PRIVATE EMPLOYMENT OF HOME CARE WORKERS AND USE OF HEALTH SERVICES BY DISABLED OLDER PEOPLE IN ITALY

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Abstract: Home care workers privately employed by households have become today the “third rail” of long-term care policies in several industrialised countries. In Italy, estimates suggested that they might be as many as over 840,000, most of them being foreign-born migrants living with the cared for person. So far, little attention has been paid to the integration and coordination of these workers within the formal care sector. We analysed a cross-sectional sample of 4,814 disabled older Italians living in the community to assess the association between the private employment of home care workers and the likelihood of using other formal services. After controlling for possible confounding effects of predisposing characteristics and need factors, we found that using private assistance at home is strongly associated with the use of all services. These correlations suggest that a “crowding-in” effect exists between the use of private care and public formal services, and a clear pattern of care tasks allocation can be identified in Italy, where family and private carers are responsible for assisting the older person with basic tasks of daily living, while the residual competences of public formal sector relate to specialised health care services.

Keywords: ageing; migrant care workers; health and social services; disabled older people; private care; Italy.

Biographical note of the main author: Mirko Di Rosa obtained his PhD degree in Economics at the Ancona University (Italy) after having attended an internship in Bucharest (Romania), City Hall Sector 1, European Integration Department. Since 2009 he collaborates at the Italian National Institute of Health and Science on Ageing (INRCA), where he has gained experience in international research projects in the following areas: family care of older people; migrant care workers; prevention of elder abuse; long term care and role of technology for improving the quality of life of older people. His other research interests are the evaluation of public policies and quality of public services.

1. Introduction

1.1. Italy as one of the oldest countries in the world

In the last century, life expectancy significantly increased in industrialised countries like Italy, whereas death rate fell, causing a growth in the share of the older population. Though initially such an increase had been largely explained by decreasing birth rates, most recent trends show that the increased average life expectancy has caused the growth of the proportion of older aged group, rather than of the total population (Baldi and Cagiano de Azevedo, 2005). In the coming decades this phenomenon is predicted to be even wider, in 2050 concerning half of the world population (Pirone, 2009).

Italian people aged 65 and over increased of 95,000 units between 2010 and 2011, now representing 20.3% of the total population (Italian National Institute of Statistics-ISTAT, 2013). Population ageing was particularly rapid in the last decades: the ageing index (i.e. the percentage between the population aged over 65 and the population aged under 15) raised from 68.1% in 1971 to 129.3% in 2001. In 2012 it was 146.8% - i.e. well above the European average of 108.6% and just the second higher value after Germany (150.2%) (Eurostat, 2013) - and it is expected to continue increasing in the next years, up to 207% in 2030 (Barbabella et al., 2013).
In addition to this, the increase in the number of disabled people is definitely the most important phenomenon accompanying the increase in life expectancy. In fact, starting at about 75-80 years the risk of disability increases steeply (Marengoni et al., 2011). The disabled population aged over 65 years living at home in 2005 was about 2,609,000 people, i.e. 4.8% of the elderly population. An even bigger share occurs in the 75-79 age group, where 17.8% are disabled, and in the 80+ age group, reaching 44.5% of dependent people in the same group (ISTAT, 2008).

However, older people can experience intermediate stages of disability status, leading to a variety of individual situations. This leads to a differentiation of needs that may range, e.g., from the need of some daily help at home to a total dependence of the person. For this reason, the state of health is intertwined with the need of social care and the provision of health and social services. With regard to living conditions, there has been a progressive increase in older couples and single-person families, mostly unmarried women or widows (by virtue of their longer female life expectancy). In contrast, only 1.8% of older people are completely dependent and live in institutions providing high-intensity care (like in nursing homes), and only 0.6% live in other residential facilities like care homes and sheltered housing (ISTAT, 2012). This gives rise to many problems that involve not only the older population, but also social and health services, as elderly require, at the time of their loss of independence, social and health assistance (Kemper, 1992).

Recently, analysts hypothesized that immigration could be a viable option to counterbalance Europe’s labor market and welfare state problems (Colombo et al., 2011). However, the change in the demographic structure, characterized by an increasing proportion of older people, will inevitably produce a series of changes in the needs of the population, on the one hand, and call for a review of social policies, on the other.

Comparative social policy studies on long-term care (LTC) have traditionally classified Italy in the cluster of the “familistic” model (Doyle and Timonen 2008, Jenson and Jacobzone, 2000). In this model, which is opposed to the so-called “statist” model typical of Nordic countries, families and individuals are the main responsible for organizing, financing and providing care services. In such contexts, few formal services are provided by the State, which prefers providing families and/or care recipients with cash allowances in order to let them manage older relatives’ assistance.

### 1.2. Formal care services

Italy is characterized by one of the highest and further increasing demand for elder care in the world but, paradoxically, also by a surprisingly low level of public provision in this sector. Indeed, the role of formal care services in Italy remains underdeveloped and unequally distributed throughout the country. Home care services reach only 5.6% of the over 65 year old population, with unequal distribution in the national territory (Barbabella et al., 2013). Coverage of domiciliary services is usually wider in Northern Italy, but in many regions the intensity of the service (in terms of nurse visits at home) is much lower than in the other parts of the country; in Veneto or Friuli-Venezia Giulia the mean number of hours of home care provided by health professionals is respectively 10 and 4 per year, whereas in Southern Italy many regions are above 40 hours per year. Another unequal distribution is true for nursing homes: Southern areas host usually less than 3 beds per 1,000 residents with 65 years or more, whereas in the North the average is higher than 5 or even 6 beds per 1,000 older people (Pesaresi and Brizioli, 2009). On the whole, the very high rate of physicians (4.2 per 1000 inhabitants), compared to a relatively low presence of nurses (5.4 per 1,000 inhabitants) (WHO, 2006), reflects a longstanding shortage of nursing staff, and the lack of measures to shift resources from the acute care to the long-term care sector.

The marginal role of Italian formal care services finds an even clearer explanation in the light of a further, basic characteristic of the Italian welfare state: its “cash-for-care” orientation. Dependent persons in Italy are entitled to receive different cash payments: a) a means-tested “disability pension” by the State, which reaches 275 Euros per month (plus a Christmas bonus of the same amount); b) a “care allowance”, also by the State, which is not means-tested and amounts in 2013 to 500 Euros per month; c) cash benefits, introduced more recently by some local authorities, which are usually means-tested, do not exceed 300-500 Euros per month and might be summed with a care-allowance provided by the State (the possibility to benefit of both national and local cash allowances depends on the eligibility criteria set by each local authority). Summing up the different types of care payments, a total sum of 500-1,300 Euros per month becomes therefore available to recipients who could count on at least two of the above mentioned allowances. Due to lack of controls, however, especially the State care allowance has reached a very wide audience – currently amounting to circa 12.5% of all over 65 year old Italians, up from 5.6% in 2001 (Lamura and Principi, 2009).
1.3. The rise of the “migrant-in-the-family” model

The “cash-for-care” orientation of the Italian welfare system, in which traditionally direct payments prevail over in-kind services, has thus gradually developed into a care regime where monetary transfers to dependent (older) people are often used to privately employ migrant care workers (MCWs) (Di Rosa et al., 2010).

In Italy, whereas in 1991 only 181,000 persons were officially employed in the domestic sector, in 2011 the number of regular contracts in this sector had increased up to 893,000 (Ministero del Lavoro e delle Politiche Sociali, 2012; Pasquinelli and Rusmini, 2010). Considering the high prevalence of undeclared work in the household services existing in the Country, recent estimates suggest that migrant care workers alone might reach over 800,000 (Pasquinelli and Rusmini, 2013), mostly cohabiting with the older persons they care for (INPS, 2010). These are mainly women coming from Eastern Europe, the Far East and Southern America, employed on a live-in (i.e. 24 hours per day) basis.

If we consider only households directly involved in providing informal care to a dependent older person, 13% of them report of privately employing a paid care worker (Lamura et al., 2008). Households who are most likely to resort to this solution are those who are involved in heavy care tasks, such as for instance to provide assistance to a demented family member (over one out of four Italian families facing this challenge is employing a MCWs) or a severely disabled one (over one third of these). This is a clear indicator of the fact that the private employment of care migrants has become in Italy a systematic solution to tackle long-term care needs, when these cannot be properly met by traditional home and residential care services.

1.4. Intersections between formal services and migrant care work: a crowding-in or crowding-out effect?

Home care workers and personal carers provide a crucial support for the quality of life and care of disabled older people living with their families (Langa et al., 2001), and it is likely that in the future elder care will largely depend on this “third rail” of long-term care policy (Stone, 2004; Howe, 2009).

In the light of the large impact of privately paid care on the patterns of elder care delivery, it is surprising that so little attention has been paid so far to the integration and coordination of these workers within the formal care sector and to understand how their employment might affect the likelihood of using other public care services. This article tries to fill this gap, by analysing the correlation between the utilisation of health care services and the private employment of home care assistants in a large sample of disabled older Italians. We will try to assess whether the employment of migrant care workers is likely to occur together with the use of formal care services (crowding-in effect) or a replacement effect instead occurs (so that the use of migrant care workers in Italy substitute the support provided by formal care services, the so-called crowding-out effect).

2. Methods

2.1. Data source

A questionnaire-based survey on “Health status and use of health care in Italy” (ISTAT, 2008) was carried out between December 2004 and September 2005, to investigate the health status and patterns of health care use among the community-dwelling Italian population. Each participant completed at first a self-administered questionnaire, and then was administered a face-to-face interview by ISTAT interviewers. Both questionnaires are based mainly on internationally validated instruments, like the SF12 Quality-of-Life instrument (Ware, Kosinski and Keller, 1996). In case the interviewed person was cognitively impaired, the questionnaire was administered to another family member who responded in his/her place.

The last wave of this cross-sectional survey gathered data on a sample of 25,183 persons aged 65 and more, which was representative in terms of age and gender of the Italian elder population (ISTAT, 2013a).

According to the World Health Organization (WHO, 2010) “disability is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations”. Following this definition, we included in the analysis only those 4,814 over 65 year old persons who during the interview reported to be unable to perform independently at least one of the Activities of Daily Living.
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(ADLs) surveyed by the questionnaire (i.e. bathing with sponge, bath, or shower, dressing, toilet use, transferring in and out of bed or chair, bathing, and eating) (Katz et al., 1970).

2.2. Dependent and independent variables

As dependent variables, we used the answers (Yes/No) to the following questions related to the use of health care services:
- Q1: “In the last 4 weeks, did you call any practitioner asking for advice concerning your health?”
- Q2: “In the last 4 weeks, have you been visited by a GP?”
- Q3: “In the last 4 weeks, have you done any blood tests?”
- Q4: “In the last 4 weeks, have you performed any diagnostic test (excluding those treatments received during a hospital stay or in day hospital?)”
- Q5: “In the last 3 months, did you receive health care at home provided by staff of the National Health Service (i.e. nurses, practitioners, etc.)?”
- Q6: “In the last 3 months, have you used any rehabilitative services like physiotherapy, language rehabilitation, sight rehabilitation, massage therapy, laser therapy, iontophoresis, etc. (excluding those treatments received in hospital settings)”
- Q7: “In the last 12 months, did you get vaccinated against seasonal flu?”

In selecting the independent variables, we followed the Andersen-Newman socio-behavioural model, which suggests an explanatory process for health care utilisation where variables are distinguished between: a) predisposing characteristics, i.e. the socio-demographic characteristics of the individuals; b) enabling resources, related to the care supports available to the individuals; and c) need factors, which are those factors representing the most immediate imperative to seek for assistance (Andersen and Newman, 1973; Andersen, 1995).

As predisposing characteristics, we retrieved from the ISTAT database gender, age and education. Among the enabling resources, we considered the marital status (partner available or not), the household size (less than 2 persons; 2-4 persons; more than 5 persons), the availability of support from a non co-resident family member and the support provided by a private home carer and home helper (self-reported). The difference between these two types of privately-paid assistance is that while home helpers provide support for carrying out the Instrumental ADLs (e.g. preparing meals, housework and shopping for groceries), home carers usually provide full assistance also with the basic ADLs. Finally, need factors were taken into account by assessing both physical and mental health status through the SF12 Quality-of-Life instrument, and the presence of chronic diseases.

2.3. Statistical analysis

After performing a bivariate analysis, we used logistic regressions to evaluate factors associated to health service utilization, controlling for possible confounding variables. Covariates were included into models with a forward stepwise procedure. Standard post-estimation tests such as F-statistics and Hosmer-Lemeshow tests were used to assess the models validity. ROC curves observation allowed to evaluate the accuracy of logistic models’ predictions.

3. Results

Overall, 12.9% of the disabled elderly employ a private home carer, 10.1% a home helper, and 4.4% both. Those who benefit from both private home care and help have higher utilisation rates for GP examinations and phone calls, blood test, health home care, and rehabilitative services, as shown in table 1. All these associations (with the exception of flu vaccine) are statistically significant (below 0.05 level). Among informal support variables, only partner’s availability is significantly associated with an increased use of specific health services, i.e. blood test, diagnostic and rehabilitative services, and flu vaccine. Household size and the availability of help from non-cohabiting relatives are not associated to the use of any of the services considered.

In table 2, odd ratios (OR) and intervals of confidence (IC) related to the enabling resources included in the models are reported, whereas they are all adjusted for other predisposing characteristics and need factors considered. Hiring a home carer and a home helper on a private basis is associated with a higher use of all services considered (except for flu vaccine). Hiring both increases the likelihood of GP examinations (OR=1.52; IC: 1.14 – 2.02), of receiving home health care (OR=2.09; IC: 1.50 – 2.92), rehabilitative services (OR=2.14; IC: 1.49 – 3.08) and of being vaccinated against seasonal flu (OR=1.47; IC: 1.04 – 2.07). Being
married predicts higher utilisation rates for rehabilitative services (OR=1.27; IC: 1.03 – 1.56) and vaccine uptake (OR=1.36; IC: 1.17 – 1.60) only.

4. Discussion

The role of predisposing characteristics like gender (Larsson and Thorslund, 2002) and socio-economic status (Glaser et al., 2006), as well as of enabling resources like marital status (Larsson and Silverstein, 2004) and family support availability (Blomgren et al., 2008) for care services utilisation has been widely discussed.

In our study, after controlling in the logistic models for possible confounding effects caused by predisposing characteristics and need factors, we found that disabled elderly receiving privately paid home care have higher odds of using public health and social care services. Interestingly, among the services considered as dependent variables, there are also important preventive services such as blood and diagnostic tests and seasonal flu vaccine.

4.1. Bridging or crowding-in?

The process of “bridging” has been proposed by previous studies to explain the higher odds of using formal care services among older people counting on family caregivers, suggesting that informal carers may act as advocates and mediators in acquiring formal help services for their older relatives (Geerlings et al., 2005). At a first glance, our findings seem to support the thesis that the process of bridging may apply also to private care work, as people counting on this form of support reported systematically a more frequent use of formal services. Another possible explanation for our results could also be that families counting on home private support, being relieved by other heavier tasks, are more effective as care manager of their older relative. Indeed, available “formal” services do provide to caregivers a professional and specialized help, but only a temporary one. The largest amount of caregiving tasks (i.e. hygiene, company, meals preparation and administration) are realized by family carers and by MCWs (Di Rosa et al., 2012). This is because employing a MCW, rather than using formal services, is a factor associated with a reduction of family caregiver burden. On the one hand, this reflects the important role that these workers play in Italy, while on the other hand, it raises several implications for policy, practice, and research (Chiatti et al., 2013). In any case, the most service characteristics that carers consider as most important are “treating the older person with dignity and respect”, the ability of the service to “improve the quality of life of the older person”, timeliness (i.e. that help is provided when it is needed), and that care workers have the required skills and training, thus suggesting that the most relevant worry of family carers is about the treatment of the older person, rather than their own situation or condition (Di Rosa et al., 2011). Conversely, this process can be considered as having a crowding-in effect: all things being equal, families engaging a MCW are indeed those in a greater state of need, so the MCW can be considered an indicator of need.

In any case, the results suggest that "private care work" and "formal services" are two complementary aspects in the care process, mainly because they have two different functions.

4.2. Limitations of the study

Although our study is based on a large and representative sample, it has a cross-sectional design and further longitudinal analyses are therefore required to unveil possible causal pathways.

In addition to this, we have also to mention that a recall bias might have occurred in respondents when assessing the past use of health care services. In this regard, however, previous studies have shown that self-report of health care services can be an accurate measure within the optimal recall period of 6 months or less (Bhandari and Wagner, 2006), and also a one-year time frame can be justified in case of rarely used medical care, such as for instance seasonal flu vaccination (Ritter et al., 2001). Moreover, we must consider the risk of under-reporting bias when assessing the use of undeclared work in private home care among the interviewees. This risk has been reduced by reassuring respondents during each interview about the fact that, according to the Italian law, ISTAT is obliged to treat all collected data in a highly confidential way. This could possibly have led to a more accurate assessment of the phenomenon of private home care work, than what is normally the case in other official surveys and data collections.
5. Conclusions

The issue of coordination and integration of migrant (often undeclared) care workers into the formal public sector remains a major concern in contexts such as the Italian one, especially considering that only by achieving this goal it will be possible to reduce the prevalence of undeclared work and to exert a more effective control on the quality of care provided by migrant workers who are privately employed in households.

The few available evidence in this regards suggests that, among the older population, receiving low-quality private care is correlated with a worse quality of life (Bilotta and Vergani, 2008) and is an important predictor of nursing-home placement (Bilotta, Nicolini and Vergani, 2009).

In addition, our results suggest that policy-makers and services managers should consider implications in terms of equity of care, as the use of public formal health and social care services results to be strongly correlated with the availability of privately-paid home care. Since family support in Italy is declining and older people rely increasingly on privately paid home care (Lamura et al., 2008), new forms of inequality in accessing important public services could arise for those persons who cannot afford to pay for private assistance. This risk has to be considered especially as Langa and colleagues (2001) noted that privately paid home care is increasingly shifting towards older people living with their children and, therefore, addressing those already benefiting from substantial social support. A possible solution to tackle this risk could be represented by the development of policies specifically targeted to older people living alone and without private support. This will occur, however, only by increasing the still low integration existing between the health and social care systems. Gathering information concerning the social background and problems of the users is indeed primarily a responsibility of the municipal social services, and communication between the latter and the professionals belonging to the health system (like GPs) is not always successful.

The policy level has reacted to this “care-revolution from the bottom” by institutionalizing it, through different measures: by granting regular residence permits and immigration quotas to “care” migrants; by means of fiscal incentives to reduce undeclared labour; and by introducing specific training and accreditation programs. All these initiatives, while contributing to make MCWs a crucial component of the “Italian way” of providing long-term care, have not being able, however, to ensure that they are granted the same rights of formal care providers (Lamura et al. 2008): an issue that, while going beyond the scope of this contribution, certainly represents a major challenge which will need to be urgently tackled in the years to come.

References


Table 1: Frequencies of use of health care services by type of enabling resource available among a sample of 4,814 dependent older Italians living in the community

<table>
<thead>
<tr>
<th>Enabling resources available (n)</th>
<th>Q1: Phone calls to a GP</th>
<th>Q2: GP visit</th>
<th>Q3: Blood test</th>
<th>Q4: Diagnostic test</th>
<th>Q5: Health Home Care</th>
<th>Q6: Rehabilitative Services</th>
<th>Q7: Flu vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% users</td>
<td>% users</td>
<td>% users</td>
<td>% users</td>
<td>% users</td>
<td>% users</td>
<td>% users</td>
</tr>
<tr>
<td>Privately-paid support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of private service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None (3,496)</td>
<td>&lt; 0,01</td>
<td>&lt; 0,01</td>
<td>&lt; 0,01</td>
<td>0,027</td>
<td>&lt; 0,01</td>
<td>&lt; 0,01</td>
<td>0,087</td>
</tr>
<tr>
<td>Only home carer (620)</td>
<td>30,5</td>
<td>41,8</td>
<td>19,6</td>
<td>9,6</td>
<td>13,4</td>
<td>10,6</td>
<td>70,5</td>
</tr>
<tr>
<td>Only home helper (485)</td>
<td>38,6</td>
<td>46,1</td>
<td>24,7</td>
<td>12,7</td>
<td>18,6</td>
<td>15,8</td>
<td>72,4</td>
</tr>
<tr>
<td>Both services (214)</td>
<td>39,6</td>
<td>50,7</td>
<td>24,7</td>
<td>12,4</td>
<td>27,0</td>
<td>15,9</td>
<td>72,6</td>
</tr>
<tr>
<td>Informal support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner available</td>
<td>0,980</td>
<td>0,731</td>
<td>&lt; 0,01</td>
<td>&lt; 0,01</td>
<td>0,786</td>
<td>&lt; 0,01</td>
<td>0,011</td>
</tr>
<tr>
<td>No (3,013)</td>
<td>32,9</td>
<td>43,6</td>
<td>18,8</td>
<td>8,7</td>
<td>16,1</td>
<td>10,7</td>
<td>70,0</td>
</tr>
<tr>
<td>Yes (1,801)</td>
<td>32,9</td>
<td>44,8</td>
<td>24,5</td>
<td>12,7</td>
<td>16,4</td>
<td>14,9</td>
<td>73,4</td>
</tr>
<tr>
<td>Household size</td>
<td>0,660</td>
<td>0,122</td>
<td>0,482</td>
<td>0,747</td>
<td>0,258</td>
<td>0,878</td>
<td>0,132</td>
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<tr>
<td>&lt; 2 persons (3,750)</td>
<td>33,2</td>
<td>43,6</td>
<td>21,2</td>
<td>10,3</td>
<td>15,9</td>
<td>12,4</td>
<td>74,4</td>
</tr>
<tr>
<td>2-4 persons (980)</td>
<td>31,7</td>
<td>43,5</td>
<td>19,7</td>
<td>9,8</td>
<td>17,7</td>
<td>11,8</td>
<td>69,8</td>
</tr>
<tr>
<td>&gt; 5 persons (84)</td>
<td>34,5</td>
<td>54,8</td>
<td>23,8</td>
<td>8,3</td>
<td>12,2</td>
<td>13,1</td>
<td>79,7</td>
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<tr>
<td>Help available from non-cohabiting relatives</td>
<td>0,524</td>
<td>0,579</td>
<td>0,388</td>
<td>0,550</td>
<td>0,818</td>
<td>0,149</td>
<td>0,208</td>
</tr>
<tr>
<td>No (740)</td>
<td>31,9</td>
<td>42,8</td>
<td>19,7</td>
<td>10,8</td>
<td>16,5</td>
<td>10,7</td>
<td>69,3</td>
</tr>
<tr>
<td>Yes (4,974)</td>
<td>33,1</td>
<td>43,9</td>
<td>21,1</td>
<td>10,1</td>
<td>16,1</td>
<td>12,6</td>
<td>71,6</td>
</tr>
<tr>
<td>Total sample</td>
<td>32,9</td>
<td>43,7</td>
<td>20,9</td>
<td>10,2</td>
<td>16,2</td>
<td>12,3</td>
<td>71,3</td>
</tr>
</tbody>
</table>

*p* Significance level of the Chi-square test. In bold are reported p-values below 0.05.
Table 2: Results of logistic regression models for estimated factors associated with health care services use among a sample of 4,814 dependent older Italians living in the community

<table>
<thead>
<tr>
<th>Enabling resources available</th>
<th>Type of service used*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1: Phone calls to a GP OR (IC 95%)</td>
</tr>
<tr>
<td>Privately-paid support</td>
<td></td>
</tr>
<tr>
<td>Type of private service</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Only home carer</td>
<td>1.37 (1.14 – 1.65)</td>
</tr>
<tr>
<td>Only home helper</td>
<td>1.24 (1.01 – 1.52)</td>
</tr>
<tr>
<td>Both services</td>
<td>1.31 (0.97 – 1.75)</td>
</tr>
<tr>
<td>Informal support</td>
<td></td>
</tr>
<tr>
<td>Partner available (yes vs. no)</td>
<td>1.00 (0.86 – 1.16)</td>
</tr>
<tr>
<td>Household size</td>
<td></td>
</tr>
<tr>
<td>&lt; 2 persons</td>
<td>1</td>
</tr>
<tr>
<td>2-4 persons</td>
<td>0.94 (0.80 – 1.10)</td>
</tr>
<tr>
<td>&gt; 5 persons</td>
<td>1.06 (0.67 – 1.69)</td>
</tr>
<tr>
<td>Help available from non cohabiting relatives (Yes vs. No)</td>
<td>1.12 (0.94 – 1.33)</td>
</tr>
</tbody>
</table>

*All ORs are adjusted for following predisposing characteristics and need factors: gender, age, educational level, mental and physical health status (SF12), presence of chronic diseases. In bold are reported ORs with a statistical significance below the 0.05 level.