



Health effects of informal caregiving across Europe: A longitudinal approach



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ABSTRACT

Due to an expected increase of people in need of care, sound knowledge about health effects of informal care provision is becoming more and more important. Theoretically, there might be positive as well as negative health effects due to caregiving to relatives. Moreover, we suppose that such health effects differ by national context – since care is differently organized in Europe – and depend on the social setting in which the care relationship takes place. Using data from the Survey of Health, Ageing and Retirement (SHARE, waves 1, 2, 3, and 5) and from the English Longitudinal Study of Ageing (ELSA, waves 2–5) we examined the connection between informal caregiving and self-perceived as well as mental health in a country comparative perspective. Taking advantage of the longitudinal structure of the data, pooled ordinary least squares (OLS) and fixed-effects models (FEM) were estimated. Our results show distinct differences in the relationship between reported health and the provision of informal care depending on whether individuals give care to someone inside or outside the household. Caregivers inside the household reported worse health, caregivers from outside the household reported better health than non-caregivers. We find that this correlation is largely due to selection into caregiving: people in worse health took up care inside while people in better health took up care outside the household. However, in most countries people who started caregiving inside the household experienced a decline in their mental health. This suggests that caregiving inside the household results in psychological stress irrespective of the type of welfare state. The results regarding self-perceived health and caregiving outside the household are less distinct. All in all our results show that health consequences of caregiving vary not only between different welfare regimes but also between countries of similar welfare state types.

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1. Introduction

In ageing societies the number of people in need of care is expected to increase (Colombo et al., 2011) – although the extent is unknown yet (Crimmins and Beltrán-Sánchez, 2011). At present, the share of people receiving long-term care varies notably across Europe (Colombo et al., 2011). For all countries, at least in relative terms, the availability of potential caregivers decreases because of demographic as well as socio-structural changes, such as lower fertility, increased mobility, and rising labor market participation of women (Brandt et al., 2016; Colombo et al., 2011). In many European countries informal care is important for the overall care provision, but the (legal and structural) duty to provide care for

older relatives differs (Genet et al., 2013). Not least with families having to “step back in” (reverse substitution, Johansson et al., 2003) and provide informal support in times of welfare state retrenchment, the wellbeing of informal caregivers gains importance. To establish environments that keep caregivers in good health and thus reduce individual costs of caregiving, evidence on negative health effects of caregiving is needed. An international comparison may help to detect “caregiver supportive environments”.

The pathways through which caregiving might affect physical and mental wellbeing are manifold. Caregivers may experience a decline in their wellbeing due to the physical and time demanding caregiving task (Zarit et al., 1980). Indeed, empirical studies suggest that caregiving impairs mental health (Hiel et al., 2015). However, adverse health effects might depend on the emotional closeness between those involved (Litwin et al., 2014) and on the motive for care provision. Different caregiving intentions have been reported for spouses and children resulting in different health effects (Broese

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van Groenou et al., 2013). Finally, contextual factors like socio-demographics or social support can moderate the caregiving burden (Pearlin et al., 1990; Tolkacheva et al., 2011). Not least, it is important to consider the country context, as the extent of caregiving tasks and thus the burden of caregiving depends on the institutional setting (Brandt, 2013). Previous research using a broad differentiation of welfare state regimes suggests that women in Southern welfare states suffer more from caregiving than those in Northern ones (Brenna and Di Novi, 2016). Yet, not all studies use longitudinal data and methods, which is necessary to take selection into caregiving into account (Vlachantoni et al., 2013).

The literature suggests that health outcomes of caregiving vary across different contexts. Taking this into account we do not just estimate an average effect of caregiving over all countries and all types of caregiving situations but allow adverse consequences of caregiving to differ between countries and place of care provision (inside and outside the household). As we use data from the Survey of Health Ageing and Retirement (SHARE, waves 1, 2, 4 and 5) and the English Longitudinal Study of Ageing (ELSA, waves 2–5) our analysis is the first of this kind covering eleven countries which represent various welfare regimes over time.

The remainder of this paper is structured as follows: We first discuss how caregiving (in specific contexts) can influence health and present previous findings in the field. Both theoretical arguments and empirical evidence lead to our expectation, that caregiving in certain welfare state and household contexts is more incriminatory for individual health (section 2). In the following we present our data and methods (section 3) and results (section 4), which we discuss in the final section (section 5).

2. Caregiving and health in context: theoretical reasoning, empirical evidence and hypotheses

According to the “Informal Care Model” (Broese van Groenou and de Boer, 2016: 273) the care decision depends on the care recipient's needs, attitudes and beliefs towards caregiving as well as on perceived difficulties. But also the relationship between those involved, the family and social network as well as the community are important factors. Furthermore the caregiving decision is framed by policy decisions and changes within society (Broese van Groenou and de Boer, 2016).

2.1. Health consequences of caregiving

Caregiving is often described as burdensome (Zarit et al., 1980) and is assumed to translate into poor health along the “stress process” (Pearlin et al., 1990: 586). Thus, health consequences of caregiving can be influenced by individual and contextual factors like age and gender, the duration of caregiving as well as support through family networks or community programs (for interaction between context and support see Schmid et al., 2012). Furthermore, “primary stressors” like the caregiver's condition as well as the capability to deal with caregiving matter for the perceived stress. They affect how somebody handles “secondary stressors” arising from family and job, financial difficulties, social exclusion or intrapsychic strain. Mediators – coping strategies and social support – can diminish the experienced stress. As those vary individually, people can experience similar stress in different ways (Pearlin et al., 1990).

Research results on caregiver's health are mixed. This can be attributed to varying samples, outcome measures and methods. On the one hand cross-sectional analyses reveal that caregivers are in worse psychological and physical health (e.g. they are more often depressed, exhibit lower well-being and have more cardiovascular problems compared to non-caregivers, Carretero et al., 2009; Hiel

et al., 2015; O'Reilly et al., 2008; Pinguart and Sørensen, 2003). On the other hand caregivers in Northern Ireland and England do not differ with respect to their physical health (Vlachantoni et al., 2013), suffer less often from a long-term illness and have a reduced mortality risk compared to non-caregivers (O'Reilly et al., 2008). This might be because people in good physical condition are more likely to take up care than individuals in poor physical condition.

Longitudinal research shows that spousal caregivers in the United States do not experience a decline in functioning as well as self-rated health (Jenkins Rahrig et al., 2009). But continued caregiving does increase depressive symptoms. This applies to adult children (married women as well as single and married men) giving care to their non-co-residing mothers (Coe and Van Houtven, 2009) as well as to women giving care to people in need of support (Schmitz and Westphal, 2015). Single men also experience a decline in physical health, whereas single women seem to be unaffected by caregiving in terms of their physical health (Coe and Van Houtven, 2009).

2.2. Caregiving, health and social context

Informal caregiving mainly occurs between spouses, or children and their parents (Colombo et al., 2011). Caregiving between the former mostly takes place in the same household, but can happen in the same or in different households with respect to the latter. In any case, these relationships are characterized by the willingness to take care of the well-being of a related person (Pearlin et al., 1990). Caregiving between children and their parents is considered as part of intergenerational solidarity (Bengtson and Roberts, 1991), but the level of commitment between grown-up children and their parents, and therefore probably also the perceived burden, varies. Compared to that, caregiving within couples is characterized by higher emotional closeness, which can go along with lower subjective burden (Broese van Groenou et al., 2013). In general, family norms or a favorable opportunity structure (e.g. low residential distance, lack of alternatives) can lead to a higher amount of given and received care and therefore also more or less subjective stress (Broese van Groenou and de Boer, 2016). Especially in case of grown-up children stress can stem also from competing family and job demands (Pearlin et al., 1990). Then again they can rely on a broader social network, e.g. their own spouse, siblings or friends, to share the burden of caregiving (Tolkacheva et al., 2011). In contrast, (older) spousal caregivers are more likely sole caregivers – as caregiving is seen as a matter of course (Litwin et al., 2014; Schulz et al., 2012). Furthermore, caregivers inside the household cannot evade the care situation easily which is linked to a higher intensity of caregiving (Litwin et al., 2014).

Taking the social context into account it was shown that for Dutch spousal and (adult) children caregivers a strong preference for informal care leads to a more positive evaluation of the caregiving situation (Broese van Groenou et al., 2013). Similarly, co-residing caregivers giving care to a confidant experience fewer depressive symptoms compared to other co-residing caregivers, though co-residing seems to be especially incriminatory for mental health (Litwin et al., 2014). Furthermore, social networks and support by professional services can influence the perceived burden. Caregiving adult children who are embedded in a large, harmonious network in which (caregiving) tasks are shared over a longer period experience a lower level of burden (Tolkacheva et al., 2011). Also professional care services can reduce negative effects on well-being because caregivers then have to spend fewer hours with caregiving (Verbakel et al., 2016).

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