Changes in social support in relation to seniors' use of home care

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Abstract

Objectives
This article examines seniors' entry into government-supported home care in relation to changes in levels of social support and in living arrangements.

Data source
The analysis is based on longitudinal data from the household component of the first two cycles of the National Population Health Survey, conducted by Statistics Canada in 1994/95 and 1996/97. Data from a sample of 2,044 people aged 65 or older who were followed prospectively were weighted to represent 2.7 million household-dwelling seniors.

Analytical techniques
Descriptive data were produced using bivariate frequencies. A multiple logistic regression model was used to examine associations between home care entry and changes in levels of social support and in living arrangements, while controlling for demographic and health-related factors.

Main results
Among people aged 65 or older who did not receive government-supported home care in 1994/95, an estimated 7% (192,000) were receiving these services in 1996/97. Changes in social support and in living arrangements between 1994/95 and 1996/97 were significantly associated with home care entry.

Key words
home care services, family characteristics, aged, longitudinal studies, health surveys, activities of daily living

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As a result of continuing constraints on health care budgets, home care has been receiving increased attention as a cost-effective means of caring for people with health problems. For example, research has focussed on the importance of home care in preventing or delaying the need for institutionalization among seniors with chronic or disabling conditions.[1,2]

Currently, government-supported home care comprises a variety of services organized under disparate administrative structures and policies. Although these differences in home care services pose a challenge to researchers, a better understanding of the factors that contribute to home care use is important because growing numbers of people are likely to need such services in coming decades. Recent information from the longitudinal component of Statistics Canada's National Population Health Survey (NPHS) offers an opportunity to study Canadians' use of home care prospectively (see *Methods*, *Limitations* and *Definitions*).

A previous study of home care users, based on cross-sectional data from the first cycle of the NPHS, examined the health and demographic characteristics of users of all

<center>**Methods**</center>

Data source

This article, which focusses on individuals aged 65 or older, is based on data from the National Population Health Survey (NPHS). The NPHS, which began in 1994/95, collects information about the health of the Canadian population every two years.[3,4] It covers household and institutional residents in all provinces and territories, except persons on Indian reserves, on Canadian Forces bases, and in some remote areas. The NPHS has both longitudinal and cross-sectional components. Respondents who are part of the longitudinal component will be followed for up to 20 years.

Individual data are organized into two files: General and Health. Socio-demographic and some health information was obtained for each member of participating households. These data are found in the General file. Additional, in-depth health information was collected for one randomly selected household member. The in-depth health information, as well as the information in the General file pertaining to that individual, is found in the Health file.

Among individuals in the longitudinal component, the person providing in-depth health information about himself or herself for the Health file was the randomly selected person for the household in cycle 1 and was usually the person who provided information on all household members for the General file in cycle 2.

The 1994/95 provincial, non-institutional sample consisted of 27,263 households, of which 88.7% agreed to participate in the survey. After the application of a screening rule to keep the sample representative, 20,725 households remained in scope.[5] In 18,342 of these households, the selected person was aged 12 or older. Their response rate to the in-depth health questions was 96.1%, or 17,626 respondents. Of these 17,626 randomly selected respondents, 17,276 were eligible for re-interview in 1996/97. A response rate of 93.6% was achieved for the longitudinal panel in 1996/97. Of these 16,168 respondents, 15,670 provided full information; that is, general and in-depth health information for both cycles of the survey.

This analysis of entry into government-supported home care in relation to changes in social support is based on longitudinal data from the household component of the first (1994/95) and second (1996/97) cycles for the 10 provinces. From a total of 2,740 people aged 65 or older randomly assigned to the household-dwelling longitudinal panel at the time of the 1994/95 interview, 194 (7%) had dropped out of the survey and 258 (9%) had died or had been insitutionalized at the time of the 1996/97 follow-up interview.[4] An additional 244 had reported receiving home care in 1994/95. The analysis is based on data from the remaining sample of 2,044. Of these, 154 had newly entered home care by 1996/97. The data, weighted to account for the sample design, non-response and poststratification, represented 2.7 million seniors (Appendix Table A).

Analytical techniques

The analysis was based on the model of determinants of health care use proposed by Andersen and Newman.[6] This model suggests that use of health care services is motivated by factors arising from the environment and from the individual. Three categories of determinants are offered: predisposing, enabling and need (illness- or disability-related).

Individual characteristics that exist before the onset of illness, such as age, sex, living arrangements (including family size) and beliefs or attitudes toward health care predispose a person to use health care, according to Andersen and Newman. An indicator of a change in living arrangements—from living with at least one person to living alone between 1994/95 and 1996/97—was derived from the NPHS data and was included as a predisposing factor. Additional predisposing factors included as control variables were: age group, sex and household income.

Andersen and Newman define enabling factors as those conditions within the family or the community that make health services available to the individual. Two NPHS variables, both of which were indicators of changes in social support, were used in the analysis as enabling factors: change in average frequency of family contacts and change in perceived emotional support. The analysis included variables representing an increase, a decrease, or no change in the level of each of these variables between cycles 1 and 2.

The analysis was also controlled for several indicators of need: having one or more of four selected chronic conditions (cancer, effects of stroke, urinary incontinence, and Alzheimer's disease or other dementia) in 1994/95, becoming dependent on the help of another person in carrying out activities of daily living (ADL) between cycles 1 and 2, and being hospitalized sometime in the 12 months before the cycle 2 interview. The need variables were selected on the basis of their association with receiving home care in previous analyses.[7,8]

With data from the longitudinal file, cross-tabulations were used to estimate the percentage of Canadians aged 65 or older who had entered formal, government-supported home care by 1996/97, by the presence of selected health-related, demographic and social characteristics. Entry into home care was defined as receiving home care in 1996/97, after reporting not receiving such care in 1994/95. Data on sex were pooled for these univariate tabulations.

Multiple logistic regression was used to model associations between entering home care by 1996/97 and indicators of change in levels of social contact, perceived social support and living arrangements, while controlling for demographic and health-related factors. To account for survey design effects, standard errors and coefficients of variation were estimated with the bootstrap technique.[9] Results at the 0.05 level were considered statistically significant.

ages.[7] This analysis, based on longitudinal data from cycles 1 (1994/95) and 2 (1996/97), extends that work by examining associations between government-supported home care entry and changes in social support, while controlling for factors already shown to be related to the use of home care. This article pertains to people aged 65 or older, the group that most commonly uses home care.

Age, need linked to home care entry

Of household residents aged 65 or older who did not receive formal, government-supported home care in 1994/95, an estimated 7%, or 192,000, were receiving such services two years later (Appendix Table A).

Certain factors distinguished individuals who entered home care at some point before their 1996/97 interview (Chart 1, Appendix Table B). Predictably, the likelihood of home care entry was higher for older seniors than for those aged 65 to 74. As well, people who were newly dependent on others for help with activities of daily living, had at least one chronic condition, or had been hospitalized in the previous year were more likely than others to enter home care.

Income also played an important role. A significantly higher percentage of lower-income individuals entered home care than did their higher-income counterparts. This may reflect the poorer health—and therefore greater need for care—of individuals with limited means. But it may also be partly because individuals with higher incomes are able to pay for private services, rather than depending on government-subsidized home care.

Chart 1

Percentage of household population aged 65 or older in 1994/95 entering home care by 1996/97, by selected characteristics, Canada excluding territories
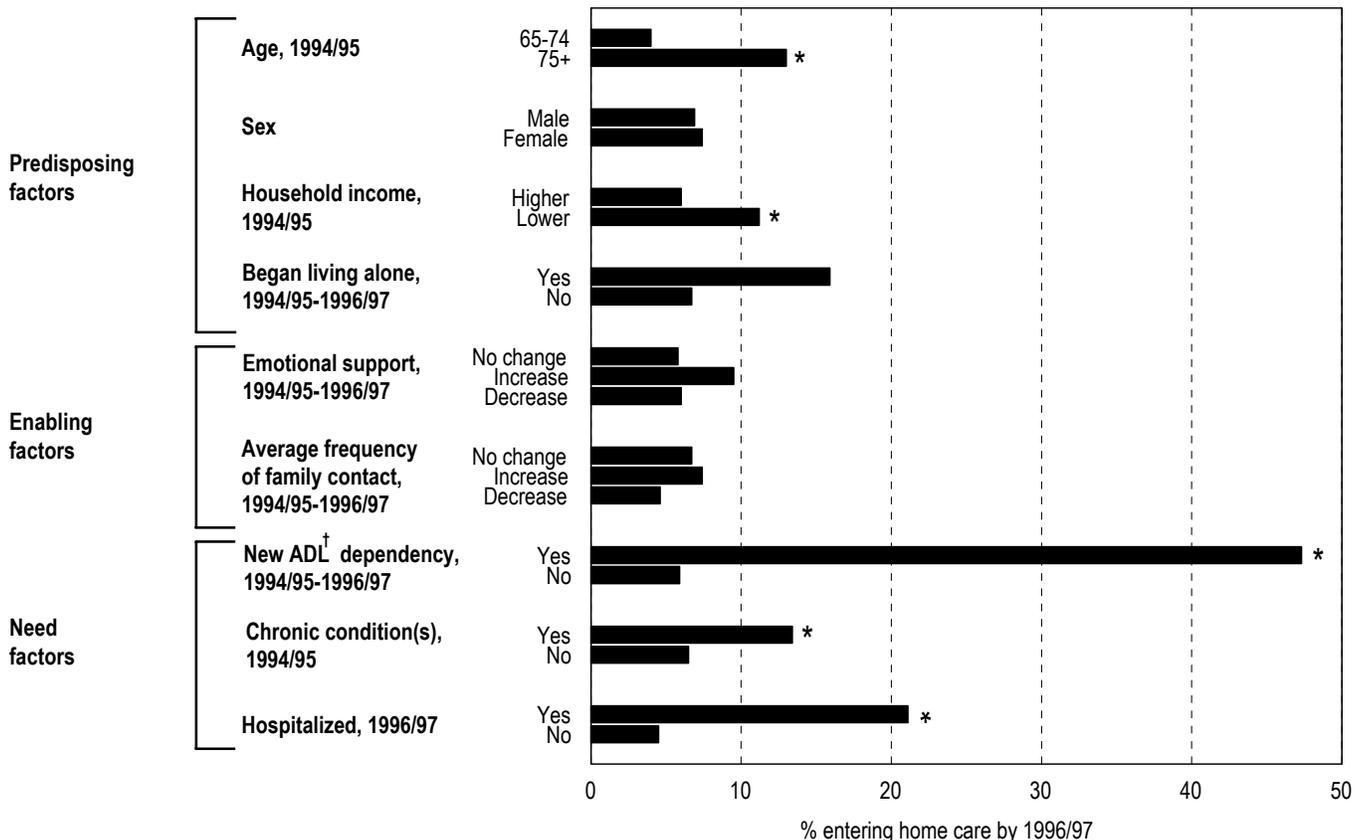
Data source: 1994/95 and 1996/97 National Population Health Survey, Longitudinal file, 1994/95 to 1996/97
† *Activities of daily living*
* Significantly higher than other value in category (p = 0.05). Critical value was adjusted to take multiple comparisons into account, where applicable.

Emotional support related to home care

Many of the factors associated with entry into home care are, of course, related. However, even when the effects of variables such as age, sex, income, and physical need were taken into account,

Limitations

Information on informal home care is not available from the National Population Health Survey (NPHS). However, other research has shown that, in many cases, seniors who are receiving formal, government-supported home care are also receiving informal care such as help from family and friends.[10,11] The characteristics and needs of individuals receiving government-supported home care may not actually differ much from those of people receiving informal care only. The similarities between these groups can be expected to dilute the strength of the associations examined in this study. As well, the NPHS provides no information on private home care, so individuals receiving such services may be misclassified as not receiving home care. Finally, because respondents were asked only about home care received in the 12 months before their interviews, there is no information on the years before the first survey period, or on the year immediately following the first interview (1995/96). Therefore, it is not known to what extent the characteristics of people who may have received home care during these periods would resemble those of people who entered home care in the 12-months before the cycle 1 and 2 interviews. Again, similarities between the groups could weaken any true associations.

Currently across Canada, and from one region to another, government-supported home care differs in its structure and access, and in the nature of services available. Such factors related to the delivery of health care are likely to affect the use of home care (and are postulated to do so by the Andersen and Newman model); however, because such information is not available from the NPHS, this analysis does not take it into account.

Because the reference period for some of the variables was the 12 months before each interview, it was not possible to determine the timing of some factors. For example, an increase in perceived emotional support might occur before entry into home care, perhaps arising from increased contact with children after the loss of a spouse. It might also occur after home care has begun, perhaps through contact with the formal caregiver.

The relatively small sample size of people aged 65 or older who are being followed longitudinally restricts the scope of this analysis. It would have been preferable to analyze the data for men and women separately, but the resulting sample sizes for the two groups were too small. It is also possible that the small sample size may have prevented some true associations from reaching the designated level of significance.

The data are self- (or proxy-) reported, and the degree to which they are biased because of reporting error is unknown. To minimize reporting error in data related to chronic conditions (including cancer, effects of stroke, urinary incontinence, and Alzheimer's disease or other dementia), respondents were instructed to report only those conditions that had been "diagnosed by a health professional."

significant associations with home care entry emerged for factors that reflected changes in social support. Notably, individuals who reported an increase in perceived emotional support had just over twice the odds of entering home care as those who reported no change (Table 1). Although the association between decreased family contact and lower odds of home care entry was significant only

Table 1
Adjusted odds ratios for home care entry, household population aged 65 or older in 1994/95, by selected characteristics, Canada excluding territories

	Odds ratio	95% confidence interval
Predisposing factors		
Age group, 1994/95		
65-74[†]	1.0	...
75+	3.0*	1.8, 4.8
Sex		
Men[†]	1.0	...
Women	1.1	0.6, 2.0
Household income, 1994/95		
Higher[†]	1.0	...
Lower	2.0*	1.0, 3.9
Began living alone, 1994/95-1996/97		
No[†]	1.0	...
Yes	3.1*	1.4, 6.9
Enabling factors		
Perceived emotional support, 1994/95-1996/97		
No change[†]	1.0	...
Increase	2.1*	1.1, 4.0
Decrease	1.1	0.6, 2.1
Average frequency of family contact, 1994/95-1996/97		
No change[†]	1.0	...
Increase	0.9	0.5, 1.7
Decrease	0.6[a]	0.3, 1.1
Need factors[‡]		
New need for help with activities of daily living, 1994/95-1996/97	7.0*	2.8, 17.3
Chronic condition(s), 1994/95	1.7	0.8, 3.7
Hospitalized in previous 12 months, 1996/97	4.7*	2.7, 8.1

Data source: *National Population Health Survey, Longitudinal file, 1994/95 to 1996/97*
Notes: *"Unknown" categories for household income level, perceived emotional support and average frequency of family contact were included in the model, but their odds ratios are not shown. Analysis is based on a sample of 2,040; 4 individuals were excluded because of missing values for one or more other variables. Because of rounding, some confidence intervals with 1.0 as the lower limit were significant.*
† Reference category, for which odds ratio is always 1.0
‡ Reference category is absence of condition.
... Not applicable
* p < 0.05
a p = 0.07

Definitions

The National Population Health Survey (NPHS) question about home care was: "Home care services are health care or homemaker services received at home, with the cost being entirely or partially covered by government. Examples are nursing care, help with bathing or housework, respite care, and meal delivery. Have/Has . . . received any home care services in the past 12 months?" *Entry into home care* was defined as receiving home care in the 12 months before the cycle 2 interview in 1996/97, but not in the corresponding period before the cycle 1 interview in 1994/95.

Several ***predisposing factors*** were used for this analysis.

Two *age groups* (age in 1994/95) were defined: 65 to 74 and 75 or older.

Household income was defined as "lower" and "higher," based on total household income and the number of household members.

People in household	Total household income	
	Lower	**Higher**
1 or 2	Less than $15,000	$15,000 or more
3 or 4	Less than $20,000	$20,000 or more
5 or more	Less than $30,000	$30,000 or more

Income data were not available for 6% of the longitudinal respondents aged 65 or older. So that other information on these respondents could be included in the regression analysis, a variable for unknown income was included in the model.

Change in *household size* was defined as living in a household with at least one other person in 1994/95, then living alone in 1996/97.

Two measures of change in *social support* between 1994/95 and 1996/97 were included as ***enabling factors***: an increase, decrease or no change in perceived emotional support, and an increase, decrease or no change in average frequency of family contact.

Perceived emotional support was measured by four questions:

"Do you have someone you can confide in or talk to about your private feelings or concerns?"

"Do you have someone you can really count on to help you out in a crisis situation?"

"Do you have someone you can really count on to give you advice when you are making important personal decisions?"

"Do you have someone who makes you feel loved and cared for?"
Each "yes" answer was scored 1, for a maximum score of 4. Total scores that were higher or lower in 1996/97 compared with 1994/95 were considered to show an increase or decrease, respectively, in perceived emotional support. Scores that remained the same in both cycles were considered to show no change.

Information on *average frequency of family contact* was ascertained from questions measuring contacts with daughters or sons (or daughters- or sons-in-law), in view of recent research on informal eldercare in Canada showing that the majority of caregivers are adult children looking after their elderly parents.[12] The NPHS asked, "In the past 12 months, how often did you have contact [either in person, by phone, or by mail with persons who do not live with you] with your daughters or daughters-in-law?" A similar question was asked about contacts with sons and sons-in-law. Responses were: "Don't have any, or all live with you," "Never," "Once a year," "A few times a year," "Once a month," "Two or three times a month," "At least once a week," "Every day." The responses were recoded so that scores ranging from 1 to 7 were assigned to successive response levels, from "never" through "every day." To calculate a respondent's average score, his or her total score was divided by the number of family relationships for which responses were provided. No contacts with daughters or sons or daughters- or sons-in-law scored 0; contact only with daughters or sons or respective in-laws, 1; and contact with both daughters and sons or respective in-laws, 2. An increase or a decrease in the average frequency was defined as a higher or lower score, respectively, in cycle 2 than in cycle 1. No change in the score was considered to reflect no change in frequency of contacts.

Because the NPHS question was asked only in reference to adult children living outside the home, people whose children lived in their homes or who had no children also had to be included. Individuals with children living in their home in cycle 1 but not in cycle 2 were defined as having a decrease in average frequency of contact; conversely, those with children in their home in cycle 2 but not in cycle 1 were defined as having an increase. People whose children lived with them in both cycles were defined as having no change in average frequency of contact. Those with no children, either inside or outside the home, in both cycles were scored as having no change in average frequency of contact. Data for individuals who responded that they had children in cycle 2 but not in cycle 1 were excluded from the analysis.

Several ***need factors*** were examined. A new need for help with activities of daily living (ADL) was determined by asking: "Because of any condition or health problem, does . . . need the help of another person in personal care such as washing, dressing or eating?" A "no" response in cycle 1 and a "yes" in cycle 2 indicated a new need for help with ADL.

Respondents were asked if a health professional had diagnosed them as having selected *chronic conditions* "that have lasted or are expected to last six months or more." A "yes" response to at least one of four specific conditions—cancer, effects of stroke, urinary incontinence, and Alzheimer's disease or other dementia—was used to determine the presence of a chronic condition in cycle 1.

Hospitalization at some time during the 12-month period before the cycle 2 interview was defined as a "yes" response to the question, "In the past 12 months, have you been a patient overnight in a hospital, nursing home or convalescent home?"

at the level of p = 0.07, it adds to the plausibility of the converse positive relationship between increased emotional support and entry into home care.

In addition, a reduction in household size resulting in living alone, which indicates a potential change in level of social support, was independently associated with entry into home care. Seniors who had begun living alone sometime between their cycle 1 and cycle 2 interviews had just over three times the odds of entering home care by 1996/97, compared with their counterparts whose household size either remained the same or increased. This finding supports other research showing that people living alone are more likely to receive formal care than those living with family members.[10,13]

As expected, age was independently predictive of entry into home care. The odds of entering government-supported home care were three times as high for people aged 75 or older as those for 65- to 74-year-olds. Income remained a factor: members of lower-income households had twice the odds of entering home care, compared with those in the higher-income group.

Consistent with other research,[8,10,14,15] physical need was associated with entering home care. For example, seniors who indicated a new need for help with the activities of daily living had seven times the odds of entering home care, compared with individuals who reported no new need. In addition, people who had been hospitalized sometime during the 12 months before the cycle 1 interview also had much higher odds (4.7) of entry into home care, compared with those who had not been hospitalized in that period. This finding also supports previous research and was not unexpected.[8] Older patients released from hospital often need continuing care or assistance, and arrangements for home care may be made as part of their discharge plan.

Social support linked to formal care

Because the NPHS does not provide information about exact dates, the timing of events related to entry into home care cannot be established. The vulnerability of the elderly can increase gradually, as in the case of a chronic, debilitating disease, or abruptly, perhaps as the result of a fracture or an acute illness. When functional decline is gradual, family members might initially provide care themselves, and thereby become more involved with the elderly person's emerging needs.[11] As the burden of care becomes too physically or emotionally demanding or too technically complex, this informal network may assume the role of advocate and mobilize the formal support system, including government-supported home care services. The role of the family and other informal networks as advocates in the use of health care has been documented by previous research,[11,16,17] and may explain the association between perceived emotional support and entry into home care. It is also possible that, in some cases, increases in perceived emotional support result from contact with the formal caregiver. In the case of a precipitating event, access to home care services may be facilitated by a health care provider who is a formal caregiver; for example, as part of a discharge plan from an acute care hospital.

The few studies that focus on social support in relation to home care utilization are contradictory and inconclusive. However, similar to the NPHS results, a study of patients in the Boston area who had been discharged to their homes from rehabilitation hospitals showed that those patients whose family and friends provided informal care were also more likely to use community-based home care services.[18] As well, a study of elderly people in Cleveland showed lower rates of use of social and health services among socially isolated seniors than others.[19] By contrast, other research has shown no associations between social resources and the use of home care,[20-22] or associations between *low* levels of social support and receiving formal home care.[10,23,24]

With the important exception of a longitudinal study of formal care use by frail elderly in the United States, most previous research of health services utilization has used variables measured at one point in time.[8] By contrast, this analysis has examined changes over time in social support and living arrangements. Associations between such changes and use of home care services may be more pronounced than associations with variables

measured only once. For example, the transition to living alone, which may often occur as a result of the death or institutionalization of an ailing spouse, reflects a loss of close companionship, and frequently, help with tasks such as housework, grocery shopping, or preparing meals. The need for home care may be greater during the period of adjustment to living alone, especially for someone who is already disabled, than it would be later on, after new ways of coping have been established. (See also *Living at home or in an institution: What makes the difference for seniors?* in this issue.)

However, the association between home care entry and the change in living arrangements may also reflect the response of the health care system. As noted in a study of Manitoba seniors, availability of informal care reduces one's assigned priority of need for formal home care service.[22] People who have recently experienced the loss of a partner may be deemed in greater need of home care than those with the same physical condition who are living with others.[25]

Concluding remarks

This analysis uses longitudinal data from the first two cycles of the National Population Health Survey to provide evidence of the importance of changes in social support in the entry of seniors into formal, government-supported home care. The analysis also adds to existing evidence of the strong associations between socio-demographic conditions and physical needs and entry into home care. Yet even when controlling for the effects of these factors, the data indicate that entry into home care is related to an increase in perceived emotional support and a change in living arrangements to a one-person household. The lack of information on the timing of events surrounding entry into home care does limit the analysis somewhat. Nonetheless, whether home care is initiated as a result of action by family members or by the health care system, this analysis suggests that the informal network operates in concert with the formal delivery system to care for older people in the community. ●

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Appendix

Table A
Distribution of selected characteristics, household population aged 65 or older in 1994/95, Canada excluding territories

	Sample size	Estimated population	
		'000	%
Total	**2,044**	**2,686**	**100**
Entered home care by 1996/97	154	192	7
Predisposing factors			
Age group, 1994/95			
65-74	1,294	1,797	67
75+	750	889	33
Sex			
Male	814	1,169	44
Female	1,230	1,517	56
Household income, 1994/95			
Higher	1,330	1,944	72
Lower	612	593	22
Unknown	102	149	6
Began living alone, 1994/95-1996/97	82	138	5
Enabling factors			
Perceived emotional support, 1994/95-1996/97			
No change	1,365	1,708	64
Increase	286	391	15
Decrease	226	313	12
Unknown	167	273	10
Average frequency of family contact, 1994/95-1996/97			
No change	888	1,111	41
Increase	508	686	26
Decrease	496	625	23
Unknown	152	264	10
Need factors			
New need for help with activities of daily living, 1994/95-1996/97	71	82	3
Chronic condition(s), 1994/95	185	253	9
Hospitalized in previous 12 months, 1996/97	333	427	16

Data source: *National Population Health Survey, Longitudinal file, 1994/95 to 1996/97*
Note: *Detail may not add to total, as data were missing for some variables.*

Table B
Distribution of selected characteristics, by home care entry status in 1996/97, household population aged 65 or older in 1994/95, Canada excluding territories

	Entered home care	Did not enter home care
	%	%
Predisposing factors		
Age group, 1994/95		
65-74	38	69
75+	62	31
Sex		
Male	42	44
Female	58	56
Household income, 1994/95		
Higher	61	73
Lower	35	21
Unknown	5	6
Began living alone, 1994/95-1996/97		
Yes	11	5
No	89	95
Enabling factors		
Perceived emotional support, 1994/95-1996/97		
No change	52	65
Increase	19	14
Decrease	10	12
Unknown	19	9
Average frequency of family contact, 1994/95-1996/97		
No change	39	42
Increase	27	25
Decrease	15	24
Unknown	20	9
Need factors		
New need for help with activities of daily living, 1994/95-1996/97		
Yes	20	2
No	80	98
Chronic condition(s), 1994/95		
Yes	18	9
No	82	91
Hospitalized in previous 12 months, 1996/97		
Yes	47	14
No	53	86

Data source: *National Population Health Survey, Longitudinal file, 1994/95 to 1996/97*
Note: *Because of rounding, detail may not add to totals.*