Centre for Healthy Aging
AT PROVIDENCE

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

Understanding Personal Health Decision Trade-offs of Older Women:

Findings from a Pilot Study

Older Women's Health

Social determinants—like income and social status, social support networks, and environment—shape the health status and outcomes of individuals and communities. Low income or living in poverty can result in material and social deprivation that impact health and quality of life. Health effects of living in poverty can manifest differently by gender and when it is experienced in one's life. The roles, relationships, and power that are culturally ascribed to older women with limited financial means in Canadian society also have important implications to their health.

Key Messages

- Women 65+ years of age are at greater risk of having inadequate financial resources & are more vulnerable to living with illness & struggling with the associated costs of care.
- Marital status & personal support networks affect a woman's ability to meet her own health needs.
- Our pilot study reveals that low-income, older women prioritize their health needs based on urgency; use a range of coping strategies to delay/reduce personal health costs; & may consult with care providers to identify more affordable health purchases.
- Trade-offs women regularly make to meet their competing health & non-health needs can have both immediate & long-term health & financial consequences.
- A community resource guide of affordable services & programs available, paired with a workbook to encourage thoughtful reflection on their own needs & health risks, may be a valuable, practical health education tool for older women.

The feminization of aging in poverty has become an important issue in Canada. The poverty rate for Canadian women 65 years of age and older was 19.1% in 2003; in BC this rate was slightly higher at 23.2% (Wister et al., 2009). Unattached older women are particularly at risk with nearly 42% of them being identified as poor in our country (Canadian Research Institute for the Advancement of Women [CRIAW], 2005). Women who age in poverty are more likely to experience illness and struggle with the associated costs of care (Plouffe, 2003).

Some research suggests older women with limited financial means demonstrate personal resilience, but that a sudden change in medical coverage, personal health, or daily expenditures would greatly challenge their capacity to make ends meet. Previous studies are limited in what they reveal about the decision-making of older women who delay or give up other purchases to address their health needs.

The health of older women was first identified as a research priority by members of the BC Home and Community Research Network (HCCRN). HCCRN was an investigative team—funded by the Michael Smith Foundation for Health Research from 2005 to 2010—that sought to increase

research capacity within the BC Home and Community Care sector to efficiently address the ever-changing health needs of seniors to optimize and maintain their well-being, dignity, and independence. In 2009, HCCRN formed a team comprised of researchers from the University of Northern British Columbia's School of Social Work, the BC Network for Aging Research (BCNAR), and the Centre for Healthy Aging at Providence (CHAP), to better understand the personal health decisions and trade-offs of older women.

At the end of 2009, the HCCRN Older Women's Health team was awarded a BCNAR Emergent Needs grant to conduct a pilot study exploring the health issues of women 65 years of age and older and their ability to manage competing health and non-health needs within limited financial resources. The team worked within two BC communities (North Vancouver and Prince George) to recruit and hold pilot focus groups with women 65 years of age and older, who self-identified as having difficulty making ends meet due to limited finances. The pilot focus groups were held in February 2010 and conducted in English.

Pilot Study Participants in North Vancouver & Prince George

The research team partnered with Vancouver Coastal Health – North Shore Community and Family Health to recruit women who lived in affordable, seniors supported housing in North Vancouver to participate in a one-time focus group. In Prince George, the research team partnered with Women North Network/Northern FIRE to recruit older women from Prince George seniors' centres and doctors' offices. Strategies used in both settings were successful in recruiting a sufficient number of participants for two pilot focus groups (one in each community).

Eleven women participated in North Vancouver and seven participated in Prince George. The average age of North Vancouver participants was 77.8 years whereas in Prince George it was slightly younger at 73.8 years. Across the two sites, all but one participant received Old Age Security (OAS). Just under three-quarters of North Vancouver participants received Guaranteed Income Supplement (GIS) while 42.9% of participants in Prince George received GIS. All but one North Vancouver participant lived alone, with the majority self-identifying as being widowed (63.6%). Over half of Prince George participants lived alone with the majority being widowed (57.1%). Most participants were born in Canada (54.5% in North Vancouver, 71.4% in Prince George) and self-identified as being Caucasian (54.5% in North Vancouver, 100% in Prince George).

A greater range in health status was reported by North Vancouver participants compared to Prince George participants (Table 1). Among North Vancouver participants, 27.3% reported that most days are quite a bit stressful or extremely stressful, and another 27.3% reported that most days are a bit stressful. In Prince George, no participants reported most days as quite a bit/extremely stressful but 85.7% of participants reported that most days are a bit stressful. The majority of participants identified as having been diagnosed with a chronic health problem (54.5% and 57.1% in North Vancouver and Prince George, respectively); 36.4% and 28.6% reported having two or more diagnosed chronic conditions in North Vancouver and Prince

George, respectively. In terms of accessing health services, the majority of participants visited their family physician within the last 30 days while only a small minority also saw other health professionals (Table 2). Interestingly, 54.5% of North Vancouver participants and 71.4% of Prince George participants reported having to go to the hospital for a health issue in the last year. Over a third (36.4%) of North Vancouver participants reported having had a health problem that they thought they should see a health professional about but did not; no Prince George participant reported such instances.

Table 1: Reported Health Status by Focus Group Participants

In general, would you say your health at this current time is:	VANCOUVER (n=11)		PRINCE GEORGE (n=7)	
	n	%	**n**	%
Excellent	2	18.2%	~	~
Very Good	1	9.1%	~	~
Good	4	36.4%	3	43%
Fair	2	18.2%	4	57%
Poor	2	18.2%	~	~

Table 2: Reported Health Professionals seen by Focus Group Participants in Last 30 Days

In the last 30 days, have you seen any of the following because of a health problem? (Please check all that apply to you)	VANCOUVER (n=11)		PRINCE GEORGE (n=7)	
Family Physician	6	54.5%	5	71.4%
Medical Specialist (e.g., cardiologist, oncologist, ophthalmologist etc.)	2	18.2%	~	~
Social Worker	~	~	~	~
Community or Public Health Nurse	~	~	~	~
Dentist	2	18.2%	2	28.6%
Chiropractor	1	9.1%	2	28.6%
Other	3	27.3%	1	14.3%
None of the above	4	36.4%	~	~

Themes from the Pilot Study

Focus groups were transcribed verbatim and analysed using "constant comparison" and "keywords in context" qualitative data analysis techniques (Onwuegbuzie et al., 2009). Moderator and Assistant Moderator notes were reviewed and NVivo version 8.0 software was used to store data files and organize codes. As this was a pilot study the emergent themes are identified for exploratory purposes only.

Findings indicate that participants, independent of living in a northern or southern BC urban setting, identified similar issues. **Prioritization of medical needs based on urgency/degree of seriousness** was a predominant theme. Similar to previous research,

our data suggest that older women tend to prioritize the purchase of prescribed medications to manage their chronic conditions over other health needs (Kinch & Jakubec, 2004; Schoenberg et al., 2009). For example, participants spoke of foregoing regular dental care or other "less serious" types of care needs only until they were absolutely necessary, but regularly purchased prescription medications, even when they were considered too expensive to afford. Seriousness of a health issue was described in terms of the physical pain it can cause or its negative impact on activities of daily living; other studies of older women living with limited income reinforce this description (Esser-Stuart, 2002; Shawler & Logsdon, 2008).

Related to the prioritization of needs was a secondary theme of using **coping strategies to delay/reduce treatment or cut expenses**. A strategy from one Prince George participant was to chew on only one side of her mouth so she wouldn't have to resort to getting the necessary but expensive dental work. One North Vancouver woman discussed using her son's old pair of glasses while another woman continued to use a broken pair so she wouldn't have to purchase new lenses. Other women would limit their purchase of food, and especially fresh fruit and vegetables, in order to pay for their medications or address health needs that would have more immediate, serious consequences were they to be ignored (such as managing diabetes). Activities that they would like to engage in, like recreation and social programs, were engaged in sporadically when they could afford to do so or no longer engaged in at all. These strategies further illustrate how medical needs are prioritized over needs related to the broader social determinants of health. While many women seemed to be aware of the impact these social factors and conditions also had on their health and well-being, their precarious financial situation meant that they saw no choice but to consider these as luxuries not always attainable.

The **value of consulting with a pharmacist, family doctor, or dentist to identify more affordable alternatives (e.g., prescription drugs under Pharmacare's Low Cost Alternative) or discounts (e.g., for dental work or purchase of orthotics)** also emerged from the pilot study. However, the scope of this work did not include a more in-depth look at the patient-provider relationship and how it impacts whether or not low-cost health purchases/alternatives could be pursued. Based on the comments received from focus group participants, it would appear that a sustained relationship with a health provider they know and trust would make breaching the subject of more affordable options a lot easier to do. There has been some published research on the value of trusting, mutually-respectful relationships between physicians and low-income, older female patients on quality of the primary care experience (O'Malley & Forrest, 2002; O'Malley, Forrest & O'Malley, 2000).

Marital status and social support networks affect one's ability to meet personal health needs. Being the primary caregiver to a spouse can impact personal health decision-making as married women spoke of dealing with their spouse's care needs before taking care of their own, which often meant limited resources available to address their own health issues. At the same time, having a spouse and/or adult children can mean a higher household

income and/or availability of financial and social support in times of greatest need. While the women in our pilot study expressed gratitude for having children they could turn to, they also expressed their desire to maintain their independence by not turning to their family, especially for financial support. In some instances, this was not possible since adult children were identified as being in the same or even more precarious financial/health situation than themselves.

We also found that some participants had several years experience with managing financial stress (e.g., raised children as a single mother) while others were relatively new in dealing with these concerns. Hence, **sources of financial stress vary and one's ability to make ends meet also changes over time**. Whether one has always experienced financial difficulty or has only recently been confronted with financial constraints (due to a recent change in status as a result of retirement, a health emergency, or death of a spouse) will also affect how health decisions and trade-offs are made. For example, some women experiencing recent financial stress resorted to relying on credit cards to "get by." Consequently, this strategy could lead to more stress and negatively impact their health and well-being later on. Awareness of available resources and relevant information also appeared to vary among participants. Although no concrete conclusions can be drawn from this initial work, we would suspect cultural and psychosocial factors are embedded within the personal health decision-making process. These factors therefore warrant further investigation in a larger research study, which could also make use of other research methods and approaches to look at health decision-making from a social-ecological and life-course perspective.

Some differences that emerged between our North Vancouver and Prince George focus groups are worth noting. First, Prince George participants tend to still drive and own their own vehicle which represented a significant expense but absolute necessity among women who can only access services and resources by car. This issue was not identified by our North Vancouver participants who all lived in a neighbourhood with a wide range of services and shopping accessible by public transit. Second, Prince George participants identified a need for more affordable seniors' housing options and anticipated an eventual move into more appropriate accommodations. These housing concerns did not emerge from our North Vancouver focus group, likely because they lived in affordable housing where some supportive services are currently available on-site.

Potential Health Risks

Trade-offs to address some health issues at the expense of others, or a decision to delay or reduce treatment, can exacerbate or result in more health problems (and the associated costs of requiring more care) in the long-run. Taking on more health risks have important implications not only for the individual but to the health care system and community as a whole. From the individual's perspective, delays in treatment can lead to unsafe practices with potentially hazardous outcomes. For example, not getting new prescription lenses can increase one's risk of falling; not using appropriate assistive devices can also increase the likelihood of falls.

Experiencing a fall can, in turn, require acute care and higher levels of formal and informal support, thereby impacting one's quality of life and ability to maintain independence. Consequently, the need for higher levels of care lead to higher costs to the health care system.

It is evident from the pilot study findings and previous literature that older women with limited financial means recognize the value of adequate and affordable housing, and access to convenient and affordable transportation, food, and opportunities to engage in both physical and social activities. And while women will manage what they can on their own or with support from their personal support networks, more awareness and support from community service providers, health care professionals and policymakers is required to improve their health circumstances and increase their opportunities for meaningful participation in our communities.

Next Steps

Older women deal with multiple financial, emotional and health-related needs, and prioritize and reconcile "what needs to happen" with "what can happen" within their current budget or circumstance. Our immediate next step from this pilot work is to seek funding to develop a resource guide for older women seeking practical solutions and support in addressing their health needs. The value of a resource guide was confirmed through our pilot study, with focus group participants demonstrating different levels of knowledge or even conflicting information about currently available free or low-cost services and programs in their community.

The resource guide would be paired with a workbook to encourage women to reflect on their personal situation and health issues. Potential risks stemming from decisions and trade-offs identified in the workbook could then be linked to resources in their community. The workbook would use case studies to highlight concrete steps one can take to reduce risks. Revealing personal hardships and coping strategies is difficult for many, but our experience with the pilot study validates the power of using anecdotal evidence from peers to open the doors to self-reflection. The development of the resource guide/workbook would take account of appropriate language to describe scenarios and key issues. For example, many of the women who participated in the pilot study did not describe themselves as "poor" or living in "poverty" and were quick to express their issues in relative terms by saying, "it could be worse," or "my situation isn't so bad compared to so-and-so." As such, the resource guide/workbook would not reinforce "labels" for these women (such as "poor," "old," "sick" or "vulnerable," etc.), but empower them by increasing their knowledge of available resources and supports, and by broadening their understanding of potential risks that can stem from their health decisions and trade-offs.

To support this work, direct partnership and consultations with older women and appropriate community organizations will be sought. In addition, we will review relevant literature on health decision aids, best practices in preparing health education materials for seniors, as well as knowledge translation and dissemination tools. The dissemination plan for the resource guide/workbook will also engage health professionals who regularly come into contact with

seniors, including family physicians, community health nurses, and pharmacists. As such, this work will also raise awareness among care providers of the multiple factors that play into their patients' health decisions. One of our longer-term goals will be to develop a supplementary resource guide and screening tool directed to the primary care provider (and in particular, the family physician).

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