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Older Persons Who Move: Reasons and Health Consequences

Namkee G. Choi
State University of New York

On the basis of data from the Longitudinal Survey of Aging (LSOA), 1984-1990, this article analyzes reasons for, and determinants of, moving among subjects 70 years or older. More than 60% of the mover sample gave their own poor health, their spouse's poor health/death, and/or their desire for close kinship as reasons they moved, and more than 25% cited money problems as a reason. Blacks and women were more likely to cite desire for close kinship than were Whites and men. The comparison between 615 movers and 3,445 nonmovers also showed that moving late in life contributes to the deterioration of health to a small but significant degree. Social services and financial assistance for children and other relatives who take in ailing elderly relatives are recommended. Social services and programs to help alleviate the stress and ease the transition of moving for older persons are also discussed.

Although mobility rates of older persons are considerably lower than those of younger people, they have become an increasingly mobile group over the past three decades (Clark & Davies, 1990). The nonelderly, working population move primarily because of changes in employment or in search of better economic opportunities (Biggar, 1980). The largely retired elders no longer need to move for job-related reasons. However, improved retirement income, which is not contingent on place of residence, and increasing life expectancy have led many younger elders—those younger than 70—to migrate to places more amenable for a leisurely lifestyle. On the other hand, older cohorts—those 70 and older—may have to move in with, or near, their children and other kin because of declining health, a spouse's death, or financial hardship.

Previous studies of elderly relocation were more focused on the interstate migration of younger cohorts of elders than the migration or local mobility of older cohorts (Biggar, Cowper, & Yeatts, 1984; Serow, Charity, Fournier, & Rasmussen, 1986). Moreover, few previous studies compared movers and stayers within the same age cohort in terms of sociodemographic and health statuses and the availability of informal support.

Focusing on an older cohort, this article aims, first, to analyze the reasons reported for moving and changes in living arrangements brought about by the moving. Do people indeed move late in life to seek help with their deteriorating health and to be with children or other relatives after their spouse's death? If so, are movers more likely than are stayers to share a residence with children/other kin because of moving? Would the financial difficulty that often accompanies old age and widowhood be a reason they move? Are there any racial or gender differences? Second, this article analyzes factors that may trigger or inhibit an older person's decision to move by comparing those who moved with those who did not, especially in situations where the need for care and support is similar. Third, the article compares the physical and functional health status of movers and stayers at two different points of time in an attempt to analyze the health effects of moving on movers. If the movers relocate to seek assistance with their poor health and to find social support, is their health better in the long run than that of stayers?

Because of the rapidly increasing number of people 70 years or older, the volume of residential relocation in this age cohort may increase in the future as well. By following movers and stayers longitudinally, this study attempts to expand the limited knowledge base on residential relocation of the older cohort of elders. It also discusses social service and policy implications of the findings. If we can better understand the patterns and determinants of these people's decision to move and the effects of moving on their well-being, we may be able to significantly improve social policy and services to them. Knowledge about racial and gender differences in moving decisions may also improve our understanding of their diversity.

Theoretical Framework and Previous Studies

Previous studies that analyzed the reasons for, and determinants of, older people's moving often found that their residential relocation had characteristics distinct from those of younger people (Clark & Davies, 1990; Serow, 1988; Speare & Meyer, 1988). More important, the studies found significant variation within the elderly population, depending on their developmental needs or tasks (Litwak & Longino, 1987; Speare & Meyer, 1988). Younger, relatively healthy, married, affluent elders tend to move in search of a better quality of life or increased amenities in the Sun Belt region or in nonmetropolitan, small-town settings; older, widowed, more dependent elders tend to move in search of care and support to locations near or with their children/other relatives (Biggar et al., 1984; Carter, 1988; Fournier, Rasmussen, & Serow, 1988; Serow, 1988).

In other words, there appear to be **two peaks of moving** among older persons: one just after retirement, between the ages of 60 and 69—the “retirement peak,” and **the other in later life, beyond age 70** (Rogers & Watkins, 1988, p. 492). Many people in their 70s and 80s still enjoy good health and are able to afford independent living, and some migrate interstate for the same reasons as the younger cohort of migrants (Rogers & Watkins, 1988). However, the second wave of moving among the older cohorts of the elderly is more likely to be determined by factors that are characteristically age related—**increases in disability and widowhood** (Bradsher, Longino, Jackson, & Zimmerman, 1992; Longino, Jackson, Zimmerman, & Bradsher, 1991). A majority of movers in the post-70 cohort move to live **with, or near, their adult children or other kin because they need help with their health and/or socioemotional support after becoming widowed; some move to a long-term-care facility** (Biggar et al., 1984; Carter, 1988; Litwak & Longino, 1987; Patrick, 1980; Serow, 1988; Speare, Avery, & Lawton, 1991). Although this type of assistance-related mobility is more likely to be local than interstate, even those of advanced age who migrate interstate tend to do so either to return from the Southeast and West to the potentially more supportive environment of their birthplace in the North or to join children who live in other regions. Such migration may also be initiated by the onset of physical and/or financial hardships or the death of a spouse (Longino, 1979; Rogers & Watkins, 1988; Watkins, 1989).

Because these movers are older and more likely to be single, they are also more likely **to be poor** than are the younger cohort of elderly movers. Thus their relocation and housing decisions are also likely to be motivated to some degree by financial hardship. Some older movers (particularly the widowed) may be forced to move in with somebody to share living expenses or even to find a place to live after being evicted (Wiseman, 1986). **For such people, moving may be involuntary, undertaken not to increase access to amenities but merely to survive.**

Given that residential relocation among persons over 70 is often based on **assistance needs**, an important question to be answered is whether moving indeed brings improvement in their physical and functional health. The health effects of moving need to be analyzed especially for those who moved because they could no longer maintain an independent household because of deteriorating health, financial difficulty, or both. Many previous studies have dealt with the effects of inter- or intrainstitutional relocation and home-to-institution relocation on health/mortality (Danermark & Ekstrom, 1990). Only a few analyzed the effect that elder relocation within the community had on the subjects' health/mortality (Dimond, McCance, & King, 1987; Eckert & Haug, 1984; Ferraro, 1982; Kasl, Ostfeld, Brody, Snell, & Price, 1980; King, Dimond, & McCance, 1987).

Studies by Dimond et al. (1987) and King et al. (1987), which analyzed forced residential relocation from a tightly bonded small rural town, found that relocation had positive as well as negative effects on elder subjects' physical and mental health. Sample members over age 70 actually adjusted to moving better than did younger subjects, probably because the older, frail ones were moved as a group. Eckert and Haug's (1984) study of the relocation adjustment of a small group of elderly hotel dwellers also found few adverse health effects. However, Ferraro's (1982) study found that both functional health and physical health of low-income older persons were negatively affected by moving, probably ascribable to the stress of relocation. Kasl et al.'s (1980) study of the effects of involuntary relocation on the health and behavior of poor urban elderly people also found that the movers experienced more hospitalizations and doctor visits, more negative self-evaluation of health, and a higher incidence of stroke and angina than stayers did. Interestingly, the movers in Kasl et al.'s study experienced these negative health changes despite substantial improvement in housing, little disruption in social networks, and higher life satisfaction because of the move.

Given the contradictory findings of this limited number of studies, it appears that we do not yet have enough evidence to make definitive conclusions about the effects of the moving experience on both voluntary and involuntary movers. It is probable that leaving a place to which one has been attached for many years, especially for reasons of declining health, a spouse's death, and/or financial difficulty, can be a traumatic experience resulting in significant deterioration in health and even in premature death. Moves initiated for these reasons may predispose older persons to "enter a new environment in a somewhat weakened state and with less ability to satisfy demands and cope with the consequences of unfavorable environmental transactions" (Golant, 1984, pp. 249-250). Moreover, the physical and emotional stresses generated by relocation itself—"packing possessions, dealing with the movers, paying out large relocation expenses, saying goodbye to neighbors and friends, and traveling to a new place"—are potential health hazards (Golant, 1984, p. 250).

Method

Data and Sample

Data for this analysis were drawn from the National Health Interview Survey: Longitudinal Study of Aging (LSOA), 70 Years and Over, 1984-1990. The LSOA interviewed a nationally representative sample of 7,527

noninstitutionalized people 70 years or older in 1984. It reinterviewed 5,151 of these sample members (Panel 1) in 1986, 1988, and 1990; and 2,376 of them (Panel 2) were reinterviewed in 1988 and 1990. At the time of the 1990 interview wave, about 30% of the 1984 sample had died, and another 15% were not interviewed for various reasons (0.06% because they had been institutionalized, 0.05% because of hearing difficulty or illness, 5.7% because they refused to be interviewed, 0.02% because they could not be located, and 9.1% for unexplained reasons).

For the analysis in this article, movers are defined as sample members who were alive at the times of the 1988 or 1990 interview waves and who had moved at least once within the community between 1984 and 1990. Stayers are defined as those who were alive at the times of the 1988 or 1990 interview waves and who had remained in the same residence within the community since 1984. (It is possible that some of the stayers as well as some of the movers had moved before the 1984 interview, but the data set did not contain any information on moves completed prior to 1984.) Those who moved from home to institution, from institution to home, or from one institution to another were not included. For those who moved more than once during the study period, the analysis was focused on the first move only.

For movers, data from the interview wave prior to moving (1984, 1986, or 1988) were used as preresidence (T1) data, whereas data from the 1988 or the 1990 wave, whichever closely followed the move, were used as postrelocation (T2) data. For the stayers who had died by 1990, data from the 1984 wave (for Panel 2) or the 1986 wave (for Panel 1) were used as T1 data, and data from the 1988 wave were used as T2 data. For stayers who were still alive in 1990, data from the 1988 wave were used as T1 data and data from the 1990 wave were used as T2 data. The sample size for movers was 615, and that for stayers was 3,445.

Analysis of sociodemographic variables shows that the mover and stayer samples did not differ from each other significantly in terms of age in 1988 (79.78 vs. 79.49 years), racial and gender composition, and number of living children. The groups did not differ substantially with regard to the level of education either, although the difference was statistically significant (10.78 vs. 10.42 years, $p < .01$). As expected, however, movers were less likely than were stayers to have been married. Of those who reported their 1984 family income, movers were more likely than stayers to be in the bottom income stratum (under \$5,000). Given that a higher proportion of movers than stayers were unmarried, the movers' income status was expected to be lower than that of the stayers. Although small in numbers, the mover group also included a higher percentage of people in the highest income stratum (\$50,000 or

Table 1. Sociodemographic and Economic Differences Between Movers and Nonmovers

	<i>Mover</i> (<i>n</i> = 615)	<i>Nonmover</i> (<i>n</i> = 3,445)
Age (years in 1988)	79.78	79.49
Years of education	10.78*	10.42*
Race (%)		
White	92.3	90.7
Black	7.1	8.4
Other	0.6	0.9
Sex (%)		
Male	35.5	37.9
Female	64.5	62.1
Marital status (%)		
Married	35.6**	46.4**
Widowed	55.6**	44.4**
Divorced/separated/never married	8.9**	9.1**
Family income status ^a (%)		
Under \$5,000	15.4**	9.8**
\$5,000-\$9,999	23.6**	23.8**
\$10,000-\$24,999	34.1**	37.8**
\$25,000-\$49,999	10.7**	12.4**
\$50,000 or more	4.5**	2.0**
Unknown (missing income)	11.8**	14.2**
Number of sons	1.24 (1.39)	1.18 (1.25)
Number of daughters	1.25 (1.28)	1.19 (1.33)

NOTE: Standard deviation from the mean is given in parentheses.

a. In 1984.

* $p < .05$; ** $p < .01$: denote significant difference between movers and nonmovers.

more) than did the stayer group (see Table 1). Because further analysis showed that movers and stayers who refused to reveal their income were equally likely to have had a level of education similar to those in the lower-middle-income stratum (between \$10,000 and \$24,999), the missing values are not judged to have distorted the income difference between the two groups.

Of the movers, 16.6% moved interstate and 83.4% moved in-state. Further analysis showed that these two groups did not differ in age, race, and sex distribution. But the interstate movers were better educated (11.74 vs. 10.58 years, $p < .01$) and had higher incomes than the in-state movers.

Method of Analysis

The self-reported reasons why the movers moved, sorted by race, gender, and type of move, are presented in Tables 2 and 3. Although the LSOA provided 10 choices, the analysis in this article collapsed together into three categories of amenities—limitations of residence (location, size, and design); weather and climate; and improved living conditions, arrangements, and environment. Changes in living arrangement because of moving and reasons reported for having a specific living arrangement are presented in Table 5.

For the determinants of moving, three maximum likelihood logistic regression models were analyzed. For all models, if the sample member had moved, the dependent variable was given a value of 1; otherwise, it was given a value of 0. Model 1 tests the significance of sociodemographic independent variables only: age, sex, race (White = 1; other = 0), marital status (married = 1; widowed = 2; divorced, separated, or never married = 3), years of education, and number of children. Marital status and the number of children are used as indicators of the availability of social support.

In Model 2, variables indicative of the sample member's health status at T1 were added to test the effect of health on the likelihood of moving: numbers of doctor visits and hospitalizations in the preceding 12 months and combined numbers of activities of daily living (ADLs) and instrumental activities of daily living (IADLs) with difficulty. (Although the numbers of doctor visits and hospitalizations are measures of health care rather than health problems per se, they were chosen because the LSOA collected the information consistently between 1984 and 1990.) The number of times each sample member had been admitted to a nursing home by 1988 (since 1984 or 1986) was also included as an independent variable. (The LSOA did not collect this information in each interview wave.) Because the number of nursing home admissions indicates a total number of times institutionalized by 1988, it may include postrelocation admissions for some movers. However, because the postrelocation incidence of nursing home admissions is likely to be positively correlated with the prerelocation incidence of nursing home admissions, the variable was chosen as a predictor variable.

In contrast to previous studies that analyzed the relationship between functional health and geographic mobility (Bradsher et al., 1992; Longino et al., 1991; Speare et al., 1991), this study includes indicators of both physical (numbers of doctor visits and hospitalizations) and functional (number of ADLs/IADLs with difficulty) health status to determine the differential effect of physical versus functional health problems on elders' decisions to relocate. Because the LSOA did not collect information on the health status

of sample members' spouses, however, we were unable to test the effect of the spouse's health on the couple's decision to move.

In Model 3, economic status (missing income = 1; annual family income under \$5,000 = 2; \$5,000-\$9,999 = 3; \$10,000-\$24,999 = 4; \$25,000 or more = 5) was included as an independent variable to test the significance of financial difficulty as a possible factor in the decision to move.

The effect of moving on the movers' health status was analyzed by (a) comparing movers' and stayers' physical and functional health status at T1 and T2 and (b) using stepwise ordinary least squares (OLS) regression models, with health status at T2 as the dependent variable and health status at T1, moving status (1 = moved; 0 = stayed), age, sex, race, and years of education as independent variables. In addition to the number of ADLs/IADLs with difficulty, the number of functional limitations—difficulty in walking a quarter mile, walking up 10 steps without rest, standing or being on feet for 2 hours, sitting for 2 hours, stooping, crouching, kneeling, reaching up over head, reaching out as if to shake hands, using fingers to grasp, lifting or carrying 25 pounds, or lifting or carrying 10 pounds—was also included as an indicator of functional health status.

Findings

Reasons for Moving

As shown in Table 2, more than 60% of the sample mentioned their own poor health; their spouse's poor health, institutionalization, or death; and/or their desire to live close to, or with, children/other kin as reasons for moving. Nearly one third of the movers apparently ended up near or with their children or other kin. Also, as many as a quarter of the movers mentioned financial hardship as a reason for moving. Further analysis shows that 28.1% of those who mentioned their own poor health as the primary reason for moving also mentioned the desire to live close to, or with, children/other kin as the secondary reason. Of those who mentioned poor health, death, or the institutionalization of a spouse as the primary reason for moving, 23.9% indicated the desire for close kinship as the secondary reason and 18.5% mentioned lack of money as the secondary reason. Deteriorating health of a spouse or widowhood must have worsened the financial situation of many of the subjects.

Another notable finding is that the desire for close kinship was given as the primary reason for moving by 41.5% of interstate movers. On the other

Table 2. Reasons Why the Movers Moved

<i>Reason</i>	<i>Primary n (%)</i>	<i>Secondary n (%)</i>	<i>Tertiary n (%)</i>	<i>Total N (%)</i>
Poor health of sample person	102 (16.6)	9 (1.5)	1 (0.2)	112 (18.2)
Poor health, death, or institutionalization of spouse	68 (11.0)	12 (2.0)	3 (0.5)	83 (13.5)
Live close to or with children/other kin	123 (20.0)	56 (9.1)	7 (1.2)	186 (30.2)
Amenities ^a	78 (12.6)	24 (3.9)	13 (2.2)	115 (18.7)
Money	110 (17.9)	36 (5.8)	11 (1.7)	157 (25.5)
Remarriage	7 (1.1)	2 (0.3)	0	9 (1.5)
Moved to retirement/community home	30 (4.9)	23 (3.7)	3 (0.4)	56 (9.1)
Other	92 (15.0)	32 (5.3)	8 (1.2)	133 (21.6)
No response	5 (0.9)	0	0	5 (0.9)
No second reason		421 (68.4)		
No third reason			569 (92.6)	

a. Inclusive of limitations of residence (location, size, and design); weather and climate; and better or improved living conditions, arrangements, and environment.

hand, those who gave lack of money as the primary reason were more likely than the others to have moved within a state. Thus it appears that even interstate migration among these older cohorts was largely driven by the need for kinship (and the physical and emotional assistance it can bring) rather than the pursuit of a leisurely lifestyle. In the same vein, although nearly one fifth of the sample mentioned amenities as a reason for moving, many of them apparently needed to move within the same state to a place where they could have a less restricted living environment, despite increasing disabilities. Only 14.1% of the movers who listed amenities as the primary reason for moving relocated to a different state, and they constituted only 10.8% of all interstate movers.

The data in Table 3 show that a higher proportion of Black than White elders (39.6% vs. 18.3%, $p < .01$) mentioned desire for kinship, whereas a much higher proportion of White than Black elders mentioned the poor health or death of a spouse and too little money. A notable gender difference is that a higher proportion of women than men mentioned their own poor health and the desire for close kinship as the primary reasons for moving, whereas a higher proportion of men than women mentioned amenities. **This gender difference is believed to be due to the fact that a higher percentage of female than male movers were single (78.6% for women vs. 36.0% for men).** Of all sample members, those who indicated poor health as the primary reason for moving were also significantly older than were most of the others.

Table 3. Primary Reasons for Moving by Type of Migration, Race, and Gender (in percentages)

	<i>Type</i>		<i>Race^a</i>		<i>Gender</i>	
	<i>Interstate</i>	<i>In-State</i>	<i>White</i>	<i>Black</i>	<i>Female</i>	<i>Male</i>
	16.6%	83.4%	92.9%	7.1%	64.5%	35.5%
	n = 102	n = 513	n = 568	n = 43	n = 396	n = 219
Poor health of sample person	17.1 (17.1)	82.9 (16.5)	94.8 (16.9)	5.2 (12.2)	75.2 (19.3)	24.8 (11.6)
Poor health, death, or institutionalization of spouse	16.6 (11.0)	83.4 (11.0)	100.0 (11.8)	0 (0)	68.2 (11.7)	31.8 (9.9)
Live close to or with children/other kin	34.5 (41.5)	65.5 (15.7)	85.8 (18.3)	14.2 (39.6)	70.5 (21.9)	29.5 (16.6)
Amenities	14.1 (10.8)	85.9 (13.0)	89.7 (12.3)	10.3 (18.4)	53.1 (10.4)	46.9 (16.7)
Money	7.0 (7.5)	93.0 (20.0)	96.4 (18.7)	3.6 (9.2)	61.9 (17.2)	38.1 (19.2)
Remarriage	26.4 (1.7)	73.6 (1.0)	83.9 (1.0)	16.1 (2.5)	40.7 (0.7)	59.3 (1.8)
Moved to retirement/community home	15.2 (4.4)	84.8 (4.9)	100.0 (5.3)	0 (0)	63.4 (4.8)	36.6 (5.0)
Other	5.0 (4.6)	95.0 (17.1)	92.9 (15.2)	7.1 (15.1)	56.5 (13.2)	43.5 (18.4)
No response	25.5 (1.3)	74.5 (0.8)	74.5 (0.7)	25.5 (3.1)	63.1 (0.8)	36.9 (0.9)

NOTE: Within-group percentages are given in parentheses. All differences are statistically significant at a level .03 or lower.

a. Races other than White and Black ($N = 4$) are deleted for this analysis.

Determinants of Moving

As shown in Table 4, the results of Model 1, where only sociodemographic variables were entered, indicated that marital status and years of education were significant factors. As compared with divorced, separated, or never-married elders, widows were significantly more likely to have moved, whereas those who were married were significantly less likely to have moved. The higher the sample member's level of education, the more likely it was that he or she had moved. The results of Model 2, where the variables indicative of health were added as covariates, show that, in addition to marital status and the level of education, the numbers of doctor visits at T1, admissions to nursing homes, and children were positively associated with the likelihood of moving. Thus poor health is indeed a significant reason why older people move. Moreover, the added significance of the number of children when health variables were controlled indicates that frail elderly parents are more likely to move when more children are available. Naturally, a greater number of children will increase the likelihood that one of these children will be able to take in the parent(s). However, in terms of the size of the effect, the number of previous nursing home admissions and marital status were especially powerful predictors of moving. With addition of the institu-

Table 4. Logistic Regression Coefficients of the Determinants of Moving in Late Life

Variable	Model 1	Model 2	Model 3
	(N = 3,728) b (SE)	(N = 3,584) b (SE)	(N = 3,584) b (SE)
Constant	-2.914 (.786)**	-3.156 (.840)**	-3.185 (.845)**
Age	.007 (.010)	.008 (.011)	.008 (.011)
Sex (male)	.116 (.110)	.133 (.114)	.149 (.115)
Race (White)	.236 (.185)	.222 (.197)	.261 (.199)
Years of education	.034 (.013)**	.036 (.014)**	.039 (.015)**
Number of children	.043 (.022)	.056 (.023)*	.051 (.023)*
Marital status			
Married	-.383 (.090)**	-.342 (.094)**	-.312 (.097)**
Widowed	.194 (.086)*	.234 (.091)*	.236 (.092)**
Number of hospitalizations		.002 (.070)	.014 (.070)
Number of doctor visits		.019 (.009)*	.019 (.009)*
Number of nursing home admissions		1.185 (.269)**	1.185 (.271)**
Number of ADLs/IADLs ^a with difficulty		-.041 (.021)	-.044 (.021)*
Level of income			
Missing income			-.215 (.119)
Under \$5,000			.326 (.125)**
\$5,000-\$9,999			-.070 (.095)
\$10,000-\$24,999			-.129 (.084)
-2 LL Model chi-square (df)	41.83 (7)	88.88 (11)	99.52 (15)

a. ADLs/IADLs = activities of daily living/instrumental activities of daily living.

* $p < .05$; ** $p < .01$.

tionalization variable and the other health variables, the Model 2 chi-square shows an impressive improvement over the Model 1 chi-square.

The results of Model 3, which includes levels of income as a covariate, show that income is also a significant predictor of moving. As compared with those whose 1984 family income was \$25,000 or more, those whose family income was under \$5,000 were more likely to move. (In 1984, the official poverty line for individuals 65 years or older was \$4,979.) Individuals whose family income was between \$5,000 and \$24,999 and those who did not provide information on income (missing income) were not significantly different from those with an income of \$25,000 or more.

When income was included as a covariate, the number of ADLs/IADLs with difficulty also became significant in Model 3. Interestingly, however, the sign of the coefficient was negative, meaning that those who had more difficulty with ADLs/IADLs were, in fact, less likely to move when income, along with physical health status and other variables, was controlled. Further analysis shows that low-income stayers had indeed significantly more prob-

lems with ADLs/IADLs than all the other stayers (including those with missing income), whereas low-income movers were not different from the rest of the movers. Thus it appears that although low-income elderly persons 70 years or older were more likely to move than were middle- and high-income elderly persons of the same age, low-income older persons who stayed had more functional health problems than middle- and high-income elders who stayed.

Changes in Living Arrangement

Given that poor health, desire for close kinship, and lack of money were major reasons why the sample members relocated, movers would be more likely than stayers to share residence with children/other kin at T2. According to data in Table 5, it appears that the living arrangement of the movers changed between T1 and T2 as compared with that of the stayers. The proportion of movers who lived alone declined at T2 as compared with T1, whereas the proportion of stayers who lived alone increased at T2. On the other hand, the proportions of movers who lived with adult children or with other adults (not including children) nearly doubled at T2 as compared with T1. The proportions of stayers in the same categories remained virtually unchanged. Of the movers who lived with adult children or others, 15.5% at T2 (compared with 7.3% at T1) said they were in a shared living arrangement because of their health, and 11.0% at T2 (compared with 7.5% at T1) said they were sharing to reduce expenses.

Changes in movers' housing tenure are also conspicuous. The number of owner-occupants decreased by more than 20 percentage points, and the number of renters increased by 17 percentage points at T2 among movers. For stayers, however, there was no change between T1 and T2. The conveniences of rented apartments/houses must suit the needs of older persons who have physical and functional disability better than owned housing units. Nevertheless, the data also indicate that movers were less likely than were stayers to have originally been owner-occupants. Thus, in conjunction with income data, movers were more likely than were stayers to have been selected from lower economic strata. Also, lack of money became an important reason for movers to relocate in order to share living expenses with their adult children/other kin.

The Effect of Moving on Health Status

Although a majority of movers gave poor health as a reason for moving, the bivariate comparison of physical and functional health status between movers and stayers shows that the two groups, on average, did not signifi-

Table 5. Changes in Living Arrangements Between T1 and T2: Comparison Between Movers and Nonmovers (in percentages)

	<i>Movers</i>	<i>Nonmovers</i>
Living arrangement		
Alone		
T1	43.0**	40.0**
T2	37.4**	42.0**
With husband/wife (and others)		
T1	37.8	43.6
T2	32.7**	40.7**
With adult child		
T1	11.1	10.2
T2	19.3**	9.7**
With others because of health ^a		
T1	7.3**	4.4**
T2	15.5**	5.5**
With others to share expenses ^a		
T1	7.5*	5.0*
T2	11.0**	6.0**
Housing tenure		
Owned/being bought		
T1	63.9**	80.8**
T2	42.0**	78.9**
Rented		
T1	31.8**	15.5**
T2	48.8**	15.6**
Rent free		
T1	3.5**	3.3**
T2	6.9**	5.1**
Unknown		
T1	0.8**	0.4**
T2	2.2**	0.4**

a. Of only those who live with others (including adult children).

* $p < .05$; ** $p < .01$: denote significant difference between movers and nonmovers.

cantly differ in health status at T1. At T2, however, movers were significantly worse off than were stayers in three out of four indicators of health status—numbers of doctor visits, functional limitations, and ADLs/IADLs with difficulty (see Table 6). Movers were also more likely than were stayers to have been in nursing homes by 1988.

Multivariate OLS regression results, as shown in Table 7, indicate that T1 health status was the most powerful predictor of T2 health status. The regression results also confirmed that moving was significantly positively

Table 6. Changes in Physical and Functional Health Status Between T1 and T2: Comparison Between Movers and Nonmovers

	<i>Movers</i>	<i>Nonmovers</i>
Number of doctor visits in the past 12 months		
T1	5.21 (6.12)	4.77 (5.19)
T2	6.01 (5.84)*	5.26 (5.54)*
Number of hospitalizations in the past 12 months		
T1	.31 (.71)	.29 (.72)
T2	.40 (.99)	.35 (.91)
Number of functional limitations ^a		
T1	2.54 (2.57)	2.43 (2.58)
T2	3.33 (2.83)*	2.97 (2.79)*
Number of ADLs/IADLs ^b with difficulty		
T1	1.56 (2.48)	1.66 (2.71)
T2	2.76 (3.56)*	2.29 (3.25)*
Number of nursing home admissions (by 1988)	0.13 (0.84)*	0.01 (0.13)*

NOTE: Standard deviation from the mean is given in parentheses.

a. Number of limitations in the following activities: walking a quarter mile, walking up 10 steps without rest, standing or being on feet for 2 hours, sitting for 2 hours, stooping, crouching, kneeling, reaching up over head, reaching out as if to shake hands, using fingers to grasp, lifting or carrying 25 pounds, or lifting or carrying 10 pounds.

b. ADLs/IADLs = activities of daily living/instrumental activities of daily living.

* $p < .01$: denotes significant difference between movers and nonmovers.

associated with the number of health problems in the same three out of four indicators of health status at T2. The stepwise procedure revealed that moving, although a significant factor, explained less than 1% of the variance for all three indicators of T2 health status. (Further analyses found that interaction terms between moving status and T1 health status were not significant. Moreover, because in some cases as much as 4 years may have elapsed between T1 health measures and moving, even the 1% of variance attributed to moving is probably still inflated slightly.) As expected, age was also significantly positively associated with the number of hospitalizations, functional limitations, and ADLs/IADLs with difficulty at T2, whereas years of education was negatively associated with the number of functional limitations and ADLs/IADLs with difficulty.

Further analysis found that those who moved primarily because of poor health were also the ones who had the most serious health problems at T2. They were older and indeed had more functional health problems at T1 than the other movers, and apparently moving did nothing to improve their health. Thus the faster deterioration of health among the movers than among the stayers appears to be due to the predisposition of some of the movers to more

Table 7. Stepwise OLS^a Regression Coefficients of the Determinants of T2 Health Status

Independent Variable	Dependent Variable: T2 Health Status in Terms of			
	Doctor Visits	Hospitalizations	Functional Limitations	ADLs/IADLs ^b With Difficulty
	(N = 3,791) b (SE)	(N = 3,876) b (SE)	(N = 3,907) b (SE)	(N = 3,905) b(SE)
Constant	3.169 (.110)**	-.409 (.234)	-2.388 (.520)**	-5.042 (.635)**
Number of T1 doctor visits	.453 (.015)**			
Number of T1 hospitalizations		.231 (.020)**		
Number of T1 functional limitations			.719 (.013)**	
Number of T1 ADLs/IADLs with difficulty				.775 (.015)**
Moving status (moved)	.549 (.228)*	<i>ns</i>	.278 (.087)**	.556 (.106)**
Age	<i>ns</i>	.008 (.003)**	.053 (.007)**	.087 (.008)**
Sex (male)	<i>ns</i>	<i>ns</i>	-.219 (.066)**	<i>ns</i>
Race (White)	<i>ns</i>	.126 (.053)*	<i>ns</i>	<i>ns</i>
Years of education	<i>ns</i>	<i>ns</i>	-.027 (.009)**	-.051 (.010)**
Multiple R	.436	.191	.707	.688
F ²	.190	.036	.500	.474
Adjusted R ²	.190	.036	.499	.473
Standard error	4.987	.907	1.977	2.394

a. OLS = ordinary least squares.

b. ADLs/IADLs = activities of daily living/instrumental activities of daily living.

* $p < .05$; ** $p < .01$.

health problems, given their preresidence health status and age. In addition, moving itself was a small but significant cause of the deterioration of health. The stress of moving, as indicated in previous studies (Ferraro, 1982; Golant, 1984), may have been a cause.

Summary and Discussion

This study shows an impressive rate of moving—15% of the sample during the study period—among persons 70 years or older because of needs for assistance with health, financial hardship, or widowhood. (If we had included the 15% of the original 1984 sample who were alive but not interviewed in 1990, the rate may have been higher.) More than 60% of the movers gave their own poor health, their spouse's poor health/death, and/or their desire for close kinship as their reasons for moving. As many as 25%

of the elderly movers also cited money problems as a reason. Multivariate logistic regression analyses confirmed that the variables indicative of poor health, widowhood, number of children (as an indicator of social support), and low income are significant determinants of moving.

In addition, about 19% of the elderly movers mentioned limitations of residence (location, size, and design); change in weather/climate; or the search for improved living conditions, arrangements, and environment as reasons for moving. Some of these amenity seekers could have moved in search of a more leisurely lifestyle, whereas others could have moved because structural restrictions of their homes further hindered their mobility, which had already been limited by physical and/or functional impairment. Thus the amenity-related moving for this group of older persons can be construed as an anticipatory adjustment or a positive choice for coping with changing environmental needs in old age. Considering that only 14% of these amenity seekers were interstate movers, it appears that unlike younger elderly persons, this older cohort of elders 70 years or older tends to limit their amenity-related moving within the same state of their residence. For this age group, the long-distance interstate movers were more likely to be driven by the desire for kinship than for amenities.

Not only did moving not help slow the deterioration of their health; it apparently contributed to further deterioration to a small but significant degree. Although the findings of previous studies have been contradictory as to the health consequences of moving in old age, this study, based on a national sample, unequivocally shows that movers were likely to have more health problems than were stayers. The primary determinant of an older person's current health status was past health status, and thus the effect of moving on health should not be emphasized too much. Nevertheless, moving itself has a small but significant negative effect on the elderly mover's health status, despite increased instrumental and emotional support, which is seen in the increased number of movers who live with adult children and other adults.

Relocation from a place where one has lived for an extended period can cause a variety of disruptions and inconveniences even for a nonelderly person. Moving late in life, even if it is a positive coping mechanism in the face of increasing isolation, restricted mobility, and inadequate social support, is most likely to involve a reluctant displacement from a place where the person spent a significant portion of his or her life. Such a reluctant displacement often engenders a sense of loss and frustration. As a consequence, moving at an older age is likely to be accompanied by grieving and a feeling of powerlessness in addition to the stress of adjusting to a new place. Moves following deteriorating health, widowhood, or lowered income may be especially likely to increase adjustment problems. It is thus no surprise

that movers experienced deterioration of health to a greater extent than did stayers. Future research needs to examine the question of whether these negative health effects are directly translated into higher mortality rates among movers than among stayers.

Nevertheless, the findings also indicate that moving replenished the movers' informal sources of support and thus may have increased their sense of security. Because family members, especially children, are the primary sources of caregiving and advocacy of formal social services for their elderly relatives (Choi, 1994), moving in with, or close to, children may better prepare the elders to deal with their deteriorating health. Nearly one third of all movers who moved in with, or close to, their children (see Table 2) may have felt more secure, if not healthy. The instrumental and emotional support these movers gained could have certainly buffered them from much more negative health effects of moving. Despite the movers' deteriorating health, moving may also have delayed or reduced the incidence of their institutionalization because of the increased availability of informal support.

In summary, residential relocation late in life is more likely to be driven by a desire to maintain life in the community than by the long-distance search for a better or more leisurely life. It is a way of adapting to old age, deteriorating health, death of a spouse, and/or financial difficulties. It can, however, also aggravate deterioration of health, probably because of the sense of loss and powerlessness and the stress of moving. Moreover, older movers' financial problems are not likely to disappear because poor health and financial difficulties often go together. Thus the older movers (and their kin who live with them) may have increased need for health care, financial assistance, and social services at their destinations. Social service providers and policymakers especially need to understand the differences between interstate and in-state movers as well as between races and genders in reasons for moving. Service and policy implications of those differences must be examined.

As mentioned, the largest proportion of interstate movers relocated to be with children/kin. Thus the destinations of the older cohort of elderly interstate migrants are not likely to be concentrated in specific geographic areas. Consequently, receiving states may not have to be concerned with social service provision for masses of elderly migrants. With the increasing number of persons living to age 70 and beyond, it appears that children and relatives will shoulder an increasing burden of care. Children and other relatives who take in ailing elderly relatives should be provided social services, financial assistance, or both to ease their newly assigned or increased responsibility for caregiving. Considering that Black elders were much more likely to cite their desire for close kinship as the primary reason for moving than were

Whites, the children and relatives of Black elderly persons appeared more likely to be in need of such assistance than their White counterparts.

In-state and White elderly movers were more likely to cite financial problems as the primary reason than were interstate and Black elderly movers. For older persons forced to move primarily because of financial difficulties, social service programs need to be proactive rather than reactive. For some elderly persons, moving can be, and indeed may have to be, prevented by means of public assistance (including home energy assistance), a rent subsidy, and/or a reverse mortgage, if applicable.

A higher proportion of women than men cited their own poor health and desire for close kinship as the primary reasons for moving, whereas a higher proportion of men than women cited the search for amenities as the primary reason. Because elderly men are more likely to be married than are elderly women, they may feel less isolated. Also, because wives tend to be younger, they tend to be their husbands' caregivers. Thus a majority of the target population of social services for older persons are women, and social policies and social service programs need to be especially sensitive to their needs.

In the meantime, social services for older persons need to be expanded to help alleviate the stress and ease the transition of moving. Pre- and postrelocation counseling and/or support groups can help elderly movers better cope with relocation trauma. **Social services provided to an elderly person before moving can continue to be provided at a new residence through coordination between agencies at the place of departure and the place of arrival.** Prompt linkage to social service programs, such as senior centers, adult day care centers, home health aide services, and transportation services, in the new community can help elderly movers adjust better.

Finally, for those elderly persons who are aging in place not by choice but by lack of choice (i.e., no children/relatives to move in with) despite failing health, social service providers should become their advocates and support systems to enable them to maintain independent living in the community as long as possible. Specifically, senior center services, meals on wheels, and home health aide services need to be provided to prevent premature institutionalization. For those older persons who need structural rehabilitation of housing units to be able to continue to live in the units, the Department of Housing and Urban Development (HUD) and social service agencies need to collaborate to institute a system of such assistance. The existing Farmers Home Administration Section 504 grant program, which provides subsidies for such rehabilitation, needs increased funding to reach more elderly persons. In addition, social service agencies and local HUD offices can mobilize volunteer corps who can provide housing advice, free labor, or both for older persons.

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Namkee G. Choi, D.S.W., is currently an associate professor at the School of Social Work, State University of New York at Buffalo. Her research has been in the area of economic status, living arrangements, and social support of older persons. Recent publications include "Patterns and Determinants of Social Service Utilization: Comparison of the Childless Elderly and Elderly Parents Living With or Apart From Their Children" (The Gerontologist, Vol. 34, No. 3) and "Racial Differences in the Determinants of the Coresidence of and Contacts Between Elderly Parents and Their Adult Children" (Journal of Gerontological Social Work, Vol. 24, Nos. 1/2).