



## Review

## Informal care, health and mortality

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## ABSTRACT

Informal care provision is an activity in which individuals are increasingly likely to become involved across their life course, and particularly in later life, as a result of demographic changes such as increasing longevity and changes in co-residential living arrangements in later life. Academic research so far has highlighted the adverse impact of informal care provision on the financial position of the carer, however, the evidence on the impact of informal care provision on the carer's physical, mental and emotional health, and on their mortality, presents a more complex picture. This paper reviews research from the UK and beyond on the provision of informal care and its subsequent impact on health and mortality outcomes. Two key findings emerge from this review paper. Firstly, the cross-sectional analysis of data shows mixed associations between informal care provision and poor health outcomes for the carer. Such research highlights the importance of the demographic and socio-economic characteristics of the carer and the person cared for, and of the specific characteristics and nature of the care provided (e.g. duration, level). Secondly, longitudinal analysis, which typically benefits from a longer timeframe to follow up the impact of caring, shows that although informal care provision is not per se associated with adverse health and mortality outcomes, nevertheless particular types and durations of caring have shown negative outcomes.

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## 1. Introduction

The provision of informal care across the life course and in later life is an increasingly common experience [1,2], which can have

positive or negative consequences on the carer's emotional, physical and mental health [3]; their availability and capacity to engage in paid work or leisure activities [4]; and their financial resources in old age [5]. Although the measurement of the impact of care-giving is a challenge in its own right [6], academic research has come a long way in improving our understanding in this field. Qualitative research has contributed to our understanding of the experience of providing informal care throughout the life course and especially in later life, and conveys a balance between the positive and negative

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feelings of informal carers towards their role [7–10]. The quantitative evidence illustrating such impact is complex and shows that the association between informal care provision and the carer's situation depends on a range of factors, such as the demographic and socio-economic characteristics of the carer at the start and during their care provision [11], the relationship between the carer and the person they care for [12], and the characteristics of the caring activity itself, such as its duration and nature [13]. Changing partnership and marriage patterns are likely to impact on health and mortality in later life [14] and will require consideration in the context of carers' health and mortality. Findings can also vary depending on the time period analysed in the research: cross-sectional analysis may reflect shorter term impacts of a different nature, compared to analysis considering provision of caring on health prospectively and over longer time periods. Drawing on evidence from the United Kingdom and beyond, this paper discusses key findings on the impact of informal care provision on the health status and mortality of the carer. The paper argues that time, both in terms of the duration of the caring activity and its timing over the life course, is a critical dimension of such analysis and should be a more vital consideration of future work in this area.

## 2. The characteristics of informal care provision

The 2001 Census showed that about 10% of the UK's population (or 5,884,450 persons) provided unpaid care to "family members, friends, neighbours or others because of long term physical or mental ill-health or disability or problems relating to old age" [13,15]. Around 65% of informal carers were aged between 35 and 64 years [15], and provided care for up to 20 hours per week. However, there are a significant number of informal carers concentrated in mid- and later life, where the intensity of caring typically increases [16]. Fewer studies have focused on older carers [17–19], although demographic changes point to the increasing importance of older carers for the future supply of informal care [1,14,20]. The 2001 Census showed that there were 1.24 million men and 1.56 million women over the age of 50 providing unpaid care to sick or disabled persons, and about half of these were concentrated in the 50–59 age category [21]. Focusing on England, data from the English Longitudinal Study of Ageing (ELSA) indicates that although approximately 56% of carers aged 50 and over provided care for up to 20 hours per week, about one-quarter of older carers provided care of 50 hours or more [22]. Indeed, research has shown that intense care provision is a common feature in later life, particularly for men. For example, using 2001 Census data, Doran et al. [13] showed that more than half of persons aged 85 and over provided at least 50 hours of care per week, while research using the 2008 ELSA data showed that carers aged 75 and over spent an average of 41 hours extra caring per week than those aged 50–64 [23].

Informal care provision tends to be associated with specific demographic characteristics, for example with being married and being a woman [24]. Analysis of the 2000 General Household Survey (GHS) shows that married or cohabiting adults are more likely to be carers than those who are single, or were previously married [12]. In terms of gender, research has consistently shown that women are more likely than men to provide informal care throughout most of the life course [25,26]. However, the opposite is the case for those aged 65 and over, with men being more likely to be informal carers than women, and this is explained by men's greater likelihood to be married and to be providing care towards their spouse at older ages [25,27–29]. Gender has an important effect on the type and duration of care provided at different stages of one's life course. Evidence from the 2006 ELSA shows that men who provided round-the-clock care tended to be aged 65 and over, and to provide spousal care, while women who provided round-the-clock care tended to

be in the 50–64 age group, and providing care to categories other than their spouses, such as their parents or parents-in-law [4].

The evidence of the impact of informal care provision is mixed. A key conceptual and methodological distinction is that between identifying the extent to which informal care provision is associated with specific characteristics at one point in time, and understanding the impact of informal care provision on the position of the carer by examining their care provision over time. The rest of the paper discusses the evidence from academic literature in these two parts, focusing on the association/impact of informal care provision on the health status and mortality of the carer.

## 3. The impact of informal care provision on the health and mortality of carers: a snapshot view

Cross-sectional analysis on the association of informal caregiving and health and mortality tends to show mixed results, which need to be considered alongside the specific characteristics of the carer and of the person cared for, and the characteristics of the care provided. For example, using data from the 2001 Northern Ireland Census, O'Reilly et al. found that generally care-givers were less likely than non-care-givers to report a Limiting Long-Term Illness (LLTI), but that men providing 50 or more hours of care per week were the exception [30]. By contrast, Doran et al. analysed the UK 2001 Census to show that 56% of informal carers across all ages reported 'good health' compared to 70% of non-carers [13]. Finally, the work by Ross et al. [11], who conducted cross-sectional analysis using the 2004 ELSA, found no differences in the health status reported by carers and non-carers aged 50 and over. However, health and wellbeing are multi-faceted concepts. Focussing on social wellbeing, defined as participating in social activities such as meeting with friends and relatives, Evandrou and Glaser used data from the 2000 British Household Panel Survey in order to explore the impact of different roles on social wellbeing [5]. The research found that an individual's participation in social activities is largely affected by their spouse's engagement in care-giving and paid work: the participation of wives in social activities was significantly reduced if their husbands provided care for over 20 hours per week, while the social participation of husbands was significantly increased if their wives were in full-time paid work.

Notwithstanding the limitations of cross-sectional analysis, such as its inability to determine the factors associated with an individual's selection into or out of care-giving, such work can go a long way to contributing to our understanding of the health status of informal carers and its association with particular types of care provision. For example, Broe et al. used data from a community survey of 630 persons aged 75 and over living in Sydney who completed the General Health Questionnaire and a life satisfaction index, and found that carers who provided personal care (e.g. dressing) were more distressed than carers who provided instrumental care (e.g. cooking) [31]. Taking the number of hours of care provided into account, Young et al. studied the provision of care among couples aged 65 and over in 2001, where at least one of the two spouses reported a LLTI, and found that 'intensive' care providers, defined as those providing 20 hours of care or more per week, reported poorer health outcomes than those who provided fewer hours of care [16].

## 4. The impact of informal care provision on the health and mortality of carers: a longitudinal view

Taking a longitudinal perspective on the impact of care-giving on the carer's health and mortality facilitates researchers to investigate the causality between caring and health outcomes. The interaction of the care-giving activity with other roles and life

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