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WELL-BEING THROUGHOUT THE SENIOR YEARS: AN ISSUES PAPER ON KEY EVENTS AND TRANSITIONS IN LATER LIFE

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QSEP Research Report No. 411

McMaster University
SOCIAL SCIENCES

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Well-Being Throughout the Senior Years: An Issues Paper on Key Events and Transitions in Later Life

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Abstract

Social Development Canada's mission is "to strengthen Canada's social foundations by supporting the well-being of individuals, families and communities and their participation through citizen focused policies, programs and services"(Social Development Canada 2005a). Well-being is a concept that goes beyond good health to encompass physical and mental fitness as well as social fitness (being able to perform one's social roles and the demands of everyday living adequately). As people age, they experience a number of transitions in their lives. They may retire, change residence, loose a spouse, become a caregiver, and/or develop a health problem or disability. These transitions, especially when they occur around the same time, may impact on their well-being and independence and prevent them from being contributing members of society. This paper summarizes the research on what we currently know about the key events and transitions experienced by seniors, their impacts, and the resources seniors have or need to successfully cope with these events throughout the senior years. It will also review what we know about opportunities, gaps or barriers in accessing social support programs and service delivery designed to assist seniors in coping successfully with adverse events and life transitions. Issues to be considered include availability, access and costs of community support and home health care services. Finally, the paper will attempt to provide potential policy research directions to address current knowledge gaps. This is an extensive literature, and we have limited the scope by focusing on the last 10 years of Canadian research published in Journals and by Statistics Canada. We have favored research based on national studies in this review, though there are many excellent case studies and qualitative studies that add texture to our knowledge. Recognizing that the senior population is a very heterogeneous group, this review will examine (where the research permits) differences by senior life-course stages, and other target groups such as women, the disabled, visible minority, immigrants, Aboriginal peoples, sub-regions, low income, and persons living alone. This review of the literature has shown that while we have basic information about many of the transitions in seniors' lives, there is very little information about the various life course stages or about various sub groups of society.

Keywords: health and well-being, retirement, marital transitions, care-giving, homecare

JEL Classifications: I10, J12, J14, J26

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1.0 Introduction

Social Development Canada's mission is "to strengthen Canada's social foundations by supporting the well-being of individuals, families and communities and their participation through citizen focused policies, programs and services"(Social Development Canada 2005a). Well-being is a concept that goes beyond good health to encompass physical, and mental fitness as well as social fitness (being able to perform one's social roles and the demands of everyday living adequately)(Chappell et al. 2003). As people age they experience a number of transitions in their. They may retire, change residence, loose a spouse, become a caregiver, and/or develop a health problem or disability. These transitions, especially when they occur around the same time, may impact on their well-being and independence and prevent them from being contributing members of society.

This paper summarizes the research on what we currently know about the key events and transitions experienced by seniors, their impacts, and the resources seniors have or need to successfully cope with these events throughout the senior years. It will also review what we know about opportunities, gaps or barriers in accessing social support programs and service delivery designed to assist seniors in coping successfully with adverse events and life transitions. Issues to be considered include availability, access and costs of community support and home health care services. The paper will attempt to provide potential policy research directions to address these knowledge gaps throughout the review of findings. Further, in the conclusion, we will attempt to identify policy research directions at a broader level. This is an extensive literature, and we have limited the scope by focusing on the last 10 years of Canadian research published in journals and Statistics Canada publications. We have favored the research based on national studies in this review, though there are many excellent case studies and qualitative studies that add texture to our knowledge.

Recognizing that the senior population is a very heterogeneous group, this review will examine (where the research permits) differences by senior life-course stages, and other target groups such as women, the disabled, visible minority, immigrants, Aboriginal peoples, sub-regions, low income, and persons living alone. This review of the literature will show, however, that while we have basic information about many of the transitions in seniors' lives, there is very little information about the various life course stages or about various sub groups of society.

Canada is one of the most ethnically and racially diverse countries in the world. The most recent (2001) Census lists 113 different ethnicities and immigrants make up 18% of the Canadian population. 5.4 million people reported that they were born outside this country, roughly 1.8 million of whom immigrated to Canada within the past 10 years. Over the century the primary sources of immigrants to Canada has changed. Whereas in the past, immigrants were more likely to have come from European nations, today's immigrants are more likely to come from Asia followed by China and India(Palameta 2004). With the shift in country of origin, there has been an increase in visible minority population so that in 2001, 13% of Canada's population identified themselves as members of a visible minority group as compared to 5% in 1981(Palameta 2004). About two-thirds of individuals who identified themselves as part of a visible minority were immigrants. Despite the increasing representation of this group among Canadian seniors, our review of the literature revealed that we know very little about the experiences of ethnic/and or visible minority seniors in Canada. Further, comparisons of the Canadian born, east European and non-European immigrants show many differences in socio-demographic factors, life style behaviour and social support(Dunn and Dyck 2000).

Very few First Nation people reach the age of 65; 3.5 percent are 65 years of age or older compared to 11.7% for all seniors in Canada(Health Canada 1998). The population of First Nations peoples are concentrated in the North and on the Prairies and about-two thirds of North American Indians live on a reserve. Seniors are the most likely First Nations people to know and use a First Nations language and serve as important links to First Nation Culture(Statistics Canada 2005). We know little about how our First Nations peoples experience the transitions in older age.

In studying aging, it is important to consider that age is both a characteristic of individuals and an aspect of social structure. Society allocates roles and responsibilities to persons based on their age. For example, youth attend school, young and middle aged adults work and older adults retire. Further, research in aging must consider the dilemma of age, period and cohort effects. While aging refers to the process of growing old, a cohort is a group of people that were born at a certain period of time who share a common history, including the social, economic, and cultural influences during this time(Gee 1995). For example, seniors born in the early part of the twentieth century were children during the depression and young adults during World War II. They have had quite different life experiences than the children born to them (i.e. the baby boomers). Period effects are historical or major events that occur and influence cohorts in different ways such as the depression mentioned above. The problem researchers studying aging face is disentangling age, period, and cohort effects. Investigators make the mistake of interpreting cross-sectional age differences as age effects. This type of mistake is referred to as the “life course fallacy”(White-Riley 1998). Longitudinal data is required to disentangle these effects. Until very recently, however, there were few Canadian longitudinal data sets available. Now that several longitudinal data sets are beginning to mature in Canada, and with the development of more sophisticated statistical analysis, we are beginning to have the tools to advance the study of aging significantly. In addition, the proposed Longitudinal Study on Aging promises to be a rich data source for future policy driven research.

1.1 Life Course Theoretical Framework

A life course framework provides the lens for studying well-being throughout the senior years. From this perspective, an individual’s lifecourse is composed of multiple, interdependent trajectories or pathways (for example, work, family, education, health, financial, etc.). What happens along one trajectory impacts what happens along other trajectories and the roles held in one trajectory are often coordinated with roles along other trajectories, for example, work and family roles(Settersten 2003). As well, trajectories are impacted by demography, and by the timing and sequencing of historical events and policies (i.e., period effects).

Trajectories are marked by life events, transitions and turning points. Events and transitions are brief in scope, and refer to changes in an individual's state. Whereas an event is characterized as an abrupt change such as the death of a spouse, however, a transition is conceptualized as a more gradual change, and one that is generally tied to acquiring or relinquishing roles such as retirement. A turning point is where a trajectory shifts significantly in a direction or is "discontinuous" in form. However, events such as retirement have been studied from the perspective of all three. An important principal of this framework is the notion of "interdependent" or "linked lives," the idea that individual lives are intimately connected to the lives of others and that individual development is bound to and shaped by these ties.

Life courses are heterogeneous, and so life course analysis must be cognizant of differences in various sub-groups in society. For example, research has shown men and women experience the life course in different ways. Gender, beyond being a characteristic of the individual, is also an important - even a defining - aspect of social organization such that our society is structured to advantage and privilege males(Chappell et al. 2003). The same may be said for other sub- groups of society such as recent immigrants, Aboriginals, or the disabled to mention a few. Sociologists argue that society is composed of a large web of interlocking statuses[1]. These statuses intersect to influence a person's life. For example, visible minority immigrant women may have a very different life trajectory compared to their non-visible minority counterparts. The challenge for social policy research is to study older sub-groups of the population in order to understand how their experiences may differ.

Throughout history people have faced risks. Modern social theorists argue, however, that risks have been increasing so that today we face a multitude of social, political, economic and individual risks(Beck 1999). The distribution of risk is related to someone's location within the social structure, varying for example, along the lines of age, gender, income, marital status and ethno-cultural group. With respect to later life, old age is associated with an increasing risk of poverty, social isolation, loneliness, loss of independence and declining health. Further, modern theorists argue that the three main sources of managing risks – the state, the market, and the family – are losing their capacity to effectively manage risk and these risks are being shifted to the individual(Esping-Andersen 1999). For the purposes of developing policy to promote senior's well-being, it is important to have a clear picture of the risks faced by seniors and to understand how these risks vary for different groups in society.

The Research Policy Initiative (RPI) has used life course theory to propose *A Life-Course Approach to Social Policy Analysis*(Social Development Canada 2004). This framework builds on sociological literature on the life-course and shows how this theory may be used to understand the roles of people in relation to different social institutions and to analyze policy. Importantly, it views the resources between an individual and the main institutions of society as a two-way flow, viewing an individual as having a stock of assets including wealth, housing, and human and social capital. An individual's stock of resources is a way of managing risk so that a setback in one resource (i.e., marital dissolution) may be buffered by other resources (i.e., social

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[1] Factors that stratify or contribute to the ranking of the social structure such as gender and ethnicity as well as factors such as education and income

networks). If compensation is not possible, or if multiple resources break down at the same time, the results may be catastrophic.

This framework is useful for policy because it allows “policy to focus more clearly on those transitions and the resources that support successful transitions”(Social Development Canada 2004). While most policy addresses problems that occur in one single trajectory, such as education or social security, needs are greatest when problems have multiple sources. As described in this document, “at the highest level of generality, the goal of social policy can be stated in terms of supporting individual well-being”(Social Development Canada 2004). The concept of “social inclusion” is useful here - “a situation that exists when everyone can participate as valued, respected, and contributing members of society.” Exclusion occurs when individuals do not have adequate resources to manage the key transitions in life. Fundamental for social inclusion are the resources that allow individuals to participate in society and the life-course framework, it is argued, is tailor-made to describe the central policy goal of inclusion.

The National Framework on Aging (NFA) identified the core principles that underlie their vision to promote the well-being and contribution of older people in all aspects of life. They are dignity, independence, participation, fairness and security. These principles that were identified by seniors in focus groups across Canada NFA argues that these are the most important principles for policies affecting seniors(Health Canada 1998).

2.0 Key Events and Transitions

The first objective of this paper is to provide a summary of research findings on what we currently know about key events and transitions experienced by seniors including events such as retirement, death of a spouse, marital dissolution in later life, geographic mobility, immigration in later life, illness of self or spouse, disability and caregiving. Further, we will attempt to identify potential policy research directions to address knowledge gaps.

2.1 Retirement

Retirement is an institution that is socially constructed and has evolved over time (Marshall 1995). The transformation of retirement involves changes in the nature and social patterning of work; the nature, timing and meaning of retirement; and the relationships between work and retirement. This transformation causes considerable policy concern at the societal level because the institution of retirement is critical for both work and social security.

Early literature on retirement focused on retirement as an event, and studied variability in the timing of the event and the consequences of the event. More recently, life course theorists have helped us to see that retirement is a social and psychological process that is shaped and constructed by social forces and experienced through social relations. Therefore, the definition of retirement is neither specific nor conclusive and there is some debate on how to define whether a person is retired. It has been defined as the cessation of work; the claiming of retirement benefits (economic definition); or as a state of mind (subjective definition). Current research views retirement as a transition point in people's lives signifying a gradual change, and one that is generally tied to acquiring or relinquishing roles (Esping-Andersen 1999).

Beginning in 1986, there has been a trend towards declining retirement age, stabilizing in 1997 and rising slightly in recent years(Scherer 2002). In 2001, the average age of retirement in Canada was 62 for men and 59 for women. 43% of Canadians retired before age 60, another 31% retired between the ages of 60 to 64, 19% retired between the ages of 65 to 69 and 7% retired after the age of 70(Statistics Canada 2003b). There are many factors influencing the timing of retirement. Employees in the public sector (i.e. government, education, health and social services) retired a full three and a half years earlier than private sector workers, while self-employed people retired later than other workers. Employees with jobs in primary occupations have the highest age of retirement. Other factors associated with an earlier retirement age include length of tenure in the job prior to retirement, having a employer pension, and higher levels of education(Statistics Canada 2003b). The influence of other people on one's retirement (linked lives) had also been shown, for example, both men and women tend to make joint retirement decisions with their spouses (Tompa 1999).

There are various ways of withdrawing from the labour market. A one-time exit from full-time employment into full-time retirement is only one of many retirement patterns. For some, retirement is a gradual process where transitions to retirement are bridged by part-time work or multiple exits from the labour force(McDonald and Donahue 2000)

Research has shown that the three main reasons older workers exit from the labour market are health, wealth and labour market redundancy (Myles 2002). While some retirement is welcomed and on-time, other retirements are involuntary or forced due to the loss of a job (Osberg 1988), an early retirement incentive (Frenken 1991), a health problem, mandatory retirement (Schellenberg 1994), lack of control with too many job strains (Trucotte and Schellenberg 2005), or to provide care to a family member(McDonald, Donahue and Marshall 2000). Generally, as workers age they prefer to work less(Moen 2000). An analysis of the 2002 General Social Survey (GSS) reveals that 27% of retirees retired involuntarily(Schellenberg and Silver 2004). This study and others found that those who retired involuntarily were more likely to have retired before the age of 60 due to health reasons or a job disruption. They were also more likely to have poorer health, to be worse off financially after retirement, less likely to have a pension and to be dissatisfied with their lives. Further, those forced to retire were more likely to be unmarried, immigrants, have lower levels of education, work in the private sector of the economy or the goods producing industries and to have experienced a longer period of unemployment(McDonald, Donahue and Marshall 2000).

Policy research is needed to investigate the consequences of involuntarily retirement. The economic consequences of mandatory retirement may not be as severe as some other forms of involuntary retirement since those affected by mandatory retirement tend to have higher wages and occupational pensions. Moreover, because it is known in advance, the individual may be better able to prepare for it financially. But there is little research on the economic, health and psycho-social impacts of being forced to retire and, moreover, how the impacts differ by the type of involuntary retirement (i.e. labour market redundancy, health, caregiving, etc.).

There is conflicting evidence on how important a role unemployment will continue to play as a route to retirement. Further, a growing number of people use unemployment and disability programs or early retirement packages as bridges into retirement. Some researchers suggest that with declining fertility rates and labour shortages in certain occupational and geographic areas there will be a demand for older workers (McDonald and Chen 1993). Other researchers predict the exact opposite (Siroonian 1993). Policy research to monitor the role of unemployment as a pathway to retirement is an important area of research.

Illness or disability is the number one reason for involuntary retirement in Canada(Statistics Canada 1997). A growing number of people use unemployment and disability programs or early retirement packages as bridges into retirement. McDonald and colleagues argue that relatively little attention has been paid to the economic consequences of retiring because of poor health, although access to disability benefits may help to bridge income into retirement, there may be additional costs related to their health conditions(McDonald, Donahue and Marshall 2000).

The emerging perspective in the retirement literature is that it is the nature and timing of retirement that affects health outcomes (physical and mental), not the event in and of itself (Marshall and Clarke 1998). There is mounting evidence that conventional scheduled retirement has no adverse effects on health, while early forced or involuntary retirement has a negative effect on health (Marshall and Clarke 1998; McDonald, Donahue and Marshall 2000). Until recently, we have lacked the longitudinal data in Canada to study this relationship though American studies suggest that negative health effects associated with involuntary retirement may be mediated through the pathway of reduced income.

There is also a dearth of Canadian literature on families and retirement. Research from other countries suggests that retirement effects on marital happiness depend on the pre-retirement quality of the relationship (Szinovacz and DeViney 2000). Retirement can enhance marital quality among already happy couples, but it will not fix pre-retirement marital problems. Virtually nothing is known about how retirement influences other family relationships. What seems clear is that for happy couples having a spouse can contribute to senior's well-being in later life. We know even less about the unmarried retiree population (most unmarried retirees are women). This is problematic because it is the unmarried who may face special problems in retirement such as financial problems or social isolation and loneliness. The well-being of the unmarried in retirement will depend on both their work and family careers, as well as the timing of marital disruptions in relation to the retirement transition. For example, a divorce or widowhood shortly before or after retirement may be particularly detrimental to senior's well-being (Davies and Denton 2002).

We know little about women's retirement in Canada and we can not assume that research done on male's retirement experiences can be generalized to women. Research suggests that women's retirement experiences differ from men's in a number of important ways because of the gendering of work and family life(Townson 2000). The economic definition of retirement does not consider the non-remunerated work carried out by women such as the effect of family roles on the workplace(Simmons and Betchild 2001), and their greater likelihood to be single or to have headed lone-parent families. Nor does it consider women's greater likelihood of retiring involuntarily, of retiring earlier than expected, and of retiring without employer or Canada pensions or with lesser pensions. Further, evidence from other countries suggests that women do less planning and are less prepared for retirement than men(Simmons and Betchild 2001; Whiting 1998). Understanding retirement as a social process provides a useful framework for understanding the ways in which women's experiences are shaped. Future policy research should be directed towards the impact of the interaction between family roles and work on the retirement process, gender differences in factors leading to retirement, and consequences of forced or involuntary retirement for women.

The assumption cannot be made that women's future retirement experiences will resemble their past experiences. An analysis of four cohorts of women reveal major differences between the cohorts in education, marital status, fertility rates, labour force participation, employment income and preparation for retirement suggesting that younger cohorts of women will fare better in retirement than their older counterparts(Rosenthal et al. 2001). Yet, their work careers and subsequently their retirement will still have been encumbered by their family and caregiving roles. It will be important to conduct research on the retirement experiences of baby boom women.

The age of retirement is expected to continue to rise due to a number of factors including: the impending labour shortage due to the aging of the Canadian population; the trend towards more seniors at work(Duchesne 2004), the lack of financial ability for some workers, especially those in the more disadvantaged groups, to leave the labour force as well as the recent decision of the Supreme Court of Canada that mandatory retirement discriminates on the basis of age and the move by some provinces that currently have legislation allowing mandatory retirement to abolish it. Some argue that the elimination of mandatory retirement will help to reduce the economic costs that have come to be viewed as emanating from population aging(Brown 1995). Policy research should address the impact of the elimination of mandatory retirement on the timing and pathways into retirement and on the economic consequences for both the individual and society.

In an analysis of the impact that the retirement of baby boomers will have on the labour market, the HRSDC forecasts that over the next 10 years, 605,000 jobs will become available in Canada, of these two-thirds will be triggered by retirements(Human Resources and Skills Development Canada 2005). Studies have shown that about half of Canadian retirees would prefer to work full- or part-time jobs if they were available(Hicks 2001; Morisssette, Schellenberg and Silver 2004; Schellenberg and Silver 2004). Given the interests in some older Canadians to continue to participate in the labour force and the benefit of their continued employment to the economy, policy research could address issues that would remove impediments and provide incentives for older workers to extend their working lives including: the retraining of older workers especially with regard to technology; the acceptance by employers and unions of greater flexibility of work days, work weeks and work years; the adjustment of pension policies to correspond to the new timing and flexibility of retirement; the changes in attitudes towards older people and their productive capabilities; and changes in attitudes and values of older people many of whom have come to regard their early departure from the labour force as a right (Gee 1995). As noted in the recent report by the Policy Research Initiative, issues around retaining and maintaining older workers are starting to move onto the radar screen (Government of Canada 2005).

The underlying assumption in the retirement literature is that older workers engage far-sightedly in financial and non-financial planning for retirement, but studies show that there is considerable variation in retirement planning. Planning for retirement differs by gender, marital status, work-force status, education and income (Denton et al. 2004; Moen 2000). In particular, those who are forced to retire early are less likely to have made adequate preparations for their retirement Marital history influences women’s planning for later life, as many older married women rely on their husband’s planning (McDonald 1997). Some evidence suggests that while women are more likely to retire for family caregiving responsibilities and for health/stress factors in planning for their retirement, they do not perceive these to be important in their own expected retirement timing (Zimmerman et al. 2000). Retirement planning is an important topic for policy research.

In Canada, we have done the basic research on retirement. We know why people retire and at what age and that the reasons differ for different sub-groups of the population. We know less about the impacts of retirement on people’s lives in terms of financial, health and social well-being. We lack an understanding of the complexities. Little is known about how the intersection of work and family career trajectories impinge on retirement processes and outcomes. Further, we know very little about the retirement experiences and consequences for many of our more vulnerable populations such as recent immigrants, Aboriginals, visible minorities etc.

2.2 Changes in Marital Status

2.2a Divorce

Divorce is becoming more common in Canada, especially among younger cohorts with one- in-every three marriages ending in divorce (Beaujot 2000; Gentleman and Park 1997). Divorced older adults are the least prevalent group, about 5% of men and 6% of women report that they had been divorced (Gentleman and Park 1997; Lindsay 1999a). The rate of older people divorcing has increased significantly (Gee 1995). It is expected then that the proportion of seniors who are divorced will increase as the baby boom generation ages. Men are more likely to remarry than women and are also more likely to be in post-marital co-habitation unions and women, therefore, are more likely to be living alone (Beaujot 2000).

Divorce has a very detrimental impact on the financial status of many older people. Divorced and separated women are among the poorest groups of seniors (Davies and Denton 2002; Galarneau and Sturrock 1997; McDonald 1997). The separated and the divorced have the lowest incomes of all marital groups, and their major source of income is government transfer payments. Further, women who become divorced or separated in mid- and later life are the most economically disadvantage group of seniors (Davies and Denton 2002) . The Divorce Act does little to protect older women who have spent much of their lives tending to family responsibilities, especially if the divorce occurred after the children have grown into adults(Townson 2000). Alimony accounts for only 3-6% of their income and the credit splitting of C/QPP benefits does not appear to make much of a difference because of the low take-up of benefits (Gee and Gutman 1995). There also appears to be regional distribution of poverty among unattached women 65 and over: a disproportionate number of older unattached women live in Quebec as compared to the rest of Canada and live in rural versus urban areas of Canada (Gee and Gutman 1995).

Divorced older people have smaller social networks than married or widowed older people (Barrett and Lynch 1999; Connidis 2001). In particular, divorced older men have the smallest social networks, the weakest social ties with their families and are less likely to receive support from their children (Connidis 2001). They are, however, more likely to remarry than older women.

This literature review has uncovered very little Canadian research on the psychosocial effects of divorce in later life including factors that may buffer these impacts, although some research suggests that married people are happier, and less lonely, on average, (especially men who are married) than non-married persons we know nothing about how older divorced men and women fare over time (Novak and Campbell 2006).

2.2b Widowhood

The widowed represent a substantial proportion of Canadian seniors. The likelihood of being widowed increases with age and is greater for women. For example, among Canadians aged 65-74, 7 % of men and 32% of women are widowed. And, among those aged 75 to 79 years, more than one-half of women are widows, compared with less than 16 % of men who are widowers(Martin Matthews 2000). Overall, among the population aged 65 and over, widows outnumber widowers by a factor of five to one. This is due to the fact that women live longer than men and also that they are less likely to remarry or take longer than men to remarry(Wu 1995).. Because there are so many more widows than widowers, most of the research on widowhood focuses on widows.

The research on widowhood has focused on four themes: the psychological process of coping; the process of role loss that is associated with going from being a member of a couple to being widowed; the economic consequences of being widowed; and the role and nature of social support.

The death of a spouse has been identified as among the most stressful of normative life events. It may bring with it reductions in income, feelings of isolation, loneliness and perhaps depression as the adjustment to living alone is made (Payne 1994). Research suggests that although most widows experience considerable distress immediately after their loss, the majority adjust over time (O'Rourke 2004). Although the number is not known, it is estimated that 20% to 40% never fully recover from their loss and there is a paucity of research that considers who adapts to conjugal bereavement and the factors that impact on recovery (Martin-Matthews 1999; Martin Matthews 1991).

While widowhood can be thought of as an "expectable life event", it may also be viewed as a social process, a transition from a self-definition based on being married to a redefinition of self (Martin Matthews 1991). This redefinition of self however is anchored in, and shaped by, experiences of the life course including the characteristics of the marriage, the marital relationship, the presence of and relationship to children, grandchildren, other relatives and friends. Also important is involvement with the community.

For some, especially women, the death of a spouse precipitates poverty among individuals who were not poor as a member of a couple (McDonald 1997; McDonald and Robb 2004). Without a continuous full-time career and the accumulation of benefits and personal wealth, many married women arrive at widowhood personally empty-handed. They are dependent on their husband's career, life-long income, pensions and investments, his time of retirement and health status for their economic security and they are less likely to have planned for retirement (McDonald 1997). They are one husband away from poverty (McDonald and Robb 2004). Longer marriages protect survivors from extreme poverty, possibly because the couple has had longer to accumulate resources and the widowed are more likely to benefit from the wealth left by their spouse and receive better protection from private pensions or C/QPP (i.e. payment of survival benefits). It should be noted, however, that the widow or widower often has a decrease in benefits. For example, employer pensions are often reduced to about 50 per cent of the original benefit(Lopata 1996; McDonald 1997). Those who are widowed between the ages of 50 and 65 are much more likely to fall into poverty because employers may delay benefits until the year the deceased spouse would have been eligible for retired-worker benefits (Lopata 1996; McDonald 1997; van den Hoonard 2001).

Supportive relationships are key to dealing with changes brought on by widowhood. These can be found in relationships with children, grandchildren, other family members and friends and neighbours. Studies document that widow/ers report the loss of some friendships upon the death of their spouse and the violation of their expected support contributes to their loss (Bess 1999). Further they may experience a distancing from their spouse's friends and relatives as time passes. To compensate for the reduction in their social network, many widows strengthen their emotional ties with friends and neighbours. Data from the 1996 GSS indicates that about half of senior widows report four or more friends and many report a close emotional tie with a neighbour (Bess 1999). As people age, they may outlive many of their friends and so the social network shrinks with age, leaving the oldest-old most vulnerable.

Connections to the community can also buffer the loss of a spouse. Research shows that widows still living in their own homes were well integrated into the community and their contacts with neighbours often provided social support (Bess 1999). Volunteering, support groups, memberships in voluntary organizations and/or associations, recreation centres, clubs, and the church can help override loneliness providing meaning and stability in people's lives(O'Rourke 2004). Some research suggests that rural widows have the potential to be quite isolated, especially if children have moved away or if the widow has not been a long-term resident of the area (Martin Matthews 1991). But, we know little about the lives of widowed women in rural areas or small communities.

Psycho-social health resources also appear to buffer the effects of the death of a spouse. Psychological resilience, (i.e. commitment to living, challenge, perceived control) is associated with life satisfaction and less psychiatric distress for a group of recently studied widows (Campbell, Connidis and Davies 1999; Lopata 1996; Martin-Matthews 1999). Future research should consider the importance of these individual resources to the distress brought on by widowhood.

The experience of widowhood is gendered in significant ways(Campbell, Connidis and Davies 1999; Lopata 1996; Martin-Matthews 1999). While women are often placed at a disadvantage in relation to finances, they remain relatively advantaged in other ways including their ability to care for themselves and to develop friendships and have closer relationships to their children. Some gendered features of the experience advantage men, for example, their financial advantage, their greater likelihood to remarry while they may be disadvantaged by their lesser ability to care for themselves and their weaker social ties to family and friends. Policy research needs to address these gender differences and the consequences for the lives of widowed men and women.

We know very little about specific subgroups such as immigrants or Aboriginal peoples who are widowed (McDonald 1997)**.** As noted by McDonald (1997) previous research has shown that the visible minorities are disadvantaged in retirement and one might expect that occupying the triple status of being a women, a visible minority and a widow, may be very economically disadvantaged in their seniors years.

2.3 Geographic Mobility

84% of senior families own their own homes, most mortgage free (Lindsay 1999a). Most homeowners want to stay in their own homes after they retire(Novak and Campbell 2006). About 5% of seniors aged 60 and over change their place of residence each year(Che-Alford and Stevenson 1998; Ostrovsky 2004). Three-quarters of senior movers move less than 50 kilometers away, with most relocating within 10 kilometers of home(Che-Alford and Stevenson 1998). The most common reasons for moving include a desire for a smaller house, to purchase or build a home, to be close to family, and to relocate to a better neighbourhood. Health reasons and desire to move closer to recreation and leisure activities are also important, especially for those over the age of 70(Ostrovsky 2004). Longitudinal analysis of Survey of Labour and Income Dynamics (SLID) data show that renters are three times as likely to move than owners and seniors with fewer financial assets are more likely to move(Che-Alford and Stevenson 1998). Also, this study shows more seniors are moving from houses to apartments than visa versa.

Findings on geographic mobility from the mid 90s suggest that there may be a trend towards downsizing among seniors as they move from larger to smaller homes, apartments and senior's residence(Ostrovsky 2004). However senior households continue to prefer ownership. They do not appear to be using the equity in their homes to finance their retirement, although more research in this area is needed(Boyd and Vickers 2000). This suggests some interesting policy research questions around the demand for and location of various types of housing (i.e., smaller bungalows, condominium houses and apartments, housing with special features, seniors' residence etc.) and the location of this housing (i.e., in neighborhoods that are closer to recreation and leisure activities).

2.4 Immigration in Later Life

A review of this literature revealed a paucity of research that focused specifically on immigration in later life. Most studies retrieved analyze the labour force and income status (discussed in another review paper) and health of immigrants in Canada (discussed below).

The proportion of immigrants who are 65 and over has grown dramatically. Currently 18% of all immigrants are seniors. Two factors explain this demographic trend: first, the aging of the established immigrant population who immigrated after the Second World War and second, the growth in the proportion of immigrants who are elderly resulting from immigration policies that emphasize family reunification, thereby allowing Canadians to sponsor elderly relatives as immigrants. More recent senior immigrants do not qualify for basic old age security benefits due to a 10 year residency rule (Boyd and Vickers 2000).

Using pooled data from the Survey of Labour and Income Dynamics, researchers analyzed the characteristics of early immigrants (immigrated over 16 years ago), mid-term immigrants (immigrated from 7 to 16 years ago, and recent immigrants (immigrated from 1-6 years ago) (Palameta 2004). For each group, the proportion of immigrants age 65 and over is 24%, 11% and 4%. This study showed that the probability of being in low income groups was greatest for the mid-term immigrant senior. This group would have arrived in Canada in their 50s and did not have much time to accumulate C/QPP or private pension benefits.

Seniors who are immigrants are more likely to be living with a family member than their Canadian counterparts (Che-Alford and Hamm 1999). This finding may be partly explained by ethnicity and culture. For example, Asian cultures are more accustomed to live in large extended families. Also, family re-unification may also account for this finding.

A considerable proportion of older immigrants leave Canada, perhaps to return to their country of origin and by age 75 net migration is actually negative(Boyd and Vickers 2000). Policy research should consider why older immigrants are leaving Canada.

We know very little about the experiences of recent immigrants who are 65 and over. This is an area of considerable interest and Statistics Canada and Citizenship and Immigration Canada are currently conducting a survey that will provide information on the health of immigrants at 6 months 2 years and 4 years after arriving in Canada. It contains information on social networks and determinants of health. This data source will provide a valuable tool for the analysis of the well-being of older recent immigrants.

2.5 Illness of Self or Spouse

While the majority of seniors living at home report their overall health as good (Lindsay 1999b), 81% report at least one chronic condition diagnosed by a health professional (Wilkins and Park 1996). The most prevalent chronic conditions were arthritis/rheumatism, high blood pressure and non-arthritic back problems(Lindsay 1999b). In addition, 33% reported cognition problems (either somewhat or very forgetful, or had difficulty thinking). 8% of seniors could not see well enough to read, even with glasses, and 6% could not hear well enough to follow a group conversation, even with a hearing aid(Schultz and Kopec 2003).

Using data from the National Population Health Survey, the impact of selected chronic conditions on the health-related quality of life showed that for older adults, chronic diseases that have the greatest impact were Alzheimer's disease, the effects of a stroke, epilepsy, bowel disorders and urinary incontinence(Canadian Study of Health & Aging Working Group 1994).

The two main conditions associated with cognitive impairment in later life are dementia and delirium. The most common types of dementia are Alzheimer's disease and vascular dementia. The Canadian Study of Health and Aging estimated the prevalence of dementia and found that 8% of all Canadians aged 65 and over met the criteria for dementia; 5.1% with Alzheimer's disease, 1.5% with vascular dementia and 1.4% with other forms of dementia. The incidence of dementia increases with age so that nearly one-third of all people over the age of 85% have some form of dementia(Canadian Study of Health & Aging Working Group 1994). Delirium is a disturbance of consciousness and cognition, its onset is sudden and may be due to a medical condition, an operation or stay in the hospital, the use or withdrawal of drugs or other conditions.

Depression is much higher among the young and decreases with age, so that about 2% of seniors suffer from depression(Statistics Canada 1999c). An analysis of the National Population Health Survey (NPHS) shows that the incidence of stress also decreases with age and women are more likely to suffer stress than men(Shields 2004). Stress can originate from different sources including recent negative life events, chronic strains and childhood traumas, and of the various sources of stress, chronic strains seemed to be the most potent(Lindsay 1999b). This analysis also showed that higher levels of distress increased the odds of having a chronic health condition suggesting that stress may be a precursor of poor health.

While most seniors live in private households about 7-8% live in long-term care institutions. The oldest-old are more likely to be living in an institution and not surprisingly their health is not as good as those living in the community. Almost all have one or more chronic condition and three-quarters need assistance with the activities of daily living. Over one-third has Alzheimer disease or some other dementia and one-fifth suffer effects from stroke. One-quarter experience vision or hearing impairment(Lindsay 1999b).

Clearly health is gendered. Women outlive men by about 6 years(Hum and Simpson 2002). The top two causes of death for both men and women are heart disease and cancer, although the type of cancer differs by gender (Wilkins and Park 1996). Studies have shown that women are more likely to rate their health as only fair or poor and that there is a higher prevalence of chronic conditions among women than men, primarily because of women's greater propensity to develop disabling chronic diseases(Martel, Belanger and Berthelot 2002). Women are more likely to report experiencing arthritis/rheumatism, high blood pressure, non-food allergies, cataracts, and migraine headaches, while men are more likely to report heart disease, diabetes, and bronchitis/emphysema(Wilkins and Park 1996). In terms of the determinants of health, social structural and psycho-social determinants of health are generally more important for women and behavioural determinants are generally more important for men(Denton, Walters and Prus 2004). Older adult's use of health care services does not appear to differ by gender(Statistics Canada 1999a).

There is a paucity of research on the health of Aboriginal seniors. We know that life expectancy and the burden of disease for Aboriginal Canadians differs from other Canadians. First Nation males and females have life expectancies that were 7.4 and 5.2 years shorter than other Canadians. Data reported for all Aboriginal Canadians indicate that compared to non-Aboriginals they are more likely to have tuberculosis, diabetes, heart disease and are over six times as likely to die of injuries (Allard, Wilkins and Bertherlot 2004). Comparing the off-reserve Aboriginal population to the non-Aboriginal population shows that the Aboriginal population was more likely to report fair or poor health, one or more chronic conditions, long-term activity restriction and experience a major depressive episode. This same research suggests that these health inequalities can largely be explained by differences in socio-economic and health behaviour characteristics (Tjepkema 2002). We know little about specific sub-groups of the Aboriginal senior population. Case studies or qualitative studies might help to fill in the knowledge gaps(Stout, Kipling and Stout 2001).

There is a growing body of research in Canada based on national health surveys that document a "healthy immigrant effect". This refers to the finding that immigrants, especially recent arrivals, enjoy better health than their Canadian-born counterparts, but that over time the health advantage decreases(Ali 2002; Chen, Wilkins and Ng 1996; Chen, Ng and Wilkins 1996). Some research suggests that the healthy immigrant effect does not extend into old age(Gee, Kobayashi and Prus 2004). Gee et al. explored the relationship between length of residence and health status (measured by self-rated health, rates of disability and HUI an overall measure of health) in mid- to later-life immigrants using the 2001 Canadian Community Health Survey(Hyman 2001). While they find strong support for the healthy immigrant effect among those 45-64, the relationship between immigrant status and health does not hold for persons 65 years of age and older. Importantly their work shows that the healthy immigrant effect did not hold for seniors and also that recent older adult immigrants had significantly poorer health than their Canadian counterparts, although much of this difference disappeared when the measures were adjusted for demographic, socio-economic and life-style factors.

Policy research directions suggest that we cannot assume the healthy immigrant effect for seniors. Why is their a steeper poor health gradient for older immigrants than for nonimmigrants? Further, we need to understand the differential needs and experiences of sub-groups of older immigrants especially those most likely to experience socio-economic disadvantage and poor health (i.e. new immigrants, refugees, women, single, from different ethno-cultural or racial groups, proficiency in English or French etc.). Multi-method studies within specific immigrant sub-groups may help us to fill these gaps in knowledge. What determinants of health contribute to changes in the health status of immigrants over time? Most of the studies to date have been cross-sectional, and while this can be used to provide comparative health data, it does not allow us to examine changes over time. As data accumulates on longitudinal health surveys, some of these questions may be able to be addressed. However, national data used to examine the health of immigrants has been collected for more general purposes and may not include information needed to understand the steeper decline in health experienced by immigrants as they age or buffers used to prevent health or other problems (such as psycho-social resources, social support etc). In addition, from a policy perspective, we need to understand how government programs and services can help to maintain and promote the health status of immigrants over time(Hyman 2001).

This brief review of the literature has shown that health status is associated with a number of personal characteristics including age, gender, marital status, levels of education and income, cultural or ethnicity, immigration status etc. Policy research should address the social determinants of health.

2.6 Disability[3] and Dependency

Maintaining independence is a goal that has been rated by older adults as integral to their quality of life(Stone 2003). Disabilities that limit everyday activities[3] can have a profound impact on seniors' lives including their mobility, agility, the ability to do activities of daily living, leisure activities, and overall psychological well being. Data from the Participation and Activities Survey (PALS) indicates that in 2001 about one-third of men and women age 65-74, and over one-half of those aged 75 and older have a disability, the most common being mobility, agility, hearing, vision and pain disabilities(Statistics Canada, 2004).

Some chronic diseases are more likely than others to lead to disability, and the type of disability experienced is related to the disease. For example, arthritis and stroke are associated with mobility limitations whereas cataracts are associated with vision disabilities. Further, arthritis, non-arthritic back problems and heart diseases are associated with dependency for activities of daily living as are chronic bronchitis/emphysema, asthma and cataracts(Marten and Belanger 2000; Wilkins and Park 1996). In addition to specific conditions, physical limitations and dependency are associated with a number of personal characteristics such as age, gender, marital status, type of chronic condition, life style, education and income. Some factors such as age and being female, or having a stoke are actually "double-jeopardy" risk factors(Hum and Simpson 2002;Marten and Belanger 2000).

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[3] Persons with disabilities include those who report having difficulties with daily living activities, or who indicate that a physical, mental or health condition reduces the kind or amount of activities they can do.

Today a 65 year old man could expect to live 16.1 more years, 12.7 of them dependence-free. 1.5 of the other three years would be spent in moderate dependence needing help with tasks like meal preparation and shopping, with 1.1 years spent in severe dependence relying on assistance with tasks like moving about the house or personal care and .8 years in an institution. A 65 year old women could expect to leave another 19.4 years but the last 6 years of her life, she will spend 2.7, 1.6 and 2.1 years, respectively, in states of increased dependence. Therefore women live longer, but spend more time in a state of dependence. This paradox is explained by the different types of diseases that afflict men and women. Men are more likely to be victims of acute illnesses such as heart disease whereas women are morel likely to suffer from chronic debilitating but not fatal diseases(Martel, Belanger and Berthelot 2002).

Cross sectional studies on health have allowed us to measure the extent of chronic diseases and disabilities in the population, but there is some evidence coming from the analysis of longitudinal data to show the dynamic nature of functional health. Using data from the National Population Health Survey researchers have shown that about one-third of seniors who had been dependent in 1994/95 had recovered their independence two years later(Hum and Simpson 2002). Further, an analysis of panel data from the Survey of Labour and Income Dynamics (SLID) has shown that while the onset of disability increases with age, the recovery from a disability is not related to age(Hum and Simpson 2002). This research is exciting and points for policy research to provide a more complete understanding of the dynamics of functional health and the factors associated with it to allow policy makers to design programs and policies conducive to successful aging.

Older adults strive to maintain their independence and autonomy despite their disabilities. For example, in a study of older adults with osteoarthritis and/or osteoporosis, researchers found that older adults managed their conditions by adapting their behaviour across different domains of activity; personal care, in-home mobility, community mobility, household activities, and valued activities. Adaptations include efforts to compensate for disability, efforts to optimize performance to avoid problems or augment reserves, decisions to limit or forgo activities, and utilization of help from others (Gignac, Cott and Badley 2000). More research is needed to develop an understanding of how people adapt to their disabilities in ways that promote their independence.

2.7 Caregiving

Caregiving refers to support provided to someone with a physical, cognitive, or mental health problem whose day-to-day activities are restricted by long-term disabilities or physical limitations. The defining characteristic of caregiving is that the help or social support provided is required by the individual. Much caregiving research has focused on instrumental assistance to seniors. This is defined as assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL). The former refer to activities necessary for survival such as personal care and feeding, while the latter refer to activities important for independence such as grocery shopping, preparing meals, housework etc (Chappell et al. 2004).

Almost half of seniors receive all their care from family and friends and there has been a shift away from institutions and the formal care system towards an increasing reliance on family care providers(Cranswick and Thomas 2005; Statistics Canada 2003a). Care is also provided through the formal care system[4] as well as health care institutions. Data from the 2002 General Social Survey (GSS) indicates that of the 1.0 million non-institutionalized seniors receiving care, 41% received help exclusively from their family and friends, 52% received at least some formal care and about half of those getting formal care also reported having informal assistance from family and friends(Cranswick and Thomas 2005). Those most likely to receive care include those with declining health, advanced age, less education, renters, and women who live alone(Cranswick and Thomas 2005). The mix of formal and informal care differs across age groups, with the proportion receiving formal care or mixed care increasing with age(Cranswick 2005). Also, the distribution of informal and formal care varies by region of the country with less formal care provided in Quebec and the Prairies and more formal care provided in Ontario(Cranswick and Thomas 2005). Of particular interest is the fact that the distribution of seniors between the formal and informal care system seems to be conditioned by factors other than health such as education, the size and composition of the social network, and the availability of formal care although these factors are not yet well understood(Cranswick and Thomas 2005).

According to the 2001 Census, close to 7-8% of all seniors are institutionalized in Canada and the percentage increases with age, with 35% of all seniors 85 and over living in institutions(Cranswick 2005). Census data also indicates that there are provincial differences in rates of institutionalization. The proportion of seniors residing in a long-term health care institution has been declining for both men and women and for all age groups. (Cranswick, 2005; Statistics Canada 2003a). Analysis of the 1996/97 NPHS indicates that those most likely to be institutionalized include women (10% of senior women and 5% of senior men), those living without a spouse and those with low incomes. Further, recent hospital admission, having one or more problems with the activities of daily living (ADL), having a severe disability, having a debilitating chronic conditions such as Alzheimer’s disease, urinary incontinence and the effect of a stroke are all strongly associated with living in an institution(Trottier et al. 2000; Wilkins and Park 1998). Of particular note is the fact that a substantial number of seniors with no disability were also residents of long-term care institutions and many seniors with severe disability lived in private households. Importantly, factors other than health such as marital status, size and composition of care networks, and the availability and financing of long-term care play an important role in determining who is institutionalized. Further, the availability of provincial home care programs may also play a role in rates of institutionalization(Wilkins and Park 1998).

An analysis of the 2002 (Cycle 16) GSS revealed that there are two main sources of unpaid informal eldercare. The first is middle aged adults (16% of adults aged 45-64 provide elder care) and the second is seniors looking after each other (8% of seniors provide elder care) (Stobert and Cranswick 2004; Williams 2005). Findings show that middle aged caregivers are most likely to be looking after their parents or parents-in-law, are working, in good health, and have children of their own. About one-quarter of these caregivers are ‘sandwiched Canadians’

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[4] Formal care is defined as care from government organizations or non-government organizations or directly by an employee paid by the senior or someone acting on behalf of the senior.

caught between caring for their children at home and providing eldercare (Williams 2004; Williams 2005). While about equal numbers of men and women are providing care, the care provided is divided by gender stereotypic lines and female caregivers spend more time per month caregiving than do males. Women spend more hours providing care because they are more likely to be the primary caregiver, to be providing care to two seniors, or to be caring for a senior who is very ill(Frederick and Fast 1999; Martin Matthews and Campbell 1995). Familial caregiving responsibilities place individuals at greater risk of leaving the work force prematurely, and as noted earlier, are an important reason why some women retire prematurely(Martin Matthews and Campbell 1995). Other frequent consequences to personal life include extra expenses, changes in social activities and changes in holidays(Williams 2004). As well, about one-third feel somewhat burdened although only about 5% felt that the burden as quite a bit or extreme(Williams 2004).

Senior caregivers are most likely to be providing care to a spouse (25%), close friend (33%) or neighbour (19%)(Stobert and Cranswick 2004). The majority of them are women, and again senior women spend more time caregiving that their male counterparts. Research has shown that their contribution is substantial both in terms of savings to the health care system, and the quality of care that is provided(Hayward et al. 2004; Robb R 1999; Zukewich 2003).

Many caregivers cited extra expenses due to their caregiving duties (Cranswick and Thomas 2003) and recent policy changes such as the doubling of the medical and disability-related expenses that can be claimed by informal care providers, the caregiver tax credit, the employment insurance compassionate care leave, the CPP general drop out provision, first nations and veterans health programming should help to defray the costs. But many of these target younger caregivers(Hayward et al. 2004). For example, a senior is not eligible for a caregiver tax credit for providing care to a spouse. Research on the impact of these policies on caregiver costs and burden should be addressed.

The major focus of research has been on the stress and burden experienced by caregivers, although there is some research than speaks to the ‘rewards’ of caregiving(Cranswick 2005; George and Gwyther 1986; Keating et al. 1999). Caregiver burden has been defined as the physical (i.e., lowered physical functioning, lower social functioning or worse general heath), psychological (i.e., depression, guilt, worry/anxiety, loneliness, emotional stress, strain, lack of sleep), social (i.e., disruptions to social activities, or holiday plans) and financial problems (i.e., extra expenses, the cost of moving , or employment consequences) that can be experienced by family members caring for impaired older adults(George and Gwyther 1986; Keating et al. 1999). (Some caregiver characteristics appear to be associated with stress and include care receiver’s functional health, gender (women experience greater impacts) , hours of caregiving, interruptions of paid employment, relationship between the caregiver and care receiver, health of the caregiver and social support(Cranswick 2005; Chappell and Penning 1996). Research suggests that caregivers for those with dementia are more burdened than those caring for the physically frail and further, that caring for a person with the behavioural manifestations of dementia is the most problematic (including such behaviors as agitation, violence, incontinence, wandering, the need to watch and control care recipients, embarrassing or dangerous behaviour, hallucinations and sleep disturbance) (Chappell and Penning 1996). Among specific caregiver tasks, ones that restrict or confine the caregiving time and space, and those requiring personal bodily contact such as bathing and toileting are most burdensome(Chappell et al. 2003).

Only a minority of caregivers experience burden. Most caregivers are not at risk of burnout, or of becoming a major user of the health care system. Research suggests that the highest level of emotional burden was experience by caregivers who spent the most time providing care(Frederick and Fast 1999). Women who spent the most time helping seniors were primary caregivers who cared for dying relatives, lived with them, and were emotionally close to them. Men, who devoted the most time were providing care to their spouse (Frederick and Fast 1999). Policy research needs to focus on identifying the minority of caregivers who are at risk and need help as well as study the positive consequences of caregiving and the beneficial coping skills of caregivers. There is some evidence to suggest that factors such as hardiness, sense of coherence and personal resiliency may all be linked to reports of less burden, better overall well-being, better health and the use of fewer formal services(Mockler, Riordan and Murphy 1998).

Less than one-in-five caregivers had someone who could give assistance if they needed a break. For the middle-aged caregiver, the person who was most likely to provide respite care was a sibling or spouse. For the senior caregiver, the person to provide respite was most likely to be a child, family or friend(Stobert and Cranswick 2004). There is an obvious need for the greater availability of respite care to caregivers of all ages and research should address the need for, and use of, respite care.

There is some evidence that ethnicity impacts on the amount and type of care provided. Ethnic origin is related to the propensity to live in multigenerational households, with Asian-origin Canadians – and particularly those who are foreign born, more likely to live in three-generation households(Keefe, Rosenthal and Beland 2000). Also, a study that examines the relationship between ethnicity and the provision of assistance to older relatives by employed Canadians shows that ethnicity influences the amount of assistance provided to older relatives. For example, care provided was higher among Asians, East Indians and Southern Europeans than for British respondents(Keefe, Rosenthal and Beland 2000). Policy research is necessary in order to better understand the complexity of caregiving, the consequences of caregiving, caregiver burden and how best to assist caregivers. Examining care giving from a life course perspective is very useful as caregiving must be understood within the context of family life events, decisions, choices or the lack thereof. Further, caregiving research needs to incorporate the needs of diverse groups including ethnic groups, visible minority groups and Aboriginals(Social Development Canada 2005b).

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3.0 Buffers

This paper has documented the transitions in seniors' lives and shown how for some, these transitions, especially when they occur concurrently can impact on well-being. To buffer these transitions, seniors have resources they can draw upon, such as their human capital (skills and knowledge), social capital or social support (their family, friends and neighbours), psycho-social resources and physical as well as financial assets. Without these resources, they are excluded from participating fully in society. In this section, we will briefly review the literature on social supports, self-care and psycho-social resources before turning to an examination of the role of existing formal health and social services in meeting the needs of older adults living in the community as well as barriers to service use.

3.1 Social Support

Social support is a broad term that is much studied by social gerontologists and has a wide variety of meanings. The majority of literature has focused on social support networks (their size and composition) and two of the functional aspects of support which play an important role in buffering seniors: emotional support and instrumental and tangible support. Two aspects of emotional support are important: companionship (having other individuals in your life with whom you can spend time and share activities) and intimacy (having one or more confidantes in your life with whom you feel free to discuss personal matters and share emotional feelings and events)(Chappell 1992). The same individual could be both a confidant and a companion or different individuals could perform these roles. Chappell and Badger report that 96% of older people have companions and 84% have confidantes and for about half of all seniors this is the same person (Chappell and Badger 1992). Research has documented that most interaction in old age is with family and friends and most elderly people have extensive contacts with an average size network of over 30 people although the size of the social network decreases for the old-old, those in poor health and those who have fewer resources (Chappell, 1992). The majority of seniors have at least one living child and lives with or near one child. More interaction takes place between older parents and their children than with any other kin, with over 80% of seniors having at least weekly contact with a child(Rosenthal, 1987). The sibling relationship is also a special social tie, and they are especially important for the never-married, the childless, the divorced and the widowed (Connidis 2001). There is a paucity of research on interactions with grandchildren, friends and neighbours, although friends seem to be particularly important for companionship.

Research documents the relationship between social support and well-being in later life. This effect may be direct (i.e., networks may provide information or access to resources) or indirect in that it may buffer or mediate the effect of stressful life events such as widowhood, retirement or illness. Although more research is needed in this area, studies show that social support appears to enhance quality of life and well-being during times of stress(Denton, Walters and Prus 2004). There is evidence, however, that there may be a stronger relationship between social support and well-being for women than men(Chappell et al 2003). It is also important to consider that the same transitions in later life that may trigger stress and reduce well-being may also result in the loss of social support.

More policy research is needed in the role played by social support in managing the transitions in later life. Social support is a multi-dimensional concept, making the drawing of general conclusions difficult. Different types of support many be more effective for different problems. For example, emotional support, a feeling of being able to turn to others for affection, assistance and advise, has been shown to buffer the psychological effects of stress but it does not appear to act as a buffer between stress and physical illness (Shields 2004). Too, social interaction can be both positive and negative, and very little is known about ‘negative’ support. Most research in this area is cross-sectional and longitudinal research is needed to sort out the causal relationship between social support and quality of life as the relationship may well flow in both directions (i.e., do people characterized by high levels of well-being have more social relationships and social support?) or could this relationship even be spurious or due to an un-related factor (Chappell et al. 2003).

In summary, the research on social support has shown that the majority of seniors have many social ties and social interactions. Those with social support during times of stress have higher levels of well-being than those without social support. Policy research should address the buffering effect of social support on the negative impacts of transitions to later life such as retirement, widowhood, immigration, dependency and caregiving.

3.2 Self-Care

Self care plays an important role in the prevention of poor health and responses to illness such as the management of chronic diseases (Morrongiello and Gottlieb 2000). The World Health Organization’s definition of self care in health refers to, “activities individuals, families and communities undertake with the intention of enhancing health, preventing disease, limited illness, and restoring health” (Ory 1998). Thus self care refers to both the personal health practices engaged in by older adults believed to be positively related to health as well as informal care provided by families and friends to older persons (discussed above).

Personal health practices may include behaviours such as: good nutrition, exercise, maintaining a healthy weight, engaging in moderate consumption of alcohol, smoking cessation, seeing a doctor and dentist for a regular checkup, or participating in a self-care program (Statistics Canada 1999b; Wister 2005). Research has shown a number of benefits to self-care, including improved quality of life and reduced health care costs through the promotion of functional independence and illness reduction (Morrongiello and Gottlieb 2000). The evidence is inconclusive with regard to the benefits of self-care to mortality and health status particularly among the very old (Morrongiello and Gottlieb 2000).

Studies show that self-care of chronic diseases has a positive effect on the course of the disease(Morrongiello and Gottlieb 2000), although the uptake of self-care behaviours varies by the type of disease (Strain 1996). Some evidence suggests that participation in personal health practices is positively related to age, being female, higher levels of education and income, being married, higher levels of self-efficacy and locus of control (Menec and Chipperfield 1997a;

Menec and Chipperfield 1997b; Morrongiello and Gottlieb 2000; Statistics Canada 2001; Wister 2005).

Again, the literature generally treats older persons as a homogenous group and there is little research on how self-care behaviour varies by age group, socio-economic status or among ethnic or cultural groups. Further, most research on self-care has utilized cross-sectional design with non-nationally representative samples, and so we know little about the prevalence, and effectiveness self care in the prevention of and treatment of illness and disability.

3.3 Psycho-social Resources

While there is substantial evidence for the buffering role of social supports, more recently attention has been shifting to the role of psycho-social resources as having both a buffering and an independent effect on health and well-being (Denton, Walters and Prus 2004). Psycho-social resources include such factors as self-esteem, self-efficacy or control/mastery of the environment and personality constructs such as optimism, extroversion, hardiness etc. One study found that psychological resilience, (i.e. commitment to living, challenge, perceived control) is associated with life satisfaction and psychiatric distress for a group of recent widows(O’Rourke 2004). Other studies have shown the power of health resources such as self-esteem, mastery of the environment, and a sense of coherence in promoting both psycho-social and physical health(Denton, Walters and Prus 2004). A promising line of research would be to examine how seniors use their psycho-social resources to buffer transitions into retirement, widowhood, immigration in later life, a geographic move, coping with chronic diseases, disability and with managing caregiving.

4.0 Opportunities and Barriers to Accessing Social Support Programs and Services Delivery

This section summarizes the research on what we know about the opportunities, as well as gaps in and/or barriers to accessing, community-based programs and services designed to assist seniors in coping successfully with adverse events and life transitions. Issues to be considered include availability of, access to and cost of community support and home health care services.

4.1 Understanding Home Care: Definitions, Mandates and the Needs of Clients

Although "home care" was identified as a priority for funding in the 1997 federal budget; as well as being emphasized in a National Forum on Health in 1997(Aronson and Neysmith 2001), the focus of a national conference in 1998 (Wilkins and Park 1998), and described as "the next essential service" by the Romanow Report (Romanow 2002) most home care and home support services are not yet covered under the Canada Health Act. "The Act's definition of comprehensiveness requires coverage of all medically necessary services delivered in hospitals or by physicians. Home care, with the exception of physician visits, therefore, need not be insured"(Baranek, Deber and Williams 1999, p. 70). As a result, Canada does not have a universally comprehensive home care program and services vary from province to province in terms of eligibility for coverage; services available and whether and to what extent service fees are charged. Thus, there is often considerable ambiguity when discussing what services are included under the umbrella of "home care" and even how the term itself should be defined and understood (Hollander and Walker 1998).

Most often, the term "home care" is understood to include both "home health care" as well as "home support" services (Hollander and Walker 1998). Whereas home health care services may consist of home nursing, physiotherapy and rehabilitation, home support services generally consist of non-medical interventions and may include housekeeping and personal care such as bathing, toileting and grooming, respite services, low-cost transportation, volunteer visiting and meals-on-wheels programs (Caplan 2005; Hollander and Walker 1998; Wilkins and Park 1998). While the aim of home nursing and therapeutic services is to meet the immediate medical needs of clients, home support services may serve to complement home nursing care or be delivered independently of medical interventions in order to promote health and delay institutionalization among those who, while not acutely ill, may experience functional limitations which hinder their ability to remain in their homes independently.

Despite the lack of a federal mandate, virtually every province has emphasized some form of in-home care services to: (1) maintain the health and independence of those experiencing long-term chronic illness; (2) as a form of long-term care substitution, or (3) as a form acute-care substitution(Hollander and Walker 1998). It is difficult to overstate the increased importance of provincially administered home care programs. Indeed, as a number of authors have noted, home care is the fastest growing segment of the health care sector in Canada(Di Matteo and Di Matteo 2001; Hollander and Walker 1998; Wilkins and Park 1998). The importance of the availability of in-home care services is underscored by the fact that those who may benefit most from the availability of these services are also amongst the most vulnerable or marginalized within society. It has been well established that low levels of educational attainment, income inequality and poverty (Cairney 2000; Hogan, Ebly and Fung 1999; Humphries and van Doorslaer 2000; Prus 2001), low levels of social integration or social supports (Arber 2004; Prus and Gee 2001; Unger et al. 1999), gender (Belanger et al. 2002; Matthews, Manor and Power 1999; Prus and Gee 2001) and ethnicity (Brotman 2003; Chappell and Lai 1998; Rosenberg and James 2000; Tennstedt and Bei-Hung 1998) are all highly significant predictors of increased morbidity, mortality and institutionalization. Moreover, a significant literature exists pointing to the clear benefits of home nursing and home support services in promoting health and independence and delaying institutionalization among those experiencing functional limitations (Hollander 2001; McWilliam et al. 1999; Soderstrom, Tousignant and Kaufman 1999; Wilkins and Park 1998). Taken together, these findings would suggest that it would be these groups who would be the most likely to access care services. Recent research indicates, however, that only about half of seniors who require personal assistance have their care needs fully met (Chen and Wilkins 1998; Wilkins and Park 1996; Wilkins and Park 1998), and that those with low levels of income and educational attainment, visible minorities are less likely to utilize in-home care services when health status is held constant (Chen and Wilkins 1998; Wilkins and Park 1996; Wilkins and Park 1998). To date, there has been limited empirical research conducted on accessibility (as opposed to utilization) to care services or barriers to use along socio-demographic lines. There has, however, been a significant literature produced on structural barriers to accessing community-based services more generally which may contribute to an understanding of why so many seniors living in the community do not utilize care services despite having care needs go unmet.

4.2 Barriers to Accessing Home Care Services

Over the past two decades virtually every province has responded to declines in federal investment in health care by reducing hospital stays, closing beds, and shifting the locus of care to the community (Chappell et al. 2003; Wilkins and Park 1998; Williams et al. 2001). These reforms were generally undertaken with the understanding that although the proportion of provincial health care budgets assigned to medical and hospital services would be reduced, there would be increases in home care funding to meet growing demand for services delivered (Penning et al. 2002). Although there is considerable variation by province in relation to the process of restructuring, service delivery and resources allocated to home care programs, in the last decade, home care expenditures in Canada have increased at a rate that was four times greater than other health care spending (Coyte 2000). These increases in funding, however, are typically seen as insufficient to meet the demands placed on the system stemming from the greater number of post-acute care clients (as a result of shorter hospital stays and increases in day surgery), as well as growing numbers of care clients experiencing long-term chronic illness (characteristic of an aging population)(Aronson, Denton and Zeytinoglu 2004; Hall and Coyte 2001; Woodward et al. 2004).

There have typically been two outcomes to the shortage of resources. The first has been to give priority to those with acute care needs (Aronson 2002b; Aronson, Denton and Zeytinoglu 2004; Coyte 2000; Hall and Coyte 2001; Penning et al. 2002; Segall and Chappell 2000;

Woodward et al. 2004). Although this approach does meet one of the objectives of home care programs, it also tends to neglect the social and preventive function of home care services, and excludes those clients who may benefit from the use of these services. “Especially with capped home care budgets, there is widespread concern that the acute hospital discharge group has been driving out those who need social and personal rather than medical services” (Baranek, Deber and Williams 1999). Thus, those not experiencing acute illness may not be able to access care services that would otherwise facilitate their living in the community independently. Moreover, the focus on medical care within the home may also have a considerable impact upon the quality of care provided to home care clients, as care workers are under increasing strain to provide care to a greater number of acute care clients without sufficient resources, training or equipment to do so (Armstrong and Armstrong 2003; Home Care Study Corporation 2003a; Home Care Study Corporation 2003b).

An alternate strategy has been to provide less service to a greater number of people, and actively seek help from non-profit and charitable institutions, particularly when the services needed have a high degree of substitutability - those services that may be delivered by those other than medical professionals (Aronson 1994; Aronson 2002a; Aronson and Neysmith 1997; Hall and Coyte 2001). A national study found that while the number of people receiving home nursing care remained relatively constant between 1994 and 1998, the numbers of those receiving personal care services (such as bathing) increased while the numbers of those who received home supports or housekeeping services decreased when health status was held constant (Home Care Study Corporation 2003a). The authors suggest that given a lack of resources, there is an increased emphasis on providing only the most ‘essential’ services to clients, leaving care recipients to increasingly rely on volunteer agencies, friends, family and neighbours (Home Care Study Corporation 2003b). Indeed, some authors have suggested that the presence of family and friends may itself be a barrier to accessing services (Armstrong 2001; Aronson and Neysmith 1997; Aronson and Neysmith 2001; Aronson and Sinding 2000; Brotman 2002; Woodward et al. 2004). This contention may be supported by research indicating that those with larger social networks are less likely to utilize formal care services (Aronson and Neysmith 1997; Brotman 2003; Chappell 1993; Crocker Houde 1998; Penning 1995a; Penning 1995b; Penning 2002; Ward-Griffin 2002) despite a research literature indicating that informal care is often not the most preferred care arrangement (Aronson 1990; Aronson 1994; Aronson 2002a; Aronson and Neysmith 1997; Chiu and Yu 2001; McCann and Evans 2002; Newsom and Schulz 1998) as well as concerns surrounding the ability of informal care providers to meet the care needs of older adults living in the community (Aronson 1990; Aronson 1994; Aronson and Neysmith 1997; Barrett and Lynch 1999; Chappell 1993; Fast and Keating 2000; Glazer 1990; McGary and Arthur 2001).

Closely related to barriers created by a lack of resources are barriers to care associated with the lack of a continuous care provider. One recent study found some clients have refused to have a service provider visit if their regular workers were unavailable even if they needed the service(Woodward, Abelson and Hutchison 2001). Among service users, the lack of continuity amongst service providers was found to be dehumanizing by older clients who often required help with intimate activities and felt uncomfortable doing these things with a succession of care workers and eroded their confidence in the ability of home care services to meet their needs(Aronson 2002a; Woodward, Abelson and Hutchison 2001; Woodward et al. 2004). Indeed, the need to re-explain care needs to new service providers who, at times, did not possess the skills to meet their needs or who were unable to carry out their duties because of an unfamiliarity with the organization of the household has also been identified as a potential barrier to service use (Woodward, Abelson and Hutchison 2001). Clients have also reported limited trust in the quality of service that could be provided, indicating that providers were often poorly trained and did not provide the care they were supposed to deliver (Woodward, Abelson and Hutchison 2001). Although there is limited empirical evidence directly linking the availability of a continuous care provider and service use, a number of authors have posited that insecurities and frustrations as well as decreased quality of care pose a barrier to service use (Aronson 2002a; Woodward, Abelson and Hutchison 2001; Woodward et al. 2004).

There are significant regional variations both in relation to the availability of services and funding among rural communities, and they are among the hardest hit by funding restrictions (Cloutier-Fisher and Joseph 2000; Coyte and Young 1999; Hall and Coyte 2001; Joseph and Cloutier-Fisher 1991; Joseph and Martin Matthews 1993). There are several reasons for this. First, services are often not available in rural communities due to staff shortages and lack of physical resources (Cloutier-Fisher and Joseph 2000; Coyte 2000; Coyte and Young 1999; Hall and Coyte 2001; Joseph and Cloutier-Fisher 1991; Joseph and Martin Matthews 1993). Indeed, both publicly subsidized and privately accessed services have typically been characterized as "limited" when compared to urban centers (Cloutier-Fisher and Joseph 2000; Coyte 2000; Coyte and Young 1999; Hall and Coyte 2001; Joseph and Cloutier-Fisher 1991; Joseph and Martin Matthews 1993). This in part may be attributed to how home and health care are funded – typically according to the size a population, leaving small communities with often meager financial resources compounded by a shortage of health care professionals within the community (Coyte 2000; Coyte and Young 1999; Hall and Coyte 2001). In addition, rural communities are typically "older" than their urban counterparts (Barnes 1997; Joseph and Cloutier-Fisher 1991; Joseph and Martin Matthews 1993). This is significant in relation to home care services not only because there is greater need, but also because older adults are among one of the largest groups of volunteers (Barnes 1997; Krause and Markides 1990; Perren, Arber and Davidson 2003; Vinton, Altholz and Marcus 1997; Young and Glasgow 1998). Thus, as communities age the pool of volunteers available to provide care is also expected to dwindle resulting in reductions in available services such as meals-on-wheels (Barnes 1997; Coyte 2000; Coyte and Young 1999). The current model of care which emphasizes the role of informal social networks and volunteer agencies as main sources of care provision while limiting formal care services to those experiencing acute care conditions may further limit accessibility to services among older adults.

Although not universal, in an effort to reduce duplication and fragmentation and create greater efficiencies within the system, several provinces including British Columbia, Manitoba and New Brunswick have single entry systems for accessing all home and long-term care services, meaning that applicants do not need to seek out all of the potential services available to them independently (Hollander and Walker 1998). Other provinces and territories such as Alberta, Saskatchewan and the Yukon have separate application procedures for home and long-term care. There is a general consensus that a single entry system is not only cost-effective, but also provides a more client-friendly introduction to the system, and reduces the possibility that care needs will go unmet. This system, however, is not without flaws. As Aronson notes: “If patients only have one entry point and do not meet the one set of criteria for care, then they could be denied access to all care services” (Aronson and Neysmith 1997). Moreover, recent findings have revealed that, in some jurisdictions, the formal appeals process can be overly bureaucratic, lengthy and intimidating to many frail older adults (Home Care Study Corporation 2003b). A general lack of awareness of services available has also been identified as a significant barrier to accessing home nursing and home support services no matter what the assessment process. Although research in Canada is limited, a telephone survey of 111 home care clients revealed that 25 percent would not know who to call if they needed changes in the types or frequency of services they received (Caplan 2005). Additional studies have found that informal caregivers felt that information on community services were not readily available to them (Haug and Prokop 2004; Minore et al. 2001). Past research on awareness of community support services has found that those with low levels of educational attainment and lower incomes were less likely to identify community based services that might be available to them(Caslyn and Roades 1993; Krout 1985; Snider 1980). Indeed, Chen and Wilkins (1998) posit that the difference in service utilization and prevalence of unmet care needs among these groups may be attributed to a lack of knowledge on the availability of formal services. Additional research examining the relationship between awareness of services and gender, marital and health status and levels of social integration has been less conclusive(Ahmad and Walker 2004; Calsyn and Winter 1999; Caslyn and Roades 1993).

Although there has been little literature produced explicitly examining barriers to service use on the basis of SES and gender in Canada, there has been some research conducted on some of the barriers faced by ethnic older adults. As noted earlier, the ethnic elderly are more likely to experience health-related care needs (Brotman 2003; Chappell and Lai 1998; Laditka and Laditka 2001; Rosenberg and James 2000), but less likely to access formal care services (Chen and Wilkins 1998; Wilkins and Park 1996; Wilkins and Park 1998). Studies on access to community-based services among older adults of varying ethnicities have found that the greatest barrier to service use among this group is related to language (Brotman 2003; Chappell and Lai 1998; Ma and Chi 2005). A recent study by Ma and Chi (2005) found that slightly more than one third of Chinese-Canadian elders did not access home and community care services due to structural barriers such as difficulty in accessing social service agencies, complicated application procedures, long waiting lists and a general lack of knowledge of the services available in their communities. In addition, cultural differences related to care preferences and different understandings of health and illness are also important determinants in whether or not older adults access available care services (Brotman 2002; Brotman 2003; Haug and Prokop 2004). Indeed, a number of authors have pointed to the need for culturally sensitive health and support services provided by those with a specialized knowledge of multicultural practice, which would encourage service utilization and meet both social and health dimensions which are seen as essential in the provision of high quality care services (Brotman 2003; Ma and Chi 2005; Minore et al. 2001).

Based on the review of the literature, we recommend policy research is needed on the availability of, accessibility to and costs of home and community services: This research should include: a consideration of structural barriers (i.e., including the shortage of resources, shift of focus to acute home care versus the preventive function of home care, the decrease in quality and continuity of care), the organization of care (i.e., provincial variations, growing reliance on charitable and non-profit organizations, growing reliance on volunteers to provide care despite the lack of resources to these organization and the growing shortage of volunteers, growing reliance on families to provide care despite the aging of the population and the participation of women in the labour force, and limitations of a single point of entry to home care in many provinces) and regional variations, especially barriers to care in rural communities. Further, policy research should investigate the socio-demographic barriers to home and community care including: gender differences, differences by income and education levels, differences by health conditions and ethnic and cultural barriers.

5.0 Conclusions

In our review of the literature we have attempted to identify policy research directions specific to understanding the various transitions that older persons face as they age. Throughout this review several important policy research themes have emerged. We will attempt to summarize these themes in the concluding section of the paper.

Older age is a time of many transitions such as a retirement, marital transitions, health problems of self or spouse, geographic moves and so on. These transitions may place older people at greater risk to poverty, social isolation, loneliness, loss of independence and declining health. These risks are greatest when problems are due to multiple sources/transitions. For example, an illness experienced by the husband may precipitate early retirement for both members of the couple, and the adoption of the role of caregiver for the wife. At the same time there is a decrease in the economic well being of the couple due to retirement and the cost of care. A second example, becoming a widow may precipitate a drop in income, a move from a family home and the onset of social isolation and loneliness. Policy research is needed to understand the impact of the accumulation of life events on well-being. Such understanding is necessary to identify risk groups and to develop programs that help individuals cope with the transitions in later life.

This review uses the life course framework to analyze the key events and transitions in older adult's lives. From this perspective, the individual's life course is composed of multiple, interdependent trajectories or pathways such as work and family life. What happens in one trajectory may impact what happens along other trajectories. Also, the notion of link lives is important as individual lives are intimately connected to the lives of others and their experiences are bounded and shaped by these ties. Throughout this review we see evidence of these interconnecting trajectories and linked lives. For example, married couples often retire together, sometimes one of them to care give for the other; widowed women fare better when they have a social network to provide them with social support; caregivers experience less burden when the care is shared by other members of the care network. Using a life course approach to developing a policy research agenda will allow policy makers to understand why some adults are better able to negotiate the transitions associated with later life and others are not.

Most people have personal and social resources that allow them to manage the transitions in life so that a setback in one (i.e., marital dissolution) may be buffered by other resources (i.e., social network). If compensation is not possible, or if multiple resources break down at the same time, then the results may have a detrimental effect on well-being. Policy research should focus more clearly on the individual resources that support successful transitions and identify policies to support these transitions.

Most research studies treat older people as a homogeneous group, with little attention given to how their life experiences differ by gender, age group, marital status, ethnic/cultural group, immigration status, income or region of the country. Research has shown that different groups experience the life course in different ways. To date, we have lacked national longitudinal data which would allow us to examine many of these variations. Many good sub-studies and qualitative studies exist, but they do not allow us to generalize findings to the larger population and are of limited use for informing national policy. We are reaching a point in Canada now where we have several national longitudinal data sets available such as the NPHS/CHS and SLID that will allow us to pool years of data to study specific subgroups of older persons. In addition, the proposed Longitudinal Study on Aging promises to be a rich data source for future policy driven research.

To date there has been little recognition of cohort/historical influences on behaviour and attitudes. Cohorts refer to people born at a given period of time and who share a common life trajectory because of the timing of their birth in relation to the economic and social forces occurring at the time. Today's cohort of elderly experienced the depression as children, the Second World War as young adults and witnessed a period of economic growth after the war. They differ in their experiences from the baby boom generation who will soon be entering the rank of senior citizen. Ellen Gee has cautioned us that policy changes must consider the ways in which cohorts differ in their ability to prepare for their old age. The large size of the baby boom cohort and the small size of the cohorts that follow should be of particular concern. Policy research must provide cohort specific data so that policy making can be done without cohort-blind lenses(de Jong Gierveld 2003). Cohort differences in health, life style, education and the like, clearly point to the importance of longitudinal analysis in which successive cohorts reshape the profile of the population.

A reoccurring theme in this review of the literature is the important influence of social structure on the lives of older adults. The context of people's lives, their age, marital status, gender, level of education and income, their ethnic or cultural group, their levels of social support and where they live (i.e. urban/rural or province) all determine their lived experiences. To give a few examples, this review shows that gender, level of education, and occupation impact the nature of retirement, the timing of retirement and the pathways to retirement. Longer years of work experience, continuous and full-time employment mediates the economic consequences of widowhood and reduces the likelihood of living in poverty for widows. Specific chronic conditions, physical limitations and dependency are associated with a number of personal characteristics such as age, marital status, and socio-economic status. An important role that Social Development Canada can play is to identify policy to support individuals who do not have the adequate resources to manage key transitions.

Social structure also conditions the amount and type of care that is received. While most older Canadians are able to manage the transitions associated with aging, some need assistance. This assistance may come in the form of social support, care with activities of daily living from family and friends, home and community care or even care in a long-term care institution. Yet the availability and the access to care is often conditioned by factors other than health. These may include socio-demographic factors such as age, marital status, education, ethnicity or cultural group, and the size and composition of their social network. The barriers may also be structural barriers including the shortage of resources, the organization of care, and regional variations in the cost, availability and access to care. Policy research is necessary to come to a fuller understanding of the relationship of these factors to the care of older persons.

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