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EXPLORING THE CHANGING RELATIONSHIP
BETWEEN FORMAL CARERS, INFORMAL CARERS AND CAREES
DURING THE ELDER-CARE PROCESS

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by
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ABSTRACT

Exploring the Changing Relationship between Formal Carers, Informal Carers
and Carees during the Elder-Care Process

by

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Master of Philosophy

There are increasing studies looking at effects of caregiving to the frail elderly in Hong Kong. However, many studies often focus only on a single dimension of caregiving in either informal or formal carers without the focus on the elderly that receiving cares. Few studies have viewed elder caregiving as an integrative and dynamic approach, with limited examination and exploration on the caring processes and interactions between the formal and informal carers and elderly carees, and the reasons for this pattern.

Thus a caregiving triad might be considered as consisting of the elderly caree, the formal and informal carer, and a tripartite model could be adopted to explore the interactions and interrelationship between the three parties.

The present research aimed to explore the changing caring relationships among carers and carees in home-based setting; the meanings behind the different caring patterns amongst the formal informal carers as well as the elderly carees and; to provide suggestions and implications for providing better care services for elderly recipients in home-based setting.

The methods used in the present study are mainly qualitative in approach, with in-depth interviews and focus group discussion. In order to ensure the credibility of the research, triangulation of various data sources is used to provide fuller picture and understanding of the research findings.

Since this is an exploratory study, a small sample was used (N=18). In order to get a deeper understanding of the caregiving process and patterns, in-depth interviews with elderly people, their family caregivers and the formal caregivers were conducted in this study. The interviews were guided by a theoretical framework with interview

guidelines. Thematic analysis was used to explore the caring relationships and pattern.

A total of 6 cases with 18 people (6 elderly people, 6 family caregivers and 6 formal caregivers) were successfully interviewed from June to September 2003.

The present study found that between the informal and formal carers, substituting and complementing effect are the most obvious through the interaction pattern. The substituting effect mainly comes from the perception of quality services by the informal carers and they think that professional and advanced care services are better to be provided by formal carers.

Regarding the complementing effect, it is found that sharing of tasks between the formal and informal carers are common through the research. Informal carers might share tasks to formal carers when they did not have time to do. Tangible supports are more often supported by formal carers and both formal and informal carers would provide intangible support.

On the side of carers and carees, both formal and informal carers are found to interact in a form of reciprocal and obligation. The continuation of care of informal carers is mainly due to the martial relationship and filial piety. The caring meanings of formal carers are varies, including the economic reward, gratification and job satisfaction and also the caring can benefit their personal growth and development.

The findings shed some light on the roles played by the three parties. It was necessary for all parties to cooperate in striving for the best quality of care. Hence more information of the perceived roles and expectations among the three parties should be further explored in order to get the optimal caring patterns. Since the optimum form of the caring relationships depends very much on the community resources available and also on the values upheld by the three parties, to achieve the greatest satisfaction of them and enhancing their quality of life, it is advisable to conduct further study on their expectations towards the caring tasks, process, and relationship while advocating their empowerment in the continuum of care.

I declare that this is an original work based primarily on my own research, and I warrant that all citations of previous research, published or unpublished, have been duly acknowledged.

HUNG Sing Nam
2004

CERTIFICATE OF APPROVAL OF THESIS

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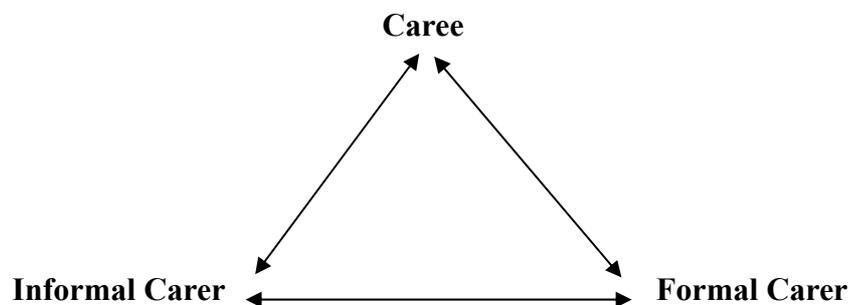
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Chapter One: Introduction

This thesis is a case study on the changing relationships, between the three parties directly involved in elder care process in Hong Kong. The three parties are the care-receiver (the older person; caree), the informal caregiver (the family caregiver; informal carer), and the formal caregiver (the caregiver from formal agency; formal carer).

There are an increasing amount of studies focusing on the effects of caregiving to the elderly in Hong Kong. However, many studies focus only on a single dimension of caregiving, either informal or formal. They often overlook the elderly, who receive the care. Few studies have used an integrative and dynamic approach in studying elder caregiving. Most are limited in their exploration of the caring processes, the interactions between formal and informal caregivers, the elderly care-receivers, and the reasons for this pattern.

A caregiving triad consists of the elderly receiving the care, the formal and the informal caregivers. A tripartite model could be adopted to explore the interactions and interrelationship between the three parties (see the following graph).



The goal of the present research is to explore the changing relationships among caregivers and those receiving care in a home-based setting; the meanings behind the different caring patterns amongst the formal informal caregivers as well as the elderly receiving care and; to provide suggestions and implications for providing better care services for elderly recipients in a home-based setting.

The methods used in the present study are mainly qualitative in nature, with in-depth interviews and focus group discussions. In order to ensure the credibility of the research, triangulation of various data sources is used to provide a fuller picture and understanding of the research findings.

Since this is an exploratory study, a small sample was used (N=18). In order to get a deeper understanding of the caregiving process and patterns, in-depth interviews were conducted with elderly people, the family who cared for them and the formal caregivers. A theoretical framework guided the interviews. Thematic analysis was used to explore the caring relationships and patterns.

A total of 6 cases with 18 people (6 elderly people, 6 family caregivers and 6 formal caregivers) were successfully interviewed between June and September 2003.

The present study found that substituting and complementing effects are the most obvious interaction patterns between informal and formal caregivers. The substituting effect derives from the informal caregiver's perception that professional and advanced care services provide higher quality care.

Regarding the complementing effect, it was found that sharing elder care tasks between formal and informal caregivers was common. Informal caregivers might share tasks with formal caregivers when they did not have time to do. Tangible support is more often given by formal caregivers and both formal and informal caregivers provide intangible support.

On the side of caregivers and care-receivers, both formal and informal caregivers interact in a form of reciprocity and obligation. The continuation of care by informal caregivers is mainly due to martial relationships and filial piety. People become formal caregivers for economic reward, gratification job satisfaction and personal growth and development.

The findings shed some light on the roles played by the three parties. All parties must cooperate in order to achieve the best care. Hence the perceived roles and expectations among the three parties should be further explored in order to find the optimal caring pattern. The optimum form of caring relationships depends on community resources and the values held by the three parties. To achieve the greatest satisfaction and quality of life, it is advisable to conduct further study on the three parties' expectations towards caring tasks, processes, and relationships in the continuum of care as well as on advocating for their social awareness, empowerment and for macro environmental improvement.

1.1 Background and rationale

Facing the ageing population and the increasing elder care service needs in Hong Kong, "Care in the community" has been the official policy since the 1973 White Paper. This advocating policy was embodied as a service provision in 1991 by the

Hong Kong government. The policy states that an elderly person should receive assistance to live in one's own community with dignity and a spectrum of services should be provided in and by the community to facilitate continued participation in society.

In order to spread out the responsibilities in the community, the sharing of duties between the formal caregiver (e.g., the state, paid caregivers) and the informal caregiver (e.g., the family, unpaid caregivers) is necessary to examine. In traditional Chinese culture, care was provided by one's family members especially the younger ones.

A study showed that based on the notion of filial piety, a network of relationships is thus established with distinct entitlements and obligations. It is of course rather difficult to ascertain the extent to which these entitlements and obligations still exist in Hong Kong nowadays, however, evidence indicates that it is still very much valued (Lau et al., 1991).

Though with the advancement of Hong Kong society in the 21st century, there exist a number of practical factors which makes it more difficult for family to be the main care provider. Firstly, many families are split because of migrant work and social reasons, i.e. bereavement or divorce. Secondly, family sizes are decreasing, thus reducing the numbers of children who can share the social and economic responsibilities of elder care. Thirdly, housing space is at a premium. Fourthly, economic circumstances and social choice mean that more women, the traditional caregivers for elderly parents or parents-in-law, are working and are not available as constant free caregivers. Last but not least, many older persons prefer more

independent living, i.e. living near but not with their children and grandchildren (Phillips and Chan, 2002). These result in the unavailability of informal caregivers.

To balance this deficit the government must provide increasing support for the elderly who formerly received care from their family. Or the elderly must become more self-reliant --- paradoxically it is the self care ability that is deteriorating. Unless there is sustained support for family caregivers, there might be an even sharper decline in informal care resulting in total withdrawal and totally dependence on the government.

It is expected that intervention from formal caregivers could ease the burden on informal caregivers and that informal care would still continue. Moreover with the inception of formal caregivers, the role specified for formal and informal caregivers has resulted in a division of labor.

Therefore it is important to examine the changing relationship between the formal, informal caregivers and care-receivers and how such changing relationships create implications for the future direction of home-based elderly services. The current research addresses and explores this tripartite relationship from a grounded theory approach, in which qualitative research methodologies with in-depth interviews are used.

1.2 The trend of demographic ageing and the elder care policy in Hong Kong

Hong Kong has been experiencing demographic ageing, an increasing elderly population and prolonged life expectancy. The demographic ageing in Hong Kong's population became noticeable in the early 1970s, constituting from 4.5% to 6.6% of

the total population (Phillips, 1988, 1992). It is projected that the elderly population will increase from 12% in 2004 to 24% in 2031 (Census and Statistics Department of Hong Kong, 2002). Like many other countries in the region, Hong Kong's rapidly growing elderly population, as well as advances in lifestyle, environmental and health provisions, have lengthened life expectancy and thus increased the size of the "dependent" population. This creates a need for reviewing the whole range of public services provided for the elderly, in particular the substantiality of the Long-term Care (LTC) policies in Hong Kong.

As in many western countries, long-term care in Hong Kong generally developed along two main streams: residential care and community-based care. Under the initiatives for "ageing in place" and "community care", older people in Hong Kong are encouraged to live in their homes for as long as possible with assistance from community support services as needed (Chan & Phillips, 2002). This created a need for good quality care for the elderly residing in their homes.

Residential care for the elderly subsidized by the Hong Kong Government can be classified according to the nature and level of care it provides – ranging from self-caring hostels, retirement homes (old people's homes), care and attention homes, nursing homes and infirmaries which provide the highest level of care. Another prominent feature of residential care is the sharp increase in the number of private homes for the elderly. As recently as 1981, there were as few as seven private homes for the elderly in Hong Kong. This number increased to 73 in 1986 and dramatically increased to over 500 in 2002. These homes provide for over half of the total residential care population (Chan & Phillips, 2002).

There are different types of community-based services including; district multi services centres, day-care centres, home-care service teams, caregivers' support centers, day-care centres for older persons suffering from dementia and day respite services. In addition, three innovative measures have been taken to improve the existing system of long-term care in terms of achieving the "care in community", including the standardized care need assessment mechanism for elderly services, a pilot project based on the continuum of care and enhanced home and community care service (EHCCS).

The priority of the government's policy is to encourage the elderly to reside in their homes as long as possible and to reduce their admission to institutional care. Moreover, home-based care is deemed to be more favorable in maintaining both the physical and psychological well-being of older people(Chan & Phillips, 2002).

1.3 Health Profile of older people in Hong Kong

Older people are in fact not necessarily frail, depressed or troublesome and definitely should not be regarded as a burden to society. The government has been promoting the concept of positive ageing for a healthy life for elderly people (Report on healthy ageing, elderly commission, HKSAR, 2001). Healthier elderly people can participate and enjoy activities that enriching their life context and make their old age worth living. It is expected that older people in the future will be wealthier and healthier than current elderly.

A welfare policy objective highlighted by the Chief Executive of the Hong Kong Special Administrative Region of China (HKSAR) in the 2001 policy address was for the future direction of elderly care and services to improve the quality of life of

older persons, ensuring that they will continue to enjoy a sense of security, belonging, good health and a feeling of worthiness. The report on healthy ageing by the Elderly Commission suggested that promoting physical well-being alone is not enough for older people and therefore a number of ways to enhance their psychological well-being are necessary (Elderly Commission, 2001).

However, besides the healthier part of elderly people, this ageing trend is always accompanied with an increased disability and a terminal dependency, resulting in an increasing demand for institutional long term care and a cost implication in caring providence. As noted by Chu & Pei (1997), there is a high prevalence of physical disability in Hong Kong's elderly population. According to their study, 13% of elderly people live in a community, while 21% of male and 48% of female elderly people live in institutions, indicating a significant limitation in Activities of Daily Living (ADL). Strokes (40.2%), dementia (27%), proximal femoral fractures (7.4%) and Parkinson's disease (5.9%) are the four most frequent severe illnesses, which lower the mobility of elderly and increase the need of caring services, which consume at least 30-40% of our public health funds (Chu & Pei, 1997).

Besides this report, a survey conducted by HOPE Worldwide and Asia-Pacific Institute of Ageing Studies (APIAS) at Lingnan University, aimed at exploring the health profiles and compiling a general health description of elderly people who live in the public housing estates in eight districts. It mainly covers the areas of prevalent illnesses amongst elderly people in Hong Kong.

As for the prevalent illnesses over the eight districts, the top three were hypertension (N=142, 28.8%), arthritis (N=85, 17.4%) and diabetic mellitus (N=55, 10.8%). From

these survey findings, it appears that current medical and social care services for the elderly people may not meet the demand for those with arthritis. From the perspective of social service providers, volunteers can educate the elderly on general energy conservation strategies in their daily living as well as referring them to domiciliary, physical or occupational therapists for home adaptation. Moreover, it is also revealed that the home-based care should be further expanded to meet the demands of the older people in Hong Kong.

1.4 The dynamics and functions of formal and informal care to older persons in Hong Kong

With the high prevalence of immobility among the ageing population, family members play an important role in caregiving, which might cause them to feel burdened and overstressed in many situation (Chiriboga et al., 1990; Stoller & Pugliesi, 1989; Poulshock & Deimling, 1984; Clipp & George, 1990; George, 1987; Ngan, 1990). In view of this, the need for formal caregivers (trained workers) to provide more professional care to the elderly recipients as well as releasing the burden from the informal caregivers is increasing. However, the relationships between formal and informal caregivers have never been clearly identified in the context of Hong Kong in previous literature.

In Chinese society there is a social responsibility and obligation to take care of respective older adults, however, taking care of the elderly and also working in a fast paced society is stressful. This strain creates family conflict, elderly abuse and / or institutionalisation of older persons. It results in a significant social cost. To strike a balance, policies on formal caring have been carried out to support the elderly who live at home, since this is the preferred choice of the elderly and it fits into the

government's policy for 'community care' or 'aging in place' (Policy Address since 1997). However, such orientations generate different caring relationships that affect the quality of care of older persons by different interaction patterns.

Only a few comprehensive studies have focused on the different caring dynamics and meanings. Among the caregiving studies (Chiriboga et al., 1990; Stoller & Pugliesi, 1989; Poulshock & Deimling, 1984; Clipp & George, 1990; George, 1987; Ngan, 1990), caring involvement, informal network, use of formal services, opinion towards informal and formal support, psychological well-being, general mental health and stresses in caregiving, caring tasks, etc., are the general investigations. These studies focused on either informal or formal caregivers, only providing snapshots of caring, and have paid considerably less attention to explanations. As a result, there is a need for more investigation on the interfaces of caring for the elderly within the whole caring process by looking at the caring activities, relationships between caregivers and care-receivers, and the result of caring patterns and their meanings.

In the caring process, there are different caring dynamics between caregivers and care-receivers that affect the quality of care. For care-receivers, there is significant literature that shows that elders prefer to be cared for by their family mainly due to psychological comfort, but they tend to be more confident when professional care is given (Phillips & Chan, 2002a; Cohen et al., 2002; Chan et al., 2003; Kwan et al., 2003). Obviously, no total replacement exists between formal and informal caregivers in the caring process.

Formal caring is not simply used, as a *substitute* for informal care; instead there

might be a **complementing** and / or a **supplementing** relationship between the two. Caregiving can be a stressful and burdensome experience generating a dilemma between care responsibility and stress on the family caregivers. Meanwhile, the formal caregiver always plays an important role in offering professional care for older people, but they tend to be task-oriented and may pay less attention to the psychological status of the elderly due to the high level of demands (skills, knowledge, coping, added-valued etc.) of caring work. These dynamics formulate various interaction patterns among older persons, formal and informal caregivers

With reference to the study conducted by Olsson (2001), **substituting, complementing and supplementing** are the three distinguished forms of caring patterns between formal and informal caring. These forms of caring patterns can be interpreted as: (1) **substituting** is a situation where the formal services care is so good that family caregiver is pleased to have their responsibilities fully taken up by the formal caregiver, (2) **complementing** is where formal and informal caregivers work together complementing each other's work, and (3) **supplementing** is to encourage the family caregiver to still be responsible for the bulk of the care, with the formal caregiver serving as a helper. All these caring dynamics and interaction patterns affect the quality of care of the older persons.

However, the above interaction patterns are much related to the caring meaning (Chan et al., 2003). Some local research has found that the meanings of care are negative in terms of stress and burden (Ngan & Cheng, 1999) and positive in terms of task fulfilment in the reciprocal relationship reinforced by appreciation (Phillips & Chan, 2002a; Cohen et al., 2002; Chan et al., 2003; Kwan et al., 2003). Just how these caregivers and care-receivers interpret the tripartite relationships (i.e. between

informal-formal caregiver, informal caregiver/care-receiver, and formal caregiver/care-receiver) will significantly affect the conduct of their tasks.

1.5 Aims of the research

Current literature mainly focuses on a single dimension of caregiving, either informal or formal caregivers and also without looking at the elderly receiving the care. Few studies have viewed caring as an integrative and dynamic approach, with limited examination and exploration on the caring processes and interactions between the caregivers and care-receivers and the reasons for this pattern. Therefore, the present research aim is to achieve the following three objectives:

1. To explore the changing caring relationships among caregivers (formal and informal) and care-receivers in home-based setting,
2. The meanings behind the different caring patterns amongst the formal and informal caregivers as well as the elderly recipients, and;
3. To provide suggestions and implications for providing better care services for elderly recipients in a home-based setting.

1.6 Organization of thesis

Chapter One introduces the rationale of the current study, the trend of demographic ageing, the elderly care policy in Hong Kong, the health profile of the elderly in Hong Kong, the dynamics and function of formal and informal care to older persons in Hong Kong, the aims of the research as well as the organization of the thesis.

Chapter Two gives a literature review, focusing on the meaning of caregiving, the importance of community care for older people in Hong Kong, the role and relationship of formal and informal caregivers towards the elders and the interfaces

between formal and informal caregivers. *Chapter Three* gives the conceptualization framework for the existing research and the triangular methods in examining and crosschecking the relationships of the different parties. *Chapter Four* focuses on the methodology with an overview on the grounded theory, research design, process and the employment of content analysis to analysis the research findings. *Chapter Five* presents the research findings based on the case interviews and different caring relationships and meanings are discussed. *Chapter Six* is discussions and implications of current research findings about the elderly care policy in Hong Kong. Appendices and references will appear in the last part.

Chapter Two: Literature review

The literature review on caregivers and care-receivers falls defines caregiving, the importance of community care for older people in Hong Kong, the role of relationships of formal and informal caregivers towards older people and the interfaces between formal and informal caregivers.

2.1 What does caregiving mean

The common term used for the activities of family groups on behalf of needy members is caregiving. It refers to the physical work and/ or financial assistance involved and also includes the accompanying comfort that family members provide (Aldous, 1994).

The emotional support incorporates the idea of caregiving, the “concern for” and “taking charge of” the welfare of others when they are troubled or unwell. Traditionally, that family member or members is a caretaker. In other words, the provider’s services are accompanied by sentiment and sensitivity to the recipient’s needs and feelings indicated by a strong desire to alleviate the sufferer.

Studies in Hong Kong and internationally have shown that caregiving can be a stressful experience for the caregivers (Chiriboga et al., 1990; Stoller & Pugliesi, 1989; Poulshock & Deimling, 1984; Clipp & George, 1990; George, 1987; Ngan, 1990), and that they suffered from physical, mental, social and financial stress.

A study by Woo et al (1995) revealed that for elderly subjects living in the Chinese community, 97% of the care was provided by an informal caregiver. Caring for

family members with chronic illnesses, particularly with functional limitations, can be demanding (Woo et al., 1995). Unlike formal caregivers, informal caregivers with no or minimal, training and often provide constant supervision and emotional support. Evidence indicates the problems and demands on informal caregivers are multidimensional (Schulz et al., 1995; Vitalians, 1997). The caregiver strain is a problem that has not received proper recognition and valuation, thus perpetuating the sense of powerlessness among family caregivers (Hooyman, 1990).

The key areas of strain include physical deterioration, negative psychological responses, frustrated social lives as well as financial strain. Boaz & Muller (1991) found that the physical burden associated with elderly care was the largest factor associated with individual caregivers' decisions to stop providing care.. However, it may be too simple to view caregiving by informal caregivers as totally negative without exploring the positive elements that make people want to help.

Giuliano et al (1990, p.786) offer another perspective. Stating “positive beliefs one hold about one’s self and one’s caregiving experience such that some beliefs or gainful outcomes are construed from it”. Positive beliefs in caregiving have been further elaborated by various researchers. There may be a range of aspects, for example, improved self-image as a result of public recognition (Kinney & Stephens, 1989); there may be traditional caregiving ideologies, such as family virtues, religion (Lawton et al., 1989); caregiving rewards (Schwartz & Gidron, 2002); positive feelings toward caregiving (Cohen et al., 2002); personal gain and management of meaning, such as praise from others (Pearlin et al., 1990); and there may be an active search for a meaning through care-giving (Farran et al., 1997).

Despite the variations in use and application of these terms, making sense of or giving meaning to care has been identified as the key variable in these studies. Farran (1997) examined caregiving from an existential perspective and asserted that difficult caregiving experiences provide caregivers with opportunities to search for ultimate meaning of life. Others, in explaining the perseverance, have adopted a more socialization perspective of where caregivers' values and philosophy were formed within their social milieu – which in turn shapes their responses to caregiving (Frankl 1963, 1978; Pearlin et al., 1990). However, such explanations still cannot account for variations in the dilemma “one would care when the others in the same family do not”, or in “one is willing to care for life and the others just do it for a few weeks”.

In fact, different people have different interpretations on the meaning of caregiving. Generally speaking and for research purposes, distinctions should be made between services that are essential for subsistence and survival, and effective involvement and social support in the family and community organizations. As argued by Liu and Kendig, (2000), there are four major and not mutually exclusive categories are mentioned relative to caregiving. They are: medical care, personal care, help with instrumental activities of daily living (IADL), and other non-specific care tasks such as staying with and watching with elderly because of the necessity of supervision for personal safety.

People with different social backgrounds and cultures define caregiving differently. This is most notable when comparing western and eastern countries and their differences in the caregiving modes to older people.

A western perspective arguably places less responsibility on the family members in taking care of elderly person in comparison with the Eastern perspective. The social exchange theory is usually adopted by western academics to explain the interchanging relationships in elderly caring (Walker & Allen, 1991; Shi, 1993; Brackbill & Kitch, 1991). The social exchange perspectives assume that people keep track of the costs and benefits for providing services in the long term and striving to maximize benefits and minimize costs in relationships with others (Thibaut & Kelly, 1959; Emmerson, 1990).

However, as stated by Hong and Liu (2000, p.169), the theory contains a major flaw since “it postulates that cost to benefit ration is the unqualified key factor in determining the satisfaction outcome of a relationship. That is, the costs paid by a caregiver would probably cause dissatisfaction and emotional distress. Most fundamentally, the social exchange theory fails to distinguish between affective and instrumental aspects of social relationship, and thus ignores the communal nature of the primary group in family caregiving.” From this perspective, the western idea on caregiving is very much based on the rational approach in calculating the costs and benefits in caregiving; however, the humanist value in care provision has been ignored in most western approaches.

Besides the social exchange theory, the reciprocity of dependency and caring also postulates that people feel obligated to help someone whom they have received help from and the reciprocal relationships are totally equal, non-obligatory and even transitory (Hong & Liu, 2000). These two major arguments explained most of the western approaches in analyzing caregiving.

In contrast with the western approach, there is little emphasis on the costs and benefits in caregiving in an eastern approach and more on the reciprocity nature of human relationship in the traditional virtue of filial piety under Confucianism. Chow (1997, p.116) stated that “based on the notion of filial piety, a network of relationships is thus established with distinct entitlements and obligations.

It is of course difficult to ascertain the extent to which these entitlements and obligations are still valid in present-day Hong Kong but as a value in itself, evidence indicates that it is still very much treasured”. There are two major obligatory norms to depict the essence of filial piety. On the passive side, children must show unqualified obedience to parents even if parents are known to be wrong and on the active side, children at any age throughout their life must always show their efforts to please their parents (Hong & Liu, 2000).

On the other hand the western approach in caregiving is deeply embedded in individualism and rationalization, which means that caregiving as a kind of social right that elderly person is entitled to receive when they become old and their children are not ethically obligated to provide cares to their parents.

The literature review on the meaning of caregiving has two levels. First, the informal caregivers might find taking care of family members burdensome. At the same time, however, they might perceive that there are positive elements, which help them to continue the work. Different interpretations vary according to different types of caregivers. This apparently reflects that informal caregivers are under psychological conflicts in providing cares for their elderly and this implies that formal caregivers should take a role in providing care when the informal one is not

able to do so.

Besides, there is a fundamental difference in caregiving provisions in eastern and western perspective. The eastern one is more on the traditional filial piety “motivating” younger generation to provide care while the western one is more on the individual responsibility as well as the state to provide care. Even though Hong Kong has been under the control of a western country, the notion of filial piety still exists in Hong Kong and most of the younger generation still regards taking care of their respective family members as essential and obligatory. All the policy papers on services to the elderly of the Hong Kong Government repeatedly reflected this mind set.

2.2 The importance of community care for older people in Hong Kong

Ageing is becoming a bigger and bigger dilemma in Asia-Pacific developed countries, especially in Hong Kong. The Census and Statistic Department showed that 11.4% of the population was 65 or above in mid-2002, and the figure is projected to be 24% in 2031 (Census and Statistical Department, 2002). This ageing trend is always accompanied with an increased disability and a terminal dependency, resulting in a rise of demand, care and cost for institutional long-term care. As noted by Chu & Pei (1997), there is a high prevalence of physical disability in Hong Kong’s elderly people. According to their study, 13% of elderly people live in the community, while 21% of male and 48% of female elderly people live in institutions, indicating a significant limitation in activities of daily living (ADL). Meanwhile, it is shown that stroke (40.2%), dementia (27%), proximal femoral fractures (7.4%) and Parkinson’s disease (5.9%) are the four most frequent severe illnesses lowering the mobility of the elders and increasing the need of caring services (Chu and Pei,

1997). This ageing trend facilitates the need for care of older persons, and a concern for providing quality caring services in Hong Kong society.

Moreover, with the advancement of Hong Kong society in the 21st century, there exist a number of practical factors, which militate against the family's easy continuation of care. First, many families are split by migrant work and social issues such as bereavement or divorce. Second, family size is decreasing, reducing the number of children to share the social and economic responsibilities of caring for elderly parents. The combined effect means that many future older people may not have any children living nearby on whom they can rely. Third, housing space is at a premium, and in most Asian cities; dwellings large enough to accommodate multi-generations are becoming rare and very expensive. Fourth, economic circumstances and social choice mean that more women, the traditional caregivers for elderly parents or parents-in-law, are working and are not available as constant free caregivers. Last but not least, many older people prefer independent living, if they are near to their children and grandchildren (Phillips & Chan, 2002).

Over the past decade, some excellent research has offered up-to-date descriptions of the needs and health of elderly people in Hong Kong (Chan & Chan, 1994; Ngan et al., 1996) and community care, as a service delivery model, arises as (1) a means to address the need for public support in family caregiving, and (2) a policy measure to contain costs while enhancing the effectiveness of elderly care (Davies & Knappy, 1994).

Community Care for the elderly in Hong Kong has been officially adopted, though sometimes be announced in various terms. "Care in the community" has been the

official policy since the 1973 White Paper. This advocating policy was embodied as a service provision in 1991 by the Hong Kong government. The policy states that an elderly person should receive assistance to live in one's own community with dignity and a spectrum of services should be provided in and by the community to facilitate continued participation in society.

One of the major aspects of community care in Hong Kong is family care and even female care when women are responsible for most of the caregiving work (Chen, 1996). It is commonly agreed that informal caregivers do not have the expertise and skill possessed by professionals to provide adequate care to the elderly and also it is evident that the willingness of the family to take up informal care does not mean that caregivers have the ability to do so (Stoller & Pugliesi, 1989; Yeung e al., 1997; 2000). Therefore the role of formal caregivers is important to maintaining the quality of care for the older people.

2.3 The roles and relationships of informal caregivers towards the elderly

It is acknowledgeable that the caregivers of persons with chronic illness typically are defined according to their relationship to the recipient. Persons who are not paid for care are considered informal support providers and they are typically family members, but they also can include friends and neighbours of the care recipient.

Formal support providers are persons who are paid for their help. Such caregivers include both paraprofessionals who supplement efforts of primary family caregivers in providing "hands-on" help with activities of daily living, and professionals who provide important but more episodic care primarily in meeting health and mental health needs (Kahana et al., 1994).

The term family caregiving (informal caregiving) is considered in a personal context and helps to differentiate between formal caregiving, which involves services provided by unrelated persons, and informal caregiving, which typically occurs in a family context and involves two related individuals. Focus is generally on the primary caregiver who is a member of the family and possibly on secondary family caregivers who supplement the aid provided by the primary caregiver. In studying significant caregivers it is useful to move beyond the family caregiver / care receiver dyad to analysis the involvement of a formal care provider, such as the primary care physician (trained worker) or other key health-care providers. A caregiving triad might thus be considered as consisting of the care receiver, the major family caregiver and a key formal caregiver.

In fact, one factor that has been well established is the dominance of the informal system of care. Families provide most long-term care. Horowitz (1985) in her review of caregiving literature illustrated that “Families provide 80% of all home health care for older people and conversely, 80% of all older people with home health care needs depend primarily on their family (Horowitz, 1985, p.189)”. Moreover, it is also found that families continue to provide care when formal services are used (Horowitz, 1985; Newhouse & McAuley, 1987).

Besides, there is some evidence that the greater the number of persons available, the more likely the individual is to receive assistance. The availability of a spouse is virtually a guarantee of some informal support (Shanas, 1979). Having children available is also a good guarantee of informal support. “The greatest predictors of informal support are both deteriorated health (need) and availability of an informal network which will provide that help, particularly spouse and children”. (Chappell

& Blandford, 1991, p.300)

Since the predominance of informal caregiving, much of the research is confined to care by immediate informal caregivers (spouses and their children), leading some to argue that caregiving research is characterized by an “ideology of intimacy” (Krause, 1990; Lee, 1985). This restricted focus detracts from the importance of other informal helpers, such as siblings, friends, and neighbours, and of formal service providers as the frail elderly’s caregivers (Krause, 1990; Penning, 1990).

Familial members, friends and close neighbours are presumed to have emotional stake in the well-being of the care receiver and therefore are well placed to provide effective support functions and personalized individual care that are sometimes missing from the formal caregivers. However, from the literature it is also evident that the emotional involvement of informal caregivers also may result in great interpersonal conflict (Litwak, 1985; Drew, 1986).

Informal caregivers for the elderly, are generally recognized as an important source of care for older people (Montgomery, 1999). Even though formal or formal services are available to the elderly, the family often still desires to take control over the elderly’s care (Stommel & Given, 1995). Care of elderly people by their family caregivers is seen as a normative act appealing to the virtue of filial piety in Chinese and Eastern societies (Liu & Kendig, 2000; Piercy, 1998; Lee et al., 1994).

A number of studies showed that older people who receive more social support from informal sources tend to acquire better quality of life and care than those who do not (Dufort et al., 1997; Emami et al., 2000). They also enjoy better living conditions

and financial support (Dufort et al., 1997). Also, informal support appears to be conducive in the use of formal services, including community supportive services and physicians' services (Miner, 1995; Lagergren, 1996). As a result, the cost of formal services is lessened as more informal support is provided (Davies et al., 1990).

2.4 The roles and relationships of formal caregivers towards the elderly

Care services rendering by formal caregivers have impacts of various aspects on the elderly. Firstly, It is generally acknowledge that professional care services are necessary as more and more people are considered elderly and the informal caregivers do not have the ability to carry out the care services (Spitze & Ward, 2000; Stoller & Pugliesi, 1989; Yeung et al., 1997; 2000). Evidence shows that elderly individuals prefer informal caregivers first but finally will resort to formal services in the community when their informal networks are no long effective and existing (due to the incapability of caring, etc.) (Sullivan, 1986).

It is also generally accepted that formal caregivers (professional services) tend to be more effective than informal care (Krause, 1990) since the they are viewed as more effective in terms of empowerment, respect, reinforcement, knowledge, network building, receptivity, advocacy, conflict minimization, integration, participation as well as clear philosophical orientation (Schalock & Kiernan, 1990).

The community support services mainly comprise of medical services provided by medical professionals and social services provided by social workers. Both parties appear to be very important gatekeepers for access to further kinds of services that could be enjoyed by the older people (Chi, 1994; 1995). Community support

services need to share goals for empowerment and promoting family care for the elderly (Lee et al., 1998). It is believed that professional services will benefit “disadvantaged elderly users” who have greater need and poor physical ability, as well as those “advantaged users” who already enjoy a better quality of life (Bass et al., 1999; Davies et al., 1990). However, professionals who receive lower pay and higher workload might make less effective contributions to their clients (Close & Estes, 1994).

2.5 The relationships between formal and informal caregivers

The relationship of formal to informal caregivers is well portrayed in a number of studies about the chronic illnesses and some other studies (Lyons, 2000; Litwak, 1985; Fischer & Eustis, 1994; Noelker & Bass, 1994). Often the extent of complexity of care needed by patients is beyond the capabilities of these services. However, in general, it is observed that the personal touches that are necessary to maintain the recipient’s emotional well-being and support may be lacking with formal service providers (Litwak, 1985). It is common sense that formal service providers lack a personal touch and therefore it is hard for them to provide psychological comfort. This can also attribute to that non-familial relation to the recipient and in part to the exigencies of a bureaucratic structure.

Studies focusing on the correlates of the utilization of formal services have primarily investigated physician services. To a large extent, deteriorating health is a major predictor of home care services (Chappell & Blandford, 1987). However, the best predictor of long-term institutional care is not health issue but rather the unavailability of informal support (Shapiro & Tate, 1985).

2.6 The interfaces between formal and informal caregivers

“There is a vast amount of gerontological literature focused on the provision of informal care to the older people” (Heinemann, 1985; Chappel & Havens, 1985; Branch & Jette, 1983) and also many studies on the utilization of formal services by older people (Chappell & Blandford, 1987; Wan & Arling, 1983; Given & Given, 1994). However comparatively fewer articles focus on the joint use of formal and informal care systems to support older people. There exist a number of models for the possible interfaces between the formal and informal caregivers. However, their focus were only put on some macro view on how the two parties can interplay with each other but without taking into consideration of the perspective of care-receivers during their analyses.

The literature reviews on interface between formal care providers and caregiving families are substantial (Chappell, 1987; Fischer & Eustis, 1994; Medalie, 1994; Kazak & Christakis, 1994; Noelker & Bass, 1994; Litwak et al., 1994; Chappell & Blandford, 1991; Lyons et al., 2000). Generally speaking, the modes of interface between formal and informal caregivers could be grouped in the following models of explaining the division of labors between the types of caregiving activities.

2.6.1 Task-specific Model

The most frequently used task-specific theory (Litwak, 1985) argued that both groups (formal and informal) and services could be classified by the same dimensions of structure. Furthermore, groups optimally can manage those services that match their structure. That means in applying to the formal and informal groups, it becomes apparent that formal organizations differ from informal ones in that they are structured to optimize technical knowledge. Consequently, the task-specific

model suggests that formal organizations should be better able to manage those services that require technical knowledge or large-scale human resources.

On the other side, the informal system, due to its primary group structure, is most appropriate for unpredictable, nonuniform, and nontechnical tasks. It should focus on affective orientation. The marital household, characterized by continual proximity, long-term commitment, small size, and common lifestyle, is best at providing assistance with the tasks, for example, personal grooming, housekeeping and food preparation and other family members, characterized by long-term commitment, geographical distance, and large numbers, are best for providing tasks such as looking after the elderly for 2 to 3 weeks, emotional support that can be provided through a letter or occasional visiting or over the telephone, or temporary loans (Litwak, 1985; Chappell & Blandford, 1991).

The formal system's group structure makes it the best for handling specialized and predictable tasks. The chief idea of the model is that assistance patterns are governed by how well group and task characteristics fit together.

Due to the fact that informal and formal groups are structurally suited to different types of tasks, dual specialization or task segregation occurs and caregivers fall within into different domains of caregiving. It is believed that the clear division of labour between formal and informal helpers promotes efficiency in task performance and prevents inter-group conflicts.

Some studies using a national sample of unmarried elderly women offered some support for the task-specific model (Soldo et al., 1990). The results found that adult

children are better suited to help with personal care and instrumental activities of daily living when compared to other informal caregivers. Moreover, another investigation (Penning, 1990) also indicated that different types of helpers, particularly spouses and adult children, assisted with different activities. Noelker & Bass (1989) reported evidence in favour of the task specificity model in their dual specialization group where both formal and informal care are provided but in different areas. However, they also found that for some elderly people, both systems are providing services in similar areas.

However, Chappell & Blandford (1991) argued that there are still no rigorous empirical tests of whether the relationship between informal and formal care represents task specificity or substitution and most of the studies did not directly test of the model.

2.6.2 Hierarchical Compensatory Model

The hierarchical compensatory model was another widely recognized conceptual approach explaining the interface between informal and formal helpers developed by Cantor (1979; 1989; 1991). “It posits that the source of assistance follows a pattern based on the primacy or closeness of social relationships. A key element in the model is the notion of succession, meaning that the societal norms about the primacy of relationships govern the elderly’s preferences for help” (Cantor, 1979, p. 157). Noelker and Bass (1989, p.235) termed this model “dual-specialization” and suggest it may decrease the level of conflict between formal and informal caregivers by clearly delineating separate responsibilities.

This conceptual framework asserts that the frail elderly’s spouse is the first choice as

caregiver, followed by children and then other kin. Therefore, caregiving activities are expected to be performed by the closest family member who is available and capable of helping. If kin are unavailable for help, friends and neighbors are the next choices for assistance, followed by formal service providers. That means that the informal sector is the prime sources of assistance for frail elderly and the formal sector is only confined to a relatively narrow range of tasks, in contrast to the informal support network, which provided a far broader base of assistance (Noelker & Bass, 1994).

Chappell & Blandford (1991) states that the model postulates substitution of the care system. This model argues for the primary importance of the family to the elderly. This normative pattern seeks kin as responding first to the needs of elders before non-kin or unrelated individuals. Among kin, there is a preferential ordering for help, first from the spouse, followed by children, then by other kin. Kin are followed in order by friends, neighbors, and finally formal organizations. In this model, each group successively provides assistance when a more preferred source is unavailable, either because one does not exist or it is unable to meet needs. This model postulates the substitutability of one service for another, but within a preferred ordering and the formal care system is used as a last resort and only when the informal sources are exhausted.

Empirical research was performed by Penning (1990), the report stated that the only evidence found supporting the hierarchical compensatory model is the order of prevalence among the different providers of assistance within the informal network. That means if a spouse is the most frequent source of assistance and then if he or she is absent, the children are the most frequent source for help. Moreover, Chappell

(1991) only partially confirmed the order of prevalence among informal caregivers consistent with the hierarchical compensatory model. Her analyses confirmed that the predominance of spouses and children as caregivers, but pointed to the prevalence of siblings and friends after spouses and children. The data only suggested a small role for other relatives in providing assistance with activities of daily living. Moreover, Messeri et al (1993) believed that the hierarchical compensatory model does not have a strong theoretical explanation for why caregiving should occur in such an order, nor does it explain why such a hierarchy does not prevail with certain specialized tasks.

Research conducted by Auslander and Litwin (1990) compared Israeli elderly who did and did not apply for public social services in order to test the premise that older persons use formal services when informal helpers are unavailable or unable to provide sufficient help. Based on the hierarchical model, it was expected that those who applied for formal assistance more often would lack formal supports. Results did show that applicants for formal services had smaller networks, had few immediate family members, and perceived the network as less emotionally supportive. However, this result can only be found among those older people that did not have spouse. No differences were found in the presence of children, other family members, friends, and neighbors.

2.6.3 Supplementation (Complementary) and Substitution Model

The supplementation mode developed by (Edelman, 1986) proposed that formal help is merely a replacement to the care provided by informal caregivers in order to alleviate stress and time demands. In some ways supplementation and substitution are part of the same continuum of formal utilization. Supplementation when the

formal helper providing identical care to the elder as the informal caregiver is no longer providing.

Noelker & Bass (1994) argued that although this framework has not been incorporated into a broader model or framework of the informal-formal relationship, it does offer an alternative perspective to the hierarchical and task-specific model. Supplementation posits that formal support buttresses the informal network by sharing the care of the impaired elderly.. The concept of “task sharing” between the informal and formal systems distinguishes supplementation from the hierarchical compensatory model, in which formal service use is associated with unavailable or insufficient informal help. The authors stated that supplementation differs from the task-specific model because formal and informal helpers can assist with the same task without negative outcomes such as inter-group conflict.

This model is usually applied to routine work rather than highly skilled or technical care. In fact, as argued by the author, the model asserts that most care needed by the chronically ill and disabled older persons are some sorts of ongoing routine assistance with personal care and activities of daily living. It emphasizes that routine care can be time-consuming and exhausting for informal caregivers, particularly elderly spouses, who can benefit from relief or respite services. Hence, in this conceptual approach, a primary purpose of formal help is to share with informal helpers rather than to substitute completely for them or solely provided specialized types of help (Noelker & Bass, 1994).

Edelman and Hughes (1990)’s research showed that supplemental help from formal providers were more frequent than substitution of formal for informal help. Findings

from the panel study showed that informal caregiving patterns were stable even four years after formal services were introduced. Moreover, their research also found that an increase in formal service use was associated with increased informal care. The role of informal caregivers seems not to be replaced by formal one even after the inception of formal services. The same conclusion could be drawn from the research from another research (Noelker & Bass, 1989). Their study of 519 spouse and adult-child primary caregivers who lived with their frail older relative showed that in 37% of the cases help with at least one type of task was given by both primary caregiver and a formal service provider. Similarity, when the elder's care needs and caregiver burden were greater, more intense service use occurred.

Greene's (1983) substitution model hypothesizes that given the option, most informal caregivers would use formal care to substitute for the assistance they provide. This model simplicity states that formal services substitute for or replace the help given by family members. This possibility is of concern to policymakers who envision a reduction in family care due to changing demographic and increased labour force participation by women, who are the traditional caregivers of older relatives (Lang & Brody, 1983; Brody, 1981).

Evidence for a substitution effect is scarce and actually only one study cited as having supporting evidence for this model (Greene, 1983). However, as cited by Noelker and Bass (1989), it limited by measurement, sampling, and design features.

2.6.4 Kin Independence Model and others

This model posits no relationship, with kin caregivers independently meeting the impaired person's assistance needs. Noelker & Bass (1989) argued that the

relationships between informal and formal caregivers are not direct and essential relationships. One possible explanation from research suggested that cultural values influence older persons to resist assistance generally, and when required, prefer it from immediate kin who accede to their wishes and also, policy-oriented research documents the formal system's barriers (eligibility criteria, uncoordinated services) that restrict that availability of, access to, and utility of services. The findings from these studies offer some explanations for the informal system's independence from the formal system.

Besides, some other theories regarding the interface between the formal and informal caregivers could be found in the "social support network" theory. A "social support network" consists of regular social interactions. A good "social support network" can help the individual fulfill physical, psychological and social needs (Scott & Roberto, 1985). This is a good framework for understanding the relationship between formal and informal help as it allows the way in which both fulfill the needs of the elderly individual to be observed. Shanas (1979) proposed that kin substituted for kin rather than formal substituting for informal. This theory is similar to Cantor's hierarchical model. Moreover, Johnson (1983) "share-functioning" kinship model posits that no one family member is primarily responsible for care, rather the role of caring is shared among family members.

To conclude, the models derived from the literature indicate that there are various types of relationships between informal and formal caregivers but actually none of them could be regarded as culturally and universally applicable and different types of elderly recipients might result in different interfaces.

The first type, task specific mode, includes family caregivers and service providers assisting impaired persons with different tasks. The second type, hierarchical compensatory model states that elderly recipients will only consider receiving care by formal one only when informal one could not be provided. The third type of the supplementation and substitution model asserts that they both help the elderly recipients in task sharing although the kind caregivers may help with some more on the additional tasks (emotional part). The differences between the supplementary and substitution models are the previous one assumes that kin caregivers are the major helpers and use service providers to augment their efforts or for respite while the latter one also includes families in which service providers are the sole sources of assistance with care recipients' needs and the formal one was used to replace the informal one. The kin independence model includes families in which no service providers help with caregiving responsibilities and different members of the family were responsible for taking care of the elderly's needs.

The above studies provide a developing trend of findings. From this trend, the comprehensiveness of understanding the elder care process is increasing. Elder care patterns were deduced and reviewed to explain the caregivers' behavior and the later study then enriched the former. The quality of care has also been examined and re-examined as well. However, how the relationship between the care recipients and the two parties of caregivers (the formal and informal) would be throughout the caring process? How would the change of these relations affect the care process?

Chapter Three: The Conceptual Framework Relating Carees, Formal Carers and Informal Carers

3.1 Conceptual framework for the study

Based on the previous discussion in Chapter 2, it was found that there are different types of discussion over the roles of formal and informal caregivers and how they can provide different roles for the care-receivers. Moreover, the interface between formal and informal caregivers have also been reviewed which showed that there are in fact different types of models explaining the relationship between the formal and informal caregivers. However, the roles of care-receivers and the dynamics between the three parties have not been examined in the current literature, especially in the context of Hong Kong.

Among the caregiving studies, caring involvement, informal network, use of formal services, opinion towards informal and formal support, psychological well-being, general mental health and stresses in caregiving, caring tasks, etc., are the common investigations. Only a few comprehensive studies have focused on the different caring dynamics and meanings in the caring process. However, these studies mainly focused on either informal or formal caregivers, only providing snapshots of caring, and have paid considerably less attention to explanations. Thus there is a need for more investigation on the interfaces of caring for the elderly within the whole caring process by looking at the caring activities, relationships between caregivers and care-receivers as well as the care-receivers, and the result of caring patterns and their meanings --- especially in local context.

There are different caring dynamics between caregivers and care-receivers in the caring process that affect the quality of care. For care-receivers, there is significant literature shows that elders prefer to be cared for by their family mainly due to psychological comfort, but they tend to be more confident when professional care is given. Obviously, no total replacement exists between formal and informal caregivers in the caring process.

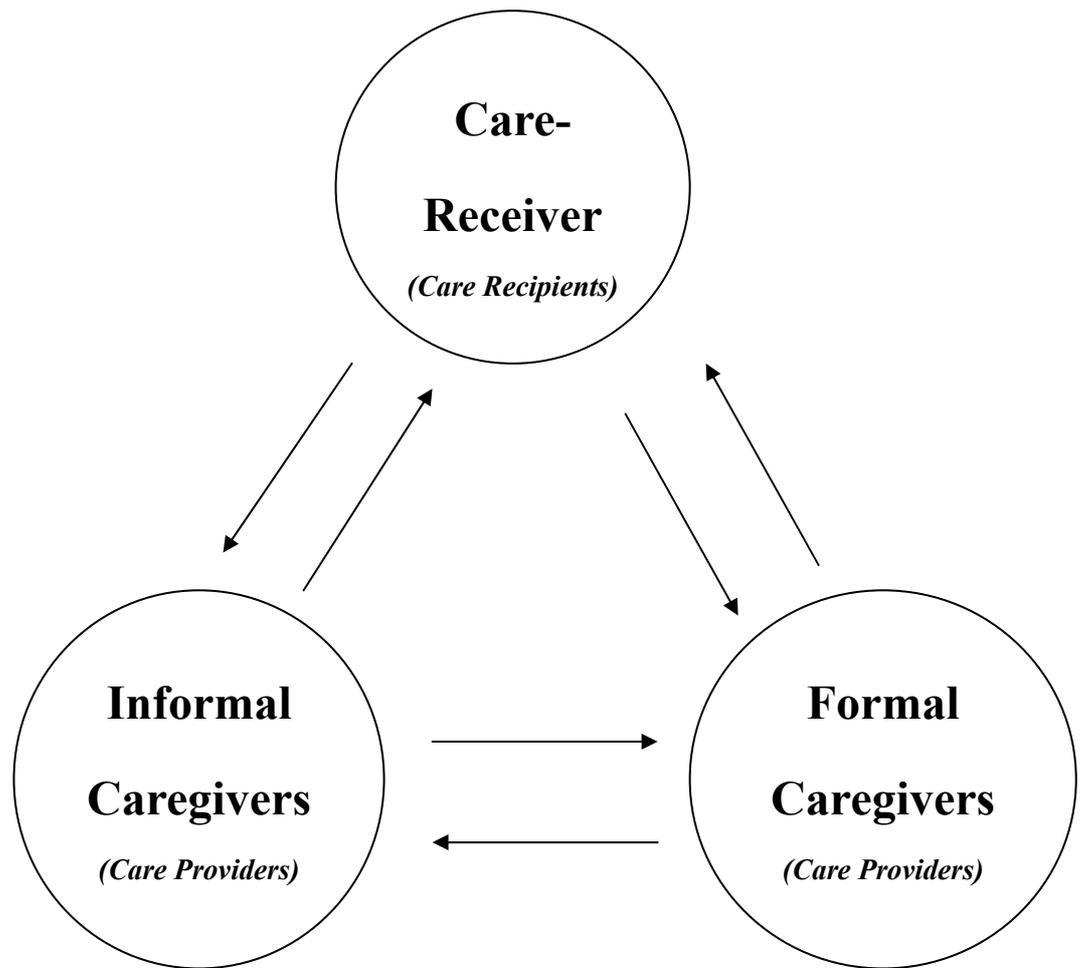
In fact, the forms of support and the roles of formal and informal caregivers may change from time to time and differ in different social contexts. Thereby the models of interface discussed in the previous chapter might not be sufficient in explaining the interfacing between the two parties. Furthermore, the role of care-receivers in the local context would be worthwhile for further research on this area.

From the rationale of grounded theory and the insufficiency of explanations of the interrelationships between the three parties, the author adopts a tripartite model framework to discuss the interactive relationships between the careers, formal caregivers and informal caregivers.

Persons who are not paid for care are considered informal support providers and they are typically family members, but they also can include friends and neighbours of the care recipient. Formal support providers are persons who are paid for their help. Such caregivers include both paraprofessionals who supplement efforts of primary family caregivers in providing “hands-on” help with activities of daily living, and professionals who provide important but more episodic care primarily in meeting health and mental health needs (Kahana et al., 1994).

Focus is generally on the primary caregiver who is a member of the family and possibly on secondary family caregivers who supplement the aid provided by the primary caregiver. In studying significant caregivers it is useful to move beyond the family caregiver / care receiver dyad to analysis the involvement of a formal care provider, such as the primary care physician (trained worker) or other key health-care providers.

Therefore, a caregiving triad might thus be considered as consisting of the care receiver (caree), the major family caregiver (informal carer) and a key formal caregiver (formal carer). With this concept in mind, in order to exploring the changing relationship between the careers, informal caregivers and formal caregivers, the current model would like to explore the interactions between the three parties in form of a tripartite model. Please refer to Figure 1 for the tripartite model with interrelationships between formal caregivers (formal carers), informal caregivers (informal carers), and care-receivers (carees).



Index: “ → “ refer to the relationship of one side to (concern, affect) the other

Figure 1: Tripartite model between the formal caregivers, informal caregivers and care-receivers

According to the researcher’s observation in his past experience in elder care service since 1979, as well as over 33 years of being an informal carer of older family members himself, change of carer-caree relationship occurs throughout the caring process. Thus the meaning of “change” in this study should be well defined.

From the theme of this study, the durable pattern change would be the focus. Also from the researcher’s rich experience, a relatively stabilized relationship change that could be recognized as durable pattern change would usually take a period of two to

six months. Thus this exploratory study that applying grounded approach theory would study cases that having a new carer (usually would be the formal carer) involved in the caring relationship not less than two months and better over six months. This also implied that the study would observe cases developed from having two parties involved in the elder care process to having three parties involved. Hence in this study “changing relationship” would refer to that during such a process of development.

Due to the application of grounded theory, no specific conceptual caring pattern was pre-empted. The researcher had only employed the above-mentioned tripartite model framework and then developed the following research questions. That would be a more appropriate attitude of applying grounded theory since the elder caring or relationship changing pattern, if any, should be deduced as that mentioned in the next chapter on methodology.

3.2 Research questions

The specific research questions addressed by this study derive from an extensive review of the literature are as follows:

1. What are the relationships between formal and informal caregivers in caring for older people in Hong Kong in home-based settings?
2. What are the caring meanings behind the different caring patterns amongst formal caregivers, informal caregivers and care-receivers?
3. What are the suggestions and implications of the findings for providing better care services for elderly recipients?

Chapter Four: Methodology

The methods used in the present study are mainly qualitative in approach, with in-depth interviews and focus group discussions. The chapter discusses the advantages of in-depth interviews and the nature of the qualitative and quantitative methods of the study. This type of research process, other than extensive cross-sectional surveys provides an alternative in conducting social research. Furthermore, in order to ensure the credibility of the research, triangulation of various data sources is used to provide fuller picture and understanding of the research findings.

4.1 Selection of the research method

Having evaluated the strengths and weakness of both quantitative and qualitative research methods, the researcher decided on using a qualitative based approach. The advantages are that the interpretations made by both the respondents and researcher could be made transparent and less restrictive for those who opposed to a pre-set questionnaire that might not provide sufficient flexibility for the interpretation processes. However, qualitative methodologies such as participatory observations, in-depth interviews with open-ended guideline have been criticized as being too subjective. In view of such criticisms and constraints, the researcher adopted various methods of data collection and interpretation for cross-checking the ideas generated by different parts of the research. As an expert in elderly care setting, the researcher is familiar with using in-depth interviews and which can help to explore the changing relationships between the different relationships between formal, informal caregivers and the care-receivers. In justifying the adopted methods, a review on the relevant methodology is necessary.

Quantitative research tends to be deductive, hypothesis-driven, particularistic, variable-based, objective and outcome-oriented (Devers, 1999, Newman & Benz, 1998). The strengths of quantitative research on the relationships of formal and informal caregivers might relate to some statistical associations on how formal and informal caregivers related to the quality of life of the older people. However, these tend to neglect the fact that the relationship might change overtime. In order to achieve the purpose of the research, qualitative research would be adopted to provide deeper understanding of the reasons for caregivers' views and opinions.

In recognition of the limitations and quantitative methods in the research of the relationship between formal and informal caregivers and care-receivers, there are growing tendency for researchers to use qualitative methods in carrying out researchers in social gerontology. Qualitative research has largely been characterized as phenomenological, involving an investigation of the meaning of people's experiences and the process by which they arrive at that meaning. They could assist theory-building and can be holistic, case-based, subjective and process-oriented (Babbie, 2001; Devers, 1999).

The strength of qualitative research lies in its ability to understand the subject in meanings, how people "see things", perceptions and attitudes to events, thoughts, perceptions and feelings experienced by informants and help to the development of concepts or theory (Reinharz & Rowels, 1988).

Since the current research argues for neither static nor directly controllable, researchers must not only verify existing theories, but also investigate concepts and / or the additional theoretical perspectives and methods, that are suitable for studying

feelings, subjective experiences, and the meanings that different types of people attribute to events and situations in real-life settings. In this way, they attempt to derive theoretical explanations based on observations in the data, the “grounded theory” approach (Glaser & Strauss, 1967).

However, there are limitations to qualitative approaches. For example, qualitative researchers have often been criticized on the basis that their findings are unsystematic, impressionistic, exploratory and subjective (Pope & May, 1995). There seems to be no wholly agreed doctrine underlying qualitative social research. In reviewing the qualitative-based literature on the relationships between formal and informal caregivers, most of the publication only describes the role of the formal and informal caregivers, meanings of caregiving as well as the different models of interfaces between the two parties. Many undoubtedly are subjective, narrative and often novel in nature. Few provide clear descriptions of the research and analysis processes (especially the models of interface did not find consistent results). With the background of the research as an expert in the elderly care setting and also triangulation process in data collection and cross-checking, the findings could be less subjective and the relationships of the three involved parties could be explored.

An additional advantage of in-depth interview in this study is that they allow the researcher to be more flexible in asking questions and to collect more comprehensive data giving insights (please refer to Appendix 1 for details). Interviewees were free to express their feelings about the questions and to explain why they have these feelings, perception and attitudes (Silverman, 2000).

4.2 Researcher's observations and experience accumulation as an expert in elder care settings

In searching for relevant literature or theories on the roles of explaining the changing relationships between formal and informal caregivers and care-receivers during the elderly care process, this author was able to obtain direct observations and gain insight from his active participation and professional experience in social work and related professional trainings in this field over 25 years. Moreover, the author has also the experience of being a informal caregiver of his older family member over 33 years, thus he was able to view from the informal elder carer's point of view as well.

Stemming from this position, for all literature reviewed and people conversed in the process, these were all considered to be crucial for exploring the interrelationship between the three concerned parties in the elder care process. In such circumstances, the author adopts a qualitative approach based on the grounded theory to develop an explanation. The initial research process could be seen as similar to an anthropological study where the author himself analysis what he has experienced and eventually he articulates all these experience and data into an explanatory model (classical studies include H. Baker's 'Chinese Family and Kinship' (1969)', 'The Polish Peasant', B Malinowsky's 'Argonauts of the Western Pacific' (1922).).

The author has been working in elderly care settings since 1979. He was a welfare assistant and eventually worked as a social worker for a number of NGOs (non-governmental organizations). He was a Welfare Assistant at SAGE Tsuen Wan Multi-services Centre for the Elderly in 1979, Welfare Assistant and Welfare Worker at Mongkok Kaifong Association Chan Hing Social Centre for the Elderly in 1980, a

Social Worker at Mongkok Kaifong Association Chan Hing Multi-services Centre for the Elderly in 1982 and at Lok Sin Tong Chu Ting Cheong Home cum Care and Attention Home for the Aged in 1988. He has been a part time social work supervisor and Professional Consultant of the North District Home Help Team of Hong Kong Evangelical Church Social Services in 1990's.

Since 1993, he has been working in the field of social work and human service education at Hong Kong Shue Yan College, City University of Hong Kong and The Hong Kong polytechnic University. He is currently working at The Hong Kong Polytechnic University as a full time Instructor in the Department of Applied Social Sciences. It is no doubt that his work experience in elderly care aids in exploring the changing relationships between the three parties.

4.3 An overview on the grounded theory

Grounded theory was initially developed by Barney Glaser and Anselm Strauss in the book entitled *The Discovery of Grounded Theory* in 1967 (Strauss & Corbin, 1998). They came from different philosophic and research backgrounds but worked in very close collaboration to develop the techniques for analyzing qualitative data that reflecting both of their educations and backgrounds (Strauss & Corbin, 1990).

“The grounded theory approach is a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon” (Strauss & Corbin, 1990, p.24). It is a general methodology for developing theory that is grounded in data and theory evolves during actual research but not through continuous interplay between analysis and data collection (Strauss & Corbin, 1998). As a methodological package, it provides a series of

systematic, exact methods that start with collecting data, transforming data into concepts and then into categories to formulate scientifically and theoretically valid research (Glaser, 1999).

The strategies of grounded theory approach, as stated by Charmaz (2000), (a) collecting and analyzing data simultaneously; (b) a coding procedure; (c) comparative methods; (d) memo writing; (e) theoretical sampling aimed at assessing appropriate sample for our research; (f) integration of the theoretical framework.

Literature review is one of the major data sources for generating the conceptual framework for the study. Technical literature refers to “reports of research studies, and theoretical or philosophical papers characteristic of professional and disciplinary writing. These can serve as background materials against which one compares findings from actual data gathered in grounded theory studies” (Strauss & Corbin, 1990, p.49). As Strauss and Corbin (1990) argued, technical literature has several basic functions: (1) The literature can be used to simulate theoretical sensitivity; (2) It can be used as secondary sources of data; (3) It can stimulate questions; (4) It can direct theoretical sampling; (5) It can be used as supplementary validation.

The researcher as a person as well as professional experience he or she has, is also important in selecting appropriate literature due to his theoretical sensitivity (Strauss & Corbin, 1990). “Professional experience is another source of sensitivity, if a researcher is fortunate enough to have had this experience. Throughout years of practice in a field, one acquires an understanding of how things work in that field, and why, and what will happen there under certain conditions” (Strauss & Corbin, 1990, p.42).

In-depth re-interview and focus groups were also conducted to gather more information of the research. “The key to triangulation is the use of dissimilar methods or measures, which do not share the same methodological weaknesses – that is, errors and biases” (Singleton et al., 1998, p.361). The use of different sources of data was able to verify the data and theories generated.

Sampling in grounded theory is the process of data collection for generating theory whereby the researcher jointly collects, codes, and analyzes the data and decides what data to collect next and where, so as to develop the theory as it emerges. This process of data collection, termed as theoretical sampling, is controlled by the emerging theory (Glaser & Strauss, 1967).

Unlike other sampling methods, theoretical sampling does not determine the size of the sample population before the study or using the random sampling method, rather depends on the expert knowledge of the researcher (Keri & Francis, 1997). Indeed theoretical sampling is a powerful method to collect data and formulate that fit and relevant to the research (Glaser & Strauss, 1967). Thus it cannot be planned before the research, but rather evolves during the research process (Strauss & Corbin, 1998).

4.4 Research design and process

This is a pilot study to explore interactions, interfaces and explanations among caregivers and care-receivers by looking at the whole elder care process, in which some manifestations and interpretations are important in understanding the caring relationships. The main purpose of the whole research is to explore the changing relationships between the formal caregivers, informal caregivers and care-receivers.

Hence, a qualitative methodology using in-depth interviews and focus group discussions was employed in this research.

4.4.1 Research method

A grounded theory approach was the theoretical underpinning to design the research, in which in-depth interviews and fieldwork observations were adopted (Glaser & Strauss, 1967; Sofaer, 1999; Strauss & Corbin, 1998). Glaser et al (1967) stated that ‘grounded theory’ is applied when a researcher does not begin a project with a preconceived theory in mind, but rather with an area of study and allows the theory to emerge from the data. More importantly, the bulk of the analysis and explanations are interpretative, thus a qualitative approach is much appropriate in this study. To get a better and deeper understanding of the details of the caring process, interview guidelines containing open-ended questions were adopted and interviews were tape-recorded for transcription. Content analysis was used to analyze the verbatim transcripts into different themes and to generate the caring relationships and patterns.

According to the researcher’s observation in his past experience in elder care service since 1979, as well as over 33 years of being an informal caregiver himself, both male and female informal caregivers existed in Hong Kong. And elder caregivers can be young adults, middle-age adults as well as older persons. However age and gender structure of formal caregivers, due to the practice of their employing agencies that nearly all formal caregivers were adult female with the age between 20’s and 40’s, and there usually did not have special age consideration when matching with the older care-receivers. Thus while taking samples, different gender, and different age range of the informal caregivers would be the most meaningful

criteria

With these considerations, a local welfare service agency was invited to support, and a purposive sample with six typical cases was referred based on their frailty and received care services. The elderly care-receivers, their family caregivers and the formal caregivers were selected as target interviewees. A total of 18 people were interviewed, including 6 elderly care-receivers, 6 family caregivers and 6 formal caregivers. All the caregivers were those who had frequent contact with and cared for the elderly. To have a full picture of the caring process and the caring relationship, three scheduled in-depth interviews were conducted for each interviewee by trained interviewers from June to August 2003 without hypothesising any outcomes. Following in-depth interview guidelines, interviews lasted one to four hours (average=2), and were tape-recorded and transcribed word for word for data analysis. With non-structural interviewing approach and follow-up probe questions, interviewees could give their own view of the caring experience. Then the researcher found that the data collection from the 18 people had reached a stage of “theoretical saturation” in which no new concepts were emerging (Strauss & Corbin, 1990). At this stage, it is generally agreed that no more interview is required, as additional interview would no longer generate new insights.

4.4.2 In-depth interview guideline

An interview guideline was made to explore the relationship changes amongst the three parties. Different sub-categories under headings were adopted to elaborate and categorize the fragmented ideas that arose during the interviews. It allowed more systematic and strategic data analysis later on. Following the interview guideline, the interviewer got a thorough understanding of caring patterns and processes

among the elderly people, family caregivers and home-helpers during the interviews. The interviewer also needed to take observation/field notes, focusing especially on the physical care environment of the elder care process. This was especially essential to rule out the possibility of misinterpretation and to ensure the data quality.

4.4.3 Data analysis and validity

Content Analysis phase

All in-depth interviews were recorded and transcribed into verbatim for systemic analysis. All verbatim transcripts were categorized by the thematic content analysis method of data interpretation. Open-coding developed the coding categories, coding description and coding. Coded notes were written in the margins of the transcripts. These acted as “memory prompts” for the analysis (Silverman, 1994).

Quantifying qualitative data

Thematic content analysis is a technique for analyzing the qualitative data into various themes, developing analytical categories and indexing (coding) the data accordingly (Strauss, 1987). For analysis of verbatim data, coding reduces a mass of qualitative data by categorizing the transcripts into theoretical concepts based on the theoretical framework. Open coding was mainly used in this study.

Open coding

The purpose of open coding is to develop concepts, open up the text and expose the thoughts, ideas, and meanings contained therein (Strauss & Corbin, 1996). This allowed the researcher to explore the relationship changing between the formal and informal caregivers and care-receivers. To avoid missing any useful data, the researcher read the transcripts line-by-line, highlighting words that expressing

description, coding similar descriptions and giving them labels. Hence the coding categories with descriptions were generated guiding towards coding the verbatim transcripts systematically.

The open-coding found that the relationships between the formal and informal caregivers are both *Complementing and Substituting*. For caring relationships between informal and formal caregivers and care-receivers, the interaction patterns were based on *Reciprocity and Obligation*.

4.4.4 Data Confirmatory phase

In this research, the data quality of the research is generally guided by triangulations (Campbell et al., 1981). Triangulation generally refers to the use of more than two methods or techniques to compare the results for the same topic (Devers, 1999). It is also of course a way of ensuring comprehensiveness and encouraging a more reflexive analysis of the data than just a pure test of validity (Pope et al., 2000). Multi-members were adopted to verify data quality in the study including the researcher's own observation and experience accumulation, in-depth interviews with formal and informal caregivers and their care-receivers, content analysis using researcher-generated categories, and focus group discussions.

The experience of the researcher in the elder care settings formed a basis for the orientation and planning of exploring the changing relationship between the formal and informal caregivers and care-receivers. The interviews then followed a circular process of defining and refining the subsequent interview schedules, and of generating relevant categories for content analysis. Again, results of each interview were checked with previous findings, for confirming previous results and also for

the purpose of adding new observations and extracting insights. In total, 6 set of cases were conducted (N=18) were conducted and finally a focus group was held with 7 participants invited from the 18 interviewed caregivers and care-receivers to confirm and cross-checked the findings obtained from the in-depth interview. Focus group could be defined as a planned meeting of targeted participants discussing focused topics (Phillips, 1998). They could be used as a means of respondents providing feedback on the results of a research study (Please refer to Appendix 2 for details of focus group guidelines). The group interaction itself can also stimulate respondents' thoughts to offset the limitations of individual in-depth interviews and to increase the reliability of the findings and especially give greater and deeper understanding.

In general, the stages of the triangulation process needs not be sequential (Marshall, 1996). Hence, in the present study, the different sources of data collection used included the in-depth interviews, focus group discussions, participants' observation and experience accumulation in elderly care settings, and literature review on the formal and informal caregiving to the older person and their interfaces. All these helped verify the overall interpretation of the research findings. Figure 2 summarizes the research process and Figure 3 illustrates the triangulation process in the current research.

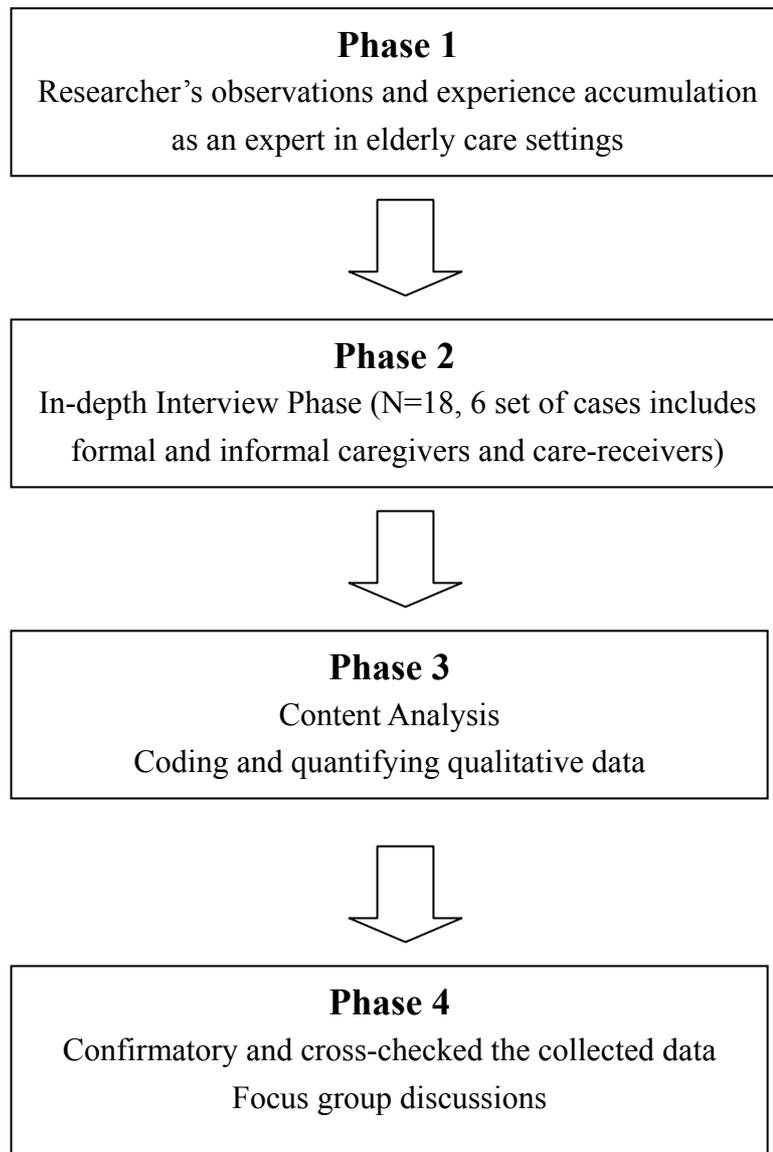
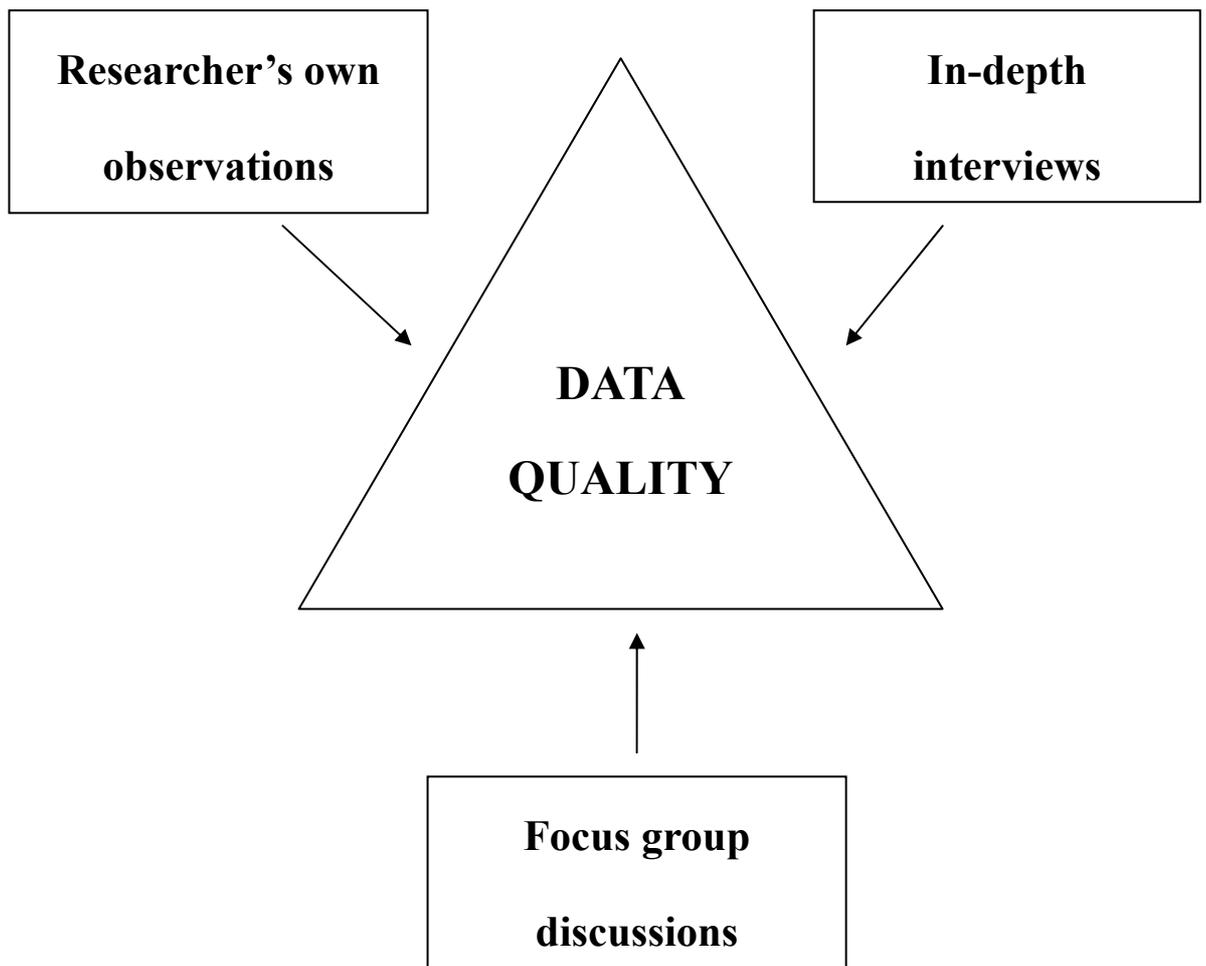


Figure 2: The research process for the study



Index: “ → ” refer to the application of the data quality assuring method

Figure 3: Triangulation process for the study

Chapter 5: Research findings

Section I: Respondent profiles

5.1 The elderly respondent profiles

For the sample profiles of the elderly respondents, most of them were female, aged between 72 and 81, with a mean age of 77.2. Four out of the six were receiving Day Care Service (DCS) from the Day Care Centre for the Elderly (DCC) and the other two were receiving Home Help Service (HSS) from the Integrated Home Care Services (IHCS). All of them had received services for about a year. They were all living with their family caregivers, such as spouse and/ or adult-children. The health status of the older people was determined by the social worker of CFSC (see Table 5.1).

Table5.1: Sample profiles of the elderly people

Case	Sex	Age	Type of service receiving	Year of service received	Health Status
1	F	72	DCS	< 1 year	Mild
2	F	76	HHS	< 1 year	Severe
3	F	77	HHS	< 1 year	Severe
4	F	81	DCS	> 1 year	Mild
5	M	76	DCS	> 1 year	Severe
6	F	81	DCS	> 1 year	Severe

Apart from the elderly respondents, their family caregivers and six formal caregivers were also invited to be interviewed to learn about their caring activities, relationship

and expectations of caring.

5.2 Family caregiver profiles

Regarding the sample profiles of the family caregivers (informal caregiver), three were female and three were male, aged from 37 to 81, with the mean age of 53.2. They were all living with the elderly respondents and providing immediate care. Regarding the length of time in a caregiver role, it ranged from several years to over ten years (see Table 5.2).

5.3 Formal caregiver profiles

For formal caregivers, all of them were middle-aged females from 32 to 48. All were in their 40's except one. Two third of them were personal care workers (PCW) in day care centres and the rest were home helpers (HH). They were all employed front line staff providing the most frequent elder care. Their caring experience for the related older interviewees ranged from several months to two years (see Table 5.2).

Table 5.2: Sample profiles of informal and formal caregivers

<u>Informal Caregivers</u>				<u>Formal Caregivers</u>			
Case	Sex	Age	Years of care-giving	Position	Sex	Age	Years of care-giving
1	F	37	5 years	PCW	F	47	9-10 months
2	M	81	5 years	HH	F	44	2-3 months
3	M	46	several years	HH	F	44	1 year
4	F	45	13 years	PCW	F	32	2 years
5	F	65	4 years	PCW	F	45	1 year
6	M	45	5 years	PCW	F	48	1 year

Section II: Tripartite relationships between formal, informal caregivers and care-receivers

In order to explore the changing relationships between the formal and informal caregivers and care-receivers, in-depth interview was adopted to ask the respondents on the changing relationships between the three parties and the following two major findings were found to explain the tripartite relationships between different parties (Please refer to Appendix 1 for the in-depth interview guideline):

1. The interaction patterns between the formal and informal caregivers and the reasons (caring activities).
2. The interaction patterns between the caregivers (formal and informal) and care-receivers, and the reasons (caring meanings).

Part I: Interaction patterns and caring activities between formal and informal caregivers

The content analysis of the caregivers (formal and informal) revealed that *substituting and complementing* are the two most obvious interaction patterns after the inception of the formal caregivers. Generally speaking, *substituting* means that one party replaces the other party while *complementing* means one party shares the role of the other party.

5.4 Perception of quality of services

In the present study, the confidence on formal caregivers in providing quality services promoted *substituting* caring patterns after the inception of formal caring. In most of the cases, the informal caregivers were observed to be not less professional

in providing tasks required for certain sorts of training and therefore they would like to choose the formal caregivers to replace their roles. Moreover, the following cases also illustrated that the informal caregivers intended to be substituted by the formal caregiver in the caring process, even if they were capable to take care of the older people. Please see the following direct quotations.

Case one: "...I am not so professional in providing care for my mother in some tasks, therefore I am happy to find out there are services provided by the center. I feel less worried about them doing the tasks. I hope that my mother can receive better and more tailor-made services afterwards. "

Case four: "...I would like to spend most of my time taking care of my mother and I realize that it is my responsibility to do so. However, the day care centre provides more professional services to my mother and I am very happy about it. Since I would like her to enjoy the best services, I feel it is better if she uses the services provided by the professionals."

Case five: "... I know my husband can bath at home since we have employed a maid...but the service has been paid to the Day Care Center, so he should go there to have a bath...I understand I can clean for him, but I believe that the formal caring provides professional care for him...I think institutionalization would be good for him and me."

Case six: "...I am willing to take care of my mum, but I am afraid I don't know how to take proper care of her...I feel that the care provided by the hospital and elderly centre must be professional and therefore I would like to replace my services by the

one with more professional....”

The first reason given for the substitution of tasks by the formal caregivers was the perception of informal caregivers that formal caregivers are more professional in providing better care services for their parents.

5.5 Sharing of tasks

Besides *substituting* effects on the formal and informal caregivers, *complementing* effect was also another major interaction pattern between informal and formal caregivers. In the following cases, it was observed that the inception of formal caregivers also helped to share some tasks with the informal caregivers. Please see to the following cases:

Case one: “...Before my mum goes to the centre (i.e. before inception of formal caring), I had taken the caring role. I feel I didn't have much time left...after using the day care service...I have some spare time to take care of my family in the morning...but I am still willing to take care of my mum, but at least I find that the formal caregivers can share my tasks in some certain....”

Case three: “I need to take care of my mother and use all of my energy to give her the best service. I don't know why but I assume that these are my duties. I however find that I could not handle my job and take care of my mother at in the same time. I feel guilty about that. Now, the formal caregivers help me a lot in sharing of my duties. I feel much happier when I take care of mother right now”.

Case four: “...I am on the committee of my estate... but I resigned from the post

when I needed to take care of my mother-in-law...now, I am glad that I have some spare time to join some social activities after using day care service...I have rejoined the committee now...and I am willing to take care of her at the same time, the formal services greatly alleviated my workload....”

Case six: “She (formal caregiver) is more professional than me in providing care services to my mother and therefore I am happy to share some of my caring tasks to her and she is great about doing her part. I have no problem in allocating tasks between us. The most important thing is that my mother gets the best service.”

The above quotations showed that the informal caregivers found that the assistance of the formal caregivers could share part of the jobs and therefore the care-receivers could receive better care services. But the in-depth interview, some more details on the division of tasks between formal and informal caregivers could be observed.

5.6 Division of tasks

Like many local caregiver studies, it was found that both formal and informal caregivers provide tangible and intangible support to older persons during the caring process. With regard to the tangible aspect, the long-term personal care was the main caring provision. It involved assisting the elderly people in activities of daily living (ADL) and instrumental activities of daily living (IADL), e.g. feeding, bathing, dressing, transporting the elders to and from home, accompanying the elders to medical consultations, washing dishes, assisting in simple exercise, etc. The intangible support mainly refers to the psychological comfort for the care-receivers.

It was found that some different patterns have been appeared on the division of tasks

between formal and informal caregivers from the following quotations.

Case one: “After the inception of the formal caregivers, I found that I still provided personal care and psychological care to my mother. However, as I have said before, informal caregivers have provided some advanced care. But I will always comfort her and make her feel happier”.

Case Three: “I will take care of her very often when I am at home but my major duties are to give her psychological comfort. You know formal caregivers cannot replace our roles, since I am her son”.

From some of the quotations, it is possible for us to make simple points on the division of tasks between formal and informal caregivers:

1. Formal caregivers mainly provided more advanced care (more professional) while informal caregivers mainly provided intangible support (psychological comfort)
2. Both formal and informal caregivers provided tangible support. However, the tangible support of advanced care, especially high level nursing and personal care were always provided by formal caregivers since they were trained up to provide some professional skills.
3. Both formal and informal caregivers provided intangible support to the older persons. However, formal caregivers were relatively difficult to provide since they did not have intimate relationships with the care-receivers and therefore

most of the intangible support are relied on the informal caregivers.

The reason was that most family caregivers perceived that advanced care required more skill and involved health care knowledge. They believed it was more reliable if provided by formal caregivers even if the family caregivers also did it. Interestingly, in both the observations and interviews, it was found that family caregivers mainly provided the intangible support, for example, emotional care and support, even when the formal caregivers also provided these.

It was revealed that family caregivers provided both tangible and intangible support. These findings were supported by many current Hong Kong studies. Nonetheless, caring provided by the informal caregiver was not as simple as stated. Nurturing the psychosocial needs of the elderly (i.e. the intangible support) was found to be the essential role of the family caregiver in the present study.

Unlike family caregivers, it was found that the formal caregiver was generally responsible for providing tangible primary care to the elderly people, which relieved the family caregivers' strain in long-term nursing and personal care. According to the six selected cases, general care provision was the responsibility of the formal caregivers. It included offering basic nursing, such as monitoring blood pressure and blood sugar levels, and personal care, such as meal provision, dressing, bathing and feeding. Nonetheless, the caring services might be restricted to basic nursing and personal care. The formal caregiver could not offer all-round caring due to the increasing demand of the workload. The details of the caring activities are shown in Table 5.3.

Table 5.3: Division of Tasks among Formal and Informal Elder Caregivers

Caring Relationship	Division of Tasks (Task specific for formal and informal elder caregivers)
Informal Elder Caregiver →	<ul style="list-style-type: none"> ● Tangible support: personal cares (ADL and IADL) (<i>minimal</i>) ● Intangible support: psychosocial support (<i>maximum</i>)
Formal Elder Caregiver →	<ul style="list-style-type: none"> ● Tangible support: Advanced care, basic nursing care, ADL and IADL. (<i>minimal</i>) ● Intangible support: psychosocial support (<i>maximum</i>)

On the whole, *substituting* and *complementing* interaction patterns have been found between formal and informal caregivers in taking care of the care-receivers and the current research did not aim at identifying which effect is more obvious during the research. Perception of quality of services by the informal caregivers was the main reason for the *substituting* effect in which some advanced and professional care activities have been replaced by formal caregivers.

Regarding the *complementing* effect, the sharing of tasks between formal and informal caregivers was found to be obvious when the informal caregivers did not have time to provide care for the care-receivers. Moreover, a rough division of tasks has been revealed in which formal caregivers more focused on the tangible support, including personal care, ADL and IADL while the informal caregivers more focused on the intangible support, mainly the psychological support. The summary of the different forms of interaction pattern between formal and informal caregivers are shown in Table 5.4

Table 5.4 Caring relationships, forms of interaction pattern and reasons (caring meanings)

Caring Relationships	Forms of Interaction Pattern	Reasons (Caring meanings)
Informal Caregiver and Formal Caregiver	Substituting effect	➤ Perception of Quality of Service (More professional and advanced care services have been substituted by formal caregivers)
	Complementing effect	➤ Sharing of Tasks (Tasks were shared with formal caregivers when informal caregivers did not have time, in which formal caregivers focused on tangible support while informal caregivers focused on intangible support)

Part II: Interaction patterns and caring activities between caregivers (formal and informal) and care-receivers

The previous section discusses the interaction patterns between formal and informal caregivers after the inception of the formal caregivers. This section would like to discuss the interaction patterns between the caregivers (formal and informal) and the care-receivers and the reasons for why interaction pattern.

When looking at the whole caring process, the major interaction patterns between the formal and informal caregivers are **reciprocity and obligation** with different reasons (caring meanings). The following analysis would be divided into two major parts. The first part is the views of informal caregiver and the second part is the views of formal caregiver.

5.7 Views of informal caregivers in caring for the elderly people

In view of the caring relationship between informal caregivers and the elderly people, **reciprocity and obligation** were the interaction patterns that motivated the family caregivers to provide continuous care to their elderly family members. In these interaction patterns, there are a number of reasons for such interaction patterns exist they could be separated for spouse and parent-child, they are:

1. For spouse as informal caregivers: Marital Relationship was the main reason for taking care of their spouses.
2. For parent-child as informal caregivers: Filial piety was the main reason for taking care of their family members.

It is important to note that all these interaction patterns and explanations for caring between informal caregivers and older persons might not have direct replacements. To gain a deeper understanding of this relationship and please read the following statements and quotations.

According to the in-depth interviews and focus group discussions, reciprocity and obligation were the most common interaction patterns in the caring relationship between spouse and the frail partner. As explained by the interviewees, the marriage

philosophy of traditional Chinese is a promise to care of their spouse for their whole life, taking love as a life-long commitment and doing what needs to be done. See the following cases as examples:

Case two: "...I prefer staying at home when the formal caregiver comes to take my wife outside. Since I am afraid that I will be hurt accidentally when going downstairs, I prefer having more rest at home so that I can provide the best care for my wife...I wish to take care of her as long as I am capable to do so...."

Case five: "...I am his wife, I should take it (i.e. the caring role)... I don't care (about the health of the older person). He falls easily...I hope he can be institutionalized as soon as possible...It's a good end for him and me...but I am his wife, I should provide support and care to him...."

On the other hand, marriage in traditional Chinese culture meant a commitment to bear any difficulties between partners. Sometimes people would be afraid of creating negative images and ruining their prestige if the spouses escaped from their responsibilities in providing care.

Case five: "...I feel very tired, even at the very beginning of taking care of my husband. But I should take care of him... even his brothers and other relatives did not come and visit him during his worst time... But I have taken care of him."

In this study, adult children were also informal caregivers to their older parents and reciprocity and obligation towards frail parents were always the interaction patterns

that motivated them to provide care. However, unlike the spouse's point of view, responsibility and reciprocity in care provision to older parents was rooted in filial piety. This is a common feature in Chinese society, in which a sense of love and norms of caregiving to older parents is the motivation for them to provide long term care.

Case six: "...I have been living with my mum for a long time, we have a good relationship...I think I should pick up the responsibility as I am her son...sometimes, I may feel tired when taking care of her, but I think it's my obligation. I should provide good care for her...when I realized that my mum disliked the former maid, I employed another one for her immediately...after taking on the caring role, I tried to search for more information about caring for frail elders in order to give her quality care...."

In some cases, these reciprocal interaction patterns were generated due to a positive caring meaning of adult children that encouraged them to pick up the caring responsibility. In the following case, the caring process provided an opportunity for the older parents and their adult children to reinforce the parent-son relationship, resulting in a better understanding of each other.

Case one: "...My mum was more attached to males than females when she was young. We didn't show much affection when I was young...I feel we are in a better relationship after starting the caring... we have become closer after more contact with each other... in caring process, I use most of my time to take care of her, and

she sometimes helps me with some household work in return...now, we are like friends rather than mother-and-daughter....”

Apart from the above caring meanings and explanations from the informal caregivers, the reciprocal caring pattern from adult children to their older parents has also been sustained due to the gratification and satisfaction from their family members. For example:

Case six: “...Although there are many inconveniences when taking care of my mum, in particular in terms of our social life (i.e. the respondent and his wife), my wife is very supportive of me. She appreciates and supports me sustaining the care... She takes care of my mother when I am on-duty. She also searches for some caring information for me....”

5.8 Views of formal caregivers in caring for the elderly people

Like the interaction patterns between family caregivers and older persons, **reciprocity and obligation** were also found as the interaction patterns between formal caregivers and older persons. However, the caring meanings and explanations were different.

According to the six selected cases, reciprocal and obligatory interaction patterns were driven by economic reward. Most of them expressed that they were willing to care for older people. However, salary still affected them in some cases.

Case five: "...I love this job since it provides me a satisfactory income...but it is not the most important reason for me to take caring as my career...I just wanted to give help to the needy... I remember that there was a deduction of salary last year...if the situation becomes worse and worse, I may not continue this job even if I love to take care of others"

Case two: "...They (respondent's colleague) take care of older persons based only on the economic rewards...they [Family caregivers] provided income to clients for fulfilling the job"

Besides economic reward, interaction patterns of reciprocity and obligation have also been found in formal caring due to the organizational culture of formal caring. One of the formal caregivers expressed that she could only take it (caring) as a job. For them, frail elderly people would only be considered as a client and therefore they were task-oriented. In the following case, the formal caregiver aimed to meet clients' needs and was committed to her job.

Case five: "...Under the instructions given by the centre, we are not allowed to build a relationship with the elders in order to avoid any unfairness and complaints.... '...We are caregivers. This is a job...this is my duty...we should not have any preference in caring for elders...the caring services provided must be the best and the most professional...there should not be any complaints...."

Other than the above caring meanings, gratification and job satisfaction, personal growth and development promoted the reciprocal and obligatory interaction patterns between formal caregivers and the older persons. In the following cases, it was

obvious that reciprocal care relationships have been encouraged due to such caring meanings.

Case two: "...I enjoy this job, I am delighted when older patients gratify my work...moreover, I feel my communication skills have improved since taking this job...."

Case six: "...With a number of years of working experience, I found I have certain professional knowledge in this field...I feel I get trust from my supervisor and boss...I cherish that I can provide care to the elderly...."

Case five: "...My family is very supportive...They understand my work is to take care of elders... they always care about my work and appreciate what I do in the caring process...."

On the whole, reciprocity and obligation were the main interaction patterns for both formal and informal caregivers to take care of the older persons. Nonetheless, different explanations (i.e. marriage and love, social norms of caregiving, economic rewards, job fulfillment and satisfaction, etc.) have been found in these caring patterns.

5.9 Views of the older care-receivers in the caring process

Before we summarize the details of the caring relationship, caring patterns and caring meanings between caregiver and care-receiver, let's listen to the voices of the older care-receivers:

Case one: “...I know I am recovering, but my daughter doesn’t believe so ... now I go to the DCC everyday and she smile at me ... I don’t like to stay in the DCC but I would do my best, so that everyone may believe that I could take care of myself ... now I am the head of volunteers group of the DCC but I don’t that ... but I would keep doing my best in front of them because my daughter has started to allow me to help her at home ... ”

Case two --- could not speak clearly , whenever the formal carer come to serve, she show signal and urge her husband to take a rest; whenever the formal carer assist her to do exercise she would try very hard to do her best --- she show by signal that she want to recover her self care ability for her husband.

Case four: “ ... I like to be independent and to serve my family as before ... I accept the formal service so that my family members may have their own time and activities and need not to worry about me ... and I hope the formal carer may help me to recover and enhance my caring (self and family)ability as soon as possible ...”

Case six--- could not speak clearly, but by broken sentences she stated that she would obey to all that arranged by the son and that he “ordered” the daughter-in-law to execute.

It is quite clear that these older care-receivers take the family relations as very important in their later life. They would treat the formal care service as a kind of support and not replacing their self care position. And their perceptions on the forms of caring pattern were mainly reciprocal and obligation.

As a overall summarization, the details of the caring relationship, caring patterns and caring meanings between caregiver and care-receiver are shown in Table 5.5.

Table 5.5 Caring relationships, patterns and meanings between caregivers and care-receivers

Caring Relationships	Forms of caring (Patterns)	Caring meaning(s) (Explanation)
Informal Caregiver and Older Receiver	Reciprocal and obligation	<p><u>For spouse:</u></p> <p>Martial Relationship</p> <ul style="list-style-type: none"> ➤ Taking a promise to care for life ➤ Taking love as a life-long commitment <p><u>For adult- children:</u></p> <p>Filial Piety</p> <ul style="list-style-type: none"> ➤ Norms of caregiving ➤ Relationship reinforcement ➤ Gratification and satisfaction from family members
Formal Caregiver and Older Care-Receiver	Reciprocal and obligation	<ul style="list-style-type: none"> ➤ Economic reward, job fulfillment, commitment and meeting clients' needs ➤ Gratification and job satisfaction ➤ Personal growth and development

Chapter 6: Conclusion and Recommendation

6.1 A brief overview of the research

By reviewing the whole caring process between the informal and formal caregivers, substitution and complementary effects are most obvious through the interaction pattern. The substitution effect mainly comes from the perception of quality services by the informal caregivers. Care-receivers think that professional and advanced care services provide better care.

Regarding the complementary effect, it is found that sharing responsibilities between the formal and informal caregivers are common. Informal caregivers found that tasks could be shared with formal caregivers when they did not have time. Furthermore, when we look at the division of tasks between the formal and informal caregivers, it is found that those tangible supports are mainly supported by formal caregivers (except those advanced and professional care that would be substituted by formal caregivers), including personal cares, ADL and IADL. As for the intangible supports, it is observed that both parties provide some intangible support, however, the bulk is provided by informal caregivers, either spouse or adult-children. Thus, different tasks are performed by different parties.

On the side of caregivers and the care-receivers, both formal and informal caregivers are found to interact in a form of reciprocity and obligation. In regard to informal caregivers towards their care-receivers, the continuation of care is mainly due to the martial relationship and filial piety. The martial relationship involves the concept of taking a promise to care and to provide care for life and taking love as a life-long

commitment while filial piety includes the concept of as a norm of caregiving, relationship reinforcement and gratification and satisfaction from family members.

The formal caregivers towards the elders also show the same interaction pattern as the informal caregivers; however the caring meanings are rather different. The reasons for taking care of the elderly are economic rewards, self-gratification, job satisfaction and also the caring can benefit personal growth and development.

To compare and contrast the findings and the conceptual framework, the study uses the “Tripartite Model between older careers, their formal caregivers and informal caregivers”. The co-existing of the three main types of mutual relationship, that are 1) older care-receivers and informal caregivers; 2) older care-receivers and formal caregivers; and 3) formal caregivers and informal caregivers, and all three may effect the quality of elder care. And this is a positive assurance to the conceptual framework of the study that quality elder care should not just focus on the side of formal and informal caregivers.

The study also shows that the changing (either the pattern, the structure, or the content) of any of these three types of relationship might affect the other relationship. And that means a systemic tripartite interfacing (a kind of interactive relationship) between these three relationships is shown. This is another exploratory support to another major analogy of the study --- the existing of a caregiving triad (instead of just involving the caregivers, while neglecting the care recipients).

However, although the dialectic dynamics (the dialectics of changing relationship, such as the positive development of a certain relationship may not consequently

result in the positive development of another relationship, and may not eventually result in the positive development of quality of care) have been somehow identified, due to the limited scope of this study, it (the dialectic dynamics) has not been further explored nor been verified. Meanwhile the theme of this study, though did relate to, did not clearly cover this area as well as wanted and further studies in this area are recommended.

The macro local social conditions discussed in chapter one seems to have induced more tension than support to elder care relations. However, most of the 18 interviewees of this case study did show somehow gaining strength from cultural and relational factors to sustain. If this is the case then cultural and relational strength, such as kinship, martial relationship and filial piety, would be much worth to further explore in rethinking and improving long term elder care policy and services. Since this has been only a preliminary observation, further study would be required for verification.

To conclude, findings about the changing relationship between formal and informal caregivers and care-receivers fall in form of two main types of interaction patterns, which are the *complementing* and *substituting* effects between the formal and informal caregiver while reciprocity and obligation are the main patterns between the caregivers (formal and informal) and their care-receivers.

6.2 Contributions of the study

The present study explores the changing relationships between formal and informal caregivers and care-receivers in Hong Kong. Discussions are rarely held on all three parties together. The interaction patterns between the three parties are also shown.

Regarding the *substituting* and *complementing* effects, the performance of different tasks by different caregivers are deemed to be right since formal caregivers are supposed to be more professional when providing quality care, however, our research found that they involve less in providing intangible support for the older persons . On the other side, informal caregivers provide less tangible supports to care-receivers but provide relatively more intangible support to care-receivers. This seems to be beneficial to the elderly. Further research should focus on whether different specification of tasks would result in enhancing the quality of life of older persons.

Regarding the forms of interaction patterns between informal caregivers and the care-receivers, it is found that martial relationship and filial piety are important motivations or factors that help informal caregivers sustain their care. These provide important insight for promoting family care and maintaining such important virtues in the community.

One interesting finding as to why formal caregivers go into the field is that besides economic reward and job satisfaction, it is found that the formal caregivers continue to do the job is because the job benefits their personal growth and development. This aspect is seldom discussed in previous research.

Indeed, the caring meanings of the same caring patterns were different among different caring relationships. It was not surprising since different cultural issues, social roles, personal beliefs and value judgments create different caring meanings. Moreover, it was important to recognize that caring patterns were always dynamic and therefore, the caring meanings and patterns were not in a cause-and-effect

relationship. The findings could only be regarded as the results of the six cases of study. Further empirical study should be conducted to get a deeper understanding of the patterns and relationships among the elderly, family caregivers and formal caregivers. Based on this findings, a holistic model of caring could be developed.

According to the observations being made by the interviewers, both elderly people and family caregivers have certain expectations towards formal service provision. It was found that elderly people have certain caring expectations towards formal and informal caregivers. As explained by the elderly respondents, they generally preferred their family caregivers to provide intimate personal care. The professional care was expected to be offered by the formal caring services. Besides, some elderly people also expressed that tailor-made case referral and social activities were important. For example, in case one, the elderly respondent mentioned that she was not as frail as the other elders in day care centre, but she had been referred by the medical social worker. Therefore, she felt bored at the centre.

In addition, most elderly respondents implicitly indicated that self-care opportunities in the caring process were desirable, as they did not want to become a burden of their family members. For instance, the son of the elderly person in case four expressed that his mother always insisted on going to the bathroom by herself. The elderly respondent in case one always emphasized functional mobility.

As to the caring expectations of informal caregivers towards frail elders and formal caregivers, most respondents would like to provide care to frail elders, but keeping good self-health status, giving more caring time and professional skill in caring, should be important in providing quality care to frail elders. For example, in case

two, the elder partner of the frail elderly had implicitly expressed that he preferred to keep healthy in order to take care of his wife as much as possible. In case one, the daughter had mentioned that she liked to take care of her mother, but she was also a caregiver to her family at the same time, therefore she could not spend as much time caring for her mother as she would like. In case four, the son of the frail elder implicitly expressed that he did not have confidence in providing caring services although he had learnt some skills. He only trusted professional care.

For formal caregivers, most respondents mentioned that close caring relationships and all-round quality care provision were the caring expectations of the frail elderly and their family members. According to the observations and case interviews, most formal caregivers strived to provide good quality care to their clients as they thought that it was their responsibility and duty to do so. They would like to provide both tangible and intangible support to the frail elders and their family members.

For formal caregivers, quality service provision was the ultimate goal from the serving point of view. The family caregivers and the elderly should be active participants and willing to express their wishes.

Some believed that they deserved to receive all-around services since they paid for it. For others, especially the frail elders, expected to receive the care services provided by the nurses, physiotherapists and other professionals when they were sick or no one else could help. For those intimate personal services, e.g. bathing, elders preferred their family caregivers to provide these.

These findings shed some light on the roles played by the three parties, i.e. the frail

elders, family caregivers and formal caregivers. It was necessary for all parties to cooperate in striving for the best quality of care. Hence, more information of the perceived roles and expectations among the three parties should be further explored in order to get the optimal caring patterns.

During the interviews and observations, it was also noted that most of the carees and informal carers would treat the care from formal carers be more advanced, professional and tangible while their own be more intangible, while the formal carers would not treat their services as professional but would expect to be more advanced and professional in the future. However, these conceptual correlations are not clearly defined and verified. For instance, informal care is not necessarily equal to intangible care. Thus, further study on the differentiation of these perceptions would help to deeper understand the meaning of the changing relationship in elder care process.

Moreover, macro local social conditions in which the relations between elder carers and carees are situated might, though seemed inducing more tension than support, perhaps be somehow compensated by strength from cultural and relational factors. Preliminary observations supported the further exploration of cultural and relational strength, such as kinship, martial relationship and filial piety, in rethinking and improving long term elder care policy, services and praxis.

Meanwhile, as supported by previous literature, the relationship of caring provision could be in the range of *supplementing*, *complementing* and *substituting*. The optimum form of the caring relationships depends on the community resources available and also on the values upheld by the three concerned parties. In order to

achieve the greatest satisfaction of care recipients and family caregivers, while advocating their empowerment in the continuum of care, it is advisable to conduct further study on their expectations towards all the caring tasks. The results of it could give a direction for the future development of community support services for elderly people. It could also delineate the roles of different parties and suggest what areas of training are required for formal and informal caregivers.

6.3 Limitations of the study

The study has also tried to explore the motivating force of formal caregivers in the provision of quality service. Reasonable salary is, of course, one of the most influential factors. Other than the material reward, reciprocal relationships or personal growth are also important.

However, for this explorative case study, the scoop and length of time somehow limited the width and depth of exploration. For example, besides the substituting and complementing relations between the three major parties involved in elder care, are there others such as conflicts and tensions? And in addition to reciprocity and obligation, are there other relations such as exchange, authoritarian, etc. It is worthwhile to study the dynamics for deeper understanding of elder care process.

Meanwhile, owing to the limitations of the study, no exploration was made on what defined quality service from the perspectives of the parties. Are personality traits or attitudes of formal caregivers an important factor? Does the caring relationship between the frail elderly and formal caregiver affect the evaluation of service? Does the level of professional training of the formal caregiver contribute to the confidence of frail elders and family caregivers? Or, is it necessary for the formal caregivers to

provide all-round services in order to provide quality service? For the advancement of service quality, it is important to explore what constitutes quality caring service for the elderly.

(In-depth interview guideline)

第三部份：照顧關係的變化

個案研究：訪談及觀察紀錄項目 照顧關係的變化(Relationship changes)	I 弱老		II 正規照顧者(服務員)		III 非正規照顧者(家人)		☆ 研究員觀察 補充
	A1 ; A2 ; B1 ; B2 ; C1 ; C2		A1 ; A2 ; B1 ; B2 ; C1 ; C2		A1 ; A2 ; B1 ; B2 ; C1 ; C2		
3 關係變化 <參考說明>	長者自我照顧	II, III 之間	長者自我照顧	II, III 之間	長者自我照顧	II, III 之間	
3.1 照顧關係的變化 * 替代關係 取代另一照顧者 Substituting Replacing the other caregiver * 協力關係 不同照顧者有不同功能；亦可互相代替 Complementing Different functions of different caregivers, maybe "inter-replace" * 互補關係 不同照顧者有不同功能；而不能互相代替 Supplementing Different functions of different caregivers that cannot "inter-replace" * 實例 甚麼是可、甚麼不能互相代替							
3.2 對變化的觀感 * 對 2.2 照顧內容變化的觀感 (+ve ; Ove ; -ve 等及說明) * 對 3.1 照顧關係變化的觀感 (+ve ; Ove ; -ve 等及說明)							

<p>3.3 面對變化的（而仍長期持續照顧）力量來源</p> <ul style="list-style-type: none"> * 照顧責任得以放下 * 照顧者感到「充權」（能力提升；成就感增加；獲應得的資源、支援決策力；有份決策） * 在照顧過程中，關係、感情的變化 * 照顧知識、技巧的增強 * 個人性格使然 * 訓練、教育而致 * 自我增強（自我肯定、確認、尊重；有所借取、啓迪） * 他人增強（獲肯定、確認、尊重；有所借取、啓迪） * 其他 							
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(FOCUS GROUP GUIDELINE)
研究焦點小組討論指引

Discussion guideline:

1. Caring activities, any differences?

- Care content, frequency, quality, and relationships
- Patterns of caring by family caregivers, formal caregivers

2. Interaction patterns, relationships and meanings, any differences?

(substitute / complement/ supplement/ reciprocal)

- Frail elderly: health / personality/ communication skills
- Formal caregiver: official responsibility/ commitment/ recognition/ skills
- Informal caregiver: Blood tie/ understanding of care-receiver

3. Any suggestions on better care services for the elderly recipients?

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