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ORIGINAL ARTICLE

Actions to influence the care network of home-dwelling elderly people: A qualitative study

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Abstract

Positive impact of care networks of home-dwelling elderly people may be based on several network mechanisms: navigation to resources, negotiation between participants and contagion of behaviours. Little is known about actions of participants—elderly people, informal caregivers or formal care providers—to activate such mechanisms and generate support. Aim of this study was to identify actions in relation to these network mechanisms. A cross-sectional qualitative study of 48 interviews with home-dwelling elderly people, informal caregivers and formal care providers in the eastern parts of the Netherlands was conducted between March and September 2016. A framework analysis on network mechanisms categorised actions. Actions were reviewed by network party and compared between networks to explore relations between actions and networks. Results showed that participants navigated through existing relations to seek support. Actions on negotiation were aimed at ameliorating existing relations. Few examples and no actions on contagion of behaviours were found. Actions seemed driven by incidents and existing relations. Elderly people rarely initiated actions, informal caregivers felt hampered by their position in the network. Consistent patterns of relations between actions and network characteristics did not emerge. We concluded that the full potential of network-based support of elderly people is probably underused. Particularly promising seem: navigating the neighbourhood for new informal care, using opposite opinions as a catalyst for change and bringing quality of life and dilemma's into dialogue in the network.

KEYWORDS

care of elderly people, care-giving, informal care, qualitative methodologies, social support

1 | INTRODUCTION

The majority of older people (aged 75 years and older) lives at home, accompanied by a care network which delivers practical, informational and emotional support (Albertini & Pavolini, 2017). Participants of these care networks may be informal caregivers, such as family,

friends, neighbours, volunteers through local organisations, and/or formal care providers such as primary care physicians, community nurses and social workers (Broese, Jacobs, Zwart-Olde, & Deeg, 2015). In view of an ageing population and cost containment in the public sector, the role of informal care and collaboration between informal and formal care have received increasing attention (Albertini

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& Pavolini, 2017; Broese, 2015; Nicholson, Jackson, & Marley, 2013). In the Netherlands, the traditional welfare state is supposed to be replaced by a participation society, in which citizens are responsible for their health and well-being, and where care is provided in community settings, involving informal caregivers and formal care providers who are connected in networks (Hengelaar et al., 2018).

Studies on care networks and its participants focus on the process of integration of care and on correlations between network configuration and perceived health (Broese et al., 2015; Desmedt et al., 2016; Jacobs, Broese van Groenou, Aartsen, & Deeg, 2018; Nicholson et al., 2013; Suanet & Antonucci, 2016). For instance, studies on social networks of people revealed that people with stronger social relationships have a higher likelihood of survival (Holt-Lunstad, Smith, & Layton, 2010). Inter-professional care, including case management and multidisciplinary teams, can improve care process and outcomes, although evidence is mixed (Trivedi et al., 2013). It is crucial to get better insight into how professionals structure their working practices, including collaboration with informal care. However, it seems that possibilities of care networks are not used optimally (Verver, Merten, Robben, & Wagner, 2018). Professionals do not use the organisational network to enable individual clients to navigate to resources (Kemper-Koebrugge, Koetsenruijter, Rogers, Laurant, & Wensing, 2016). Also health and social care professionals rarely go beyond mapping the informal network (Chambers, Wilson, Thompson, Harden, & Coiera, 2012). The world of informal care and formal care is mostly separated and contact is limited (Jacobs, Broese, Boer, & Deeg, 2014). A recent thematic synthesis highlighted the professional perspective on collaboration, showing that formal care providers act as experts in a hierarchy and that collaboration with informal care was hampered by legislative and societal systems in which formal care providers work (Hengelaar et al., 2018). The shift towards more collaboration in care networks around home-dwelling elderly persons demands that participants know which actions could have a positive influence on the functioning of the network and generated support.

Research on the influence of social context on health provides some concepts that can explain the functioning of care networks and the actions participants employ to influence these networks (Holt-Lunstad & Smith, 2012; van Dam et al., 2005; Vassilev et al., 2011). On the basis of empirical research, three broad mechanisms of actions on networks to generate support have been distinguished (Kennedy et al., 2014; Vassilev, Rogers, Kennedy, & Koetsenruijter, 2014). First, actions can relate to navigation; identifying and connecting to persons or organisations who can provide support (Cohen, 2004; Tsisis, Evans, & Owen, 2012). An elder person can activate more support if he has invested in this "social capital" through selection of supportive individuals into the network and removal of unproductive connections. Second, actions can relate to negotiation on sharing care tasks and shaping relationships (Ford, Wells, & Bailey, 2004). Third, actions of participants can be the result of contagion, when ideas, attitudes or behaviours have spread from one group of people to another. Patterns in and between care networks influence cultures of people and organisations within the network and vice versa (Tsisis et al., 2012). This influence can be

What is known about this topic

- Studies on care networks of home-dwelling elderly people often focus on the process of integration of care and on correlations between network constellation and perceived health.
- Research on the influence of social context on health provides some concepts that can explain actions participants employ to influence these networks: navigation, negotiation and contagion.

What this paper adds

- Actions of participants in care networks of home-dwelling elderly people were incident- and relation-driven.
- The framework of network mechanisms proved useful for exploring actions and showed new fields for network-related actions.
- Formal care providers should overcome their fear of mingling in the informal network to develop new ways of connecting formal and informal care.

positive for health and well-being, but also negative. To provide insight in actions of participants in networks, the central question in this study is: Which actions in relation to network mechanisms are used or mentioned by elderly people, informal caregivers and formal care providers to influence the care network in order to generate support for home-dwelling elderly people?

2 | MATERIALS AND METHODS

2.1 | Design

To explore actions and viewpoints of participants of care networks of home-dwelling elderly people, the current study was a (cross-sectional) qualitative interview study, based on interviews with a purposeful sample of participants of care networks. This study adds to scientific knowledge as we interviewed three different parties per network separately: the elder person, an informal caregiver and a formal care provider (Groen et al., 2018). The research team had a background in nursing and education.

The design and report of the study followed the COREQ guidelines, which safeguards quality of the research on aspects of the research team, study methods, context of the study, findings, analysis and interpretation (Tong, Sainsbury, & Craig, 2007).

2.2 | Study sample and data collection

Elderly people were purposefully sampled. Inclusion criteria were features of the home-dwelling elder person (being 75 and over with multiple chronic illnesses) and a care network with both informal

and formal care, with at least one contact a month. The choice of the informal caregiver and formal care provider was made in consultation with the elder person on base of the relevance from this person for the elder person and aimed diversity in informal caregivers and formal care providers in the sample. Respondents were recruited in several ways to get as much heterogeneity as possible; through home care organisations, a local welfare organisation, a home care services and a church community, all in the eastern part of the Netherlands. We aimed for diversity in education levels in order to see if actions differed with the level of education. The principal researcher first communicated with the contacts of the organisations or community, the contacts selected and approached clients personally. A confirmation letter gave more information about the study. Respondents were quoted by N network number and by network party: A elder person, B informal caregiver and C formal care provider. Data were collected between March and September 2016. Interviews with participants of one network were no more than 2 weeks apart in order to prevent differences in network situation blurring differences in actions between participants. Interviews were held in the home situation of the respondent, unless the respondent preferred another location. Informed consent was obtained through a written consent form, which was sent to the respondent before the interview and if needed explained further at the beginning of the interview.

2.3 | Interviews

A semi-structured interview guide guided the interviews. The interview guide for the elder person, the informal caregiver and the formal care provider was identical, apart from formulation of the question from the perspective of the network party. Respondents were asked to answer from their own perspective about the current situation in the network. The interview contained only open-ended questions. Asking about actions and generated support started by exploring the network context: asking which informal caregivers and formal care providers support and describing how the network works. When respondents named an organisation, the organisation was listed, when respondent named persons specifically, all persons were listed. Ways of and actions on navigation, negotiation and contagion were explored through open questions and asking for specific examples of situations. Every network mechanism had one leading question. Navigation: "If something changes in the situation: how would Mrs/Mister address this? How do you seek for persons or organisations that could help?" Negotiation: "How do participants interact to find out what the elder person needs and to divide care tasks?" Contagion: "How would you define positive or negatives influences in or around the network?" "How is this influence reinforced by the way people interact?" Also respondents were explicitly asked which actions they employed to influence the network. WK was the primary researcher, WK, JN, LB and MP conducted all interviews and attended training beforehand. The interviews were conducted face-to-face or by phone and lasted about 60 min. Interviews were recorded and verbatim transcribed by the researchers.

2.4 | Data-analysis

After familiarisation with the data at the level of the individual participant of a network and at network level, network situation was explored through open coding on the questions of who was in the network and how the network works. Second qualitative framework analysis on the network mechanisms was undertaken to label meaningful units on actions in relation to network mechanisms and generated support (Gale, Heath, Cameron, Rashid, & Redwood, 2013) (Table 1).

TABLE 1 Analytical framework

Navigation	Identification possible resources
	Connecting to resources
	Using online information and networks
	Promoting factors navigation
	Impeding factors navigation
	Actions on navigation
Negotiation	Coordinating care activities
	Shaping relationships
	Reciprocity
	Promoting factors negotiation
	Impeding factors negotiation
	Actions on negotiation
Contagion	Contagion examples
	Impeding factors contagion
	Promoting factors negotiation
	Actions on contagion
Support	Information
	Practical support
	Emotional support
	Perceived support

The coding in ATLAS-ti was done first separately by two researchers (WK and JN), then compared and discussed by both researchers. Disagreements were solved in a consensus meeting with a third researcher (ML). Second, meaningful units on actions in relation to network mechanisms and generated support were recoded through open coding. Third, findings were reviewed per network participant to examine whether different positions in the network bring different views on actions and generated support. Fourth, actions were compared between care networks to explore differences in actions between different networks configurations and types of caregivers.

3 | RESULTS

In total 48 respondents of 19 care networks were included. Eleven networks with all three network parties, five networks with two out of three network parties (2 networks A/C, 2 networks A/B, 1

TABLE 2 Characteristics respondents

48 respondents total	Origin	Sex	Age mean (range)	Level of education
17 elderly people (A)	-	4 male 13 female	81 (75-92)	7 lower education 3 middle level education 7 higher education
16 informal caregivers (B)	2 partner 11 family 1 neighbour 2 volunteers/clubs	2 male 14 female	57 (38-84)	2 lower education 4 middle level education 10 higher level education
15 formal care providers (C)	3 welfare 3 home services 7 home care 1 case manager 1 specialised nurse	2 male 13 female	48 (24-61)	1 lower education 5 middle level education 9 higher education

network B/C), three networks with one network party (2 A, 1 B). Where not three different network parties were interviewed, this was caused by changes in the situation of the elder person or because the elder person thought this was too much strain for a caregiver. We included these interviews, since they contained information about our research question. Table 2 shows the characteristics of the respondents.

3.1 | Network context

All networks were ego networks around a home-dwelling elderly person. The elder person had chronic health problems like impaired hearing, eye disease, dementia in an early stage, diabetes or physical inconveniences through ageing. Table 3 shows the configuration of their support networks.

The table gives an indication how the elder person, informal caregiver and formal care provider interviewed perceived the participants of the network. Findings are corrected for duplications. The numbers give no indication of the amount of support provided per participant. We subcategorised informal and formal care to give more insight in the network configuration. Within formal care we found respondents made a difference between formal care as accessible through organisations, funded by government, or formal care which they paid for by own means. When support was delivered through a formal care organisation, respondents named the organisation. High numbers of organisations in formal care meant more specialised care. Within family and friends elderly persons named grand children who visited, sometimes other elderly persons in day-care were seen as friends. Volunteers came from the church community or daycare. Formal care providers were mostly home care. Formal care providers paid for by own means were domestic help, pedicure, hairdresser or extra hours of help on top of the formal care funded by government.

Networks were developed around practical support: the elder person needed assistance with doing chores, arranging things and transport to various occasions. Also participants, as well informal care as formal care, guided undertaking small-scale activities like drinking coffee. The initiative for this provided support mostly came

from informal caregivers, the elder person undergoing this passively. Within the provided support, the practical and emotional support were closely intertwined.

Stories of participants within one network did not always match. In most cases, the elder person did not see all participants other network parties saw and hence not all given support and coordination behind that support. When there was a concrete situation to negotiate support, informal and formal care found each other, not always in accordance or dialogue with the elder person.

3.2 | Actions related to navigation

Navigation in the care networks of home-dwelling elderly people concentrated on using existing relations to enlarge support. Elderly people took little or no action in navigation. They saw barriers before they even started navigating, like "those people do not match my level of development," "I find it hard to ask," "people always have other priorities." The underlying assumption was that something new was scary or tense or that change was not possible. When elderly people navigated outside their network it was in a nearby existing context: the community in the apartment building or the church community.

In connecting to relevant resources elderly people relied on informal or formal care. Informal caregivers and formal care providers stimulated the elder person, showing consideration with anxiety. Informal caregivers and formal care providers stressed the importance of a warm transfer to a new participant. Actions they named were: joining the elder in first meetings, introducing the elder person personally to another elder person.

"I first introduce a new participant in the network through warm transfer, then let the new participant take the elder person outside to meet other people"
(N19C, casemanager)

To weigh risks and need for extra care, informal caregivers and formal care providers monitored the situation by asking the elder person about support and reliability of other participants.

TABLE 3 Network configuration

Network (respondents)	Informal care: Family and friends (number of persons named)	Informal care: Volunteers, clubs (number of persons named)	Formal care: Contracted with own means (number of persons named)	Formal care: Contracted through organisations (number of organisations named)
1 (A,B,C)	9	2	4	3
2 (A,B,C)	1	0	7	4
3 (A,B,C)	10	1	1	6
4 (A,B,C)	6	2	2	9
5 (A)	3	0	0	4
6 (A,B,C)	10	1	2	4
7 (A)	3	0	0	2
8 (A,B,C)	8	3	0	8
9 (A,B,C)	6	0	0	6
10 (A,B,C)	7	0	0	5
11 (A,B,C)	7	2	1	3
12 (A,B,C)	6	0	1	3
13 (A,B)	8	0	1	2
14 (A,B,C)	6	3	0	6
15 (A,B)	2	2	2	2
16 (A,B,C)	5	1	3	4
17 (A,C)	9	1	2	3
18 (B)	4	0	0	4
19 (B,C)	6	3	1	3

In networks dominated by chronic illness, websites, information meetings and professionals working in hospitals were a reliable resource for informal caregivers and formal care providers. If action was necessary to find new supporting caregivers or care providers, participants aimed at existing relations. The elder person addressed the informal caregiver or formal care provider within the network, the informal caregiver addressed known relatives or the formal care provider and the formal care provider addressed close colleagues or transferred a solution from one client to another client.

Informal caregivers and formal care providers did not undertake specific actions to improve their ways of navigation, but pointed at a field of potential opportunity for identifying relevant resources: Navigating the broader context of the neighbourhood in search of informal care. "I wouldn't know how to find extra network in the neighbourhood." "It swarms of support, if you know where to find them." Next to better identification of relevant resources in the neighbourhood, potential is in the way clients could be connected to other people:

'We could improve in ways to match. One time we matched our clients within an apartment building, but we do not do these things often enough'

(N8C; nurse)

Navigation was an individual action, the elder person, informal care and formal care did not navigate together.

3.3 | Actions related to negotiation

Elderly people were not explicit about actions on negotiation. In their view, relationships were a result of live events. Elderly people felt dependent, which meant they could not say too much. Elderly people found it difficult to bother someone else and communicate frankly, but also felt angry if passed over.

Informal caregivers aimed their actions at keeping the relationship positive through maintaining a positive spirit, complementing the elder person and avoiding difficulties. They directed their energy on a dialogue with the elder person. Informal caregivers did not feel the position to enforce new actions by the elder person, feeling they have to compromise:

"This is my life long pattern with my mother, I cannot change this, only someone from the outside can"
(N1B)

Actions from formal care providers did not differ much from the actions from informal caregivers. Their basis was building trust with the elder person, ameliorating existing contacts and within these contacts framing things positively. For example, they sent postcards to informal caregivers for their birthday. They also directed their energy on a dialogue with the elder person, often defining it as seducing the elder person to change behaviours which could improve his or her quality of life or health situation. They sometimes used their professional status or the status from a primary care physician to enforce decisions. If the situation

demanded more care, they navigated to organisations for formal care.

Informal caregivers and formal care providers sometimes struggled with the elder person, proclaiming the elder person was not clear in his wishes or was stubborn. They sometimes avoided expected objection of the elder person by just providing support without involving the elder person in the decision process, when it was concerned to be a necessity by informal and or formal care.

Negotiation in these care networks showed itself as incident-driven. Formal care and informal care were two separate worlds with limited contact in case of an illness situation, emergency or rehousing. Some networks had more regularly personal contact and mutual understanding when daily care for the elder person demanded presence in the house. Other contact was mostly by phone calls and through a care record. Often formal care asked for one appointed contact from informal care towards formal care.

In sharing care tasks mostly two different basis principles of coordination were visible; either coordination by the elder person with participants keeping a close eye, or one central actor from informal or formal care. Informal caregivers and formal care providers seldom met, because they made sure the elder person saw someone each day.

In two networks participants used a digital care network to coordinate actions, but they did not include the elder person. Division of care tasks altered when burdening became too heavy for family or more people were needed. No anticipation for future care was visible, except for some informal caregivers within a church community; they communicated which each other which future care needs they saw within their community.

Actions on reciprocity, as an underlying principle of negotiation, were not visible. Elderly people often felt they could not do something back, informal care givers stimulated elderly people "to allow somebody else to help you." If examples were visible, like babysitting children or giving advice, the elder person felt physically capable and was asked by informal care. Informal caregivers and formal care providers named reciprocity as a seducing strategy to stimulate the elder person: new activities are a chance for the elder person to help somebody else. They found it difficult though to specify examples from this strategy. An informal caregiver skilled in motivational interviewing skills explained how difficult it could be to seduce the elder:

'If I tell her that she cannot live alone anymore, she will only try to convince me that that is not the case. So I compliment her on her strength living alone and that that is what she wants, so she feels the space to tell me what is difficult.

Also I let her show me how she goes upstairs to the bathroom, and on the way tell me how she gets around, what does not function well, and what she sees as an acceptable solution. By asking questions I discover removing the bathroom door is more acceptable for her than moving the laundry basket' (N18B)

3.4 | Actions related to contagion

Participants named no actions that related to contagion of behaviours. When all interviews were considered together, three examples of contagion emerged from broader context, often a barrier for improvement. Participants saw the abilities from elderly people as fixed: "it is what it is, it will not get any better," "she has lived for this for eighty years I cannot change it." Second formal care providers saw professional boundaries as reason not to interfere with family relations: "I am not a therapist." Third patterns in the context hampered or helped: "people do not have much contact with each other in this neighbourhood" or "helping each other is normal in this church community."

3.5 | Generated support

All participants saw providing support as something you do when asked by the elder person or when the situation was seen as risky or acute. Participants did not proactively anticipate future care demand in the health or living situation of the elder person.

"Every time we step up a little bit to convert" (N12B)

Informal caregivers and formal care providers did not really know how the elder person perceived the support provided by them. Perceived support was not an explicit topic of conversation with informal care and formal care together. They held dialogue with the elder person or other participants separately, about concrete circumstances and the provision of support:

"I think she perceives our support as positive because she seems satisfied" (N2B)

Elderly people, informal caregivers and formal care providers looked different towards the desired situation. Elderly people wanted to keep everything the same or did not accept the current situation, where sometimes informal or formal care could see possibilities. This led to the dilemma to confront an elder person with this view or to let it go. To strive for better generated support as outcome was not an intentional strategy for participants.

When all interviews are taken into consideration, informal and formal care struggle with dilemma's which withhold them to take actions to improve network functioning or generated support. They do not want to intrude in the elder person's life, but see risks. They weigh between their own wishes and needs versus what the elder person expresses.

3.6 | Actions reviewed per network party

When findings were reviewed per network party, elderly people appeared passive, relying on participants to fulfil care needs. Informal caregivers felt their position as family member often hampered them to take action. They could see useful changes in daily life or

participation from the elder person, but felt patterns in their life-long relationship made it not possible to stimulate change. They weighed risks to determine if they should take action. Formal care providers took most actions in the network. Their actions were aimed at maintaining existing relationships or enlarging formal care through existing relationships.

3.7 | Actions reviewed on network configuration

A network configuration with home care had a potential positive influence on negotiation since home care knew most informal caregivers, but home care respondents did not use this knowledge to involve caregivers outside family. When a coordinating role from informal care was in other hands than the older person, it was a partner or a child and as result negotiation together with home care improved. Homecare and welfare volunteers did not navigate together, since the welfare volunteer concentrated on her own setting.

When the level of education was higher among the elder person and informal care they navigated more towards specialised formal care. Actions were not consistently related to characteristics of the elder person. Elderly persons being higher educated meant they were more specific in their choice of support, but it did not change their actions on navigation or negotiation. Informal care in the sample consisted mostly of women. Actions on network mechanisms of these women did not differ from the men, both named the same kind of actions.

4 | DISCUSSION

We uncovered that actions in networks were mostly incident- and relation-driven, in which participants affirmed status quo or changed support as response to a life event. Previous research on care networks of home-dwelling elderly people concentrated on integration of care or network constellation and did not explore network-related actions of home-dwelling elderly people, informal caregivers or formal care providers to influence the functioning of the care network or generated support.

The framework of network mechanisms proved useful for exploring actions and also showed fields of network-related actions that participants did not use. This corresponds with research that shows that most actions in networks are aimed at individuals and directed at the existing network and that few actions council participants to break social ties or to find new ties (Latkin & Knowlton, 2015; Spencer-Bonilla et al., 2017). This study shows how participants find it hard to navigate the neighbourhood in search of informal caregivers. Local (non-)kin could be mobilised more often (Jacobs et al., 2018). Further research should explore navigation strategies to meet other people and to use contact moments to enlarge informal care possibilities. Second, actions on negotiation seemed less effective because of avoidant or compromising behaviour of informal caregivers or formal care providers. Studies on conflict management styles of nursing students, allied health

professions and nurses showed a prevalence for compromise, followed by avoidance (Sportsman & Hamilton, 2007; Valentine, 2001). Since informal caregivers are often hampered by their position in the network, effectively using conflict or opposite opinions as a catalyst for initiating change should be the challenge for the formal care provider. Shared decision-making, which was developed from the patient-physician dyad, could aid, but developing it to support decision-making in a care network asks for further research (Groen-van, 2018). How to embed elderly persons in this decision-making demands further research, since they seem resistant towards group conferences in fear of losing control (Metze, Kwekkeboom, & Abma, 2015). Third actions on contagion were not visible. Big data research shows that people are not infected by their close environment, but by circles around that (Pentland & Elskamp, 2014). Awareness about these contagion factors could improve conscious action. Further research should consider evaluation of actions in these fields to make better use of the care network of home-dwelling elderly people (Chambers et al., 2012).

Through the eyes of participants elderly people seemed passive [not undertaking an action], or stubborn [not wanting to undertake an action]. Although physical or cognitive decline may cause less activity, research does not confirm passivity as a trait from the ageing process (Lommi, Matarese, Alvaro, Piredda, & De Marinis, 2015). People make decisions on basis of their attitudes towards their life and future, having an optimistic character helps to make changes (Lommi et al., 2015; Sörensen, Hirsch, & Lyness, 2014). Heid also established that stubborn behaviours from elderly people were not fully explained by personality, thus situational and relationship issues may also drive these behaviours (Heid, Zarit, & Fingerma, 2016). Even stronger; research shows that environmental factors and the execution of services and expectations from informal caregivers and formal care providers may contribute to the individual elder person being on the verge of being passive. (Vik & Eide, 2013; Yu, Kolanowski, & Litaker, 2006). In this way, passivity could be the result of contagion of the way we perceive elderly people and organise support. Chronic diseases and experienced barriers in daily life do not have to be the cause of a lesser quality of life (Wolff, Lindenberger, Brose, & Schmiedek, 2016). Reframing the views of participants on the quality of life of the elder person and capability for change could be a strategy that creates other network support.

In this study, contact with formal and informal care was merely organised by one central appointed contact. This is effective when the informal network can resolve conflicts and trusts the appointed contact (Lieberman & Fisher, 1999). Obviously, this is not always the case. Especially, home care professionals should use their knowledge of the informal network and overcome their fear of mingling in the informal network to develop new ways of connecting formal and informal care.

Limitation of this study is we could not account for actions participants employ not-consciously. We compensated through asking about situations and how the network works and asked respondents to describe what they did. Asking about contagion did not deliver any answers; observation might be more suited to see examples of contagion.

Bias was possible because contacts of organisations approached elderly persons personally. Weakness of our study was that the sample was not large enough to enable us to differentiate in the analysis on navigation and negotiation within networks with strong ties compared to network with weak ties. Richness in data came from the diversity in network parties and level of education of elderly persons, although informal caregivers were more high educated. No questions were asked though about how long the current configuration in the network existed, so how interaction in the care network develops during time is underexposed.

5 | CONCLUSION

Not all potential mechanisms to activate support networks are used in practice in care networks of home-dwelling elderly people. Participants take actions within the existing network and do seldom employ network-related strategies. How care network characteristics, interaction and actions develop during time demands further research.

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CONFLICT OF INTEREST

The authors declare that they have no competing interests. The authors alone are responsible for the content and writing of the paper.


AUTHOR CONTRIBUTION

W. Kemper planned the study, performed data collection, data analysis and wrote the paper. M. Adriaansen supervised the interpretation of findings, and contributed to revising the manuscript. M. Laurant supervised the study, data collection, analysis, interpretation of findings and contributed to writing of the manuscript. M. Wensing supervised the study design and interpretation of findings, and contributed to writing of the manuscript. All agreed with the final manuscript.

ETHICAL APPROVAL

Permission was obtained from the advisory board Practice-oriented research in the Faculty of Health, Behavior and Society, HAN University, ACPO 24.03/16.

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