THE BABEŞ-BOLYAI UNIVERSITY

THE FACULTATEA OF SOCIOLOGY AND SOCIAL ASSISTANCE

SUMMARY OF THE DOCTORAL THESIS

THE THIRD AGE BETWEEN AUTONOMY AND VULNERABILITY

Doctorate guiding

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Contents

Summary

Key words: elderly, autonomy, vulnerability, dependence, people being institutionalized, people not being institutionalized and quality of life.

The present PhD thesis aims at talking about problems, process and phenomena related to autonomy and vulnerability in elderly. A period of time when people face a series of different difficulties, starting with health issues and continuing with social and economical issues. These issues can be diminished or increased by objective or subjective factors starting from national policies and conditions to local community involvement and decisions or different opportunities and attitudes of the family.

Lately, as an increasing life span and more complex issues of the national economies, the ageing of the population has become a very important social problem. Relation with demographic trends and forecast processes for the next decades increases the concerns, in regards to finding solutions to keep appropriate conditions of a decent living environment for the elderly.

On top of all the existing issues, the economical and financial crisis aggravated these problems. Unfortunately, also the middle age generation felt these effects. Among the measurements taken by different countries, including Romania, there is to be mentioned the cutting pensions and increasing the retirement age. Effects of all these measures, as those of the legislative provisions regarding health insurance, care and support programs for elderly and families, are felt even more in the daily life of elderly.

The decision of choosing this PhD topic was determined by a series of questions appeared after describing the above socio-economical and political conditions. What is the share of family and society responsibilities towards the elderly? What needs become a priority at this age and which needs prevails and what has to be done to satisfy them? How do, elderly, accept the loss of their autonomy and becoming dependent of another. What can be done, through new kind of activities, for increasing the sense of usefulness, a central concept when talking about

health and life span? For all these questions – and far more alike – society looks for answers. Sometimes new solutions are found, sometimes not.

I have considered important and necessary approaching in this theme because of the limited specialized literature regarding the subject, but also because the dynamic of the changes is fast. That is why I have considered important and necessary because the volume of the research in this field is not that big, but also because the dynamic of changes that happen regarding this field is extremely pronounced. Therefore, any contribution, no matter how small, to the knowledge of phenomena that occur at this segment of society, can lead to objective interpretation of data and to reach political and administrative results along with possible ways to resolving certain problems or correcting certain categories of elderly.

The thesis, divided into five chapters, aims to reveal:

- development of theoretical approach to aging and contemporary demographic trends;
- premises of vulnerability in elderly, approaching aging myths and theories of dependency preservation;
- the role of preserving health for elderly' s quality of life;
- characteristics of social services for elderly: social support at home versus institutionalization;
- middle age – between autonomy and vulnerability, complex research on a sample over 600 people, at home or institutionalized – 570 questionnaires, 30 semi-structured interviews and 10 case presentations.

Starting from the premises set and comparing elderly at home and in institutions, this research has as a main purpose to know the actual problems the elderly are facing, their relationship with those around them such as family or stuff, the man determinants of autonomy or vulnerability.

The thesis's conclusions, generally speaking or at each chapter, our approach aims to stimulate the authorities, communities, families concerns in order to help the elderly to overcome the difficulties of this period of life.

The chapter I of the thesis, named **THE PROCESS OF AGING**, tries to define the concepts regarding aging process and presents a brief history of social perception regarding this process. This chapter also presents a wide image of growing the middle age population

worldwide, with focus onto Romania and a case study of Cluj County. For a wider frame of demographic phenomena and especially to have support for conclusions regarding the future, we included summaries of views of researchers or organizations related to demographic projections about Romania in the following decades.

C. Muresan (1999) makes a projection of the Romanian population by 2030. according to Table 1, the author has divided the Romanian population, as far as her record to 1st of January 1997, in homogeneous subgroups in age and gender and applied them to specific conditions of mortality and fertility observed in the previous calendar (year 1996), them she calculated the livestock births according to the assumptions on fertility rates and female quotas fertile structures. According to these projections, there is continued the future decreasing of population number.

Table 1. Romania's projected population and its demographic structure, according to projecting method P1 – constant mortality and fertility in the year 1996

	1997	**2000**	**2005**	**2010**	**2015**	**2020**	**2025**	**2030**
Total population (thousands)	22 582	22 435	22 130	21 698	21 112	20 378	19 554	18 671
Percentage comparing to 1997	100%	99,30%	98%	96,10%	93,50%	90,20%	86,60%	82,70%
Births during the year (thousands)	234	235	226	211	182	159	146	137
Youth (0-19 years) (thousands)	6 340	5 850	5 280	4 602	4 302	3 997	3 617	3 236
Adults (20-59 years) (thousands)	12 198	12 410	12 731	13 002	12 567	12 000	11 699	10 974
Seniors (60 + years)	4 044	4 174	4 120	4 094	4 243	4 380	4 238	4 460
Percentage of young (0-19 years) (thousands)	28,10%	26,10%	23,90%	21,20%	20,40%	19,60%	18,50%	17,30%
Percentage	54%	55,30%	57,50%	59,90%	59,50%	58,90%	59,80%	58,80%

adults (20-59 years) (thousands)								
Percentage seniors (60+years)	17,90%	18,60%	18,60%	18,90%	20,10%	21,50%	21,70%	23,90%
Percentage females	51%	51,10%	51,30%	51,50%	81,70%	51,80%	52%	52,20%
Percentage males	49%	48,90%	48,70%	48,50%	48,30%	48,20%	48%	47,80%

Source: C. Mureşan, 1999, Page. 212

Census results in 2011 did not confirm these forecasts, but the situation is not relevant because of the decrease number population due to migration, and future developments if the European situation can cause the reverse process.

According to data provided by the regional Statistics Cluj (2011), as well as in Cluj County as in Romania, the population number is decreasing from 1990. Since 1990, the number decreased by a difference of 53,001 residents, from 744,049 in 1990 to 691,048 in 2010. And in the future there is thought that the population number will decrease more and will increase more in the county of Cluj, increasing the elderly and decreasing the youth.

Table 2. Population number in county of Cluj 1990 – 2012

Years 1990-2010	**Population number**
Year 1990	744049
Year 1995	727656
Year 2000	719864
Year 2005	694511
Year 2010	691048

Source: INS, Regional Statistics Department of Cluj, 2011. Note: according to the results of 2011 census population of 674,903 inhabitants in Cluj.

The chapter II – THE PREMISES OF VULNERABILITY AT ELDERLY – approaches the problems of vulnerability in elderly from a biological, psychological and social point of view.

The term of vulnerability or fragility appeared in the medical language about 20 years ago, during the last decade of the last century (P. Godeanu, 2002).

With age, biological aging occurs, which means that appear changes in all organs of the body and the damaging of a system entails the damage of another, allowing the emergence of vulnerability. An autonomous person can become deeply dependent and evolve to a syndrome of sliding towards a fatal termination. to describe the phenomena in cascading, the domino theory was discusses, a metaphor that falling plates involves successive fall f the others (P.Meir,2000).

No matter what one tries, the changes gradually appear in all body parts and organs. (V.Donca, 2008). Even if the biological aging is due to modifications to various organs and systems, some events that occur during the existence of elderly precipitates an increased psychically vulnerability called *psychological aging* (H. Dumitraşcu, 2006). According to E. Erikson's theory (1968), the last period of life represents a desperate struggle with integrity, but every elderly person perceives in a different way events that happen in his life and this perception depends on everyone's life experience, material belongings or relations with others (E. Bocsa, 2003).

Biological and psychological aging is added social aging, because, unfortunately, old age has come to be associated by others with diseases, impotence, conservatism, lack of judgement, irritability and dependence on others. The elderly are often treated with contempt and we forget that they are a wealth of society (V. M. Bucur, 2007).

Society often associates aging with loss of sensory capacity and mobility changes; however, some researchers shown that for most elders these changes are not that burdensome, not as obvious as we might imagine (K. K. Miley, M. O'Melia, B. DuBois, 2006). So I consider important how the old persons perceive the aging, especially the report between their wish to remain active in the social life and the fact to be sustained by the others in order to assure their needs.

The present research is highlighting the fact that sociological theories: disengagement theory, activity theory, age stratification theory, social exchange theory, socio-economical theory, are the most well-known sociological theories which explain aging from a social point of view, but they also contain elements that constitute the basis for stakeholders action to alleviate or delay the effects of aging.

In this paper, along with presenting different interpretations on stags of aging, including key issues involved in each stage and psychological and social theories on aging; the chapter gives considerable space to deepen the needs of older people, the analysis of pension system and reform and the social policy on the protection of elderly.

The third chapter – HEALTH AND SOCIAL POLICY - presents a study on health and healthcare reform, material and moral factors involved in improving or impairment of health, and how the pension system and social policy affects health on elderly in Romania.

Health is one of the most important aspects regarding elderly. A good health means a better life. Unfortunately, currently in Romania, the health system is not enough developed to meet the population needs, especially the elderly population.

The analysis in this research we took into account five key areas of health identified in 1996 by B. Spiker: physical and functional capacity, social interaction, economical factors/social status and religious/spiritual state and systematization (D. Hahn and W. Payne, 1997) that these areas correspond to dimensions of health: *Physical dimension*, *Emotional dimension, Social dimension*, *Spiritual dimension* and *Employment dimension.*

The access of the population of Romania to the health services is principally regulated by the following laws: The law of health insurances (145/1997), The law regarding the reform in the domain of the health (95/2005) and The law which introduces the co-payment for some of the medical services (220/2011). For the elders, these laws define the quality of ensured persons and the conditions of contribution or co-payment for the ensured persons with different categories of incomes, including the exemptions of which benefit the pensioners with incomes at the level of the minimal salary on economy (740 lei/month).

Although these laws provide a series of rights which ensures the health of the elderly, in practice these rights have no correspondent.

Not even the *Uniform pension system* (old-age pension, early retirement, partial early retirement, disability pension) provides a decent living for elderly. Because in most cases, pensions provides a getting through the day living.

It is shown that two important aspects that leave a major mark in elderly life are health and income, and a solution for a better life could be a health and pension reform, that would take into account the real needs of the third age population.

Chapter IV – SOCIAL SERVICIES FOR ELDERLY: SOCIAL ASSISTANCE AT HOME VERSUS INSTITUTIONALIZATION – is dedicated to social services for elderly and aims to make a comparison between social support at home and institutionalization.

Social services in Romania provided to elderly are not developed enough to satisfy the needs of the society. It is about social assistance at home, but also about institutionalization.

Under normal circumstances, home care is most desirable solution, from a *social, emotional, financial and educational* point of view. In many ways it is better to bring the services to the client than the client to the services, but often this thing is not always possible or it is not for the best interest of the elderly. There are situations when willingness is to be replaced by professionalism and possibilities. This means institutionalization that has to be done according to the law, ethics and morality. Actually, each case must be carefully analyzed, as objective as possible, and taken the best decision for the person concerned, according to the family and society possibilities.

The analysis gives special attention *primary and specialized social services*, starting from requirements and realities of social policy.

Social protection means all institutions, structures and service networks of actions intended to create a normal living for all members within a society, especially for those with limited resources and capacity of self-realization (B. Neamțu, 1999). Social protection system in Romania is made out of two components: *social insurance* and *social assistance (*A. Badiu, 2008).

In Romania, in March 2011 there were 375 institutions for elderly and disabled persons, from which 322 were residential centers, and 53 day care centers (A.N.P.H., Statistical Bulletin, 31st of March 2011). Comparing the number of elderly, there are very few centers that provide necessary care for elderly.

To increase the relevance of the research data, we focused the analysis on the situation in Cluj county, where there are 2 centers for elderly and 5 health care centers that provide various services: socialization, support and assistance, counseling, cultural and educational activities,

physical activity, leisure activities, etc. The number of applicants exceeds the possibilities of institutionalizing centers, and even the fact that there are 17 more private centers and 5 accredited associations (DGASPC, Cluj-Napoca, 2011) does not cover the number of applications.

Currently, NGOs are called to increase the services that would respond to population needs, especially elderly needs. In Cluj county there are 5 providers of home nursing and rehabilitation services – medical gym and physiotherapy.

The chapter V – ELDERLY BETWEEN AUTHONOMY AND VULNERABILITY – represents the applied and practical research for this paper and consists of a sociological survey among elderly.

The aim of this research is to compare the life quality of elderly from care and assistance institutions with life quality of elderly that are not in those institutions, taking into account on which degree each of these institutions, in conjunction with other factors, influences the autonomy or dependence of elderly and gives some solutions to improve the conditions offered to preserve the autonomy of elderly.

There were applied ***570 questionnaires*** – 324 for elderly that beneficiated from home nursing and 246 for elderly that beneficiated from nursing within an institution and ***30 semi-structured interviews*** (15 for those beneficiated from home nursing and 15 for those that beneficiated from nursing within an institution). Topics addressed by the questions of the interview were: assessing the income and the needs, food appreciation in terms of quantity and quality, access to health services, availability of drug treatment, relationship with family, leisure activities and proposal for such activities, satisfaction with life quality. Processing the data from the interviews has been made using content analysis. In addition to this survey were conducted ***10 case presentations***, 5 for people at home and 5 for people in institutions.

The presentation of the lots for the study: for this research I composed two compatible lots with persons of at least 60 years of age and who don't suffer of dementia or mental retardation – one lot with persons at home – 326, and one with institutionalized persons – 246. Both of the lots contain immobilized persons and mobile ones. All these persons gave their accord to participate to the research and to answer the questionnaires.

Out of the 570 people that were surveyed, 56, 8 % were elderly that were home nursed and 43, 2 % were institutionalized elderly.

Data analysis has been made by age groups: 60-64 years old,65-69 years old, 70-74 years old, 75-79 years old, 80-84 years old, 85-89 years old, over 90 years old.

In this summary, it is presented some of the influences on life quality of elderly – at home or in institutions – in terms of degree of autonomy and vulnerability, the following factors: ***income***, ***food, self-assessment of health,living conditions, satisfaction of life, relationship with family and relationship with friends/community.***

The role and the effects of the income on the life quality of the elderly

The information resulting from our research confirms that when the life quality of the elderly is being talked about a very important factor has to be taken into consideration, such as the amount of the income. A better life depends on a higher income or at least one that can provide decent living standards.

In the table 3 is featured the amount of the income from the lot of respondents

Table 3. The income of the respondents

Monthly Income	**Total-500 respondents**	**Non-institutionalized**	**Institutionalized**
0-300 Ron	4,9%	3,2%	7,2%
301-600 Ron	38,2%	30,2%	49,3%
601-1000 Ron	39,3%	40,5%	37,7%
1001-1500 Ron	14,4%	20,9%	5,4%
More than 1500	3,2%	5,1%	0,4%
The chi-squared test p = 0,001			

As foreseen in the statistics only for the daily diet the Romanians should be making at least 750 RON, the low income is one of the most important factors that influence the level of vulnerability for the elderly.

For all respondents in the two environments (institution- home) the results of the amount are similar, with two exceptions: the number of the persons with an income between 301-601 lei

is higher for the institutionalized, while the number of the persons with the income between 1001-1500 is higher for the non institutionalized. It is an expected result, given the fact that in institutions a lot of social cases have to be taken into consideration.

The average amount of the monthly allowance for the state social security was 743 lei in 2010 (4^{th} trimester) in the country, and 798 in Cluj county. The average allowance for farmers was almost half: throughout the country was 310 lei, while in Cluj was 317 lei.

Because of the low income, the elderly fail to save money (for safety funds), to overcome any possible future problems. Not even half of the non institutionalized persons (41, 4%) manage to save money to face any type of future problems. Those institutionalized manage to save money in rate of 27%.

From the 570 respondents, over 60% noted that their income is insufficient or is barely enough for the strictly necessary. In Table 4 an enlightening picture of the situation is presented.

Table 4. Income judgment towards necessities (non institutionalized+ institutionalized)

How do you appreciate your income in relations to your necessities	**Percentage**
is not enough not even for the basic necessities	12,5%
is enough only for the basic necessities	48,2%
is enough only for a decent living	35,1%
I manage to buy even more expensive items but it takes lot's of efforts	3,3%
I manage to buy all that I need without any effort	0,9%

This study, based on the cumulated results, confirms the research carried out by Simona Bodogai in 2009, being that a general problem of the senior population is represented by poverty and lack of material things.

Separating the institutionalized from the non-institutionalized, a notable difference is represented by the level that *my income is enough for a decent living*, where is noted that this statement is made by a 46, 9 % from the institutionalized persons, compared to an only 26, 7%

for the non-institutionalized. This happens also because in the institution all of necessary conditions for a living are being provided: food, warmth, clothing, footwear etc.

The result are similar also for the section my *income is enough for the basic necessities*, 47, 8 % from those living at home and 48,7% from those living in institutions. These results are statistically significant after using the chi-squared test. [1]

Table. 5. The income judgment towards necessities proportion with the daily necessities

(non-institutionalized and institutionalized)

How do You appreciate your income in proportion with the necessities?					
Quality of the person	**is not enough not even for the basic necessities**	**is enough only for the basic necessities**	**is enough only for a decent living**	**I manage to buy even more expensive items but it takes lot's of efforts**	**I manage to buy all that I need without any effort**
non institutionalized	19,2%	47,8%	26,7%	5,3%	0,9%
institutionalized	3,1%	48,7%	46,9%	0,4%	0,9%
The chi-squared test p = 0,01					

Those institutionalized have to pay according to the law, a monthly fee of 602 lei, in centers and of 482 lei in day care centers. The residents that haven't got an income do not pay anything. Therefore, they consider that their income is enough only for the basic necessities.

On the other hand most of the money of the non institutionalized persons is spent on the utilities 64,4%, 21,1% spend it on food, 8,9% spend it on drugs and medicine, and 0,9 % spend it

[11] "The chi-squared test is used as a test when the analysis involves one or more nominal variables. Therefore, the data is frequencies. The fundamental principle of the chi-squared test is the comparison of the frequency of the members of the sample with the anticipated frequencies for the population from which the sample had been extracted." (D. Howitt, D. Cramer, 2010, page. 161-162).

on other things. (Table6). The chi-squared test demonstrates that the values are statistically significant p = 0, 01 p< 0, 05).

Table 6. What do you spend most of your money on?

What do you spend most of your money on?	**Utilities**	**Food**	**drugs**	**others**
Total	64,4%	21,1%	8,9%	0,9%
non institutionalized	47,3%	35%	16,1%	1,6%
Institutionalized	96%	4%	0%	0%
The chi-squared test p = 0,01				

The data obtained after the interviews are concordance with the data resulted after the application of the questionnaire. The majority of the non-institutionalized complain of a very low allowance, after working a whole lifetime. Because of lacking money, they cannot do the things of which they dreamt of doing since youth.

Every time I go shopping, I have to be very calculated with my money. The allowance I have (540 lei) has to be enough for my electricity, water, gas and food, and above all this I have to buy drugs in total amount of 100 lei. If my children did not helped me, I would not know what to do. (R.S., sex: F, age: 81, sales person).

By the time I grew old I told myself I would go to trips and do all the thing I could not do in my youth. When I was young I did not had the time, but I had the money, now I have the time, but I do not have the money. (G.M., sex F., accountant).

Those institutionalized, although have a low allowance see things differently than those living at home. They are carefree concerning their every days in regards to their utilities and purchasing their medicine, still some of them are frustrated that they are not home (the opinions are different from case to case).

Here we have everything we need, but sometimes (thinks), if one is not with one's family, in one's own home... Better to eat bread crumbs, but to know one is with his own, in one's own house, with one's own family, and not among strangers.(M.A., sex F, age: 72, teacher).

I am glad I am here. At home I had nobody, made money from the work the people in the village gave me. After an accident (on the field) I could not work anymore and I lacked food. I took charity from those neighbors who felt pity for me Also with their help I got to live here in the center, where I live better, than ever before. (F.G., sex M, age: 62 shepherd).

The diet

A proper diet keeps a better functioning of the body. The deteriorating of this balance with age, can determine a series of disease which make the elderly become fragile.

From this point of view 57, 7% of the asked lot, consider that food is enough, 34, 7%, that food is quite a lot, and 7, 7% are those who consider that food is not enough.

Making a comparison between the old institutionalized people and the non-institutionalized ones, we can observe differences concerning the way of appreciating the quantity and the quality of the nourishment. Those at home – 76,7^% consider that the nourishment is enough and only 32,8% of the institutionalized persons accept this. 64,8% of the institutionalized persons and 11,6% of the persons at home agree that they have a rich alimentation, and 2,5% of the institutionalized persons and 11,6% of the persons at home consider to have an insufficient alimentation.

Table 7. The diet appreciation (institutionalized and non-institutionalized)

The diet appreciation	**Insufficient**	**Sufficient**	**Rich**
Non institutionalized	11,6%	76,7%	11,6%
Institutionalized	2,5%	32,8%	64,8%
The chi- squared test p = 0,01			

For those in Care and Assistance Centers, the food allowance is established by the Government's Decision No. 50/19.02.2011 at 10 RON/resident/day and it is diversified, adapted to the age, to the affections and even to the preferences, with menus established for 2 weeks and prepared in the own kitchen. The amount is small, but the menus are enriched by donations and sponsorships.

Data resulted after the interviews, concerning the appreciation of their diet.

In regards to the appreciation of their diet, amongst those living at home this is not always sufficient (quantitative and qualitative). Most of the times attention and calculations are needed for what and how much is being bought, because the prices are way too high compared to the allowances.

I manage to buy almost all the food I need, but sometimes it is necessary to tighten the belt. (D.I., sex M, age: 64 construction worker).

I do what I can. During the week I cook pasta, vegetables etc, and only at the end of the weeks I cook with meat. (L.O., sex F, age: 73 cook).

Those living in institutions are pretty satisfied concerning the quantity and also the quality of their diet.

I have been home for some days, but I missed coming back. And I hear my colleagues that they are not satisfied and they wish they could cook too. But when they are being called to the kitchen to help out, they say no. I think we should be more grateful. (C.N.,

sex F., age: 68 tailor).

The food is very good and diversified. At home we do not have so many dishes (smiles). (C.I., sex M, age: 84, driver).

The self appreciation of health as a factor of influencing autonomy or dependence

Some of the most significant indicators concerning the quality of life of the third age is the health condition. It is obvious that once a third aged person is dealing with a poorer health condition, this represent the risk of losing one's autonomy.

There are persons who get to a very advanced age, with a high level of autonomy, exactly because they keep their health. But health is influenced by a complexity of factors, for which the persons, the family and the society have the duty to ensure quality living (and not just when growing old but also and young ages).

Concerning the self appreciation of health, the institutionalized persons appreciate at a higher percentage (52, 1%), than those living at their own homes (48, 4%), of having a satisfactory health condition. All of those institutionalized say that in a percentage of 26, 5% that their health condition is good compared to those non-institutionalized, for which the percentage is 22, 5%. The full data is given in the table below. After applying the chi-squared test the results are not statistically significant p=0,112).

Table 8. Self appreciation of health condition

Self appreciation of health being	**Total - 500 respondents**	**Non-institutionalized**	**Institutionalized**
very good	1,6%	2,2%	0,8%
Good	24%	22%	26,5%
satisfactory	49,2	47%	52,1%
Bad	20,9%	24,3%	16,4%

very bad	4,4%	4,5%	4,2%
The chi-squared test p = 0,112			

It can be concluded that all these differences are because in the institutional environment, is medically supervised. The monitoring and the treatment ensured 24 hours a day. This way the impact of the disease on the person is being diminished as intensity and importance. For those living at home this is not possible, the accessibility to the family doctor or specialist being harder. For this reason the perception of the disease is different.

Based on the obtained data, the thesis present the ***Spearman's rank correlation coefficient*** between the dependence in the basic and instrumental activities of daily living, also the appreciation of one's health being and the satisfaction towards the living conditions, made on four groups of persons: ***mobile non institutionalized, non mobile non institutionalized, mobile institutionalized and non mobile institutionalized.***

Concerning the access to medicine, the elderly can not entirely afford the medicine they need. Those living at home are able to do this in 57%, for those in institution things are different, the institution offers the treatment in (97,8%). But there are cases when it is needed that the beneficiary to contribute with a minimal amount for some medicine than are not compensated.

Table 9. Access to medicine

Do you have total access to the medicine you need?				
The quality of the person?	**yes**	**usually**	**Partial**	**no**
Uninstitutionalized	57%	22,6%	15,7%	4,6%
Institutionalized	97,8%	1,8%	0%	0,4%
The chi-squared test p = 0,001				

Taking part in social life

Unfortunately the retired do not do the activities they dreamt of doing when the time of retiring comes. In some cases the retirement has a negative impact in the life of the elderly.

"Maybe the most common characteristic of the retirement period is the increasing of leisure time, which draws with itself advantages and also problematic for p. The advantages are connected to the fact that the available free time can be used for activities postponed for a long time. The problematic situations are connected with the change of the life rhythm and the difficulty to adapt to the new rhythm, also with the lack of a structured life from the outside (as the person was used to act when had to conform to the working- or children schedule" (D. Gal, 2003, page. 109, 110).

According the data resulted from the given research the daily activities made by the elderly vary, but are sedentary, thus: most of them watch TV-– 81%, pray- 80, 8%. In quite a high percentage listening to the radio- 37%, followed by reading the newspaper-23,5 or reading some books-17,2%. Get visits 5, 8%, or visit 2, 6%. In a percentage of 6, 4% go to an association. On the last places is frequenting any shows (0, 4%) or volunteering.(0,6%).

Table 10. Frequency of daily activities (570 persons)

Daily activities Non institutionalized + Institutionalized	**everyday**	**1+2 times a week**	**A few times a month**	**Yearly**	**I do not do this activity**
Watching TV	81%	10,2%	4,1%	0,4%	4,3%
Listening to the radio	37%	11,7%	8,8%	2%	40,4%
Visiting my family and friends	2,6%	16,7%	31,1%	19,8%	29,9%
Receiving visits	5,8%	27%	42,9%	16,2%	8%
Reading books	17,2%	15,4%	14,3%	11,5%	41,6%
Reading newspapers	23,5%	19,3%	12%	4,2%	40,9%
Going to church	6%	42,4%	16,3%	8,9%	26,4%
Praying	80,8%	11%	3,3%	1,1%	3,8%
Going to shows	0,4%	0,6%	6,9%	22,6%	69,5 %
Frequent a show or communities	6,4%	10,1%	2,4%	0,7%	80,3%
Volunteering	0,6%	2,5%	0,4%	0,9%	95,7%

Comparing the non institutionalized and institutionalized persons concerning the frequency of some leisure time activities we can notice that: so the ones living at home (85,7%) as the ones living in an institution (74, 9%) watch TV very often, but the radio being listened to more by those living at home.

Receive visits or visit in a bigger percentage the non-institutionalized than the institutionalized. These visits involve money and transport, and the institutionalized cannot afford this too often. Usually people in an institution are accompanied by family, the family being that who takes them out for visiting home or their relatives.

The books and newspapers are read more often by those living at home also because in institutions there are more unschooled persons.

Most of the persons living at home go to church, but for those living in an institution the priest comes to hold the mass. Concerning praying, the percentages are similar in most environments. A lot of third aged persons are very interested in religion.

Concerning the frequenting an association or taking part in shows or volunteering the percentage is very small, so for the non-institutionalized as for the institutionalized. We think that a higher promotion of such activities can go to a more active participation of the senior citizens.

The PhD thesis gets into some of the aspects which determine the different way of using leisure time, its role being in fact to keep a certain higher level of autonomy, and presents the ***Spearman's rank correlation coefficient*** between the basic and the instrumental activities, and the satisfaction of leisure time activities and the appreciation of life as interesting, for four groups of persons: mobile non institutionalized, non mobile non institutionalized , mobile institutionalized and non mobile institutionalized.

The conclusion is that a higher responsibility and res of the society is needed concerning the extension autonomy for the elderly and the enhancement of their physical intellectual potential. The functional autonomy is influenced by the daily exercise, but also by feeling useful. If in the family or in the society the elderly feels that for him/her there nothing to be done, and one senior's activities are being taken over, this is not care taking, but condemnation to a slowly

diminishment of the elderly' s capacities. The opposite as well is true. As the elderly tries harder to enhance the potential specific to his age, that is how he will draw attention more to this and will determine requesting this from one's family or society. In other words taking part in the social life involves family, society and the seniors themselves; and between such participating and keeping one's functional autonomy is a direct, important and beneficial relation.

Living conditions

The living conditions represent one of the most important factors in one's comfort and even more for the senior's comfort, them being touched by vulnerability and special needs. If the living standards foresee some parameters concerning the living environments of a person, in Romania these standards are fulfilled only to a certain percentage. The living conditions are different and their appreciation is different too, and the impact of satisfaction for a senior's life in significant. Those institutionalized are unhappy because in the institution they do not have enough privacy. They would like to live with fewer persons in the room, because they lack space. Each institutionalized person has a personalized spot, but this is too tiny to feel like at home, they say.

Those living at home are satisfied with their living conditions, only they cannot afford the winter heating utilities as they would like to.

Living satisfaction

One's emotional state is an important feature concerning the life quality. The question which reflects this *is How often did you went through the following experiences during the last week?* We wanted to know the state of mind that the elderly had in the last week before questioning. From the total 570 persons questioned, almost half 49, 2% were sometimes sad, while 25, 1% said they were not sad at all.

Depressed (sometimes) were almost half (47, 9%) from all the questioned ones. Discouraged (sometimes) are in a very big percentage 47, 3%. Concerning loneliness 40, 5% say did not felt lonely, 39% say that they sometimes felt lonely, 15, 2% often, 5,4% almost always.

Calm were in percentage of 44,5%, almost always, 50,2% say they did not felt furious at all in a very big percentage (65,9%) say that they were sometimes jolly, 9,8% saying they were never jolly.

Analyzing the two environments (home-institution) it is noticeable that state of mind and the manifestations determined by this are a diverse palette, being of all sort of feelings and states.

Even if in both environments sadness is frequent, joyfulness is not lacked. These last week these had part of joys too.

A bigger percentage of those in an institution were calm and peaceful compared to those living at home. Fury is more often meat at those living at home, these ones having more responsibilities in their lives, than those living in an institution.

A very often meat feeling for the seniors is loneliness. Loneliness is the weak point for most of the seniors. There are a lot of cases in which the elderly are not suffering because they are not being taken cared of properly or lack anything, but because they feel forgotten by their relatives or friends. There are people who feel abandoned and who do not ask for anything else than to spend every once in a while some time together, to being listened to and to communicate with others. Loneliness can be associated with vulnerability.

According to our research loneliness seems to be frequently meat at all age categories and has the tendency to increase with aging. Thus in 60-64 age group de percentage is 13,9%, increasing the percentage of 23,3% for age group 85-89 to, although according to the chi squared test these results are statistically insignificant ($p>0,05$, $p = 0,012$).

Sadness is a frequently meat feeling at third age. And most of the time sadness is associated with depression. And this is available for all age categories tendency to increase with aging. Often at the first age group 60-64 are sad in a percentage of 20, 3%, and at the age group of 85-89 in percentage 28, 9%, although the data is not significantly statistic considering the chi square test ($p>0, 05$, $p = 0,175$).

The family relationship

According to Barbara Larsen (1995) concerning the relationship between the elderly and their family this can be experienced in various ways, but most often this relationship is being characterized with what sociologists call intimacy spatiality, meaning living separately, but not far from each other.

Persons with a poorer health condition are more vulnerable and more dependent manifesting more strongly the need to stay with their families. With all these it is not rare that in some families different generations have trouble adapting to new aged induced roles.

It is worth mentioning that there are four family models: harmonious families with financial possibilities, harmonious families without financial possibilities, disharmonious families and persons without family. In the first two situations the family helps systematically the elderly to ensure better living conditions and to keep one's autonomy for a longer time. The disharmonious family pushes the elderly to dependency given social reasons, if not trough violence or abuse, determines disabled medical affections. The lack of a family is an increasing factor of vulnerability and dependency.

Concerning the family relationships, according to this study, the majority of the elderly have a very good relationship with their families in a percentage of 44, 2%, or a good one in percentage of 39, 90 %. Only 11, 4% have a satisfactory relationship, 3% have a bad relationship, and 1, 5% have a very bad relationship.

Comparing the family relationship of those living at home with those living in an institution, those at home have a better relationship with their families as those institutionalized. Some persons in institutions are abandoned by their families. And in most of the cases their agreement is not required when being institutionalized.

Table 11. Family relationships

How is your relationship with your family? (%)					
The quality of the person	**very good**	**good**	**satisfactory**	**bad**	**very bad**
Total 570 respondents	44,2%	39,9%	11,4%	3%	1,5%

Non institutionalized	51%	40%	7,4%	1,3%	0,3%
Institutionalized	34,8%	39,7%	17%	5,4%	3,1%
chi-squared test p = 0,001					

The relationship with friends/community

Most of the respondents– 75, 7% have friends and 91, 2% keep in touch with them. More than half (53, 2%) see their friends on a daily basis.

There are differences between the institutionalized and non-institutionalized. The percentage of those who have more friends is bigger at those living at home (88, 2%) than at those living in an institution (59, 5%). More of those living in an institution have lost touch with their old friends and built new relationships with the others in the center or in another center.

The involvement of the community in keeping the autonomy of the elderly is very low. For real intervention possibilities to exist in maintaining the independence of the elderly, the community members should be having good living standards or at least a decent or balanced living. When the members of the community will not have to think of solutions for getting through the day, then probably they could be thinking how they might be helpful for those in need and how to have the willingness to help them.

The influence of the living factors on the grade of autonomy/dependence

It is noted that the factors leading to the loss of autonomy that lead to a more or less accentuated level of dependence, are basically medical and social factors. The medical factors are represented by affections of various systems and lead to a degree of disability, and the social factors would be the lack of a house, an insufficient or absent income.

For measuring independence in terms of carrying out daily activities, we used the Katz independence index (taken from the report of Comparative Studies on the Situation of the Elderly in Romania, from 2010).

This accentuates the difficulties elderly people confront with. The lowest value means that the questioned subjects are independent, and the highest value means that these are

dependent. The basic activities used by Katz, and the instrumental activities used by Lawton in 1969, applied in the Canadian Study of Health and Aging (Ostbye et all,1997) and with the Government Decision suggested in 2000. The basic everyday activities are: eating, washing (bathing, shower), personal hygiene, dressing, inside transportation, telephone use. The instrumental activities are: doing the shopping, cooking, making food, transportation, medication, paying taxes, filling out forms.

Generally speaking the population studied by the time of the research is autonomous. Some difficulties which occur at instrumental activities are observed: cleaning, doing the laundry, making food, paying taxes, filling out forms.

The score for these 2 groups (institutionalized and non-institutionalized) concerning dependency for everyday basic activities is 10, 94 for non institutionalized and 13, 81 for institutionalized elderly (the standard diversion being 9, 03 and 8, 64).

The test has a value of 3,801, which means that the observed difference between the 2 groups is statistically significant at the threshold of 0,001, thus the research hypothesis is confirmed: the institutionalized elderly group proves a higher rate of dependence that the non-institutionalized elderly group.

Table 12. Differences in the scores for everyday instrumental activities for the institutionalized and non institutionalized elderly

Belonging to an institution	**N**	**The average score**	**Diversion std.**[2]	***T Value***	**Sig.**
non institutionalized	313	10.94	9.03	-3.801	0,001
institutionalized	242	13.81	8.64		

Concerning the instrumental activities the average for the non-institutionalized is 14, 95, while for the ones living in institutions is way higher 30, 62. The values of the test is 17,539, which means that the difference between the two is significant, the threshold of s is de 0,001. The difference between the two averages is owed to the fact that elderly persons rarely do instrumental activities.

Table 13. Differences in the scores for everyday instrumental activities for the institutionalized and non institutionalized elderly

Belonging to an institution	**N**	**Average score**	**Diversion std.**[3]	**Value *t***[4]	**Sig.**
non institutionalized	308	14.95	11.50	-17.539	0,001
institutionalized	240	30.62	9.41		

To carry out everyday activities in which elders might encounter difficulties, those living at home are helped by their children, relatives or in some cases neighbors and those in institutions are helped by the caregiver personnel.

In regards to the level of contentment towards the given help for realizing the activities (basic or instrumental) it is noted that those living at home are more satisfied than those in institutions. This can be explained with the fact that a lot of institutionalized persons consider

[3] Std Diversion –standard diversion

[4] „The t test is used to evaluate statistically and is used to evaluate the statistical significance of the difference between the two sets of scores. In other words, it helps clarifying a commonly found question in the context of investigations, precisely if the average value for a set of scores differs significantly from the average value for a different set of scores "(Dennis Howitt, Duncan Cramer, 2010, p. 140)

being in an institution more an obligation of the society not as help provided in a certain situation.

The interpretation of the conclusions resulted from the case studies

There has been studied the case of ten persons, five in institutions and five living at home. It has been kept in mind that the factual data to be the same for both categories, condition that allows their comparison. From the institutionalized persons two men and three women have been chosen, with the ages between 62 and 83; three from these persons have middle school studies and two have bachelor studies; two mobile female and three disabled male. From the home environment two women and three men were been chosen, with ages 62 and 83; three from these have high school studies and two have bachelor studies; three mobile female and two disabled male.

All of these ten persons have complex life stories, each going through a lot of beautiful and also difficult life stories. None of them lacked sorrows or problems. What is first of all different, is the way of living, this likely to leave its mark to the level if dependence or independence at old age. It is noticeable that the persons living at home, the mobile and non mobile ones have similar problems. One of these is loneliness. Although independent persons could have a social network to fill up their free time and to train them for various activities, it is not at all like that. For non institutionalized disabled persons it is more difficult to create socializing conditions. This involves more transport costs, help for mobilization, company etc. Compared to the persons living at home, those from the institution mobile or not, although miss their family are involved in a series of activities which are growing their sense of satisfaction and their self esteem. With all this instituting it is not seen as a solution for the elderly. It is confirmed M. Marsha's (1993) statement that the institution may be the last stop in a man's life. But sometimes the elderly are not happy at home, and they feel alone and in their last phase of life, for death does not exclude anyone, no matter where they might be According E. Goffman (2004), the barriers pulled up by the institution between individuals and society leads to the loss of self. Taking into consideration the statement made by the persons living at home, these feel even lonelier than the ones in institutions. And then it is not enough to live at home and be autonomous if one is not satisfied with the living conditions and the satisfaction grade is low.

GENERAL CONCLUSIONS

The general conclusions drawn at the end of such research, through which we tried to get a modest contribution to a better knowledge of the life of the third aged persons, aimed at both those around the elderly, in families or institutions, and those who make the laws take decisions for elderly, and those who get to the old age able to do a lot of things to make their life easier more beautiful and.

The aging of the population in the first half of this century represents as shown in the foresights based on statistics (C. Mureşan, 1999) quite an important problem for the Romanian society, thus a careful and responsible attention from the state, from the communities, specialized institutions, families and the citizens themselves is needed.

The importance of this thesis is to signal and prove as much as possible that the demographic aging can be accentuated by autonomy of the state or by vulnerability of senior citizens, and this is as important to the society as it is to the families or to each person. The vulnerability is a phenomenon that does not have to be treated after its emergence, but should be prevented through the lifestyle that starts in youth, for ensuring a better and longer lasting autonomy.

The fact that this problem was not sufficiently treated in research and specialized literature, together with personal inclinations for the person category and the gained experience through the work in this field were important factors in choosing this theme.

In the thesis I permanently had in mind two essential aspects: first was the spotting and the clarifying these two theoretical concepts and the definitions relating to the aging process, the autonomy and vulnerability of the elderly, the rights and social services from which they benefit or should be benefitting. The second aspect includes the own approach for concrete knowledge of the seniors in the current stage and under the given conditions, through a personal research, which aimed at pointing out a more truthful picture of the life of the senior citizens and the extraction of a set of conclusions and proposals connected to the autonomy and vulnerability of this important social segment.

For the scientific support of the thesis I had in mind the given bibliography, relevant works in the field I had access to, studies realized by research institutions, state institutions, associations and foundations, published articles in specialized magazines. I considered that making reference to the given legislations is needed, for older and more recent periods too, with changes in the field of social work, of pensions, of the health care. The statistic data and obtained information from the National Institute of Statistics have made up an important support for getting to know the dynamics of some indicators, and the focalization on the situation of Cluj county, via the data from the Cluj Center of Statistics has allowed the actualization of the data and realizing some relevant correlation concerning a series of aspects of the lives of the elderly.

The rise of the scientific work of the thesis was given by own research, the application of 570 questionnaires, the realizing of 30 individually semi-structured interviews and the making of 10 case presentations, as the processing, that makes an addition of information and enables the possibility of some useful conclusion, that will be given by the *considerations on verifying the research hypothesis and some recommendations.* So, the aging of the population becomes a national vulnerability because people becoming old must be sustained when they will be dependent and must he helped to keep their autonomy as long as possible.

The myth of aging as poor health and senility is not confirmed but is sustained the idea that the elderly are more exposed to difficulties, and aging itself, is not a disease (H. Cox, 1994). There are no reasons to exclusively relate poor health with aging. At this age more illnesses appear than in youth, but a good health care can extend the health being. From our research it is notable that 74, 8% respondents, appreciate their health condition as satisfactory, good or very good. Senility, as well it is not dominant and in most of the cases the idea related to the wisdom of the elders, just as romance connected to youth does not go away entirely at this age. From the replies to the questionnaires it results that the elderly are different in regards to life style, and in most of the cases have predisposition to adaptability.

It is confirmed the predominant hypothesis that **vulnerability is given by the poor material conditions and by the feeling lonely.** If the percentage of those (institutionalized un non institutionalized) who appreciate that their income is not enough for the bare necessities or barely enough for the necessities is 60,7%, it is close in percentage with the feeling of loneliness, respectively 59,5% felt alone all the time, often or sometimes.

It is confirmed that the **lack of schooling and education at its time, can constitute a risk for the growth of vulnerability at an old age**. From our research it results that two directions are manifested a) a lower schooling determines a lower income at both categories of persons resulted from our research. b) reduced schooling and education determine to institutionalization; for institutionalized the percentage of unschooled is 10, 6%, those with elementary school is 26,4%, and those with middle school is 30,9%, therefore 70 percent are unschooled persons or with low level of schooling, while those living at home the percentage of non schooled is only 1,6% and are significantly big percents of high school, college or university studies.

The recomandations are orientated to the decision factors from the domain of the national and local social politics, respectively to the families and the residential institutions who represent the social milieu of life.

Factors of decisions at national level

*Maintaining as stable as possible the level of the incomes for the elderly population through the correlation of the inflation index with the pension index**;** The social politics* for elderly has to respect the decisions of the international and European Organisms. The Universal Declaration of Human Rights (O.N.U December 10th, 1948), The International Principles of the United Nations for Older Persons (O.N.U November 16th, 1991) The international Plan of Action on Aging (Worldwide Assemble of Aging July 26th- August 6th 1982), The Book of the European Union for Fundamental Rights (2000), the outlines of the Basic Treaty and Documents of the European Union; *The social protection systems* concerning social and health insurances should outline and provide special conditions and facilities for senior citizens; financial facilities to medical services, easier access to these and some free of charge home services.

Communities

The local insurance for some facilities for the senior citizens; in hospitals, for urban transport, for access to cultural institutions, the improvement of specialized clubs; *The use of European funds and local availability* for building new centers of care giving and assistance, daily centers and other type of permanent settlements for elderly, the percentage being reported being too little compared to the average European population; *The initiating and organizing of*

educational programs, which includes both senior citizens and adult population, in the idea of such a lifestyle that might lead to the prolonging of autonomy.

Families

*Keeping the elderly in activity zone, as far as their possibilities allows them to, in order to feel not the loss of powers or inutility**;** The consulting of the senior citizens in certain problems*, because of their experience as for their real ideas, and to avoid them feeling disrespected; *The increased concern for health of the senior citizens* (the elderly because of material reasons, or to avoid disturbance tend to neglect themselves)

Care and assistance institutions:

Promoting the existing services in *institutions and actions to educate society* to look at institutions as an alternative and not unwanted solution.

Therefore it should not be omitted that the third aged persons need somebody close to them and all that can be done should be done to ensure for the longest possible period of time their health and autonomy. It is a moral duty of the family, and society in general to create and maintain certain conditions for people, who have reached to a certain age, but this is a duty and reward as well to the contribution of the previous generations to enhance the gift the present generation is enjoying. It might be possible that the way we can organize the social and institutional frame for the old people of today to become a model of a future frame of social integration of our own generation.

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