



Expectations for future care provision in a population-based cohort of baby-boomers



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ABSTRACT

Objective: We describe sources expected to provide for future care needs among baby-boomers in their late sixties and examine how expectations vary according to earlier health and social experiences. We hypothesised that greater integration in social relationships across adulthood is associated with greater expectation of informal care, and that greater morbidity over a longer time period is associated with greater expectation of formal care.

Method: The MRC National Survey of Health and Development, a population-based birth cohort study set in mainland Britain, provided data on care expectations for 2135 participants aged 68–69. The outcome was who, besides the partner or spouse, is expected to provide for the future care needs, coded as adult children, other relatives, friends/neighbours, paid/professional care, or no one. Adult children were taken as the reference category and the latter two categories were combined as ‘formal care’ in the multiple regression analysis.

Results: 91% had an adult child, of whom 74% expected them to provide care if needed, and 11% expected formal care. The latter rose to 33% of those with no adult children. Geographical distance to adult children (over 25 miles) was strongly correlated with expectations but, independently of this, lack of someone to help in a crisis from midlife onwards and low social contact were associated with expecting formal care. Expectations did not differ by number of chronic conditions, functional limitations or longstanding illness from age 60 + .

Conclusion: Those lacking social relationships in midlife onwards and those living further from adult children are more likely to expect formal help with their future care needs. As personal care needs are projected to rise with population ageing and families are increasingly expected to provide for these needs, initiatives to remove barriers to smaller distances between ageing parents and their children and to support and maintain high-quality family relationships across the life course should be considered.

1. Introduction

The challenges in meeting current and future social care needs and expectations are being widely discussed [1]. Continued rises in the need for long-term care are projected [2,3]. In Britain and other Western societies, the majority of older people needing help and care with activities of daily living receive this informally from family either from their spouse or partner or their adult children [4,5]. As life expectancy continues to increase at the oldest ages, more adult children with parents needing care may be already at retirement age themselves and less able to help. Care by adult children may or may not align with the preferences and expectations older people, and future generations of older people, have for their own care needs. Preferences and expectations may be changing in light of societal trends relevant for care

provision including smaller family sizes and increasing childlessness, an increase in women’s paid employment, and increasing residential mobility [6–8]. Understanding the expectations that the baby-boomer generation has for their future care needs may help with planning and identifying groups at risk of not having their needs met in the expected way.

Studies have categorised preferences for informal, formal or mixed (formal plus informal) support and found they depend on socio-economic and demographic factors [9]. Higher educational attainment is associated with greater preference for formal care [10,11], a pattern which is reflected in actual receipt of formal support [12,13]. Being married and having more contact with relatives is associated with a greater preference for informal or mixed support compared to formal support [9] whereas marital dissolution is associated with fewer

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transfers to elderly parents in midlife [14,15] and may have long-term consequences for later informal care.

Most previous quantitative studies are cross-sectional and considered only proximal factors. The impact of earlier health and social experiences on later life expectations for different types of care has received insufficient attention. Care-giving and receiving are a fundamental part of social relationships across the life course [16] so earlier support exchanges may influence the extent to which a person feels able to depend on an informal support network in older age. Chronic exposure to poor health may also affect care preferences and expectations [9] whereas the literature on the role of current activity limitations is inconsistent [9,11,17,18]. The aim of the current study was to describe the main sources expected to provide help with daily activities in a population-based baby-boomer cohort approaching their seventies. Arguably, expectations are based on a pragmatic assessment of a person's current and future circumstances and social care needs but they are hypothetical in nature. We examine how these expectations vary according to socioeconomic position, social networks, health, and caregiving experience in middle to late adulthood. We hypothesised that i) a more advantaged socioeconomic position would be associated with greater expectation that care needs will be met formally; ii) greater integration in social relationships across adulthood would be associated with greater expectation of informal care, and iii) greater morbidity over a longer time period would be associated with greater expectation that needs will be met formally (by a paid professional) because informal networks may not be able to provide intensive help.

2. Data & methods

The MRC National Survey of Health and Development is a representative sample of 2815 men and 2547 women who were born in England, Scotland and Wales in one week in March 1946. The 24th data collection was conducted between 2014 and 2015 when study members were aged 68–69 years. Of the 2816 people in the target sample living in mainland Britain, 2370 (84.2%) completed a postal questionnaire. Of the remaining 2546 (47%) study members: 957 (18%) had already died, 620 (12%) had previously withdrawn permanently, 574 (11%) lived abroad, and 395 (7%) had been untraceable for more than 5 years [19]. Study members found to be still living in Great Britain ($n = 2698$) were invited to have a home visit by a research nurse: 2149 (79.7%) completed this. For this data collection, we obtained ethical approval from the NRES Queen Square REC (14/LO/1073) and Scotland A REC (14/SS/1009). The main adult sweeps prior to this were conducted when study members were 26, 33, 43, 53, and 60–64 years.

2.1. Expectations for future care

During the home visit, participants were asked who would be most likely to provide help in the event that they (and their spouse or partner) needed help with daily activities because of sickness, frailty or disability. Responses were coded as: daughter or son; other family member; friend, neighbour or voluntary worker; paid professional help. Ten participants who were unable to nominate a person were combined with those who nominated paid professional help in the analysis. The spouse or partner was not permitted as a response option because this would likely be collinear with current partnership status [20,21]. Participants were asked to nominate only one source and where two or more were nominated ($n = 737$), these were coded according to the priority order listed above (e.g. if both daughter and other family member were nominated, the response was coded as “daughter” for analysis).

Information on family factors, socioeconomic position, characteristics of the social network, care-giving experience, and health was collected at several ages.

2.1.1. Family factors

Marital status and marital transitions were captured at each adult sweep. Geographical proximity to the nearest adult child was captured at age 68–69.

2.1.2. Socioeconomic position

We included occupation of the head of the household at age 53 (the most recently available data preceding changes related to retirement), coded using the Registrar General's classification. We also included highest educational qualification attained by age 26 (when most participants in this cohort had finished full-time study).

2.1.3. Characteristics of the social network

These included both quality and quantity of social contact. At ages 68–69 and 60–64, study members reported the frequency of visits with family not living in the same household and with friends. We combined these to create a cumulative social contact score with high values indicating greatest contact. At ages 60–64, 53 and 43, they reported whether they had any friends, neighbours or relatives who would help if a problem or crisis came up. These were also combined to create a cumulative score. At age 43, study members were asked whether they were emotionally close to their surviving parents.

2.1.4. Care-giving experience

This included hours of care provided for someone frail or with a disability within or outside the home at ages 68–69 and 60–64. These were combined to classify participants into those who provided no care, those who provided 20+ hours of care at both ages, and those providing intermediate levels of care. At age 43, we identified study members who provided at least weekly help with personal or household tasks for a parent who was unable to look after themselves.

2.1.5. Health

At age 68–69, we captured the burden of disease by distinguishing participants with 0, 1, 2, 3+ doctor diagnosed diseases over the previous ten years. The research nurse asked the participant about 19 disorders: heart failure, angina, myocardial infarction, hyper/hypotension, stroke, diabetes, transient ischaemic attacks, cancer, chronic lung disease, asthma, osteoarthritis, rheumatoid arthritis, osteoporosis, serious eye trouble, depression, epilepsy, Parkinson's disease, memory problems and kidney disease.

We also captured health-related limitations in six daily activities (walking ¼ mile, walking up and down stairs, difficulty keeping balance, bending down and straightening, reaching arms above head, and holding, gripping or turning something). Study members additionally reported longstanding illness that limited their usual activities at ages 68–69 and 60–64.

2.2. Statistical analysis

We first described expectations for those with and without a living child at age 68–69. Correlates of expectations for the sample with at least one child were then identified using multinomial regression models including i) gender only, ii) all covariates. Estimates are presented as average marginal effects, interpreted as the change in probability of the outcome per one unit change in exposure. (In preliminary analysis, we tested whether associations with any of the covariates were modified by gender and found no evidence for this, hence we present gender-adjusted rather than gender-stratified models.) For all analyses, we restricted the sample to those with observed data on care expectations and used multiple imputation by chained equations to impute missing covariate data in 20 datasets, under the assumption that these were missing at random.

Participation at the home visit at age 68–69 was highest among those with a higher number of prior contacts with the study, those with better self-rated health, and those with non-limiting longstanding

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