Frail elderly: a study about the subjective wellbeing factors when choosing a location of care in the Netherlands

Summary

This thesis will focus on finding out what are important subjective well-being factors for frail elderly people when they decide on a location of care. As there is already quite some research on physical wellbeing, this thesis will mostly focus on subjective wellbeing. Literature on this topic suggests that the geographical proximity of children and the life-space of a person are important factors when deciding on a location of care With means of qualitative method, eight elderly people who are either widowed or separated are interviewed by means of in-depth semi-structured interviews. The results suggest that factors that matter for elderly people when deciding on a location of care are: feeling safe (regarding care), a sense of belonging, the roots of a person and the life-space of a person.

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1. Introduction

1.1 Background

An often researched theme in research done about living environments of elderly people evolves around ‘’aging in place’’ (Wiles et al, 2011; Golant, 2020). This concept is defined as ‘’remaining living in the community, with some level of independence, rather than in residential care’’ (Davey et al, 2004, p.133). Furthermore, it could be explained as elderly preferring to get care at home instead of institutional care in nursery homes or hospitals (Wiles et al, 2011; Barken, 2021). Important considered reasons for ‘’aging in place’’ are: remaining independent, feeling an emotional bond with a place and staying in contact with social contacts (Golant, 2020; Wiles, 2011). While most of the current research on ‘’aging in place’’ does not focus on a specific demographic within the group elderly people (e.g. Wiles et al, 2011; Barken, 2021), this paper will. This paper will namely focus on frail elderly people. Furthermore this implies means that this paper will, next to the concept of ‘’aging in place’’, also look at where frail elderly people would ideally like to receive care when they don’t have the option to receive at-home care.

Frailty can be described as follows: ‘’a state that occurs when there is diminished ability to carry out the important practical and social activities of daily living’’ (Morley et al, 2002, p. 698-704). This state of frailty mostly affects elderly people. Due to injury or illness the physical condition of these people can quickly go from stable to vulnerable (Clegg et al, 2013). In many cases, Clegg et al (2013) state that this increasing vulnerability impacts health and wellbeing causing that many frail people will, at some point, need some sort of care. During the process of finding sufficient care for frail elderly people, an important notion is the location of this care. In the 20th century, healthcare in western countries mostly took place in hospitals and nursing home’s (Björnsdóttir, 2002), however due to new policies this has shifted into more care at home. For elderly people, this sometimes means being taken care of by family or friends. Where this situation is often quite difficult for the family of the elderly person (Björnsdóttir, 2002), being close to family members does have a positive effect on the subjective wellbeing of elderly persons and could thus be a good reason to find a location of care near family members (van der Pers, 2015). Next to close geographical proximity, the life-space of a elderly person is also an important factor when choosing a location for care (Douma et al, 2021).

1.2 Research aims

Prior research on frail elderly and wellbeing mostly focuses on the physical aspect of wellbeing (e.g. Schuurmans et al, 2004; Douma et al, 2021), however not much research has been done on the subjective aspect of wellbeing. And as mentioned before, limited research is available on what factors matter to elderly frail people when deciding on a location for care. This research therefore aims to find out what are important subjective wellbeing factors for elderly frail people when deciding upon a sufficient location for care. In order to keep this research narrow and focused, this research will focus mostly on subjective wellbeing factors, but does also takes into account physical wellbeing factors. Next to this, this research will only look at elderly who are widowed or separated, as this is an under researched topic. Furthermore, the research has an explorative character, meaning that it is intended to create new insights on the topic.

For this research, the following research question has been formulated:

‘’ Which subjective wellbeing factors matter to (single) frail elderly when deciding on the location of care?’’

Sub questions:

- In what way do elderly take into account their physical and mental health when deciding on a location of care?

- How does having children influence the location of care for elderly people?
- Does the life space of an elderly person matter when deciding on the location of care?

1.3 Structure of the paper

This paper consists out of five chapters. In the first chapter, a brief introduction is given about the topic and the research. In the second chapter existing theories and concepts about the topic are analysed in the theoretical framework. In the third chapter, the research method is explained in the methodology. In the fourth chapter the results of the qualitative interviews are explained and analysed. In the fifth chapter, the results are linked to the research questions in the conclusion. And at last, in the sixth chapter a brief reflection on the research process and recommendations for future research are given.

2. Theoretical framework

2.1 Subjective wellbeing

Subjective wellbeing could be described as to what degree a person is appraising his or her life, considering good and bad. Or shortly summarized: ‘’how a person feels, instead of what a person does’’ (Veenhoven, 2008, p.44). According to Schimmack (2008), subjective wellbeing can be divided into two sorts: cognitive wellbeing and affective wellbeing. Cognitive wellbeing symbolizes the beliefs and attitudes people have about life. This includes how satisfied people are with their life and what individual aspects are responsible for this (Schimmack, 2008). Affective wellbeing symbolizes the feelings, both negative and positive, that people have in their daily life’s. Next to the sorts of subjective wellbeing, the term can also be divided into different components. According to Diener (1985), subjective wellbeing includes life satisfaction, positive affect and negative affect. Life satisfaction explains the way how a person rates his or her life not directly taking into account emotions. Positive and negative affect cover the negative and positive emotions that influence the wellbeing of people (Schimmack, 2008; Diener, 1985). When looking at the influence of age on subjective wellbeing, Pinquart & Sörensen (2000) state that subjective wellbeing does not necessarily decrease when age increases. However, some factors that cover subjective wellbeing do get more or less important when age increases (Pinquart & Sörensen, 2000). An example of a more important factor is the quality of social relations, whereas the quantity of social contacts seems to become less important.

2.2 Theories about location of care in relation to subjective wellbeing

A concept strongly linked to subjective wellbeing is the geographical life-space of a person (Douma et al, 2021). Douma et al define life-space as follows: ‘’Geographical life-space can be defined as the spatial area in which a person lives, gets out and about, interacts, participates, conducts his or her societal roles, and engages in activities in the course of everyday life’’ (2021, p.1). In order to create a clear image of the life-space of an elderly person, Douma et al (2021) came up with a life-space model (See figure 1). In the model, the life-space of a person gets divided into multiple layers, ranging from the bedroom of a person as the first layer, to where a person goes abroad as the final layer. Furthermore, they have divided levels into what extent the life space layer is accessible to an elderly person. This ranges from ‘accessible without any further help’ to ‘not part of life space’.

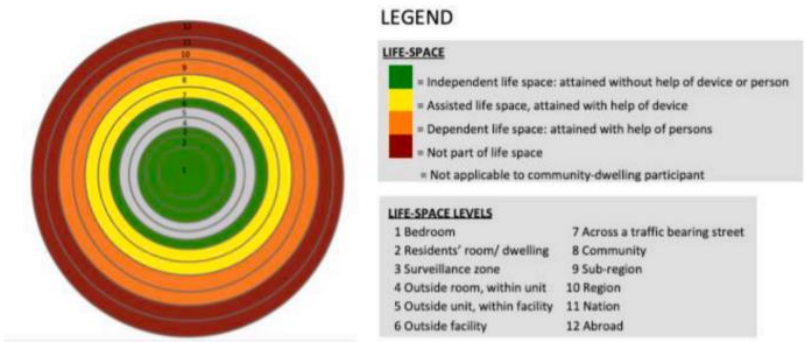

Figure 1: Life-space model (Douma, 2021)

The life-space concept is a useful tool to explain the subjective wellbeing level of elderly persons. According to Douma et al (2021), elderly people that have a restricted life space experience lower levels of subjective wellbeing than people with an unrestricted life-space. However, in line with

Pinquart and Sörensen's (2000) study, overall levels of subjective wellbeing still seem to be high, regardless of the age and life-space (unrestricted or restricted).

For many frail widowed or divorced elderly people, having adult children at a close geographical proximity benefits their subjective wellbeing. This is because the close distance of children helps with fulfilling their physical and social needs (Van der Pers et al., 2015; Lin, 1997). In line with the shift from care at hospitals to care at home that has been happening in the 21th century (Björnsdóttir, 2002), children also form an important source of care for elderly frail people (Artamonova et al, 2020). While in the USA 50 % of the elderly people have at least one child who lives in close proximity (+-25km) to them (Lin et al, 1997), in northern European countries such as Sweden and the Netherlands this percentage is even higher, namely around 60% (Hank, 2007). This close geographical proximity of children to elderly is important for the process of care, because the closer the child lives, the more support they can give (Artamonova et al, 2020). However, when looking at the moving patterns of children it can be seen that they don't often move necessarily closer to their elderly parent(s). For frail elderly people, it can be seen that instead of moving closer to a child/children, they more often move to an institutionalised care facility to get care (Thomas et al, 2020).

The difference of having at least one child in a nearby geographical proximity can also be made between widowed and/or separated elderly and elderly who still have a partner (Van der Perse et al, 2015). Next to having children nearby for physical care, they can also provide emotional support. In the case of widowed and/or separated frail elderly, children can compensate the loss of emotional support and affinity that were formerly given by their partner (Dykstra, 1993). However, Van der Pers et al (2015) argue that having children live in a close geographical proximity has no direct effect on the subjective well-being of widowed and/or separated elderly. Their findings do suggest that widowed and/or separated elderly benefit from having children living nearby, but it can't compensate for the emotional and physical loss that happens during widowhood or divorce. Van der Pers et al (2015) therefore argue that the partner still remains the most important source of the fulfilling of emotional and physical needs.

When frail elderly can't or don't want to receive care at-home, they often move to care homes in order get institutionalized care (Andersson, 2006). According to Hall et al (2009), it is important to maintain a sense of dignity when frail elderly move to a care-home, since for most people who move into a care-home, it will be their final destination . Following Hall et al and Franklin et al (2006), important components of dignity entail the physical state of the body, fragility and dependence and inner strength and a sense of coherence. When frail elderly that live in a care-home don't have or lost this sense of dignity, living in a care-home could be quite stressful and uncomfortable. Andersson (2006) states that for these people the facilities offered in the care-home cannot compensate the losses of moving out of their own home. Examples of this are: losing feeling of power and control, missing social interaction, feeling lonely.

2.3 Conceptual model

From the analysed literature, a conceptual model has been created (see figure 2). First, the model describes that subjective wellbeing will influence the decision on the location of care. In turn, two main factors will influence subjective wellbeing. These components are: the geographical proximity of children, and the current life-space.

Furthermore, it is conceptualized that the importance of geographical proximity of children is moderated by the fact whether elderly people are widowed or separated and thus living alone. Finally, the level of frailty or independency (physical and mental health) is conceptualized to moderate the relationship between subjective wellbeing and the location of care.

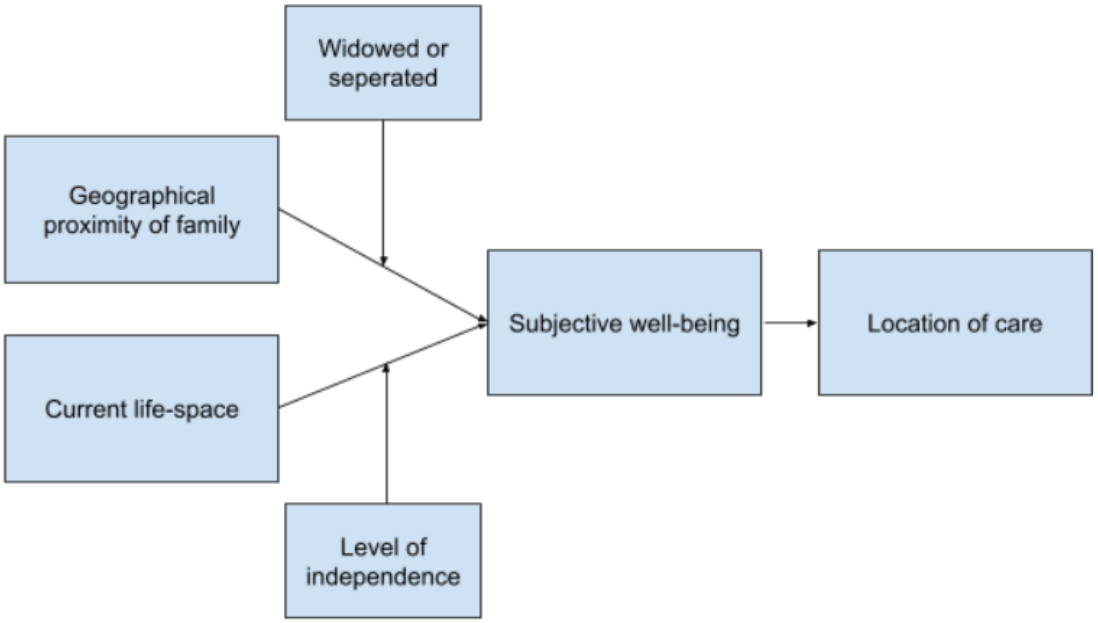

Figure 2: Conceptual model

2.4 Expectations

Since this research follows a qualitative method, no hypotheses will be drawn up. Instead, this thesis will use expectations (Punch, 2014). When looking at written literature, it can be expected that when choosing a location for care, elderly people would like to remain self-dependent for as long as they can. Furthermore, the geographical proximity of children influences the choice frail elderly make when choosing a location of care. Moreover, with frail elderly being widowed and/or separated, it will be expected that they become more dependent on family and other social contacts considering physical and mental wellbeing and geographical proximity of children will become even more important. At last, it can be expected that the kind of life-space (restricted or unrestricted) a frail elderly has can influence the choice of location of care. \

3. Methodology

3.1 Data collection method

The data collection in this thesis follows a qualitative method. This data collection method is chosen because it allows a clear demonstration of the feelings and opinions of the respondents (Punch, 2014). Initially, the plan was to interview frail elderly, however after multiple considerations, the researcher chose to renounce from this plan. Instead this research follows a methodology form similar to vignette methodology. Vignette methodology implies that the researcher creates a fictional scenario, where he or she than asks questions about (Barner & Renold, 1999). In this study this meant that a scenario was made where the interviewee should imagine that he or she would need more extensive care in the future. After the scenario was thoroughly explained, questions were asked and interviewees would share their thoughts and opinions on the scenario. The vignette methodology was chosen because it allows to ask not-frail elderly what they would do if they would become frail in the future.

For this research mostly primary data is used as there is limited secondary data available. This implies that all the interviews are done by the researcher himself. Furthermore, the researcher audio-recorded all the interviews. When the data was gathered, it was analysed by means of coding. Firstly, the researcher transcribed the audio-recorded interviews. After this common themes and opinions in the interviews were linked and labelled by means of codes. The coding is done by the programme Atlas.ti.

3.2 Interviews and data analysis

As this study has a qualitative nature and relies on the answers and opinions of the interviewees, there has been chosen for conducting semi-structured interviews. This method of interviewing has been chosen, because it allows for a clear structure in the interview, but at the same time also leaving room for interviewees to give more open answers.

As can be seen in Table 1, eight persons have been interviewed. All these persons were either single or widowed. Furthermore, all interviewees did have some sort of care, but they could not be considered as frail when following the definition given by Morely et al (2002). However, with the help of vignette methodology they could still answer questions and give responses in the context of them being frail.

Table 1: Descriptive statistics interviewees

Interviewee	**Place**	**Gender**	**Age**	**Date of interview**
1	Enschede	Female	90-95	10-11-2021
2	Enschede	Female	85-90	10-11-2021
3	Oldenzaal	Male	70-75	18-11-2021
4	Oldenzaal	Male	80-85	18-11-2021
5	Oldenzaal	Female	85-90	18-11-2021
6	Oldenzaal	Male	80-85	18-11-2021
7	Leens	Male	85-90	22-11-2021
8	Groningen	Male	80-85	23-11-2021

The recruiting of the interviewees was done via the researcher's personal network and the theory of snowballing. This method is chosen because it is a good tool to reach people who are not easy to access (Naderifar, 2017). Possible interviewees were then approached via an e-mail, or via a care-taker of that person, since some of the respondents were not able to communicate via email themselves. All interviews have been done on location, taking into account all rules and measures surrounding the Covid-19 pandemic.

3.3 Ethical considerations

As this research focuses on frail elderly people, there is carefully considered whether an interview at location would be possible. Especially when considering the Covid-19 pandemic. In order to do the interviews as safely as possible, respondents were asked whether they are comfortable with an interview at location or if they rather do it via another way. When the respondent stated that they were comfortable with an interview on location, a follow-up e-mail would be sent about the date and location of the interview. As digital ways of interviewing could be hard to set-up for some elderly people, the researcher in some cases also got in contact with a care-giver of the elderly person and asked this person to help the respondent set up the interview.

Furthermore, respondents were being made aware of their rights before, during and after the interview. This meant that respondents had the right to refuse answering questions, could stop their participation in the study and could look into their transcript if they wanted to. As many interviewees shared private and intimate information, results and interviewees have been anonymised.

4. Results

The results shown in this chapter are based on the codes identified and created from the interviews done with eight elderly people. All the codes were analysed and then divided into four main codes (see appendix 3). These four main codes are: health and independency, family and social contacts, life-space & aging in place and living situations. The results will exist out of four sub-chapters who each represent a different main code.

4.1 Health status and remaining independent

In this study, most of the respondents stated that they were relatively healthy. Some of them do have underlying conditions, such as leukaemia and heart issues, but they do not see this as directly life-threatening. Other small complaints regarding their health are mostly described by the respondents as a consequence of getting older and thus something that older people have to accept. When looking at current care, there can be stated that most of the respondents do not have a significant form of regular healthcare. Some respondents get help with small tasks (e.g. cleaning, taking medication etc.), but they feel like this not actual care. Although the respondents do not need or have any regular healthcare, some of them still have immediate access to it if they need it. Respondent 1 explains:

''I have this little strap around my arm which is connected to a device. When I fall and I cannot reach the phone, I can press this and I will be connected to 'Thuiszorg', who will ask me what is wrong. Even when I don't answer, they will still come.'' – (Respondent 1)

The device that respondent 1 is talking about offers a 24 hour monitoring service that alerts healthcare care services when immediate care is needed. As this healthcare service ensures care when needed, it functions like a safety net upon which elderly people can rely. For the respondents, this feeling of safety and reassurance made them more confident to remain living at home. The safety net could therefore be considered as an important factor for elderly people when deciding whether they want to get care at home or somewhere else. Following the research on the ''aging in place'' concept (Wiles, 2011; Golant, 2011), respondents mentioned that they ideally would like to live independently (i.e. without care) at their own home for as long as possible. However, with people getting more fragile by a higher age, the respondents do realize that one day their self-dependency will fade. Respondent 7 said the following about this:

''I do am very attached to my independency. I like to keep everything under my own control and therefore I'm trying to keep self-dependent for as long as possible. However when I had a brain infarct, I had to live in a care home for 2 months, so you never know what crosses your path.''- (Respondent 7)

The respondents mentioned that the uncertainty of when their self-dependency will fade makes it hard for them to make a clear decision on whether to remain living at home or get care somewhere else. As they want to ''age in place'', remaining self-dependent is an important condition. This suggests that as long as elderly people can remain self-dependent, having a (chronically) disease, being disabled or having an illness are not a direct reason to move.

4.2 Children and social contacts

4.2.1 Closeness of children

Following the research of Lin (1997) and Hank (2007), children could be considered as an important source of physical and emotional support for elderly frail people. Furthermore, having a child or multiple children living nearby increases the level of subjective wellbeing. In this study, the widowed and/or separated respondents experienced the (nearby) presence of children more as a sense of belonging than actual emotional and physical support. When being lonely or not having anyone to talk to, the presence of children made that they still feel belonged. However, in line with van der Pers (2015), they felt like the emotional and physical support of their children can not compensate for the loss of emotional and physical support that was given by their partner. Respondent 3 said the following about this:

''You can't share the things you would share with your wife with anyone. Things like what I experienced during the day or how I feel, I now keep for myself. That is something I miss the most'' – Respondent 3

Although elderly people would want it, children are not able to give the same emotional support as a partner can. For physical support however, this is contrary. In the form of healthcare, children are able to offer the same physical support as a partner. However, elderly people do not accept this type of support from their children. They feel like children are not the right persons to give this care as they have their own children and lives to take care of. Next to this, they do not want to interfere with their personal lives as they feel that they become a burden for their children. Because of these reasons, moving closer to children in order to get care often is not an option considered by elderly people. However when a child already is living close, it is a reason to stay in the same place or region as them to get care.

4.2.2 Social contacts

Most of the social contacts that the respondents have are either people living close to them (e.g. neighbours), or family. In line with Pinquart & Sörensen (2003), the respondents further said that over time, the quality of social contacts gets more important than the quantity. They mentioned that with a higher age the options to come into contact with new people are shrinking and that it is therefore hard to build new meaningful relationships. Respondent 1 explains:

''When you're this old you don't make any new friends. That social life is than gone and the contacts you do have are with people in your surroundings.'' – Respondent 1

Following this, existing social contacts become even more important. Furthermore, it means that when elderly people would decide to move away for care, they would leave behind a big part of their social circle. As building new relationships is hard and often not desired, having a social network in a certain place is an important motive for elderly people to stay at in that place. This also means that having a social network is an important factor when elderly people decide about the location of care. With a social network, they are more likely to stay at the place where they are currently at, while without a social network, the place of care would matter less.

4.3 Life space and aging in place

In this study, all the respondents still live independently at home. The type of houses that they live in are either freestanding houses or apartments in larger flats. When asked about what kind of bond the respondents had with their home, all of them talked about the neighbourhood in which their home is located. For many elderly people, the neighbourhood or flat in which they live forms a safety net of support where they can rely on. Respondent 3 explains:

''In this neighbourhood we look after each other. Not that it is intrusive, but we just check whether everyone is doing okay'' – Respondent 3

This safety net of support allows for mainly two things: experiencing a feeling of safety as the neighbourhood checks whether the people living in it are fine, and experiencing a feeling of belonging, as the neighbourhood helps with fulfilling social needs. This makes that the safety net that the neighbourhood offers allows elderly people to remain living at home independently for a longer amount of time. Furthermore, it forms an important factor in the decision on a location of care as without the support of the neighbourhood, elderly people would be more vulnerable and sooner inclined to get care at a different location.

When looking at the personal living area, there can be seen that the house elderly people are living in often forms a place of emotional value. The bond that people have with their house mostly lays in the experiences and memories they had here. Furthermore, elderly people with many experiences and memories in their current house are more attached to it than elderly with less experiences and memories. This makes that the level of attachment one has with his or her house, influences whether this person wants to stay at this house or move somewhere else when needing care:

''I have too much connection with this place. Now there are still things I can do here, but when I leave I'm afraid they'll say that I'm not welcome anymore''- Respondent 7

When following the life-space theory of Douma et al (2021), the life-space of a person reaches from a independent life-space to an dependent life space (see figure 1). A life-space gets determined by the level of restriction. In the case of elderly people, the life-space often poses some restrictions. Many therefore have an assisted life-space. This means that they can get to most places, but do need the help of a device (e.g. rollator). As people get more vulnerable as they age, having a life-space that is restricted makes it hard for a person to full-fill his or her personal needs. The results in this study suggest that as long as elderly people can full-fill their own personal needs, their life-space remains on a level of restriction that allows them to remain living independently at home. However, when an elderly person is not able to full-fill his or her needs, the life-space gets too restricted to live independently at home. By following this result, the life-space of a person can be considered as an important factor when deciding on a location of care.

4.4 Ideal place of care: perceptions for the future

Following the ‘’aging in place’’ theory (Wiles et al, 2011; Golant, 2020), elderly people ideally would like to live independently in their own home for as long as possible. However, when considering aging and thus becoming more frail, they do have the realization that living independently at a certain point will become hard. Therefore, there are different approaches that elderly people consider in order to get sufficient care. From the responses in this study, three approaches have been distinguished. The first one focuses on an independent way of getting care. This could be done by healthcare workers that will provide care in the house of elderly people or, in the case of respondent 3, by building a completely new care-friendly house. The second approach focuses on a semi-independent way of getting care. This entails that elderly people will live in a ‘’aanleunwoning’’. This is a house or apartment that is under the supervision of a care-home. It means that whenever a inhabitant needs care, a healthcare worker from the care-home will check within a few minutes. The third approach is a more dependent approach, as it focuses on institutionalised care. A primary example of this is living in a care-home. This form of care often is not desired by older people as it limits the feeling of belonging. This is because, when elderly people move to a care-home, they lose their social network. Furthermore, as making new social contacts is hard for older people, they don’t have confidence in finding new social contacts when they move from their home.

When looking at the location of care in the context of regions and villages, a noticeable finding is that elderly people like to get care in the region or village where there roots lie. This because of past memories and experiences, they are used to how things work in this region.

‘’We’re used to how things work here. When I think of the south, the west and the north, it seems to me that the care is organized a bit different, but you will get used to it. Here, we are used to the way they do it in the east.’’ – Respondent 6

As the elderly people know how things work in a region, it feels safe and familiar to return or stay in this place when getting care. Following this, there can be stated that the roots of a person are a factor during deciding on a location of care.

5. Conclusion

5.1 Sub research-questions

This study began with asking 3 sub research questions. The first one being: ‘’In what way do elderly take into account their health when deciding on a location of care?’’ In short, aggravation of health (e.g. illness, disability or chronic disease) is not a direct reason for elderly people to move to another location for care. An important notion to make here that this statements only stands as long as there is a safety net for them to rely on. This safety net, existing out of healthcare services such as 24 hour monitoring and check-ups from healthcare workers, allows elderly people to remain living independently at home. As long as this safety net stands, elderly people don’t feel the need to find another place of care, as they can receive care in their own home.

The second sub-question is: ‘’ How does having children influence the location of care for elderly people?’’. Having children does not influence the choice of location for elderly people when looking at receiving care. Although children can give emotional and physical support, they can either: not give the same kind of support (emotional) or not be accepted as primary source of support (physical). Because of these two factors, moving closer to their children is often not a option for elderly people. When however looking at the situation where children are already nearby, there can be seen that this does influence the choice of location to a certain extent. Elderly people tend to stay in the same place or region to get care when their child(ren) are already living there.

The third and final sub question is stated as follows: ‘’Does the life space of an elderly person matter when deciding on the location of care?’’. The level of restriction that a life-space has, determines whether an elderly person can full his or her personal needs and thus remain living at home independently. If a life-space is not or merely restricted and a person is still able to full-fill his or her own needs, this person is most likely be able to live at home independently. However, when a life-space gets too restricted and a person is not able to full-fill his or her own needs anymore, it is likely for this person to find care. Therefore the life-space of a elderly person does matter when deciding on a location of care.

5.2 Main research question

The main research question of this study is formulated as follows: ‘’ Which subjective wellbeing factors matter to (single) frail elderly when deciding on a location of care?’’

When following gathered results and concepts and theories from written literature, 6 subjective well-being factors have been distinguished. When however looking at which factors matter to frail elderly when deciding on a location, a division should be made. The factors that do not matter are: children and changes in health. These factors do influence elderly people in the question on whether they should get care, but not in the decision on the location of care. The factors that do matter to frail elderly when deciding on a location of care and are thus form the answer to the main research question are: Feeling safe (regarding care), a sense of belonging, the roots of a person and the life-space of a person.

6. Reflection and recommendations for future research

When looking back on the research process and this research overall, there can be stated that this research does have some limitations. The first one being that, although this is a qualitative research, the number of respondents is still relatively low. This makes that results and statements are mostly assumptions which can not be projected onto the whole population. Secondly, 4 of the 8 persons that participated in the interviews already knew each other and were also living very close to each other. This makes that some of the statements and results about for example the importance of the neighbourhood are possibly a bit biased. Thirdly, as also underlined by participants, the way of how healthcare is organised differs between different regions and provinces. As participants of this study were living either the province of Groningen or Overijssel, it is unclear whether results and statements made are also applicable for other provinces in the Netherlands. Although the study did have some limitations, the results and findings can still be an interesting step-up for further research

As this research mostly focuses on the factors of choosing a location, it could be interesting to research if there could be ways in which some of these factors, for example the feeling of safety and belonging can be kept when elderly people need to get care. Furthermore, as many respondents in this study stated that they want to live independently at home for as long as possible, it could be interesting to research how elderly people can get care, but still have the feeling of living independently at home.

References

Andersson, I. Pettersson, E. Sidenvall, B. (2006). Daily life after moving into a care home – experiences from older people, relatives and contact persons. *Journal of Clinical Nursing,* 16, 1712-1718.

Artamonova, A. Gillespie, B, J. Branden, M. (2020). Geographic mobility among older people and their adult children: The role of parents' health issues and family ties. *Popul Space Place,* 26, 2371

Barken, R. (2021). The temporal aspects of mobility intentions: older people's reflections on present and future support arrangements. *Ageing & Society,* 41 (3), 561-581.

Björnsdóttir, K. (2002). From the state to the family: reconfiguring the responsibility for long-term nursing care at home. *Nursing inquiry*, 9(1), 3-11.

Clegg, A., Young, J., IIiffe, S., Olde Rikkert, M., Rockwood, K. (2013) Frailty in elderly people. *The Lancet*, 381, 752-762.

Davey, J., Nana, G. de Joux, V., Arcus, M. (2004) Accommodation options for older people in Aotearoa/New Zealand. *New Zealand institute for research on aging.*

Diener, E. (1984). Subjective well-being. *Psychological Bulletin*, 95(3), 542-575.

Douma, L,. Steverink, N., Meijering, L. (2021). Geographical life-space and subjective wellbeing in later-life. *Health and place*, 70.

Golant, S, M. (2020). The distance to death perceptions of older adults explain why they age in place: A theoretical examination. *Journal of aging studies*, 54.

Lin, G. & Rogerson, P, A. (1995). Elderly parents and the Geographic Availability of Their Adult Children. *Research on Aging*, 17 (3), 303-331.

Hall, S. Longhurst, S. Higginson, I. (2009). Living and dying with dignity: a qualitative study of the views of older people in nursing homes. *Age and Ageing*, 38, 411-416.

Hank, K. (2007). Proximity and contacts between older parents and their children: A European comparison. *Journal of Marriage and Family*, 69, 157-173.

Morley, J, E., Perry H. M., Miller, D, K. (2002). Editorial: Something about frailty. *Journal of Gerontology, 57 (11), 698-704.*

Naderifar, M., Goli, H., Ghaljaie, F. (2017) Snowball Sampling: A Purposeful Method of Sampling in Qualitative Research. *Strides in development of Medical Education,* 14 (3).

Punch, K, F. (2014). Introduction to social research: Quantitative and Qualitative Approaches.

Pers van der, M., Mulder, C, H., Steverink, N. (2015). Geographic proximity of adult children and the well-being of older persons. *Research on aging*, 37(5), 524-551.

Pinquart, M., Sörensen, S. (2003). Differences between caregivers and noncaregivers in psychological health and physical health: a meta-analysis. *Psychology and aging*, 18(2), 250-267.

Schimmack, U. (2008). The structure of subjective well-being. *The science of subjective well-being*, 97-107.

Thomas, M, J. Dommermuth, L. (2020). Internal Migration and the Role of Intergenerational Family Ties and Life Events. *Journal of Marriage and Family*, 82 (5), 1461-1478.

Veenhoven, R. (2008). Sociological theories of subjective well-being. *The science of subjective well-being,* 44-66.

Wolf, D, A., Freedman, V., Soldo, B, J. (1997). The division of family labor: care for elderly parents. *The Journals of Gerontology*, 52B, 102-109.

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

Appendices

Appendix 1. Agreement of participation

Overeenkomst van deelname

Naam onderzoeker: Dax Eisen
Onderzoek: Bachelor scriptie Sociale Geografie
Onderwijsinstelling: Rijksuniversiteit Groningen
Titel: Welke subjectieve factoren van welbevinden spelen een rol bij alleenstaande ouderen wanneer zij afhankelijk worden van zorg?

Geachte heer/mevrouw,

Allereerst, bedankt dat u mij wilt helpen met mijn onderzoek. Via deze brief wil ik u informeren over de inhoud van het interview.

Het doel van het interview is om te achterhalen waarom alleenstaande oudere mensen kiezen voor een bepaalde locatie om hulp te krijgen. Hierbij zal ik u vragen stellen over uw vroegere en huidige levenssituatie, maar het grootste deel van het interview zal gaan over welk beeld u heeft over de toekomst en u onverhoopt afhankelijk wordt van zorg. Belangrijk hierbij is dat u op elk moment kan aangeven te willen stoppen met het interview of een vraag niet te willen beantwoorden. Het interview zal circa 45 min. duren en is semigestructureerd. Dit houdt in dat het interview bestaat uit een aantal gestructureerde vragen over het thema, maar ook dat u te allen tijde antwoorden extra kan toelichten.

Het interview zal worden opgenomen door middel van een audiorecorder. De gesproken tekst wordt naderhand door mij uitgetypt. De uitgetypte tekst zal worden gebruikt om de informatie uit de interviews te analyseren om zo tot resultaten voor het onderzoek te komen. Wanneer de scriptie is goedgekeurd zullen de audio opnames verwijderd worden. De resultaten zullen anoniem worden verwerkt. Concreet betekent dit dat uw uitspraken kunnen worden geciteerd, maar zonder vermelding van uw naam, woonplaats of andere informatie die naar u te herleiden is.

De interviews zullen worden afgenomen in een omgeving en op een tijdstip dat u past. U kunt ten allen tijde besluiten dat het interview niet door kan gaan, of dat het op een andere plek of via een andere methode (telefonisch of online) moet plaatsvinden. Omdat de COVID-19 pandemie nog steeds aanwezig is in Nederland, is het belangrijk dat u zich veilig voelt. Dit houdt in dat zowel u, als ik op elk moment kan aangeven dat vanwege onze gezondheid het interview niet plaats kan vinden. Wanneer dit het geval is, zal het interview verschoven worden naar een andere datum, of op een andere manier plaatsvinden. Wanneer het interview wel kan doorgaan op een veilige manier, zal ik als onderzoeker op minimaal 1,5m afstand van u blijven en zal ik, mocht u dat willen, een mondkapje dragen. Verder ben ik volledig gevaccineerd met het Pfizer-vaccin.

Samenvattend verklaart u met deze overeenkomst dat:

- U begrijpt wat het doel van het interview is en waar het interview over gaat.
- U begrijpt dat u ten allen tijde het recht heeft om het interview te stoppen of vragen niet te beantwoorden.
- U begrijpt dat informatie uit de interviews vertrouwelijk wordt behandeld en dat, zonder bezwaar, deze informatie gebruikt kan worden in het onderzoek (algemeen en citaten).
- U begrijpt dat u anoniem blijft gedurende het onderzoek
- U begrijpt dat u na afloop van het interview uw antwoorden kan aanpassen op onjuistheden.

Voor verdere vragen kunt u contact opnemen met:

Dax Eisen (Student)

d.y.eisen@student.rug.nl

+31642590433

Wanneer u akkoord gaat met het bovenstaande, gelieve in te vullen:

Ik geef toestemming tot het opnemen van het interview voor onderzoeksdoeleinden JA/NEE

Naam deelnemer interview…….....

Datum……..

Email……...
(Indien u het interview wilt controleren op onjuistheden en daarom de transcriptie wilt ontvangen)

Handtekening……..

Appendix 2: Interview guide

Interview guide

Introduction

- Ask how interviewee is doing
- Remind interviewee about research topic & research aim
- Inform interviewee about structure of the interview
- Remind the interviewee of their rights

Main questions

- Can you tell me who you are, your age and what kind of job you had?

- Do you have any form of healthcare at the moment?

- Depending on answer: Where and how are you getting this care?

- What kind of bond do you have with your current place of living?

- What are negative/positive points of this place?

- How is your contact with family/children?

- Would moving to your children in order to get care be an option?

- Imagine a scenario where you would need more extensive care in the future. Where would you like to receive this care?

- And why?

Closing remarks:

- Ask if interviewee has any questions.
- Thank interviewee for participation

Appendix 3: Code scheme

Code scheme

Code	**Main code(s)**
Health	
Current care	
Self-dependency	
Uncertainty	Health and independency
Family	
Moving to children	
Other times	
Social contacts	
Being lonely	
Husband	Family and social contacts
Relationship to place of living	
Roots	
Experiences and feelings	Life-space
Type of living	
Ideal scenario	
Influenced by others	Living situation