

Diversity in Late Life – Project 4

Moving into a residential care facility:

Antecedents and consequences for health, personal relationships and wellbeing

Opname in een verzorgingshuis:

Antecedenten en gevolgen voor gezondheid, persoonlijke relaties en welbevinden

A research project conducted at the Department of Sociology & Social Gerontology of the Vrije Universiteit Amsterdam and the Netherlands Interdisciplinary Demographic Institute (NIDI) and funded by the Social Science Research Council (MaGW) of the Netherlands Organization for Scientific Research (NWO). The project is part of the research program Diversity in Late Life.

Principal investigators

dr. P.A. Dykstra (NIDI)

dr. T.G. van Tilburg (Vrije Universiteit Amsterdam)

Concise summary of research problematic

The links between institutionalization, health and earlier life experiences will be studied. Both antecedents and consequences of a move into a residential care facility will be investigated. The research questions are: (1) Which older adults are likely to be institutionalized, and who continue to live independently? Is institutionalization triggered by recent changes in the domains of marriage, the household, the family, personal relationships, health and the domicile? (2) To what degree has the 'de-institutionalization policy' in the Netherlands resulted in intercohort differences in institutionalization rates and age at admission? (3) Is the risk of institutionalization conditioned by (gender related) differences in the marital, parental, occupational, health and residential histories of the older adult? (4) To what extent and under which conditions does institutionalization affect supportive exchanges within different personal relationship types, loneliness and health negatively? Are institutionalized elderly exposed to a higher mortality risk than non-institutionalized?

Scientific relevance

The goal of the present project is to investigate the antecedents and consequences of a non-temporary move into a residential care facility among Dutch older adults. Institutionalization of older adults has been studied earlier. Previous studies have largely been *cross-sectional*: the general procedure is to identify determinants of institutionalization by means of comparing institutional and non-institutional elderly sub-populations (te Wierik & Frederiks, 1990; Timmermans, 1996; Dolinsky & Rosenwaike, 1988). Where *longitudinal* data are used to explain differences in long term care institutionalization, explanatory variables are usually restricted to base-line characteristics of older persons and their environment (e.g., Branch & Jette, 1982; Steinbach, 1992; Coward, Netzer & Mullens, 1996). The present study will adopt a more dynamic approach. In doing so, insights from the life course perspective and ecological or person-environment fit models will be integrated. Ecological models deal with the person in terms of competence to cope with environmental demands (Carp, 1987; Schaie & Willis, 1999). A loss of competence resulting from incongruence between the individual and the environment may reflect decreases in the abilities of the individual, changes in environmental demands and resources or a combination of these. Firstly, the project explicitly pays attention to the interrelation of a move into a residential care facility on the one hand and late life changes in other life domains (health, the family and the personal network) on the other hand. Secondly, this study investigates to what extent moving to a long-time care setting can be an important compensatory mechanism for coping with late-life losses and can help older adults to maintain some level of competence in their everyday lives, which may in turn contribute to their quality of life and wellbeing.

Elaboration of the problematic

As old people age many encounter physical, mental, social and functional losses. In the mo-

del of selective optimization with compensation, Baltes and Baltes (1990) distinguish three types of adjustments older adults may make: (1) to give up domains and activities hampered by functional loss; (2) to compensate for losses by searching for new means to maintain activities; (3) to become increasingly dependent in threatened domains to free energy for the pursuit of other activities that have higher personal priority. Institutionalization can be an important compensatory mechanism for some older adults that minimizes the losses associated with aging and maximizes wellbeing and functioning (Baltes & Horgas, 1997). Although need factors appear to play a dominant role in the decision to give up independent living, institutionalization is not a simple function of poor health (e.g., Carp, 1987; Green & Ondrich, 1990; Kleibsch, Stürmer, Siebert & Brenner, 1998; Shapiro & Tate, 1988; Steinbach, 1992). From previous research, four clusters of variables can be identified that predict admission into residential care facilities: (i) Socio-demographic characteristics, such as age, gender, marital status, income and home ownership. (ii) Health characteristics. (iii) Social embeddedness, such as support provided within the household, by children and by the exchanges within the extended personal network. (iv) Residential context, such as rural or urban setting, and home adaptation. Controlled for other factors, the risk of institutionalization is usually observed to be higher for older persons, persons living alone, in poorer health, stronger functionally disabled, and with smaller and less supportive networks. However, Branch and Jette (1982) concluded that none of the factors studied consistently differentiated institutionalized from non-institutionalized elders. Their conclusion also applies to more recent research. Many severely disabled elderly continue to live in the community, whereas sometimes less disabled persons enter institutions.

In this project, institutionalization is considered to be the result of a decision making process whereby changes in other life domains, such as widowhood or declining health, affect the older adult's competence and thus trigger a reevaluation of current living arrangement against other options. Differences in the occurrence and timing of (non-temporary) admissions into residential care facilities among Dutch older adults will be described. As in earlier research, triggering mechanisms in the domains of marriage, the household, the domicile (Carp, 1987), family (Freedman, 1996), personal relationships and health (Wolinsky, Callahan, Fitzgerald & Johnson, 1993) will be identified. *(1a) Which older adults are likely to be institutionalized, and who continue to live independently? (1b) Is institutionalization triggered by recent changes in the domains of marriage, the household, the family, personal relationships, health and the domicile?*

Alternative solutions for compensating loss of competence are conditioned by the institutional context, such as the availability of services and admission regulations for long term care arrangements. Historically, institutionalization rates for the Netherlands have been very high compared to other western countries (de Jong Gierveld & van Solinge, 1995). This situation is now changing, due to government policy aimed at reducing admission into a residential care facility amongst others by increasing the possibilities for formal ambulant care ('de-institutionalization policy'). As a result an increasing number of frail elderly live in the community, and the residents of care facilities are much older and more disabled than in the past (van Solinge, 1995). *(2) To what degree has the 'de-institutionalization policy' in the Netherlands resulted in intercohort differences in institutionalization rates and age at admission?*

The aim of the present project is to not only consider the late life situation, but also circumstances in a person's past. Every day competence is considered a dynamic process: competence of the individual as well as situational characteristics change over the adult life course. Differences in competence may to a large extent be a function of individual and cohort-related differences in opportunity structures prior to advanced old age (Schaie & Willes, 1999). Access to resources for compensating unhealthiness (such as income and informal help) that may prevent institutionalization is likely to be shaped by earlier transitions in other domains. We are looking for *personological* explanations (Dannefer & Uhlenberg, 1999) to describe analyses involving individual characteristics, but also biographical characteristics that stem from earlier experience and earlier contextual factors, such as having grown up in a particular social class or region, factors that were contextual in the past, but have become person-bound. For example, divorced older adults are less likely to have supportive relationships with their adult children than older adults whose marriages have remained intact (Dyk-

stra, 1998). Financial autonomy at an older age is strongly related to marital and occupational history, particularly for women (Fokkema & van Solinge, 1998). Earlier residential relocations might have severely disrupted social support networks and affected social integration in the community negatively (see project 3), but may also have contributed to a person's autonomy (de Boer, 1999). Rural elders may have access to a smaller number and narrower range of in-home and ambulatory services, thus reducing their ability to remain living independently in the community (Coward, Netzer & Mullens, 1996). The differences in life trajectories of older adults may be responsible for diversity in late life as far as access to relevant resources is concerned, and thus may be a clue in understanding differential risks of institutionalization. (3) *Is the risk of institutionalization conditioned by (gender related) differences in the marital, parental, occupational, health and residential histories of the older adult?*

Previous research has paid little attention to the transition process itself as well as to the consequences of the transition in terms of health and wellbeing. High mortality rates, especially shortly after admission (Steinbach, 1992; Wimmers, Buijssen & Mertens, 1987; Wolinsky, Stump & Callahan, 1997), indicate that institutionalization may affect health negatively. Moving into a residential care facility is also likely to have consequences for older adults' social embeddedness. There is a loss of social ties and the necessity of building new ones within the new living environment. This has negative consequences for wellbeing (Broese van Groenou & Thomése, 1996). Other studies, however, report also beneficiary effects. Baltes and Horgas (1997) found that many nursing home residents were able to maintain levels of engagement in social and leisure activities comparable to non-institutionalized elderly. Carp's (1987) research on older persons moving to a residential setting shows different effects according to the social embeddedness before the move. De Jong Gierveld, Dykstra and Kamphuis (1987) suggest that institutionalization might alleviate loneliness. However, the previous studies did not control for differences in health and wellbeing before institutionalization, and the results might be confounded. Longitudinal data are required to establish whether there are beneficial or harmful effects of institutionalization. Moreover, the study by de Jong Gierveld et al. was conducted in the early 1980s. Since then criteria for admission into residential care facilities have become more strict, with the result that residents of care facilities are older and frailer. (4a) *To what extent and under which conditions does institutionalization affect supportive exchanges within different personal relationship types, loneliness and health negatively?* (4b) *Are institutionalized older adults exposed to a higher mortality risk than non-institutionalized, after controlling for other characteristics?*

Methods

In addition to descriptive analyses, various multivariate analyses will be conducted. Three categories of respondents will be distinguished. (i) Those who have moved into a residential care facility. (ii) Those who were living in a residential care facility at T1 and continue to do so. (iii) Those who remained living independently since T1. For question 1, the risk of institutionalization [respondents in the categories (i) and (ii) versus those in (iii)] will be assessed by means of logistic regression and survival analysis. Furthermore, antecedents of institutionalization will be studied by a longitudinal comparison of respondents in category (i) and (iii). Additionally, it will be assessed to what degree cohort specific rates of institutionalization are associated with contextual variables such as the historical period specific availability of residential care facilities (question 2). For question 3, the risk of institutionalization will be further specified by differences in life-course trajectories. For the study of consequences of institutionalization (question 4), a cross-sectional analysis will be conducted by analyzing differences in the outcomes for the three categories. Furthermore, for those institutionalized after T1, health, mortality, loneliness and social embeddedness before and after the institutionalization will be compared. The changes will be compared with changes among those who remained living independently since T1.

Societal relevance

The Dutch government policy on institutionalization has changed in the last decades (see above). There is, however, a limited amount of recent information on the processes that precipitate a move into a residential care facility, and the consequences of this transition in

terms of health and wellbeing. The societal relevance of the proposed project is three-fold. First, at the macro-level, given the high costs associated with institutionalization, understanding of factors related to residential care admission is of considerable interest. The study will also provide insight into which sub-groups have been affected most strongly by de-institutionalization policy. Second, institutions may benefit from the knowledge of the effects of institutionalization. Prevention programs require knowledge about risk factors: which type of residents, for example, are exposed to higher risks of social isolation and loneliness? For what type of persons, and under which conditions is admission beneficial? Moreover, the result of this study may contribute to improved procedures for the assessment of urgency of admission into a residential care facility. This may improve the association between 'need' and 'urgency of admission', as suggested by Mehciz and van Tilburg (1996). Third, at the micro level, insight in how individual behavior is shaped within a changing environment, may enhance our knowledge to explain the diversity in the way older adults respond to difficulties in performing activities of daily living.

Data sources relevant to the project

General information on the data sources is provided in the program proposal. Within the context of LASA, addresses are updated yearly, making it possible to construct residential histories, including admission to residential care facilities. Cross-sectional data is available for 480 institutionalized respondents, of whom 73% have deceased, and 4009 respondents who remained living independently since T1, of whom 34% have deceased. Longitudinal data is available for 130 respondents who moved into a residential care facility, 99 respondents who already lived in an institution at T1, and 2876 respondents who remained living independently since T1. Among the factors potentially associated with institutionalization we distinguish: socio-demographic variables, health and functional status, wellbeing, personal network characteristics, sources of formal and informal support, and earlier and recent changes in the domains of marriage, the family, health and housing.

Relevance and position of the project within the program

The move into a residential care facility marks the entrance into the last phase of life. Contrary to the events studied in the projects 1 and 3, it is generally seen as a crisis, with negative consequences for wellbeing. The project uses the central life course concepts to identify and describe differences in events and processes that precipitate a move into a residential care facility and the consequences of this transition for health and wellbeing. The concept of *chronology* emphasizes the importance of earlier transitions in other domains with regard to health and the access to resources that may prevent or delay institutionalization. The concept of *multidimensionality* refers to the interrelation between the move into a residential care facility and changes in other life domains. For example, changes in functional status, and the loss of incapacity of a partner may trigger institutionalization. The concept of *embeddedness* emphasizes that people's lives are linked through personal relationships. The move into a residential care facility will be considered in relation to the older adult's supportive exchanges within different relationships. *Historic specificity* is acknowledged by addressing intercohort differences in occurrence and timing of institutionalization due to changes since the 1980s in Dutch government policy, implying that rules for admission into residential care facilities became much stricter.

Publication plan

The four research questions will be treated in a number of papers to be submitted to international journals. In addition, findings specific for the Dutch situation will be reported in Dutch journals. Provisional titles of the papers are: (1) Determinants of the move into a residential care facility among Dutch older adults. (2) Intercohort differences in the occurrence and timing of institutionalization and the role of Dutch government policy. (3) Understanding differential risks of institutionalization: does earlier life transitions matter? (4) The move into a residential care facility: consequences for personal relationships, wellbeing, health and mortality.