

Care ideals in the Netherlands: Shifts between 2002 and 2011

Thijs van den Broek, Pearl A. Dykstra, & Romke J. van der Veen

Author information

Thijs van den Broek, M.Sc., Erasmus University Rotterdam, Department of Sociology, P.O. Box 1738, 3000 DR Rotterdam, The Netherlands, e-mail: broek@fsw.eur.nl

Pearl A. Dykstra, PhD, Erasmus University Rotterdam, Department of Sociology, P.O. Box 1738, 3000 DR Rotterdam, The Netherlands, e-mail: dykstra@fsw.eur.nl

Romke J. van der Veen, PhD, Erasmus University Rotterdam, Department of Sociology, P.O. Box 1738, 3000 DR Rotterdam, The Netherlands, e-mail: vanderveen@fsw.eur.nl

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Abstract

Our point of departure is that normative care beliefs can inform the current care policy debate. We conduct latent class regression analyses on two waves of Netherlands Kinship Panel Study data (N=4,163) to distinguish *care ideals* that capture multiple dimensions of normative care beliefs simultaneously. We also assess how these care ideals have shifted in the early 21st century. We distinguish four care ideals: *warm-modern* (family and state jointly responsible for caring, egalitarian gender roles), *cold-modern* (large state responsibility, restricted family responsibility, egalitarian gender roles), *traditional* (restricted state responsibility, large family responsibility, moderately traditional gender roles) and *cold-traditional* (large state responsibility, restricted family responsibility, traditional gender roles). Between 2002 and 2011 a shift away from warm-modern care ideals and towards cold-modern care ideals has taken place. This is remarkable, because Dutch policy makers have increasingly encouraged family members to take on an active role in caring for dependent relatives.

Introduction

Largely due to population ageing and the associated greater need for long-term care (OECD, 2011), policy arrangements in many developed countries are being reconsidered (Pavolini & Ranci, 2008). Normative beliefs about what is appropriate with regard to caregiving are crucial in the care policy debate (Hochschild, 1995), in addition to concerns about public expenditure and quality of care (cf. Mot, 2010). Mau (2004) has argued that “any reform attempt will be more likely to be successful if it possesses a good deal of *moral plausibility*, that is, if it responds to people’s moral assumptions of how societal contingencies should be collectively dealt with and how burdens and benefits should be distributed” (p. 69, italics added).

Scholars have examined specific aspects of normative care beliefs, such as filial responsibility, i.e. the generalized expectation that children should support their older parents when they are in need (Dykstra & Fokkema, 2012; Gans & Silverstein, 2006), or the extent to which individuals perceive the state as responsible for financing care for the frail old (Deeming & Keen, 2003). These different aspects of normative care beliefs are largely autonomous. Daatland and Herlofson (2003) found, for instance, that norms regarding filial obligations and welfare state orientations are only weakly associated. A multi-faceted approach is required to fully grasp normative care beliefs.

The first aim of the current study is to distinguish *care ideals* in an attempt to capture multiple dimensions of normative care beliefs simultaneously. Drawing on an essay by Hochschild (1995), we distinguish three key dimensions along which care ideals differ: a state dimension, a family dimension and a gender dimension. In a large, representative sample of the Dutch population, we aim to identify care ideals with characteristic patterns for the three dimensions. The second aim of this paper is to assess shifts in these care ideals over time in the early 21st century. With women’s engagement in paid work increasingly becoming the norm, a shift towards care ideals in which men and women have similar roles and in which family members have a restricted caring role is to be

expected. In what follows, we argue that such a shift might weaken the moral plausibility of Dutch long-term care policy, given recent policy changes.

In many developed countries, long-term care arrangements are being reconsidered, with policy makers increasingly seeking ways to activate and maintain family members as caregivers (Chappell, 1993; Österle & Rothgang, 2010; Pavolini & Ranci, 2008). The Netherlands is exemplary with regard to this development. The country has historically had generous long-term care arrangements, but in the last two decades these arrangements have been reformed in order to contain costs. Concomitantly, Dutch policy makers have been encouraging family members to take on an active role in caring for dependent relatives (Morée, Van der Zee, & Struijs, 2007; Van den Broek, 2013). Sustained moral plausibility of Dutch long-term care policy calls for shifts in care ideals *away from* rather than towards care ideals in which men and women have similar roles and in which family members have a restricted caring role. In the current study, we assess how care ideals have effectively shifted in the Netherlands in the early 21st century to gain insight into the moral plausibility of recent changes in long-term care policies.

Background

Hochschild's cultural ideals of care

Hochschild's (1995) typology of cultural ideals of care is unique in that it addresses multiple dimensions of normative care beliefs simultaneously. Unfortunately, her typology lacks an empirical assessment of its validity. Hochschild distinguishes a traditional, a cold-modern, a warm-modern and a postmodern care ideal, and she applies these care ideals not just to care for the frail old, but also to care for young children. Three key dimensions can be distinguished in Hochschild's ornate descriptions of her four cultural ideals of care. They are: (a) the extent to which the state is deemed responsible for the provision of care, (b) the extent to which the family is deemed

responsible for the provision of care and (c) whether or not men and women are deemed to be equally involved in family caregiving. A simple schematic overview of Hochschild's four care ideals is presented in Table 1.

<TABLE 1 SOMEWHERE HERE>

Individuals adhering to a *traditional* care ideal believe that the family carries the principal responsibility regarding care for those in need. They embrace the male breadwinner model and feel that women should stay at home and provide unpaid care to family members with care needs. In this care ideal, the state's responsibility for care provision is limited: family members - more specifically *female* family members - are the main providers of care and the state's role is only to enable and support family caregiving.

Diametrically opposed to the traditional care ideal is the *cold-modern* care ideal. Individuals adhering to a cold-modern care ideal believe that providing care to those in need is primarily the responsibility of the state rather than that of the family. They also feel that men and women alike should be in the workforce rather than take on care tasks. To illustrate the cold-modern care ideal with regard to care for the frail old, Hochschild (1995) states that "[how] much of [an] older person's life is to be spent in institutional care is a matter of degree, but the cold-modern position presses for maximum hours and institutional control" (p. 340).

State involvement in care is also crucial in the *warm-modern* care ideal. Unlike those adhering to a cold-modern ideal, however, individuals adhering to a warm modern care ideal believe that care responsibility should be shared between the family and the state. They also value equal involvement of men and women in family caregiving and that both should be enabled to combine caregiving with participation in the labor market. In a warm-modern care ideal, family involvement in caregiving is considered important because it assures a level of warmth in the care provided to those in need. Individuals with a warm-modern care ideal believe that the state is responsible for a

share of the care tasks so that for family members the burdens associated with caregiving are limited. Realization of this care ideal manifests itself in forms of care in which family members and formal caregivers jointly engage, such as when relatives and home care professionals share the care for community-dwelling older adults with functional limitations (cf. Sims-Gould & Martin-Matthews, 2010).

In a *postmodern* care ideal¹, the responsibility of adequately arranging care first and foremost rests with those in need themselves, rather than with the family or the state. Individuals adhering to this care ideal expect neither women nor men to participate strongly in unpaid caregiving. Neither do they perceive the state as an entity with large caring responsibilities. Manifestation of the postmodern care ideal would thus result in very low aggregate levels of care provision. The cognitive dissonance that women, in particular, experience between the demands of a career in paid work and the feeling of responsibility towards relatives in need of care (Aronson, 1990) is reduced by downplaying the latter (cf. Hochschild, 1994). This can for instance be done by portraying frail older adults “as ‘content on their own’” (Hochschild, 1995, p. 339).

The Dutch context: Rising female labor participation and re-familialization

As argued previously, we expect shifts in care ideals over time given the decline of the male breadwinner model in which men engage in paid work and women take on the role of homemaker and unpaid caregiver. The Netherlands has seen a dramatic rise in women’s participation in paid work in the second half of the 20th century and the first decade of the 21st century (Janssen & Portegijs, 2011; Van Doorne-Huiskes & Schippers, 2010). The labour force participation rate of Dutch women is today above the European Union average (EIGE, 2013), but Dutch women tend to work part-time. In the early 21st the average number of hours worked has slightly increased (Janssen & Portegijs, 2011): women became more likely to have a full-time or large part-time job and less likely to have a small part-time job.

Women's rising engagement in paid work is arguably related to changing social norms regarding female labor force participation. According to Vlasblom and Schippers (2004), in the Netherlands as well as in other European countries, norms and values have changed in a way that women are increasingly expected to participate in the labor market, also when they are married or have children. Dutch women value paid labor as a means for self-development to the same degree as their male counterparts (Janssen & Portegijs, 2011). A 2008 survey conducted by the Netherlands Institute for Social Research indicated that young women, in particular, are ambitious with regard to paid work. Six out of ten Dutch women younger than 26 years old seek promotion to a higher rank or position in their organization and eight out of ten pursue a wage increase.

When women are more and more expected, by themselves and by others, to focus on a career in paid work, this is likely to be accompanied with an increasingly negative stance towards family caregiving. Research suggests that providing informal care to a dependent relative hampers a career in paid work. Longitudinal studies conducted in Europe (Kotsadam, 2011), Australia (Berecki-Gisolf *et al.*, 2008) and the United States (Pavalko & Artis, 1997) indicate that working women providing informal care are more likely to reduce working hours or to leave their jobs altogether. The changing social norms regarding female labor market participation and the risen ambitions in paid work of, in particular young, women can thus be expected to be accompanied with a shift towards care ideals in which men and women have similar roles and in which family members only have a limited caring role. In Hochschild's terms, this is a shift towards *cold-modern* care ideals.

When men and women alike increasingly focus on paid work and wish to be freed from strenuous caregiving responsibilities, so-called "decommodified defamilialization" of care is called for. This entails widely available, affordable, publicly supported long-term care services (Saraceno & Keck, 2011; cf. Esping-Andersen, 1990; Esping-Andersen, 1999; Lister, 1994). Along with the Nordic

countries, long-term care in the Netherlands has traditionally been characterized by a high degree of decommodified defamilialization (Saraceno & Keck, 2011). As noted previously, the Netherlands has, along with many other European countries (Pavolini & Ranci, 2008; Österle & Rothgang, 2010), been reforming its historically generous public long-term care arrangements since the late 1990s and continuing in the early 21st century in order to contain costs (Van Hooren & Becker, 2012).

Meanwhile, the substantial increase of the number of informal caregivers has become a formal policy goal (Mot, 2010). Increased pressure on family members to provide care to dependent relatives is for instance evident in definitions of certain forms of care as “usual care”, i.e. “normal, daily care that nuclear family members or other people who share a household can be expected to provide to one another” (CIZ 2012, p. 9, authors’ translation). The usual care concept is formalized in a protocol, with the explicit intention to limit formal care provision (Morée, Van der Zee, & Struijs 2007). For individuals sharing a household, it restricts the entitlement to benefits under the Exceptional Medical Expenses Act (Dutch: *Algemene Wet Bijzondere Ziektekosten, AWBZ*), which aims to provide a general insurance covering the Dutch population against exceptional health care needs. Individuals sharing a household also have only limited access to publically provided domestic help because municipalities entrusted with the execution of the Social Support Act (Dutch: *Wet Maatschappelijke Ondersteuning, WMO*) - which aims to offer support to people who need it to sustain their independence and participation in society - mostly use a protocol similar to the usual care protocol when assessing eligibility (Tuynman & Marangos, 2010).

The developments in Dutch long-term care policy outlined here can be seen as manifestations of “re-familialization” rather than decommodified defamilialization. Given that family caregivers tend to be women, the long-term care policy arrangements work out differently by gender (Saraceno, 2010; Saraceno & Keck, 2011). Policy makers encouraging family members to take on a caring role are effectively addressing women (Schenk, 2013; Van den Broek, 2013). Assuming that normative

care beliefs show changes that match policy changes (cf. Svallfors, 2010) and thus that the moral plausibility of long-term care policy is sustained regardless of policy changes, we might expect to find a shift *away from* rather than towards cold-modern care ideals in which men and women have similar roles and in which family members have a restricted caring role.

Socio-demographic predictors

Apart from examining shifts over time, we assess whether key predictors based on previous research distinguish specific care ideals. Gender is such a predictor. American findings show that women have stronger norms of filial obligation than men (Gans & Silverstein, 2006), but studies conducted in Western European countries tend to find the opposite pattern (Daatland & Herlofson, 2003; Daatland, Herlofson, & Lima, 2011; Dykstra & Fokkema, 2012; Herlofson *et al.*, 2011). Dykstra and Fokkema (2012) argue that men may find it important that children care for ageing parents merely in a theoretical sense. Daughters are more often expected to provide burdensome care tasks than sons (Finch & Mason, 1991). For daughters, valuing family caregiving is therefore more likely to imply a perceived personal duty to take on demanding care tasks if need be than for sons. This leads us to expect that women are less likely than men to adhere to a care ideal in which family members have a large caring responsibility, such as a traditional care ideal

The employed and the higher educated arguably have relatively strong feelings of autonomy, making them more likely to adhere to a care ideal in which the principal care responsibility rests with the individual rather than the family or the state (cf. Daatland, Herlofson, & Lima, 2011). In Hochschild's terms, we expect them to be relatively likely to adhere to a postmodern care ideal. Research has shown that people with severe care needs tend to prefer receiving care from a professional, rather than from a family member (Wielink, Huijsman, & McDonnell, 1997; cf. Daatland & Herlofson, 2003). Therefore, we expect them to be relatively unlikely to adhere to a

traditional care ideal in which the family is considered primarily responsible for the provision of care to the frail old.

A person's family situation is likely to shape specific care ideals. Divorce may be detrimental for feelings of family obligations (Ganong & Coleman, 1999), plausibly making it more likely to adhere to a care ideal in which the family carries a restricted caring responsibility. Parents may also be more likely than childless persons to adhere to such care ideals. Research has shown that older parents tend to have relatively weak feelings of filial obligations (Daatland *et al.* 2011; Herlofson *et al.*, 2011), possibly because parents do not want to burden their own children with demanding care tasks (Cahill *et al.*, 2009). Gans and Silverstein (2006) have found that the death of the last living parent is associated with a substantial weakening of filial norms, presumably because the possibility of being a care recipient becomes more real following generational succession. In sum, we expect to find that the divorced, those with children and those who no longer have living parents may be particularly likely to adhere to care ideals in which family members have a restricted caring responsibility, such as a cold-modern care ideal.

Method

To distinguish care ideals among the Dutch population and to identify shifts over time in care ideals, we estimate latent class regression models with covariates. Latent class analysis (LCA) enables the empirical identification of a multidimensional discrete latent variable from a cross-classification of two or more observed (or "manifest") categorical variables (McCutcheon, 1987; Hagenaars & Halman, 1989). It distinguishes a set of mutually exclusive latent classes that account for the distribution of cases across all scores on the joint observed discrete variables. The relationship between the latent variable and the observed variables is probabilistic, rather than deterministic. Stated differently, "the fact that one belongs to a particular class instead of to another

enhances or diminishes the probability of obtaining a particular scoring pattern on the observed variables, but it does not absolutely determine this pattern” (Hagenaars & Halman, 1989, p. 84).

To predict class membership, we estimate latent class regression models that allow the prior probabilities of belonging to various latent classes to vary as a function of a set of observed covariates (Linzer & Lewis, 2010). Rather than calculating the predicted scores on the latent variables and subsequently treating these as observed dependent variables in a regression model as is commonly done, we estimate the coefficients on the covariates simultaneously as part of the latent class model. The advantage of this approach is a reduction of bias in the coefficient estimates (Bolck, Croon, & Hagenaars, 2004). A downside is that - depending on the number latent classes, the number of manifest variables and the number of these variables’ categories - only a limited number of covariates can be included before models become unidentified (Linzer & Lewis, 2010).

We use the poLCA package in R (Linzer & Lewis, 2010) which uses the expectation-maximization (EM) algorithm to estimate the latent class model by maximizing the log-likelihood function (see Dempster, Laird, & Rubin, 1977). The iterative nature of the EM algorithm allows poLCA to estimate LCA-models with missing observations on manifest variables (Linzer & Lewis, 2010). A known problem of the EM algorithm is that, depending upon the initial parameter values chosen in the first iteration, it may only find a local rather than the global maximum of the log-likelihood function (McLachlan & Krishnan, 1997). In order to locate the estimated model parameters that correspond to the model with the global maximum, rather than a local maximum, each model is estimated 500 times.

We start with a model with two classes and subsequently keep adding classes until an additional class no longer improves the model fit. Given the number of manifest variables, the number of these variables’ categories and the number of covariates we want to include in our model, a model with five or more classes would be unidentified (see Linzer & Lewis, 2010). For that reason, we estimate

models with up to four classes. To determine whether a model with an added class has a better model fit than the model with one class fewer, we compare the Bayesian information criteria of both models (Schwarz, 1978).

Data

Our data are from the public release file of the first and third wave of the Netherlands Kinship Panel Study (NKPS). Second wave data were not used, because the indicator for the gender dimension of care ideals was not available in this wave. In the first wave, 8,161 men and women aged 18–80, and living in private households, were interviewed between 2002 and 2004 (Dykstra *et al.*, 2005). The overall response rate in wave 1 was 45 percent, which is lower than rates obtained in other countries, but comparable to that of other large-scale family surveys in the Netherlands.

We restricted our sample to the 4,390 respondents who were still present in the panel during wave 3. Data collection for this wave took place in 2010 and 2011. The wave 3 sample significantly differs from the Dutch population at large with respect to important socio-demographic characteristics (see Merz *et al.* 2012). Women are overrepresented, with about 60 percent of respondents being female. The distribution of age ranges is skewed, with those in the middle age ranges overly likely to participate in the data collection. The married and those living with children (except for single fathers) are over-represented in the NKPS data, while those living alone or with their parents are under-represented. The degree of urbanization of the respondents' living environment matches that of the Dutch population at large. The distribution by region is also quite representative for the Dutch population, with the East slightly over-represented and the West somewhat under-represented.

We excluded respondents with missing values on any of our models' covariates in either of the waves, leaving a final sample of 4,186. We randomly selected one observation per respondent,

effectively turning our panel data into a repeated cross-section. By doing so, we avoid violating the assumption of non-independence underlying our analyses. To check the robustness of our findings, we repeated the procedure of randomly selecting one observation per respondent five times and estimated our models on each of the five additional samples.²

Measures

Manifest variables

We aim to identify latent classes underlying the responses to four survey questions. As an indicator for the extent to which the state is deemed responsible for the provision of care, we use the question whether the respondent considered care for the elderly more of a task for the family or more of a task for the government. Answering categories were “primarily a task for the government”, “(somewhat) more a task for the government”, “(somewhat) more a task for the family” and “primarily a task for the family”.

The state dimension is measured only relative to the extent to which the family is deemed responsible for the provision of care. Proper interpretation therefore requires also taking the family dimension into account. Respondents were asked to what extent they agreed with two statements: “Children should look after their sick parents” and “In old age, parents must be able to live in with their children”. For both statements, the response categories were “strongly agreed”, “agreed”, “neither agreed, nor disagreed”, “disagreed” or “strongly disagreed”. To ensure a manageable number of cells in our data matrix, we collapsed response categories (cf. Halman & Hageaars, 1989; Hogan, Eggebeen, & Clogg, 1993). For each statement we created a categorical variable with three categories instead of the original five. Respondents who “disagreed” or “strongly disagreed” with the statement were assigned to the first category, those who “neither agreed, nor disagreed”

were assigned to the second category and those who “agreed” or “strongly agreed” were assigned to the third category.

To capture the gender dimension of care ideals, we included a measure indicating whether a respondent believed that, within the family, it was the man’s task to provide income. Respondents were asked who in a family made up of a father, a mother and children should carry out the task “earning money”. The answering categories were “primarily the father”, “both equally” and “primarily the mother”. Again, we collapsed categories, merging “both equally” and “primarily the mother”. It should be noted that less than one percent of our respondents indicated that, within a family such as described, it was primarily the mother’s task to earn money. For wave 1, this question was only asked to a subsample of 1,369 NKPS respondents, who were Dutch nationals and household heads. These respondents served as controls for the Social Position and Use of Welfare Provisions by Migrants survey (Dutch: *Sociale Positie en Voorzieningengebruik van Allochtonen, SPVA*), that was commissioned by the Dutch Minorities Integration Policy Department and conducted in 2002 and 2003 (Dykstra *et al.*, 2005).

Covariates

To estimate whether dispositions for specific care ideals varied between the period 2002-2004 (wave 1) and the period 2010-2011 (wave 3), we included a dummy coded as 1 when observations were from wave 3, and as 0 when observations were from wave 1. Since our data are derived from a panel, our respondents are older in wave 3 than in wave 1. By statistically controlling for respondents’ age in our models we avoid estimating a time period effect that effectively captures an age effect.

We included a dummy variable for gender, coded 1 for women and 0 for men. Employment status was measured with a dummy variable indicating whether the respondent was employed. We coded it 1 for those who indicated that the status “working” applied most to their personal situation, and 0

for those who picked any of the alternative statuses: "unemployed or job seeking", "homemaking", "prolonged sick leave or occupationally disabled", "studying, at school", "retired (early)" or "other". An additional dummy variable was included to capture whether or not the respondent was higher educated. We coded it 1 for those with higher vocational, university or post-graduate degrees and 0 for those with lower levels of education. Another dummy variable was included to measure whether the respondent reported coping with a disability and/or a chronic disease. Those indicating that they had one or more prolonged illnesses, health disorders or handicaps and that this restricted them lightly or severely in their daily activities were coded 1. Those indicating they had no prolonged illnesses, health disorders or handicaps, or that they did not feel restricted in their daily activities despite their health issues were coded 0.

Marital disruption was measured with a dummy variable coded as 1 for those indicating that they were divorced and 0 for those who were either married, never married or widowed. The presence of children was measured with a dummy variable coded as 1 for those with at least one child and 0 for those who were childless. We finally included a dummy variable indicating whether both parents had passed away (coded as 1) versus whether at least one parent was still alive (coded as 0).

Results

Descriptive information on the respondents is presented in Table 2. A comparison of Bayesian information criteria indicates that the model fit of our latent class regression model with four classes is better than that of the models with two or three classes.³

<TABLE 2 SOMEWHERE HERE>

Estimated conditional probabilities of scores on our manifest variables on normative care beliefs are presented in Table 3. The most prevalent latent class is the one with a response pattern that is

consistent with a *warm-modern* care ideal, which values joint engagement of family and state in caregiving. Members of this class are relatively unlikely to be outspoken about either state or family carrying of the principal responsibility for care provision to the frail old: they have low probabilities on each of the two most extreme responses. They have a relatively high probability (62%) to regard care for the frail old as somewhat more of a task for the government than for the family, but this does not imply that they do not also perceive the family as carrying responsibility. They have a very low probability (0%) to disagree with the statement that adult children should care for sick parents. They have a high probability (71%) to have an undecided or neutral stance towards this statement and have a probability of 29 percent to outspokenly agree. Despite this moderately receptive stance towards family involvement in care for the frail old, they tend to have strong reservations regarding children's obligation to let frail old parents move in with them. This suggests that they believe that family members can only be expected to engage in forms of caregiving that do not excessively impact the privacy and the personal life of the family caregiver. The probability of outspoken agreement with the statement that parents should be able to live with their children is extremely low (0%). Members of the most prevalent class have a relatively low probability (8%) to perceive earning money as a task for men rather than for women. This suggests that they tend to believe that men and women should be equally involved in family caregiving.

<TABLE 3 SOMEWHERE HERE>

The response pattern of the second latent class is consistent with a *cold-modern* care ideal, in which state involvement in caregiving is greatly valued and family caregiving is not. In this class, the probability to regard care for the frail old as primarily a task for the government is relatively high (36%) and the probability to perceive it as primarily (1%) or somewhat more a task for the family (11%) is low. The probability to disagree with the statements that children should care for sick parents (92%) and that parents must be able to live with their children (96%) is very high. The

probability to perceive earning money as a task for men rather than for women is low (6%).

Arguably, members of this class believe that male as well female family members should be in the workforce, with the state taking full responsibility for the provision of care.

The response pattern of the third latent class is consistent with a *traditional care* ideal. Here, female family members are deemed responsible for the provision of care and the state is perceived as an entity with only few caring responsibilities. Members of this class have a relatively high probability to regard care for the frail old as primarily (6%) or somewhat more a task (33%) for the family. They have a high probability of agreeing with the statement that children should care for sick parents (87%) and also tend to have a neutral (44%) or positive (39%) stance towards the idea that older parents should be able to move in with their children. They have a moderate probability of regarding earning money as a task for men rather than for women (28%), suggesting that they may also be relatively unsupportive of equal involvement of men and women in family caregiving.

The fourth latent class shows a response pattern that does not fully fit with any of Hochschild's four cultural ideals of care. Somewhat consistent with a cold-modern care ideal, members of this class have a relatively high probability to regard care for the frail old as primarily a task for the government rather than for the family (35%) and a high probability of disagreeing with the statement that parents must be able to live with their children (91%). Inconsistent with a cold-modern care ideal, however, they are unlikely to have a clearly negative stance towards family involvement in caregiving for the frail old. The probability of agreeing with the statement that children should care for sick parents (30%) is about as high as the probability of disagreeing (33%) or of being undecided (37%). Remarkably, they have by far the highest probability of all classes to perceive earning money as a task for men rather than for women (82%). We label this class *cold-traditional*. Individuals adhering to this care ideal are not likely to greatly value family involvement

in the provision of care to the frail old, making this care ideal, in Hochschild's terms, cold. They tend to have traditional ideas regarding gender roles.

Results of the latent class regression model predicting class membership are presented in Table 4. Controlling for all other characteristics, the model predicts that in 2010-2011, when wave 3 data were collected, the odds of having a warm-modern care ideal relative to a cold-modern care ideal were lower than in 2002-2004 during the data collection for wave 1 (OR: .729, $p < .05$).

<TABLE 4 SOMEWHERE HERE>

The model furthermore predicts the following. Controlling for all other characteristics, every year increase in age is associated with decreases in the odds of having a warm-modern (OR: .984, $p < .05$) or a traditional (OR: .941, $p < .001$) care ideal relative to a cold-modern care ideal. Compared to men, women have lower odds of having a warm-modern (OR: .760, $p < .05$), traditional (OR: .318, $p < .001$) or cold-traditional care ideal (OR: .438, $p < .01$) relative to a cold-modern care ideal. Those with a higher education degree are less likely than those without a higher education degree to have a traditional (OR: .651, $p < .05$) or a cold-traditional care ideal (OR: .228, $p < .001$) relative to a cold-modern care ideal. The employed are less likely than the jobless to have a traditional (OR: .600, $p < .01$) or a cold-traditional care ideal (OR: .482, $p < .05$) relative to a cold-modern care ideal. The odds of having a cold-traditional care ideal relative to a cold-modern care ideal are a factor 2.103 ($p < .05$) higher for parents than for childless individuals. Divorced individuals are less likely to have a cold-traditional care ideal relative to a cold-modern care ideal than the non-divorced (OR: .247, $p < .05$). We did not find that coping with a disability or chronic illness or that no longer having living parents were associated with a disposition for specific care ideals.

<FIGURE 1 SOMEWHERE HERE>

<FIGURE 2 SOMEWHERE HERE>

<FIGURE 3 SOMEWHERE HERE>

<FIGURE 4 SOMEWHERE HERE>

For easier interpretation of the findings, we calculated predicted probabilities for a “typical” woman or man in waves 1 and 3 to have each of the distinguished care ideals. We performed separate calculations for those with and those without a higher education degree. Age was set to the mean and the categorical predictor variables were set to the mode.⁴ Predictions for lower and higher educated women are depicted in Figure 1 and Figure 2 respectively. Figure 3 and Figure 4 show predictions for, respectively, lower and higher educated men. Model predictions suggest that between 2002-2004 (wave 1) and 2010-2011 (wave 3) there has been a shift away from the warm-modern care ideal and towards a cold-modern care ideal. The predicted probability for a typical woman with (without) a higher education degree of adhering to a warm-modern care ideal was about 53 percent (47 percent) during wave 1 and it declined to a predicted probability of about 46 percent (40 percent) in wave 3. For a typical man with (without) a higher education degree, the predicted probability of having a warm-modern care ideal declined from 49 percent (39 percent) to 42 percent (32 percent) over the same time period. Concomitantly, the predicted probability of adhering to a cold-modern care ideal increased. The magnitude of this increase varied from two percentage points for men without a higher education degree to six percentage points for women with a higher education degree.

Discussion

Scholars have examined specific aspects of normative care beliefs, such as filial responsibility or the extent to which the state is deemed responsible for financing care for the frail old. We have argued that a multi-faceted approach is required to fully grasp normative care beliefs. The first aim of the current study was to distinguish care ideals in an attempt to capture multiple dimensions of

normative care beliefs simultaneously. The second aim was to assess how care ideals have shifted in the Netherlands in the early 21st century.

Our analyses indicate that four care ideals can be distinguished in the Netherlands, three of which are consistent with the cultural ideals of care presented by Hochschild (1995). The most prevalent latent class is consistent with a warm-modern care ideal. Individuals adhering to this care ideal value joint engagement of family and state in caregiving and tend to have egalitarian gender roles. We also distinguish care ideals consistent with, respectively, a cold-modern and a traditional care ideal. Individuals adhering to the former care ideal believe that women and men should be in the workforce, with the state taking full responsibility for the provision of care for the frail old. Those adhering to the latter care ideal believe that female family members are responsible for the provision of care and that the state is an entity with only few caring responsibilities. Furthermore, we find a new care ideal that we label “cold-traditional”. Those adhering to this care ideal are traditional with regard to gender roles. Perhaps in anticipation of the expected retrenchment of long-term care arrangements, they are of the opinion that the state is primarily responsible for the provision of care to the frail old and that the family only has a restricted caring role (cf. Pierson, 1996).

We did not find a latent class consistent with Hochschild’s postmodern care ideal. In a postmodern care ideal neither state nor family but rather the persons in need themselves carry the principal responsibility of adequately arranging care. Individuals adhering to such a care ideal would therefore find it difficult to identify either state or family as carrier of the principal responsibility for care provision to the frail old. This would result in a response pattern with low probabilities on the two most outspoken responses on the manifest state-versus-family item. A post-modern response pattern would further be characterized by high probabilities of disagreement with the statements that children should care for sick parents and that parents must be able to live with

their children. Individuals with a post-modern care ideal would also be unlikely to regard earning money as a task for men rather than for women. The fact that we did not find a postmodern care ideal among the Dutch population suggests that gloomy presentations of contemporary society as a society where individualism thrives and solidarity has disappeared are exaggerated.

We expected the rising female labor market participation in the Netherlands to be accompanied with shifts in care ideals. Consistent with our expectations, our findings indicate that in the early 21st century a shift has taken place towards a cold-modern care ideal in which state involvement in caregiving is greatly valued and family caregiving is not. This shift suggests a discrepancy between Dutch long-term care policy and people's normative care beliefs. Dutch policy makers increasingly aim to activate and maintain family members as caregivers, but our findings show a trend away from rather than towards care ideals in which the family has a prominent caring role. In Mau's (2004) terminology, the *moral plausibility* of Dutch long-term care policy may thus be declining. This apparent discrepancy should not be exaggerated, however. After all, Dutch older adults are still largely protected against unmet needs for care despite the long-term care policy changes that have taken place over the last decades (Smits *et al.*, 2014).

The current study roughly pertained to changes in the first decade of the 21st century. Further reforms in long-term care policy have been implemented since then and more reforms are on their way.. In 2015 the Exceptional Medical Expenses Act will be replaced by the long-term care act (Dutch: *Wet Langdurige Zorg, WLZ*). The aim of the long-term care act is to provide care to people who are in need of care 24 hours per day. Lighter forms of nursing care and most personal care services will be transferred from the Exceptional Medical Expenses Act to the Health Insurance Act (Dutch: *Zorgverzekeringswet, ZVW*). A small share of personal care services will be transferred to the Social Support Act. Municipalities will be responsible for the organization of support to inhabitants coping with limitations performing activities of daily living. As a result, this form of care

will no longer be a right to which those in need are entitled, but a social provision. Before taking on caring responsibilities, municipalities will first require individuals in need - provided that they have the financial means - to buy services on the market and to turn to family members and others in their personal networks for support.

Future studies should address the moral plausibility of the planned reforms. To gain proper insight, additional indicators on normative care ideals are needed. In the current study, we perceived low scores on the family and state dimensions of our care ideals as a sign that the respondent believed that the principal responsibility of adequately arranging care rested with those in need themselves. This operationalization of individual responsibility does capture combinations of individual, family and state responsibility, and such a combination is exactly the direction in which Dutch policy is moving. Assessing the moral plausibility of the planned policy reforms will only be possible when datasets become available that not only include measures of the extent to which family and state are deemed responsible for care provision, but also measures of the extent to which individuals in need themselves are deemed responsible.

While our results suggest a discrepancy between the Netherlands' long-term care policy and normative care beliefs of the Dutch population, it is important to acknowledge that public opinion tends to support more individual responsibility when care for the deserving and needy is guaranteed (cf. Van der Veen, Achterberg, & Raven 2012). The state still tends to be held responsible for the protection of individuals in need, but those in need are increasingly expected to reciprocate and to organize the fulfilment of their care needs themselves. Taking responsibility will be more straightforward for older adults in need of lighter forms of care than for those in need of more demanding forms of care. Concomitantly, the latter are more likely to be perceived as deserving than the latter. Normative beliefs about lighter forms of care may therefore differ from normative beliefs about more demanding forms of care. Data that capture the intricacies of state,

family and individual responsibilities in relation to gender as well as to deservingness and need, will enable future researchers to extend our approach and possibly further refine the care ideals distinguished in this study.

Notes

1. Labeling this care ideal as postmodern may elicit confusion, because Hochschild's (1995) postmodern care ideal is at odds with Lyotard's (1987) account of postmodernity. Postmodernity as used by Hochschild refers to a state of great individualism, rather than to a state of incredulity towards metanarratives. Because Hochschild's typology forms the theoretical point of departure for this study, we use her original labels.
2. Results available on request. The results of the additional analyses did not differ substantially from the results of the analyses presented here.
3. Bayesian information criteria for the full models with two, three and four classes are, respectively, 25,650.8, 25,560.2 and 25,536.0. It was not possible to estimate our full model with five classes, but a model fit comparison of latent class models without covariates indicated that a model with four classes fits our data better than a model with five classes. Bayesian information criteria for the LCA models without covariates are 25,757.3 for the model with four classes and 25,823.8 for the model with five classes
4. Thus, predicted probabilities were calculated for employed parents, who were not divorced, did not have a chronic illness or disability and had at least one parent who was still alive.

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Table 1. *Schematic overview of Hochschild's four cultural ideals of care*

	Traditional	Cold-modern	Warm-modern	Post-modern
State involvement	-	+	+	-
Family involvement	+	-	+	-
Equal (non-)involvement men and women	-	+	+	+

Table 2. *Descriptive statistics*

	Range	Mean	SD
Wave 3	0/1	.490	
Age	18-89	49.727	14.413
Gender (female = 1)	0/1	.611	
Chronic illness / disability	0/1	.248	
Higher education degree	0/1	.396	
Employed	0/1	.604	
Divorced	0/1	.101	
Has children	0/1	.758	
Both parents deceased	0/1	.334	

Source: Netherlands Kinship Panel Study; N = 4,186

Table 3. *Estimated class-conditional response probabilities*

		Total	Warm- modern	Cold- modern	Traditional	Cold- traditional
Principal responsibility care for the elderly	primarily family	.02	.00	.01	.06	.03
	(somewhat) more family	.19	.18	.11	.33	.15
	(somewhat) more government	.54	.62	.53	.47	.47
	primarily government	.25	.20	.36	.14	.35
Children should care for sick parents	(strongly) disagree	.27	.00	.92	.00	.33
	neither agree nor disagree	.37	.71	.00	.13	.37
	(strongly) agree	.36	.29	.08	.87	.30
Parents must be able to live with their children	(strongly) disagree	.70	.73	.96	.18	.91
	neither agree nor disagree	.22	.27	.03	.44	.09
	(strongly) agree	.08	.00	.01	.39	.01
Father is responsible for earning money	no	.76	.92	.95	.72	.18
	yes	.24	.08	.06	.28	.82
Estimated class population share			.40	.24	.20	.17
Observations	4,186					
Fully observed cases	2,341					

Source: Netherlands Kinship Panel Study

Table 4. Results of latent class regression analysis predicting class membership

	Warm-modern		Traditional		Cold-traditional	
	B	(SE)	B	(SE)	B	(SE)
Constant	1.746***	.339	4.165***	.366	.493	.706
Wave 3	-.315*	.104	-.094	.134	.000	.267
Age	-.016*	.005	-.061***	.007	-.000	.010
Gender (female = 1)	-.275*	.108	-1.145***	.132	-.825**	.199
Chronic illness / disability	-.024	.115	.093	.148	-.343	.202
Higher education degree	-.146	.102	-.429*	.133	-1.480***	.275
Employed	.188	.125	-.510**	.152	-.728*	.241
Divorced	-.057	.144	-.009	.193	-1.399*	.438
Has children	-.193	.119	-.285	.141	.743*	.298
Both parents deceased	.113	.138	.007	.192	.074	.245
Observations	4,186					
Fully observed cases	2,341					
Estimated parameters	62					
Residual degrees of freedom	9					
Log-likelihood	-12,509.5					
BIC	25,536.0					

Source: Netherlands Kinship Panel Study; Reference category: cold-modern.

Figure 1. Predicted probabilities class membership women without higher education degree

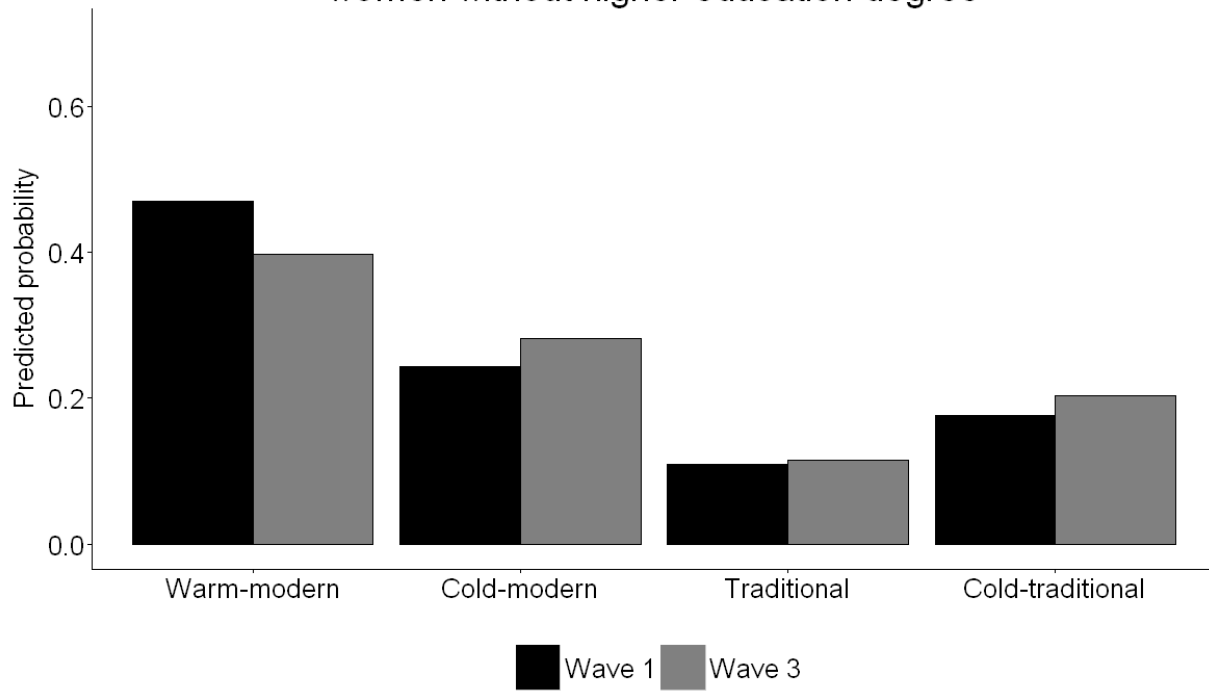


Figure 2. Predicted probabilities class membership women with higher education degree

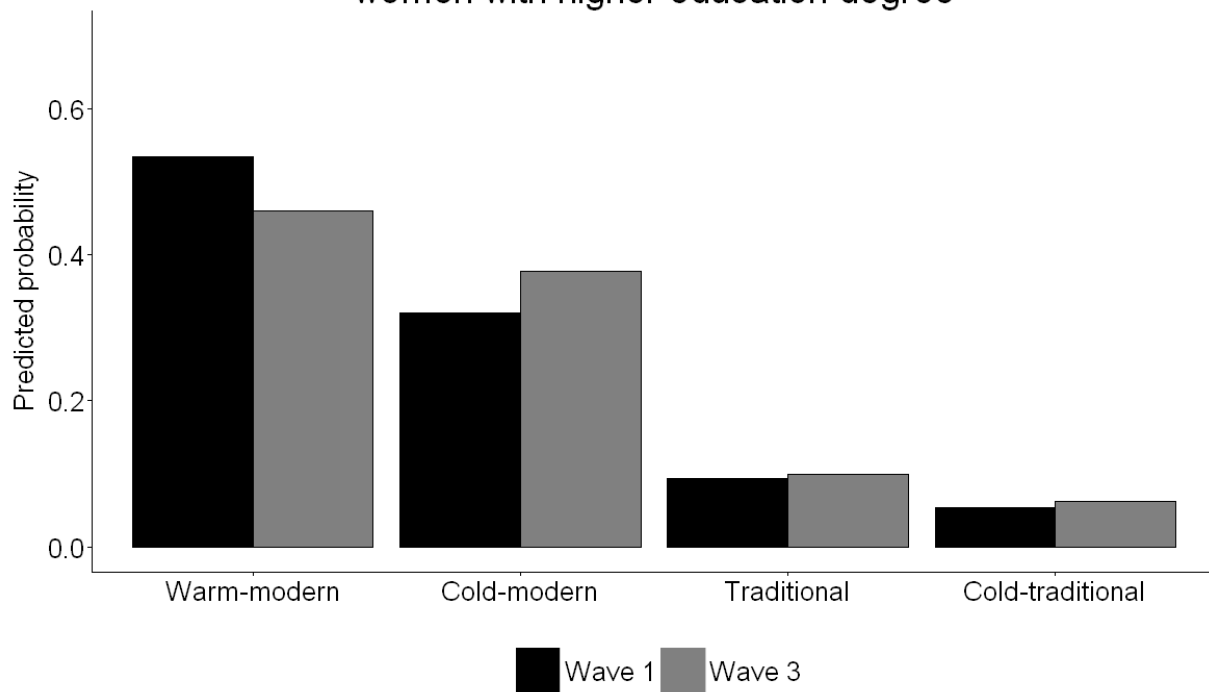


Figure 3. Predicted probabilities class membership men without higher education degree

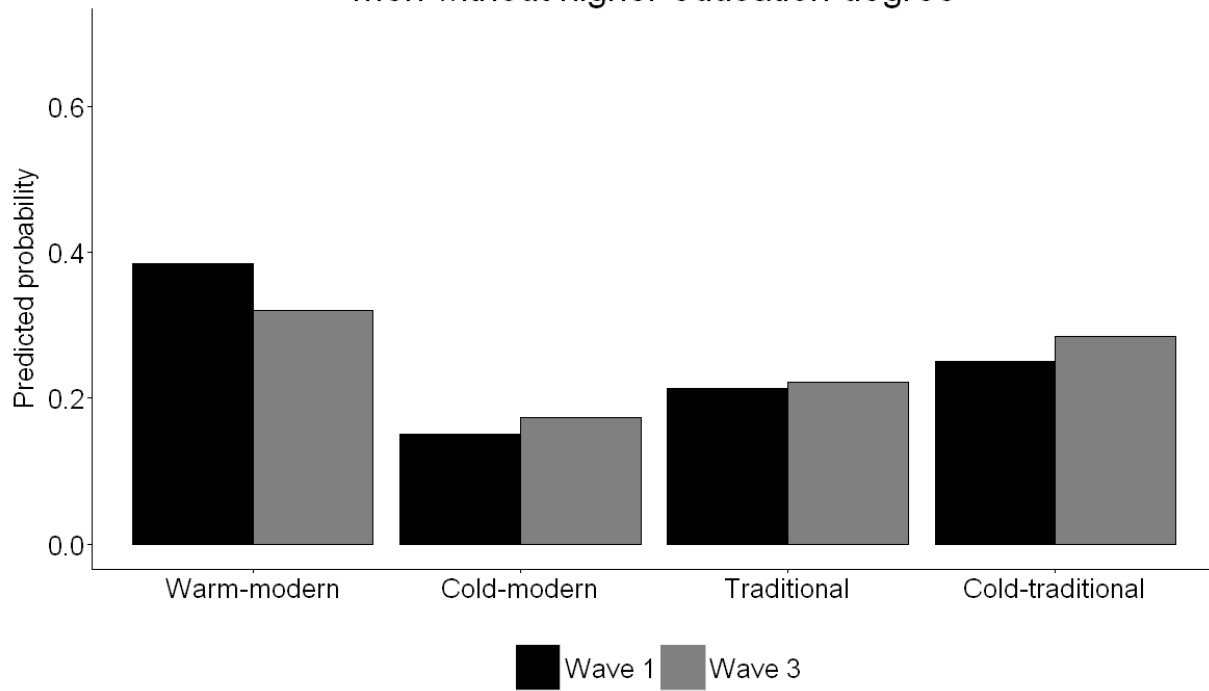


Figure 4. Predicted probabilities class membership men with higher education degree

