of the sample had one or more living relatives.

3.2 HOUSING ENVIRONMENT

Questions related to the sample's living environment provided data on their past and present physical accommodation. The variables included the location of the respondent's previous housing, the type and style of that housing, ownership of past accommodation, and satisfaction with the new accommodation. The interview captured the resources perceived as available to the sample in their past and present housing environment. These variables included what resources were available in their old neighbourhood, what additional resources were desired, the available resources in the new neighbourhood, and what resources were still required in the new neighbourhood.

3.2.1 Physical Accommodation

The largest proportion of the present accommodation was located in the central areas of the city. A total of 13 or 43.3% of the sample resided in the central and north central districts. These sample members resided in the inner city or old city area of Metro. Six persons or 20% of the sample were located in the north east district which contains an area of the old city but is mostly suburban. The remaining 11 persons or 36.7% were located in the south, north west, west, and south east districts.

Sixty percent or 18 persons were interviewed in bachelor apartments, and remaining 40% of the sample were interviewed in one bedroom apartments. Fifteen women (50%) were living in high-rise apartment complexes with only 4 or 13.3% in single story accommodation. However, 46.7% or 14 persons had lived in single detached housing just prior to the move while 43.3% or 13 persons had previously lived in an apartment. Three women had lived in other accommodation such as a duplex or town house. All but one woman who had lived in a single detached house had owned the house.

Persons moving into the city from a rural area constituted 36.6% of the sample. With one person moving back to Manitoba from another province, the remainder of the sample or 63.4% identified their previous residence as being Winnipeg. In fact, 40% of the sample relocated within the same neighbourhood. Over half, 53.4% had lived in their previous residence over 10 years, with 8 or 50% of those persons having lived there over 25 years. The remainder of the sample, 14 women or 46.6% had resided in their previous housing from 3 to 10 years, seven or 23.3% having been there for five years.

Fifteen or 50% of the sample stated they were completely satisfied with the design, location and physical layout of their new home. The location of the apartment block represented the highest percentage of dissatisfaction, with 6 persons or 20% stating they were only partly satisfied.

In regards to the physical layout of the apartment, sleeping accommodation (16.6%) and storage space (16.6%) were aspects of their new housing which created dissatisfaction; followed by laundry facilities, ventilation and general space (10% each); then cooking facilities and lack of windows (6.7% each). As well, noise, general repair of the block, heating, lighting and rent which were each rated as unsatisfactory by 3.3% of the sample.

3.2.2 Resources

Resources were those known to the sample members in their old and new neighbourhoods. Seven or 23.3% of the sample stated there were no resources available in their old neighbourhood. Of the resources available, 63.3% indicated public conveniences such as grocery stores, post offices and banks. Forty-three point three percent indicated informal supports such as neighbours and friends and 6.7% indicated there was no need for external resources as their family met all their needs. Only 5 women, or 16.7% of the sample indicated that they knew of formal supports such as government programs.

When asked, in general, what resources they perceived as needed in their old neighbourhood, 46.7% indicated they could not think of anything. Twenty-three point three percent mentioned the poor location of their previous housing would not warrant additional resources. Statements

were made by the respondents which indicated that the location was 'too isolated', 'it was a small town and could not be expected to have all the facilities', and 'it was a place for young people not seniors'. Twenty percent of the respondents indicated that the accommodation was completely unsuitable and that no resource would be appropriate. For example, one woman stated that 'the house was too large for her too manage alone'. Another stated that 'nothing would help'. Another woman was not able to climb the stairs to the bathroom in her old accommodation. Public conveniences such as grocery stores, clothing stores, transportation and banks were indicated (16.7%) as the most needed additional resources. Thirteen point three percent indicated a need for increased formal supports such as government programs to assist with activities of daily living and home maintenance, and 6.6% percent of the sample mentioned the need for improved security.

When asked about the use of resources, 86.7% of the sample stated they would use resources if they had to. However, 3.3% said they would not and 10.0% were not sure if they would or would not use a resource. Just over half of the sample (56.6%) indicated that they were aware of some resources in their new neighbourhood. Only one person indicated there were no resources available in her new location.

Public conveniences such as those described earlier were cited by 93.3% of the sample, as was organized in-house activities such as cards, bingo and social gatherings. Thirty-six point seven percent indicated that regular in-house meal service and volunteer services were available. The safety call systems (pull cords) in bathrooms and by bedsides were important to 30% of the sample. Twenty-three point three percent stated that there were organized outdoor activities like lawn bowling or shuffle board. Sixteen point seven percent indicated that health services including doctors' offices or clinics were within easy access. Informal supports from neighbours and friends were important to 13.3% of the sample and 10% mentioned parking as being important and available.

When asked what resources they would like to see available in their new location, twenty-three point three percent of the sample indicated no additional resources were required. Seven or 23.3% stated the location was too far from the city center for easy access to needed resources such as doctors' offices. Sixteen point seven percent said an improved public transportation system was needed, and 13.3% wanted better postal services, specifically for posting letters. As well, 13.3% indicated there should be more volunteer services for residents.

As far as the structure/environment of the building itself, 40% indicated there should be more space such as a

bedroom and a larger storage area. Twenty-six point seven percent mentioned improved air control such as heating and ventilation; 13.3% stated a need for more common rooms to socialize with families and friends; 10% indicated a call system to summon assistance within the building; and 10% stated there should be more green space within easy access of the building. Two women (6.7%) indicated better laundry facilities. One person stated there should not be carpets on the floors as they hampered wheelchair and walker mobility. One other person felt isolated, in that other residents within the building did not bother with her.

In general, when asked how they would rate the listed services/opportunities available for people their age, 36.7% of the sample indicated all services listed by the researcher were convenient, adequate or not needed. Services listed as totally (100.0%) convenient, adequate or not needed were: employment services, clubs, police and fire departments, hospitals, home help, visiting nurses, recreation facilities, language facilities and ambulance services. Four women or 13.3% stated there was some need for parks, while three or 10.0% indicated shopping services and postal outlets. Two persons or 6.7% of the sample saw some need for services such as church, public transportation, educational facilities, senior citizen activities, and banks. One respondent indicated that there was an extreme need for improved public transportation.

3.2.3 Summary

The data on the physical housing environment revealed that many of these women relocated within their inner city neighbourhood into public high rise bachelor accommodation even though they had previously lived in single detached housing. However, several of the subjects relocated to a Winnipeg E.P.H. from rural Manitoba. Most of the sample had lived 10 years or more in their previous residence. Regarding their new home, the most dissatisfactions expressed by residents were related to the location of the complex, the bachelor type accommodation, and the limited storage space.

Only a small percentage of the sample members knew formal support programs available to them in their old location. However, they felt that no additional resources would have assisted them to remain there. More sample members were aware of resources in their new neighbourhood especially public conveniences and inhouse activities. Nearly all the women stated they would use formal supports if necessary. Additional resources were not perceived as a great need.

3.3 ACTIVIYIES OF DAILY LIVING

This section of the questionnaire provided data on health functioning. The variables included mental status and memory; physical functioning ability; perceived health status; perceived health problems and known health services. Other variables captured data regarding help required to meet the activities of daily living (ADL); who was providing the required assistance; what formal services were known to the respondent; and would these services be used if required at a future time.

3.3.1 Mental Status and Emotional Health

Twenty-seven or 90% of the sample knew the day's date, and 96.7% could name the Prime Minister of Canada. While 53.3% of the sample did not know the name of the Prime Minister's predecessor. There were three questions in the interview guide designed to capture the mental status of the subjects. Each mental status question (M.S.Q.) was assigned one point. Thus, three points represented three correct responses. Thirty subjects, with all correct responses would have a total M.S.Q. score of 90 points. A total M.S.Q. score of 70 points was reported for the sample. The total scores for each question ranged from 14 to 29. Question one had a M.S.Q. score of 27 with 27 or 90% of the women answering the question correctly. Question two had a M.S.Q. score of 29 with 96.6% of the respondents answering

correctly. Question three, which asked for the name of the Prime Minister of Canada prior to Mr. Trudeau, had a M.S.Q. score of 14. In this question only 14 or 46.6% of the women responded correctly. The low score on the third question may be understandable given the length of time that Mr. Trudeau had been in office and therefore, this question may have skewed the mental status results. However, 14 or 46.6% of the women had the maximum M.S.Q. score of three for each question, while 14 women or 46.6% had one question wrong or a M.S.Q. score of 2, and 4 women or 13.3% of the sample had M.S.Q. score of 1. Of these 4 women 3 did not know the day's date. One woman stated, 'it was too early, she had not seen the daily paper yet.' Only one woman did not know that Mr. Trudeau was the Prime Minister. She stated that she saw him often on T.V. but could not remember his name at the time. Nineteen or 63.3% of the women indicated that they never forgot the names of close relatives or friends. Of the 36.7% who indicated they were forgetful, most stated that they could recall the close relative or friends name quickly. Only one person stated that they needed to be reminded.

Eighteen or 63.3% of the sample stated that they saw the relative to whom they felt closest weekly or more often, and 23.3% saw that relative at least monthly. However, when asked if they would like to see that relative more often, 60% said no. The reasons given by the 40% who wished more

contact stated their adult children were too busy. These children who comprise the middle generation or 'sandwich generation' are caught between their own children's needs and their parent's needs. As well, with the reality of today's economy, both husband and wife are often working outside the home. This latter reason accounted for 26.7% of those persons who wished more family involvement. Other reasons for having insufficient contact indicated by the sample were a long distance to travel (6.7%) and the advanced age of the relative (3.3%). Two sample members stated that they did not know why there was not more contact.

The 'nearest' relative in distance as opposed to the 'closest' relative emotionally lived within the neighbourhood of 96.7% of the sample members. The one remaining sample member's relative lived less than a day's journey by land. Sixty percent of the sample had contact with their nearest relative at least once a week while another 23.3% saw them a few times a month and 10% less often than once a month.

3.3.2 Health Status

The majority of the sample (56.7%) indicated that in their opinion and compared to other people their age, their health was good. Five or 16.7% described their health as excellent while 7 or 23.3% indicated fair. One (3.3%)

person stated her health was poor. In comparing their health today with their health 5 years ago, 60% perceived their health today to be the same or improved from 5 years ago. The latter statement was indicated by six women. Forty percent or 12 persons thought their health was worse now.

All respondents had a regular doctor. Fifty-three point three percent of the sample had seen their doctor 2, 3, 4, and 5 times over the previous six months, while 5 women or 16.6% had seen him monthly. Ten percent of the respondents had not seen a physician for six months. Two women (6.7%) had seen him more than once a month, and one woman had seen him only once during the previous six months. No one reported any difficulty in obtaining appointments.

Sample members were asked to recall how many days over the last six months they had felt sick enough to remain in bed. Seventy percent stated none. Ten percent indicated 4 to 7 days, 6.7% indicated more than a week but less than a month, and 13.3% or 5 persons stated a month or more.

The sample perceived their health problems as relating to diseases of the circulatory system (63.3%) such as coronary artery disease and conjestive heart failure; musculoskeletal system (60%) such as arthritis; ill defined conditions (40%) such as weakness, frailty, fatigue; nervous system and sense organs (36.7%) such as poor eyesight and hearing; endocrine

system (16.7%) such as diabetes; mental health problems (13.3%) such as depression and anxiety; and the digestive system (13.3%) such as gastric ulcers. Diseases of the respiratory system and diseases of the skin and blood forming organs each were mentioned by 10% of the sample. Neoplasms were only indicated by 6.7% of the subjects. Infectious diseases and diseases of the genitourinary system were each indicated by one person. In total, 33.3% of the sample indicated they had four or more of the above health problems. Another 30% stated they had three health problems. Twenty-six point seven percent indicated at least two health problems. However, one person said she had no health problems, and one person indicated five problems.

Despite the number of health problems identified, 30% of the sample engaged in at least 7 activities on a regular basis, and 73% engaged in 5 or more to a maximum of 7 activities. The activity engaged in by most of the sample (66.7%) was watching T.V. or listening to the radio. Sixty-three point three percent visited with friends and relatives, and/or did handiwork such as knitting and crocheting. Sixty percent enjoyed walking, and 56.7% read to pass the time. Church, either in the building or in the locality, was attended by 43.3% of the sample. Organized passive indoor activities such as cards and bingo were engaged in by 43.3%. However, only 16.7% participated in active organized indoor activities such as carpet bowling.

Thirty-six point seven percent of the sample enjoyed travelling, 26.7% enjoyed gardening (indoors or outdoors) and 20% went to concerts, movies or dined out. Other active type activities including exercise classes, swimming, curling, and cross country skiing were participated in by 13.3% of the members. Educational classes were attended by 10% of the sample.

3.3.3 Supportive Assistance

Twenty-nine or 96.7% of the sample stated they had sufficient assistance. However, if more help was needed, 73.3% would call on their informal system with 66.7% stating that a child or other relative would assist them, while the remainder (6.6%) would call a friend. Twenty-six point seven percent indicated they would look to an agency for assistance. When asked what help they were receiving and who was providing the help, 53.3% were independent in all ADL. Conversely, 10% were house bound and could only go out if someone helped them. Family was indicated as helping with cleaning (20%), finances (20%), and shopping (30%).

The Home Care program provided assistance with home making in 16.7% of the sample and nursing service in 16.7%. Two women or 6.7% employed private cleaning ladies, and one woman (3.3%) had help from a neighbour to do the laundry. A formalized Meals on Wheels (MOW) program brought meals to two women or 6.7% of respondents. The women's diets were

perceived as adequate by 93.3% of the sample. Only one woman thought that her diet was not adequate. However, her comment was related to a poor appetite rather than the unavailability of an appropriate diet. She stated that, 'eating with company would help'.

When asked if sample members knew of any health services, 23.3% stated they knew of none. Additionally, 13.3% who stated they did not know of any services would seek such information from the apartment block caretaker/manager. Twenty-one or 73.3% knew of government organized services such as Home Care, and 76.7% knew of organized non-profit agencies/services like the Red Cross, Age and Opportunity, Community Home Services and MOW.

In regard to transportation to appointments, 43.3% of the sample used public transportation while 30% used taxis. Sixteen point seven percent relied on family and the remainder walked or drove themselves.

3.3.4 Summary

The activity of daily living data indicated the sample managed their activities of daily living with very little outside assistance. They were alert, oriented and had good memory recall. On the average, the sample was satisfied with the contact and support received from their middle aged children and understood the stresses placed upon this age

group. Sample members saw family as their main support in time of need even though most (76.7%) knew of other organized services.

Most sample members did not see their health as deteriorating over the last five years. However, all of the sample had physicians whom most of them saw approximately once a month. Nearly all the respondents perceived that they suffered from at least two chronic health conditions such as diseases associated with the circulatory and musculoskeletal systems. However, most of the sample (70%) indicated that they had not spent any days in bed during the last six month period due to illness but many complained of weakness, frailty and fatigue.

Sample members maintained an activity level of 7 stated activities. However, most of these activities were passive, isolating activities such as watching T.V., handicrafts, and reading. Other passive but socializing activities were visiting friends and relatives, attending church services, and organized indoor games. Most enjoyed walking out of doors when the weather permitted. The sample member's usual modes of travel were public transportation or taxis.

3.4 MOVING PATTERNS

The data gathered by the questionnaire captured the moving patterns of the sample including variables regarding who the respondent lived with, where she lived, how long she had lived there, how the present E.P.H. was chosen, the reason for moving, and what type of housing arrangement was preferred by the respondent.

3.4.1 Past Living Arrangements

Although the sample consisted totally of women living alone in E.P.H., only 50% of the sample had lived alone prior to this move. Thirty percent had lived with a spouse. Another 10% lived with relatives and 10% lived with a friend or significant other. The range of years alone for 26 women or 86.7% of the sample who were widowed, divorced or separated was from 2 to 47 years. Twenty-one women (70%) were widowed. Five women had been widowed within two years of the move. Four or 13.3% of the sample were single.

Sixty percent of the sample had help in selecting the apartment complex. Forty percent were helped by a child or relative, 10% were helped by a friend and 6.7% by an agency. The wait for the apartment was less than six months for 73.3% of the sample, which in the respondents' opinions was not a long wait. Twenty percent waited from 6 months to a year and one person each waited 1 to 2 years and over 3

years. Ninety-three point three percent of the sample received assistance to move to their new apartment: 53.3% from a child, 36.7% from another relative, and 3.3% from a friend.

3.4.2 Reasons for Moving

The data gathered regarding the respondent's reasons for relocating were grouped and categorized under six headings. These were:

1. Independence, which meant that the woman was able to manage her own affairs in the community without support or with the least amount of support possible. This category was further divided into two sub-categories indicating those women who had moved within the city and those who had relocated from a rural area.
2. Finances, which meant moving to more affordable accommodation. This category was further subdivided into those women who found E.P.H., now that they were old enough to qualify, a cheap housing alternative and those women who indicated finances to be a problem due to a sudden reduction in income after the death of a spouse or companion.
3. Poor health, which related to the respondent's perceived deterioration of their health and subsequent inability to continue their previous living arrangements.

4. Physical safety, which referred to those women who felt vulnerable in their old neighbourhoods and were afraid to remain there alone.
5. Companionship, which referred to those women who wished to live in an environment with age peers.
6. Dissatisfaction, which was defined as a situation where the interpersonal relationship had deteriorated resulting in the termination of the pervious living arrangements.

Two or more reasons for moving were indicated by 22 or 73.4% of the respondents. Fifteen women or 50% of the sample mentioned two reasons for moving with an additional 7 or 23.3% indicating three reasons for relocating. Table 7, illustrates the respondents' categorized reasons for moving. The ability to remain independent was mentioned by 73.2% of the sample. Of that 73.2%, one-half or 36.6%, moved from a rural setting to the urban setting to facilitate their independence. Forty-six point six percent moved because of finances. However, 30% indicated that finances were a problem due to loss of income after the death of a spouse or companion. Five women or 16.6% stated the rent was cheap; as one lady stated, "It was the best deal in town". Poor health or diminished health functioning was mentioned by 40% of the sample. Sixteen point six percent gave improved physical safety as a reason, and another 16.6% indicated that they desired to be with peers. One person had moved

TABLE 7

Reasons for Relocating among the Respondents

Reason	Sample No.	Percent
Independence	n=22	73.2%
(in city)	(n=11)	(36.6%)
(rural)	(n=11)	(36.6%)
Finances	n=14	46.6%
(cheap)	(n=05)	(16.6%)
(reduction)	(n=09)	(30.0%)
Poor Health	n=12	40.0%
Safety	n=05	16.6%
Companionship	n=05	16.6%
Dissatisfaction	n=01	3.3%

because of disagreeable interpersonal relationships in her previous household. For reasons of confidentiality, this subject, although calculated in the statistical analysis, will not be identified in the documented results or tables.

In general, the young-old (aged 60 to 74) years indicated more reasons for moving than the old-old (aged 75 and older). The mean for the young-old sample group was 2.06 reasons whereas, the mean for the old-old sample was 1.86 reasons.

Differences for reasons in moving by age category are illustrated in Table 8. This table is the result of

applying the chi-square statistic to each class of reasons identified by the sample members. There were no significant differences between the young-old and the old-old age groups as to whether a specific reason for relocating was mentioned or not mentioned by the respondents. However, some comparisons between the young-old and the old-old age group's ranking of their reasons for moving are worth indicating as seen in Table 8.

Both the young-old and the old-old groups indicated their primary reason for moving was to maintain independence. In the old-old group this reason was mostly related to moving within the city, while more of the young-old age group relocated from a rural area into the city. Secondly, finances was given more frequently as a reason by the young-old which was due mostly to a sudden loss in income resulting from the death of a spouse or companion. For the old-old age group, poor health was ranked second compared to being ranked third by the young-old age group. The old-old group ranked finances and a desire to be with peers equally. Safety was ranked fourth by both age groups. One person in the young-old group mentioned a desire to be with peers.

TABLE 8

Reasons for Moving among the Age Grouping

Reasons	Young-old	Old-old
Independence	12 (40.0%)*	10 (33.3%)
	x^2=0.049 df=1	p=0.8253
(in city)	05 (16.6%)	06 (20.0%)
	x^2=0.433 df=1	p=0.5104
(rural)	07 (23.3%)	04 (13.3%)
	x^2=0.741 df=1	p=0.3894
Finances	10 (33.3%)	04 (13.3%)
	x^2=3.453 df=1	p=0.0831
(cheap)	04 (13.3%)	01 (3.3%)
	x^2=1.714 df=1	p=0.1804
(reduction)	06 (20.0%)	03 (10.0%)
	x^2=0.918 df=1	p=0.3379
Poor Health	06 (20.0%)	06 (20.0%)
	x^2=0.089 df=1	p=0.7651
Safety	04 (12.2%)	01 (3.8%)
	x^2=1.714 df=1	p=0.1904
Companionship	01 (3.3%)	04 (13.3%)
	x^2=2.678 df=1	p=0.1017

*column number and percent

Differences in reasons for moving by applying chi-square to the young-old age group by the housing categories are illustrated in Table 9. Again, there were no significant differences among the public, non-profit and profit housing

groups as to whether a specific reason for their relocation was mentioned or not mentioned by the subjects. However, the ranking of the reasons by each housing group does illustrate some variations as noted in Table 9.

The respondents in public housing gave as their major reason for moving a wish to maintain their independence with most of the women moving within the city. Secondly, this group indicated finances was the motivating factor followed by poor health, safety, and lastly a desire to be with peers. The young-old, non-profit housing group also ranked a desire to maintain their independence first with all but one person moving from a rural area to the urban center. Poor health and finances were equally rated as their second reason. Lastly, physical safety was mentioned by one person. The primary reason given by the respondents for moving changed in the young-old profit housing group who stated their major reason was finances which was mostly due to a sudden loss of income. Secondly, this group wished to maintain their independence either by moving from a rural area or within the city. Lastly, safety was mentioned by one person.

The reasons for relocating given by the old-old age group within each housing type is illustrated by the chi-square results in Table 10. The results for this category showed no significant differences stated by the respondents among the old-old public, non-profit and profit housing groups as

TABLE 9

Reasons for Moving among the Young-old Respondents by Housing Category

Reasons	Public	Non-profit	Profit
Independence	05 (31.2%)*	05 (31.2%)	02 (12.5%)
	x^2=2.444	df=2	p=0.2946
(in city)	03 (18.7%)	01 (8.2%)	01 (16.2%)
	x^2=0.446	df=2	p=0.8001
(rural)	02 (12.5%))	04 (25.0%)	01 (16.2%)
	x^2=3.945	df=2	p=0.1391
Finances	04 (25.0%))	03 (18.7%)	03 (18.7%)
	x^2=2.347	df=2	p=0.1093
(cheap)	02 (12.5%)	01 (6.2%)	01 (6.2%)
	x^2=0.178	df=2	p=0.9148
(reduction)	02 (12.5%)	02 (12.5%)	02 (12.5%)
	x^2=1.636	df=2	p=0.4414
Poor Health	03 (18.7%)	03 (18.7%)	00 (0.0%)
	x^2=2.880	df=2	p=0.2368
Safety	02 (12.5%)	01 (6.2%)	01 (6.2%)
	x^2=0.178	df=2	p=0.9149
Companionship	01 (6.2%)	00 (0.0%)	00 (0.0%)
	x^2=1.067	df=2	p=0.5886

*column number and percent

to whether a specific reason was mentioned or not mentioned. As with Tables 8 & 9, there are some differences in the way

the old-old housing group sample members ranked their reasons for moving.

Firstly, the old-old public housing group ranked maintaining their independence as a reason for moving with nearly all relocating within the city. Secondly, poor health and a desire to be with peers were ranked equally. Finances was only mentioned by one of the members which was due to a sudden loss of income. In the non-profit old-old housing sample, maintaining independence was ranked first with most respondents moving from a rural to an urban setting. Poor health was ranked second, followed by financial reasons either because of a need for cheaper accommodation or a sudden loss of income. However, the greatest difference in ranking is seen in the old-old profit housing group. The desire to be with peers was ranked first as this groups major reason for relocating. To maintain independance, finances (due to sudden loss of income), safety and poor health each were equally rated second. No respondents moved from a rural area.

The respondents were asked how and where they would like to live. Eighty-six point seven percent stated that their desire was to live alone. Only 6.7% indicated they would like to live with relatives, and another 6.7% stated they would prefer to reside with their peers. Eighty percent stated they would prefer to live in an apartment while 16.7% stated they would prefer their own house. One respondent

TABLE 10

Reasons for Moving among the Old-old Respondents by Housing Category

Reasons	Public	Non-profit	Profit
Independence	05 (35.0%)*	04 (28.5%)	01 (7.1%)
	x^2=2.630	df=2	p=0.2554
(in city)	04 (28.5%)	01 (7.1%)	01 (7.1%)
	x^2=2.567	df=2	p=0.2771
(rural)	01 (7.1%)	03 (21.4%)	00 (0.0%)
	x^2=4.037	df=2	p=0.1329
Finances	01 (7.1%)	02 (14.2%)	01 (7.1%)
	x^2=0.770	df=2	p=0.6805
(cheap)	00 (0.0%)	01 (7.1%)	00 (0.0%)
	x^2=1.938	df=2	p=0.3794
(reduction)	01 (7.1%)	01 (7.1%)	01 (7.1%)
	x^2=0.339	df=2	p=0.8439
Poor Health	02 (14.2%)	03 (21.4%)	01 (7.1%)
	x^2=0.933	df=2	p=0.5271
Safety	00 (0.0%)	00 (0.0%)	01 (7.1%)
	x^2=3.949	df=2	p=0.1389
Companionship	02 (14.2%)	00 (0.0%)	02 (14.2%)
	x^2=4.200	df=2	p=0.1225

*column number and percent

mentioned a preference to live in a child's house. Within the total sample, 76.6% indicated they liked to spend time with people of all ages, and 20% indicated a preference to be with peers.

3.4.3 Summary

One half of the sample had lived with a spouse, companion or other relative prior to the move and many had been widowed within the last two years. Children, relatives or friends helped most of the sample choose their new apartment for which the average six month waiting period was not considered long. In general, the young-old group gave more reasons than the old-old group for moving. However, most of the women stated two or more reasons with the primary reason being a desire to maintain their independence. For over one-third of the sample, the wish to remain independent meant relocating from a rural setting in order to be closer to resources and services. Finances were mentioned by nearly half of the women which was mostly a result of a sudden loss of household income. Only two fifths of the sample indicated their decreasing health status as a predisposing factor and few stated a need for physical safety.

Within public housing most of the young-old and the old-old age groups moved within the city to maintain their independence. However, the second reason given by the young-old age group was to gain cheaper accommodation while for the old-old the second most important reason was poor health or gaining peer companionship. Physical safety was a decision-making factor for only the young-old age group.

The non-profit housing young-old and old-old age groups moved to the city from rural areas to maintain their independence. Secondly, the old-old age group moved because of poor health while the young-old age group stated finances, which was mostly related to a sudden loss of income. Physical safety was only mentioned by the young-old age group.

The profit housing young-old age group relocated because of a sudden loss of household income whereas, the old-old age group moved for companionship. To maintain independence was a secondary reason for both the young-old and the old-old groupings. One-half of the young-old group moved within the city whereas, all the old-old group did. Safety was a concern for both age groups and poor health was only mentioned by the old-old age group.

In general, nearly all the women liked to spend time with people of all ages and wished to live alone in an apartment near relatives who were perceived as supportive to them. Indeed, most of the women in the sample saw a supportive relative once a week or more often.

Chapter IV

DISCUSSION

4.1 DEMOGRAPHIC DATA

The female/male ratio in the population 60 years has been increasing. This ratio is even greater in the advanced years of 80 and over. Therefore the sample for the study consisted of women only. Statistics Canada (June 1982) reported that since 1961 women have been the more predominant of the two sexes in the population 65 years and over. This ratio is predicted to increase so that by the year 2001 there will be approximately 150 females to every 100 males aged 65 years and over; 200 females to every 100 males aged 75 and over, and 219 females to every 100 males aged 80 years and older.

In addition, many of this seemingly vulnerable group of women from 65 to 80 years of age are living alone. In 1961, Statistics Canada (June 1982) reported that the 15% of women over 65 years were living alone. This percentage had more than doubled to 33% by 1976. This percentage remained constant in the 1981 census (Canada, April 1984) with 32.4% of the women over the age of 65 years living alone. A further age breakdown in the 1981 census reported 25.5% of

women over age 85 living alone. This age pattern was observed in the sample for the mean age (73.9 years) fell within the young-old age category. An Ontario study by Connidis & Remple (1982) of 400 community dwelling people over aged 65 years found that 48.1% of the women in their study lived alone, whereas only 13% of the men did. They also reported that over one-third of their subjects lived in apartments with the majority (80.4%) residing in high-rise buildings. This finding differs from this sample in that 50% of all the apartment dwellers resided in high-rise complexes. This difference may, in part, be due to the gender of the Ontario sample which included men. Another factor in the Ontario sample was that two-thirds of the sample maintained their own home and "men were significantly more likely than women to own their own homes and to live in houses" (Connidis & Remple, 1982:93). They concluded that sex differences in home ownership suggested men live in more stable environments than women.

Further, in relation to the Winnipeg sample's relative youngness, it may be reasonable to assume that with advancing age (85 years and older) more care may be required and living alone may no longer be a feasible alternative. Thus more women of this age may be living in institutions. In fact, the Statistics Canada (June 1982) 1981 census tract indicated 36.6% of women 85 years and over resided in nursing homes compared to 8.5% of women 65 years and older.

Of note in the study findings is the economic implications of elderly women living alone. The least number of women (20%) lived in a profit or a commercial complex which charge the market rate but also offer more comfort, such as a bedroom. The majority of the sample (46.6%) opted for subsidized public or non-profit (33.3%) housing and in most instances bachelor accommodation (60%). Widowhood according to Connidis & Remple (1982) is associated with a reduced income and may force women to move to areas quite different from what they are accustomed to. In addition, ownership decreases with female widowhood whereas with widowed men home ownership remains fairly constant. Connidis and Remple (1982) concluded that home ownership is a women's issue and that the unique life experiences of women account for this difference, not the marital status per se.

The study data indicated 86.7% of the present sample had at one time been married while 13.3% remained single. Further, 70% were widowed with the remainder being separated or divorced. However, Statistics Canada (1984) reported 9% of the female population aged 65 years and over was single and 2% divorced. Some of this difference may be due to the age of this study's sample beginning at 60 years rather than 65 years.

The mean years alone of the elderly women in the sample was 14.4 years. Of interest is the difference in the mean

years alone of the old-old group in profit housing (5.6 years) compared to the mean years alone (20.8 years) in public housing. This difference may possibly be explained by the decreased earning capacity of women, spread over many years. The longer a women is alone, either through separation, divorce or widowhood, probably with the additional responsibility of single parenthood coupled with a decreased earning power (compared to men), the less likely she is to have financial resources other than her old aged pension for the retirement years. Whereas, women in the same age group, but alone for a shorter period of time, have benefited from the higher household income of their spouse and may have had a home, free of mortgage, to liquidate. The 1981 census (Supply & Services, 1984) reports that the major source of income for 74% of women over the age of 65 years is Old Age Security. Further, only 5% of women, compared to 13% of men, in the census data, ranked retirement and other income as their second highest income source "reflecting differences in labour force participation during the working lifetime of these people"(Supply & Services, 1984:16).

Moreover, Brock (1984) study of the United States population age 65 and over stated widowhood is a likely consequence of marriage for 79% of women compared to 39% of men. In the United States widows are the poorest segment of the population with little chance (2:100) of remarrying

after the age of 65 years. In her sample the mean length of time widowed was 7.17 years. It is a well documented fact that the older women become, the fewer men there are proportionately in the population. This sex ratio difference of men per 1,000 women has decreased (Supply & Services 1984) from 1,050 in 1901 to 749 in 1981.

4.2 HOUSING ENVIRONMENT

Of interest is the change in life style required by nearly one-half (46.7%) of the sample population associated with their move from a single detached home to a public high-rise apartment complex. A Central Mortgage and Housing Corporation report (1975) stated that high-rise apartment buildings are planned to reduce the cost per unit when built on premium urban land even though it may not be the choice of elderly people accustomed to living at ground levels with easy access to the street. The Corporation further recognized that "most dwelling units designed for the elderly are smaller in space and have fewer rooms than traditional residential accommodation.....elderly singles are usually housed in bachelor units with bed-alcoves" (Central Mortgage and Housing Corporation, 1975:26). This report further stated that with increasing longevity and a lowering of age eligibility (now 55 years) occupancy may run up to 30 years. Therefore, it is "probable that dissatisfaction with bed-alcove units will increase with

such a long period" (Central Mortgage and Housing Corporation, 1975:26). However, in Winnipeg over the past nine years bachelor type apartment housing for the elderly continues to be built. Connidis and Remple (1982) suggested that as an individual's resources and life space shrink in old age, their living environment becomes more important to their feeling of well-being. Lawton (1983) further reported that living in a high-rise building is associated with less travel outside the housing environment. The vertical distance is a barrier to fully integrating into the local neighbourhood.

Although 40% of the sample relocated within their previous neighbourhood, 36.6% moved from a rural setting to the urban setting requiring an additional adjustment in life style and most probably additional stress. Rural elderly persons (Strain & Chappell, 1980) seemed to be involved in larger social networks including community activities and expressed greater general happiness when compared to their urban counterparts. Scheidt (1984) reported his findings derived from a sample of 990 elderly rural residents in 18 small towns in the United States. He found the majority (87%) resided in single-family housing and that their increased social contacts and their involvement with the community at large improved their physical and mental health status. Thus, for the Winnipeg respondents the move to the city by elderly people may result in fewer social and

community activities, a decrease in their feelings of general happiness, followed by a decrease in their mental and physical health status. Added to this may be a further decrease in community involvement associated with high-rise apartment dwelling.

However, of the total Winnipeg sample, 50% stated they were satisfied with their new accommodation. This may be a genuinely truthful statement of how these elderly women felt, or it may be a statement rationalizing the situation into which they have been forced. Lawton (1983) reported that some elderly persons accept their poor situation by making positive statements about it which may psychologically help them deal with the situation. Examples from this study of positive psychological statements may be one woman who stated that there were 'only bachelor suites' and another woman who indicated that 'a bedroom would be nice'. Neither of these women seemed distraught but were resigned to the smaller space. Other respondents indicated there were long waiting lists for one bedroom suites, indicating a high demand for a limited resource.

Those persons who did express dissatisfaction indicated physical aspects such as ventilation, heating, lighting, storage, limited space, and cooking and laundry facilities. Gutman's (1980) longitudinal study of elderly people in British Columbia reported that the amount of space within the apartment, even if it was a bachelor design, was

important. She found that satisfaction dropped proportionately with the amount of space (square footage) available within the suite and continued to drop over time. The longer the elderly person was in the small suite, the more dissatisfied he/she became. If this is so, then dissatisfaction expressed at the beginning of the tenancy may become a major issue as time goes on. Comments from some respondents suggested they had decided to move to a smaller apartment with less personal space because, they rationalized, more space would cost more. Another lady indicated a need for more space but then supported her decision by stating the need for more space was 'silly, I don't need it'. However she 'had to get rid of an antique bed'. The bed was obviously important to her.

In regard to cooking facilities, comments made by the respondents indicated that cupboards were too high. Gutman (1980) also reported this finding. Other respondents indicated the kitchen heated up to an uncomfortable level because it was small with no ventilation. One lady stated she kept 'banging her elbows' because of the cramped space. Another indicated a fan in the kitchen would improve the ventilation.

Those individuals who mentioned dissatisfaction with other physical conditions of their new apartments were few. One lady found the heating to be unstable either 'too hot or too cold with no happy medium'. One lady stated she was too

weak to open the windows when she wished to. Another lady in an older complex was distraught because the laundry facilities were in another building which hampered her ability to do her laundry in the winter. As well, she felt the general state of repair of the complex was poor. Many stated that air conditioning was an item that should be provided just as heat is. Many elderly people find our hot summers as distressing as our cold winters. In Manitoba, there is an increasing number of people installing air conditioning into their homes and most apartment blocks provide units in each suite. The Central Mortgage and Housing report(1975) recognized this as a need and stated:

> small apartment units tend to be uncomfortablely hot during extremes of summer temperatures, and consequently can be the cause of great discomfort to old people....It would seem rational to incorporate a capacity for a future air cooling system (Central Mortgage and Housing Corporation, 1975:21).

The sample's response in relation to the resources in their old neighbourhood was somewhat surprising with nearly one-quarter of the sample stating no additional resources could be made available to them. This response is undoubtedly related to the rural-urban migration. These respondents felt their previous rural location was too isolated for additional services to be available. There did not seem to be any question in their minds that more resources or more alternatives were available to them only in a larger urban center. People who moved within the urban

area felt that improved public transportation and more formal supports would have been an asset to them.

However, a little over one-half of the sample (56.7%) were not aware of formal supports in their new neighbourhood. A large percentage (86.7%) stated they would use a formal support if they perceived the need to do so. Many indicated that should the need arise, their family, a friend or the caretaker/manager of the block would put them in touch with the appropriate agency/resource. The formal supports known to the sample respondents were: VON (they had seen the nurse in the building), Home Care (someone they knew had a homemaker), and Age and Opportunity Center (many had had personal contact with the agency).

The need to improve public transportation was cited as an issue for many in their new location. This was especially a problem for the people located in the suburbs. Bus service is geared for working people. Services on Sundays and holidays are limited when the elderly person is wanting to travel to church or to visit friends and family. This necessitates relying on others to pick them up which many elderly people feel is an imposition and so they choose to stay at home. One lady stated she must take a taxi downtown at a cost of $11.30 one way. Even her local shopping center was 'three long blocks away'. Further, in some areas the bus stop was one to two blocks away from the E.P.H. which increased isolation in the winter. One lady indicated the bus step was too high for elderly people to negotiate.

Conversely, some persons who resided in E.P.H. located in the city center and on major traffic routes found the noise from the street very taxing. During a five o'clock interview it was necessary to stop and wait for traffic noise to subside as the woman could not distinguish the questions from the background traffic noise. This woman also complained about the smell of car fumes coming through her open window.

Gutman (1983) stated that her sample supported the recommendation that any new sites for E.P.H.'s should consider the importance of easy public transportation and downtown amenities. She found that if there was a trade off between a high-rise in a good location close to public transportation and community services, and a low-rise in a poor location, the high-rise would be preferred. This preference was supported by one woman in the current sample who indicated her new home was too far out, but she quickly added the distance didn't really make any difference because she couldn't walk anyway. She therefore was totally confined to her apartment block. Another respondent expressed concern about the local supermarket (one block away) which would be closing within the next month. This would mean a bus trip of some distance to the next supermarket or relying on friends and relatives to take her shopping.

An additional concern for many were the long distances to postal outlets. Mail delivery was no problem as mail boxes were in the building. However, some shut-ins relied on the post man, 'out of the goodness of his heart' to take and mail letters. Alternately, family, friends, visitors and service providers were asked to do this. One lady indicated she usually asked the nurse who came weekly, but felt that this was an inappropriate request. She stated that some would and some would not mail her letters.

In general, the new home was seen as far superior to the old one in that resources and services were more readily available and attainable. The physical layout and the space was seen as adequate and most everyone enjoyed the socializing and activities associated with living in an E.P.H.. One woman stated 'she could be busy every night'. The older complexes had less of the organized social activities leaving the residents to informal arrangements. However, this was difficult as some of the older complexes did not have common rooms for activities. One lady expressed her feelings of forced isolation.

Some of the newer complexes are putting carpets on the floors which for some people may pose a mobility problem if confined to a wheelchair. One lady worked very hard to upgrade her ambulation to using a walker which then allowed her access to the block. She felt strongly that floors should be all tiled and residents could provide their our carpeting if they desired.

Outdoor activities were not as plentiful or as well organized as indoor ones. Many of the sample felt they would like more green space available to them. This is another issue when considering the seemingly desirable location of the 'down-town' urban E.P.H..

4.3 ACTIVITIES OF DAILY LIVING

All sample members were alert with respect to day, place and time. For nearly two-thirds (60%) of the sample their psychological well-being, as related to desired contact with the person perceived as most important to them, was viewed as adequate. For many of the women, the person they felt closest to, was also the relative to whom they lived closest (in distance). This relative, was most often the person providing any assistance required by the elderly woman. Thus many women from rural and urban settings choose E.P.H.'s near to this emotionally supportive person. However, some of the women, who indicated a desire for more contact also lived in close proximity to that significant person. These women expressed an understanding of the dynamics of the middle aged generation with growing families and working parents. One woman stated 'they are good to me. I don't want to bother them'. Only two women in the sample expressed concern that the 'special' family member was not seen as often as they would like and one was unable to explain why.

In addition, most (73.4%) of the sample perceived their health to be at least good. Sixty percent stated it was the same as it was five years ago. Thus the contact with physicians would seem high as 59.9% of the sample saw their physician at least once every two months with 16% visiting their physician monthly. One might question the necessity for all these visits to take place in the physician's office, or whether some of the on-going follow up could be done through a health clinic with referal to the physician when clinical instability was detected. Snider's (1980) study on the use of health services by the elderly referred to the need to consider factors that inhibited the use of health service outside the physician's office. His study found that "awareness of health services is more central to the issue of health service use than measures of health status and/or income" (Snider, 1980:1181). Further, he found that health service awareness increased for elderly reporting poor or fair health status compared to the respondents who rated their health status as good or excellent. This factor supports the findings evident in this study. Additional data by Snider (1980) indicated that enabling factors such as income, education, access to facilitating services and the use of ancillary health services are more likely to result in efficient use of health services than are predisposing factors such as; a poor self-rated health status, increasing age, the female sex and urban residence.

Snider (1981) hypothesized that health service needs increase for the old-old (75 plus) compared to the young-old (65-75) indicating this is partly due to the higher number of widowed females who use more health services than do males. However, his study failed to support that hypothesis on an absolute basis. Similarly, Roos, Shapiro & Roos (1984) suggested hospital usage increases with age and those 85 years and older consume ten times as many hospital days as persons under 60 years of age, whereas, 70 year olds consume only three times as much. However, "the great majority of elderly, even the very elderly, are healthy and infrequently are hospitalized" (Roos, Shapiro & Roos, 1984:31). Therefore, they concluded that a small group of elderly persons account for a high proportion of use of health services such as hospital and nursing homes.

Although, a high percentage of the sample rated their health as good or excellent, 60% of the sample listed at least three major health problems and 30% indicated four. Not surprisingly, these health problems were related to chronic conditions such as diseases of the circulatory system, arthritis, sense organs such as decreased hearing and vision, and general weakness and fatigue of unknown origin. Of importance here is the functional limitations resulting from these chronic conditions. For the most part these women were independent in their activities of daily living. In fact, 53.3% of the sample was totally

independent requiring no assistance whatsoever. Those requiring help received minimal assistance and retained a high degree of independence with 70% of the sample stating they had not spent time in bed over the past six months due to illness. In addition, sample members retained a fairly high level of activity with many participating in seven different activities. However, this may be partially explained by the sample's relative "youth" (mean age 73 years).

The types of recreational activities engaged in are notable. Many were passive and isolating in nature, keeping the respondent within their apartment. Very few of the respondents engaged in some physical exercise that would be of a health promotional or 'participaction' nature. Although, 60% of the sample stated that they enjoyed walking, this was not a regularly planned activity and participation very much depended on good weather conditions.

Family was an important support system to the sample. Although 90% of the sample stated they had sufficient assistance, 16.7% indicated if more assistance was required they would seek out family members to provide it. Of the 46.7% who were receiving assistance at the time of the interview, family helped with cleaning (20%), finances (20%) and shopping (30%). Cantor's (1983) study in New York on informal support systems for the elderly found when the major caregiver was a child, they were mainly married women

with families. Within this group of caregivers she found a high percentage (60%) who were working. They tended to be middle-aged and live in a separate household from the parent resulting in a duplication of household activities. Cantor (1983) termed this a "generation in the middle with potential for considerable stress from situational as well as personal factors" (Cantor, 1983:559). This stress can in turn place strain on the parent/child relationship, especially if each has different expectations. Cantor (1983) indicated that there was a relationship between the closeness of the child/parent bond and the differences in expectations and realities between them. The differences were magnified the closer the kinship bond and the need for continuous involvement. The caregiver (child) tended to give up free time for them self, vacations, socializing with their own friends, leisure time pursuits and running their own homes to meet the extra demands.

Further, in today's society many of those caregivers may be single parent women with the additional stresses inherent in that situation. Thus, it is quite feasible for the 40 - 50 year old woman to be raising an adolescent family, working, running two households and providing care to an elderly parent. It is not surprising that some of these women feel they can not continue to help their elderly parent under any circumstances. Adult children with marital disruption (Cicirelli, 1983) showed less filial obligation

than their married cohorts. At some point the adult child may feel the cost of providing assistance is too great. For example, job responsibilities for the single parent is a major priority. Concurrently , elderly parents may avoid communicating their needs to their adult children to prevent over-burdening them.

A small percentage (16.7%) of the sample were receiving formal supports such as home making services and professional nursing services through the provincial Home Care Program while 73.3% of the sample were aware of such services. The relatively small numbers of elderly women in the sample requiring service is consistent with the fact (Roos, Shapiro & Roos, 1984) that most elderly persons are healthy and independent.

Public transportation was the most extensively (43.3%) used form of transportation by the sample. A large proportion (30%) of the elderly women could not manage public transportation because of their poor ambulation. In order to maintain some degree of independence and not 'bother' family members, they took taxis to appointments. This can be very expensive, especially for elderly women with limited incomes.

Worth noting is the small percentage (10%) who drove their own cars. Parking space is a problem with most E.P.H.'s, especially those built in or near the city center.

However, this problem will continue and increase as more and more women are learning to drive and will continue to drive into their elder years. For many the car symbolizes their independence providing them with a great deal of freedom. One lady was aghast that parking was only available on a limited basis. She had worked at two jobs so she could purchase a car. She had a difficult time comprehending the rationale of planners of E.P.H.'s who thought everyone over age 60 should take the bus rather than drive their own car. Central Mortgaging and Housing (1975) recommended that parking for E.P.H.'s in a downtown area with good access to public transport and parking lots be one space per six E.P.H. units. This parking was to serve residents, employees and visitors to the E.P.H..

4.4 MOVING PATTERNS

Once the decision to move was made and the application completed, the move followed quickly. For 73.3% of the sample the move took place within six months and was perceived as a short waiting period. The perception of short may indicate some vulnerability within the sample and perhaps some reluctance of the sample members to change their location. A six month wait for an apartment by a different age group would most likely be seen as a long waiting period.

The observation that 50% of the sample had lived with a spouse, companion or relative prior to the decision to move is consistent with the findings of Connidis and Remple (1982) and Chappell (1983) about informal support networks. The remaining 50% of the sample had lived alone prior to their move. However, 86.7% were widowed, separated or divorced and the remainder (13.3%) had never been married. Chappell's (1980) study of Adult Day Care (A.D.C.) participants found 54% were widowed while 13% were single, separated or divorced. She compared her figures with two Manitoba samples. An elderly Winnipeg sample of non-home care recipients living in the community reported 34% widowed and 12% single, separated or divorced while for Manitoba elderly community residents the figures were 10% single, separated or divorced and 32% widowed. These studies included both men and women in their samples which may account for the lower percentages in that more elderly men (National Health & Welfare, 1982) are married or remarry than elderly women. A Halifax study (Downe-Wamboldt & Melanson, 1982) of 889 elderly men and women residing in Senior Citizen's Public Housing found 59% of the sample widowed and 27% unmarried.

In this study as in Chappell's (1980) study, the persons widowed or alone had been alone for a varying number of years. However, of note in the current study is the small percentage (10%) who had been widowed for only two years.

This is a significant time frame for these women are extremely vulnerable. In fact according to Brock, "vulnerability to death is highest during the first two years following widowhood or widowerhood" (Brock, 1984:10). Moreover, she notes that death of a spouse is often immediately followed by many other life style changes causing stress which may result in illness (Brock, 1984).

Most subjects (73.3%) had at least two reasons for moving which indicated a decision making process. Almost two-thirds of the sample (60%) discussed the proposed move with their informal support system of child, family, relative or friend. This person actually helped them choose the apartment complex. On the average, the young-old group cited 2.06 reasons for moving compared to the old-old group who cited 1.85 reasons.

The most often cited reason for the relocation was to maintain independence as perceived by the subject. Statements such as, 'independence is priceless' and 'great desire to be independent' were stated by the sample members. Moving from a rural area with seemingly few resources to an urban area either closer to resources such as a larger medical center, or closer to family/relatives who would provide services if needed were seen by many as maintaining their independence. This desire, by the elderly, to be close to medical resources was identified by Gutman's (1983) Setton Villa subjects (69.4%) who moved into the retirement

housing because of a present or possible future need for medical help.

That the elderly population's perception of independence related to living alone but close to informal supports is evident in the sample. For example, one woman stated that if she moved in with her sister 'everything would be hers' and she 'would miss her own things...people get older and set in the way they do things'. Gutman's (1983) study supports this notion of independence. She found that 35.5% of her sample choose a particular building to be close to family while, actual moving in with the supportive family member was viewed as a loss of independence. Further, she found that 43.5% of the Setton Villa sample desired to be free from the responsibility of maintaining a home. In this study, the subjects who moved from the rural setting stated the move to an urban E.P.H. was precipitated by the amount of work required to maintain a country home and the isolation of the small rural community compounded by their inability to drive a car. The inability to drive was expressed by one woman as 'the biggest mistake I ever made, not to learn to drive'!

The sample also expressed poor health or a decrease in their functioning in activities of daily living as a major reason for relocating. However, often this was related to the inability to continue functioning in the previous location because of the physical nature or the location of

the accommodation. For example, one lady, whose health was very unstable, could no longer manage the stairs to the second floor bathroom. Another women who was living in the country did not have running water. In some other situations, the subjects had been a caregiver to a spouse, or relative until it became too much for them necessitating a change for both the caregiver and the care recipient. For some the change in location was precipitated by an acute illness requiring hospitalization. The decision to move to an E.P.H. was part of the hospital discharge plan with families making the necessary arrangements during the hospitalization. Gutman (1983) cited a change in health or physical strength by 33.9% of her Setton Villa residents and 33.3% of the New Vista residents. However, in Setton Villa 19.4% of the respondents indicated difficulty in looking after their previous residence compared to 8.3% in New Vista.

The third most frequently mentioned reason for moving was finances (46.7%), with 30% indicating a sudden reduction in income, either due to the death of a spouse or significant other who shared in the upkeep of the previous residence. One example is a subject whose role for many years had been that of nurse and companion to an elderly women in the latter's home. When the elderly women passed away, her family sold the home. Financial reasons for moving are supported by Gutman's (1983) study. Setton Villa residents

indicated financial reasons 19.4% of the time while, and New Vista residents mentioned cost in 58.3% of cases. In addition, the Setton Villa people moved because of the death of a spouse in 12.9% of the cases whereas the New Vista residents did not indicate death as a reason.

In general, the fourth most frequent reasons for moving were: desire to be with peers (16.6%) and perceived need for more security/protection (16.6%). One woman who had lived in an apartment block prior to relocating to the E.P.H. described her feelings of isolation during the daytime when everyone was working. She stated she wanted to be with people in similar circumstances as herself. Other women cited an increase in vandalism in their previous neighbourhood and a subsequent feeling of vulnerability due to age and being alone. These reasons are also supported by Gutman's (1983) study. The Setton Villa subjects cited a desire to be with peers 46.8% and New Vista 41.7%. Loneliness was indicated by Setton Villa group 27.4% and New Vista 16.7%. Dissatisfaction with the previous neighbourhood was indicated by Setton Villa (14.5%) and by New Vista (29.2%).

The ranking of the reasons given by the young-old and old-old groups, is an interesting observation. The old-old group (38.4%) desired to maintain their independence more often than the young-old group (36.3%). As well a higher percentage of the young-old (21.2%) compared to the old-old

(15.3%) moved from the rural to urban settings. Finances, which was indicated by 30.3% of the young-old group was much lower at 15.3% of the old-old group. Within both the groups, sudden loss of income was mentioned due to death of spouse, relative or significant other but in the young-old the move to E.P.H. also related equally to finances because the rent was cheaper. One lady in this category indicated her need to rebudget now that she was not working. Another lady indicated that now that she met the age requirements for E.P.H., these units offered her the nicest housing for her money. However, she felt that she did not really fit in with the other residents as they were so much older than she. She stated her 'friends wondered why she moved in with 75 and 80 years olds'. She therefore, 'just comes and goes' as she would in any other block. Others cited continually increasing rents in other apartment blocks as their reason to move into E.P.H..

As was expected, more of the old-old group (23%) cited poor health as a reason for relocating compared to the young-old group (18.1%). Security was a main reason for the young-old (12.1%) compared to the old-old group (3.8%). In addition to property vandalism, some of the sample cited personal experiences with purse snatchers. One incident was in the late afternoon and another late at night. The difference between the two groupings may be related to the young-old group's activity level which in turn may place

them in a more vulnerable position. Conversely, the desire to be with peers was mentioned by 15.3% of the old-old sample compared to 3% of the young-old group. This may further indicate the confinement or decreased activity level of the old-old group whereby, the young-old group are out of their homes making contact with other people.

In comparing the types of housing and the age groupings, some interesting differences in ranking are noted. In both age groupings in public and non-profit housing the desire to remain independent was ranked highest. However, in the young-old group, the desire to be independent was highest within the non-profit housing group (41.6%) with most (33.3%) moving from rural areas. Whereas, in the old-old group the desire to remain independent was ranked highest (50%) by subjects in the public housing category with only 10% moving from rural areas. This may suggest that the old-old group, living in the urban area found finances more of a problem than the young-old living in rural settings and therefore, moved into public subsidized E.P.H.. However, in the young-old public housing group there were also fewer persons moving from rural areas in order to maintain their independence. Conversely, in the old-old (30%) and the young-old (33.3%) non-profit housing groups most respondents moved from rural to urban settings. Therefore, not only do more of the rural dwellers move into non-profit housing for economic reasons, but possibly also because of the ethnic or

religious affiliation of these facilities. This type of housing is probably more widely known to rural people than profit or public housing. Further, the similarities of ethnicity and religion may be viewed as decreasing the stress of the move. Conversely, if a suitable ethnic E.P.H. had been available in the rural area, the move to the city may not have been necessary.

The young-old in profit housing indicated finances (50%) as their major reason with most (33.3%) related to a sudden loss of income due to sudden death of a spouse/significant other. It would seem that these women had assets to liquidate (eg. house) even though gross income was reduced by the loss.

The young-old public housing group (26.7%) indicated finances as their second reason with the majority (20%) stating cheaper rent as the precipitating factor. In the non-profit group finances was mentioned second by 25% of the sample but the major reason was due to loss of income (16.7%). As may be expected, the old-old public housing group cited poor health (20%). However, a desire to be with peers was cited equally (20%) by this group. In the old-old non-profit housing group, poor health (30%) was the second reason for moving, followed by finances (20%). Whereas, the young-old public housing gave poor health (20%) as their third reason and the non-profit housing group ranked poor health (25%) equally with finances (25%). Therefore, the pattern changed in the old-old public and non-profit group

with the former ranking a desire to be with peers equal to poor health (20%) while the latter ranked finances third.

In the old-old profit housing group, the major reason stated for moving by the sample was to be with peers (33.3%) which again may speak to increased isolation due to decreased activity levels. In this group the remaining reasons were evenly distributed (16.7%). In the young-old profit housing group independence ranked second (33.3%) evenly split (16.6%) between a move from rural Manitoba and the need to remain independent. However, in this category security was ranked third (16.7%) which again may speak to the vulnerability felt by this younger group.

In this study the subjects in nearly all cases (76.6%) indicated they liked to spend time with people of all ages. This may account for the small percentage of subjects who gave the reason for moving into E.P.H. as a desire to be with peers. Continuity theory (Zyl, 1979) suggested that an individual develops habits and preferences which become part of his personality and as he/she grows older attempts are made to maintain this continuity. Thus, in the elderly a strong desire to maintain independence, a perceived failing of health and ability, and poor finances may take priority over a desire to remain in a living environment with people of all ages. The sample's desire for independence is further supported by 86.7% who wished to live alone. However, the reality of this desire to maintain independence

given their health and financial problems have most probably culminated in the acknowledgement by 80% of the sample that apartment dwelling is now the best alternative for them. One woman, who was suffering from three chronic health conditions stated she 'did not want to live with her children' but that she 'wanted to maintain her own life'. Her children did her shopping and finances. Another lady with arthritis stated that she wanted to live alone, not with a relative as she would miss her own things. However, she could no longer manage her own home.

Another important support available but yet allowing for the subject's maximum independence is the nearness of family. Persons willing to provide care (Hill, 1984) for an elderly relative are decreasing in numbers due to decreasing fertility rates combined with an increasing number of women entering the labour force. This dwindling pool of available care providing resources comes at a time when the elderly population is growing. However, in 96.7% of the sample relatives lived within the neighbourhood and with 83.3% of the sample contact with that support system was several times a month. Families who choose the role of caregiver require supports (Hill, 1984) geared to meet their physical and emotional needs if prolonged care is to be sustained.

Chapter V

CONCLUSIONS

5.1 SUMMARY

The study was designed to look specifically at the needs of elderly women in relation to the important decision of where to live. Today, issues regarding women are gaining attention and are being discussed openly. Equality and the changing male/female roles within families are almost common place in social conversation. However, women 60 years and older come from a different generation. The woman's movement had not gained the momentum in their young adult years that it has today. Many of the women of that era were raised in traditional families, married and themselves raised traditional families. They were the wife and mother of someone, cared for and housed by the 'bread winner' and 'head of the household', their husband. It may not have been necessary for them to be independent, to be financially wise, nor to make the major decisions about their environment.

Thus, the women from this traditional background are now alone and in the position of having to make these decisions. By the very nature of the E.P.H., persons moving into this

type of accommodation must be able to manage their activities of daily living either without assistance or with minimal assistance. The assistance can be from an informal or formal network but, in Manitoba, when the daily functioning of an individual becomes too great a burden for the combined support systems, institutionalization such as nursing home residence is sought. This fact most probably accounted for the age distribution found in the study sample whereby the mean age of the sample fell in the young-old category. In addition, there were few members (6.6%) in the sample over 85 years.

Generally people in their advanced years will suffer more from failing health, therefore requiring an increase in assistance. Further, this older age group is becoming an increasing segment of our population and is comprised mostly of women. The growth rate of the Canadian elderly population (Supply & Services, 1984) in 1981 out paced other Canadian age groups. In the last decade (1971 to 1981) the census data revealed that the age (65 plus) increased by 35% compared to a 13% increase in the total population and a 14% decrease in children (0 to 14 years). Further, within the elderly population the sex ratio of females to males in 1971 was 8.1% and 9.7% in 1981. The Manitoba 1996 population projections of the very elderly, based on the 1981 census (Supply & Services, 1984) are 32.0 thousands or an increase of 28.5% in the 75 to 79 year group; 23.1 thousands or 50%

increase in the 80 to 89 year olds; 11.7 thousands or 50% increase in the 85 to 89 year old group and 5.1 thousands or an increase of 24.4% in the 90 years plus group. The total population increase by 1996 is estimated to be 7.6%. In 1996, the projected life expectancy for males is 74.9 years and for females 81.5 years.

The issues associated with a population aging are broad such as income security, retirement age, transportation, housing and social welfare. All segments of society will be affected. for example, as the age of the consumer, the 'Pepsie Generation' grows older business advertizing will be altered to capture this older market. Further, based on the elderly population projections for 1996, the sample moving into E.P.H. today will most likely continue to remain in E.P.H. as a healthier but frailer population. Support for this trend would be encouraged by the health system which over the past decade has focused on deinstitutionalization. However, what of the women aged 50 years today? What choices will they have at age 60 or 65 years? These women will most likely be alone as the female/male ratio spread increases. Will they be better equiped economically, and psychologically to make decisions relative to their future? Will limited finances and years of traditional life styles limit their alternatives?

One of the research questions asked at the onset of this study was whether or not the elderly female just moving into

an E.P.H. was aware of programs/services in her old neighbourhood that may have altered her decision to move. The unanimous response to this question was that there were none. However, formal support programs are available throughout the province such as the Home Care Program which will provide supports to remain at home. As well, community groups funded by government have the capacity to organize and provide services to meet the particular needs of a given community.

However, the sample respondents could not answer the question of what programs/services would need to be developed in the community to prevent the relocation as they could see no mechanism for alternatives. At the point of the interview, the decision to relocate had already been made and in the respondents' minds all the possible alternatives known to them had been explored. Thus, the only alternative left was to move. Hence, further questions that may need to be asked are: how well informed were these women when the decision was made and what had been their past decision-making style? Do people act first and think later regardless of how well informed they are? These questions become increasingly important for the 50% of the sample who had suffered a significant loss of a spouse, relative or companion prior to the move.

Exploring the respondent's stated reasons for relocating sheds some light on what needs could be addressed to prevent

relocation. However, nearly three-quarters (73.3%) of the sample had two or more reasons for moving. The ability to maintain independence was foremost. The question becomes one of how to foster independence with the least stress to the individual? To the sample members a perceived need for future health services because of chronic health problems or failing health and the perceived void of services, especially in rural areas was a major decision factor. The future health needs perceived by sample members were either of a clinical/medical nature or of a support nature to assist them in their daily activities. Again, the question arises as to how well informed the women were of the services already available? Added to the problems of geography and distance for rural residents, especially if one does not drive, is the problem of the physical strength required to maintain a farm home and large yard. In some cases, this home is without the modern conveniences of sewer and water.

Even within the city, failing health played a major role in the decision-making process. This is especially true for the older woman living on her own for many years, at or near the poverty line, and so forced into questionable housing. Many women were not employed in occupations that provided for retirement income. For many, their earning years were spent in privately arranged care providing activities or domestic-type self employment. On the other hand, women

employed in the market place at the low end of the labour continuum, but with built in retirement plans have little chance to improve their financial status through employment contributions. Those women who have not worked outside their homes but who are fortunate enough to have reached retirement with their spouse are somewhat better off, especially if they have assets to liquidate. However, with the death of their spouse a major portion of their income is gone and former life styles become financially impossible. There is no doubt that perceived and/or actual failing health coupled with a decreased or depressed economic situation are major reasons for relocation and for limiting the viable housing options for these elderly women.

Given the choice of what age group these women most enjoyed spending their time with, nearly all the respondents stated people of all ages. Gutman (1983) found 25% to 61.9% of her sample preferred a combination of middle-aged and retired adults rather than retired people only if rents were equitable. However, the literature (Connidis & Remple, 1982; Lawton, 1983) indicated that in high-rise E.P.H. contacts with the surrounding community is decreased as the complex increasingly becomes the total environment of the elderly person. Thus, the trend for many reasons, is to build E.P.H. units in the inner city areas, the contact with an external community of varying age groups is further diminished. Further, many elderly women feel vulnerable and

are afraid of vandalism. They move for security and the protection afforded by the E.P.H.. However, moving for this reason may be a further limiting factor in decreasing their contact with the community external to the complex. On the other hand, for some mobile young elderly women, E.P.H. was seen as affordable nice accommodation allowing them to maintain or even enhance a former life style. These women enjoyed traveling and very active lives. Many remained in or close to previous neighbourhoods so former community ties were not severed. The age that the resident moves into E.P.H. may be a determining factor in how well she adjusts to the alteration in her living situation. Younger elderly women who retained a great deal of their former life style and past milieu, may experience less stress associated with the move.

The importance of extended family is emphasized as nearly all the sample members relocated closer to the significant family member perceived as the one taking on the care giving role if needed. Therefore, one must weigh the pros and cons of relocating for the elderly at this time in their life. The question that remains is not whether relocation to E.P.H. is a 'good' or 'bad' decision but how can we, as health professionals, help elderly women make a more informed decision about this important life style change? How can we assist them and their families to make the best decision? If the decision to move to E.P.H. is the

desirable alternative, then what resources/services need to be available within or around the E.P.H. which will allow the elderly woman to pursue and maintain health in it's broadest definition?

5.2 STUDY RELEVANCE

The information gained from this study will have import for nursing and the health care system. As a consequence of identifying the decision-making factors, further knowledge will be added to the field of health promotion. This additional data may be used by health professionals in the community who are assessing the needs of elderly clients. The health professional is often requested to participate with the client and family in the decision-making process which may ultimately affect the elderly persons life style. The health professional may provide additional information to the client and family so that a more informed decision can be reached.

As well, the knowledge gained by indicating the predisposing factors causing relocation may be useful to planners and management personnel within the field of elderly person's housing who are responsible for developing programs to meet the needs of residents within these complexes such as providing space for exercise classes and having more green space for outdoor activities.

Moreover, based on the information gleaned from the survey, there is need for further research to be undertaken that would identify indicators of persons 'at risk' of making inappropriate decisions. If persons 'at risk' could be identified; an assessment for health and social programs, which offer support services, could be done and if necessary home care or support services made available which would allow them to remain in their long-time community residence. Such services may prevent an unnecessary move and thereby reduce stress upon the elderly individual at a vulnerable time in his/her life cycle.

However, the study is limited. The sample, although fairly representative of the urban elderly female population. The findings can not be generalized to the Manitoba or the Canadian elderly population due to sample size and the restrictions to urban Winnipeg. The small sample limits external validity. A larger sample and one which included males as well as rural populations would be required to reduce the possibility of sampling error and to allow the findings to be generalized.

5.3 APPLICATION OF CONCEPTUAL FRAMEWORK AND NURSING MODELS

The conceptual framework outlined for this study was Dunn's (1961) theory of high-level wellness (Figure 4) which conceptualizes the wholeness of man whose health-illness status results from his interaction with his environment. Lawton (1980) describes the environment as including

physical, social, and psychological elements in the neighbourhood. He contends that it is impossible to understand aging or the aged without knowing the contexts in which their lives are lived. He (Lawton, 1980) further stated the environment is often overlooked even though, it plays an increasingly significant role in the quality of life of older people. Man's ability to adapt (Dunn, 1961) is central to his quality of life. A healthy person is able to adapt to his environment in a successful and meaningful way. Conversly, capacity for adaptation is limited by a decreased health status.

The three assumptions discussed in Dunn's (1961) conceptual framework were evident in the study. The first assumption which is that people move toward a higher level of functioning was evident in many of the sample members who stated a desire to remain independent was very important to them. The second assumption is that there is always an open ended and expanding future which challenges the person to pursue his potential. The expanding future for the sample was the change in life style. For many of the sample members moving from a rural to an urban area poses a great deal of challenge and in some ways could be seen as a new beginning. The third assumption states there is an integration of the whole being of the person (body, mind, and spirit). The sample were all alert and able to make responsible decisions about themselves and very much in

control of their own lives even though some had physical disabilities. Further, in considering where sample members are located on Dunn's Health Grid (Figure 4) variations are seen. For example, the very active well elderly women who moved into E.P.H. for economic reasons could be located in the emergent high-level wellness quadrant. Assuming that their health status does not change, they may either remain at their present point on the environmental axis or they may move into the favourable quadrant with adaptation. However, if their satisfaction with the E.P.H. decreases over time causing stress and affecting their health status, they may move into the poor health quadrant. In summary, the greater the stress associated with the new residence, the greater the affect upon the resident's health status.

The concept of wellness is important to nursing. In 1970 Rogers developed a conceptual framework for nursing (Falco & Lobo, 1980) which looked at the total individual:

> nursing.....is a humanistic and a humanitarian science directed toward describing and explaining the human being in a synergistic wholeness and in developing the hypothetical generalizations and predictive principles basic to knowledgeable practice (Falco & Lobo, 1980:166).

Because of this wholeness, life is a dynamic process resulting in variable and changing patterns in which an individual engages. Further, Roger's theory assumes the individual and the environment are constantly exchanging energy with each other. Both the individual and the environment are open systems. This assumption is similar to

Dunn's assumption that an individual is an open-ended system always expanding into the future which challenges the individual to pursue his potential. Roger's (Falco & Lobo, 1980) assumes that the life process of the individual evolves along a continuum over which he can never go backwards. This life process continuum is the expression of the totality of events both past and present. Rogers contends this continuum allows for the individual's self-regulation, rhythmicity and dynamism. The basis for the human life process continuum in Roger's theory (Falco & Lobo, 1980) is a phenomenon of the wholeness, continuity, dynamic and creative changes of the human life. "It possesses it's own unity. It is inseparable from the environment" (Falco & Lobo, 1980:167).

Further, like Dunn, Roger's theory strongly parallels general systems theory which is a general science of wholeness and an important theory when looking at nursing today. Nursing has been defined (Hall & Weaver, 1977) as:

> an abstract body of knowledge concerned with the life process in human systems as they relate in a complex hierarchy of individuals, families, groups, social or organizations, communities, and societies (Hall & Weaver, 1977:5).

Further, nursing interventions (Hall & Weaver, 1977) are directed toward well-being of the whole person in the context of their super systems and focuses on man in relation to his environment, not merely the disease process.

Rogers (Falco & Lobo, 1980) sees the life processes of humanity as the core of nursing. The science of nursing is therefore directed to describing, explaining and predicting the nature and direction of these life processes. The principle of complementarity is the continuous interaction between the individual and the environment. Resonancy is the nature of the change resulting from the interaction and helicy is the direction the change takes given the individual's past encounters and directions. Schematically, this would take a spiraled horn form, ever evolving and moving forward in a patterned, organized way. This schemata is similar to one of Dunn's which characterizes the dynamic state of illness and wellness which depicted man as a whirling mass moving over time in a spiral course through the environment. High-level wellness is depicted as the ever-changing spiral as man moves along.

As individuals adapt to their new environment it is quite likely that for some of the sample members the move will be viewed as favourable because they were able to maintain their independence which was viewed as important to them. If their independence is easier to maintain in the E.P.H., decreasing the stress experienced in their previous location then their health status should improve. Health status, in this sense relates to Dunn's 'high-level wellness' which he described as "an integrated method of functioning which is oriented toward maximizing the potential of which the

'individual' is capable, within the environment where he is functioning" (Dunn, 1961:4).

5.4 NURSING IMPLICATIONS

The profession of nursing has always identified the promotion of health as one of it's goals. Nursing is not only concerned with health promotion of the individual but with the family and the community as well. The wholeness of man is considered. However, man is made up of various systems or parts that interact, affecting one another. As such, man functions within a family system and a community system; ie, his environment. Changes in any one of these systems affects the other systems in negative and positive ways.

Elderly women are a growing segment of our community. The health of this aging segment must be of concern to health planners and to nursing. Nurses working in institutions and the community will be involved in the care of these elderly women. In order to assist these women in maintaining their health and taking responsibility for their own health nurses must have the knowledge allowing them to understand elderly women's needs. This knowledge base must be broad and not merely the physical or psychological symptoms of a disease process. However, disease process is also important because the elderly will react differently than other age groups. Albeit, more important than a

diagnosis of a medical condition in the elderly population is their ability to cope and adapt to chronic illness and subsequently to function in their daily routines. The way these women will adapt will depend, to some degree, on how they have adapted to other crises or stresses in their lives. Nurses must therefore, understand the developmental processes these women have been through as well as understand what other factors, environmental or otherwise, were present or changing that may have had an affect on those developmental stages.

Some specific implications for nursing concerned with the health status of elderly women similar to the sample members can be grouped into four broad headings; administration, education, practice and research.

5.4.1 Nursing Administration

Administration is a new field for many nurses. Traditionally nurses have been the doers, at the bedside, caring for the ill. Others have been the administrators and planners of programs designed to meet the needs of people using health care services.

However, the number of nurses moving into management, where decisions are made is increasing. Nurses are bringing an added dimension to the planning team. In addition, nurses at the management level, liaise with planners from

other departments/agencies. Through this networking system their thoughts can influence the direction other planners may take. For example, through our nursing knowledge, we know that psychological well-being affects one's quality of life and subsequent health status.

The largest proportion of women today, aged 65 years and over have come from traditional family roles of wife and mother. They have spent a lifetime of cooking and preparing 'special' dishes for their families. An activity from which they have gained much satisfaction and self-worth. Knowing the target population the E.P.H. is going to serve, planners should place emphasis on the kitchen area so that cooking can be done with ease and comfort allowing the resident to continue making 'special' treats for grandchildren.

As well, many of the women in the sample moved from large homes with yards to high-rise bachelor suites. For many women of this era a clean tidy home said positive things about them, the housekeeper. For example, the first morning task was to make the beds, for bedrooms were used to sleep in or to rest if one were sick. However, in a bachelor suite when your bed is in your living room it becomes difficult to maintain the 'tidy image' so meaningful to this age group. These suites are small and often cluttered as people try to keep as many of their life treasures as possible. To compensate for the bedroom image some women purchase hide-a-beds which become difficult to make on a

daily basis, and therefore, tax energy reserves. The Canadian Mortgage and Housing Corporation stated people probably make greater use of the bedroom than any other room in the unit.....Bedrooms should be designed to accept a television and chair as well as normal bedroom furniture"(C.M.H.C., 1975:27). Further, if family reside in another town there is no room in a bachelor suite for them to stay overnight. Lawton (1983) and Gutman(1983) identified a number of physical aspects of housing for the elderly that led to increased general satisfaction such as kitchen storage space and counter tops. Gutman (1983) in her longitudinal study found an increase in complaints about unit design and lack of bedrooms over longer time periods.

When we know that most of the occupants of E.P.H. units will be women living alone, there obviously needs to be more emphasis placed on these areas when complexes are designed if we are truly considering the health of the occupant and the impact of the environment upon that health status.

5.4.2 Nursing Education

The field of Gerontology is quickly becoming a specialty area of nursing. It is a multi-disciplinary field requiring that each discipline within the team have a sound knowledge base and be able to demonstrate their areas of expertise to colleagues. Martinson (1984) defined gerontological nursing as a specialty concerned with the nursing of older people.

Further, she stated "the nurse must be knowledgeable and skilled in general nursing before she can add the knowledge and skills required for gerontological nursing" (Martinson,1984:7). Those who believe gerontology is simply providing attention to the old are missing the challenge of some of the most complex care problems in nursing. It is the challenge of maximizing the individual's independence to manage the activities of daily living by promoting, restoring and maintaining health. The subjects in this study identified maintaining their independence as a major reason for moving. Nurses must be knowledgeable about the concept of self-care and facilitate the elderly person's desire for independence. In order to meet these goals, nursing strives to identify the individual's strengths and actively involves the older person in the decision-making processes affecting their lives.

Additionally, the nurse working in the field of gerontology must be able to supervise, administer and train others, for much of the 'hands-on' care is provided by aides, attendants, orderlies, volunteers and families. Although most of the sample members were independent in their A.D.L., a few (10%) were house bound and required assistance. Although monitoring of health status may be a necessary function of the nurse, the day to day tasks can be done by aides. The provision of services through others requires leadership, co-ordination and communication skills.

These skills become increasingly important when services are delivered out side the confined walls of the institution.

However, co-ordination is a fairly new concept within the nursing field but is increasingly gaining in popularity as we strive for efficient and effective ways to deliver health care services. Kernaghan and Kuper (1983) stated that co-ordination as a:

> concept and practice has become an increasingly important focus of attention.....widely viewed as essential to efficient, effective and responsive government and is considered especially desireable during periods of financial constraint (Kernaghan & Kuper, 1983:12).

In times of economic restraint, the cost of health care becomes a serious question to be dealt with. Tertiary, acute care hospital beds are designed to meet the needs of persons with acute illness not the chronic conditions suffered by so many elderly persons. Most of the sample members identified at least three degenerative illnesses and yet few found it necessary to be confined to bed.

Nursing in the community adds further dimensions to basic nursing knowledge such as adapting the care needed by the individual to her environment rather than she to the institution. Care plans must be developed with input from the individual and family or friends and then adapted to the specific environmental milieu. This often calls for creative nursing interventions. Therefore, the community nurse must work autonomously as an independent professional.

Baccalaureate preparation of the future nurse by the year 2000 may provide the necessary education for these independent practitioners. However, the course content of these baccalaureate programs will need to be scrutinized closely to ensure sufficient content in the areas of Community and Gerontological nursing. The Entry to Practice Report Synopsis (1984) completed by the Manitoba Association of Registered Nurses (M.A.R.N.) in February, 1984 speculated on the future competencies required by the nurse in all areas of practice.

5.4.3 Nursing Practice

What is nursing? What are the parameters of nursing? These are questions many nurses grapple with on a day to day basis while working within multi-disciplinary teams. As well, the public's view of nursing is often different than the professional's view. Webster (1970) defined the nurse as "a person having the care of the sick, especially a woman trained as a doctor's assistant" (Webster, 1970:407). This definition is most likely the basis of the perception of nursing held by an elderly population. This is a population whose major contact with nurses has been in a hospital setting. These older persons must wonder what a nurse working in the community does, and why she or he would visit them in their homes. In this study some of the women initially contacted to participate seemed insecure and

refused to be interviewed even though the researcher identified herself as a nurse.

Therefore, our first goal as nurses is one of gaining acceptance and establishing a trusting relationship with the elderly person before any nursing interventions can be initiated. However, this task is further complicated, especially in Manitoba, by the multi-cultural nature of the population. Over one-third of the respondents indicated their nationality was not Anglo-Saxon. This multi-culturalism was evident in the study. Many people have come to Canada with well established social and cultural backgrounds which must be taken into consideration in the provision of care. Secondly, added to these cultural factors are the problem of communication/comprehension when the individual's first language is other than English. Many potential subjects were ruled out of the study because of language difficulties. Thirdly, and more specifically evident in this study, is the vulnerability of, and the issues related to being an elderly female in today's society. Therefore, assessment and nursing diagnosis which are key concepts in any nursing activity become increasingly important with this age group. A paper (Murphy, 1984) presented at the Second Annual Gerontological Nurses Conference in Winnipeg described nursing diagnosis as having gained acceptance in practice but about which confusion continues to exist. She (Murphy, 1984) defined nursing diagnosis as a clinical judgement about an individual/family

and community derived from a deliberate, systematic collection and analysis of data which becomes the basis for definitive therapy for which the nurse is accountable. Thus nurses working in the community, cognizant of the community's profile, are in prime positions to identify potential risk factors identified in the study such as resent widowhood or hospitalization. This population at potential risk may need interventions to prevent further decreases in functioning and to promote an optimal level of independence.

Conversely, should interventions be necessary, what form should it take? What does this vulnerable predominately female population expect of the nurse and the health care system? Literature (B. Havens, personal communication, February 18, 1983 & Snider, 1981) has cited the increase in use of health care services by elderly females and further noted additional increase in use of services following a relocation and change in life style. The majority of the sample members (75.9%) visited their physician once every two months which may or may not be appropriate.

In addition to assessment and analysis of the situation at the time of risk, there is a need to provide information and knowledge to those individuals and families to assist them in making more informed decisions. They need to be enabled to look at alternatives before decisions are made. Many of the sample members were unaware of resources in

their old or new neighbourhoods. Should they choose to remain in their present environment then services may need to be provided to facilitate the independence of the individual and family so that goals of self-care and responsibility for one's own health are fostered. In this way self-image and self-worth are preserved. Conversely, should the decision be made to relocate to E.P.H., then the decision must be supported and again resources/services may need to be placed to enhance personal independence and promote health.

Many of the E.P.H.'s visited in the study seemed to have numerous well planned and organized socialization programs for their residents. However, most were of a sedentary nature such as card playing and bingo. In addition, these seemed to be geared to those people who were socially outgoing, who would seek out the contact. As one's emotional health and feelings of self-worth are important factors in relation to illness, nurses have a role in enabling residents to participate in the building's activities and to assist in planning programs to meet special needs such as activity programs for apartment-bound residents and residents in wheelchairs.

Organized activities such as classes on health promotion could be developed, organized, and given by nurses within the complexes. These group classes could cover topic areas such as the myths of aging, attitudes toward aging,

nutritional needs and food preparation for one, importance of regular exercise and physical activity, issues specifically related to elderly women (finances and coping with loss), medication use and misuse, and many others as indicated by the women. Through these groups individuals may be identified who require a more one-on-one approach or referal to other health professionals such as physicians. Thus goals of self-care and maximization of the individual's personal functioning may be enhanced through cost effective measures based on the needs of individuals and groups.

5.4.4 Nursing Research

Research in the nursing field has been increasing over the last decade and will continue to do so in our highly technological society. New fields such as gerontological nursing must be studied to form a sound base of knowledge in addition to general nursing knowledge. Martinson (1984) stated nursing research cuts across traditional lines and draws from several fields. It focuses on the nursing perspective which includes clinical studies on the fundamental knowledge underlying health, health promotion and living with illness. The whole area of health service provision requires research to increase our understanding. Why do the elderly not seem aware of services/resources? How can they be made more knowledgeable? What types of services best meet their needs and how should those services

be delivered? For example, would regular nursing clinics in E.P.H.'s decrease the apparent need to see the physician as frequently as many elderly women in the study were? Should physicians be the 'gate keepers' to the health care system? Are nursing clinics an effective and efficient way to deliver health care? Would these clinics foster independence or dependence? These are questions with many program and policy implications and therefore, require research before implementation, especially in times of scarce health care dollars. Snider (1982) indicated:

> the importance of health issues is reflected in the elderly's use of health services, projections indicate a rising demand for those services as the numbers of non-institutionalized elderly grow. These services are also increasingly expensive to provide (Snider, 1982:409).

Further, the importance of social indicators such as 'quality of life' in policy analysis based on program outcomes rather than narrowly defined mortality and morbidity rates can not be overstressed. The result of this latter approach (Snider, 1982) is an underdevelopment of evaluative research designed to measure the effectiveness of programs and services to the elderly.

5.5 RECOMMENDATIONS FOR FURTHER STUDY

This descriptive study was designed to look at the decision-making factors predisposing the relocation of elderly women from established homes to segregated E.P.H.. The study interview guide considered four areas of exploration with sample members. These four areas were:

1. Personal characteristics
2. Present and previous living arrangements
3. Health status and ability to function
4. Identified needs and resources

The underlying assumption of the study was that any change in relocation or life style causes stress and thus has a negative impact on health as seen in increased usage (Gutman, 1980; Lange, 1980 & Snider, 1981) of health care services. In addition, the study assumed there would be an added negative impact for these elderly women resulting in greater stress because the relocation was from an established home within a multi-aged community to the age-segregated community in an E.P.H.. The resources available in the past and present locations were explored in combination with the reasons for moving to identify what additional services/resources would have been needed to allow these elderly women to remain in their established residences and what implications that would have for nursing.

The study revealed that most of the elderly women in the sample would prefer to spend time with people of all ages but that their decision to move to E.P.H. was based on at least two major reasons, the desire to remain independent and finances. The study results alluded to some of the social and health issues facing women and specifically the vulnerable elderly women in present day society. As did the

Aging in Manitoba study (1973), this study suggested that many resources available to the elderly in Manitoba are unknown to them. This is particularly evident in rural areas of the province. However, these women, for the most part, moved to maintain an independent life style at least what was for them maximizing their personal level of independence. To meet this desired level, they relocated to be nearer to family who were seen as being of support in time of need and decreasing ability to function in day-to-day activities.

Thus, this study designed to describe what was occurring in the lives of a small sample of elderly women moving into E.P.H. has generated more questions than answers. Further research needs to be done to:

1. Identify why established services/resources are not known or seen as required by some elderly persons.
2. Evaluate the need for different modes of service delivery throughout the province based on the diverse make up of the population.
3. Evaluate the services/resources now available in E.P.H. to identify whether residents' needs are being met and if not what additional resources/services should be developed and how should they be delivered.
4. Evaluate the feasibility of upgrading/improving the older E.P.H.'s where the physical facilities are not designed to meet the needs of daily living or of socialization for the elderly resident.

5. Establish risk factors to identify persons who may be at risk of making inappropriate or uninformed decisions regarding relocation so that these elderly persons can be informed of alternatives available to them by the provision of services or the development of resources, especially for the vulnerable elderly female.
6. Evaluate the effects of living, over a prolonged period of time, in an age-segregated environment.
7. Study the effects of care giving responsibilities on family members and what resources would best support them in fulfilling that role.
8. Examine the decision-making process or style employed by elderly women who are making the decision to relocate and thereby alter their life style. How much information was available to them and did the information make any differences in their decision-making process?

However, researchers, in identifying the needs of the elderly population today, and how best nurses working within the multi-disciplinary field of gerontology can meet these needs, must never loose sight of the future. What will the next generation of elderly people be like? Will the age of 65 years used to define the beginning of elderly age groups still be appropriate in the twenty-first century? With rising divorce rates and more single parent families, will

the family structure as we know it change and, if so, to what? With advances in technology and computers, how will health services be delivered? What affect will five and six generation families have on health delivery when the care givers themselves may be older and frailer than today's care givers? Lastly, with what kinds of health issues/problems will health professionals be dealing and who will be a health professional? These are questions that future research in nursing must consider if nursing believes in the concept of Health Promotion. To achieve a healthy society, health professionals must be cognizant of the needs of the community, the family, and the individual. The health of the individual is basic and will only be maintained or enhanced when (s)he is viewed as a whole being interacting with the environment in which (s)he lives. Styles (1982) in On nursing:Toward a new endowment stated:

> In these [community] settings our [nurses] particular clinical contributions should be in enhancing health by providing self-care information in understandable, usable forms and in promoting prevention of illness and coping with the stresses of a complex environment; in primary care in clinics; and in home care for the elderly and chronically ill (Styles, 1982:232).

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Appendix A

LETTER OF INTRODUCTION

School of Nursing
Bison Building
University of Manitoba
Fort Garry Campus
R3T 2N2

Dear

I am a graduate student in the Masters of Nursing Program at the University of Manitoba. Part of my course requirement is a thesis presentation involving a study which will look at the moving patterns of older women. As well, as a nurse working in the community, I am most interested in the living environments people choose.

I would be most appreciative if you would allow me to visit you in your home for the purpose of completing a questionnaire. I am collecting all the information required for the study and your participation will be known only to me. Your name will be kept confidential.

Your participation in the study would be greatly appreciated. The knowledge gained from the study will be helpful to Public Health Nurses working in the community. Public Health Nurses are often asked to help women who are in the process of making a decision to move.

If you would like further information about the project, please call me at 1-757-9293 in the evening or contact my professor at the School of Nursing, University of Manitoba, Ms. Lesley Degner, 474-9664.

Thank you for considering to participate in this study. I will be in touch with you by telephone within the next ten days. The results of the study will be available to you upon request.

Yours truly,

Appendix B

PARAPHRASE FOR RELOCATION STUDY

I am a graduate student in Nursing at the University of Manitoba conducting a study in Community Health Nursing. The purpose of the study is to gain information about reasons why people in Winnipeg move into Senior Citizen Housing. I am interested in your perspective on the reasons for your move, and the effect the move has had on you.

This study will involve an interview with myself of no longer than one hour. The interview will be tape-recorded and a questionnaire will be completed by myself. Questions regarding personal characteristics, past and present living arrangements, health and functioning status and needs and resource availability to you will be asked. These questions are important to the purpose of the study. Your name will not be identified on the questionnaire nor the tape recording. All participants in the study will remain anonymous. The tapes will be erased by myself on completion of the study.

This study is conducted under the supervision of the Nursing Faculty of the University of Manitoba. Participation in the study is entirely voluntary; you may refuse to participate if you wish without fear of reprisal.

The results of this study will be based on group information, not individual questions and will be published in the form of a thesis presentation. If you would like information regarding results of this study, please give me your address. A summary of the results will be mailed to you.

Appendix C

CONSENT TO PARTICIPATE

I agree to participate in the study conducted by Janet Porth, a nurse and graduate student in the School of Nursing, University of Manitoba. I understand the study will examine the reasons why elderly persons move from long established neighbourhoods into Senior Citizen Housing.

The researcher has explained the procedure and I have read the letter of explanation. I understand that the study will involve a tape-recorded interview conducted by the student. The interviewer will ask questions with regard to personal characteristics, past and present living arrangements, health and functioning status and needs and resources available to me. There are no known risks or benifits to participating in this study.

I know I may refuse to participate in the study. I also know that I may terminate my participation in the study at any time. I know the student, Janet Porth may be reached at 1-757-9293 in the evenings to answer any questions I may have.

Date_____ Signature of Subject_____

Signature of Interviewer_____

I wish to receive a copy of the findings of this study when they become available.

Permanent Address_____

_____

Appendix D

M.H.S.C. COMMITTEE APPROVAL

MANITOBA
MANITOBA HEALTH SERVICES COMMISSION
Box 925
599 Empress Street
Winnipeg, Manitoba
R3C 2T6

Ms. Janet Porth,
Box 30, Group 360, R.R. #3,
WINNIPEG, Manitoba.
R3C 2E7

October 20, 1983

Dear Ms. Porth:

The Access and Confidentiality Committee has recommended to the Commission that they respond favourably to your request of August 2, 1983 subject to your concurrence with the procedures set out in Mr. Toll's letter of September 20, 1983, as you are already aware. I understand confirmation of the procedures was contained in your letter of October 14, 1983.

We have accepted the recommendation of the Committee, and Mr. Toll will be in contact with you shortly regarding the listing.

/bsg

Appendix E

ETHICAL REVIEW COMMITTEE APPROVAL

THE UNIVERSITY OF MANITOBA

SCHOOL OF NURSING

Room 215 Bison Building
Winnipeg, Manitoba
Canada R3T 2N2

CONFIDENTIAL

December 15, 1983

Mrs. Janet Porth
Box 30, Group 360, R.R. #3
WINNIPEG, Manitoba
R3C 2E7

Dear Mrs. Porth:

RE: Ethical Review of Your Thesis Proposal: Relocation of the Elderly: Decision-Making Factors.

At the December 12th meeting of the Ethical Review Committee, your proposal was approved on ethical grounds. The only comment made was that you should include the approximate length of time involved to complete the questionnaire in your consent form.

Yours sincerely,

CG:vp

Appendix F

QUESTIONNAIRE

F.1 FACE SHEET

Face Sheet (completed after the interview)

1. I.D. number of respondent_____

2. District-South_____
North Central_____
Central_____
North East_____
South West_____
West_____
South East_____

3. Type- Public Housing_____
Non-profit_____
Profit_____

4. Type of apartment-Bachelor_____
One Bedroom_____
Two Bedroom_____
More than two Bedroom____

5. Style- Walk-up_____
Medium-rise_____
High-rise_____

F.2 PERSONAL CHARACTERISTICS

1. Sex Female_____

2. What is the name of this place?
_____

3. How old were you on your last birthday?
_____

Date of birth. (day/month/year)_____

4. What is today's date? (day/month/years)_____

5. Who is the Prime Minister of Canada?_____

6. Who was the Prime Minister before him?_____

7. What is your marital status?
Married_____
Single_____
Widow(er)_____
Divorced_____
Separated_____

8. If married, widowed, separated or divorced, how long?
_____

9. What nationality descent do you consider yourself?
_____ (if Canadian-probe for ethnic origin).

10. What language do you speak most often?
_____

11. How many years or grades did you complete in school?
_____

12. Do you have any children? Yes_____ No_____

13. Do you have grandchildren? Yes_____ No_____
Brothers/sisters? Yes_____ No_____
Parents? Yes_____ No_____
(in-laws included in above two)
Other relatives? Yes_____ No_____

14. How often do you see the relative you feel most closest to?
Daily_____
Several times a week_____
Once or twice a week_____
Once or twice a month_____
Several times a year_____
Once a year_____
Never_____

15. Would you like to see him/her more often? Yes_____
No_____ If yes, in your opinion why do you not see him/her as often as you would like?

_____

_____

16. What kind of work have you done most of your life?
Never employed_____
Housewife_____
Employed (specify)_____

17. Are you employed now? (include volunteer) Yes_____
No_____ If yes, specify type and frequency.

_____

_____

F.3 LIVING ARRANGEMENTS

1. What type of housing were you living in before you moved?
Self-contained suite_____
Whole house_____
Self-contained in multiple dwelling_____
(includes duplex, town-house, and row-housing)

2. Did you and/or your spouse (if applicable) own this?
Yes_____ No_____

3. Was your residence before you moved to this apartment close?
Specify_____

_____

Probe: in the immediate area of this apartment;
in the neighborhood;
in the surrounding neighborhood;
another town, less than a day's journey;
in an area more than a day's journey.

4. Had you lived in your previous household long?
probe: Less than six months
Six months to one year
One to three years
Three to five years
Six to ten years
Eleven to twenty-five years
Over twenty-five years

_____

_____

5. Are you living alone now? Yes_____ No____ If no, specify with whom_____

6. Before moving, did you live alone or with others?
Alone_____
With spouse only_____
With spouse and other relative (specify)_____
With relatives (specify)_____
With friend_____
Other (specify)_____

7. Cue card is to be used with this question. How satisfied are you with the following aspects of your new apartment? Think in terms of the following.
1.satisfied 2.partly sat. 3.not satisfied

heating_____
ventilation_____
lighting_____
windows_____
sleep accom._____
cooking fac._____
bathroom fac._____
laundry fac._____
location_____
grab bars_____
telephone_____
storage area_____
privacy_____
noise_____
cost of rent_____
stairs (indoor)_____

general state of repair_____
elevator (if relevant)_____
stair railings (indoor)_____
stair railings (outdoor)_____
stairs (outdoor)_____
space_____

8. Did you chose this apartment building yourself? Yes____ No____

If no, specify who_____
Probe: spouse
a child
a relative
a friend or neighbor
a person from an agency/hospital/doctor

9. Was there a long waiting list? Yes_____ No_____

Specify how long the wait was_____
probe: less than six months
six months to one year
one year to two years
two to three years
over three years (specify)

10. If it were a matter of your choice, how and where would you like to live?

_____

probe: children; relatives;
with others of own age;
with others regardless of age;
alone or with spouse.
probe: in your own house;
in a child's house;
in your old neighborhood;
in another part of the city;
in another village/town/city,
other (specify).

11. In your opinion, what was the major reason for your move to this Senior Citizen Housing complex?

_____

_____

_____

probe: finances; death of spouse;
decrease in health functioning;
loss of support network (family move);

unable to maintain previous home;
vandalism in neighbourhood; security;
change in neighborhood structure;
move closer to friends or people
of similar ethnic background, age,
community/neighborhood; comfort;
part of retirement plan; independence.

12. What resources were available to you in your old neighborhood?

_____

_____

_____

13. What additional resources would you have liked to have had in your old home or previous neighborhood?

_____

_____

_____

14. What resources are available to you in your new neighborhood?

_____

_____

_____

15. What additional resources would you like to have in your new neighborhood?

_____

_____

_____

F.4 HEALTH STATUS AND ABILITY TO FUNCTION

1. Some people have difficulty in doing things without help. Does anybody usually help you with the following? (Specify how and how much)

_____

_____

_____

probe: doing light housework;
doing heavy housework;
making a cup of tea; preparing a meal;
shopping; managing financial affairs;
laundry; bathing, grooming & dressing;
remembering medications; going out of doors or up & down stairs;
other (specify)

2. In general, how do you get to appointments; to visit friends or to shop?_____

_____

_____

probe: walk; drive self; family; friends;
taxi; take a bus; volunteer driver or escort; other (specify).

3. What kinds of things do you enjoy doing in your spare time?

_____

_____

probe: reading magazines or books;
watching T.V.; playing cards;
going to movies/concerts;
going for walks;
going to meetings,clubs,church;
gardening indoors and out;
working at a hobby;
playing sports, golf, pool, swimming, bowling, tennis; travelling;
visiting friends/relatives

4. Would you say you prefer to spend time with people:
About your own age?_____
Younger?_____
Older?_____

People of all ages?_____

5. Compared to people your own age, would you say your health is?
   Excellent_____
   Good_____
   Fair_____
   Poor_____

6. Is your health better, about the same, or worse than it was five years ago?_____

7. Do you have a regular doctor or clinic? Yes____ No___

8. How many times have you seen a health professional or doctor during the past six months and did you have any trouble seeing them? (specify)

   _____

   _____

   _____

9. How many days were you sick during the last six months and were you sick enough to be in bed?

   Specify_____
   Probe: none
   one to three days
   four days to one week
   more than a week but less than a month
   a month or more

10. Do you have any of the following health problems that affect your ability to carry out daily activities?(specify)

    _____

    _____

    probe: heart or circulatory problems; stroke; arthritis or rheumatism; hearing or visual impairment; respiratory (cough or SOB); skin problems; speech problems (not language); obesity; nerves; memory deficient; cancer; other (specify)

11. Do you find that you sometimes forget the name of relatives or friends that you have known well? Yes___ No___ If yes, specify

_____

_____

probe: occasionally/frequently;
recall quickley/slowly;
recall only when reminded;
do not recall

12. In your opinion, do you have a good nutritious diet?
Yes_____No_____

If no, how could it be improved?_____

_____

probe: someone to prepare meals; company;
unable to shop; no appetite;
complicated diet; to tired;

F.5 NEEDS AND RESOURCES

1. How far away does your closest (in distance) relative live?
In building_____
In neighbourhood/community_____
Less than one day's journey (by land)_____
More than a days journey (by land)_____

2. Of the relatives that you feel closest to, how often do you see one of them?
Everyday_____
Once a week_____
A few times a month_____
Once a month_____
Less often than once a month_____

3. Who managed your move to this apartment?
Self and/or spouse_____
Child_____
(residing with parent or not)
Relative (specify)_____
Friend (age peer or not)_____
Neighbor (age peer or not)_____
Social or health agency_____

4. Are your income and assets such that you feel you need help beyond what you are now getting? Yes____ No_____
   probe: can you meet emergencies?
   can you buy little extras?
   can you meet future needs?
   are there assets to fall back on?

_____

_____

_____

5. If you required help for a period of time, who would help you?
   Self or no one_____
   Spouse_____
   Child or relative (specify)_____
   Friend or neighbour_____
   Organized service or agency (specify)_____

6. Is the help that you are receiving sufficient?

   Yes_____ No_____

   If no, specify: doing light housework_____
   doing heavy housework_____
   making a cup of tea_____
   preparing a meal_____
   shopping_____
   managing financial affairs_____
   laundry_____
   bathing, grooming & dressing_____
   remembering medications_____
   going out of doors or up and down stairs_____
   other (specify)_____

   Probe: no help or additional help wanted
   a little help, none now used
   a little more help
   some more help, none now used
   some more help
   a lot more help, none now used
   a lot more help

7. Are you aware of any resources in this neighbourhood that could be of assistance to you?
   Yes_____ No_____

8. What services are they? (specify)_____

_____

_____

9. Have you, do you, or would you use them? Yes__ No__

If no, why not?_____

_____

10. Cue cards to be used for this question. What services or opportunities do you see as needed or not adequately and conveniently available for people your age?

1.convenient and adequate or not needed;
2. very little need 3.some need
4.considerable need 5.extreme need

shopping outlets_____
restaurants_____
parks_____
church_____
library_____
banks_____
public transportation_____
postal outlets_____
information services_____
employment opportunity_____
clubs_____
senior citizen activity_____
educational fac._____
police service_____
fire department service_____

doctor/dentist_____
hospitals/clinics_____
public health services_____
public social serv._____
meal delivery_____
home help services_____
visiting nurse serv._____
friendly visitor_____
home repair service_____
volunteer services_____
recreational fac._____
legal services_____
language oriented fac._____
ambulance service_____

comments_____

_____

_____