EUROPEAN CENTRE FOR SOCIAL WELFARE POLICY AND RESEARCH
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EUROPÄISCHES ZENTRUM FÜR WOHLFAHRTSPOLITIK UND SOZIALFORSCHUNG
IN ZUSAMMENARBEIT MIT DEN VEREINTEN NATIONEN

CENTRE EUROPÉEN DE RECHERCHE EN POLITIQUE SOCIALE
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Comparing patterns and types of care provision of older people in poor and good health in Europe

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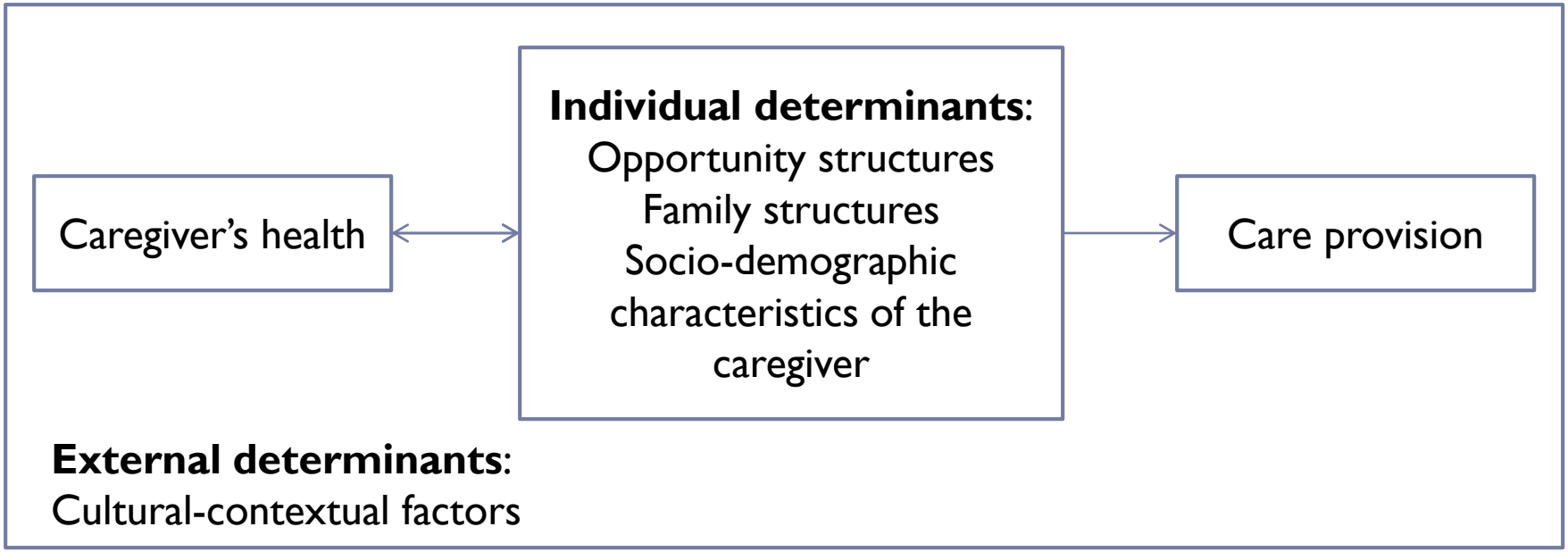
Overview

- Active ageing and informal caregiving (MOPACT)
- The determinants of care provision – a theoretical framework
- Data & Methods
- Some results
  - Care provision and morbidity status
  - Main determinants of care provision
  - Types of care giving
- Directions for public policy

Active ageing and informal care giving

- Promoting active and healthy ageing is a policy priority at the European level
- As part of a wider research effort to identify the determinants of continued social participation in older age (MoPAct – WP5), we focus on the provision of informal care among older Europeans
  - Informal care provision has been identified by the active ageing index and other EU policy documents as one of the dimension of social participation that promotes healthy and active ageing
- Different patterns of caregiving between people in good and in poor health, as the presence of chronic diseases might limit the potential for active participation of the latter

The determinants of care provision



adapted from Igel and Szydlik (2011)

- The caregiver's health status is more than just a determinant in the decision to provide care and likely interacts with each of the determinants
- As individuals become restricted in their activity patterns by deteriorating health, their social participation levels decline, marking the progress from physical ailment to *disability* (Verbrugge & Jette, 1994)

Operationalization

- Main health dimension: multi-morbidity status (i.e. suffers from two or more chronic conditions)
- Opportunity structures
  - Education, Income, Employment status
  - Social participation
- Family structures
  - Household size, number of children, marital status
- Socio-demographic characteristics of the caregiver
  - Age, gender
- Other health status controls
  - Self reported health, poor mental health, disability

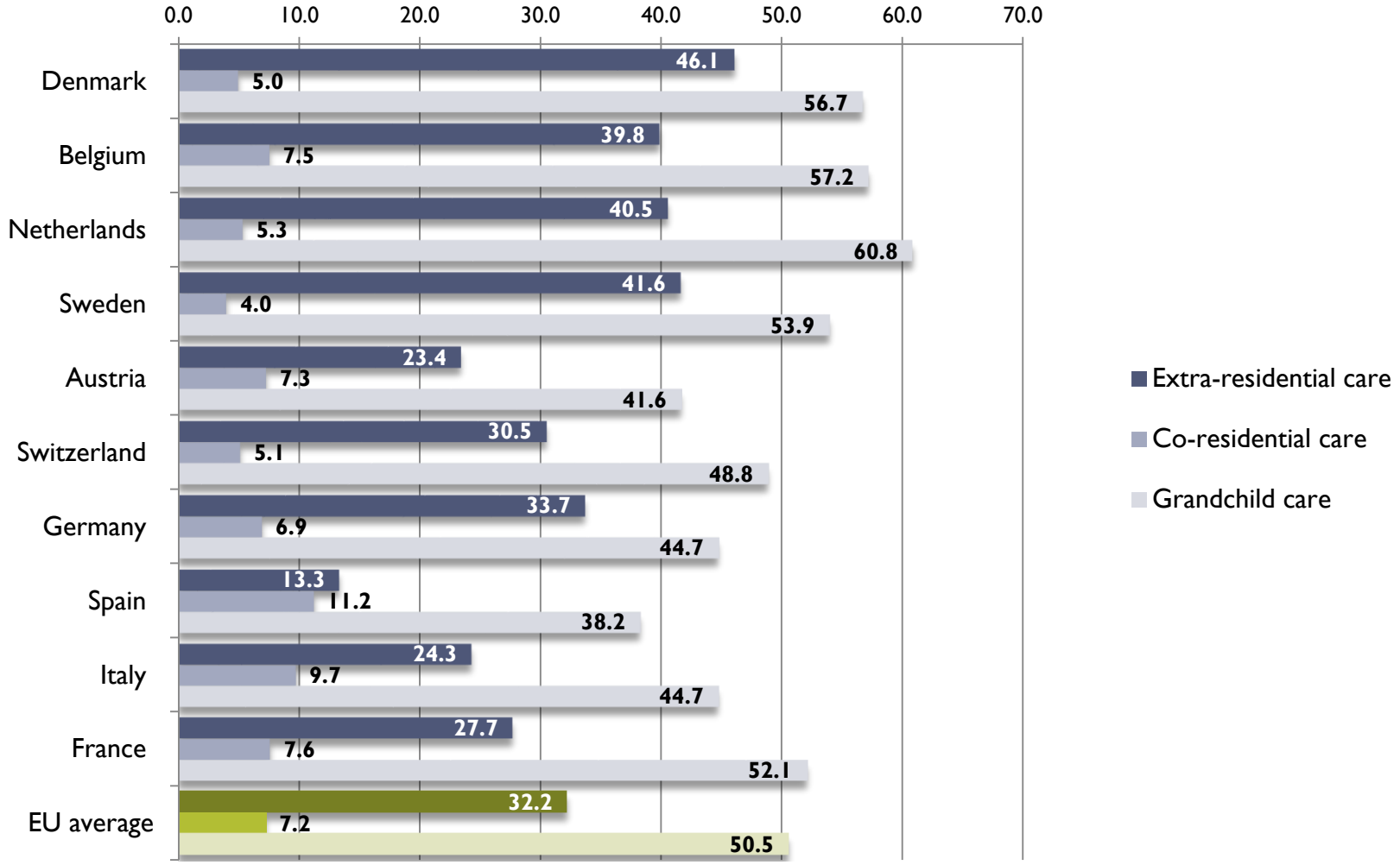
Three types of informal care

- Adding to the extant literature, we distinguish between three types of inter-related but conceptually different types of care provision:
  - co-residential care – provided with high regularity to a dependent member of the household
  - extra-residential care activities provided on a regular basis for frail, ill or disabled family members, friends or neighbors living outside the caregivers household
  - non-custodial care for grandchildren in the absence of their parents ('grandparenting')

Data & Methods

- The three panel waves of the SHARE survey (2004-05, 2006-07 and 2011-12)
- 10 countries in: Northern Europe (Denmark, Sweden, the Netherlands and Belgium), Central Europe (Germany, Switzerland, Austria) and Southern Europe (Spain, Italy and France)
- 79,263 observations, corresponding to 48,636 community dwelling individuals aged 50 and above
- Logistic regression models, accounting for individual level heterogeneity (random effects estimator) and controlling for country and time fixed effects

Prevalence of care provision by country and type of care (in %)



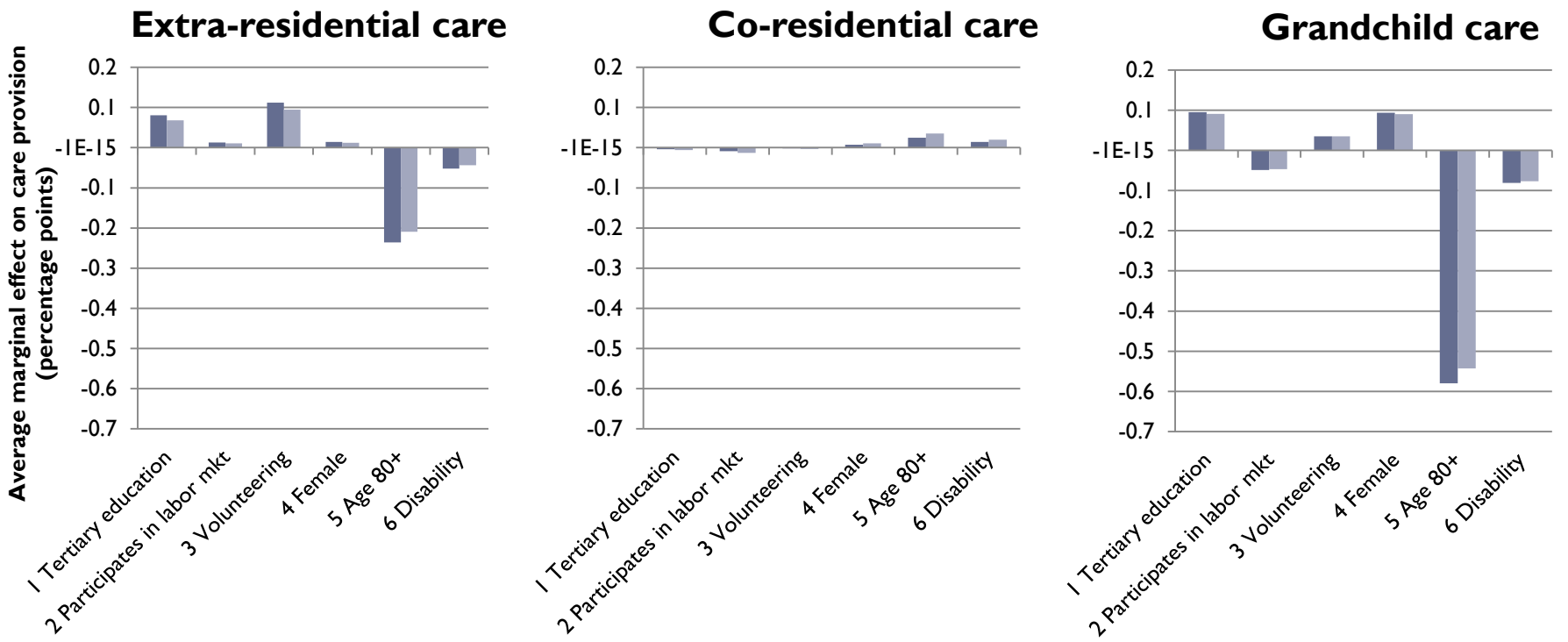
Results (AME by group and contrasts)

	Extra-residential care to frail adults			Co-residential care to frail adults			Grandchild care		
	No MMorb	MMorb	Diff.	No MMorb	MMorb	Diff.	No MMorb	MMorb	Diff.
Opportunity structures									
Education (ref. Primary education)									
Secondary education	0.064***	0.054***	- 0.010***	- 0.003	- 0.004	- 0.001	0.074***	0.070***	- 0.003***
Tertiary education	0.081***	0.068***	- 0.013***	- 0.004*	- 0.006*	- 0.002*	0.095***	0.091***	- 0.004***
Income (ref. 1st quartile)									
2nd income quartile	0.020***	0.017***	- 0.003***	0.001	0.002	0.001	0.039***	0.037***	- 0.002***
3rd income quartile	0.028***	0.024***	- 0.005***	0.001	0.001	0.001	0.072***	0.069***	- 0.003***
4th income quartile	0.035***	0.029***	- 0.006***	- 0.002	- 0.002	- 0.001	0.086***	0.083***	- 0.003***
Employed	0.013*	0.011*	- 0.002*	- 0.009***	- 0.013***	- 0.004***	- 0.049***	- 0.047***	0.002***
Social participation									
Participated in voluntary work	0.112***	0.095***	- 0.016***	- 0.002	- 0.003	- 0.001	0.035***	0.035***	- 0.001***
Participated in education activities	0.070***	0.059***	- 0.010***	- 0.001	- 0.001	- 0.001	0.060***	0.059***	- 0.001***
Participated in clubs	0.049***	0.041***	- 0.008***	- 0.004***	- 0.007***	- 0.002***	0.060***	0.058***	- 0.001***
Participated in religious activities	0.056***	0.047***	- 0.009***	0.004	0.005	- 0.002	0.034***	0.034***	- 0.001***
Family structures									
Household size	0.005	0.004	- 0.001	0.010***	0.017***	0.006***	0.014	0.013	- 0.001
Has children	- 0.013	- 0.011	0.002	- 0.018***	- 0.028***	- 0.010***	0.389***	0.325***	- 0.064***
Married	- 0.018**	- 0.015**	0.003**	- 0.007***	- 0.010***	- 0.004***	0.170***	0.160***	- 0.010***
Socio-demographic charcteristics									
Female	0.014**	0.012**	- 0.002**	0.007***	0.011***	0.004***	0.094***	0.090***	- 0.004***
Age (ref. 50 - 65)									
65-80	- 0.116***	- 0.105***	0.010***	0.008***	0.011***	0.003***	- 0.183***	- 0.189***	- 0.006***
80+	- 0.236***	- 0.209***	0.027***	0.025***	0.035***	0.010***	- 0.580***	- 0.543***	0.037***
Provided care outside household	-	-	-	0.008***	0.013***	0.005***	0.133***	0.132***	- 0.001***
Provided care inside household	0.061***	0.052***	- 0.009***	-	-	-	- 0.042***	- 0.040***	0.002*
Provided grandchild care	0.084***	0.071***	- 0.014***	- 0.004***	- 0.006***	0.002***	-	-	-
Observations		**69661**			**62763**			**42360**	

Results (cont'd)

- We confirm numerous significant differences between multi-morbidity groups! However, they are confined to the sizes of the effects and do not impact on the direction of the associations
  - There is no evidence in our data that the determinants of informal care provision are different between multi-morbidity groups.
- There are marked differences between types of care
  - Co-residential care stands out of the group, as its dynamics resemble that of a constraining activity rather than a voluntary one (i.e. the decision to provide care is determined by family structures and socio-demographic characteristics, rather than by opportunity structures)
  - On the other hand, extra-residential care to older adults and grandchild care share many similarities to each other: most noteworthy, the centrality of opportunity structure in the provision decision and the positive association with voluntary activities in general

Regression results by type of care and morbidity group (selected variables)



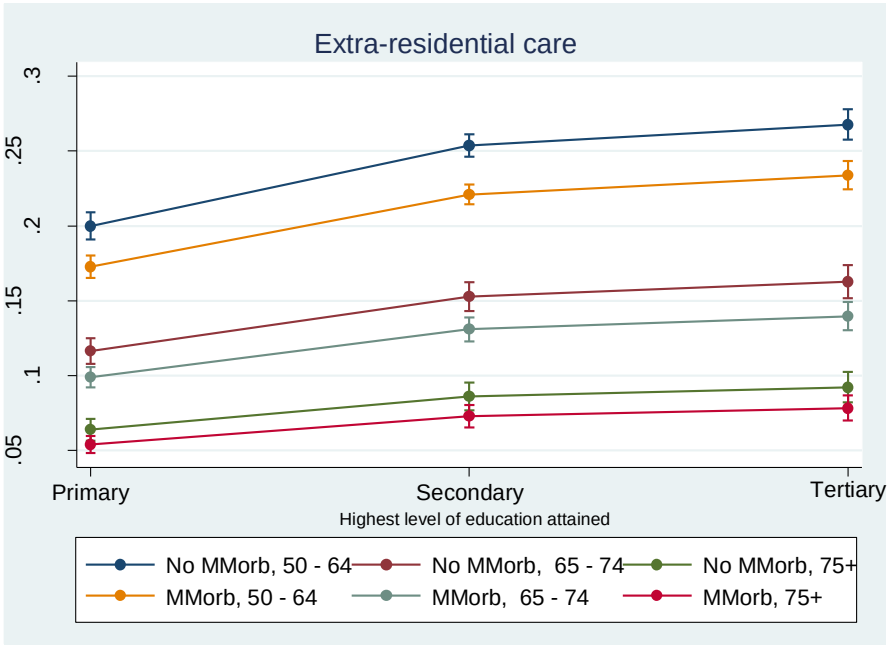
All results significant at p<0.05. Reference groups: 1 Primary education; 2 Retired; 3 No volunteering; 4 Male; 5 Age 50-65; 6 No disability.

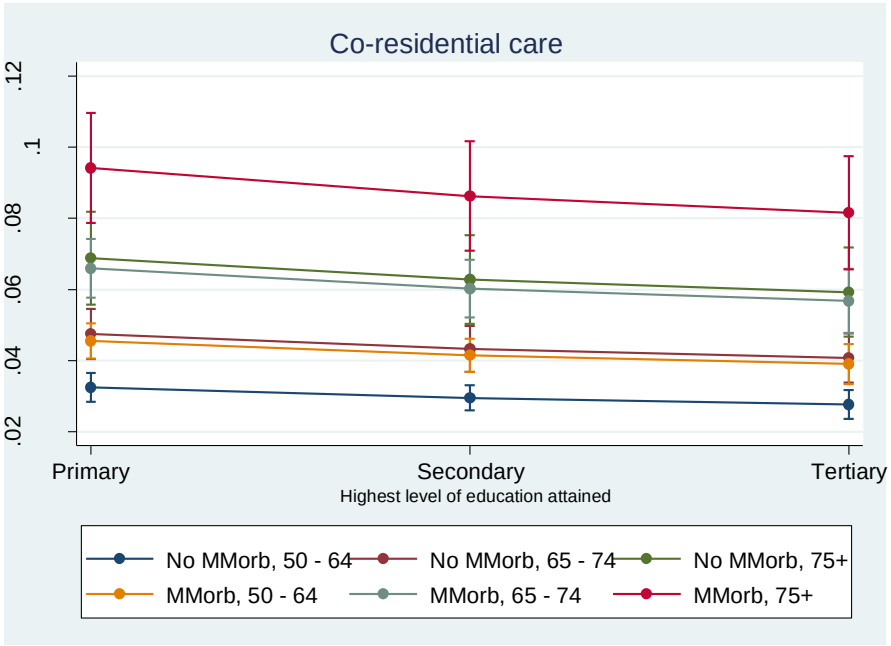
No Multi –morbidity Multi-morbidity

Results (cont'd)

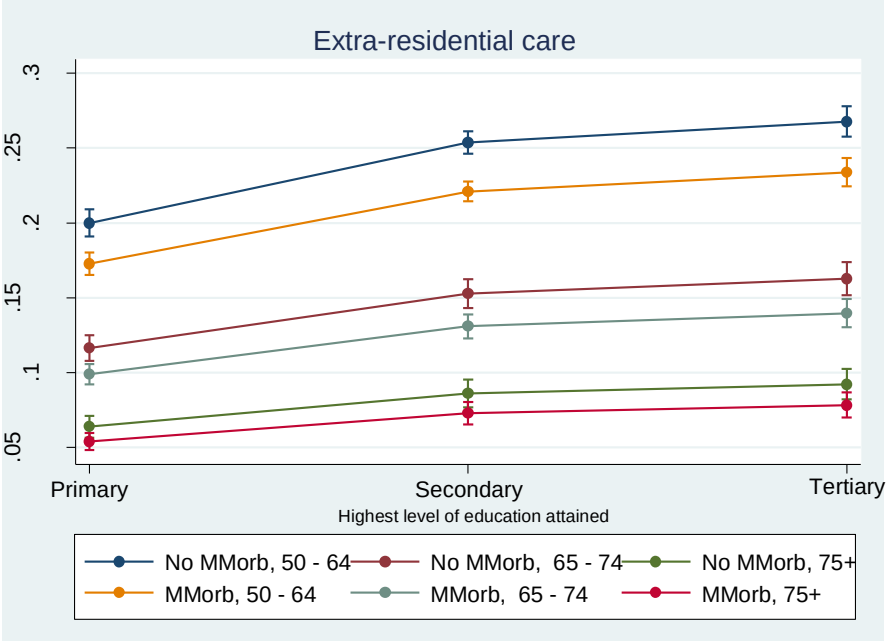
- Opportunity structures impact very little on co-residential care but are highly significant for the other two care types
- Family structures are closely related to the provision of co-residential care and grandparenting, but the association is weaker for the provision of care outside the household
- Socio-demographic characteristics are closely tied to the decision to provide any type of care in older age

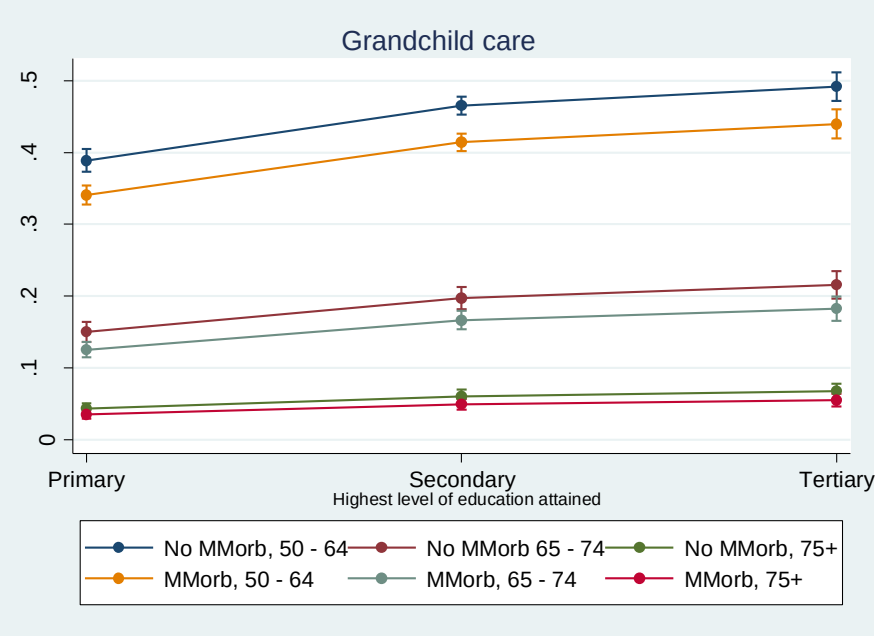
Predictive margins for provision of care to older adults





Predictive margins by educational achievement for provision of extra-residential and grandchild care





Directions for public policy

- Older people in poorer health have limited capacity to remain socially engaged (i.e. to provide care) and targeted policies allowing them to be socially active could prove to be great enablers.
- Co-residential caregiving is negatively associated with other forms of social participation. Co-residential caregivers should become primary targets of policy measures, aimed at providing support with care tasks and enhancing social engagement.
- In Southern European countries, where relatively more older individuals are engaged in co-residential care provision, policies should aim to strengthen the formal care system.
- In Northern and Central European countries, where levels of participation in extra-residential and grandchild care are considerably higher, public policies would likely be best targeted to low income and low education groups that are more vulnerable to social isolation.

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Thank you for your attention!

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