FACTS May 2006

Older adults' care network typologies

Summary

The policy shift toward community care rests on the assumption that older adults are embedded in groups of people who provide them with support and care. While the extant literature has focused primarily on caregiver – care receiver dyads, little is known about how caregiving responsibility is shared among groups of family members and friends. We analyzed Statistics Canada's 2002 General Social Survey on aging and social support to describe the size and composition of care networks, and to develop typologies of care networks for Canadians aged 65 and older. We also examined whether the type and amount of care older adults receive vary across care network types. We found that:

- The majority of Canadian seniors who received assistance with instrumental activities of daily living, received such care from individual caregivers (65%) rather than care networks (35%). Care networks were small, ranging from 1 to 4 or more members, with an average of 1.5[1].
- Six types of care networks varying in size and composition were identified: (1) *Children at Home*, (2) *Close Kin and Friends*, (3) *Lone Spouse*, (4) *Younger Diverse*, (5) *Older Diverse*, and (6) *Spouse and Children*. Most care networks had been providing care for more than two years.
- Almost half (47%) of care networks examined were *Close Kin and Friends*. *Children at Home* were the least common, comprising 5% of older adults' care networks.
- Different types of care networks provided different amounts and types of care to older adults with long term health problems or physical limitations.
  - Compared to other types of care networks, *Spouse and Children* and *Lone Spouse* care networks provided considerably more hours of care (18.1 and 10.9 hr/wk respectively) and a greater number of care tasks (3.5 and 3.4 respectively), while *Younger Diverse* care networks provided significantly less hours of care (2.9 hr/wk) and fewer tasks (1.3).
  - *Lone Spouse* and *Spouse and Children* care networks also provided more hours of personal care than other types of care networks. Given the relatively small size of these care networks, the age of *Lone Spouse* caregivers and their own possible health problems, and the competing demands of paid employment of *Spouse and Children* care networks, members of these care networks may be vulnerable and need targeted programs to support their caring work.
- The type and nature of frail older adults' care networks are important factors to consider when assessing older adults' needs for Home Care and other formal services. Programs that account for variability in care networks and support multiple caregivers will more adequately support older adults and sustain their care networks.
- The federal Compassionate Care Benefit recognizes the existence of care networks by allowing benefits to be shared among 2 or more eligible, employed caregivers. More work is needed to shift the focus from individual caregivers to care networks when developing programs to better support family/friend caregivers.

[1] Note: This is a very conservative way of defining care networks. Networks were excluded from the analysis if members provided help only with emotional support, care management, or monitoring as no information was collected about their personal characteristics. Networks in which the information on one or more members was incomplete also were excluded.

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As health and continuing care costs have escalated, governments seem to have 'rediscovered' families as the primary source of community-based care. The policy shift assumes that people requiring care are embedded in networks of individuals who are available and willing to provide care. While families and friends already provide 80-90% of care to others, little is known about how caregiving responsibility is shared among groups of family members and friends, and whether differences among care networks affect the type and amount of care provided. This study explored the characteristics of family and friend care networks and the nature of the care they provide.

Research Objectives

- To investigate whether care for older adults is provided by care networks;
- To determine whether there are significant differences among care network types on selected network characteristics;
- To examine whether different kinds of care networks provide different amounts and types of care.

Data source

We analyzed Statistics Canada's 2002 General Social Survey (GSS) on aging and social support. From the total sample of 24,870 respondents aged 45 and older, we drew a sub-sample of 2,407 people aged 65 and older who received help with one or more tasks in the previous year because of a long term health or physical limitation. Care tasks included housekeeping, meal preparation, outdoor maintenance, transportation, banking/bills, shopping, and personal care. Care management, checking up, and emotional support were not included.

Analysis

Each respondent's *family/friend care network* comprised all individuals they identified as having helped them with one or more tasks because of the respondent's long-term health problem or physical limitation.

- Descriptive statistics were used to examine the size and composition (gender, relationship, age, proximity, employment status, and duration of care) of care networks.
- Cluster analyses used 7 network characteristics to create types of care networks.
- Cross-tabular analysis and Analysis of Variance were used to identify significant differences among care network types in the amount and number of care tasks provided.

Data were weighted to ensure that estimates were representative of the Canadian population.

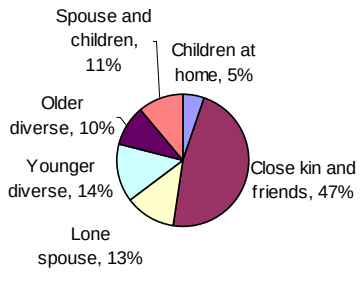
Older adults' care networks are small

About 35% of older adults who received care had a care network, but about 65% received care from a single caregiver. Care network size ranged from 1 to 4 or more people, but most care networks were quite small, averaging 1.5 members who provided assistance with instrumental activities of daily living. Care network size did not include those who assisted only with care management, emotional support or checking up.

Types of care networks vary

Six types of care networks were identified; details about each type are provided in Table 1. Most care networks had been providing care for more than two years. The distribution of care network types is illustrated in Figure 1.

Figure 1. Distribution of older adults' care network types



1. *Children at Home* networks were mainly close kin, more likely to be aged 25-44, employed, and lived with the care recipient. A slightly higher proportion of men (57%) comprised this network.

2. *Close Kin and Friends* networks were a mix of close kin (spouse and children) and friends. Most members were aged 45-64, employed, and lived nearby. A slightly higher proportion of women (54%) comprised this network.

3. *Lone Spouse* networks consisted of one spousal caregiver who lived with the care receiver. Most were over 65 and not employed. Equal proportions of men and women comprised this network.

4. *Younger Diverse* networks were a mix of distant kin and friends, who were more likely to be male, aged 25-44, employed, and lived nearby.

5. *Older Diverse* networks were comprised mainly of friends with some kin. Most were over 65, not employed, and lived nearby. A slightly higher proportion of men (58%) comprised this network.

6. *Spouse and Children* networks consisted of close kin, the majority of whom were female. Compared with other networks, this type was more diverse in terms of age, proximity, and employment composition.

Care received varies across care network types

Care network types strongly influenced the amount of care received by older adults, as shown in Table 2. *Spouse and Children* and *Lone Spouse* care networks (highlighted in green), provided considerably more hours of care (18.1 and 10.9 hr/wk respectively) than other types despite their small average sizes. In contrast, *Younger Diverse* networks (highlighted in purple) provided significantly less hours of care (2.9 hr/wk).

Care network type also influenced the number of care tasks received. *Younger Diverse* care networks performed significantly fewer care tasks (1.3) than either *Spouse and Children* or *Lone Spouse* care networks (3.5 and 3.4 respectively).

Personal care is one of the most demanding and intense tasks caregivers can provide. We found that *Spouse and Children* and *Lone Spouse* care networks spent more time on personal care than other network types. These two care networks,

Table 1. Characteristics of older adults' care network typologies

Care Network Type	Mean Size	Gender (% women)	Age (% in the major age group)	Employed (%)	Proximity	Care Duration (2 years +)	Relationships
Children at Home	1.6	43	64% aged 25-44	72	82% co-resident	89%	84% close kin
Close Kin & Friends	1.9	54	62% aged 45-64	67	79% live nearby	74%	Mixed: close kin & non-kin
Lone Spouse	1.0	49	86% aged 65+	4	99% co-resident	82%	94% close kin
Younger Diverse	1.3	38	56% aged 25-44	62	92% live nearby	74%	Mixed: distant kin & non-kin
Older Diverse	1.4	42	74% aged 65+	14	76% live nearby	68%	Mixed: 42% non-kin
Spouse & Children	1.4	61	47% aged 45-64	44	53% co-resident	80%	80% close kin

which represent nearly one quarter of all older adults' care networks, spent more time on care, did more tasks, and more intense types of tasks than other care network types.

networks that provide them with support. However, existing policies and programs tend to focus on providing support to individual caregivers, thereby overlooking the contributions of other members of care networks. Recognizing the existence of and variability in the size and make-up of care networks is the first step in enhancing support for all members of family/friend care networks.

Table 2. Time (hrs/wk) and number of tasks by care network

	Time (hours/week)	Number of Tasks
Children at Home	10.2	2.9
Close Kin & Friends	6.9	2.7
Lone Spouse	10.9	3.4
Younger Diverse	2.9	1.3
Older Diverse	6.2	2.4
Spouse & Children	18.1	3.5

The characteristics of *Spouse and Children* and *Lone Spouse* care networks raise concern about the sustainability of their heavy caregiving load. For example, 85% of members of *Lone Spouse* care networks were over 65, caring alone, and some will have their own health problems to contend with. As well, nearly half the members in *Spouse and Children* care networks were employed and so are juggling their paid work along with caregiving responsibilities.

Policy implications

Our findings clearly illustrate that many older adults who have long term health or physical limitations are embedded in small care

Public programs are evolving. For example, the federal Compassionate Care Benefit Program, which provides job protection and partial income replacement to those caring for a gravely ill family member, allows the benefits to be shared among more than one eligible, employed caregiver in the family. While limited in scope, this program does acknowledge the existence of care networks and has the potential to help care network members share their caring responsibilities.

It also is important to note that there is considerable variability among older adults' care networks. Some older adults with chronic health problems get more care or help with more tasks than others, depending on the size and composition of their care network. Recognizing the sources of this variability can help us identify those older adults and their care networks, who may be particularly vulnerable.

Assessing the presence and risk factors of older adults' care networks could help target Home Care services to older adults at risk of inadequate care and family/friend care networks at risk of collapse. These are likely to include *Lone Spouse* and *Spouse and Children* care networks, both of which are very small yet provide more care, assistance with more tasks, and more demanding types of care. Targeting these vulnerable care networks may ensure the adequacy of care for frail older adults in the short term, and sustain care networks in the long term.

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The Social Sciences & Humanities Research Council (SSHRC) under the Major Collaborative Research Initiative (MCRI) Program was the major funder of this project.