CARE SHORTAGES IN LATER LIFE: THE ROLE OF INDIVIDUAL AND CONTEXTUAL VARIABLES IN FLANDERS, BELGIUM

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Abstract

Like many other European countries, Belgium has a strong policy of 'ageing in place'. Older people are invited to stay as long as possible in their own home/environment. This policy is instigated by shortages in nursing homes and preferences of the older people themselves. Although Belgium is considered to have an effective social security system, 6.4 % of the older people living at home report care shortages.

In order to analyze these care shortages, we used - data from our own survey, the Belgian Ageing Studies (BAS). In over 100 cities in Flanders, Belgium, a stratified sample was drawn from the population data, using gender and age as stratification. A sample of 64280 residents aged sixty and over was interviewed between January 2004 and December 2009. The results show that both individual, socio-demographic and contextual variables like regional differences, living conditions and housing are needed to explain care shortages among older people.

Key Words: *care shortages, ageing in place, housing arrangements, older people, environmental gerontology.*

JEL Classification: I00

1. INTRODUCTION

The older population is growing rapidly in the entire Europe. Recent demographic projections predict an increase until 2050. In Belgium, about one third of the population will be 60 years or

older at that time. This ageing process can be explained in different ways. The increase in life expectancy results in a growing number of people reaching very old age. Due to improved medical conditions, mortality rates in the older population are decreasing. Moreover, birth rates are declining (Nicholas and Smith, 2006) which results in an additional increase of the proportion of older people in the overall population (Grundy 2006). As a consequence, the proportional numbers of older people aged 85 and over, will increase dramatically in the next twenty years (Verloo, Depoorter et al. 2002). It is obvious that an ageing population will have its consequences in terms of supporting care, not least for the family support. The dependency index, a measure of the number of available younger caregivers (aged 65-69) to provide care for the oldest old, decreased from 7 in 1970 to 2 in 2000 (De Koker in Cantillon, Van den Bosch et al, 2007).

In order to cope with the challenges of an ageing population, European governments have changed their vision towards health care provision (de Gooijer, 2007). This policy mainly reflects a deinstitutionalisation of services in order to provide opportunities for older people to stay in their own homes as long as possible. Institutionalisation in a nursing home is restricted to situations where it's really necessary. However, a policy that is mainly focused on 'ageing in place' creates new challenges. First, a network of community care services, both public and private, must be developed. Second, as the older people population will highly depend on the suitability of their own housing conditions (Costa-Font, Elvira et al. 2009) the reorganisation of their living arrangements will become unavoidable.

Both formal and informal care has been researched thoroughly in the older population. Research on care shortages, however, is rather limited. Care shortages refers to situations where an older person needs care, but does not receive care. In response to this lacuna, this article provides insights into the individual and contextual determinants of care shortages in late life.

2. BACKGROUND

2.1 Housing arrangements and preferences

Like many other European countries, Belgium has a strong policy of incentives for homeownership. Tax relief on mortgage payments encourages the acquisition of property. Homeownership is culturally accepted, and can be seen as a mechanism for saving for old age (Costa-Font, Elvira et al. 2009). But homeownership for older people entails some disadvantages. Some authors suggest that older people who own a house are asset rich, but income poor (Hancock 1998). Owning a house means having some wealth, but it is quite difficult for older people to convert this wealth into cash. Another disadvantage of homeownership is that the demands of housing characteristics change over a life course. Older people are more likely to be exposed to housing inappropriateness since they spend more time at home and suffer increasingly more from health- related problems. However, most elderly people prefer not to carry out changes in their dwellings and with increased age, the likelihood that they carry out changes decreases even more.

Most older people still prefer to cope with their unsuitable environment rather than move elsewhere. In Flanders, for instance, only 15% of the population over-60 moved in the last 10 years (Verté, De Witte et al. 2007). There are several explanations for this phenomenon. Emotional attachment to their homes and financial and health costs of moving, which increase with age, are some of the most important reasons why older people prefer to stay in their home for as long as possible.

2.2 Formal and informal care

As mentioned above, older people want to live independently in their own home as long as possible (Verté, De Witte et al. 2007; de Blok, Meijboom et al. 2009), assisted by health care support when needed. This support can be offered by means of formal or informal care.

The formal care system in Belgium is characterised by a lack of transparency, uncoordinated medical services and a lack of health management. Furthermore, Belgium's home health care is supply-driven; the existing supply is the point of departure for care and service provision. To some extent, this type of care provision has not always the desired effect. Moreover, given the growing numbers of older people, such a care provision is difficult to sustain. Especially those older people who have fewer resources and face more difficulties as a result of certain life events express a stronger need for care. Consequently, they are also more vulnerable to care shortages. The needs of older people may be understood as an expression of disturbance, or a gap between the current and desired state of health or well-being. Interventions are necessary to bridge this gap or diminish the disturbance (de Blok, Meijboom et al. 2009). It is necessary however to take into account that subjective needs vary considerably between older people, and constantly subject to change. Two individuals with the same disability, for instance can be very different in what kinds of needs they express. Therefore, the need for care is highly personal , in addition, a large variety of needs can be expected (de Blok, eijboom et al. 2009). A sufficient income can allow older people to buy care if necessary (Viitanen 2007).

Informal care is often seen as an alternative for the expensive formal care. In Spain for example, care is mainly provided by family members and government services play a subsidiary role in those situations where there is a lack of economic means or family support (Costa-Font, Elvira et al. 2009). According to Bonsang (2009), there is no consensus in the literature about the effect of a formal care policy on informal care. Some authors found no effect of increasing formal care on informal care. Other authors point out that subsidies for formal care reduce the amount of informal care. In a study in 12 European countries, an increase in long-term care expenditure decreased informal care (Viitanen 2007). Moreover, informal care substitutes formal home care (Bolin, Lindgren et al. 2008). However, informal care is only an effective substitute for formal paid care as long as the older people don't have special needs and care-givers don't require special training(Bonsang 2009). If the individual is suffering from heavy disabilities this substitution effect disappears. As the spouse and the children are the most common informal caregiver, they are important partners in the reduction of care shortages. Yet informal care is considered to be under pressure as a consequence of macro-sociological changes. Several reasons are identified. First, processes of individualisation impact upon the way people conceive their roles in society. In this view, it is argued that people spend- less time with each other, this applying to children as well as to older people. A second development that has been identified is the so-called 'leisure industry'. While previously, free time was spend to a large extent with the family, some authors notice a shift towards an increasing amount of time being spend to leisure instead. A third development is the increasing number of reconstituted families. In many cases, both husband and wife have full time job, and have less time to spend on family

3. AIM

As policy is often focused on 'ageing in place', the lack of knowledge concerning care shortages raises questions about how to develop health care systems in the future. The aim of the study was to investigate the individual and contextual variables in relation to care shortages. The research

question was: what are the individual and contextual differences between older people receiving help and older people receiving no help?

4. METHODS

4.1 Participants

For this study, we used data from the Belgian Ageing Studies, that has been carried out in 136 municipalities in the Dutch speaking part of Belgium between January 2004 and December 2009. In this project, information about various aspects regarding quality of live and living conditions was gathered from older people aged 60 and over living self-reliantly in their community. In each municipality, a randomly stratified sample was taken from the population registers. The variables we used to stratify were age (60 to 69, 70 to 79 and 80+) and gender. Special attention was given to these quota, so they matched the makeup of the underlying population perfectly. As a consequence, the most vulnerable age group (80+) is not underrepresented, which is a major lack in many other studies addressing needs and care in old age. All respondents (N=64280) were interviewed in their homes using a structured questionnaire. The mean age of the respondents was 71,5 years (sd = 7,9, range 60:107). 45,1% belongs to the age group of 60 to 69 years, 36,9% was 70 to 79 years and 18,6% was 80 or older. Women (54,8%) outnumbered men.

4.2 Measures

In order to detect older people experiencing care shortages a specific strategy was used. First, older people declaring they need and receive help for housekeeping and/or, transfers and/or personal care were selected. This selection contained 15813 respondents, which corresponds to 24,6% of the total sample. The mean age of this group is 76,4 years (sd 8,2, range 60:107). 22,1% of them are in the group 60 to 69 years, 38,8% in the group 70 to 79 years and 39,1% is 80 or older.

Table 1: The care needs of the group receiving care and the group receiving no care

	Care needed and received	Care needed, no care received
N	15813	1097
Needs care for (%)	100	100
Transfers, housekeeping, personal care	28,1	18,5
Transfers,housekeeping	17,8	15,5
Transfers,personal care	2,1	2,9
Transfers	20,4	28,9
Housekeeping, personal care	3,1	2,6
Housekeeping	26,3	28,1
Personal care	2,1	3,5
Needs no care (%)	-	-

This should come as no surprise because with increasing age, the risk of needing help increases. Within this group of older people, 28,1% needs help on all three aspects, 26,3% needs help with housekeeping and 20,4% needs help with transfers (see table 1) Next, older people declaring they need help but do not receive help were detected. In this group (N=1097), the care needs stay more or less the same except for needing help with transfers, which rises from 20,4% to 28,9% and for needing help on all three aspects which drops from 28,1 to 18,5%. A possible explanation for the decline in this group could be that older people needing care on all three aspects reallocated to a

nursing home. The group older people in need of care and not receiving any care will be the focus of the next results.

5. RESULTS

5.1 Demographic profile of the older people receiving no care.

Within the group receiving no care, 62,6% are women, which is significantly less then their proportion in the group receiving care (68,2%). The mean age is 73,8 (sd 7,6, range 60:99) , which is 3,6 years lower than those receiving care. With regards to age groups, 24,5% of the older people receiving no care are 80 years or older. This is 14,6% less compared with older people who do receive care (see table 2).

As mentioned above, the spouse and children are the most important informal caregivers. Within the group receiving no care, 71,6% have a partner which is significantly higher than within the group receiving care (53,6%). The percentage of older people having children is more or less the same for the two groups (see table 2).

Educational level and household income are often used indicators for the socio-economic status of respondents. For education, we found a significant difference between the two groups. Older people receiving no care are less educated. For 57,7% of them, elementary school was the highest level of education. In terms of income, older people receiving no care are better off. The percentage with an income less then 1000 euro is 26,3%, which is significantly lower then the 33,2% in the group receiving care. The fact that in this group older people are less likely to have a spouse is a plausible explanation. No differences were found regarding experienced difficulties to get by on the income (see table 2).

5.2 Health status of the older people receiving no care at all.

To measure the objective health status, a module of the Medical Outcome Scale measuring physical functioning was used. The respondents could declare how long they had restrictions. The group receiving care reported more physical restrictions, indicating that deteriorating health is the trigger to receive care. The total score of this module was calculated according to the guidelines of the authors. On average, those receiving care scored significantly lower (1,37) on the MOS scale than those receiving no care (1,41, $p < 0,05$).

5.3 Social network of the older people receiving no care at all.

As mentioned in the literature overview, societal changes could disturb the social network of individuals. To get an idea of the size of the social network, we added up all persons (children, grandchildren, brother/sister, elders, family, friends and neighbours) with whom respondents have had at least one contact a month. Within this network, three of them are potential informal caregivers (spouse, children, neighbours). These contacts were also summed. We found that the size of the social network differs not significantly between the two groups, but the size of the informal network does (see table 3).

5.3 Living arrangement of the older people receiving no care at all.

As mentioned above, Belgium had a strong policy with regards to property acquisition. Within the group receiving no care, 80,3 % owns a house, 10,1% rents a house on the private market and 4,2% rents a public house. These percentages differ significantly with those of the group receiving

care. Most of the older people receiving no care live independently (93,5%). 22,8% of them complain about the fact that their children are not in their proximity (see table 4).

Table 2: Demographic characteristics of the older people receiving care and receiving no care

	Care needed and received	Care needed, no care received	
N	15813	1097	
Gender (%)			*
Men	31,8	37,4	
Women	68,2	62,6	
Age (years) and Age groups (%)			
Mean	76,4	73,8	*
60_69 years	22,1	30,8	
70-79 years	38,8	44,5	
80+	39,1	24,7	
Spouse (%)			
Yes	53,6	71,6	*
Married	52,0	68,9	
Living together	1,3	2,7	
No	46,4	28,4	*
Never been married	4,7	3,4	
Divorced	2,8	4,2	
Widow(er)	38,9	20,8	
Children (%)			
Yes	90,4	90,6	
No	9,6	9,4	
Education (%)			*
No education or elementary school	52,0	57,7	
Secondary school	38,0	32,9	
Higher education or university	9,0	9,4	
Household Income (%)			*
500_999€	33,2	26,3	
1000_1499€	39,0	37,7	
>1500€	27,9	35,5	

* p <0,001

When ageing, reallocation becomes less common. The percentage of people who reallocated differs merely whether or not older people receive care (14,9 vs. 14,5). As a consequence, the time lived in the municipality is long. Those receiving no care live 50,3 years in the municipality, which raises to 54,5 years for those receiving care (see table 4).

In the Flanders 13 central cities are distinguished. These cities are located in metropolitan or regional urban areas and exerts perform a central function on its environment for employment, health care, education, culture and entertainment. In our study, 9,4% of the older people receiving care lived in a central city. For those receiving no care, this percentage drops to 7,1% (see table 4).

Table 3: Living arrangements of the older people receiving care and receiving no care

	Care needed and received	Care needed, no care received	
Size of the total network	2,6	2,5	
Size of the informal network	1,8	1.6	**

** p <0,01

Table 4: Living arrangements of the older people receiving care and receiving no care

	Care needed and received	Care needed, no care received	
N	15813	1097	
Home ownership (%)			
Proprietor	76,1	80,3	**
Rents on private market	9,7	10,1	
Rents a public house	5,8	4,2	
Other	8,4	5,4	
Living conditions (%)			**
Independent	90,4	93,5	
With children	5,6	3,2	
Other	4,0	3,3	
Number of years lived in the municipality	54,5	50,3	*
Reallocation during the past 10 years	14,9	14,5	
Proximity of children			
Not in the neighbourhood	18,2	22.8	**
Locality			
Central City	9,4	7,1	***
Non central city or rural	90,6	92,9	

* p <0,001, ** p < 0,01, *** p <0,05

6. CONCLUSION

Despite Belgium's social security system, 6,4% of the older people in need of care do not receive any care at all. The descriptive profile of this study shows that these care shortages are more common in rural regions than in central cities. As regards health status, we find that receiving help is triggered by deteriorating health. Although older people receiving no care are younger, less educated, have a slightly better health and a higher income, they are more vulnerable to care shortages. Despite their higher incomes, they tend not to 'buy' care to reduces their care shortages, which will might threaten their living conditions in the future.

As expected, the informal network of older people who don't receive care is smaller, this providing an explanation for their care shortages. On the other hand, most of these older people are married or have a spouse, providing some evidence that informal care from the spouse is not as self-evident as expected. Moreover, their children often live outside their proximity. A policy focusing on informal care should take these two findings into account. The difference in proportion for the oldest old group between those receiving care and those who do't receive- care suggests that care shortages are a trigger to enter a nursing home. This suggests that the deinstitutionalization policy, where older people can only enter a nursing home if really necessary, must be reconsidered.

Because of the ageing population and societal changes, an increasing number of older people reporting care shortages can be expected. As a consequence, more requests for institutionalization can be assumed. In order to maintain the actual policy of 'ageing in place', older people with care shortages must be detected. Moreover, the care provided at home must be reconsidered in such a way that it's distribution is fair and reaches every older person who needs care. The only alternative policy makers have is to abandon the 'ageing in place' policy and to work towards the expansion of nursing homes.

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