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Family Caregiving in Singapore

(Principal Investigator: Dr Ng Guat Tin
Co-Principal Investigator: Dr Kalyani Mehta
Collaborator: Dr Allison Rowlands)



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Study Report of Singapore Family Caregiving Survey

Guat Tin Ng

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Assistant Professor
Department of Social Work
Faculty of Arts and Social Sciences
Block AS6, 4th Floor
11 Law Link, Singapore 117570
Republic of Singapore
Tel: (65) 6516 7604
Fax: (65) 6778 1213
Email: swkngt@nus.edu.sg

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Abstract

This paper reports on the results of Phase I of the research project on Family Caregiving in Singapore. The survey on family caregiving was carried out between December 2005 and March 2006. The community-based agencies, which participated in the survey, included day activity centers, Neighborhood Links, home help service, senior activity centers, and specialized agencies such as Alzheimer's Disease Association, Hospice Care Association, and Singapore National Stroke Association. Of the 342 survey forms received, 323 were usable. The study results are presented in four sub-sections, according to the profile of caregivers, profile of care recipients, caregiving activities, and caring for a second person.

A review of the extensive international literature on aging and caregiving clearly indicates that in most countries, family caregivers provide substantial care, thereby forestalling the need for extensive formal care services and minimizing the need for institutional care; consequently, public spending on care of the aged and disabled is reduced (see e.g. Delaney, 2004; Merlis, 2000; Montgomery & Feinberg, 2003; World Health Organization & the Milbank Memorial Fund, 2000). As a country's population ages, as in the case of Singapore, the role of family members becomes even more critical in facilitating "ageing in place" and long-term care of older persons. The attention given to family caregiving, however, tends to be sidelined by the focus on aging issues. The needs of family caregivers are often presented in terms of shoring up support for older persons. The most recent 2006 report issued by the Committee on Ageing Issues (Singapore) illustrates this approach to the well-being of family caregivers. The Committee reiterates, throughout its report, the principle set forth by the Inter-Ministerial Committee on the Ageing Population: That the family should be the first line of support in looking after the physical and emotional needs of their senior members and a range of comprehensive services in the community will be available to support their caring responsibilities. The Committee recognizes, in principle, that caregiving can be an onerous responsibility and urges the government to step up efforts to support caregivers.

Recognition of the role and responsibilities of family caregivers can be traced to the 1995 National Survey of Senior Citizens in Singapore. The results yielded through this survey, though dated and targeted at only senior citizens, is informative, given minimal local research on family caregiving. The sample size was 4,750 persons, aged 55 and above. Of this number, only 4.4% (about 209) had a principal carer, defined as "the main person who looked after the senior citizen and took care of his/her daily personal needs" (Ministry of Community Development, 1996, p. 72). The principal caregivers comprised mostly children (35%) and maids (25%), followed by spouses (23%) and relatives (14%). When maids were

excluded, the findings showed equal proportions of sons (24%) and daughters (24%). Spouses comprised 31% and children-in-law, another 16%. The profile of caregivers (excluding maids) showed that about half were in the economically active age group, below 50 years of age, and another 36% aged between 50 and 69 years. The rest were 70 years and above. Slightly more than two-thirds (67%) were married and 24% were single. A very high proportion (97%) of caregivers lived with older persons. Two out of five (42%) caregivers were working and about one in five (21%) gave up their jobs to look after the senior citizens. About 58% had been providing care for five years or more.

The major caregiving activities identified by caregivers were shopping/marketing (57%), doing laundry (56%), and house cleaning (55%). Smaller proportions were involved with bathing (27%), feeding (20%), and assistance with toileting (19%). The majority of caregivers did not report adverse effects on their social life (70%), health (78%), feelings of resentment toward other family members who did not help (80%), and feeling of depression (73%). Only a minority (less than 5%) reported adverse effects “most of the time”. However, about 25% reported a worsening of financial position, having taken on the caregiving role. Although the caregivers indicated varying levels of awareness of various residential and community-based services the usage of such services was generally low. The main reasons given were that they preferred family support or those services were not required as yet.

Other than the 1995 National Survey of Senior Citizens, there are a number of small studies done at the National University of Singapore but these tend to be small-scale qualitative research carried out by students or focused only on care of dementia patients, for example, Kua and Tan’s study (1997) of 50 caregivers of elderly Chinese patients with dementia. In their study, they found only 24% of the study sample used community psychogeriatric services such as day care or domiciliary nurse, even though many more said they needed home help (90%), day care (72%), or transport service to the day centre (64%).

Another study of 93 patients, with mild to moderate dementia, found that almost half of the caregivers were already experiencing significant problems and as such, were considering institutionalization of their care recipients (see Lim, Sahadevan, Choo, & Anthony, 1999).

Given the important supportive role played by family caregivers in the care of family members with different health and physical conditions, limited research on caregiving in Singapore, and the call by the Interministerial Committee on Aging Population to accord high policy priority to family caregivers, a research project on family caregiving was initiated in September 2005, with funding support from the National University of Singapore.

The project is carried out in two major phases. As access to a national universe of family caregivers in Singapore is currently not available there is a need to identify potential research participants and invite them to participate in research studies. The objectives of Phase I of the research project are to sketch a broad profile of caregivers in Singapore and provide a sampling frame for subsequent studies in phase II. Hence, Phase I involves making wide contacts with community-based health and social service providers that provide supportive services to the aged and those with health conditions such as stroke and dementias. We solicited the assistance of these service providers in distributing a survey form, asking for basic information about caregivers and their care recipients. This paper reports on the results of phase I of the study project, namely, the characteristics of caregivers, characteristics of their care recipients, and their caregiving activities.

Methodology

To meet the objectives of phase I it was decided to use a survey instrument that captures basic demographic characteristics and caregiving activities among caregivers in the community (see appendix). The most practical source of recruitment of study sample is through community-based health and social service agencies. The sampling approach adopted

is that of convenience sampling, which limits the generalizability of the study results. This approach tends to recruit those care recipients already receiving services and known to service providers. To remedy this shortcoming attempts were made to recruit from a wide range of service providers, including agencies that provide services that are informational rather than rehabilitative, namely, Neighbourhood Links¹. Another source of recruitment was through personal contacts of social work faculty and student researchers. To ensure wider representation the agencies approached for assistance were drawn from geographical areas in different parts of Singapore.

The survey instrument was pilot tested in November 2005 among undergraduate students enrolled in a level-1000 module in the Department of Social Work (National University of Singapore). There were 300 students enrolled in this module. During class, students (about 270, assuming 90% attendance) were asked to give the survey form to parents, relatives, neighbors, or friends whom they know were caring for someone who is frail aged, sick, or disabled. Twenty-six forms were returned. Based on the responses, changes were made to several questions to improve clarity of the survey form (self-report) used in the actual study. The revised form was translated into Chinese. As response from the non-Chinese ethnic groups was low, the form was later translated into Malay language to increase the number of Malay respondents.

The survey was carried out between December 2005 and March 2006. Eleven research assistants (undergraduates majoring in social work at the National University of Singapore) assisted in data collection. Their responsibility was to contact community-based agencies to solicit their cooperation to distribute and encourage their service users who are caregivers to complete the survey form. On some occasions students were on the spot to

¹ Neighbourhood Links are located in various public housing estates. They serve as contact points in the community where residents can obtain information on social services, volunteer their services, interact and form mutual help groups.

distribute the survey form to caregivers, as when a service provider conducts a public talk or activity for service users. In a number of cases, care recipients (particularly those in day activity centres) were asked to give the forms to their caregivers to complete and return via the community-based agencies. A small number of survey forms was returned through the mail.

The community-based agencies participating in the survey included day activity centres, Neighborhood Links, home help service, senior activity centres, and specialized agencies such as Alzheimer 's disease Association, Hospice Care Association, and Singapore National Stroke Association. These agencies were located in different parts of Singapore: Ang Mo Kio, Bedok, Boon Lay, Bukit Batok, Bukit Panjang, Bukit Merah, Choa Chu Kang, Clementi, Geylang, Hougang, Jurong East, Queenstown, Marine Parade, Sembawang, Toa Payoh, and Yishun. In all, 38 agencies participated in the study. The survey forms were pre-coded (prior to distribution) to facilitate subsequent analysis of sources of survey response, for example, senior activity centres were coded SAC and Neighbourhood Links as NL. See table 1 for sources of survey respondents, listed according to type of agencies. As shown, the major source of survey response was through day activity centers (35%), Neighborhood Links (15%), home-based services (13%), and senior activity centers (10%).

For the purpose of this phase of the research project, *family caregiving* is defined as providing unpaid care or personal assistance to a family member of any age, with an illness or disability. Hence, caregivers who indicated they are volunteers or friends were excluded from analysis. In addition, if information on health/physical conditions was not provided and the respondents did not provide any caregiver assistance these respondents were also excluded from analysis. Of the 342 forms received by the end of March 2006, 19 forms were not usable, for the reasons given above and also, where there were inconsistencies in data provided. Consequently, the sample size used in the analysis was 323. Random comparison

of database records with survey forms were made to check for data entry error and thereby reduce one possible source of errors. Data analysis was done using SPSS version 14.0.

Table 1. Sources of Survey Respondents

	% of Respondents
Day Activity Centers	35
Neighborhood Links	15
Home nursing, home medical, home help services	13
Other Voluntary Welfare Organizations	12
Senior Activity Centers	10
Social Work faculty and students	9
Hospice	4
Hospitals	1
Total	99

Results

The results are presented in four sub-sections, according to the profile of caregivers, profile of care recipients, caregiving activities, and caring for a second person.

Profile of Caregivers

The majority (62%) of caregivers are middle-aged, in the 40 to 59 years age category. About 14% are below 40 years old and 24% aged 60 years and above. As with the situation in other countries, the caregivers are mostly female (74%). In terms of religion, the sample comprises a disproportionate number of Christians (35%) as compared to Census 2000 figure of 15% (Singapore Department of Statistics, 2001). There are about 43% Buddhists, 6% Muslims,

3% Hindus, and 13% others². As for marital status, there is a higher proportion of married persons (63%) as compared to single persons (30%), widowed (4%), and divorced/separated (3%). The profile, however, is similar to that reported in Census 2000³. Slightly more than half (54%) are working, with 40% working full-time and the other 14% working part-time. There are about 40% homemakers and retirees. However, there is a gender pattern in the employment status of caregivers (see table 2). For those working full-time, there are more male caregivers than female (49% vs. 36%, respectively). But for those working part-time, there are more female caregivers than male (17% vs. 7%). Similarly, for caregivers who are homemaker/retiree, there are more female than male caregivers (44% vs. 30%). The results are statistically significant ($\chi^2=22.98$, $df=4$, $p<.0001$).

Table 2. Gender of Caregivers by Employment Status

<i>Employment status</i>	<i>Gender</i>	
	Female	Male
Working full-time	36%	49%
Working part-time	17%	7%
Homemaker/retiree	44%	30%
Student	0.4%	1%
Others	3%	13%
Total	100% (<i>n</i> =236)	100% (<i>n</i> =84)

The sample also comprises mostly those with household income less than S\$2,000 (47%), with another 36% with household income between S\$2,000 to S\$4,999. Only a

² Corresponding figures from Census 2000 data are 43% Buddhists, 15% Muslims, 4% Hindus, and 23% others.

³ Census figures show 62% married persons, 31% single persons, 5% widowed, and 2% divorced/separated (Singapore Department of Statistics, 2001).

minority has household income S\$5,000 and above (17%). Compared to Census 2000 data, the study sample captures a higher proportion of the lower income households (the corresponding figures are 27%, 38%, and 35%) (Singapore Department of Statistics, 2001).

Profile of care recipients

The care recipients are mostly “old-old”, with 60% aged 75 years and above. Another 28% are between 60 and 74 years old. Only 12% are less than 60 years old. However, when analysis is disaggregated by gender of recipients, the results show that for younger age groups there are more male care recipients than female care recipients (see table 3). The reverse is true for the oldest age group, 75 years and above. There are more female care recipients (68%) than male care recipients (48%), a difference of 20 percentage points. The findings are statistically significant ($\chi^2=21.14$, $df=3$, $p<.0001$).

Table 3. Gender of Care Recipients According to Age Categories

	<i>Gender</i>	
	Female	Male
<i>Age</i>		
Less than 40 years old	2%	7%
40-59 years old	5%	16%
60-74 years old	26%	30%
75 years and above	68%	48%
Total	100% (n=195)	100% (n=115)

As with caregivers, the care recipients are also predominantly female (63%). Though male care recipients (78%) have a higher proportion of female caregivers than female care recipients (72%), the results are not statistically significant ($\chi^2=1.31$, $df=1$, $p=.25$).

Care recipients are mostly parents (64%) or parents-in-law (7%) to their caregivers. Spousal relationships account for only 16% of the caregiving dyads (12% are husbands of caregivers and 4% are wives). The rest include grandparents (3%), children (3%), siblings (4%), and others (3%).

Given the age profile of this sample, it is not surprising that frailty in old age ($n=116$) is top on the list of health/physical conditions of the care recipients, followed by stroke ($n=86$), Alzheimer’s disease/dementia ($n=67$), and physical disability ($n=51$) (see table 4). A number of the care recipients have more than one health/physical conditions. The majority of care recipients live with their caregivers (73%). Only a small proportion live alone (4%) or in institutional care (6%). Another 16% live in a different household from their caregivers.

Table 4. Health/Physical Conditions of Care Recipients

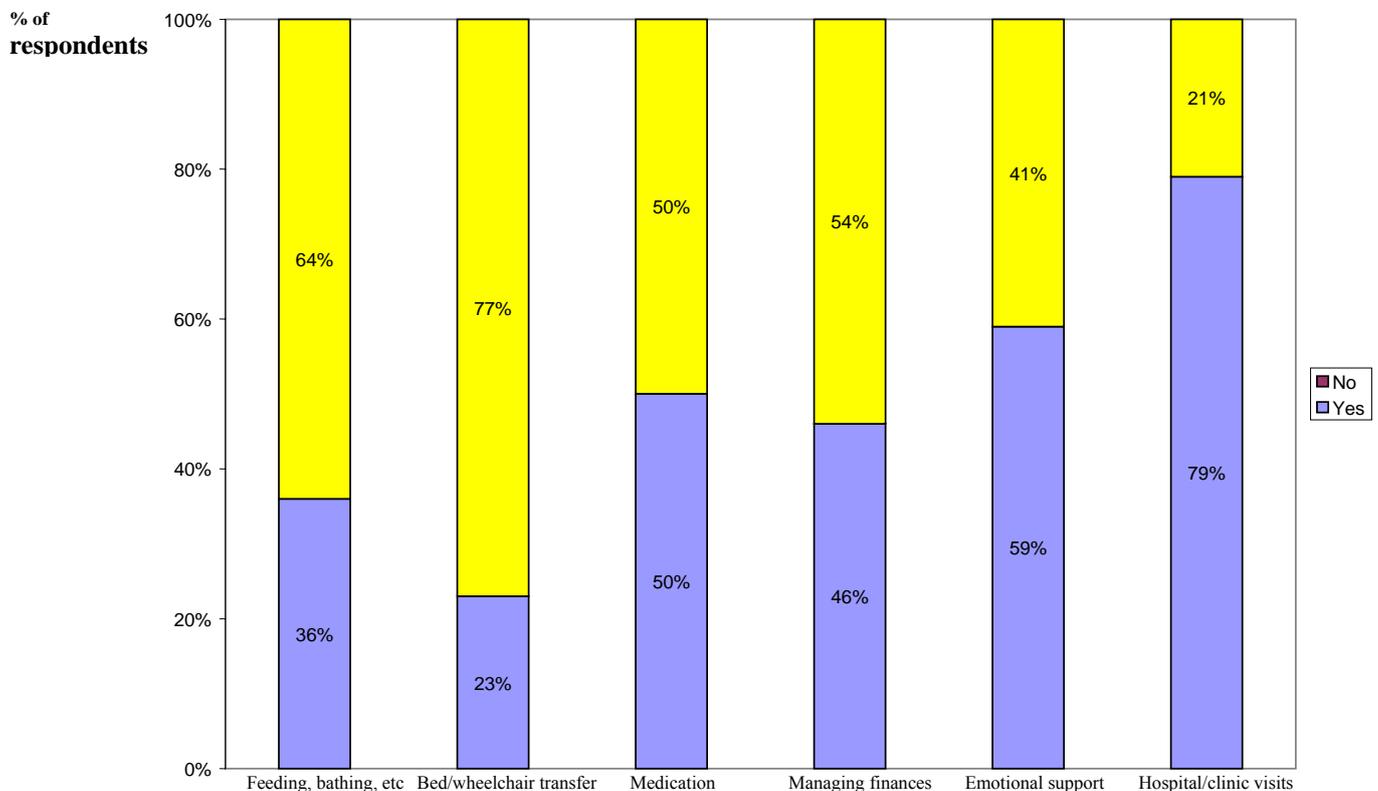
<i>Health/Physical Conditions</i>	<i>No. of Care Recipients*</i>
Frailty in Old Age	116
Stroke	86
Alzheimer’s disease/dementia	67
Physical disability	51
Mental illness	29
Cancer	18
Parkinson’s disease	18
Intellectual disability	12
Others	94

* Adds up to more than 323 as some have more than one health/physical conditions

Caregiving Activities

High on the list of caregiving activities is that of accompanying care recipients on hospital/clinic visits, with 79% of the caregivers responding “yes” to this question on whether assistance is provided (see figure 1). The next most frequent responses are providing emotional support (59%), administering medication (50%), and managing finances (46%). Only about one in three indicated assistance with feeding, bathing, toileting, and dressing, and an even lower number assist with bed or wheelchair transfer (about one in five). In response to the open-ended question on other types of assistance provided, most respondents indicate cooking/preparing meals and others indicate bringing or buying food for care recipients.

Figure 1. Caregiver Assistance with Activities of Daily Living and Instrumental Activities of Daily Living



When asked about assistance from others in caregiving, the results show that 18% do not have any other person to assist them, 44% have one other person, and 27% have two other persons. The range is between 0 and 5, with a mean of 1.35 persons. Of those who have one person to assist them ($n=142$), the majority indicate siblings (22% are sisters and 11% are brothers). There are equal proportions of children (23%) and maids (23%) who provide assistance. Assistance from spouses comprises 17%. Others who provide assistance include parents (2%), nieces and neighbors (2%).

With respect to the use of community-based health and social services, the results show that usage of meal delivery, support groups, respite care, and hospice care is very low (all less than 3%), except for the use of social day care/rehabilitative day care (48%) and home medical/home nursing/home help (8%).

The study also shows that caregivers have been providing, on average, 6.5 years of assistance. The range, however, is very wide, between 1 month and 47 years. In addition, 39 caregivers (12%) also care for a second person. The next sub-section reports on the results of the second care recipient being cared for.

Caring for a Second Person

The second care recipients are mostly parents (66%) or parents-in-law (16%) of the caregivers. The health/physical conditions of care recipients are similar to those reported for the first care recipient, that is, frailty in old age ($n=15$), stroke ($n=6$), and physical disability ($n=5$). In terms of living arrangement, a lower proportion than that shown for the first care recipient live with their caregivers (53% vs. 73%). More live in another household (32% vs. 16%). The results for assistance provided to care recipients mirror, to a large extent, that given to the first care recipients: 71% accompanying on hospital/clinic visits, 63% providing emotional support, 45% managing finances, 37% administering medication, 13% assisting

with bed or wheelchair transfer, and only 16% provide assistance with feeding, bathing, toileting, and dressing. Assistance from others again show the same pattern as that for the first care recipient, with greater assistance from siblings (sisters 40% and brothers 29%), maids (24%), spouses (13%), children (13%), and grandchildren (3%). The usage of community-based health and social services similarly reflect that reported for the first care recipients: below 3% for meal delivery and hospice care and greater usage of social daycare/rehabilitative day care (18%) and home medical/home nursing/home help (11%).

Discussion

The results are discussed first in terms of representativeness of sample and then in the context of both local and international literature.

Representativeness of Sample

When compared to the national profile of ethnicity and religions the study sample appears to be non-representative. However, an informal check with representatives of service providers at a networking meeting on 1 March 2006 (presentation of preliminary results was made by Principal Investigator at this meeting) suggests that the ethnic profile “matches” their clientele profile, that is, the service users are predominantly Chinese. The over-representation of Christian caregivers, however, is hard to account for.

Usage of Community-based Services

Comparing the 1995 National Survey of Senior Citizens with this study shows a number of similarities and differences in study findings. Notwithstanding the focus only on care of senior citizens, different strategies in sampling, the time span of 11 years, and different questions asked, some of the findings suggest convergence. For example, both studies show

low usage of most community-based services (with the exception of day activity centres), implying dependence on capacity within the family to manage caregiving responsibilities. In a study of caregivers' use of community-based services in Canada, the researchers found that the most frequent reasons for not using services are family/friends are providing assistance and lack of awareness of services such as day centres, day hospitals, in-home respite services, hospital respite, and nursing home respite (see Strain & Blandford, 2002). Similarly, the Australian Institute of Health & Welfare (cited in Carers Australia, 2005) found that those without a primary carer use more formal services such as social support, domestic assistance, food services, transport, home maintenance, and rehabilitation, than those with carers. Those with carers, however, are more likely to use personal support services and respite services. An overview of state-supported caregiver services in the United States also found that respite care— temporary, short-term relief provided in or outside the home that includes in-home respite, institutional respite, daycare, and day health program— is the most prevalent service provided (Coleman, 2000). If respite care is broadly defined to include daycare and rehabilitative day care then this study sample's 50% utilization rate of day care services can be considered as congruent with the prevalence finding in the United States.

If, however, the usage of respite care is narrowly defined as out-of-home care, as in short-term stay in an institutional facility when the caregiver goes away or takes a break at home, then the rate is very low (less than 1%). It is an area for concern, given the well documented need of family caregivers for respite. Respite service directly benefits caregivers in terms of their physical and psychological well-being. One factor cited by local service providers for the low usage of out-of-home care is the high cost of service (paid for in cash rather than Medisave account) and the low income of potential service users (Meeting of caregiver service providers, organized by the Central Singapore Community Development Council in March 2006). One service provider also informs that some caregivers

consequently admit their care recipients to hospitals as a way in which they obtain respite and also to utilize their Medisave accounts to pay for care. More affordable respite care, combined with counselling, may help prevent caregivers from using hospitalization as an alternative coping mechanism.

Maids as Caregivers

Both the National Survey on Senior Citizens and this study indicate dependence on maids (foreign domestic workers) as a source of support in family caregiving. The 1995 National Survey of Senior Citizens indicates that maids are often employed not for the sole purpose of caring for an aged family member but also to do household chores and care for young children. The 1995 Survey further indicates higher frequency of maids caring for those aged 75 and above and female senior citizens. Hence, government policy that facilitates affordable employment of foreign domestic workers to care for dependents, whether children, parents, or siblings, will provide the necessary support for family caregivers.

Comparative Profile of Caregivers

The profile of family caregivers generated through this study resembles in some ways the profiles in other countries. Table 5 provides a rough comparison with other countries. The profiles obtained in these countries are based on nationally representative sampling and hence, provide a more representative picture of caregiving as compared with this study, which used convenience sampling.

Table 5. Comparative Data on Profile of Caregivers

<i>Demographic characteristics</i>	<i>NUS study</i>	<i>Great Britain</i> ⁴	<i>Australia</i> ⁵	<i>United States</i> ⁶
Caregiver gender (female)	74%	58%	70%	61% or 65%
Caregivers married/living with a partner	63%	73%	-	62%
Caregivers living in the same household	73%	-	79%	24%
Caring for a spouse/partner	14%	18%	43%	-
Caring for a parent (in-law)	64% (7%)	38% (14%)	21%	44%
Care recipient gender (female)	61%	72%	-	65%
Care recipient age	88% aged 60 and over	83% aged 65 and over	-	80% aged 50 and over

In Great Britain, the General Household Survey⁷ 2000 produced this profile of caregivers: primarily women (58%); middle-aged (45% between 45 to 64 years old) or older person (20% aged 65 or over); married or co-habiting (73%); caring for their parents or parent-in-law (52%) or their spouse or partner (18%) (Maher & Green, 2002). Nearly half of them (45%) had been caring for someone for 5 years or more. The majority (62%) were looking after someone with a physical disability, whereas only 14% said that the person receiving care was aged. About two in five (39%) reported that their physical or mental health had been affected as a result of caregiving.

⁴ Maher & Green (2002).

⁵ Carers Australia, n.d.

⁶ National Alliance for Caregiving and AARP (2004).

⁷ Based on a nationally representative sample of about 14,000 adults living in private households.

As for Australian carers the profile is as follows: Mostly female (70%); caring for someone in the same household (79%); caring mostly for a partner (43%), child (25%), or parent (21%); of workforce age (78% between 18 to 64 years old) or older (21% aged 65 or over); and most (68%) have been caring for more than 5 years (Carers Australia⁸, n.d.).

A study of caregiving in the United States shows this profile (National Alliance for Caregiving and AARP, 2004): Typical caregiver is a 46-year old woman, who has at least some college experience, and provides more than 20 hours of care each week to her mother. Most caregivers are married or living with a partner (62%) and, on average, have been providing care for 4.3 years. Care recipients are mostly female (65%), widowed (42%), and live in their own home (55%). The average age is 75 years old. Caregivers who care for someone aged 50 or older tend to be caring for someone who is their mother (34%), grandmother (11%), or father (10%).

Looking at the profiles across different nations suggest similarities such as predominantly female caregivers and care recipients (particularly in the older age groups). The caregivers are mostly married (or living with a partner) and in countries like Singapore and Australia, are more likely to live in the same household as their care recipients. However, there are also probably cultural differences in terms of which family members assume greater responsibilities and what kind of caregiving tasks is required. For example, in Japan, daughters-in-law (especially wives of eldest sons) are socially expected to provide the most care as compared to Western societies where care by daughters and sons are expected more than care by children-in-law (Campbell & Ikegami, cited in Brodsky, Habib, & Hirschfeld, 2003; Montgomery & Feinberg, 2003). This study seems to indicate a pattern of sibling care of aged parents. In addition, the provision of community-based services (particularly the

⁸ Sources of data include Australian Institute of Health and Welfare 2003, Carers Association of Australia (2003), and Australian Bureau of Statistics (1998).

availability of respite services) and government support of family caregivers vary in these countries, and these differences would have an impact on family caregiving activities.

Implications for Practice and Research

Practice

One important implication arising from this study is the concept of family caregiver, that is, who is a family caregiver? As the survey forms were distributed through “third parties” the onus falls on individuals to self-identify as family caregivers. There may be many who did not do so as they may consider physical, emotional, and social support as part of their “normal” parenting or spousal responsibilities. This may explain the much smaller number of parent and spousal caregivers in this study. They may not perceive themselves as caregivers, which is a social construct, conceptualized in the West. Even in these Western societies, male caregivers may not identify with their role as a caregiver (Barratt & Bulsara, cited in Delaney, 2004). Identification as a caregiver was an issue that our student researchers encountered in the early phase of data collection and which other caregiving studies also face (see e.g. AARP, 2001). At the same time, there were some respondents (though not many) who were volunteers with the service providers or friends, self-identifying as caregivers.

Notwithstanding the position taken by the Inter-Ministerial Committee that family caregiving be accorded high policy priority, public understanding of who is a family caregiver may still be limited (Ministry of Community Development and Sports, 1999). If family caregivers do not identify themselves as such, services developed for them are not likely to be utilized. Though TOUCH Caregiver Centre had initiated Family Caregivers Week, greater efforts in public education, at the national level, are required.

A related issue is the service providers’ contact with family caregivers. In the initial phase of data collection student researchers reported problem with recruiting caregivers

among the service providers, particularly among day activity centres and senior activity centres. The staff-in-charge informed that they have minimal contact with family caregivers as the service users either attend the programme on their own or are accompanied by maids. The implication of lack of contact suggests that services provided as such are targeted at older persons rather than family caregivers, though indirectly they provide a form of support (or daytime respite) to them. It also implies that the potential to reach out to and support caregivers in other ways, for example, emotional and social support, is not fully tapped, as the target for service delivery is older persons, rather than family caregivers. As articulated by Montgomery and Feinberg (2003) assessment of caregivers' own needs is still quite limited. Feinberg, Wolkwitz, & Goldstein (2006) report of a trend among American states in developing systematic assessment of caregivers, and not just the care recipients only, so as to better assist them.

A number of researchers have highlighted family caregivers as "hidden patients", in view of the stresses and hassles of caregiving. This study found a high proportion of family caregivers engaged in accompanying care recipients on hospital or clinic visits. Even as these caregivers may play an advocate or activist role in care recipient's health needs, such visits present opportunities for physicians to assess caregivers' own health needs and "intervene", if necessary (Glasser, Prohaska, & Gravdal, 2001). General Practitioners or family physicians are important first points of contact for caregivers but they also need access to information and resources (Delaney, 2004). The Committee on Aging Issues (Singapore) recognizes that community-based family physicians are "best positioned to provide a holistic approach to primary prevention, maintenance of health and screening of diseases" (2006, p. 38). Their role can be expanded to provide preventive health care to family caregivers.

Research

The Inter-Ministerial Committee on Aging Population report laments the “dearth of data on ... the needs of family care-givers, quality of services, and provision of future services” (Ministry of Community Development and Sports, 1999, p. 101).

As the results show, this study sample includes small numbers of family caregivers of mentally ill, physically disabled, and younger care recipients (less than 40 years old). Their needs may well differ and also be similar in other ways to caregivers of older persons.

Policies for various target groups may be the same or differ according to their varied needs. For example, carers of children with lifelong disabilities will have a comparatively longer period of caregiving than caring for someone with an acute health condition. For policies to be sensitive to varied needs of different caregivers, more research, focusing on different target groups, including those who are intellectually disabled and AIDs patients, is required. Hence, for future research, a nationally representative profile of caregivers in Singapore and not just targeted at caregivers of older persons, will be helpful for policy making.

There is also a need to examine the type of support that working caregivers require to fulfill their family caregiving responsibilities, for example, flexible work schedule and provision of family leave that provides paid leave to care for dependents, whether children or adults (see Montgomery & Feinberg 2003 for employment leave). Current research indicates that family caregiving responsibilities affect job performance and that most employers are not aware of or sensitive to employee’s obligations to care for family members (Delaney, 2004).

One limitation of this study is that, given the nature of survey as a research method, there is a lack of depth of understanding of the issues requiring appropriate social service response. For example, the low usage of community-based services is well documented but the reasons for non-use may not be simply lack of services or awareness of services (Strain & Blandford, 2002). Other possible reasons include care recipient’s desire for control over

service options, flexibility of services in meeting needs, attitudes of care recipients, attitudes of caregivers, and even attitudes of service providers. As such, an in-depth study or studies would be helpful to probe into the needs of care recipients and caregivers in Singapore and identify how the relevant health and social services can be better organized or packaged to meet these needs. Phase II of this project, which is already in place, is an effort to address the need for in-depth studies. The research team undertakes three separate but related investigations of different age groups and health/physical conditions, namely, spousal caregivers of family members, adult children and children-in-law as caregivers of aged family members, and caregivers of family members with a disability.

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Singapore Family Caregiving Survey

A project by the **Department of Social Work**

Faculty of Arts and Social Science

National University of Singapore

(Researchers: Dr Ng Guat Tin, Dr Kalyani Mehta, and Dr Allison Rowlands

Enquiries: Research Assistant's telephone number:)

In cooperation with TOUCH Caregivers Centre

(TOUCH Caregivers Centre helpline number: 1800-3521622)

Are you currently taking care of a family member who is elderly, sick, or disabled?

We want to hear from YOU!

The purpose of this survey is to gather information on the demographics
and responsibilities of family caregivers in Singapore

Please take a moment to complete this questionnaire and return it to us
by hand, through your service provider,
or by post, to this address:

Singapore Family Caregiving Survey
Department of Social Work
National University of Singapore
Block AS6, 4th Floor, 11 Law Link
S117570

Mental illness (e.g. schizophrenia, depression) _____
Others (please describe) _____

12. Where does this person you care for live? With you _____
 Alone _____
 In another household _____
 In institutional care _____
 Others (please describe) _____

13. What kind of personal assistance do you provide? (check all that apply)

Feeding, bathing, toileting, dressing _____
Assisting with bed or wheelchair transfer _____
Administering medication _____
Managing finances _____
Providing emotional support _____
Accompanying on hospital/clinic visits _____
Others (please describe) _____

14. How long have you been providing such assistance? _____ (years)

15. Do you have assistance from any the following? (check all that apply)

Spouse _____ Children _____ Grandchildren _____ Sisters _____ Brothers _____
Parents _____ Maid _____ Others (please specify) _____

16. Which community services do you currently use? (check all that apply)?

Social day care/rehabilitation day care _____
Home medical/home nursing/home help _____
Respite care _____
Support group _____
Meal delivery _____
Hospice _____
Others (please describe) _____

17. Are you taking care of **another** family member who is elderly, sick, or disabled? If YES, please complete page 3.

18. Any other information you would like to share with us?

THANK YOU for your time and patience in answering this questionnaire. It is optional to give your name and telephone number below. If you are willing to participate in a more detailed study or require community assistance, we would appreciate getting your name and contact information :

Name: Mr/Mrs/Miss

Contact number:

Address:

Caring for a second family member who is elderly, sick, or disabled

19. What is your relationship to this other person you care for? He/she is my

- | | | | |
|-------------|-----|---------------------------------|-----|
| Parent | ___ | Parent-in-law | ___ |
| Husband | ___ | Wife | ___ |
| Grandparent | ___ | Child | ___ |
| Sibling | ___ | Other relative (please specify) | ___ |

20. What is the health or physical condition(s) of this person you care for? (Check all that apply)

- Alzheimer’s disease or dementia _____
- Stroke _____
- Cancer _____
- Frailty in old age _____
- Parkinson ’s disease _____
- Physical disability _____
- Intellectual disability _____
- Mental illness (e.g. schizophrenia, depression) _____
- Others (please describe) _____

21. Where does this person you care for live?

With you	___
Alone	___
In another household	___
In institutional care	___
Others (please describe)	___

22. What kind of personal assistance do you provide? (check all that apply)

- Feeding, bathing, toileting, dressing _____
- Assisting with bed or wheelchair transfer _____
- Administering medication _____
- Managing finances _____
- Providing emotional support _____
- Accompanying on hospital/clinic visits _____
- Others (please describe) _____

23. How long have you been providing such assistance? ___ (years)

24. Do you have assistance from any the following? (check all that apply)

- Spouse ___ Children ___ Grandchildren ___ Sisters ___ Brothers ___
- Parents ___ Maid ___ Others (please specify) ___

25. Which community services do you currently use? (check all that apply)?

- Social day care/rehabilitation day care _____
- Home medical/home nursing/home help _____
- Respite care _____
- Support group _____
- Meal delivery _____
- Hospice _____
- Others (please describe) _____