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The utilisation of aged care services by the frail elderly and their family caregivers

Key Messages

1. The service needs of the frail elderly and their caregivers are dynamic, changing with alteration in the health status of the frail elderly and the burden on their caregivers.
2. A wide range of aged care services are provided to the frail elderly and their caregivers living in the community, however, multiple barriers prohibit the use of these services.
3. A continuum of aged care services should be in place so that frail elderly and their caregivers receive what is needed in a timely manner according to changes in health status.
4. Clear referral or admission/ re-admission and transfer/ discharge procedures are required to ensure that the frail elderly can move freely within the care continuum according to their changing needs.

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Introduction

Hong Kong has a rapidly increasing ageing population. Family caregiving is essential to maintaining the frail elderly in the community.[1] However, research has shown that caregiving often has a negative effect on the physical and mental well-being of caregivers.[2,3] Thus, it is important to assess the aged care service needs of caregivers so that they will not feel over-burdened by their duties.[4]

Aims and objectives

This study set out to (1) identify the aged care service needs of the frail elderly and their caregivers, (2) identify access barriers to these services, (3) explore factors influencing the need for services, and (4) assess the impact of these barriers to care.

Methods

This study was conducted from January 1997 to November 1998, using both qualitative and quantitative research methods. We conducted four focus groups comprising two groups of service providers (n=11) and two groups of caregivers (n=13) to assess perceptions of aged care service needs among the frail elderly and their caregivers. Participants were identified through purposive sampling by social service agencies and units. Previously published guidelines were followed in the analysis.[5]

We also conducted a large-scale prospective (n=496) follow-up study. The survey sample was selected using random digit dialling. Face-to-face interviews were conducted by trained interviewers. We used hierarchical regression analysis to assess the relative contribution of (a) predisposing factors (including care recipients' and caregivers' age, gender, marital status, education, and caregivers' employment status), (b) enabling factors (care recipients' personal income, number of unpaid secondary caregivers, number of paid secondary caregivers, caregivers' social support, motivation for caregiving, active behavioural coping, active cognitive coping, and avoidance coping), and (c) need factors (care recipients' perceived health status, number of chronic illnesses, somatic symptoms, cognitive ability, Instrumental Activities of Daily Living [IADL], caregivers' perceived health status, caregiving burden, frequency and duration of providing Activities of Daily Living [ADL], frequency and duration of providing IADL tasks) proposed by the Andersen model.[6] Chi squared tests were used to test the association between different categories of barrier by service type.

Results

From the focus groups, we identified 10 service needs of the frail elderly and their caregivers (Box 1), as well as barriers to service access and utilisation (Box 2). We surveyed 496 frail elderly and their primary caregivers to determine their current service utilisation (Table).

Using cluster analysis to group the responses, we identified seven categories

Box 1. Service needs of the frail elderly

Public education
Re-housing or special arrangements in the home
Counselling for both the frail elderly and their caregivers
Caregiver mutual support group
Respite services
Transport services
Financial support
Hotline services
Volunteer training services
Occupational and physiotherapy home-based services

Box 2. Barriers to service provision and access for the frail elderly

Short duration of service provision
Long waiting lists
Lack of services during non-office hours
Strict eligibility/admission criteria (barring clients with incontinence, dementia, blindness)
Lack of knowledge
Poor service availability
Delayed resumption of services after discharge from hospital

of need: (1) tangible needs (financial support, tax-relief, legal aid, and material donation), (2) respite service needs, (3) hotline service and emotional support service needs (caregivers' mutual support groups, individual and group counselling), (4) knowledge/skills need (caring skill, disease management, communication and coping skills), (5) job/housing needs (eg resettlement and job referral), (6) therapist needs (occupational and physiotherapy), and (7) home-based service needs (eg medical services, home help, escort, and meal delivery).

We used hierarchical regression analysis to identify the contribution of predisposing (R^2=0.06), enabling (R^2=0.16), and need factors (R^2=0.18) to perceived service need. Overall, 34% of the variance in perceived service need was explained by caregivers' age, Lubben Social Network Score, avoidance coping, perceived health status, number of somatic symptoms, Zarit Burden Interview Score, and duration of providing IADL tasks. With respect to changes in perceived service need over time, predisposing, enabling and need factors explained 48% of the variance.

Barriers to utilisation of services

In our baseline focus interview, we found that lack of knowledge about aged care services was a major barrier to utilisation, especially for social services. Many respondents reported "no need" as the most frequently occurring barrier. Transportation problems were a barrier to use of day care centres for the elderly, respite services, day hospital, and out-patient clinics. "No accommodation for people with disability or dementia" or "higher priority for the other" prevented the frail elderly with dementia from using five categories of services including social centres for the elderly, canteen services, home help services, day care centres, and respite services. A complicated application procedure was another major barrier to utilisation of respite services and day hospital care. Lastly, long waiting times were an important barrier to utilisation of home help services.

Table. Aged care service use by the frail elderly

Type of service	%
Specialist out-patient clinic	45.5
Public assistance	22.2
Hospital	20.6
General out-patient clinic	18.0
Social centre for the elderly	14.7
Emergency rooms	14.7
Day care centre	12.9
Paramedical service	9.5
Home help service	7.5
Outreach team for the elderly	5.1
Day hospital for the elderly	4.0
Caregiver mutual support group	2.4
Health centre for the elderly	2.0
Community nurse	1.8
Medical outreach team	1.6
Private elderly residential facility	1.2
Canteen services	1.0
Respite services	0.8

Discussion

We have identified factors that contribute to the perceived service needs of informal caregivers and the frail elderly within the Andersen framework.[6] These perceived needs depend on two dynamic factors—the health status of the elderly and the perceived burden on the caregivers—which account for 13 to 47% of the explained variance. At least 20% of the explained variance is accounted for in the full Andersen model, confirming the usefulness of the model as a framework for investigating aged service needs in a Chinese population.

The study outcome identifies several policy and service implications related to: (a) the service needs of the frail elderly and their caregivers, (b) the existing social and health care services, (c) the continuity of care between or among aged care services, and (d) the quality of life of the frail elderly and their informal caregivers.

Service needs

Social support was the most important enabling factor. Those with more social support including instrumental and emotional support were less likely to report service use. Caregiver burden was positively and consistently related to tangible service needs, respite services, emotional support, job/housing needs, home-based and hotline services. Caregiving burden was an important predictor of service need. Knowledge was negatively associated with the provision of ADL and IADL tasks. It is important to provide caregivers the appropriate knowledge for their role at the beginning of their caregiving careers.

Existing health care services

Complicated application procedures, lengthy waiting times,

transportation difficulties including difficulties using the rehabilitation bus, and restrictive selection criteria were common barriers to medical and health services, including specialist out-patient clinics, day hospitals, general out-patient clinics, and accident and emergency departments. Day hospitals were associated with the greatest number of barriers to service utilisation. Many answered "no need" to questions referring to service provision and utilisation. Such a response may be more indicative of frustration related to access than a real perception of need. Addressing this issue is the key to ensuring the success of any service delivery improvement or de-hospitalisation strategy.

A continuum of services

The health status of the frail elderly, especially those with chronic illnesses and decreased ADL capacity is positively associated with several service need categories. Service needs change in response to changes in the physical condition of the frail elderly. Discontinuity of services when the frail elderly are discharged from hospital, or when services are terminated or interrupted, hinders caregiving by family caregivers and further contributes to the caregivers' burden and the possibility of poorer health status of the frail elderly client.

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