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Factors Affecting the Preferences for Informal Care of Older Chinese People—Using Social and Health Factors

Zihan Zhang[1], Chieko Kato[2], Yoshiomi Otsuka[2]

[1]Faculty of Information Sciences and Arts, Graduate School, Toyo University, Kawagoe, Japan
[2]Faculty of Information Sciences and Arts, Toyo University, Kawagoe, Japan
Email: s4b102110018@toyo.jp

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Abstract

Introduction/Objectives: The aging of society is leading to significant reforms in long-term care policy and systems in many countries. The demand for informal care has increased significantly at the same time that the demand for care cannot be met by formal care. It is necessary to verify the effect of social and health factors on the informal care preferences of older people. **Methods:** Three hundred Chinese respondents (60 years old and above) were recruited for this quantitative cross-sectional study. The data were analyzed by factor analysis and multiple regression analysis. **Results:** Informal care preferences among older Chinese people were positively correlated with gender, cohabitation, social participation, support from the community, and health status; and negatively correlated with educational background. However, age and family savings were not found to have a significant effect on preferences for informal care among the older Chinese people in this study. **Conclusion:** Understanding the influence of various factors on preferences for informal care among older people can help family members as caregivers to provide more appropriate care.

Keywords

Chinese, Older People, Informal Care, Social Factor, Health Factor, Multiple Regression Analysis

1. Introduction

1.1. Background

Most countries in the world are experiencing growth in the proportion of older people in the population.

Long-term care involves various services designed to meet a person's health or personal care needs during a short or long period. These services help people live as independently and safely as possible when they can no longer perform everyday activities on their own. Long-term care is provided in different places by different caregivers, depending on a person's needs (Kane, 1998). Compared to the formal care provided by a professional caregiver or care facility, informal care is generally defined as the unpaid care provided to older and dependent persons by a person with whom they have a social relationship, such as a spouse, parent, child, other relatives, neighbor, friend or other non-kin (Bom & Stöckel, 2021). Many countries aim to stimulate informal care provision to meet the growing long-term care demand. The duration of long-term care is influenced by factors related to the condition of the older adult receiving care and the condition of the family members or staff providing care, and there is no consistent standard. However, according to results obtained from a 4-year-long continuous observational study, the average duration of informal care, primarily residential at home, is 923 days. The average duration of formal care, primarily residential in a nursing facility, is 59 days (short stay) and 784 days (long stay), about 64% of those receiving short care would move to long stay (Xie et al., 2005).

Although informal care can be a challenging and demanding job that often has a negative impact on the physical and mental health of the family members providing care. For instance, physical strain, emotional stress, sleep disturbances, social isolation, and financial stress due to lack of working time (Lee et al., 2002; Cheng, 2020; Leggett et al., 2020). However, it cannot be denied that informal care also has many benefits, such as building a solid bonding connection between the care receiver (usually the parents) and the caregiver (usually the children) and significant savings in care costs. In general, older people prefer to live at home for as long as possible, even when faced with circumstances that limit their autonomy. Informal care reflects this emergency preference by allowing older people to "age in place" in a familiar setting rather than receiving formal care for chronic health conditions or aging needs in an institutional setting (Mah et al., 2021).

Social factors (or social determinants) generally include, among others, family structure, financial status, education, and social connections. For the older population, it is always defined as the conditions in which older people live, work, and face aging, influencing their health and care demands (World Health Organization, 2020).

China currently has the largest older population in the world. As of 2020, China's elderly population aged 60 (the age defined as "older adults" in China) and above has reached 264 million, accounting for 18.7% of the total population (World Health Organization, 2023). Although many older Asian people would prefer to be cared for by family members, several studies have found that today's Asian older adults value privacy more than ever before and do not want to burden their families (Shi & Hu, 2020). In addition, as society continues to evolve, today's older people also have more financial resources than ever before and are

generally healthier and better educated than their ancestors. These have influenced the type of long-term care they need or choose (Alders et al, 2019). Older people in China prefer to live at home, and adult children have historically been the dominant long-term caregivers in China (Feng et al. 2011). Therefore, the more common form of care in China is family care or seeking the help of a caregiver who can come to the home. According to a national survey, about 85% of older people wanted to live with or near their children to receive informal care when needed, and about 15% wanted to live independently or in a nursing home (Wang et al., 2022).

Older people have been reluctant to go to long-term care facilities, and their children have been less willing to send their parents to long-term care facilities. Some of these reasons may include cultural values, language and cultural barriers, lack of trust, financial concerns, and fear of losing independence (Lee et al., 2002; Low et al., 2007; He et al., 2021). As a result, they may prefer to stay in their own homes where they feel more comfortable and in control.

1.2. Literature Review

Previous studies have demonstrated that preferences for long-term care among older adults are affected by various social factors.

Age, gender (Zhi et al., 2021; Nakanishi, 2014; Mah et al., 2021), and level of social participation (Nishiyama & Iwasaki, 2000; Fujiwara, 2018), which are considered to be linked to physical and mental capabilities, were found to affect the preferences for long-term care. Educational background, which is thought to have a significant impact on perceptions and awareness of care and living arrangements (Mah et al., 2021), was found to affect the preferences for long-term care. Support from the community (Zhi et al., 2021), such as the number of medical and healthcare facilities in the region, and family structure, such as cohabitation (Zhi et al., 2021), which are considered to be linked to the support from others, were also found to affect the preferences for long-term care. Moreover, the financial situation, such as family savings, which primarily measure the financial level of retired older people (Mah et al., 2021; Nakanishi, 2014), was found to affect the preferences for long-term care. In addition, health status (Zhi et al., 2021), which is considered to be linked to the affordability and demand for formal care, was found to affect the preferences for long-term care.

Furthermore, a strong association between social and health factors has also been demonstrated. For instance, differences in wealth, education, occupation, and life circumstances tend to produce large differences in health levels (Institute of Medicine and National Research Council, 2013). Therefore, the influence of social and health factors on the long-term care preferences of older people should be considered and validated more comprehensively.

1.3. Objective and Hypothesis

The objective of this study was to verify the influence of social factors as well as health factors on the long-term care preferences of older people. Based on the rele-

vant previous studies, the hypothesis of this study is age, gender, educational background, cohabitation, social participation, family savings, support from the community, and health status significantly affect the preferences for informal care of older Chinese people. At a time when the development of informal care is increasingly expected, this study would explore older Chinese people's preferences for informal care and bring references for informal care and community care services at home.

2. Method

2.1. Data Collection

Respondents were set to be older than 60 years of age (the age of the Chinese definition of "older adults"), could live independently, and had no experience of receiving long-term care. A balanced set of respondents in terms of gender and geographic location was also identified. We explained the purpose of the study and the composition of the questionnaire to those who wished to be recruited (326 people in total). Ultimately, 300 respondents (150 male and 150 female) completed the questionnaire online (92% return rate).

2.2. Statistical Analysis

Factor analysis was conducted to confirm the reliability of the measurement of participation. Multiple regressions were performed to determine the contributions of independent variables (social and health factors) to the dependent variables (preference for informal care). Statistical significance was defined as $^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$.

2.3. Measurements

The questionnaire included questions about social factors and measurements of preferences for informal care (Watanabe, Karasawa, & Ohtakam, 2011), and social participation (Inoue et al., 2016). The measurements used in this study were translated and re-confirmed by experts, and mocked up separately to ensure appropriate corrections were made. The items are shown in **Table 1**.

2.4. Ethical Considerations

The Research and Ethics Committee of Toyo University approved this study. It did not impose an excessive physical or psychological burden on the respondents. Before data collection, the respondents were informed of the purpose and procedure of the study. They were also assured of their anonymity and confidentiality, protection of personal information data disposal, and freedom to withdraw from the study at any time.

3. Results

3.1. Results of the Descriptive Statistics

Table 2 shows the descriptive statistics of assessment variables. The higher the

mean values, the higher the degrees of the corresponding independent variables for the respondents.

3.2. Factor Analysis and Reliability of Social Participation

To provide a confirmatory analysis of the latent structure of the scales, factor analyses of the measurement of social participation was run on a randomly assigned sample. Results of the factor analysis is displayed in Table 3, where each domain is given factor loadings and communality values. The results show the factor loadings for all items with values at or above 0.40, which means the loadings were very acceptable. Moreover, a Cronbach α-value of 0.87 was accepted to verify the reliability; the cumulative contribution ratio of this factor is 60.25% (Table 3). The results of the factor analysis was consistent with the previous study (Inoue et al., 2016).

3.3. Results of Multiple Regression Analysis

Table 4 summarizes the estimated standard parameters of multiple regression analysis. The results revealed that the model of this study significantly predicted factors influencing the preferences for informal care of older Chinese people. The results of the multiple regression analysis indicated that informal care preferences among older Chinese people were positively correlated with gender ($\beta = 0.211$, $p < 0.001$), negatively correlated with educational background ($\beta = -0.145$, $p = 0.04$), positively correlated with cohabitation ($\beta = 0.512$, $p < 0.001$), positively correlated with 2 factors of social participation (Community contributive activities: $\beta = 0.227$, $p = 0.026$, Self-enlightenment activities: $\beta = 0.211$, $p = 0.031$), positively correlated with support from the community ($\beta = 0.201$, $p = 0.038$), and positively correlated with health status ($\beta = 0.423$, $p < 0.001$). Age

Table 1. Measurements and items.

Measurements	Preferences for informal care
Items	1. I am happy to be taken care of by my family.
	2. I want to be taken care of by people I know.
	*3. I do not want to be taken care of by my family members.
	4. It is desirable to be taken care of by family members.
Measurements	**Social participation**
Items	Refer to Table 3

*Represents a reversed item.

Table 2. Descriptive statistics of assessment variables (n = 300).

Variables	Min.	Max.	Mean	SD
Preferences for informal care	4	16	10.15	2.51
Social participation	6	18	13.14	2.74

Table 3. Factor Analysis of Social Participation (Maximum Likelihood Method and Promax Rotation).

Social participation(L) (α = 0.87)				
		Factor loading		
		Factor1	Factor2	Communality
Factor1 [Community contributive activities] (L) (α = 0.82, Cumulative contribution ratio = 39.77%)				
5	Activities related to community development such as environmental beautification. (O)	0.765	0.021	0.732
1	Activities related to traffic safety and crime prevention. (O)	0.723	0.043	0.521
2	Activities related to support for the elderly. (O)	0.675	−0.052	0.499
Factor2 [Self-enlightenment activities] (L) (α = 0.75, Cumulative contribution ratio = 60.25%)				
6	Meals and tea-talking with people other than those living together. (O)	−0.146	0.833	0.699
4	Physical activities such as gymnastics and sports. (O)	0.153	0.693	0.601
3	Cultural activities such as hobby groups. (O)	0.272	0624	0.488
Factor Correlation		Factor1	Factor2	
Factor1 [Community contributive activities]			0.621	
Factor2 [Self-enlightenment activities]		0.621		

Table 4. Summary of multiple regression of the preferences for informal care (n = 300).

Independent variables	B	SE	t	β	*p*
Age	−0.216	0.331	−0.81	−0.054	0.548
Gender	0.332	0.111	3.621	0.211***	0.001
Educational background	0.286	0.147	2.231	−0.145*	0.04
Cohabitation	0.521	0.072	8.546	0.512***	0.001
Community contributive activities (factor 1 of social participation)	0.073	0.029	2.537	0.227*	0.026
Self-enlightenment activities (factor 2 of social participation)	0.062	0.028	2.421	0.211*	0.031
Family savings	0.006	0.132	0.231	0.021	0.771
Support from the community	0.289	0.167	2.423	0.201*	0.038
Health status	0.528	0.054	8.654	0.423***	0.001

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

and family savings were not found to have a significant effect on preferences for informal care among the older Chinese people in this study.

4. Discussion

This study verified the influence of age, gender, social and health factors on the preferences for informal care among older Chinese people.

The results show that older female people have a higher preference and motivation for informal care than older male people in this study. This is generally

consistent with the findings of previous studies. The following considerations about such results have been discussed in previous studies. Firstly, combined with the characteristics of Chinese people, in the traditional Chinese culture, men are mainly responsible for work outside the home, and women are mainly responsible for things inside the home. Therefore, women are more likely to have a closer and more robust connection to the family than men (Zhi et al., 2021). Secondly, men tend to be more independent and receptive to the outside world than women, and women have a greater sense of security and dependence on their families (Nakanishi, 2014). In addition, in China, older women who are physically and mentally healthier often have to help their children take care of their grandchildren. Older women often still have a sense of responsibility and prefer to live at home when they can choose to do so. Therefore, the findings of higher preference for informal care among older females than older males in this study are consistent with previous studies and the cultural and traditional characteristics of China.

Among the respondents in this study, the preference for informal care was also lower among those older people with better educational backgrounds. Older people with better educational backgrounds are more receptive to new things other than traditional ideas and are less likely to insist that their children take care of them, but have more open-minded ideas (Zhi et al., 2021); At the same time, older people with better educational backgrounds tend to have high aspirations for spiritual life, and living at home, although comfortable, lacks variety. In a nursing home, they can meet different people and experience a more diverse life, which may be what they are looking forward to.

In this study, older people with more cohabitants were more motivated by informal care than those with fewer cohabitants or those living alone. This is consistent with the general perception that having (more) cohabitants tends to mean stronger family relationships and more stable access to long-term care, which makes older people more expectant of home-based informal care. In addition, older people living alone often can not receive timely and practical assistance in the event of a health condition, which increases their desire and demand for formal care.

Respondents with better health status were found to have higher motivation to receive informal care. For example, Zhi et al. (2021) analyzed the "frequency of medical consultations in the past month" as a measure of the health of older people and showed that those who had not seen a doctor in the past month were more likely to prefer informal care. In addition, when older people perceived themselves as healthier, they had less need for professional nursing care and were more inclined to stay with their families. Similarly, older people with access to more community support were more likely to choose informal care. In this study, "support from the community" means having more access to help with health and care in the area where they live. Examples include community health counseling, nursing training, the number of clinics, and medical support services. The more abundant this wide range of support is, the more comfortable older

people can remain living at home and therefore have a higher propensity to use informal care (Zhi et al., 2021).

In this study, the preference for informal care was also higher among older people with higher levels of social participation. According to the results of the factor analysis of social participation, the two factors of community contributive activities and self-enlightenment activities can represent different aspects of social participation in this study. The results of their multiple regression analysis also showed consistency. This is mainly because of two reasons: 1) Older people with higher levels of social participation tend to have better physical and mental health (Hyyppä & Mäki, 2003; Amoah, 2018), and this positive effect increases with age (Lee et al., 2008), and according to the results of this study, better level of health can increase their confidence to continue living at home and reduce their need for formal care; 2) The social participation of older people is mainly centered around activities in their own community, and higher social participation also enhances the connection between older people and their community, which can also increase their preference for informal care. Although social participation decreases significantly with age, the impact of social participation on health status increases with age. Social participation as a social characteristic of individuals is essential for health in all age groups. Although the impact of social participation varies by age and gender, social participation should be a fundamental consideration in the field of community care interventions. Promoting the social participation of individuals may lead to better health and, therefore, may be an effective strategy for health promotion (Lee et al., 2008).

However, in this study, age and family savings were not found to significantly affect the preferences for long-term care among older Chinese people. The respondents in this study were all over 60 years old. However, due to difficulties in recruiting the respondents, there needed to be a balance in age grouping, and there were fewer respondents over 75 years old, so the level of significant differences could not be found. This is also the limitation of this study.

Regarding the effect of family savings on preferences for long-term care, previous studies have also not shown consistent results. The use of professional formal care services often requires more financial support, especially in China, where care insurance for seniors is lacking, and full self-payment is still the predominant approach. Even in Japan, where nursing care insurance is more developed, it is also not easy to financially receive professional services in a nursing care facility (Yamato, 2008; Tanimura, 2013). Zhi et al. (2021) also suggests that older people with better family finances have higher spiritual aspirations and are more eager to receive recognition from those around them, such as interacting with others in a nursing care facility, while conversely, older people with worse finances are more attached to the traditional concept that the elderly should be cared for by their children.

However, due to the reciprocal relationship between older parents and children (children providing long-term care and parents providing financial support to their children, including inheritance), there are also previous studies that sug-

gest that older people with better financial situations are more dependent on informal care from family members (Fujisaki, 2000; Kobayashi, 2007).

5. Conclusion

This study verified the influence of some social and health factors on the informal care preferences of older adults. Although the study was conducted with older Chinese people, it has high reference significance for other East Asian countries or regions. Understanding the influence of various factors on preferences for informal care among older people can help family members as caregivers to provide more appropriate care. Also, as an effective complement to informal care, community services should pay attention to the relevant background of older people, and community nurses need to provide more effective assistance.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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