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The Prevalence of Older Couples With ADL Limitations and Factors Associated With ADL Help Receipt

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Abstract

Using the Andersen-Newman model, we investigated the prevalence of Activities of Daily Living (ADLs) limitations in married couples, and couple characteristics associated with ADL help receipt. In this sample of 3,235 couples age 65+ in the 2004 Health and Retirement Study, 74.3%, 22.1% and 3.6% were couples in which neither, one or two partners had limitations, respectively. Logistic regression results indicate help receipt was associated with certain health needs in the couple, but not with their predisposing characteristics or enabling resources. Social workers could target couples most in need of assistance by assessing both partners' health problems.

Keywords

health; functional limitations; care needs; spousal caregiving; marital dyad

Family members provide the majority of care to older people with functional impairments (Agree & Glaser, 2009), and married older individuals who require assistance with activities of daily living (ADLs) most often receive help from their spouse (Silverstein & Giarrusso, 2010). However, recent studies reveal that receipt of care is less likely when both members of the couple have functional limitations (Feld, Dunkle, Schroepfer, & Shen, 2010). This suggests that researchers should consider the health and assistance needs of both partners of a couple when studying help receipt. To further inform the existing knowledge base, this study examined factors associated with receipt of ADL help among couples in which neither, one, or both partners have functional limitations.

Previous studies indicate interdependence within couples in terms of their physical health, health behaviors, and depressive symptoms (Hoppmann, Gerstorf, & Hibbert, 2011; Meyler, Stimpson, & Peek, 2007). For example, in their systematic review of the literature, Meyler and colleagues (2007) found evidence of concordance in chronic illnesses such as heart disease and blood pressure, as well as risky health behaviors such as smoking and drinking alcohol. Such covariation means that not examining the couple as a unit likely results in biased findings that inaccurately attribute outcomes to individual characteristics. Previous research on help receipt among older married people with functional limitations typically has focused on *individuals* who are married rather than married *couples* as a unit. The generalizability of findings about married individuals to help receipt among couples is questionable. Applying research on married older individuals to couples implicitly assumes that factors influencing each partner's receipt and provision of care are independent, an assumption that ignores similarities and interdependencies typically existing within couples.

Lack of attention to couples as a unit in prior caregiving studies also limits our knowledge about two key issues. First, prior studies have not identified whether there are differences in the characteristics of couples in which neither, one, or both partners have functional limitations that might influence help receipt. Second, these studies have not ascertained the likelihood of differences in the receipt of assistance among these three types of couples, or the characteristics of couples associated with help receipt. It is not clear whether help is more likely among couples in which both partners have functional limitations or couples in which only one partner has limitations. One possibility is that fewer couples with two functionally limited partners receive help due to the inability of one or both partners to provide help to the other (Cantor & Brennan, 2000), whereas among couples with one functionally limited partner, the healthy spouse may be able to provide care. Alternatively, more couples in which both partners have functional limitations may receive any help because their assistance needs are more visible to those outside the marital unit, or because the partners recognize their inability to help one another and therefore are more likely to seek and accept outside help (Laditka & Laditka, 2001). Research focused on the couple as a unit could clarify these issues, and could assist social workers and others evaluating the needs of older couples. For example, information on the prevalence of couples in which both partners have assistance needs could help social workers identify couples who may be at risk of unmet need for assistance and related negative outcomes such as institutionalization or decreased quality of life. In addition, identifying differences in the likelihood that couples with one or two members with ADL limitations receive assistance could help social workers determine appropriate informal and formal sources of support to meet these respective couples' needs.

We focused on ADL problems for several reasons. First, the need for assistance with ADLs among older adults appears high. In 2005, over 4.3 million (12.5%) individuals 65 and over had difficulty performing ADLs (Brault, 2008). Second, many individuals with ADL limitations live without receiving any ADL assistance (Sands et al., 2006), which can put them at risk for health deterioration, early nursing home placement, or even death (Gaugler, Duval, Anderson, & Kane, 2007; Grando et al., 2002; Sands et al., 2006). Understanding the

prevalence of ADL limitations in couples and the help they receive could allow policymakers and practitioners to target elders most in need of assistance.

Literature Review

Prevalence of Older Individuals With ADL Limitations

Activities of daily living measure functional performance in basic self-care activities such as bathing, dressing, transferring (e.g., out of bed), toileting, feeding, and continence. In representative national samples, 15%–30% of noninstitutionalized older individuals have limitations in ADLs (Desai, Lentzner, & Weeks, 2001; Sands et al., 2006). These varying estimates may be related to differences in the observation years, the specific ADL tasks assessed, and the ways researchers define ADL limitations and older persons. For instance, Desai and his colleagues (2001) assessed seven ADLs for adults age 70 and older and defined limitations as experiencing difficulties performing activities. Winblad, et al. (2001) used six items in a sample of people 75 years and older in Finland and defined ADL limitations as dependence in one or more functions. The one study we located reporting prevalence of ADL limitations among older married individuals (Stoller & Cutler, 1992) included those 55 and older and found that 15.5% had any difficulty performing ADLs based on a seven-item scale.

Attributes of Older Individuals With ADL Limitations

Several attributes of older persons appear to be consistently associated with ADL limitations in representative samples. Elders with limitations performing ADLs are more likely to be older (Rivlin, Wiener, Hanley, Hanley, & Spence, 1988), experience limitations in the more complex instrumental activities of daily living (IADL) (e.g., laundry, shopping, preparing meals) (Stoller & Cutler, 1992), and have limited economic resources (Clark, Stump, Hui, & Wolinsky, 1998). Additionally, Black and Hispanic elders are more likely than their White counterparts to experience ADL limitations (Shih, Song, Chang, & Dunlop, 2005).

Help Receipt for Older Individuals With ADL Limitations

Although a substantial number of community-dwelling elders have ADL limitations, many of them do not receive assistance with them. Limitations in ADLs can include having difficulty with, not being able to do without assistance, or not performing the task at all, depending on the measures used in a particular study. Stoller and Cutler (1992) found that 58% of married individuals age 55 or older with any ADL limitations lacked any ADL help. More recently, Noël-Miller (2010), using data from married individuals ages 50 and older participating in the 2000 Health and Retirement Study (HRS), found that 63% of husbands and 65% of wives with any ADL or IADL limitation received no help. In another study using data from the 1994 National Health Interview Survey's Supplement on Aging, around 30% of individuals aged 70 and older with any ADL limitations either did not receive any help or needed more than they received (Desai et al., 2001).

Factors Associated With Help Receipt for Older Individuals With ADL Limitations

The revised Andersen-Newman Behavioral Health Model is the most widely used conceptual framework of factors influencing the use of formal health services for general

health problems, and has more recently been used to examine the use of formal and informal help (Hong, 2010; McAuley, Spector, & Van Nostrand, 2009; Verbrugge & Sevak, 2002). We used the three categories proposed in the revised Andersen-Newman Behavioral Model to organize factors potentially influencing ADL help receipt: (1) predisposing characteristics, (2) enabling resources, and (3) health needs (Andersen, 1995). Predisposing factors are personal characteristics such as demographic, status-related and attitudinal-belief variables. Enabling resources include factors that facilitate or impede individuals from receiving formal or informal help. Health needs refer to individuals' perceived health needs as well as needs evaluated by professionals. Health needs are viewed by Andersen as the most immediate determinant of formal health service usage, and there is considerable evidence that health needs are the primary influences on service use (McAuley et al., 2009).

Two key predisposing socio-demographic factors influencing individuals' ADL help receipt are age and race/ethnicity. Older age, according to Andersen (1995), represents a "... biological imperative suggesting the likelihood that people will need health services" (p.2). Empirical evidence regarding the effects of age on ADL help receipt is limited, however, with one study indicating older age was independently associated with less help receipt (e.g. Norgard & Rodgers, 1997), while others report no relationship between age and help receipt (Desai et al., 2001; Sands et al., 2006). People with different racial/ethnic backgrounds may differ in health service usage because of variations in their socioeconomic status, beliefs and attitudes (e.g., beliefs about the causes of illness and perceptions of health care providers) (Scheppers, Van Dongen, Dekker, Geertzen, & Dekker, 2006), and cultural values and norms (Dilworth-Anderson, Williams, & Gibson, 2002). One study found no variations in help receipt among different racial/ethnic groups (Desai et al., 2001), another reported less help receipt among White than African American elders (Jackson, 1991), and two others found more help receipt by White elders compared to other racial/ethnic groups (Norgard & Rodgers, 1997; Sands et al., 2006).

Studies have addressed enabling resources related to access to potential informal helpers (e.g. spouses or adult children), as well as financial resources necessary to access to formal helpers for help with ADL limitations. Children are second only to spouses as the most likely kin to provide informal help for elders with ADL limitations (Stone et al., 1987). However, one national study found no relationship between having any living children and ADL/IADL help receipt (Norgard & Rodgers, 1997). This study, however, did not consider either gender or proximity of children, both of which are important as daughters are more likely than sons to provide care to their older parents (Stone et al., 1987), and proximate children might decrease solo spousal caregiving by providing care themselves or linking their parents to formal resources (Logan & Spitze, 1994). In terms of financial resources, higher income might increase the possibility of purchasing assistance from the private sector, whereas very low income might increase the opportunity to receive public sector ADL assistance through Medicaid coverage (McAuley, Spector, Van Nostrand, & Shaffer, 2004). Evidence for a relationship between economic vulnerability and the likelihood of formal help receipt is limited and mixed, since two national studies found low family income was associated with unmet need or lack of help receipt (Desai et al., 2001; Norgard & Rodgers, 1997), while another did not find this relationship (Lima & Allen, 2001).

Need for care is the third component of the Andersen-Newman Model, and considerable research suggests that greater need for care is associated with more use of formal health services (e.g., McAuley et al., 2009). The more limited research on the relationship between need and the use of informal caregivers has addressed the number of ADL or IADL limitations, the presence of cognitive problems or chronic health conditions, and the use of assistive equipment. The effect of an older person's functional limitations has received the most attention. Desai et al. (2001) found that elders with a larger number of ADL limitations were more likely to have unmet needs, but other studies did not find this relationship (Lima & Allen, 2001; Norgard & Rodgers, 1997). One study found that elders with cognitive problems were less likely to receive any ADL/ IADL help (Norgard & Rodgers, 1997). Other research found no relationship between number of chronic health conditions and ADL unmet need (Desai et al., 2001) or ADL help receipt (Sands et al., 2006). Prior research on the use of equipment designed to assist with ADL limitations indicates that equipment use signals health needs, but does not provide a clear hypothesis about how it might affect the receipt of human help (Pressler & Ferraro, 2010). The use of such devices could supplement human ADL help and thus may not affect the receipt of assistance from others. However, there could also be situations in which devices may substitute for human help on certain tasks.

Prior research on predisposing, enabling, and need factors potentially associated with ADL help receipt is based on older individuals, not older couples. Indeed, because prior studies have not examined couples, we could not locate any literature examining the relationship between number of partners in a couple needing ADL assistance and their help receipt. Based on the Andersen-Newman Model, it is possible that because couples in which both partners experience ADL limitations have greater care needs, they might be more likely to receive help than couples in which one partner has limitations. This possibility, however, does not take into account the spouse's critical role in the provision of assistance to his or her partner, which may lessen when both partners have ADL limitations.

Rationale Supporting the Research Questions

Three limitations of the existing literature highlight the need for the present study's focus on the prevalence of older couples in which neither, one, or both partners have ADL limitations, and the factors associated with ADL help receipt using the couple as an analysis unit. First, many studies of individuals' care needs have not focused specifically on older married couples (e.g., Sands et al., 2006). Second, the few studies of married elders (e.g. Noel-Miller, 2010) explored the care needs or help receipt of married individuals, rather than the couple as a unit. Studies of married individuals cannot accurately estimate the prevalence of couples in which neither, one or both partners have ADL limitations. Finally, studies of married individuals cannot take into account similarities in health and other characteristics of both partners. Building on prior findings concerning married individuals, we begin to explore these issues among married couples.

The present study's unit of analysis is the couple. This approach simultaneously considers the care needs and other characteristics of both partners of an older couple in order to expand our understanding of the relationship between the couple's ADL limitations and

ADL help receipt. We addressed four research questions: (1) How prevalent are couples in which neither, one, or both partners have ADL limitations? (2) Are there predisposing socio-demographic characteristics, enabling family and financial resources, and health needs that distinguish these three types of couples? (3) Does ADL help receipt differ between couples in which one versus two partners has ADL limitations? (4) Are there predisposing characteristics, enabling resources, and health needs independently associated with couples' ADL help receipt among couples in which one versus two partners have ADL limitations?

Methods

Data and Sample

Data were from the 2004 Health and Retirement Study (HRS), a nationally representative sample of 20,129 persons aged 50 and older and their spouses or partners (see Servais, 2010). The original HRS data collection started in 1992 using a multi-stage area probability sample design that oversampled African Americans, Hispanics and Floridians. Biennial data were collected from these respondents with periodic supplementation of additional cohorts to insure that the ongoing surveys were continually representative of the United States population age 50 or older.

The present study used a subsample from the 6,382 community-dwelling couples (12,764 individuals) who participated in the 2004 HRS survey. Couples were defined as two co-residing persons who self-identified as married or partnered. We selected couples in which at least one partner was 65 years of age or older ($n=3,643$), consisted of a husband and wife ($n=3,639$), and with both partners self-identifying as non-Hispanic White, non-Hispanic Black/African-American, or Mexican American ($n=3,323$). We limited the subsample to these three group because of evidence that race/ethnicity may affect network composition and help receipt (Dilworth-Anderson et al., 2005; Sands et al., 2006) as well as the small number of couples in other racial/ethnic groups. Mexican Americans were included as they were the largest group among Hispanic Americans and evidence showed that Mexican Americans differed from other Hispanic Americans in many aspects, such as health status (Lee & Ferraro, 2007). We also excluded couples missing data on ADL limitations, ADL help receipt, and other study variables described below, yielding a final sample of 3,235 couples.

Measures

Presence of ADL limitations in couples—The six ADL tasks were dressing, bathing, eating, toileting, walking across a room, and getting in or out of bed. Each partner was defined as having any ADL limitation if he or she responded positively to a question concerning having difficulty with, not being able to do, or not performing any ADL task, and it was expected to last more than three months due to health or memory reasons. We categorized couples as having zero, one or two partners with any ADL limitation.

Couples' receipt of any ADL help—ADL help receipt was measured only among couples in which one or two partners had ADL limitations. The HRS asked individuals reporting an ADL limitation whether anyone, either an informal or formal source, helps with

that limitation. Responses were dichotomously coded to indicate whether at least one partner received any ADL help (coded 1) or neither partner received any such help (coded 0).

Couples' attributes—The predisposing socio-demographic characteristics, enabling family and financial resources, and health needs of both partners of the couple were based on previously cited evidence indicating their possible relationship to the presence of ADL limitations or help receipt. The two predisposing socio-demographic characteristics included the partners' ages and race/ethnicity. Preliminary analysis showed that the probability of receiving help did not increase as more members of the couple (0, 1, or 2) were 75 or older (data not shown). Because of this non-linear relationship, couples in which at least one partner was 75 years old or older (coded 1) were compared to those in which both partners were 74 years or younger (coded 0). Race/ethnicity comparisons were made among couples in which both partners were non-Hispanic White, non-Hispanic Black, and Mexican American, with White as the omitted reference category for multivariate analyses.

Four enabling resources were included: number of proximate sons, number of proximate daughters, the poverty ratio, and Medicaid coverage. Proximate sons and daughters were defined as those co-residing with the couple or living less than ten miles away. The poverty ratio was calculated from the couple's prior year's household income (based on imputed income data from RAND HRS) divided by that year's federal poverty figure for a given household size and composition. The availability of Medicaid coverage for health care was included to account for possible public sector assistance. Because of a non-linear relationship between the number of the partners (0, 1, or 2) with Medicaid coverage and help receipt, we measured a couple's Medicaid coverage comparing couples in which at least one partner had Medicaid coverage (coded 1) to couples in which neither partner was covered (coded 0).

Five aspects of the couple's health needs were assessed: the presence of three or more ADL limitations, any equipment used for walking across the room or bed transferring, any cognitive problems, any IADL limitations, and any health conditions. The presence of three or more ADL limitations could only be assessed among couples in which one or two partners had any ADL limitations. We compared such couples in which at least one partner had three or more ADL limitations (coded 1) to those in which neither partner had three or more ADL limitations (coded 0). Based on preliminary analyses showing non-linear relationships to help receipt, variables assessing equipment usage for walking or bed transferring as well as any cognitive problems compared couples in which at least one partner had this problem (coded 1) to those in which neither partner reported it (coded 0). HRS assessed equipment usage for walking and bed transfer for all respondents, regardless of whether they reported limitations with these activities. A person was identified as having a cognitive problem if he or she met either one of the following conditions: (1) was a self-respondent on the Telephone Interview for Cognitive Status and had a score less than or equal to ten where a maximum score was 35 (Rodgers, Ofstedal, & Herzog, 2003), or (2) a proxy respondent reported the individual had any cognitive problem (poor memory, gets lost in familiar places, wanders off, or cannot be left alone) (Freedman, Aykan, & Martin, 2001).

Couples' IADL limitations and health conditions were treated as three-level ordinal variables coded as neither (0), one (1), or both (2) partners had any IADL limitation or health condition. An IADL limitation was identified when an individual reported difficulty doing, could not do, or did not do any specified task (i.e., preparing a hot meal, shopping for groceries, making a telephone call, and taking medications) for health or memory reasons. Individuals were identified as having any health condition if a doctor had ever diagnosed diabetes, a heart condition, stroke, lung disease, or cancer; they saw a doctor for arthritis, or psychiatric problems in the past 12 months; reported problems with urine control in the last 12 months; or were legally blind or had very poor eyesight.

Analytical Strategies

The unit of analysis was a couple; therefore, all variables were defined at the couple level. For this reason, gender could not be considered as a variable because each couple included a husband and a wife. Among couples in which one partner had ADL limitations, similar percentages were ones in which the husband (51%) or the wife (49%) had any limitation (data not shown).

To obtain accurate statistics and standard errors, all analyses used survey commands in Stata's statistical package to take into account HRS's complex multistage sample design (StataCorp, 2009). These commands adjusted for sampling weights, clustering and stratification of the sample by geographic location and size of place.

To test descriptive differences among the groups related to the first three research questions, we used the Chi-Square test for categorical variables, and regression procedures for continuous variables since there is no Stata procedure analogous to analysis of variance (ANOVA) when survey commands are applied. Binomial logistic regression was used to address the fourth research question about the characteristics of couples associated with the receipt of ADL help.

Results

Descriptive Findings

The characteristics of the sample are reported in Table 1. Regarding the first research question concerning the prevalence of ADL limitations, we found that couples in which neither partner had any ADL limitations were most prevalent (74.3%). Couples in which one partner had any ADL limitation comprised a substantial group (22.1%), while the previously unrecognized group of couples in which both partners had ADL limitations was least prevalent (3.6%).

For the second research question, Table 1 shows that most of the assessed predisposing, enabling and need attributes of couples differed significantly among the three types of couples. These differences suggest an association between the number of partners with any ADL limitations and other vulnerabilities. As the number of individuals in the couple with limitations increased, the likelihood of being Black and living close to the poverty level also increased. The more partners with ADL limitations the more likely the couple included one or more partner(s) who: (1) was 75 years or older, (2) had Medicaid coverage, (3) had 3 or

more ADL limitations, (4) used assistive equipment, and had (5) cognitive problems, (6) IADL limitations, and (7) any health conditions.

Regarding the third research question, Table 1 shows that only 46.6% of couples with one partner with ADL limitations received any assistance, compared to 70.3% of couples in which both partners reported ADL limitations. However, while the majority of couples with two partners experiencing ADL limitations received some help, often both partners did not. Specifically, among those couples in which both partners had ADL limitations, in 22.9% both partners received ADL help, in 47.5% only one partner received help, and in 29.6% neither partner received help (data not shown).

Couple Characteristics Predicting Any ADL Help Receipt for Couples in Which One or Both Partners Had ADL Limitations

The logistic regression results in Table 2 address the fourth research question concerning whether predisposing socio-demographic characteristics, enabling family and financial resources, and health needs of married couples are associated with couples' ADL help receipt. The data indicate that only certain health needs, but none of the predisposing or enabling characteristics, were significantly associated with help receipt. Help receipt was associated with (1) at least one partner having three or more ADL limitations, (2) at least one partner using equipment for walking or bed transferring, and (3) the number of partners with any IADL limitations. The odds of getting any ADL help were 10.7 times greater in couples in which at least one partner had three or more ADL limitations than in couples in which each partner had fewer than three ADL limitations (referent). The odds of a couple receiving ADL help were 2.7 times greater for couples in which at least one partner used equipment for walking or bed transferring than in couples in which neither used equipment (referent). The odds of getting ADL help doubled with each increase in the number of partners in a couple who had any IADL limitations. At least one partner having cognitive problems was marginally associated ($p = .066$) with help receipt. The number of partners with any ADL limitations or any health conditions did not have significant independent effects.

Discussion

In several ways, our findings contribute to knowledge about couples with ADL limitations and the relevance of the revised Andersen-Newman's Behavioral Model of Health Services Use (Andersen, 1995) in understanding their help receipt. In a nationally representative sample of older Americans, these findings provide the first estimates of the prevalence of couples in which neither, one, or both partners have ADL problems, and of the characteristics that differentiate these three types of couples. The descriptive data also show that couples in which both partners have ADL limitations were more likely to receive any ADL help than were couples with one such partner. However, when the couples' predisposing socio-demographic characteristics, enabling family and financial resources, and health needs were taken into account, only the couple-level measures of health needs (i.e., ADL limitations, IADL limitations, and use of equipment) emerged as key determinants of ADL help receipt. Whether the couple included one or two partners with

ADL limitations was not among the significant predictors. This finding suggests that it is not simply the number of partners in a couple with ADL limitations but other aspects of the health of the couple that influence their help receipt.

Our study is one of the first to provide nationally representative data on the presence of ADL limitations in each partner of older married couples. Specifically, in 74.3% of these couples neither partner had ADL limitations, in 22.1% one partner had limitations and in 3.6% both partners had limitations. Data from the Census Bureau indicated there were about 20 million married older individuals in 2004 (Current Population Survey Report, 2004), or roughly 10 million married older couples. Using this number and our finding of 3.6% couples in which both partners had ADL limitations, we estimated that nearly 400,000 couples in 2004 of this type. These figures highlight the presence of a relatively small but not negligible group of community-dwelling couples in which both partners have ADL limitations.

The descriptive data from this nationally representative sample also show that the more partners in a couple with ADL limitations, the more likely it was that the couple included one or more partners who were very old, members of racial/ethnic minorities, poor, and dealing with other health problems. For practitioners working with married older adults with ADL limitations, this evidence suggests the importance of assessing the presence of other health care needs in one or both partners in the marital dyad, as well as the barriers that may prevent the couple from receiving needed assistance.

Similar to prior research on married older individuals (e.g. Noël-Miller, 2010), approximately half of all the couples in our sample in which at least one partner had ADL limitations received help. We also found that when both partners had ADL limitations, a higher percentage received help (70%) than couples with one ADL-limited partner (46%). Findings in the present study appear consistent with our view that the Andersen-Newman Model suggests couples in which both partners experience ADL problems have greater care needs and thus might be more likely to get help than couples in which one has limitations. Upon closer examination, however, in only 23% of these couples did both partners receive any ADL help (data not shown), while only one of the partners with ADL limitations received help in 48% of these couples. These findings raise some important questions.

First, among couples in which only one of the partners has an ADL limitation, why do less than half receive any ADL assistance from either their spouse without any such impairment or anyone else? A possible explanation may be related to the psychological meaning of receiving personal assistance. Various theories suggest that many older persons with a disability seek to maintain a sense of independence, competence, and control (Verbrugge & Sevak, 2002). These elders may not ask for or accept help from their spouse or anyone else. Similarly, spouses and other potential helpers may hesitate to provide assistance for fear of threatening a person's sense of independence. It is also possible that willingness to accept spousal help or offer help to a spouse may differ among husbands and wives (Calasanti, 2003). Because the present study considers a couple as the analysis unit, we are unable to address this issue. Nevertheless our findings reinforce the importance of social work practitioners not assuming that having a spouse present who does not have similar health

problems to the partner experiencing limitations ensures that care needs are being met. To assist such couples, social workers might ask both partners about their feelings related to accepting help and providing help. Evidence on these questions is not available in HRS or other large-scale surveys, but should be examined in future research.

Second, when both spouses have ADL care needs, why is it rare for both partners to receive help? This finding may also be tied to the psychological meaning of receiving assistance, as well as to factors distinctive to the situation of these couples. Recognizing the typical caregiving pattern of spouses providing primary and often sole care to their partners with functional limitations (Noël-Miller, 2010), we suspect that when both partners of a couple require ADL assistance, one or both might be reluctant to ask for help from the other because of concerns for their partner's own care needs. Relatedly, even if assistance is desired the other partner may also not be able to help because of his or her own limitations. Furthermore, these couples may be especially reluctant to ask for outside help because they fear that accessing help could result in a separation of the marital partners (O'Connor, 1995), including nursing home placement (Barusch, 1988). These are issues that social workers may be able to clarify and address with their clients, thereby assisting them to reduce unmet ADL needs. Here too, HRS data cannot be used to test these ideas, but they do point to directions for future research.

Third, how do married couples in which one or both partners have ADL limitations manage to remain in the community when they do not receive any assistance? Longitudinal studies have shown that over time the absence of or inadequacy of assistance can lead to an increased risk for other health problems, admission to nursing homes, and death (Gaugler, Kane, Kane, & Newcomer, 2005; Sands et al., 2006). For future research, it is important to understand how older couples with ADL limitations handle lack of help and avoid or delay institutionalization, and whether the absence of assistance results in other negative outcomes such as poor quality of life. It is possible that these couples may be better served by formal care, including care provided in institutions.

Supporting prior research based on the revised Andersen-Newman model concerning the key role of individual health needs (e.g. McAuley et al., 2009), we found that only certain health needs were significantly associated with ADL help receipt. Specifically, the presence of several ADL problems, equipment usage for ADL limitations, and any IADL limitations were important determinants of receipt of help. The positive association between using adaptive equipment for bed transferring and walking and couple's receipt of ADL help is consistent with evidence that individuals' use of equipment reflects high disability levels (Verbrugge & Sevak, 2002) and supports viewing equipment as supplementing rather than substituting for help from other persons. However, the present study did not support our interpretation of the Andersen-Newman Model as suggesting that couples with two partners with ADL limitations may be in need of greater assistance and, would therefore be more likely to receive help than those with one such partner. Prior research on individual predisposing characteristics (e.g. Norgard & Rodgers, 1997) and enabling resources (e.g. McAuley, Spector, Van Nostrand, & Shaffer, 2004) has yielded inconsistent findings about their association with help receipt and we found none of these characteristics of couples were associated with help receipt. These findings reinforce the value of practitioners

assessing the totality of health needs in older married couples as a unit, including evaluations of the severity and range of health problems experienced by each partner.

A few limitations of the present study should be noted and addressed in future research. First, the phrasing of the questions in HRS related to ADL limitations did not permit us to define their severity in terms of the extent of limitations or the nature of the daily tasks for which there were limitations, both of which could be linked to the likelihood of receiving assistance. For example, couples in which a partner has difficulty bathing may require less help than couples in which a partner is unable to bathe without assistance, and these differences may influence the likelihood that help is received. The need for and likelihood of obtaining help may also differ among ADL tasks, such as eating versus getting dressed. Additional research that considers the influences of severity and types of tasks on older couple's help receipt is needed. Furthermore, due to the structure of the HRS questionnaire, we could not determine the extent to which the need for help with limitations was met by the help received. Second, we were unable to consider the factors associated with whether one or both partners of couples in which both partners had ADL limitations received help because of the small number of such couples in which both partners received ADL help ($n=27$). To remedy this limitation, future research based on a larger number of couples in which both have ADL limitations is needed. Third, we could not determine causality because of the cross sectional design of this study. Finally, it is important to note the possibility of nonresponse in the HRS due to the nonrandom losses of proxy respondents as there is evidence that the most cognitively impaired people are likely to be underrepresented (Ofstedal et al., 2005).

Despite these limitations, this study provides the first published data on the presence of ADL limitations in each partner among a representative sample of older married couples living in the United States. Our findings suggest it is important that social work practitioners, researchers and policymakers do not assume that ADL needs are being met for this group simply because a spouse is present. Indeed, our study suggests that about half of partners with ADL limitations may not be receiving any help from their spouse or other sources. Practitioners whose assessments take into account the needs and abilities of each partner in a couple may be better able to provide appropriate assistance with unmet needs. Such efforts could be facilitated by the development and testing of assessment instruments that evaluate the needs of couples rather than only individuals. Currently there is no single assessment tool for older people who may require formal assistance through community-based services such as Medicaid Waiver Home and Community Based Services. Future long term care services and supports should include family caregivers and their needs in assessment and care planning (U.S. Senate, 2013). Findings from the present study provide further support for this recommendation. Based on our research findings, policies and programs that pay attention to the functional assistance needs of both partners may contribute to better meeting their needs and, ultimately, increase their quality of life.

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Table 1
Descriptive Differences among Couples Varying in the Number of Partners with Any ADL Limitations (N = 3,235)

Variable	All Couples % or Mean(SD)	Presence of Any ADL Limitations in Couples			p
		Both w/o ADLs n = 2,403 (74.3%)	One w/ ADLs n = 714 (22.1%)	Both w/ ADLs n = 118 (3.6%)	
Couple's Predisposing Characteristics					
Race/ethnicity					**
Both Black	10.3%	9.2% ^a	12.3% ^b	20.3% ^c	
Both Mexican American	4.3%	3.8%	5.2%	7.6%	
Both White	85.4%	86.9%	82.5%	72.0%	
Ages					***
At least one 75+	39.1%	34.7% ^a	50.4% ^b	59.3% ^c	
Both <= 75	60.9%	65.3%	49.6%	40.7%	
Couple's Enabling Resources					
No. of proximate sons (0-7)	0.6(0.9)	0.6	0.7	0.7	
No. of proximate daughters (0-6)	0.6(0.9)	0.6	0.6	0.8	
Poverty ratio (0-13)	4.7(3.3)	5.0 ^a	3.8 ^b	3.2 ^c	***
Medicaid coverage					***
At least one partner	6.0%	4.1% ^a	9.5% ^b	23.7% ^c	
Neither	94.0%	95.9%	90.5%	76.3%	
Couple's Health Needs					
3 or more ADL limitations					***
At least one partner	8.0%	-	28.2%	50.0%	
Neither	92.0%	-	71.8%	50.0%	
Equipment use					***
At least one partner	19.7%	7.2% ^a	52.2% ^b	78.8% ^c	
Neither	80.3%	92.8%	47.8%	21.2%	
Any cognitive problems					***

Variable	All Couples % or Mean(SD)	Presence of Any ADL Limitations in Couples			p
		Both w/o ADLs n = 2,403 (74.3%)	One w/ ADLs n = 714 (22.1%)	Both w/ ADLs n = 118 (3.6%)	
At least one partner	7.2%	4.0% ^a	14.3% ^b	29.7% ^c	
Neither	92.8%	96.0%	85.7%	70.3%	
No. with IADL limitations (0–2)	0.2(0.5)	0.1 ^a	0.5 ^b	1.0 ^c	***
No. with any health conditions (0–2)	1.7(0.5)	1.6 ^a	1.8 ^b	2.0 ^c	***
Couple receives any ADL help					***
Yes (At least one partner)	50.0%	-	46.6%	70.3%	
No (Neither partner)	50.0%	-	53.4%	29.7%	

Notes: Entries are means unless noted otherwise. Means and percentages are based on raw data. All significance tests take design effects into account by using the Stata software. Reported *p*-values indicated by asterisk test overall significant differences across all three groups (both without, one with, and both with ADL limitations). When overall *p*-values were significant, we performed additional tests testing the differences between any two of the three groups; for each variable, groups that have different superscripts (^a, ^b, and ^c) differed from one another at least at *p* .05.

*
p .05
**
p .01

p .001

Table 2

Logistic Regression Model Predicting Receipt of Any ADL Help for Couples in Which At Least One Partner Has ADL Limitations (n = 832)

Variable	<i>b</i> ^a	<i>p</i>	Odds Ratio
Couple's Predisposing Characteristics			
Race/ethnicity			
Both Black	-0.55		0.58
Both Mexican American	0.08		1.08
(Both White)			
Ages			
At least one 75+	-0.23		0.79
(Both <= 75)			
Couple's Enabling Resources			
No. of proximate sons (0-7)	0.04		1.04
No. of proximate daughters (0-6)	0.04		1.04
Poverty ratio (0-13)	-0.04		0.96
Medicaid coverage			
At least one partner	0.22		1.25
(Neither)			
Couple's Health Needs			
3 or more ADL limitations			
At least one partner	2.37	***	10.65
(Neither)			
Equipment use			
At least one partner	1.01	***	2.75
(Neither)			
Any cognitive problems			
At least one partner	0.58		1.78
(Neither)			
No. with IADL limitations (0-2)	0.70	***	2.01
No. with any health conditions (0-2)	0.20		1.22
No. of partners with ADL Limitations			
Both partners	0.13		1.14
(Only one partner)			

Notes. The overall *F* for the model = 11.51 (*p* = .000).

^aUnstandardized regression coefficients.

*
p .05

**
p .01

p .001