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Convoys of care: Theorizing intersections of formal and informal care

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Although most care to frail elders is provided informally, much of this care is paired with formal care services. Yet, common approaches to conceptualizing the formal–informal intersection often are static, do not consider self-care, and typically do not account for multi-level influences. In response, we introduce the "convoy of care" model as an alternative way to conceptualize the intersection and to theorize connections between care convoy properties and caregiver and recipient outcomes. The model draws on Kahn and Antonucci's (1980) convoy model of social relations, expanding it to include both formal and informal care providers and also incorporates theoretical and conceptual threads from life course, feminist gerontology, social ecology, and symbolic interactionist perspectives. This article synthesizes theoretical and empirical knowledge and demonstrates the convoy of care model in an increasingly popular long-term care setting, assisted living. We conceptualize care convoys as dynamic, evolving, person- and family-specific, and influenced by a host of multi-level factors. Care convoys have implications for older adults' quality of care and ability to age in place, for job satisfaction and retention among formal caregivers, and for informal caregiver burden. The model moves beyond existing conceptual work to provide a comprehensive, multi-level, multi-factor framework that can be used to inform future research, including research in other care settings, and to spark further theoretical development.

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Introduction

Presently, as was true in the past, most care for frail older adults in the United States is provided informally by family and friends at home (National Alliance for Caregiving & AARP, 2009). Yet, increasing longevity, changing family structures (i.e., the rise of divorce and single-parent households, delayed child bearing, decreasing family size) and gender expectations, including women's increasing labor force participation, mean a growing number of elders require and will use formal long-term care (LTC) services, including home care, nursing homes, and a rapidly growing segment of the industry, assisted living (AL). The National Alliance for Caregiving and AARP's (2009) recent survey on informal caregiving suggests that nearly 43.5 million people in the United States provide informal care to someone 50 years of age and older, and many do so with formal support in the home or other LTC environments.

Over the years gerontologists have highlighted the need to understand the relationship between formal and informal care as it pertains to supporting frail elders in the United States and elsewhere (Litwin & Attias-Donfut, 2009; Lyons & Zarit, 1999; McAuley, Travis, & Safewright, 1990; Ward-Griffin & Marshall, 2003). Researchers have investigated formal–informal care intersections in home care (e.g., Ayalon, 2009; Ball & Whittington, 1995; Martin-Matthews, 2007; Neysmith & Aronson, 1997; Parks, 2003; Ward-Griffin & Marshall, 2003), nursing homes (e.g., Gladstone & Wexler, 2002a, 2002b; Shield, 2003), and, to a lesser extent, AL settings (Ball et al., 2005). Yet

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existing work does not offer a comprehensive understanding of the intersection of formal and informal care, including the factors that influence its interface and ensuing outcomes for care recipients and their caregivers. This knowledge gap is related in large part to limited theoretical development. Developing more advanced understandings of the formal–informal care relationship has important implications for improving the well-being, quality of life, quality of care, and satisfaction of those who give and receive paid and unpaid care, including the increasing numbers who are projected to do so in the future.

In this article we consider common approaches to understanding the formal–informal care intersection, and, responding to the strengths and shortcomings of existing models, propose an alternative approach based on a synthesis of theory and empirical data. The main tenets of this proposed approach are applicable across care settings. However, we illustrate the approach in the AL context and draw on existing empirical research, including, but not limited, to our own.

Existing conceptual models

Research interest in the formal–informal care intersection goes back decades, but, as suggested, remains theoretically underdeveloped. Scholarly observers (see for example, Connidis, 2010; Litwin & Attias-Donfut, 2009; Lyons & Zarit, 1999) identify several conceptual models that dominate the literature and are considered “conventional” (Ward-Griffin & Marshall, 2003, p. 191). First, Cantor's (1979, 1991) hierarchical compensatory model suggests a preferred ordering of caregivers based on social relationships, with those who are closer to the care recipients, usually kin, being the most preferred and formal care workers the least. Among kin, spouses are at the top of the hierarchy, followed by children, other family members, and friends. Next, the substitution model (see Greene, 1983) hypothesizes that once formal care is introduced it replaces informal care. Thus, little interface exists between the two sources as informal caregivers are understood to use formal care to substitute for their care. Third, the task specificity model put forth by Litwak (1985) suggests that the care task dictates the caregiver type, with more skilled care being performed by formal, trained caregivers, and formal and informal care complement one another. Finally, the complementary model (see Chappell & Blandford, 1991) hypothesizes that formal care can both compensate for and supplement informal care; in this case formal care supplements informal care based on the older adult's escalating care needs.

In their examination of home care and the interface between nurses and family caregivers in Canada, Ward-Griffin and Marshall (2003) critiqued these conceptual models using a socialist-feminist lens. They note that the models treat formal and informal care as two separate, rather than potentially overlapping, spheres and privilege normative assumptions of family care as preferred and natural. Their empirical work involving nurses from community nursing agencies and family caregivers of elderly relatives demonstrates how skilled care work often is transferred from nurses to family members, which suggests a blurring of boundaries between formal and informal domains. Highlighting the absence of wider political, social, and economic contexts in conventional models, Ward-Griffin and Marshall (2003) identify structural arrangements, such as gender roles, power relations, the feminization of care, reduced state funding for home care, and increasing nurse case loads as keys to understanding formal–informal care intersections.

Conventional models also exclude care recipients as potentially active participants in their own care (i.e., self-care), including their roles in care management and supervision, and do not reflect the dynamic (i.e. evolutionary) nature of care processes or the increasing complex medical care needs of those with chronic disease and disability. Moreover, they do little to account for how different care settings influence formal–informal care intersections. Homes, nursing homes, and AL facilities differ considerably from one another as well as among themselves. Regarding across-setting variation, AL, for example, often is marketed as homelike and ideally facilitates aging in place by maximizing independence and altering support as necessary (Ball, Perkins, Whittington, Connell, et al., 2004; Ball, Perkins, Whittington, Hollingsworth, et al., 2004; Eckert, Carder, Morgan, Frankowski, & Roth, 2009). Unlike other formal care settings, AL environments are non-medical and typically do not provide skilled care. AL also was not designed to provide total care (Golant, 2008) and assumes a certain amount of informal care, including self-care and kin work (Ball et al., 2005). Thus, residents and families represent an important source of support and are integral to realizing AL's social (as opposed to medical) model of care (Hyde, Perez, & Reed, 2008). Port et al.'s (2005) LTC research finds that AL residents' family members experience more burden than those of nursing home residents — a finding that likely reflects greater opportunity and demand for informal care in these settings.

Gaugler and Kane's (2007) synthesis of qualitative and quantitative research on family involvement in AL concludes by noting the prevalence of “simplistic causal models” (p. 95). Identifying variation across AL settings and families, they suggest the need to account for the influences of facility-level characteristics and family structure. They also note the common use of cross-sectional data despite the “transitional nature of family involvement” (p. 97).

In an earlier synthesis of research on families in nursing homes and AL, Gaugler (2005, p. 113) highlighted the practice of relying on a “‘primary’ family member” as a conceptual limitation and the challenge of interpreting findings for residents without family. He offers a potential model of family involvement incorporating elements of Aneshensel, Pearlin, Mullan, Zarit and Whitlach's (1995) multi-dimensional stress process model. Gaugler suggests that the pre-placement caregiving situation and post-placement facility, resident, staff, and family factors join to influence family involvement in formal care settings, all of which have outcomes for family members (psychosocial adaption and care satisfaction), residents (quality of life and health outcomes), staff (job satisfaction and quality of care provided), and facilities (family-orientation). This model addresses many shortcomings of existing work but does not account for broader social and life course influences, non-kin caregivers, or self-care, and its intended focus is family involvement rather than care collaboration. Thus, while this and other models offer guidance, additional theoretical work and an alternative approach are needed in order to provide a comprehensive understanding of formal–informal care relationships.

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