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FAMILIES AS CARE-PROVIDERS VERSUS CARE-MANAGERS? GENDER AND TYPE OF CARE IN A SAMPLE OF EMPLOYED CANADIANS

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SEDAP Research Paper No. 4

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FAMILIES AS CARE-PROVIDERS VERSUS CARE-MANAGERS?

GENDER AND TYPE OF CARE IN A SAMPLE OF EMPLOYED CANADIANS

by

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ABSTRACT

This article extends previous research by examining care management as a distinct type of informal care. Using data drawn from a large Canadian study of work and family, the research is based on a study of a sub-sample of women (1068) and men (805) who were employed full-time and who had provided help to an elderly relative during the six month period preceding the interview. Results indicate that managerial care is a meaningful construct that denotes a distinct type of care. Most commonly, individuals combine managerial care with other types of assistance. Managerial care is a very common activity among caregivers and usually involves aspects of care other than arranging for formal services. Managerial care has an adverse impact on job costs and personal costs, and, among women, is associated with greater stress.

FAMILIES AS CARE-PROVIDERS VERSUS CARE-MANAGERS?

GENDER AND TYPE OF CARE IN A SAMPLE OF EMPLOYED CANADIANS

INTRODUCTION

In 1983, in an article in Family Relations, Patricia Archbold observed that most of the literature on family caregiving assumed one caregiving role -- direct, “hands-on” care provision. Since 1983, the caregiving literature has grown exponentially, yet her comment remains largely accurate. While she identified a second type of family caregiver role, that of care-manager, very little subsequent research further explored this aspect of caregiving. Among family caregivers, care management was found by Archbold to be more common among employed women than women not in the paid labour force. The increase in labour force participation rates for women implies that care management will become increasingly common as a form of family care provision. It seems important, therefore, to learn more about care management as a type of parent care behaviour.

LITERATURE REVIEW

In the literature review which follows, we first identify existing research on informal caregiving which has explicitly or implicitly included care management as an aspect of caregiving. Next, we review literature which sheds light on the prevalence and distinctiveness of the managerial care role. We then review literature on a number of caregiver characteristics, such as gender and socioeconomic status, which are associated with whether individuals provide direct or managerial care. Finally, we briefly review

adverse outcomes associated with caregiving, since the paper will address the question of whether and in what respects managerial care is associated with negative outcomes for caregivers.

Managerial Care as a Component of Caregiving

Research on informal care has, by and large, operationalized caregiving to older relatives as the direct provision of services, namely as help with the basic and instrumental activities of daily living (see. for example: Dwyer and Seccombe, 1991; Neal et al., 1993; Stoller et al., 1992; Scharlach and Boyd, 1989). Conceptually, however, as a number of scholars have noted, the scope of caregiving extends beyond “hands on” assistance. Scholars have long recognized the important role families play in linking older adults to the bureaucracies of human service organizations (Shanas and Sussman, 1977), and researchers studying caregiving have recognized that caregiving may include obtaining or coordinating formal services (Horowitz, 1985; James, 1992; Fischer and Eustis, 1988; Brody, 1990:28; Zarit and Pearlin, 1993), and indeed may include other dimensions as well. Horowitz (1985), for example, conceptualized family care as falling into four categories: direct services, emotional support, mediation with formal organizations and providers, and financial assistance. James (1992) conceptualized caring as involving three components: physical labour (help with ADLs or IADLs), emotional labour (providing emotional support), and organizational or managerial labour (making sure care is provided at the appropriate time and in a way that is acceptable to the care recipient). Archbold (1983) identified two types of caregiving: "The care-provider identifies those services the

parent needs and performs them herself. The care-manager identifies the needed services and manages their provision by others" (Archbold, 1983: 41). Brody (1990:28) elaborated on what is involved in the management role: knowledge of entitlements, identifying what services are needed and whether they are available in the community, gaining access to services, and following through to see whether services are actually received.

As the preceding paragraph suggests, while scholars have acknowledged that caregiving may involve a number of roles, aside from direct help with ADLs and IADLs, the conceptualization of managerial care has been somewhat vague and perhaps inconsistent. In particular, there has been more ready acknowledgement of the family's role in relation to formal services than in other aspects of managerial care. The work of Fischer and Eustis (1988) is instructive in this regard. They conducted a qualitative study of family caregivers of patients during hospitalization and post-discharge. They found the managerial role for families included mediating, supervising, and planning. Families mediated between care recipients and health professionals, and advocated on behalf of care recipients. Supervision included supervising care in the home and in the hospital, striving for continuity among a diverse set of formal care providers. Families acted as planners in relation to post-hospital care. Fischer and Eustis (1988:388) state, "These arrangements usually entail coordinating care from both formal service providers...and informal caregivers, particularly close family members." It is noteworthy that Fischer and Eustis saw the coordination of informal care as being part of the managerial role. This role involves ongoing negotiation with the care-recipient and with the network of other caregivers.

Archbold's (1983) study is unique in that it was specifically designed to study care management by families. The convenience sample was selected so as to contain 15 care-managers and 15 care-providers; only women were included in the sample. While this strategy was appropriate for identifying some of the contrasts between the two types of caregiving and for generating hypotheses, the method of sampling and the small sample size obviously prevent firm conclusions or generalizations. Fischer and Eustis, too, had a small sample (31 caregivers). Therefore, while previous research indicates the existence of the managerial role among family caregivers, and has identified some of the features of managerial care, many questions relating to the prevalence of this type of care, the circumstances under which it occurs, its association with caregiver characteristics, and its impact on caregivers remain unaddressed. The purpose of this paper is to focus explicitly on managerial care, using a large sample of employed caregivers, in order to address some of these questions.

Prevalence and Distinctiveness of the Managerial Care Role

In the absence of large studies, it is not known how common it is for families to assume the managerial role, nor is it known whether managerial care is typically performed in combination with hands-on care provision. Existing research, however, provides some information about each of these issues.

Some studies provide an indication of the extent to which families are involved in obtaining formal services for an older member. For example, Seltzer et al. (1987) conducted a study of families of older adults who were clients of a social service agency.

They found that two-thirds of families performed case management tasks, defined in that study as tasks relating to obtaining or coordinating formal services for an elderly relative.

Coordination of the informal support network is another facet of managerial care. Studies which include information about secondary caregivers shed some light on the prevalence of this type of activity. Stommel et al. (1995) found that between 52% and 67% of care recipients in their study received help with ADLs from both an informal primary caregiver and other helpers (either formal or informal). Connidis et al. (1996) found that, among employed adults who provided at least one hour of care per week to an older relative, 61% said that other family members were also involved in providing care. One may infer, then, that primary caregivers are often required to perform coordination activities.

While care management and direct care provision are different types of care, it is unclear from the literature whether these two caregiving roles tend to be mutually exclusive, or whether they tend to be combined. In Archbold's (1983) study they occurred separately, but this may well have been an artifact of sampling. Other work (James 1992) implies that they occur together, although previous research has not explicitly addressed this issue. One area of research that casts some light on the issue, at least on the component of managerial care that relates to formal services, is the research on the interface between informal and formal care (e.g. Noelker and Bass, 1989; Bass and Noelker, 1987). This body of work tends to show that formal care does not replace informal care. Rather, informal care tends to precede the use of formal services, and, when formal services are sought, families either maintain or increase the amount of informal care

(Stoller, 1989; refs). One would thus expect that many caregivers combine the roles of care-provider (which precedes the seeking of formal services) and care-manager (which is “added” to the care-provider role once services are needed).

Caregiver Characteristics

Gender is arguably the most important sociodemographic characteristic of caregivers. Women predominate as primary caregivers (Neal et al., 1997; Stone et al., 1987), and spend more time providing care than do men (Neal et al., 1997). In general, research has pointed to a gendered division of labour in performing caregiving tasks, with daughters being more likely than sons to help with transportation, housekeeping, shopping, cooking, care when ill, and personal care (Martin Matthews and Campbell, 1995; Finley, 1989; O'Bryant and Morgan, 1990; Stoller, 1990; Horowitz, 1985). Sons tend to provide more assistance than daughters do with home repairs and yard work, decision-making, financial advice and financial support (O'Bryant and Morgan, 1990). Recently, however, studies of employed caregivers have shown fewer gender differences in tasks and suggest that employment dampens the gender effect (Neal et al., 1997). There has been little attention to managerial care in general, but there are indications that the likelihood of providing this type of care does not vary by gender (Neal et al.; 1997; Finley, 1989). More research on employed adults, which further examines gender differences and similarities, is in order, particularly with respect to managerial care. Moreover, it is possible that gender differences would be found if the different components of managerial care were examined separately.

Socio-economic status was found, In Archbold's (1983) study, to be related to whether a woman was a care-provider or care-manager. Income was the major determinant of whether and how many services were purchased. Higher income gave caregivers more options and flexibility in obtaining services to meet their parents' needs. Archbold also found that being employed full-time in a high prestige occupation was associated with being a care-manager. Archbold (1983: 41) notes, "Career commitment provides a salient competing role to caregiving. This clarity in the importance of the occupational role enables managers to delegate parent-caring activities with little internal conflict." Few care-providers were in the paid labour force, and those who were had little career orientation. As well, their comparatively low salaries did not permit the purchasing of services.

As discussed above, being a primary caregiver may be a factor associated with providing managerial care, since primary caregivers are in the best position to coordinate formal and informal assistance by other helpers. Similarly, people who are sole caregivers, that is, whose relative is not being helped by anyone else, might be expected to be more likely to provide these aspects of managerial care than persons who are secondary caregivers. As well, having no siblings might be expected to increase the likelihood of providing managerial care since persons without siblings would be more likely to be primary and sole caregivers.

Geographical proximity to the care recipient may be associated with the provision of managerial care, although not to the degree that it would be associated with the provision of direct care. To some degree, one might expect that increasing distance would make it

more difficult to coordinate formal and informal care. As well, increasing distance would be associated with a decreasing likelihood of being a primary caregiver, assuming other family members were available to take on this role. On the other hand, distant children who have no siblings might take on the role of care-manager as opposed to care-provider.

Adverse Outcomes

Among the adverse outcomes associated with caregiving are: personal costs such as reduced time for leisure, lack of rest; job costs such as reducing hours of work; conflict between work and family roles; and stress (see, for example, Aneshensel et al., 1995; Martin Matthews and Rosenthal, 1993). However, research which explicitly examines the association between managerial care and these outcomes is rare and fragmentary.

Care-managers in Archbold's (1983) study reported time limitations, career interruption, financial problems, and guilt as the major costs of caregiving. Among the problems encountered by care-managers were the challenges of becoming familiar with available services and how to access them; these tasks were time-consuming and difficult. Decreased time for participation in "career development" interfered with the caregiver's work career. The intrusion or "spillover" of care-management activities into work time was especially difficult for women in nonprofessional, bureaucratic positions. Care-managers also reported incurring heavy financial costs. Most care-managers could not afford to purchase services for long periods of time and almost all felt the "financial pinch".

Several studies suggest that locating and coordinating formal services increases the stress on family caregivers (Stoller and Pugliesi, 1989; Neal et al., 1993:134). As well,

coordinating care among family members may be stressful. For example, respondents in Archbold's (1983) study reported conflict with siblings over perceived inequities in the distribution of parent-caring activities. In a study of primary caregivers of hospitalized older relatives, 21% of caregivers reported problems in getting other family members to cooperate in the patient's care (Rosenthal et al., 1992). Gottlieb et al. (1994) found that managerial activities were associated with increased stress, work-family conflict, and job costs; their analysis, however, did not did not distinguish among the different aspects of managerial care in order to identify the components which are the major contributors to these negative outcomes.

Among employed caregivers, work-family conflict is common (Neal et al., 1993: 126-128)). In the absence of studies focusing explicitly on managerial care, the extent to which managerial care is associated with work-family conflict is unknown. The spillover of care management activities into work time was one of the problems reported by care-managers in Archbold's (1983) study. Gottlieb et al. (1994) found managerial care was related to caregivers feeling that their family responsibilities interfered with work, and speculated that this was due, in part, to the fact that formal service agencies must be contacted during the day, that is, during hours in which employed caregivers are at the workplace.

Combining caregiving and paid employment often has job-related costs. These include absenteeism (Neal et al., 1993: 131; Martin Matthews and Rosenthal, 1993), altering or reducing work schedules (Neal et al., 1993: 127; Pavalko and Artis, 1997), and turning down opportunities such as those related to training, promotions or new positions (Martin Matthews and Rosenthal, 1993; Scharlach and Boyd, 1989). The extent to which

managerial care is associated with these job costs is not known.

In this paper, we view informal care management as a type of caregiving that may include but is by no means limited to the managing of formal services. This is in keeping with James' (1992) term, "organizational or managerial labour," which we suggest might include all aspects of care that do not include direct, hands-on services or emotional support. Coordination of care may include care-related discussions and negotiations with other family members or the care recipient, dealing with fiinancial matters, doing relevant paperwork, and seeking information. In this paper, we adopt Archbold's (1983) terminology. The term "caregiving" denotes providing help to an older relative, without specifying the type of help provided. The term "care-provider" is used to refer to a caregiver who provides help with ADL/IADL. The term "care-manager" is used to refer to a caregiver who provides help that is not "hands on" or direct care. Given the greater likelihood that employed persons will use formal services than persons who are not employed in paid labour (Stoller, 1989), and that using formal services is usually thought to comprise an aspect of care management, we focus on a sample of employed persons.

RESEARCH QUESTIONS

1. Is there empirical evidence which supports the validity of care management as a construct distinct from care provision?
2. How common is it for employed adults to perform managerial care activities for older relatives, and is the provision of managerial care patterned by gender?

3. Are people either care-managers or care-providers, or do they typically combine these two types of care?
4. How do men and women who provide only managerial care differ from persons who provide other types of care in terms of: income, occupation, geographical proximity to older relatives, amount of care provided, sibling availability, being the primary caregiver, and being the sole caregiver?
5. What is the relationship between managerial care and adverse outcomes (stress, work-family conflict, personal and job costs) and does this relationship vary by gender?

METHODS

Design:

The data for this study are drawn from the Work and Family Survey conducted by the Work and Eldercare Research Group of CARNET: The Canadian Aging Research Network. The survey was conducted in nine Canadian organizations representing five employment sectors (government agencies, financial services, manufacturing, health services, and educational institutions). Four of the organizations were public sector employers, the remainder were private sector.

In six of the organizations, the sample was restricted to employees over the age of 35, whereas no age restrictions were placed on the sample in the remaining three organizations. We chose to over-sample this older age group in order to optimize the likelihood of identifying employees who were helping older relatives.

Of the 10,219 surveys distributed, 5496 usable surveys were returned, yielding an

overall response rate of 54%, which compares favourably with the overall response rates obtained in other large dependent care surveys of employees. For example, Scharlach et al. (1991) obtained a response rate of 52%, while Neal et al. (1993:37) obtained a 34% response rate. In our study, response rates vary widely by organization, ranging from 23% to 73%. This is a function of a number of different factors, including the importance assigned to the subject by the organization, as reflected in the cover letter written by the employer, the method of distribution, whether or not permission was granted to complete the survey on company time, the company's adherence to the plan for issuing reminder notices, the length of the survey (14 pages), and the respondent's personal interest in the survey's subject matter. (For further information on the study and the relationship of its major findings to the literature on work and elder care, see Martin Matthews and Rosenthal, 1993).

Sample:

In this paper, we focus only on persons who are employed full-time (n=4695). From this group, we drew a sub-sample consisting of persons who, in the past 6 months, had provided help to an elderly relative with at least one ADL or two IADLs or two managerial care activities (see measures section). This yielded a sub-sample of 1068 women and 805 men who may be considered to be caregivers (although we hasten to note that this is a very liberal definition of caregiving). Table 1 presents sociodemographic information for this sub-sample and compares the sub-sample with the remainder of the sample of full-time employees. T-tests indicated no significant differences between the two samples in

terms of gender. Differences were found, however, on occupation (as indicated by chi square), age, education, and income. The sub-sample was significantly older, with a mean age of 44 compared to 43 in the remainder of the sample. The sub-sample had more education, higher income, and higher levels of occupational prestige.

-- Table 1 about here --

Measures:

Type of care: In this paper, we distinguish between two types of caregivers, “care-providers” and “care-managers,” based on the type of care provided. The survey asked employees to rate the frequency with which they provided 18 kinds of assistance to a relative aged 65 or older during the prior 6 months. The 6-point Likert-type response scale ranged from "never" to "daily". Specifically, they were asked..."how often have you done each of the following for your older relative(s) during the past 6 months, because of their age or health"? Twelve items referred to direct care provision. Of these, five items asked about helping with Activities of Daily Living (dressing, personal hygiene, toileting, eating, medication use), and seven asked about Instrumental Activities of Daily Living (laundry, transportation, home maintenance, meal preparation, shopping, household chores, mobility inside and outside the home). The checklist also included three items that we categorize as care management activities: assisting with money management, completing forms, and providing financial assistance. Following all these questions, individuals were asked how many hours per week, on average, they had spent helping their elderly relative during the last six months. As well, respondents were asked whether they had done any of the following in the past 6 months "to meet or prepare for any of your older relative's need for

care": looked into places that provide long term care, sought information about community services for seniors, put money aside to help meet the needs of an older relative, discussed care arrangements with an older relative, discussed care arrangements with other family members, or arranged for an older relative to receive in-home nursing, meals, homemaking or other services. These six items, along with the three noted above, were considered to be managerial care activities.

Adverse Outcomes: In the analysis, we examine the relationship between type of care provided and personal opportunity costs, job opportunity costs, work-family conflict and stress.

Personal opportunity costs were measured by a series of items which asked respondents whether, in the past 6 months, their family responsibilities had caused them to reduce the amount of time they devoted to: volunteer work; leisure activities; socializing with friends; continuing education classes; sleeping/resting. The response format was dichotomous; individuals could reply in the affirmative or the negative. Responses were summed to create an index ranging from 0 to 5, reflecting the total number of personal opportunity costs (Cronbach's alpha = .87). (For further information on this measure, see Gottlieb et al., 1994)

Job opportunity costs were measured by asking respondents whether, in the past 6 months, their responsibilities outside work had caused them to miss meetings or training sessions, decline business travel, extra projects, or promotions, or to be unable to attend job-related social events that were scheduled outside regular work hours. A dichotomous response format was used for these items as well, and an index was created in the same

manner as for the personal opportunity costs (Cronbach's alpha =.62). (For further information on this measure, see Gottlieb et al., 19ADD).

Work-family conflict: Following Gutek, Searle and Klepa (1991), a 4-item scale was used to measure Work Interference with Family (Cronbach's alpha =.81) and Family Interference with Work (Cronbach's alpha = .79), rather than a single scale measuring work-family conflict. Each construct taps time restriction, fatigue, mental preoccupation, and the quality of involvement caused by the demands of the other role. For example, the time restriction item in the Work Interference with Family (WIF) Scale states that: "My job prevents me from spending as much time as I would like with family members", while the reciprocal item in the Family Interference with Work (FIW) scale states that: "My family responsibilities take up time that I'd like to spend working on my job". A four-point Likert-type response format reflecting strength of agreement/disagreement was used, yielding scores that range from 4-16. In this paper, we make use of the FIW but not the WIF scale.

Stress was measured through Cohen and Williamson's (1988) Perceived Stress Scale, a 14-item global measure of perceived stress that has been widely used in field surveys. Items are rated on a 5-point Likert-type response format, ranging from "never" to "very often", yielding scores between 0 and 56. The authors offer evidence for the validity and reliability of the scale. In the current study, the scale demonstrated adequate internal consistency (Cronbach's alpha=.83).

Sole caregiver: Respondents were asked whether other family members regularly help care for their older relative. Responses were yes/no.

Primary caregiver: Respondents were asked whether they were the person who is most

responsible for the care of their older relative? Responses were yes/no.

Occupation: Respondents were asked to describe the kind of work they did. Answers were coded into occupational categories and then ranked according to socio-economic status (Pineo, 1985). In the analysis, these rankings are collapsed into three categories: managerial/professional; semi-professional; and clerical, sales, service, crafts and trades occupations.

Distance from older relative: Respondents were asked how long it usually takes to travel from their home to the older relative's residence. Time was coded in minutes. Those sharing a household with the relative were coded "0".

Full-time employment status: Respondents were asked how many hours they worked each week. Those who said they worked 35 hours or more were coded as working full-time.

Analysis:

To answer the first research question, principal components analysis is used. The second research question is addressed by examining frequency distributions for managerial care activities. The third research question is answered by grouping respondents into three categories based on whether they provide managerial care only, managerial care plus ADL/IADL care, or ADL/IADL care only. The fourth research question is addressed through the use analysis of variance, chi square and t-tests. Finally, the fifth research question is addressed using analysis of variance to examine differences among the three care groups and multiple regression analysis to examine the relationship between managerial care and negative outcomes. Throughout the analysis, gender

differences are examined.

RESULTS

Are care management and care provision distinct constructs?

To investigate the validity of care management as a construct distinct from care provision, a principal components analysing, using the entire sample of full-time employees, was conducted on all 21 items that comprise the caregiving tasks. This yielded 6 factors, one denoting help with ADLs, two denoting help with IADLs, and three denoting help with care management. The ADL factor consisted of 5 items and had an alpha of .80. Of the two IADL factors, one referred to mobility (transportation, shopping, getting around inside or outside the home) and one to domestic chores (chores, home maintenance and yard work, preparing meals, doing laundry). The 7-item IADL scale had an alpha of .85. The 9 managerial items taken together had an alpha of .83. The managerial factors consisted of: (1) orchestrating care (5 items -- looking into places that provide long term care, seeking information about services, discussing care arrangements with the older relative, discussing care arrangements with other family members, arranging for a relative to receive services; alpha .82); (2) financial and bureaucratic management (2 items -- managing money, completing forms and documents; alpha .78); (3) financial assistance (2 items -- financial assistance, putting money aside to help an older relative; alpha .62). The factor structure of the managerial items shows that managerial care is not a unidimensional construct but consists, in our data, of three dimensions.

How common is managerial care and is its provision patterned by gender?

Looking first at the entire sample of full-time employees (Table 2), close to one-third of respondents had performed at least one managerial care activity in the past six months. Percentages were very similar for men and women. The most commonly performed activities were managing money and completing forms, followed by discussing care arranging with other family members or with the relative.

Next, we examine the frequency distributions for managerial care activities, among the caregiver sub-sample, comprised of respondents who had performed one ADL care-activity or two IADL or managerial activities in the past 6 months (Table 2). The percentage of respondents doing managerial care rises dramatically to 85% or more. These respondents performed an average of 2.7 managerial activities in the past six months, with no differences between men and women. The most common activity is completing forms; this is done by close to two-thirds of caregivers. Managing money and discussing care arrangements with other family members or with the older relative are also quite common, being reported by one-third or more respondents. It is noteworthy that arranging services is reported by only 11% of men and 14% of women. This is the least common managerial activity among men and the second least common among women. It is important conceptually, then, that managerial care not be equated with arranging for services.

-- Table 2 about here --

Are people either care-providers or care-managers or do the two types of care typically occur together?

To see whether managerial care is typically provided in combination with other types of care or whether it is typically provided alone, we created three mutually exclusive groups of respondents based on the combinations of care they provided: (1) managerial care only; (2) managerial + other (ADL/IADL) care; (3) other care only (Table 3). The majority of caregivers combine managerial care and other care. Relatively small percentages of respondents perform managerial care only, but it is also the case that relatively small percentages of respondents perform other (ADL/IADL) care only.

-- Table 3 about here --

How do men and women who provide only managerial care differ from persons who provide other types of care?

We now focus on respondents who provide only managerial care, to see how their characteristics differ from persons who provide the other two combinations of care. Each gender is examined separately. Comparisons were made using analysis of variance and cross-tabular analysis (Table 4). In presenting these results, we first describe results which were consistent across gender groups. We then present separate results for women and men where findings varied by gender.

For both women and men, the number of hours spent providing care varied significantly among care groups. Those providing managerial care plus other care provided more hours of care per week than did the other two groups. The group providing managerial care only provided the least number of hours of the three groups. Respondents providing managerial care only were more likely to be primary caregiver than those providing

managerial plus other care but less likely to be primary caregiver than those providing other care only. Neither occupation nor having no siblings was significantly associated with the type of care group.

In addition to the above findings, among women, distance was significant in that women providing managerial care only live at a greater distance from their relative than women who provide managerial care in combination with other care. As well, women who provided managerial care only were more likely to be sole caregivers than women providing managerial plus other care, but are not more likely to be sole caregivers than women who provide other care only. No significant association was found for income.

Income was significant for men, in that men who provide managerial care only reported higher income than men who provided other care only. Distance was significant for men, but in a slightly different way than for women; men providing managerial care only live at a significantly greater distance from the older relative than the other two care groups. Men who provided managerial care only were less likely to be sole caregivers than men providing other care only, but appear equally likely to be sole caregivers as men providing managerial plus other care.

-- Table 4 about here --

What is the relationship between managerial care and adverse outcomes?

-- Table 5 about here --

Table 5 presents results for analyses of variance for the three care groups, conducted in order to examine the relationship between typeof care and adverse outcomes.

Reference will also be made to Table 4, since some characteristics examined there need to be taken into account when examining the outcomes of interest in this section.

As was seen in Table 4, amongst men, those providing a combination of managerial and other care provided the highest number of hours of care per week, and those providing managerial care only, the lowest. Nevertheless, it is the men who provide managerial care only who report the highest level of job costs (Table 5). However, the mean scores on the measure of job costs were extremely low, suggesting that this difference is not substantively important.

Amongst women as well, those providing managerial and other care provide the highest number of hours of care per week, and those providing managerial care only, the lowest (Table 5). Indeed, the perception that family responsibilities interfere with work is highest for this group of women, as are personal costs. There were no differences among groups in reported job costs.

It is noteworthy that for both men and women there are no differences among groups in reported levels of stress.

To examine whether managerial care is related to adverse outcomes, after controlling for other types of care, we conducted multiple hierarchical regression analyses for men and women (Table 6). In the regression analyses, the two IADL factors are summed to provide a single measure.

-- Table 6 about here --

In the first set of regressions, the managerial factors are treated as a single measure, in order to draw comparisons to the other types of care. Table 6 shows that managerial

care as a single construct is significantly related to stress, job costs, and personal costs for women. It is not related to stress among men, but is related to job and personal costs.

In the second set of regressions, the managerial factors are treated as separate variables, in order to examine the relationship between each type of managerial care and adverse outcomes. These results are shown as the information set off by indentation near the bottom of Table 6. For women, orchestrating care and managing money and forms are significantly related to stress. For both men and women, of the three types of managerial care, only orchestrating care is significantly related to job costs and personal costs. Therefore, the relationship seen earlier between managerial care and job/personal costs actually reflects the impact of orchestrating care.

DISCUSSION

In this paper, we explored a number of questions relating to a type of family caregiving which we have termed “managerial care.” We remind the reader that our sample was comprised of individuals who were employed full-time. Our discussion and interpretation of findings, therefore, is limited to this context.

Our analysis shows that managerial care is distinct from other types of care (ADL and IADL). Managerial care is therefore a meaningful construct that denotes a type of care, separate from other types.

We find in our sub-sample of caregivers that there are some people who do only managerial care and some who do only other, direct care, involving help with ADLs and IADLs. Most commonly, however, individuals combine managerial care with other types

of assistance. Archbold (1983) made a valuable contribution in identifying and contrasting the two parent-caring roles of care provision and care management. It must be remembered, however, that she selected her convenience sample to obtain 15 care-providers and 15 care-managers. Obviously, generalizations could not be made from that study, yet there seems to be an implicit assumption in Archbold's discussion that the two types of caregiving occur separately rather than in combination. Based on the frequency distributions in both our samples -- our entire sample and the more restricted caregiver sub-sample -- it may be concluded that most caregivers combine these two types of caregiving.

Managerial care is a very common activity among caregivers, being among the care activities of 85% and 86% of male and female caregivers, respectively. It is important to note, however, that managerial care usually involves aspects of care other than arranging for formal services. This contrasts with Archbold's (1983), Brody's (1990:28) and Seltzer and colleagues' (1987) delineation of the work of care-managers. The broader conceptualization of managerial care used in our study likely contributes to the higher percentages of caregivers whose activities include managerial care than were found in the study by Seltzer and colleagues (1987).

Within managerial care, there are a variety of components that comprise management tasks; therefore care management is multi-dimensional. Our analysis indicates that the three components comprising managerial care are orchestrating care, providing financial assistance, and financial and bureaucratic management. While we had a fairly large number of indicators, there may well be additional indicators which, if used in future

research, would identify other components of managerial care.

Our analysis showed that individuals who provide a combination of managerial and other care spent the highest number of hours providing care, while those who did managerial care only provided the least number of hours of care. However, most people combine types of care and the additional of managerial care to hands-on care increases significantly the amount of time devoted to caregiving.

We were interested in identifying characteristics which distinguished persons who provided managerial care only from those who provided other types of care. Our finding that men who provided managerial care only were distinguished by higher income, compared to men in other groups, is consistent with Archbold's (1983) findings for the women in her sample. Interestingly, we did not find significant income differences for women who provided managerial care only, although the pattern was the same as was found for men.

Greater geographical distance distinguished the managerial care only group, on the whole. This no doubt reflects the fact that the provision of direct, “hands-on” care tends to require a reasonable degree of geographical proximity. Persons providing managerial care only reported the lowest number of hours of care per week. This does not imply that managerial care activities do not require time, but rather that other types of care are more time consuming. The findings regarding the relationship between providing managerial care only and being primary or sole caregiver are interesting. If managerial care consisted primarily of arranging and managing formal services, one might expect to find persons who provide managerial care only to be less likely to be primary caregivers or sole caregivers.

This is because one would expect the primary caregiver to provide a combination of types of care and to be in the best position of those in the caregiving network to co-ordinate care. Since our measure of managerial care went beyond formal services, however, this relationship becomes less expected. In fact, in our data, men and women who provide managerial care only are more likely to be primary caregivers than those who provide a combination of types of care but less likely than those who provide other care only. Women who provide managerial care only are also more likely to be sole caregivers than were women who provided a combination of types of care. Men showed a different pattern, in that men who provided managerial care only were less likely to be sole caregivers than men who provided other care only. The findings regarding sole caregiver and primary caregiver do not support our expectations and are somewhat puzzling. We intend to pursue further multivariate analysis of the characteristics associated with providing managerial care only.

Managerial care has an adverse impact on job costs and personal costs, over and above the impact associated with direct care provision. This is an important finding, indicating that research on the impact of caregiving needs to move beyond the usual focus on assistance with ADLs and IADLs. Managerial care also had an impact on stress among women but not men. Overall, these findings show that managerial care is not a "lesser" form of care that we can ignore because we assume it has little impact on those who provide it. While researchers have not explicitly expressed this attitude, some of the literature implies that care management is not very demanding. Finley (1989), for example, suggests that having external resources such as income from employment confers greater

power in the family and will be translated into doing less caregiving. While this may be true in terms of overall time spent in caregiving, our analysis nonetheless shows that managerial care does have a negative impact and therefore merits attention in its own right.

An important contribution of our study is the examination of the association between the different components of managerial care and negative outcomes. Gottlieb et al. (1994) showed that managerial activities were associated with higher stress, work-family conflict and job costs, but did not distinguish among the different aspects of managerial care. Other research has suggested locating and coordinating formal services is associated with stress (Neal et al., 1993; Stoller and Pugliesi, 1989), but did not examine additional types of managerial care. While managerial care actually consists of three different types of tasks, our analysis shows that the orchestration of care -- which includes both formal services and informal assistance from other family members -- is the aspect of managerial care that is associated with personal costs or job costs. With respect to stress in women respondents, both orchestration and money management contributed to stress, but orchestration was the stronger of the two.

The analysis of variance showed no differences in stress among the three care groups. This finding is important and underlines that providing managerial care only, in the absence of hands-on care, still engenders some stress. This was true for both men and women. This finding suggests managerial care is not necessarily less emotionally difficult than direct care.

The analysis showed the importance of separate examinations of patterns amongst men

and women. Amongst men, there were essentially no differences in outcomes by care group, while for women, care group was related to family interference with work and personal costs. At the same time, it is important to note that we did not find gender differences in the percentage of employed caregivers who provided managerial care. This is consistent with the findings of Neal et al. (1997) and Finley (1992) who suggested managerial care is not structured by gender.

It must be acknowledged that the R-squares are low for all models (ranging from .05 to .10 for the models in which managerial care was significant). Therefore, the impact of managerial care, or indeed any type of care, on the outcome variables should not be over-emphasized. Our purpose, however, has been to highlight managerial care as a distinct type of care activity, and to examine it in relation to other types of care, rather than to identify all the predictors of the adverse outcomes we examined. We also acknowledge that our study is limited in that it focuses on negative outcomes only. There may be positive outcomes as well; however, out data did not permit us to explore this possibility.

CONCLUSION

Our purpose in this paper has been to explore and examine managerial care, an aspect of caregiving that has, for the most part, been neglected in research. Managerial care is distinct from other types of care and is a meaningful construct. Helping with managerial tasks is a very common activity among persons who help older relatives. In contrast to Archbold's (1983) distinction between care-managers and care-providers, we found that

most caregivers in fact combined the two types of care. Care management is multi-dimensional, consisting of orchestrating care, financial and bureaucratic management, and financial assistance. Providing managerial care contributes to stress among women and to personal and job costs for both men and women. Moreover, orchestration of care is the aspect of care management that accounts for these relationships.

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TABLE 1

Differences in Sample Characteristics

Between Sub-Sample and Remainder of Study Sample

	t
Gender	-.80
Age	3.78***
Education	3.61***
Income	4.18***
Occupation[a]	6.32*

[a] for occupation, chi square was used, rather than t-test

* $p < .05$

*** $p < .001$

n caregiver sub-sample = 1873; remainder of study sample = 2875

TABLE 2

MANAGERIAL CARE ACTIVITIES PERFORMED IN PAST SIX MONTHS

PERCENTAGE DISTRIBUTIONS

		Whole Sample		Sub-sample of Caregivers[a]	
		Men	Women	Men	Women
		(n=2007)	(n=2741)	(n=805)	(n=1068)
Managing money		20	16	49	40
Completing forms		28	26	65	63
Regular financial assistance		9	7	20	17
Put money aside		5	5	13	13
Looked into facilities		6	6	16	15
Sought information		10	11	26	29
Discussed care with relative		13	14	33	35
Discussed care with family		17	19	43	48
Arranged services		5	5	11	14
Number of managerial activities	0	62	64	15	14
	1	10	10	16	19
	2+	28	26	70	68

[a] Full-time employees who, in past 6 months, provided assistance with at least one ADL or two IADLS or two managerial tasks.

TABLE 3

PERCENTAGE OF RESPONDENTS IN CAREGIVER SAMPLE

IN THREE TYPES OF CARE GROUPS

Type of Care	Men (n=805) %	Women (n=1068) %
Managerial care only	13	7
Managerial care + other (ADL/IADL) care	72	79
Other care (ADL/IADL)	15	14

TABLE 4

COMPARISON OF CHARACTERISTICS OF THREE TYPES OF CARE GROUPS

A. ANOVAS

	Men			Women		
	Care group[a]	$\bar{X}$	s.d.	Care group	$\bar{X}$	s.d.
Household Income	1	8.9 **[b]	2.7	1	7.6	3.0
	2	7.7	2.8	2	6.9	2.9
	3	8.5	2.8	3	7.4	2.9
Distance from relative (minutes)	1	299.8 ***[c]	682.7	1	122.1 *[d]	201.2
	2	72.2	129.7	2	69.8	287.8
	3	67.7	134.3	3	59.2	148.3
	1	1.5 ***[e]	1.7	1	2.7 ***[f]	6.7
	2	2.7	2.2	2	3.8	5.2
	3	3.9	4.9	3	6.2	7.8
B. CHI SQUARES		%			%	
Occupation % coded "professional"	1	52		1	38	
	2	45		2	30	
	3	52		3	34	
Sole Caregiver % saying no one else helps	1	34 **		1	49 ***	
	2	49		2	50	
	3	32		3	36	
Primary Caregivers % saying give most help	1	79 ***		1	69 ***	
	2	84		2	82	
	3	63		3	55	
Siblings % saying have no siblings	1	10		1	4	
	2	3		2	5	
	3	9		3	6	

TABLE 4 CONTINUED

* P<.05
** p<.01
*** p<.001

[a] Care group 1 = managerial care only
Care group 2 = other care only
Care group 3 = managerial + other care

[b] Group 1 significantly different from group 2 (Scheffe's test)
Group 3 significantly different from group 2 (Scheffe's test)

[c] Group 1 significantly different from groups 2 and 3 (Scheffe's test)

[d] Group 1 significantly different from group 3 (Scheffe's test)

[e] Group 3 significantly different from groups 1 and 2 (Scheffe's test)

[f] Group 3 significantly different from groups 1 and 2 (Scheffe's test)

TABLE 5

TYPE OF CARE, GENDER, & OUTCOMES (ANOVAS)

	Men			Women		
	Care group[a]	$\bar{X}$	s.d.	Care group	$\bar{X}$	s.d.
Stress	1	23.4	6.7	1	25.0	7.3
	2	22.5	6.0	2	24.3	6.6
	3	23.6	6.6	3	25.1	6.5
Family Interference with work	1	7.5	2.0	1	7.4**[b]7.	1.7
	2	7.4	1.7	2	7	1.7
	3	7.7	1.8	3	8.0	1.9
Job Costs	1	.5*[c]	1.0	1	.5	.9
	2	.2	.6	2	.4	.8
	3	.4	.8	3	.5	.8
Personal Costs	1	2.0	2.1	1	2.7*[d]	2.5
	2	1.8	2.0	2	2.3	2.2
	3	2.3	2.1	3	2.8	2.2

* p<.05

** p<.01

[a] Care group 1 = managerial care only
Care group 2 = other care only
Care group 3 = managerial + other care

[b] Group 3 significantly different from group 1 (Scheffe's test)

[c] Group 1 significantly different from group 2 (Scheffe's test)

[d] Group 3 significantly different from group 2 (Scheffe's test)

TABLE 6
HIERARCHICAL REGRESSION ANALYSES FOR STRESS, FAMILY INTERFERENCE WITH WORK, JOB COSTS AND PERSONAL COSTS: STANDARDIZED BETA WEIGHTS (β)

	Men				Women			
	Stress	Family Interference With Work	Job Costs	Personal Costs	Stress	Family Interference With Work	Job Costs	Personal Costs
Primary Caregiver	.02	.04	.03	.07*	.02	.03	.01	.02
Occupation	.04	.04	.08*	.08*	.02	.02	-.09**	.02
Caregiver's Age	-.13***	-.12***	-.15***	-.26***	-.17***	-.11***	-.20***	-.12***
Sole Caregiver	-.07	-.04	-.00	.03	.00***	-.01	.01	.04
Income	.02	.04	.07	-.02	-.13***	-.04	-.07*	.03
Education	-.10*	-.07	-.03	-.03	.02	.05	.09**	.14***
ADL Care	.10*	.07	.08*	.11**	.11***	.14***	.12***	.09**
IADL Care	-.02	-.03	-.01	.03	-.02	.06	-.03	.03
Managerial Care	.07	.07	.11**	.11**	.08**	.07	.14***	.18***
Managerial 3[a]	.03	-	.03	-.05	-.03	.02	.01	.02
Managerial 2	.08	.01	.01	.02	.03**	.03	-.01	.02
Managerial 1	.00	.08	.11**	.15***	.09***	.05	.16***	.19***
R^2	.05	.03	.05	.10	.06	.06	.09	.10

* P<.05
** p<.01
*** p<.001

[a] Managerial 3 = provide/save money
Managerial 2 = manage money/forms
Managerial 1 = orchestrate care

SEDAP RESEARCH PAPERS

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