

Supporting Ageing Parents

Comparative analyses of upward intergenerational support

Steun aan hulpbehoevende ouders

Vergelijkende analyses van opwaartse intergenerationele steun

Proefschrift

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Mijn promotieonderzoek gaat over opwaartse intergenerationele steun: de steun die volwassen kinderen verlenen aan hun ouders. Studies laten echter steevast zien dat dergelijke steun in het niet valt bij de steun die volwassen kinderen van hun ouders ontvangen. Ik vorm op deze bevinding zeker geen uitzondering. Pap en mam, het geeft een geweldig gevoel te weten dat jullie altijd voor me klaar staan. Jullie stonden ook achter me toen ik ervoor koos om weer in de avond te gaan studeren en om het bedrijf waar jullie ruim 30 jaar aan hadden gebouwd niet over te nemen. De wetenschap dat jullie trots zijn dat ik dit promotietraject heb volbracht geeft deze gebeurtenis voor mij extra glans.

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Thijs van den Broek

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Samenvatting (Dutch summary)

Achtergrond onderzoek

Langdurige zorg omvat een veelheid aan voorzieningen ter ondersteuning van mensen wiens gezondheidsproblemen zodanig van aard zijn dat zij problemen hebben bij het uitvoeren van algemene dagelijkse levensverrichtingen (Österle & Rothgang, 2010). Hulpbehoevende mensen waren van oudsher overgeleverd aan familienetwerken en, tot op zekere hoogte, aan liefdadigheid en lokale sociale ondersteuningsinitiatieven. In veel Europese landen is dit lange tijd grotendeels onveranderd gebleven vanwege hardnekkige institutionele en culturele tradities (Österle & Rothgang, 2010; Pavolini & Ranci, 2008). Een uitzondering hierop vormen de Noordse landen, maar ook Nederland en tot op zekere hoogte het Verenigd Koninkrijk. In de tweede helft van de twintigste eeuw begonnen deze landen langdurige zorg te organiseren volgens een zogenaamd universalistisch model. Overheden in deze landen zorgden ervoor dat zorgdiensten in ruime mate beschikbaar werden voor hulpbehoevende ingezetenen (Österle & Rothgang, 2010) en namen zo de verantwoordelijkheid voor de zorg van hulpbehoevendenden ten minste deels over van de familie (cf. Lister, 1994).

Aan het eind van de twintigste eeuw leidden zorgen over de financiële houdbaarheid van het systeem van langdurige zorg in universalistische landen tot hervormingen. De hervormingen die in verschillende landen werden doorgevoerd hadden een aantal duidelijke overeenkomsten. Door de overheid ondersteunde zorgdiensten werden sterker gericht op personen met een grotere hulpbehoefte (Österle & Rothgang, 2010; Pavolini & Ranci, 2008; Ranci & Pavolini, 2015; Swartz, 2013). Vooral in lichtere vormen van zorg, zoals huishoudelijke zorg, werd gesneden; toekenningscriteria werden strenger en eigen bijdragen werden verhoogd. Verder werd er ingezet op een verschuiving van intramurale zorg naar extramurale zorg (Österle & Rothgang, 2010; Pavolini & Ranci, 2008; Rostgaard, 2002, 2011; Swartz, 2013). Tot slot kregen lagere overheden meer bevoegdheden

bij het bepalen welke zorgvoorzieningen beschikbaar werden gesteld voor hulpbehoevenden en de toekenningscriteria voor deze voorzieningen (Ranci & Pavolini, 2015). Ranci en Pavolini (2015) stellen dat deze hervormingen er tezamen toe hebben geleid dat de verantwoordelijkheden voor de zorg voor hulpbehoevenden verschoven. De verantwoordelijkheden van de familie zijn toegenomen, terwijl de verantwoordelijkheden van de overheid beperkter geworden zijn.

In dit proefschrift heb ik de steun die volwassen kinderen verlenen aan hulpbehoevende ouderen onderzocht. Samen met echtgenoten en partners vormen volwassen kinderen de belangrijkste bron van steun voor hulpbehoevende ouderen (Dykstra, 2015; Wolff & Kasper, 2006). Mijn doel was om inzichten te verschaffen over mogelijke implicaties van de zorghervormingen in van oudsher universalistische landen. Ten eerste was ik geïnteresseerd of van de hervormingen daadwerkelijk verwacht kan worden dat zij leiden tot een verhoogde participatie van volwassen kinderen. Is het daadwerkelijk zo dat volwassen kinderen meer doen voor hun ouders wanneer door de overheid ondersteunde zorgdiensten beperkter beschikbaar zijn? Ten tweede richtte ik me op de vraag of vooral kinderen waarvan reeds bekend is dat ze hun ouders vaak ondersteunen, zoals dochters en enig kinderen, meer steun verlenen aan hulpbehoevende ouders wanneer door de overheid ondersteunde zorgdiensten beperkter beschikbaar zijn. Tot slot heb ik bekeken in hoeverre de zorghervormingen zoals doorgevoerd in van oudsher universalistische landen corresponderden met opvattingen onder de bevolking over hoe langdurige zorg georganiseerd zou moeten worden.

Om bovenstaande onderzoeksvragen te beantwoorden heb ik longitudinale, landenvergelijkende en regionaal-vergelijkende analyses uitgevoerd. Ik heb het verlenen van huishoudelijke hulp (Hoofdstuk 2) en persoonlijke verzorging (Hoofdstuk 3) door volwassen kinderen onderzocht. Deze twee vormen van steun komen in afzonderlijke hoofdstukken aan bod, omdat het verlenen van huishoudelijke hulp vrijblijvender is dan het verlenen van persoonlijke verzorging en omdat van de twee vormen van steun bekend is dat zij duidelijk verschillende determinanten hebben (Brandt, Haberkern & Szydlik, 2009). Naast huishoudelijke hulp en persoonlijke verzorging heb ik de keuzen van volwassen kinderen waar te wonen onderzocht (Hoofdstuk 4), omdat bekend is dat de fysieke afstand tussen ouders en kinderen in sterke mate van invloed is op de uitwisseling van steun tussen ouderen en hun volwassen kinderen. Tot slot heb ik de opvattingen van mensen over hoe zorg georganiseerd behoort te worden verkend (Hoofdstuk 5), waarbij ik verschillende dimensies van dergelijke opvattingen in samenhang met elkaar heb bekeken.

Belangrijkste bevindingen per hoofdstuk

Omgekeerde substitutie van huishoudelijke hulp

In hoofdstuk 2 heb ik me gericht op Nederland. Zorghervormingen in Nederland zijn exemplarisch voor de veranderingen in de langdurige zorg die in de veel landen met een universalistisch model zijn doorgevoerd. Zo is in Nederland toegang tot lichtere vormen van zorg, zoals huishoudelijke zorg, beperkt. Ik heb onderzocht of volwassen kinderen in reactie hierop vaker en meer huishoudelijke hulp zijn gaan verlenen aan hulpbehoevende, zelfstandig wonende ouders zonder partner. Uit analyses van data van vier ronden van de Netherlands Kinship Panel Study (2002-2014, $n = 1,354$) verzameld tussen 2002 en 2014 blijkt dat dit het geval is. Ik heb ook onderzocht of de toename in verleende huishoudelijke hulp vooral sterk was bij twee categorieën kinderen waarvan bekend is dat ze relatief vaak steun aan hulpbehoevende ouders bieden: dochters en kinderen zonder broers of zussen. De analyses wezen echter niet uit dat dit het geval was.

De beschikbaarheid van bedden in zorginstellingen en het verlenen van persoonlijke verzorging aan thuiswonende ouders

In veel van oudsher universalistische landen is de beschikbaarheid van bedden in zorginstellingen de laatste decennia substantieel verminderd. In Hoofdstuk 3 heb ik de samenhang onderzocht tussen de beschikbaarheid van bedden in zorginstellingen en de mate waarin volwassen kinderen persoonlijke zorg, zoals hulp bij wassen, aankleden of naar het toilet gaan, verlenen aan hulpbehoevende, thuiswonende ouderen zonder partner.

Eerder onderzoek heeft uitgewezen dat volwassen kinderen vaker persoonlijke zorg verlenen aan thuiswonende ouders wanneer de beschikbaarheid van bedden in zorginstellingen beperkter is (Pickard, 2012; Ulmanen & Szebehely, 2015), maar over de onderliggende mechanismen is weinig bekend. Landenvergelijkende analyses van data van de Survey of Health, Ageing and Retirement in Europe (SHARE) over 1,214 ouder-kind-paren uit 12 verschillende landen wezen uit dat volwassen kinderen minder vaak persoonlijke zorg aan thuiswonende ouders verleenden in landen waar de beschikbaarheid van bedden in zorginstellingen groter was, omdat de functionele beperkingen van thuiswonende, hulpbehoevende ouders in dergelijke landen minder ernstig waren en omdat volwassen kinderen en hulpbehoevende ouders in dergelijke landen minder vaak een huishouden deelden. Dat volwassen kinderen minder vaak persoonlijke zorg verleenden aan hulpbehoevende ouders in landen waar bedden in zorginstellingen in grotere mate beschikbaar waren was echter niet volledig te verklaren door verschillen in de ernst

van de functionele beperkingen van hulpbehoevende ouders en hoe vaak ouders en kinderen een huishouden deelden. Dit lijkt te suggereren dat het eenvoudige besef dat zorg in een zorginstelling beschikbaar is het gevoel van urgentie bij volwassen kinderen ondermijnt om persoonlijke zorg voor de hulpbehoevende ouder op zich te nemen.

Regionale verschillen in de geografische afstand tussen volwassen kinderen en hun ouders

In veel van oudsher universalistische landen zijn steeds meer bevoegdheden bij het bepalen welke zorgvoorzieningen beschikbaar worden gesteld voor hulpbehoevenden en de toekenningscriteria voor deze voorzieningen overgedragen aan lagere overheden. Door deze ontwikkeling kunnen regionale verschillen in de beschikbaarheid van door de overheid ondersteunde zorgdiensten ontstaan. Dergelijke regionale verschillen zijn in Duitsland reeds substantieel (Rothgang, Kulik, Müller & Unger, 2009).

In Hoofdstuk 4 heb ik onderzocht of de beschikbaarheid van door de overheid ondersteunde zorgdiensten en andere regionale kenmerken van invloed zijn op de mate waarin kinderen met of zonder broers en zussen ervoor kiezen om dichtbij de ouder te wonen of een huishouden met de ouder te delen. Analyses van data van de German Ageing Survey verrijkt met indicatoren op districtsniveau (NUTS3) ($n = 1,989$) lieten zien dat volwassen kinderen, en dan vooral kinderen zonder broers of zussen, vaker een huishouden deelden en minder vaak ver weg woonden van ouders wanneer deze ouders kampten met ernstige beperkingen. Ik heb geen bewijs gevonden dat de regionale beschikbaarheid van door de overheid ondersteunde zorgdiensten van invloed is op de keuze van kinderen waar te wonen.

Opvattingen over langdurige zorg

In Hoofdstuk 5 richtte ik me weer op Nederland. Ik onderzocht hoe opvattingen onder de Nederlandse bevolking over hoe zorg voor hulpbehoevende ouderen dient te worden georganiseerd zijn veranderd in het eerste decennium van de eenentwintigste eeuw. Voortbouwend op het werk van Hochschild (1995), koos ik voor een aanpak waarin ik drie dimensies van morele opvattingen over hoe zorg georganiseerd moet worden in samenhang met elkaar bekeek: (1) de mate waarin de overheid verantwoordelijk wordt geacht voor de zorg voor hulpbehoevenden, (2) de mate waarin de familie hiervoor verantwoordelijk wordt geacht en (3) de mate waarin van mannen en vrouwen een gelijke betrokkenheid in de zorg voor hulpbehoevenden wordt verwacht.

Latent class regression analyses van data van twee rondes van de Netherlands Kinship Panel Study ($n = 4,186$) lieten zien dat er onder de Nederlandse bevolking vier zorgidealen te onderscheiden zijn. In het traditionele zorgideaal neemt de familie – en hierbinnen in de eerste plaats vrouwen – het leeuwendeel van de zorgtaken op zich en wordt de zorgverantwoordelijkheid van de overheid slechts als zeer beperkt beschouwd. Mensen die een warmmodern zorgideaal aanhangen vinden dat familie en de overheid een gezamenlijke verantwoordelijkheid dragen voor de zorg aan hulpbehoevenden. Mensen met een koudmodern zorgideaal zien zorgverlening door familieleden als onwenselijk. Zij vinden dat zowel mannen als vrouwen zich moeten richten op betaald werk. Van de overheid wordt verwacht dat zij dit mogelijk maakt door zorgtaken grotendeels op zich te nemen. Mensen die een koudtraditioneel zorgideaal aanhangen geloven, tot slot, ook dat de zorgverantwoordelijkheid van de overheid groot is en die van de familie beperkt. In tegenstelling tot mensen met een koudmodern zorgideaal houden koudtraditionelen er echter conservatieve man-vrouwopvattingen op na. Betaald werk wordt door hen gezien als een taak voor mannen. Tussen 2002 en 2011 heeft een verschuiving van het warm-moderne zorgideaal naar het koudmoderne zorgideaal plaatsgevonden. Dit is opmerkelijk, omdat de Nederlandse overheid een steeds dringender beroep heeft gedaan op familieleden om zorgtaken op zich te nemen.

Conclusie en discussie

Beschikbaarheid van zorgdiensten en opwaartse intergenerationele steun

In de literatuur zijn verschillende modellen gepresenteerd over hoe door de overheid ondersteunde zorgdiensten en de steun die familieleden verlenen aan hulpbehoevenden met elkaar samenhangen. Mijn bevindingen zijn grotendeels in lijn met het omgekeerde-substitutiemodel van Johansson, Sundström en Hassing (2003). Dit model stelt dat volwassen kinderen meer steun zullen verlenen aan hulpbehoevende ouders in reactie op bezuinigingen op zorgdiensten. In overeenstemming met dit model heb ik in Hoofdstuk 2 laten zien dat Nederlandse volwassen kinderen vaker en meer huishoudelijke hulp zijn gaan verlenen aan hulpbehoevende, alleenwonende ouders toen door de overheid ondersteunde huishoudelijke zorgdiensten beperkter beschikbaar werden.

Eerdere longitudinale studies uitgevoerd in Engeland (Pickard, 2012) en Zweden (Ulmanen & Szebehely, 2015) wijzen erop dat ook het verminderen van de beschikbaarheid van bedden in zorginstellingen leidt tot omgekeerde substitutie. In de onderzochte landen zijn volwassen kinderen meer zorg gaan verlenen aan hun

ouders toen de beschikbaarheid van bedden in zorginstellingen werd verminderd. Overeenkomstig met de resultaten van deze studies laten mijn landenvergelijkende analyses in Hoofdstuk 3 een negatieve samenhang zien tussen de beschikbaarheid van bedden in zorginstellingen en het verlenen van persoonlijke zorg door volwassen kinderen aan zelfstandig wonende, hulpbehoevende ouders zonder partner.

Mijn bevindingen geven redenen om vraagtekens te zetten bij twee theoretische modellen die zijn voorgesteld door wetenschappers die het idee van omgekeerde substitutie bestrijden: het complementariteitsmodel en het specialisatiemodel. Volgens het complementariteitsmodel (Chappell en Blandford, 1991; cf. Stoller, 1989) moedigen zorgdiensten familieleden aan om ook zorgtaken op zich te nemen. Aanhangers van dit model geloven dat het voor familieleden laagdrempeliger wordt om de rol van zorgverlener aan te nemen wanneer de zorglast gedeeld kan worden met professionele zorgmedewerkers. Mijn bevindingen zijn echter niet zoals dit model zou doen verwachten. Hoofdstuk 2 laat zien dat Nederlandse kinderen van hulpbehoevende ouders vaker huishoudelijke hulp zijn gaan verlenen toen door de toegang tot huishoudelijke zorgdiensten werd beperkt. Volgens het complementariteitsmodel zou een afname te verwachten zijn, omdat de mogelijkheden voor kinderen om huishoudelijke te delen met professionele zorgmedewerkers steeds beperkter werden. Het complementariteitsmodel suggereert ook dat, na controle voor de ernst van de zorgbehoefte van de ouder, kinderen meer geneigd zouden zijn om persoonlijke zorg aan hulpbehoevende ouders te verlenen wanneer de ouders thuiszorg ontvangen. Wanneer dit het geval is kunnen volwassen kinderen de zorglast immers delen met professionele zorgmedewerkers. In Hoofdstuk 3 heb ik echter geen positieve samenhang gevonden tussen het ontvangen van thuiszorg door ouders en het verlenen van persoonlijke zorg door volwassen kinderen.

Het specialisatiemodel (Brandt e.a., 2009; Igel, Brandt, Haberkern & Szydlik, 2009) stelt dat een grotere beschikbaarheid van door de overheid ondersteunde zorgdiensten de noodzaak voor familieleden beperkt om de meest belastende zorgtaken, zoals persoonlijke zorg, op zich te nemen. De beperkte noodzaak belastende vormen van zorg te verlenen zou de mogelijkheden voor en de bereidheid van familieleden vergroten om lichtere zorgtaken, zoals huishoudelijke hulp, op zich te nemen. Snijden in door de overheid ondersteunde zorgdiensten zou volgens dit model dus zorgen voor een verhoogde druk op familieleden om belastende zorgtaken op zich te nemen, wat weer ten koste zou gaan van de bereidheid en mogelijkheden om lichtere vormen van zorg, zoals huishoudelijke hulp, te verlenen.

De redenering achter het specialisatiemodel zou plausibel kunnen zijn wanneer hervormingen betrekking hebben op door de overheid ondersteunde diensten voor zeer intensieve zorg. In universalistische landen hebben zorghervormingen echter vooral gevolgen gehad voor de beschikbaarheid van lichtere vormen van zorg, zoals huishoudelijke hulp. Hervormingen hebben de druk om persoonlijke zorg te verlenen dan ook niet substantieel verhoogd. Het is daarom niet verrassend dat mijn onderzoeksresultaten strijdig zijn met het specialisatiemodel. Zoals beschreven leidt dit model tot de verwachting dat huishoudelijke hulp – door aanhangers van het specialisatiemodel beschouwd als een lichte, vrijblijvende vorm van zorg (Brandt e.a., 2009) – door kinderen zal afnemen wanneer gesneden wordt in door de overheid ondersteunde zorgdiensten. In Hoofdstuk 2 vond ik echter geen afname maar een toename. Op basis van het specialisatiemodel zou verder verwacht mogen worden dat volwassen kinderen minder vaak persoonlijke zorg aan zelfstandig wonende ouders zouden verlenen wanneer de ouders ook thuiszorg zouden ontvangen. Persoonlijke zorg wordt door aanhangers van het specialisatiemodel immers beschouwd als een zwaardere, niet vrijblijvende vorm van zorg (Brandt e.a., 2009). In Hoofdstuk 3 heb ik echter geen negatieve samenhang gevonden tussen het ontvangen van thuiszorg door de ouder en de kans voor een volwassen kind om persoonlijke zorg te verlenen.

Mijn bevindingen sluiten niet dat de hervormingen in universalistische landen specialisatie tussen familie en overheid bevorderen, zij het op een andere manier dan gesuggereerd in het specialisatiemodel van Brandt en collega's. Toekomstig onderzoek is nodig om de houdbaarheid te toetsen van een aangepast model dat ik voorlopig gespecialiseerde omgekeerde substitutie zou noemen. Gespecialiseerde omgekeerde substitutie zou inhouden (1) dat de toegang tot door de overheid ondersteunde zorgdiensten beperkter wordt en dat familieleden juist meer zorgtaken op zich nemen, (2) dat deze verschuiving zowel bij lichtere als bij zwaardere vormen plaatsvindt, maar (3) dat de verschuiving van zorgverantwoordelijkheden van de overheid naar de familie sterker is waar het lichtere vormen van zorg betreft dan waar het zwaardere vormen van zorg betreft. Dit zou betekenen dat een groeiend aandeel van het krimpende pakket aan door de overheid ondersteunde zorgdiensten bestaat uit diensten gericht op zware noden van ernstig hulpbehoevenden, terwijl een dalend aandeel van het groeiende pakket aan zorgtaken dat familieleden op zich nemen gericht is op lenigen van dergelijke noden.

Verschillen tussen categorieën kinderen

Onderzoek wijst stevast uit dat bepaalde categorieën kinderen hulpbehoevende ouders bovengemiddeld vaak ondersteunen. De steun door dochters overstijgt de

steun door zoons en een enig kind verleent vaker steun dan een kind met een broer of zus (Haberkern & Szydlik, 2010; Knijn & Liefbroer, 2006; Ogg & Renaut, 2006; Rainer & Siedler, 2012). De analyses in dit proefschrift bevestigen deze patronen. Ik heb laten zien dat dochters vergeleken met zoons actiever zijn bij het verlenen van huishoudelijke hulp (Hoofdstuk 2) en dat ze vaker persoonlijke zorg verlenen aan hulpbehoevende ouders (Hoofdstuk 3). Ook blijkt uit mijn analyses dat de kans dat volwassen kinderen persoonlijke zorg verlenen groter is wanneer zij minder broers of zussen hebben. Tot slot wees Hoofdstuk 4 uit dat volwassen kinderen zonder broers of zussen relatief vaak een huishouden deelde met een oudere ouder, vooral wanneer de ouder sterk hulpbehoefstig was.

Elders is gesuggereerd dat de mate waarin de steun die bepaalde categorieën kinderen verlenen die van andere groepen kinderen overstijgt afhankelijk is van de beschikbaarheid van door de overheid ondersteunde zorgdiensten (Haberkern & Szydlik, 2010; Saraceno & Keck, 2011; Schmid, Brandt & Haberkern, 2012). Mijn analyses bieden echter geen steun voor dit idee. Dit is wellicht voor een deel toe te schrijven aan plafondeffecten. In Hoofdstuk 2, bijvoorbeeld, verleenden dochters al tijdens het eerste meetmoment – toen de beschikbaarheid van huishoudelijke zorgdiensten nog relatief groot was – veel vaker huishoudelijke hulp dan zoons. Toen de toegang tot huishoudelijke zorgdiensten beperkter werd was er voor dochters dus minder ruimte voor toename van huishoudelijke hulpverlening dan voor zoons.

Morele plausibiliteit

De verschuiving van verantwoordelijkheden in universalistische landen is een geleidelijk proces dat in de jaren '90 in gang is gezet en nog steeds gaande is. Mijn bevindingen maken aannemelijk dat pogingen om nog meer zorgverantwoordelijkheden over te hevelen van de overheid naar de familie zullen stuiten op weerstand. De morele plausibiliteit, dit wil zeggen de mate van overeenstemming met morele opvattingen onder de bevolking (Mau, 2004), van dergelijke inspanningen is immers beperkt.

Het universalistische model van langdurige zorg, waarin door de overheid ondersteunde zorgdiensten in ruime mate beschikbaar zijn, is een realisering van het zorgideaal dat Hochschild (1995) koudmodern noemt. Mensen met een koudmodern zorgideaal verwachten dat mannen en vrouwen zich richten op betaald werk. De overheid moet dit in de ogen van koudmoderneren mogelijk maken door de verantwoordelijkheid voor de zorg voor hulpbehoevenden op zich te nemen, waardoor de noodzaak voor de familie om zorg te verlenen verdwijnt. Door de

eerder genoemde hervormingen beweegt de langdurige zorg in van oudsher universalistische landen zich weg van een zorgmodel dat aansluit bij dit ideaal (cf. Ranci & Pavolini, 2015). Dit zou moreel plausibel kunnen zijn bij een afname van de populariteit van het koudmoderne zorgideaal. In Hoofdstuk 5 heb ik echter aangetoond dat het koudmoderne zorgideaal, tenminste in Nederland, steeds meer, in plaats van minder, aanhang geniet. Mijn bevindingen duiden er dus niet op dat pogingen om te herdefiniëren hoe de overheid en de familie zorgverantwoordelijkheden moeten delen breed worden omarmd.

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Chapter 1

Setting the stage

1.1 Introduction

Long-term care (LTC) entails a heterogeneous range of provisions that help and support people coping with health problems that limit them in their activities of daily living (Österle & Rothgang, 2010). The need for LTC has only relatively recently been recognized by European countries as a specific social risk requiring welfare policy intervention (Österle & Rothgang, 2010; Ranci & Pavolini, 2015). People with care needs have traditionally relied on family networks, and, to some extent, on charitable sources or local social assistance. In many European countries this has long remained largely unchanged because of persistent institutional and cultural traditions (Österle & Rothgang, 2010; Pavolini & Ranci, 2008). The Nordic countries, but also the Netherlands and to some extent the United Kingdom, form an exception. In some cases as early as in the 1940s, these countries adopted a so-called universalistic LTC model. They made state supported LTC services available for persons in need (Österle & Rothgang, 2010), thus removing the responsibility to support those in need, at least partly, from the family (cf. Lister, 1994).

By the end of the twentieth century, growing concerns about financial sustainability of LTC led countries with universalistic models to consider reforms. Across countries, implemented LTC reforms had similar characteristics. State supported LTC services typically became increasingly targeted to those with the most severe needs (Österle & Rothgang, 2010; Pavolini & Ranci, 2008; Ranci & Pavolini, 2015; Swartz, 2013). Particularly lighter forms of LTC services, such as household support, were subject to cutbacks; eligibility criteria became stricter and co-payments were increased. Furthermore, a stronger emphasis was placed on home-based care services rather than on care provided in institutions (Österle & Rothgang, 2010; Pavolini & Ranci, 2008; Rostgaard, 2002, 2011; Swartz, 2013). Finally, more authority in determining the LTC services to be provided and their eligibility criteria was delegated to lower level governments (Ranci & Pavolini, 2015). Ranci and Pavolini (2015) have argued that the reforms have redefined the relation between the state and the family. Part of the responsibility for the care for those in need has been shifted to informal networks, most notably the family.

In this dissertation, I focus on upward intergenerational support, i.e. support provided by adult children to parents with care needs. Together with spouses and partners, adult children are the most prominent providers of informal support to older persons in need (Dykstra, 2015; Wolff & Kasper, 2006). My aim is to shed light on the implications of the ongoing policy shifts in countries with a universalistic LTC approach. Firstly, I am interested in whether the reforms implemented

in countries can be expected to have the outcomes they envisioned. Is the involvement of adult children in caregiving effectively greater when state supported LTC services are less widely available? Secondly, I am interested in unforeseen negative consequences that the reforms may have. Can they be expected to amplify the extent to which the involvement in caregiving of particular categories of family members exceeds that of others? Finally, I explore how public opinion responds to reforms. Does the shift towards a LTC model with more family responsibilities and fewer state responsibilities correspond with moral beliefs among the population about how LTC should be organized? The shift of caring responsibilities in universalistic countries is a gradual process that has been taking place since the 1990s. A lack of correspondence with what people hold as just may hamper this process, particularly when LTC is deemed a highly important policy subject (cf. Burstein, 2003).

The interrelations between state supported LTC services and the support that family members provide to ageing family members in need have been subject of scholarly debate for decades. Different theoretical models on these interrelations have been developed, most notably the reverse substitution model (Johansson et al., 2003), the complementarity model (Chappell and Blandford, 1991; cf. Stoller, 1989) and the specialization model (Brandt et al., 2009; Igel et al., 2009). Depending on the chosen model, expectations with regard to the outcomes of the ongoing LTC reforms in universalistic countries differ greatly. I will conduct a range of comparative analyses to determine the merits of each of these models. In addition, I acknowledge that the implications of LTC reforms may vary across categories of children. It is well-established that certain categories of children – most notably daughters and children lacking siblings – are more likely than others to provide support to ageing parents in need. Research on whether cutbacks in state supported LTC services amplify these differences is scarce, however. I will address this question. Finally, the research presented in this dissertation will contribute to the knowledge of moral beliefs regarding LTC by taking into account the multiple dimensions of these beliefs conjointly. From the work of Hochschild (1995) it can be derived that only with a multidimensional approach moral beliefs about care – and thus the consistency between LTC reforms and public opinion – can truly be understood.

1.2 Theoretical background

1.2.1 Reverse substitution, complementarity and specialization

The envisioned outcome of the reforms implemented in countries with a universalistic LTC approach is reverse substitution (Johansson et al., 2003): family members are expected to step in and take over the support tasks for which state supported services have been made less widely available. This is particularly the case for lighter forms of support, e.g. household help. Family support and state supported services are thus expected to be substitutes (cf. Greene, 1983). Whether they effectively are has been highly debated among scholars. Already in the 1980s, Stoller (1989) called the idea of substitution a myth, after noting that older persons using formal care services in upstate New York typically also received personal care from informal providers. In a similar vein, Motel-Klingebiel, Tesch-Römer, and Von Kondratowitz (2005) claimed that the total amount of care that older persons received from state supported services and informal providers together was greatest in countries where state-supported services were widely available. This would imply that family support and state supported services are not perfect substitutes.

The two main theoretical models proposed by scholars challenging the idea of (reverse) substitution are the complementarity model (Chappell and Blandford, 1991; cf. Stoller, 1989) and the specialization model (Brandt et al., 2009; Igel et al., 2009). Chappell and Blandford's (1991) complementarity model holds that state supported services encourage, rather than discourage, family members to provide support to parents in need. Barriers for family members to take on the caregiver role – and the risk that they have to relinquish this role again because of being overburdened – are assumed to be lower when there is the possibility to share the overall care load with formal caregivers. Applied to the LTC policy developments in universalistic countries, this reasoning would lead one to expect that the cutbacks in state supported services decrease, rather than increase, family involvement in caregiving.

The specialization model developed by Brandt et al. (2009; Igel et al., 2009) builds on Litwak's task-specific theory. Litwak (1985; Litwak, Silverstein, Bengtson, and Wilson Hirst, 2003; Messeri, Silverstein, and Litwak, 1993) has argued that support for older persons in need tends to be provided by the available source whose characteristics best match what is needed for the support task at hand. For example, adult children typically have long-term, internalized commitment towards their parents, but they tend to lack the technical knowledge to provide

complex tasks. These characteristics make them suitable for, for instance, temporary help with household tasks when the parent is ill. Should 24 hour personal care, e.g. help with bathing or toileting, be needed, then formal care providers are more suited for the task at hand. Formal care providers have received formal training that equips them with the technical knowledge to provide such tasks, and they are prepared to take on tasks requiring extended time and effort because they are economically motivated.

Proponents of the specialization model argue that when state supported LTC services are more widely available, the need for family members to provide onerous support tasks, e.g. personal care, to relatives in need is lower. This, in turn, presumably makes family members more able and willing to provide lighter forms of support, e.g. household support. According to this model, cutbacks in services would, thus, increase pressure on family members to provide more demanding support, as a result of which their ability and willingness to provide lighter forms of support would be undermined. In other words, cutbacks yield changes in the nature, rather than in the amount of support that adult children provide.

1.2.2 Differences across categories of children

Saraceno and Keck (2011) have argued that equal division of care tasks among family members calls for so-called “decommodified defamilialization” of care, i.e. widely available, affordable, state supported LTC services that relieve family members of the responsibility to care for relatives in need (cf. Lister, 1994). In traditionally universalistic countries, such services have become less widely available over the last decades. It is plausible that the shift of care responsibilities from the state to the family will have particularly strong consequences for daughters and children lacking siblings.

The pressure to live up to the expectation to be responsive to the needs of others is particularly strong for women (Aronson, 1990). A recent study by Lee and colleagues (2015) on the gendered association between employment and caregiving among middle-aged persons provides a striking illustration. The authors show that men typically provide care when their work commitments allow them to do so, whereas women only remain active in paid work as long as their caring commitments allow them to do so (cf. Dykstra & Van Putten, 2010). Aronson (1992) posits that reduced provision of state supported LTC services can create material constraints shaping women’s sense of obligation. She argues that ideologies and assumptions about care as a task for women manifest themselves more strongly when alternative sources of care are less widely available. Policy reforms yielding a stronger appeal for the family to take on care tasks may thus make the

provision of intergenerational support even more gendered (Haber Kern, Schmid, and Szydlik, 2015; Schmid et al., 2012; cf. Hagestad and Dykstra, 2016).

Like daughters, children without brothers or sisters are known to be relatively likely to provide support to ageing parents (Knijn & Liefbroer, 2006; Rainer & Siedler, 2012). They are also more likely than their counterparts with siblings to live close to their parents, plausibly because the pressure to do so in response to parents' need and desire for a child living nearby is greater for them (Malmberg & Pettersson, 2007; Rainer & Siedler, 2009). Rainer and Siedler (2012) argue that residential choice differences between only children and children with siblings are more pronounced when state supported LTC services are less widely available, because parents' need for a child living nearby is greater in such situations. This reasoning may also apply to differences between only children and children with siblings regarding the provision of support to ageing parents.

1.2.3 Moral plausibility

Ranci and Pavolini (2015) view the ongoing reforms as an attempt to redefine the relation between the family and the state, with the former taking on more and the latter taking on fewer responsibilities for the provision of support to those in need. It has been argued that reforms are more likely to achieve their intended effects when they are morally plausible, that is, when they are in line with people's moral beliefs (Mau, 2004; Svallfors, 2010).

Two decades ago, Hochschild (1995) wrote an essay in which she described four so-called care ideals, that, according to her, "set down the basic terms of political debate about care" (p. 332). The four care ideals capture four distinct, idealtypical perceptions of how care ought to be provided. They differ on three dimensions: (1) the level of responsibility assigned to the family, (2) the level of responsibility assigned to the state and (3) the sharing of tasks between men and women in families. Looking merely at one of these dimensions – as is typically done (e.g. Deeming & Keen, 2003; Gans & Silverstein, 2006) – does not suffice to fully grasp people's moral beliefs with regard to care. Therefore, an approach in which the three dimensions are not assessed conjointly is not suited for determining the moral plausibility of LTC reforms.

The universalistic LTC model, based on the extensive provision of state supported LTC services, is a manifestation of the care ideal that Hochschild (1995) labels *cold-modern*. People adhering to a cold-modern care ideal expect women and men to focus on a career in paid labor. They expect the state to enable this by taking full responsibility for the provision of care for those in need, making

family caregiving unnecessary. The ongoing policy reforms in traditionally universalistic countries imply a move away from an LTC approach that fits with this ideal (cf. Ranci & Pavolini, 2015). This is only morally plausible if it goes hand in hand with a decline in adherence to the cold-modern care ideal.

1.3 Comparative perspective

In this dissertation, I choose a comparative approach. Tesch-Römer and Von Kondratowitz (2006) emphasize the differences between two distinct comparative perspectives. A *nomothetic* perspective is often adopted by anthropologists. From this perspective, the aim of comparisons is to identify universal patterns across different contexts. In an *idiographic* perspective, on the other hand, the focus is on differences across contexts, rather than on commonalities or similarities. I adopt the latter perspective, because I am interested in the differences across contexts that vary with regard to the way LTC is organized. I conduct three types of comparative analyses that complement each other. Longitudinal analyses enable the assessment of the effects of policy reforms in specific countries. Cross-national analyses allow one to assess how adult children's support to ageing parents varies across countries with different LTC systems. Cross-regional analyses, finally, are useful to shed light on the impact of regional differences in the organization of LTC. The delegation of responsibilities for the organization of LTC to lower level governments – one of the key elements of LTC reforms in universalistic countries – makes such regional differences an increasingly salient issue.

1.3.1 Longitudinal analyses

The Netherlands make a good case for longitudinal analyses, because the LTC reforms taken by the Dutch are exemplary of those taking place in countries with a universalistic LTC model based on extensive provision of state supported services. Consistent with other countries with universalistic LTC models, de-institutionalization has been promoted in the Netherlands since the 1980s (Companje, 2015; Da Roit, 2012). Figure 1.1 illustrates the extent to which LTC has been de-institutionalized in the Netherlands. The number of LTC beds relative to the population aged 65 and older declined by over a third between 1990 and 2012.

Like in several other countries with universalistic LTC systems, LTC services have been increasingly targeted to those with the most severe care needs. Reforms have brought about particularly strong changes in the provision of lighter forms of state supported services, such as household support. Eligibility criteria have

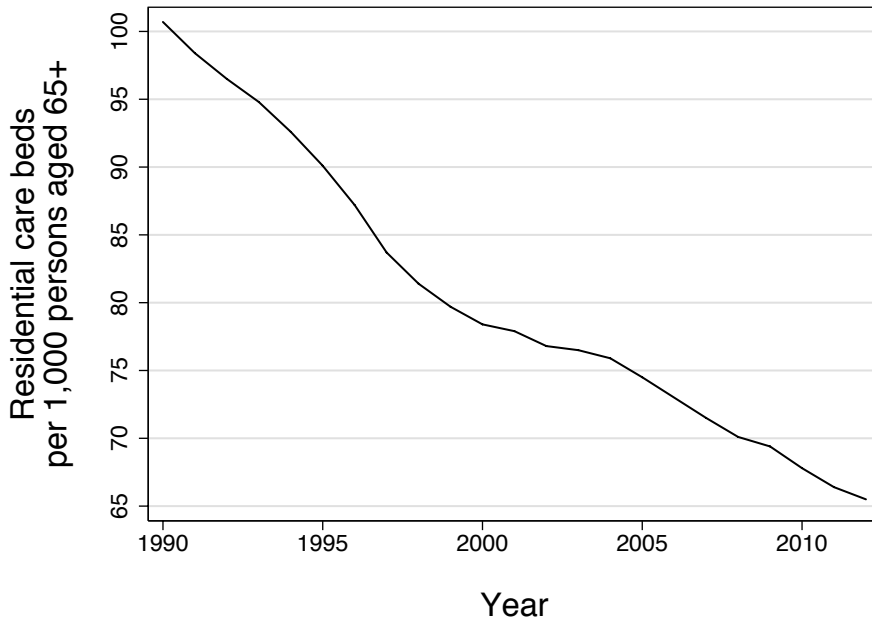


FIGURE 1.1: Beds in residential care settings in the Netherlands.
Source: OECD Health Indicators.

become stricter and – consistent with the idea of subsidiarity – needs assessors are urged to consider the availability of informal care when determining eligibility for services (Dijkhoff, 2014; Grootegoed, Van Barneveld, & Duyvendak, 2015; Kromhout et al., 2014). Figure 1.2 shows yearly index numbers of the number of people who were granted state supported household services relative to the total population in two age groups. The index numbers were based on Statistics Netherlands data for the period 2004-2010, with 2004 as the year of reference. The figure shows that in the 65-80 age group the share of people using state supported household services declined with over 20 percent between 2004 and 2010. Among the 80-plus age group the relative decrease in the share of persons receiving state supported household services was 6 percent over the same period. The growing difference between the older age group – where the average care need is higher – and the younger age group – with less severe needs – indicates increasingly strict targeting.

For the assessment of changes in intergenerational support and public opinion in response to the Dutch LTC reforms, I will use the Netherlands Kinship Panel Study (NKPS) (Dykstra et al., 2005, 2012; Hogerbrugge et al., 2015; Merz et al.,

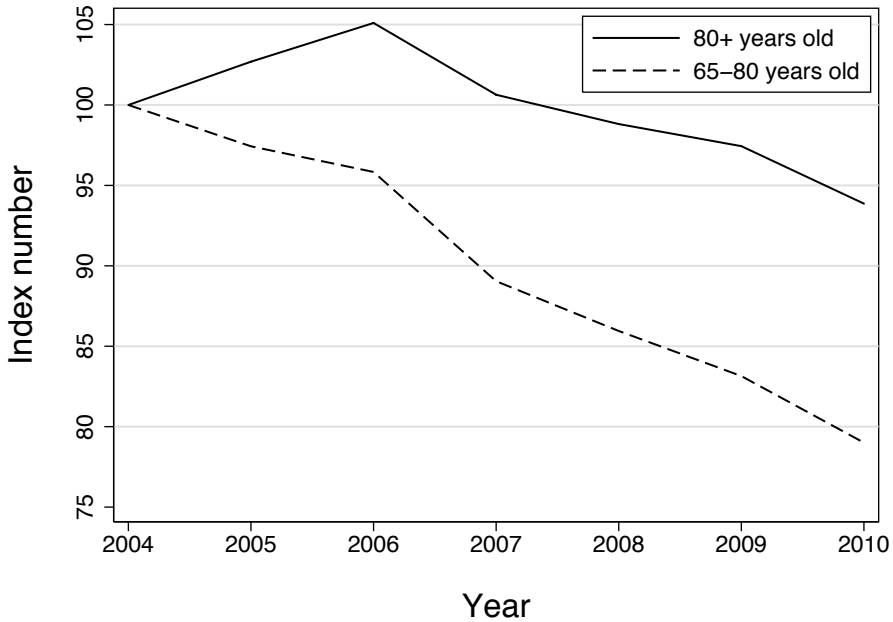


FIGURE 1.2: Share of age group receiving state supported household services, relative to 2004.
Source: Statistics Netherlands.

2012). The NKPS is a large-scale, longitudinal dataset about family solidarity in the Netherlands. In addition to information on themselves, parents have been asked to provide extensive information on up to two randomly chosen children. Thus far, four waves of NKPS data have been collected. Data collection of the first wave took place between 2002 and 2004 and the data for subsequent waves were collected in 2006-2007, 2011 and 2014, respectively.

1.3.2 Cross-national analyses

Despite convergence (Pavolini & Ranci, 2008; Swartz, 2013), substantial differences across European countries persist in the way that LTC is organized. Börsch-Supan (2012) even goes as far as calling Europe as a “[laboratory] where we observe different policies, such as health and long-term care provision, retirement and pension policies” (p. 65). He believes that the impact of contextual factors – including policies – on persons’ lives “becomes apparent only in comparison to other countries” (p. 68).

In the last two decades, many rich, large-scale datasets that allow the assessment of country level differences in individual level outcomes have become available, for instance the Generations and Gender Surveys (GGS) (Vikat et al., 2007), the European Quality of Life Survey (EQLS) (European Foundation for the Improvement of Living and Working Conditions, 2014) and the Survey of Health, Ageing and Retirement in Europe (SHARE) (Börsch-Supan et al., 2013). Given my focus on support to ageing persons with health limitations, I will use the latter survey for my cross-national analyses. SHARE is a cross-national panel database containing microdata on health, socio-economic status and social and family networks of persons aged 50 and older from different European countries and Israel. Instruments, in particular those capturing need for care, are relatively consistent across countries compared to the GGS (Keenan, Foverskov, & Grundy, 2016). Currently, five waves of SHARE data are available. For most countries, data from the first two waves contained information on received professional home care services and informal care from coresiding and independently living adult children.

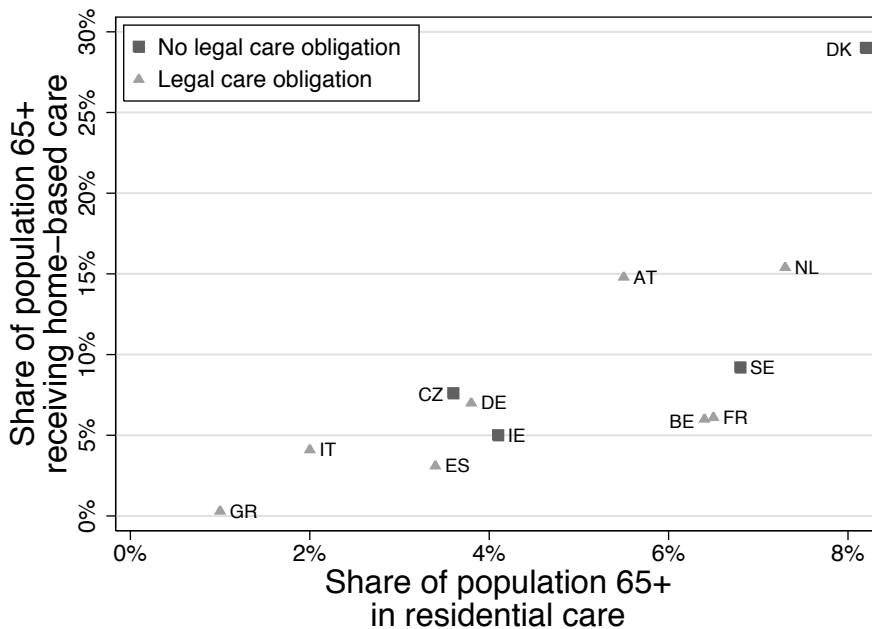


FIGURE 1.3: LTC services and legal obligations towards ageing parents.
Sources: MULTILINKS; Mestheneos and Triantafyllou (2005).

The MULTILINKS database¹ of social policy indicators (Keck & Saraceno, 2011) provides the opportunity to enrich SHARE microdata with country level information on a range of social policy matters. It offers comparative social policy indicators for 27 EU countries plus Norway, Russia and Georgia. The database was created as part of the MULTILINKS research programme (Dykstra & Komter, 2012). The combination of SHARE micro indicators and MULTILINKS macro indicators of interest was available for twelve European countries: Austria, Belgium, Czech Republic, Denmark, France, Germany, Greece, Ireland, Italy, the Netherlands, Spain and Sweden. As Figure 1.3 illustrates, these countries differ greatly with regard to the provision of care in residential settings and the provision of home care services. In some of the countries included in the analyses, but not in others, adult children carry a legal obligation to support parents in need. Service provision tends to be greatest in countries with a universalistic tradition, such as Denmark, Sweden and the Netherlands.

1.3.3 Cross-regional analyses

In many countries, regional differences exist in the way LTC is organized, given the increasingly important role of lower level governments (Grootegoed, Van Barnveld, & Duyvendak, 2015; Karpinska & Dykstra, 2014; Rothgang et al., 2009). Assessment of the consequences of these differences asks for a cross-regional approach. For such an approach to be viable, it is essential that the number of distinct regions is sufficiently large and that the contextual characteristics of interest vary substantially across regions. The case of Germany meets both of these criteria.

Germany is divided in a large number of districts (German: *Kreise*). The current number of districts is 402 (EUROSTAT, 2015). Districts are so-called Nomenclature of Statistical Territorial Units (NUTS) level 3 units. The NUTS classification system was developed by the European Union for the purpose of producing regional statistics for the European Community. Level 3 units are the smallest regional entities in the NUTS-system (EUROSTAT, 2015). Wiest, Nowosadek, and Tesch-Römer (2015) have shown that the ageing experience varies greatly across German districts, even after a range of socio-demographic characteristics are controlled for. Subjective, functional and mental health tend to be relatively poor for older persons in so-called weak structure districts, i.e. non-touristic, sparsely populated districts lacking competitive industries. These districts can mainly, but not exclusively, be found in the Eastern Germany. Moreover, substantial differences exist across districts with regard to access to LTC

¹For more information, see <http://multilinks-database.wzb.eu>

services. For instance, the ratio of full-time equivalent home care workers relative to the number of inhabitants aged 75 or older is more than 65 percent higher in the upper quintile than in the bottom quintile of German districts and the number of LTC beds per 100 inhabitants aged 75 or older is less than 1 in the bottom quintile and more than 30 in the upper quintile of German districts (Rothgang et al., 2009). Districts where the availability of LTC services is limited are – like weak structure districts – relatively prevalent in Eastern Germany, but they can also be found in the West.

The cross-regional analyses in this dissertation draw on data from the German Ageing Survey (DEAS) (Engstler & Schmiade, 2013; Lejeune & Engstler, 2014; Motel-Klingebiel, Wurm, et al., 2010), provided by the Research Data Centre (FDZ-DEAS) of the German Centre of Gerontology (DZA). DEAS is a nationwide representative cross-sectional and longitudinal survey of the German population aged over 40. In the scientific release of DEAS, information on the respondents' region of residence is limited to the *Bundesland* (state) in which they live. However, to enable me to identify effects of regional characteristics, FDZ-DEAS has provided a set of additional district level indicators from the 2012 edition of the INKAR (Indicators, Maps and Graphics for Spatial and Urban Development) dataset of the Federal Institute for Research on Building, Urban Affairs and Spatial Development (BBSR) that can be linked to DEAS microdata – which I gratefully acknowledge.

1.4 Structure of the book

The empirical studies that form the core of this dissertation are presented in the following four chapters. In each of the first three empirical chapters, I focus on specific forms of support. In the final empirical chapter, I look into moral beliefs about how LTC should be organized.

When assessing adult children's support to ageing parents, it is important to be specific about the types of support one is looking into. A key distinction to make is the one between support with so-called *activities of daily living* (ADLs) and *instrumental activities of daily living* (IADLs). ADLs are basic tasks of everyday life, including eating, bathing, dressing and toileting. IADLs capture a range of activities that are more complex than those needed for the ADLs. They include meal preparation, grocery shopping and doing housework (Wiener, Hanley, Clark, & Van Nostrand, 1990). Brandt et al. (2009) emphasize the qualitative distinctions between ADL and IADL support, with the provision of latter being less obligatory than the former, and show that the two forms of support have

markedly different determinants. Therefore, I look into adult children's involvement in IADL and ADL support separately in, respectively, Chapters 2 and 3.

In addition to IADL support and ADL support, I explore adult children's residential choice. Although not a form of functional support in itself, living with or close to a parent in need of support is a prerequisite for support with ADLs and IADLs. Whereas physical proximity is not a necessity for other forms of support exchange, e.g. financial support or emotional support, ADL support and IADL support requires face-to-face contact. Research consistently shows that adult children are more likely to provide support to ageing parents when they live close to or share a household with them (Knijn & Liefbroer, 2006; Leopold, Raab, & Engelhardt, 2014). It has been argued that adult children – in particular those without siblings – let parents' future need for care influence their choices on where to live (Konrad, Künemund, Lommerud, & Robledo, 2002; Rainer & Siedler, 2009). In Chapter 4, I explore whether the extent to which this is the case is context dependent.

In Chapter 5, I look into the moral plausibility of Dutch LTC reforms. I aim to distinguish care ideals among the Dutch population and assess whether changes in their respective adherence correspond with LTC policy reforms. I will look for distinct ideals that differ on the three aforementioned dimensions (state, family and gender). To my best knowledge, this is also a first attempt to empirically test the validity of Hochschild's (1995) typology of care ideals. Taken together, the empirical chapters will allow me formulate answers to the research questions formulated in the introductory paragraphs. I will do so in the concluding chapter.

Chapter 2

Adult children stepping in: Reverse substitution of household support to impaired older persons in the Netherlands

This chapter is co-authored by Pearl A. Dykstra and Romke J. van der Veen. A paper based on this chapter is currently under review at an international, peer-reviewed journal.

In this chapter, I provide an overview of recent long-term care (LTC) reforms in the Netherlands and argue that these reforms are exemplary of those taking place in countries that had traditionally adopted a universalistic LTC model based on extensive provision of state supported services. The scope of services to which the Dutch are entitled has been reduced. Potential informal caregivers – mainly family members – are increasingly encouraged to provide support to those in need. Services have been developed to support caregivers in need, and access to lighter forms of LTC services, such as household help, has been restricted. Using data from four waves of the Netherlands Kinship Panel Study (2002-2014, $n = 1,354$), I assess whether adult children of Dutch impaired older persons living alone increased their provision of household support in response to these reforms. In addition, I investigate whether the increase was particularly strong for two categories of children already known to be likely providers of support: daughters and only children.

2.1 Introduction

Faced with ageing populations, many European countries are grappling with the issue of how to meet the care needs of the older population at a cost that is acceptable to society. Countries where the state traditionally carried the main responsibility for the provision of care to older persons in need have shifted towards a model in which this responsibility is shared with the family. The case of the Netherlands is exemplary for this development.

Half a century ago, the Dutch introduced a comprehensive social insurance scheme covering long-term care (LTC) for all citizens in need, and in the decades that followed they expanded its scope. Since the mid-1980s, financial constraints led to reforms. Initially, cost-containment was mainly pursued through supply regulation and budgetary restrictions. Reforms enacted in the twenty-first century mainly aimed at encouraging potential informal caregivers – in particular family members – to provide support to those in need.

In this chapter, I sketch the LTC reforms that have taken place in Europe, and specifically in the Netherlands, over the last decades. I explore how the provision of household support by adult children of impaired older persons living alone has changed in the wake of Dutch LTC reforms. I focus on household support, because LTC reforms have brought about particularly strong changes in the

provision of state supported household services. Given the primacy of spousal or partner support over intergenerational support when a spouse or partner is available (Messeri et al., 1993), I only focus on adult children's provision of support to parents who are living alone (cf. Johansson et al., 2003).

The reverse substitution thesis (Johansson et al., 2003) would lead one to expect to expect that adult children stepped in and increasingly provided household support as access to state supported services became more restricted. Such an increase would imply that the Dutch policy shift towards subsidiarity with regard to household support has been successful.

I also look whether the Dutch LTC reforms had more pronounced consequences for some categories of adult children than for others. It is well-established that daughters take on a larger share of intergenerational support than sons, and that only children are more likely to provide support to ageing parents than their counterparts with siblings (Knijn & Liefbroer, 2006; Rainer & Siedler, 2012). It has been suggested elsewhere that shifting care and support responsibilities from the state to the family may reinforce such differences (Haberkern, Schmid, & Szydlik, 2015; Rainer & Siedler, 2012; Saraceno & Keck, 2011; Van den Broek, 2013b). In the current study, I assess whether the difference between daughters' and sons' provision of household support to ageing parents and the difference between the provision by only children and by children with siblings have grown in the wake of the LTC reforms implemented in the Netherlands.

2.2 Long-term care reforms in Europe

2.2.1 Residual model and universalistic model

Compared to risks like illness or unemployment, the need for LTC has only quite recently been recognized by European countries as a specific social risk requiring welfare policy intervention (Österle & Rothgang, 2010; Ranci & Pavolini, 2015). People with care needs have traditionally relied on family networks, and, to some extent, on charitable sources or local social assistance. Particularly in countries in Southern Europe, but also in for instance Germany and France, the reliance on informal and charity networks has long remained largely unchanged because of persistent institutional and cultural traditions (Österle & Rothgang, 2010; Pavolini & Ranci, 2008). Until recently, these countries had limited provisions of state supported services for those in need. Some cash transfers were available to meet part of the supplementary costs associated with dependency. Persons in need of care were largely responsible for organizing ways of having their care needs met themselves, typically by relying on their families and social networks

(Pavolini & Ranci, 2008). Following Ranci and Pavolini (2015), I use the term *residual LTC model* for this way of organizing LTC. Other labels used for this approach are *informal care-led model* (Pavolini & Ranci, 2008) and *family care model* (Anttonen & Sipilä, 1996).

A radically different approach to organizing LTC was taken in the Nordic countries, but also in, for instance, England. In some cases as early as in the 1940s, state supported LTC services were made available for all persons in need (Österle & Rothgang, 2010). Through extensive provision of services the caring responsibility was, at least partly, removed from the family (cf. Lister, 1994). Ranci and Pavolini (2015) use the label *universalistic LTC model* for this approach to LTC. Other terms used include *services-led model* (Pavolini & Ranci, 2008) and the *Scandinavian model of public services* (Anttonen & Sipilä, 1996).

2.2.2 Convergence

Since the 1990s the differences in the approach to LTC between the countries that adopted a residual model and those that adopted a universalistic model have become considerably less clear-cut than before (Pavolini & Ranci, 2008; Österle & Rothgang, 2010; Ranci & Pavolini, 2015; Rostgaard, 2002; Swartz, 2013). The main driver for convergence was demographic change. As a result of low fertility and longer life expectancy, the number of older persons increased in absolute terms and as a proportion of the total population. Concomitantly, the need for care grew, despite the healthier status of more recent cohorts of older adults (OECD, 2011). The residual LTC model as well as the universalistic LTC model encountered problems in facing increasing care needs.

In countries with a residual LTC model, families were facing ever greater difficulties meeting the rising demand for care (Pavolini & Ranci, 2008; Ranci & Pavolini, 2015). In addition to population ageing, the rising female labor participation contributed to making a purely residual LTC model unfeasible. Women – who had traditionally taken on the bulk of the care tasks – more often had paid work obligations, making caregiving less self-evident. Many countries, started to acknowledge, rather than take for granted, family caregiving. This recognition, which “care feminists” had plead for since the 1980s (O’Connor, 1996; Waerness, 1987), came, for instance, in the form of cash-for-care benefits and the introduction of measures to support caring families (Pavolini & Ranci, 2008). By expanding the coverage of LTC services, countries with LTC systems that could previously be characterized as residual, shifted towards a model in which the responsibility to provide care for those in need was shared between state and family (Ranci & Pavolini, 2015; Rostgaard, 2002, 2011).

Like countries with traditionally residual LTC models, countries that had adopted universalistic LTC models also felt the urge to reform. Concerns about the financial sustainability of their LTC systems against the backdrop of ageing populations were the driving force, rather than concerns about the ability to meet the rising demand of care (Ranci & Pavolini, 2015). In many countries service levels were frozen, care services were increasingly targeted to those with the most severe needs and reimbursements for care providers were restricted in order to contain costs (Österle & Rothgang, 2010; Pavolini & Ranci, 2008; Ranci & Pavolini, 2015; Swartz, 2013). In addition, a stronger emphasis was placed on home-based care services rather than on care provided in institutions (Österle & Rothgang, 2010; Pavolini & Ranci, 2008; Rostgaard, 2002, 2011; Swartz, 2013). Co-payments from persons with less severe care needs were increased (Pavolini & Ranci, 2008; Rostgaard, 2011). Local governments – which are often responsible for the organization of home care services – scaled down the provision of lighter forms of care, such as household help, or removed these services from the scope of home care altogether (Rostgaard, 2011). When defining eligibility for home care services, a person’s need tends to be not merely assessed on the basis of health limitations, but increasingly also on the presence of family members as potential informal caregivers (Ibid.). The changes described here led to a de facto reduction of universalism.

2.3 The case of the Netherlands

The Netherlands is exemplary for the changing approach to LTC in countries with a universalistic model. The country has covered LTC risks extensively since 1968, when the Exceptional Medical Expenses Act (Dutch: *Algemene Wet Bijzondere Ziektekosten*, AWBZ) came into effect. The AWBZ was a social insurance covering care and medical treatment of which the associated expenses are beyond the ability of virtually anyone to pay (Companje, 2015). A social insurance was considered necessary, because people with foreseeably high risks of needing these services, e.g. those with a chronic disease or a disability requiring prolonged care, could not be insured under a private insurance (Mot, 2010; Van der Veen, 2011).

When the AWBZ was introduced, it entitled the Dutch to nursing care, personal care and medical help in recognized hospitals and institutions (Companje, 2015). In 1970, extramural care, i.e. care not provided in institutions, was added to the AWBZ and in the following decades the act’s scope continued to expand (Companje, 2015; Da Roit, 2013; Mot, 2010; Schut & Van den Berg, 2010). As a consequence, AWBZ expenditure rose rapidly and in the early 1980s, when the

Netherlands was experiencing economic downturn, measures to contain costs were called for (Comanje, 2015).

From 1980 onwards, de-institutionalization was promoted: whenever possible, care preferably had to be provided at home, rather than in residential care settings. This fitted with changing ideas about autonomy and independence, but it was also a cost-containment strategy, because care provided at home was less expensive than institutional care (Comanje, 2015; Da Roit, 2012). Supply regulation and budgetary restrictions were also implemented in the mid-1980s. They proved to be successful cost-containment measures, but came at the expense of a perceived deterioration in the quality of care and longer waiting lists. The Dutch were entitled to the provisions covered under the AWBZ, because it was a social insurance. In 1999, the court confirmed that AWBZ care could not be withheld for budgetary reasons. Budgetary constraints were lifted and this resulted in substantial reductions of waiting lists (Comanje, 2015). LTC expenditures increased rapidly again, however (Schut & Van den Berg, 2010).

Several measures were taken to reduce the rise of LTC expenditures. Needs assessors increasingly considered the availability of informal care when determining eligibility for AWBZ services (Grootegoed, Van Barneveld, & Duyvendak, 2015; Jörg, Boeije, Huijsman, De Weert, & Schrijvers, 2002; Morée, Van der Zee, & Struijs, 2007). Moreover, co-payments – which had been relatively low until that time – were increased substantially in 2004, particularly for home-based services (Da Roit, 2012; Schut & Van den Berg, 2010). This made such services less attractive, particularly for persons with higher incomes. In addition, the personal budget (Dutch: *Persoonsgebonden Budget*, PGB), introduced in 1995, was expanded. For most types of LTC, users could now choose a cash benefit instead of care in kind. Apart from the obligation to demonstrate that the money was spent on care delivered by a professional or informal caregiver, recipients were largely free as to how they might spend the PGB (Mot, 2010). The PGB scheme was introduced to increase independence, autonomy and choice for persons with care needs. It was, however, also designed as a cost-containment measure, because PGB benefits were typically 25 percent lower than expenses for care in kind (Da Roit, 2012). By 2001, all who had been approved for homecare for at least 3 months were eligible for a PGB (Da Roit, 2013). The impact of the PGB scheme on the Dutch LTC system was limited, however (Da Roit & Le Bihan, 2010). The PGB was more popular among younger persons with care needs than among their older counterparts. It was rarely used for LTC for older persons (Mot, 2010). As a cost-containment measure, the PGB was not very effective. Its setup created a demand: persons who would not have applied for home care services applied for a PGB to recompense previously unpaid informal caregivers (Da Roit, 2013;

Schut & Van den Berg, 2010).

With the introduction of the Social Support Act (Dutch: *Wet maatschappelijke ondersteuning*, Wmo) in 2007, municipalities' role in supporting older persons with care needs has increased. Municipalities now have the obligation to support informal caregivers, for example by providing respite care. They also have become responsible for the provision of household services, e.g. cleaning the home. Given that municipalities receive a non-earmarked budget for household services (Mot, 2010), they have an incentive to limit spending. Within boundaries prescribed by law, municipalities have increased their efforts to reduce expenses related to the Wmo. A common strategy is to better verify which informal sources of support are potentially available (Kromhout et al., 2014). Rising numbers of municipalities, for instance, organize so-called "kitchen table conversations" in which a consultant, in line with the ideology behind the Wmo, makes an inventory of the extent to which a Wmo applicant's problems can be resolved within his/her family and social network (Dijkhoff, 2014). Unlike the AWBZ, the Wmo is based on the principle of subsidiarity: "ideally, citizens should take responsibility themselves in matters of social assistance [...]. When this is not sufficient, they can apply to the local council, which has a great degree of freedom in making its own policy and responding to local circumstances" (Mot, 2010, p.17).

The introduction of the Wmo implied a split between, on the one hand, care and support services that remained in the AWBZ and to which people were legally entitled, and, on the other hand, services that no longer fell under a strong legal entitlement. The transfer of household services from the AWBZ to the Wmo is arguably the most substantial element of a Dutch reform strategy that Da Roit (2013) calls "hollowing": moving elements of social protection from the scope of the AWBZ to schemes that respond to different logics and have other entitlement structures. In 2015, this trend culminated in the replacement of the AWBZ by the Long-Term Care Act (Dutch: *Wet Langdurige Zorg*, Wlz). The Wlz is a social insurance, like the AWBZ, but its scope is much more limited, only covering care to people who need support 24 hours per day. Lighter forms of nursing care and personal care services have been transferred to the Health Insurance Act (Dutch: *Zorgverzekeringswet*, Zvw) and the Wmo. As a consequence, municipalities are now responsible for a broader range of services, and they are encouraged to manage and provide them according to the principle of subsidiarity that underlies the Wmo.

Ranci and Pavolini (2015) have argued that in many European countries the relationship between the state and the family has been recast. This observation clearly applies to the Netherlands. The scope of services to which the Dutch are

entitled has been reduced. Informal caregivers – mainly family members – have increasingly been encouraged to support those in need. On the one hand, services have been developed to support caregivers in need. On the other hand, access to lighter forms of services, such as household help, has been restricted through increased co-payments and stricter needs assessment that takes into account the presence of potential informal support providers.

2.4 Hypotheses

The aim of the current study is to assess how Dutch adult children of impaired parents living alone responded to the LTC reforms described above. In this section, I elaborate on existing research and formulate hypotheses about adult children's expected response.

2.4.1 Reverse substitution

Health problems encountered by older persons tend to impact not only their own lives, but also the lives of those close to them, in particular family members. Around the world, family members respond to relatives' need by providing support (Blomgren, Breeze, Koskinen, & Martikainen, 2012; Brandt et al., 2009; Cooney & Dykstra, 2011; Deindl & Brandt, 2011; Grootegoed & Van Dijk, 2012; Grundy, 2005; Van den Broek & Dykstra, 2016). Life course researchers have emphasized that interdependencies between lives are not given or stable, but shaped by context (Elder, 1994; Hagestad & Dykstra, 2016). Impaired older persons are least dependent on family support when care is highly defamilialized, that is, when state supported LTC services are widely available for those in need (Saraceno, 2010; cf. Lister, 1994).

The substitution thesis (Greene, 1983) posits that family and friends will provide less support to impaired older persons when state supported LTC services become more widely available. Johansson et al. (2003) coined the term “reverse substitution” for the opposite pattern. They found that family support to older persons in need increased in Sweden in response to cutbacks of state supported care services (cf. Jegermalm & Jeppsson Grassman, 2012; Szebehely & Trydegård, 2012; Ulmanen & Szebehely, 2015).

As described above, the most drastic changes brought about by recent LTC reforms in the Netherlands concern the provision of lighter forms of state supported LTC services. The state still takes on a large responsibility for the provision of care services for those with severe needs, e.g. those in need of long-term personal care or nursing care, but for lighter forms of support, such as household

help, informal caregivers – and in particular family members – are increasingly being called upon. With regard to these forms of support, reverse substitution is the envisioned outcome of the Dutch policy shift towards subsidiarity. To assess whether this goal has been realized, I test the following reverse substitution hypothesis:

H1. In the Netherlands in the early twenty-first century, adult children have increasingly stepped in to provide household support to impaired parents who were living alone.

2.4.2 Gendered reverse substitution

Scholars have expressed concerns about the potentially gendered consequences of Dutch LTC reforms (Schenk, Dykstra, Maas, and Van Gaalen, 2014; Van den Broek, 2013a; Van Hooren and Becker, 2012; cf. Grootegoed, Van Barneveld, and Duyvendak, 2015). Studies have consistently pointed out that daughters provide more support to parents than do sons (Knijn & Liefbroer, 2006; Van den Broek & Dykstra, 2016). The extent to which the support behaviors of daughters and sons differ depends on the policy context (Saraceno and Keck, 2011; cf. Hagestad and Dykstra, 2016). Aronson (1992) has argued that women’s sense of responsibility towards ageing parents will be reinforced when state supported LTC services become increasingly unavailable. Consistent with this argument, Finch (1983, p.6) warned over three decades ago that reforms aiming to shift care responsibilities from the state to the community may amplify the differences between women’s and men’s caregiving involvement: “for community read family, and for family read women”. These considerations lead me to formulate a gendered reverse substitution hypothesis:

H2. In the Netherlands in the early twenty-first century, daughters’ provision of household support to impaired parents living alone increased more than did sons’.

2.4.3 Sibling-contingent reverse substitution

Like daughters, only children are known to be particularly likely to provide support to ageing parents (Knijn & Liefbroer, 2006; Rainer & Siedler, 2012). When care responsibility is increasingly shifted from the state to the family, this may have a particularly pronounced impact for only children. This is because they lack siblings with whom these responsibilities can be shared. This reasoning is reflected in the following sibling-contingent reverse substitution hypothesis:

H3. In the Netherlands in the early twenty-first century, only children's provision of household support to impaired parents living alone increased stronger for children with fewer siblings.

2.5 Data and methods

2.5.1 Data

The data used in this study are from the public release file of the Netherlands Kinship Panel Study (NKPS) (Dykstra et al., 2005, 2012; Hogerbrugge et al., 2015; Merz et al., 2012). In the first wave 8,161 men and women, aged 18–80 and living in private households, were interviewed. 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 (De Leeuw & De Heer, 2001). Data collection of the first wave took place between 2002 and 2004 and the data for subsequent waves were collected in 2006–2007, 2011 and 2014, respectively. The numbers of respondents in follow-up interview rounds were, respectively, 6,091 (wave 2), 4,390 (wave 3) and 2,920 (wave 4). In all waves, the NKPS sample differed somewhat from the Dutch population at large. Most notably, women, middle-aged persons and higher educated persons were overrepresented (for more details, see Dykstra et al., 2005, 2012; Hogerbrugge et al., 2015; Merz et al., 2012).

I restricted the analyses to older parents who were living alone and in need of care, i.e. who reported that they had one or more prolonged illnesses, health disorders or handicaps that restricted them lightly or severely in their daily activities (cf. Walker, Pratt, & Eddy, 1995). Across waves, 1,067 interviews were conducted with 677 parents who met these criteria when data were collected. In the NKPS, parents were each wave asked to provide information on the up to two children who were randomly chosen when data for wave 1 were collected. The choice for two randomly selected children, rather than, for instance, the two oldest children or two children selected by the parent, has the benefit that the generalizability of findings is not restricted to specific groups of children. Within the selection of parents, 1,761 parent-child observations were collected across waves. After exclusion of observations with missing values on any of the variables of interest, a final sample of 1,354 parent-child dyad observations remained.

2.5.2 Measures

The dependent variable in this study is household support provided by the adult child. For each of the up to two randomly selected children, respondents were asked whether this child provided help with housework, such as preparing meals, cleaning, fetching groceries, doing the laundry, during the last three months. The question allowed distinguishing occasional and frequent household support, with the answering categories being (1) “not at all”, (2) “once or twice”, and (3) “several times”.

I measured the changing Dutch LTC context with an indicator for the wave number. Values range from 1 for observations from 2002 or 2003, to 4 for observations collected in 2014. The intervals between rounds of data collection are largely equal, with roughly four years between waves. As described above, access to state supported household services became more restricted with every later wave. I controlled for the respondents’ age to avoid that the estimated wave effect effectively captures an age effect. Age was centered on the mean.

To further minimize bias in the estimate of the wave effect, I controlled for a range of parent and child characteristics that are known predictors of inter-generational support (e.g. Blomgren et al., 2012; Brandt et al., 2009; Deindl & Brandt, 2011; Kalmijn & Saraceno, 2008; Knijn & Liefbroer, 2006). With regard to the parent, I included gender, coded as 1 for mothers and 0 for fathers, and number of children. I also included a dummy variable coded 1 for parents who were divorced and 0 for parents who were living alone because of widowhood or of never having been married. I distinguished three categories of parents’ educational attainment: low (lower secondary education degree or less), intermediate (higher secondary education degree or a vocational degree) and high (bachelor, master or post-graduate degree).

The analyses are limited to parent-child dyads in which the parents were coping with a prolonged illness, health disorder or handicap. The level of care needs varied between parents, however. To measure the level of need, I included a dummy variable distinguishing parents who reported that their health problems restricted them severely in their daily activities (coded as 1) from those who reported being only lightly restricted (coded as 0).

Child characteristics in the model included gender, coded as 1 for daughters and 0 for sons, and age. The latter was centered on the mean. I further included a dummy variable distinguishing children who were married from those who were not. Finally, I included a dummy variable for the presence of children of 12 years or younger in the adult child’s household.

2.5.3 Method

Given that the dependent variable in this study is ordinal with three categories, I used ordered logistic regression analyses to test the formulated hypotheses. I assess whether the parallel regression underlying these analyses is violated by conducting a Brant test (Brant, 1990). A significant Brant test would indicate that constraining coefficient estimates to be in the same direction for different categories of the dependent variable, as is done in ordered logit models, is problematic. When this is the case, a multinomial model is preferred.

The units of analysis in the current study were parent-child dyad observations, of which up to two could be nested per parent at every time point. As a consequence, the data had a multiple membership structure, with parent-child dyad observations nested in parents as well as in time points. I estimated the models with robust standard errors to account for the non-independence of the observations (White, 1980).

I first estimated models that included wave number, as well as the control variables described above, including parent and child age. Straightforward inclusion of the wave number in the models would imply constraining the wave effect on the log odds of a higher category on the dependent variable to be linear. However, the impact of going from one wave to the next is not necessarily stable across waves. I therefore also estimated models in which I added the wave number squared. In such a model, the wave effect can be curvilinear. I compared the Bayesian Information Criterion (BIC) scores of the models with linear and curvilinear specifications of the wave effect to determine which model best fitted the data (Schwarz, 1978). For child age and parent age, I followed a similar procedure.

To test the gendered reverse substitution hypothesis and the sibling hypothesis, I subsequently estimated models in which I allowed the wave effect to vary, respectively, between daughters and sons and between only children and children with siblings. I did so through the inclusion of interaction terms. Again, I compared BIC-scores to determine whether the inclusion of these interaction terms improved the model fit.

2.6 Results

Table 2.1 presents descriptive statistics. In slightly less than one third of the observations, adult children provided household support to the ageing parent with care needs. The prevalence of occasional (i.e. provided once or twice) and frequent (i.e. provided several times) household support was roughly similar. Four

TABLE 2.1: Descriptive statistics.

Variable	M	SD	Range
Household support given			
Once or twice	.148		0 – 1
Several times	.161		0 – 1
Parent characteristics:			
Gender (Female = 1)	.807		0 – 1
Age ^a	69.210	9.413	41 – 89
Number of children	2.993	1.557	1 – 12
Divorced	.387		0 – 1
Educational attainment:			
Low	.618		0 – 1
Mid	.196		0 – 1
High	.185		0 – 1
Severe care needs	.396		0 – 1
Child characteristics:			
Gender (Female = 1)	.533		0 – 1
Age ^a	41.457	9.227	18 – 68
Married	.588		0 – 1
Has young children	.375		0 – 1

Notes: Data are from waves 1-4 of the Netherlands Kinship Panel Study (NKPS); n = 1,354;

^a Values before centering.

in five parents in the analyses were women. This is a consequence of the choice to limit the analyses to impaired parents who were living alone. Women are more prevalent than men in this category, largely because women tend to outlive their male partners (Arber & Ginn, 1994) and because widowed men are more likely to repartner than widowed women (Smith, Zick, & Duncan, 1991).

I estimated ordered logit models with linear and curvilinear specifications for the effects of child age and parent age. A comparison of Bayesian Information Criterion (BIC) scores (results are available on request) indicated that a model with a curvilinear specification of the child age effect and a linear specification of the effect of parent age fitted the data best. The results of this model are presented in Table 2.2. The Brant test was not significant ($\chi^2(13) = 14.9, p = .31$). I thus have no reason to assume that I violated the parallel regression assumption underlying ordered logit models. To test whether the wave effect was curvilinear, rather than linear, I estimated an additional model in which I included the wave number squared. The squared term was not significant and the BIC-score of the

TABLE 2.2: Coefficient estimates of ordered logistic regression predicting household support.

Variable	B	Robust SE
Parent:		
Gender (Female = 1)	0.265	0.163
Age ^a	0.016	0.013
Number of children	0.005	0.038
Divorced	-0.349*	0.153
Educational attainment (ref.: low):		
Mid	0.008	0.152
High	0.151	0.163
Severe care needs	0.272*	0.122
Child:		
Gender (Female = 1)	0.630***	0.121
Age ^a	-0.024*	0.012
Age ^a squared	0.002**	0.001
Married	-0.223	0.134
Has young children	0.171	0.132
Wave	0.194**	0.064
Cutpoint 1	1.964***	0.304
Cutpoint 2	2.846***	0.313
Bayesian Information Criterion	2,295.6	

Notes: Data are from waves 1-4 of the Netherlands Kinship Panel Study (NKPS); n = 1,354;

^a Mean centered;

* $p < .05$, ** $p < .01$, *** $p < .001$

model with the curvilinear wave effect (BIC: 2,299.9, full results are available on request) implied that it did not fit the data better than the more parsimonious model with the linear wave effect presented in Table 2.2.

Consistent with the reverse substitution hypothesis (H1), provision of household support was positively associated with wave number. This implies that adult children have increasingly stepped in to provide household support to impaired parents living alone as access to state supported household services became more restricted. The model further showed that less household support was provided when parents were divorced. More household support was provided when parents coped with severe care needs than when parents' care needs were light. Daughters provided more household support than sons.

With increasing age of the child, less household support was provided, but the negative effect associated with an additional year weakened with increasing age. None of the other parent and child characteristics included in the model were significantly associated with the provision of household support.

I estimated an additional model (not presented in Table 2.2) to test my second hypothesis positing that particularly daughters increasingly stepped in to provide household support to impaired parents living alone. In this model I allowed the wave effect to vary as a function of child gender. The interaction term of child gender and wave was not significant and its inclusion did not yield an improvement of the model fit (BIC: 2,299.6, full results are available on request). The analyses thus did not support the gendered reverse substitution hypothesis. Although daughters provided more household support than sons, the increase in household support provision over time did not significantly differ between daughters and sons. The addition of an interaction term between the wave number and the parent's number of children in yet another model (not presented in Table 2.2) did not improve the model fit either (BIC: 2,302.2, full results are available on request), and the term was not statistically significant. No support was thus found for the sibling-contingent reverse substitution hypothesis, postulating a stronger increase for children with fewer siblings.

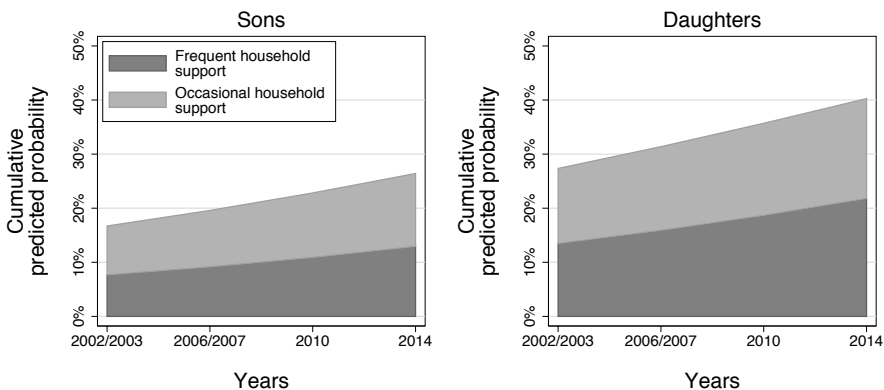


FIGURE 2.1: Predicted probabilities of household support provision.
Source: Netherlands Kinship Panel Study (NKPS), Wave 1-4.

I calculated the predicted probabilities that sons and daughters provide household support to a parent in need. These predictions are presented in Figure 2.1. With the exception of wave number and child gender, all parent and child characteristics were set to the sample mean (see Table 2.1). The figure displays the

predicted probabilities over time in the early twenty-first century. The predicted probabilities for a typical daughter to provide occasional (i.e. provided once or twice) or frequent (i.e. provided several times) household support have risen with, respectively, 4.5 and 8 percentage points between wave 1 (2002-2003) and wave 4 (2014). For a typical son, the predicted probabilities have risen with, respectively, 4.5 and 5 percentage points over the same period.

2.7 Discussion

Since the 1990s, many countries with universalistic LTC models have moved towards a model in which the state and the family share the responsibility for the provision of care to those in need. They did so by placing restrictions on services provision and encouraging greater family involvement in caregiving tasks. The Netherlands is exemplary for this change in approach. The scope of services to which the Dutch are entitled has been reduced. Informal caregivers – mainly family members – are increasingly being called upon to provide support – particularly lighter forms of support, such as household help – to those in need. My analyses show that reverse substitution of household support has taken place: as access to state supported services became more restricted, adult children increased their provision of household support to impaired parents living alone. This corresponds with what Dutch LTC reforms envisioned. Contrary to the gendered reverse substitution hypothesis, I did not find that daughters' provision of household support increased more than did sons'. Neither did I find that the provision of household support increased more for children with fewer siblings. It should be noted, however, that daughters still provide occasional and frequent household support to ageing parents much more often than do sons.

The current study has a number of limitations. The analyses presented here draw on parents' reports of the support they received from their children. Recipients tend to report lower levels of support than providers report giving (Mandemakers & Dykstra, 2008). The extent to which adult children provide household support may thus be underreported in this study. Furthermore, I did not look into the support provided by children who shared a household with an impaired parent. Adult children who live with a parent in need are known to be relatively likely to provide intergenerational support (Leopold, Raab, & Engelhardt, 2014; Van den Broek & Dykstra, 2016). Access to state supported services is moreover most strongly restricted when older persons with care needs share a household with family members (Grootegoed, Van Barneveld, & Duyvendak, 2015; Morée et al., 2007; Van den Broek, 2013b). The prevalence of coresidence of impaired older parents and adult children in the Netherlands is, however, very low (Van

den Broek and Dykstra, 2016; cf. Fokkema and Liefbroer, 2008).

Whereas I did not find support for the gendered reverse substitution hypothesis, two recent cross-national studies (Schmid et al., 2012; Haberkern, Schmid, & Szydlik, 2015) have linked the organization of LTC with the extent to which daughters' involvement in caregiving exceeds sons'. It should be noted that both studies use a different dependent variable than the current study. The current study specifically pertains to adult children's provision of household support, whereas both Schmid and colleagues and Haberkern and colleagues use a broad measure of support that does not allow them to distinguish IADL support (e.g. household support) and ADL support (e.g. personal care). This is remarkable, because IADL support and ADL support are known to have markedly different determinants (Brandt et al., 2009). Given that both cross-national studies have only a small number of units at the country level, they may furthermore be prone to omitted variable bias, because only few – if any – potential confounding variables at the higher level can be controlled for in the models (cf. Lijphart, 1971). The authors did not consider the possibility that the effects of the organization of LTC found in their studies might capture effects of other country characteristics not included in the models, e.g. cultural climate or economic opportunities for women. Moreover, Haberkern, Schmid, and Szydlik (2015) estimated multilevel models with so-called cross-level interactions in which they allowed the effects of child gender to vary as a function of various variables at the country level, despite having only 14 countries in their sample. Stegmueller (2013) has pointed out that coefficient estimates and confidence intervals can be seriously biased in models of this kind when so few countries are present in the sample.

Also in apparent contrast to the findings presented here, Swinkels, Suanet, Deeg, and Broese van Groenou (2015) recently concluded that the provision of informal support to ageing Dutch older persons dramatically *declined* between 1992 and 2012. Again, it is important to consider the differences between their study and mine. Firstly, Swinkels and colleagues looked at whether or not an older adult received informal support from any source, not just from adult children. The analyses presented in this chapter pertain specifically to support provided by children. Predictors of adult children's support are very different from predictors of, for instance, spousal support (Blomgren et al., 2012). Secondly, Swinkels and colleagues did not distinguish between household support and personal care and, as pointed out earlier, the antecedents of these two types of support differ markedly (Brandt et al., 2009). Thirdly, Swinkels and colleagues did not limit their analyses to older persons living alone. Neither did they limit their analyses to those in need of care. Although they controlled for physical and cognitive functioning, a sample including older persons not in need of care may bias the

coefficient estimates of other predictors of care receipt, because these are constrained to be the same for persons with care needs and persons not in need of care.

Other studies have presented a more optimistic view on informal solidarity in contemporary Dutch society than have Swinkels and colleagues (2015). Grootegoed and Van Dijk (2012) found, for instance, that the social network – mainly family – of persons with care needs in the Dutch city of Rotterdam largely replaced the practical support that was no longer provided through the AWBZ after a reform. Van der Pas, Van Tilburg, and Knipscheer (2007) found that more recent cohorts of older parents have more contact and support exchanges with their children than earlier cohorts. The Netherlands Institute for Social Research concluded recently that the willingness among the Dutch to do something for someone else was strong and certainly not declining, with a relatively large share of the population providing informal care and volunteering (Bijl, Boelhouwer, Pommer, & Sonck, 2013). My finding that Dutch adult children stepped in as access to state supported household services became more restricted also suggests that informal solidarity across generations has remained strong in the Netherlands.

Chapter 3

Residential care and care to community-dwelling parents: Out-selection, in-selection, and diffusion of responsibility

This chapter is co-authored by Pearl A. Dykstra. A paper based on this chapter is published as:
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De-institutionalization, i.e. the reduction of beds in residential care settings, is a common element in the long-term care (LTC) reforms in countries that traditionally adopted a universalistic model. In this chapter, I assess the links between the availability of beds in residential care settings and adult children's provision of personal care, e.g. help with bathing, dressing or toileting, to impaired, community-dwelling parents living alone. Research suggests that adult children are less likely to provide care when beds in residential care settings are more widely available, but the underlying mechanisms are not well understood. I describe three potential explanations for this negative association and test them using data from the Survey of Health, Ageing and Retirement in Europe (SHARE) on 1,214 parent-child dyads from 12 countries.

3.1 Introduction

Population ageing and the associated greater need for long-term care (LTC) imply a challenge for policy makers to balance safeguarding financial sustainability and providing adequate care for those in need. In many countries, part of the solution to this puzzle is sought in caring for impaired elderly in the community rather than in residential care settings (Pavolini & Ranci, 2008; Rostgaard, 2002, 2011), and, related to this, in maintaining or activating informal caregiving resources (Le Bihan & Martin, 2012; Österle & Rothgang, 2010). Particularly family members are increasingly perceived as important potential caregivers (Grootegoed, Van Barneveld, & Duyvendak, 2015; Österle & Rothgang, 2010; Pavolini & Ranci, 2008). In the current study, I explore the relationship between the availability of beds in residential care settings and the provision of care by adult children to impaired community-dwelling parents. Given the primacy of spousal care over intergenerational caregiving when spouses are present (Jacobs, Broese van Groenou, Aartsen, & Deeg, 2016; Litwak, 1985; Messeri et al., 1993; Stoller & Earl, 1983), I focus on intergenerational caregiving to community-dwelling parents lacking a spouse or partner.

Many scholars have explored how the care that adult children provide to parents is related to formal care services. In the bulk of this work, the focus is on formal home care services. Recent research suggests, however, that the availability of beds in residential care settings also has an impact on intergenerational caregiving to impaired community-dwelling older adults. Pickard (2012) noted a decline in intense care provision to older parents in England by coresident adult children between 1985 and 1990, which she attributed to the risen numbers of

people aged 80 and over in residential care. She also showed that between 1995 and 2000, when residential care became less widely available, the numbers of people aged 80 and over receiving intense care from coresident children began to rise again. A similar finding was reported by Ulmanen and Szebehely (2015), who showed that care provision by independently living adult children and friends to community-dwelling impaired older Swedes increased considerably in the first decade of twenty-first century. The authors attributed the change to the dramatically declining coverage of residential care in Sweden over the same period.

The mechanisms underlying the negative association between the availability of residential care and the provision of care to community-dwelling older parents by their adult children have thus far not been explicated and tested. Pickard (2012) and Ulmanen and Szebehely (2015) have suggested that this negative association may in part be mediated by the levels of care needs among community-dwelling parents. Consistent with this idea, Haberkern and Szydlik's (2010) cross-national analysis of intergenerational care provision in Europe showed a negative association between the availability of residential care and care provision from adult children to their parents that was no longer statistically significant in a multivariate model which controlled for many characteristics of the parent and the adult child, including the parent's physical limitations. The studies summed up here, while providing valuable suggestions for a potential explanation of the negative association between the availability of residential care and intergenerational caregiving to community-dwelling older parents, do not provide a direct test of the supposed underlying mechanism. Furthermore, additional theoretical explanations can be developed and tested. The current study is a first attempt to do so. I use data from the Survey of Health, Ageing and Retirement in Europe enriched with country level information from the MULTILINKS database of social policy indicators to answer the following research question:

How does the availability of beds in residential care settings shape adult children's provision of care to community-dwelling impaired parents lacking a spouse or partner?

3.2 Theoretical background and hypotheses

In this Chapter, I focus on adult children's provision of personal care, e.g. help with bathing, dressing or toileting, to ageing, community-dwelling parents and the way this provision is shaped by the availability of beds in residential care settings. As Pickard (2012) pointed out, most scholarly work on the relation between formal and informal care has focused on formal home care. The substitution model

(Greene, 1983) holds that informal care provision to a person in need is lower when this person receives formal home care. Other scholars have argued that formal home care and informal care complement, rather than substitute, each other. Complementarity can come either in the form of task specific division of labor (Litwak, 1985; Litwak et al., 2003; Messeri et al., 1993; cf. Brandt et al., 2009) or by formal home care professionals and informal caregivers sharing similar care tasks (Chappell & Blandford, 1991). In the former theoretical model, the provision of formal home care enables a division of labor, with formal caregivers taking on demanding care tasks for which they received professional training, e.g. nursing and personal care, allowing family members to focus on tasks for which they are best equipped, e.g. practical help and emotional support. In the latter theoretical model, there is a positive association between formal care and family care, because family members are more inclined to provide care to a relative when burdens are lightened due to the sharing of the overall care load with formal caregivers.

The substitution thesis and the models of complementarity suppose a relationship between actual receipt of formal care services and support from informal caregivers. Given that community-dwelling impaired older adults are by definition not in residential care settings, none of the models briefly described here helps to explain why family caregiving to community-dwelling older adults is less common when beds in residential care settings are more widely available. To better understand the association between the availability of beds in residential care settings and adult children's provision of care to community-dwelling impaired parents, new theoretical mechanisms need to be developed and tested. Drawing on the work of Pickard (2012) and Ulmanen and Szebehely (2015), I formulate an *out-selection* hypothesis. In addition, I describe two new potential mechanisms that I capture, respectively, in the *in-selection* and *diffusion of responsibility* hypotheses. A schematic overview of the three hypotheses to be tested in the current study is presented in Figure 3.1.

3.2.1 Out-selection hypothesis

The availability of beds in residential care settings has an impact on who resides in the community and who does not. As described earlier, Pickard (2012) and Ulmanen and Szebehely (2015) have suggested that the negative association between the availability of residential care and the provision of care to community-dwelling older individuals by their adult children may in part be mediated by the prevalence of severe care needs among community-dwelling individuals. It is well-established that adult children are more likely to provide care to parents when

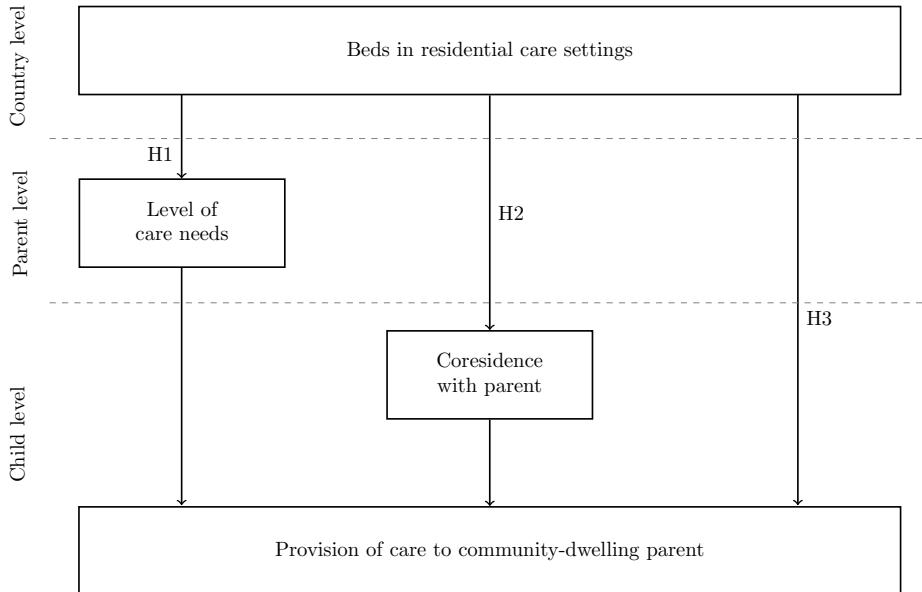


FIGURE 3.1: Conceptual model.

the latter's care needs are more severe (Blomgren et al., 2012; Brandt et al., 2009; Haberkern & Szydlik, 2010; Ogg & Renaut, 2006; Vlachantoni, Shaw, Evandrou, & Falkingham, 2015). When beds in residential care settings are relatively widely available, particularly older adults with severe needs will more often be admitted to residential care settings, and thus be selected out of the community (cf. Greene & Ondrich, 1990; Grundy, 2011; Grundy & Jitlal, 2007). As a result, the average level of need of those remaining in the community can be expected to be lower. These considerations lead me to formulate an *out-selection* hypothesis (H1):

The impairments of community-dwelling older parents with care needs tend to be less severe in countries where beds in residential care settings are more widely available, and consequently their adult children are less likely to provide personal care.

3.2.2 In-selection hypothesis

The availability of beds in residential care settings may also determine the extent to which impaired older adults and their adult children select themselves into living arrangements with an optimal opportunity structure for intergenerational family caregiving. Unlike for instance emotional or financial support, the provision of personal care requires the physical presence of the caregiver. It is,

therefore, not surprising that geographical distance between parent and the adult child hampers the adult child's provision of care (Brandt et al., 2009; Haberkern & Szydlik, 2010; Leopold, Raab, & Engelhardt, 2014; Ogg & Renaut, 2006). The barriers to provide care are lowest when the adult child and the parent share a household (cf. Silverstein, 1995). Coresident adult children are more likely than their independently living counterparts to take on the role of caregiver (Leopold, Raab, & Engelhardt, 2014). When an older parent is confronted with care needs, sharing a household with an adult child may therefore be a viable strategy. Research has shown, however, that other strategies are preferred. When receiving care in one's own home is no longer possible, people in West European countries generally prefer a move to a residential care setting over moving in with an adult child (Huber, Rodrigues, Hoffmann, Gasior, & Marin, 2008). This preferred option is less viable in countries where beds in residential care settings are less widely available. Under those circumstances, older adults might be compelled to move in with an adult child in order to receive the care that they need (cf. Choi, 2003; Silverstein, 1995; Smits, Van Gaalen, & Mulder, 2010). This brings me to the *in-selection* hypothesis (H2):

Adult children are less likely to share a household with impaired community-dwelling parents in countries where beds in residential care settings are more widely available, and consequently they are less likely to provide personal care.

3.2.3 Diffusion of responsibility hypothesis

Finally, the availability of beds in residential care settings may have an impact on intergenerational family caregiving to community-dwelling older adults that goes beyond selection. It shapes the context in which adult children decide whether they will provide care to community-dwelling impaired parents. The bare presence of widely available beds in residential care settings may foster "social shirking" (Sagan, 2004; cf. Perrow, 1984), or, in social-psychological terminology: diffusion of responsibility (Darley & Latané, 1968; Nadler, 2012). Adult children may perceive the wide availability of beds in residential care settings as a backup system guaranteeing adequate provision of care to impaired older adults when relatives cannot or do not provide the care needed. The awareness of the presence of this safety net may undermine adult children's sense of urgency to step in and provide care to their impaired parents (cf. Perrow, 1984). This leads me to formulate a *diffusion of responsibility* hypothesis (H3):

Adult children are less likely to provide care to impaired community-dwelling parents in countries where beds in residential care settings are more widely available,

even when differences in the severity of care needs and the prevalence of parent-child coresidence are accounted for.

3.3 Data

Data for the analyses were taken from the Survey of Health, Ageing and Retirement in Europe (SHARE). SHARE is a longitudinal, cross-national dataset on the health, socio-economic status and social relations of European individuals of 50 and older (Börsch-Supan et al., 2013). I pooled data from the first and second rounds to increase statistical power and maximize the number of countries in the sample.

Round 1 data were collected in 2004 and 2005 in Austria, Belgium, Denmark, France, Germany, Greece, Israel, Italy, the Netherlands, Spain, Sweden and Switzerland. Round 2 data were collected in 2006 and 2007 in the same countries, except Israel, and furthermore in the Czech Republic, Ireland and Poland. For countries that were also represented in the first round, the SHARE team focused on re-contacting round 1 respondents. However, a “refresher” sample was also drawn in all first round countries except Austria and the Flemish part of Belgium. I did not use the round 3 dataset, collected in 2008 and 2009, because it was not comparable with the prior two rounds due to its focus on life histories. I did not use round 4 and round 5 data, collected in, respectively, 2010-2011 and 2013-2014, because information about the provision of personal care was not collected.

SHARE micro-data were enriched with a country level indicator from the MULTILINKS database of comparative social policy indicators (Keck & Saraceno, 2011). This database offers comparative social policy indicators for 27 EU countries plus Norway, Russia and Georgia. It was created as part of the MULTILINKS research programme (Dykstra & Komter, 2012).

I selected respondents who had adult children but no non-adult children, were not living with a spouse or partner and were coping with limitations performing at least one activity of daily living (ADL).² In the SHARE questionnaire, parents were asked to provide extensive information about up to four of their children. Per parent, I randomly selected one parent-child dyad observation. Respondents from Switzerland and Israel were excluded, because no country level information

²The ADLs about which respondents could report difficulties were (1) dressing, including putting on shoes and socks, (2) walking across a room, (3) bathing or showering, (4) eating, such as cutting up your food, (5) getting in and out of bed, and (6) using the toilet, including getting up or down.

was available in the MULTILINKS database. Furthermore, I excluded respondents with missing values on any of the variables of interest. The final sample consists of 1,214 impaired parent-child dyads nested in 12 countries: Austria, Belgium, Czech Republic, Denmark, France, Germany, Greece, Ireland, Italy, the Netherlands, Spain and Sweden.

3.4 Measures

3.4.1 Dependent variable

The dependent variable in the current study is a dichotomous variable indicating whether or not an adult child provided personal care to the impaired parent. The design of SHARE's questionnaire necessitated me to code this dummy variable separately for adult children who shared a household with the impaired parent and for those who did not. Coding for the latter category was based on questions regarding out-of-household support received by the impaired parent. Impaired parents were asked whether they received any kind of support from any family member outside the household, any friend or neighbor during the last twelve months.³ Parents who indicated that they received support from outside the household were asked to name up to three persons who gave support most often. For each mentioned person, respondents were asked whether the provided support included personal care, such as help with dressing, bathing or showering, eating, getting in and out of bed, using the toilet. I coded a non-coresident adult child as a provider of personal care when the impaired parent mentioned this child as out-of-household provider of assistance with personal care tasks. For coresident adult children, coding was based on questions regarding intra-household support with personal care. Impaired parents were asked whether there was someone living in their household who had helped them regularly during the last twelve months with personal care, such as washing, getting out of bed, or dressing.⁴ I coded a

³The wording of this question was different in wave 2 for respondents who were also interviewed in wave 1. These respondents were asked whether they received any kind of support from any family member outside the household, any friend or neighbor since the first interview. The period between two interviews is longer than 12 months. Therefore, respondents who were interviewed for the second time may more often report receiving care from a given adult child. I reduce this potential bias through the inclusion in the model of a dummy variable that distinguishes first and second wave observations.

⁴The wording of this question was different in wave 2 for respondents who were also interviewed in wave 1. These respondents were asked whether there was someone living in their household who had helped them regularly with personal care, such as washing, getting out of bed, or dressing since the first interview. The period between two interviews is longer than 12 months. Therefore, respondents who were interviewed for the second time may more often

coresident adult child as a provider of personal care when the impaired parent mentioned this child as an intra-household provider of assistance with personal care tasks.

3.4.2 Child characteristics

The in-selection hypothesis supposes that parent-child coresidence mediates the negative association between the availability of beds in residential care settings and the likelihood that a given adult child will provide care. I therefore included a dummy variable that distinguished adult children who shared a household with the impaired parent from those who did not.

Drawing on Andersen and Newman's (1973, 1995) behavioral model of health services' use⁵, I included several measures that capture predisposing and enabling factors for filial caregiving. A dummy variable was included to distinguish daughters and sons. The adult child's age was recoded into a categorical variable with three categories. Adult children younger than 45 were assigned to the first category, those aged between 45 and 59 were assigned to the second category and those of 60 years old and older were assigned to the third category.

Another dummy variable was included to capture whether or not the adult child was married. Furthermore, I created a categorical variable for adult children's educational attainment. Those with a lower secondary education degree or less were coded as being lower educated. Adult children with a higher secondary education or a vocational degree were coded as having an intermediate level of education. Those with a college or university degree were coded as being higher educated. A categorical variable was also created to capture the adult child's employment status, distinguishing fulltime employment, part-time employment and not being employed. A final dummy variable was included to capture whether or not the adult child had children.

3.4.3 Parent characteristics

The out-selection hypothesis supposes that the severity of the parent's care needs mediates the negative association between the availability of beds in residential care settings and the likelihood that a given adult child provides care. To capture

report receiving care from a given adult child. I reduce this potential bias through the inclusion in the model of a dummy variable that distinguishes first and second wave observations.

⁵Andersen and Newman's (1973, 1995) behavioral model of health services' use was initially designed to predict and explain the use of formal health care services, but it has also been applied to the provision of informal care (e.g., Broese van Groenou, Glaser, Tomassini, & Jacobs, 2006; Willis, Glaser, & Price, 2010).

the severity of the parent's care needs, I used the number of limitations in performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). In the SHARE questionnaire, respondents were asked about possible difficulties performing 6 ADLs: (1) dressing, including putting on shoes and socks, (2) walking across a room, (3) bathing or showering, (4) eating, such as cutting up food, (5) getting in and out of bed, and (6) using the toilet, including getting up or down. In addition, they could report limitations on seven IADLs: (1) using a map to figure out how to get around in a strange place, (2) preparing a hot meal, (3) shopping for groceries, (4) making telephone calls, (5) taking medication, (6) doing work around the house or garden, and (7) managing money, such as paying bills and keeping track of expenses. I performed a logarithmic transformation to adjust for the positively skewed distribution of the total number of ADL / IADL limitations.

Several parent characteristics were included because they are known predictors of intergenerational care (Blomgren et al., 2012; Brandt et al., 2009; Haberkern & Szydluk, 2010; Ogg & Renaut, 2006). I included a dummy variable to distinguish mothers from fathers, as well as measures for the impaired parent's age and number of children. Parent's age was recoded into a categorical variable with three categories. Respondents younger than 65 were assigned to the first category, those aged between 65 and 79 were assigned to the second category and those of 80 years old and older were assigned to the third category. I included the number of children of the parent in the models, as this may be negatively related to the likelihood of a given adult child to step in and provide care (Freedman, Wolf, Soldo, & Stephen, 1991; Rainer & Siedler, 2012; Van Gaalen, Dykstra, & Flap, 2008). In addition, I included two dummy variables indicating whether the parent received, respectively, formal home care services and professional household help during the last twelve months.

I created a categorical variable for the impaired parent's educational attainment. Those with a lower secondary education degree or less were coded as being lower educated. Respondents reporting having a higher secondary education or a vocational degree were coded as having an intermediate level of education. Those with a college or a university degree were coded as being higher educated. An indicator for poor financial status was derived from the question of whether the respondent's household was "able to make ends meet". I created a dummy variable, coding it 1 when difficulty or great difficulty to make ends meet was reported and 0 when the household was able to make ends meet easily or fairly easily. As described earlier, the analyses only pertain to impaired parents not living with a spouse or partner. I included a dummy variable to distinguish those who were divorced from those who were never married, widowed or living separated from the

person they were married to. A final parent level dummy variable was included to distinguish observations from the second wave from those from the first wave.

3.4.4 Country characteristics

To capture the availability of care beds in residential care settings at the country level, I enriched the SHARE micro-data with a country level variable indicating the share of the national population of 65 years and older in residential care. This variable was taken from the MULTILINKS database of comparative social policy indicators (Keck & Saraceno, 2011).

3.5 Method

In the data used for the current study, parent-child dyads are nested in countries. To account for the non-independence of parent-child dyads within countries when testing the hypotheses, I estimate multilevel logistic regression models. Given that the in-selection and out-selection hypotheses posit that the effect of the availability of beds in residential care settings on the likelihood of intergenerational care provision is mediated, I first estimate a reduced form model in which the assumed mediators are omitted. I compare the total effect of the availability of beds in residential care settings in this model with the remaining direct effect in a full model that includes the assumed mediators. I use Karlson, Holm and Breen's KHB decomposition method (Kohler, Karlson, & Holm, 2011) to assess whether the difference, i.e. the indirect effect, is significant and, if so, to what extent it can be attributed to each of the assumed mediators. Unlike traditional methods for mediation analysis (e.g., Sobel, 1982), the KHB-method accounts for attenuation bias that can occur when comparing nonlinear models.

3.6 Results

Table 3.1 provides descriptive statistics. One in nine adult children provided care to the parent, whereas one in twelve adult children shared a household with the parent. The average number of ADL / IADL limitations that parents in the sample coped with was 4.4 (on a scale from 0 to 13). The likelihood of care provision and intergenerational coresidence and the average number of ADL / IADL limitations varied markedly across countries, however. As Figure 3.2 illustrates, care provision and intergenerational coresidence were less likely and the average number of ADL / IADL limitations was lower in countries where beds in residential care settings were more widely available.

TABLE 3.1: Descriptive statistics.

Variable	M	SD	Range
Child characteristics:			
Provided care to parent	.112		0 – 1
Shares household with parent	.085		0 – 1
Female	.498		0 – 1
Age			
Under 45	.308		0 – 1
45 – 59	.506		0 – 1
60 or older	.186		0 – 1
Married	.686		0 – 1
Education level:			
Low	.345		0 – 1
Intermediate	.400		0 – 1
High	.255		0 – 1
Employment status:			
Not employed	.311		0 – 1
Part-time	.058		0 – 1
Fulltime	.630		0 – 1
Has children	.759		0 – 1
Parent characteristics:			
Number of ADL / IADL-limitations ^a	4.415	3.143	1 – 13
Female	.806		0 – 1
Age			
Under 65	.154		0 – 1
65 – 79	.358		0 – 1
80 or older	.488		0 – 1
Divorced	.150		0 – 1
Education level:			
Low	.747		0 – 1
Intermediate	.170		0 – 1
High	.083		0 – 1
Poor financial status	.527		0 – 1
Number of children	2.591	1.491	1 – 9
Receives formal home care	.235		0 – 1
Receives professional household support	.332		0 – 1
Wave			
1	.427		0 – 1
2	.573		0 – 1
Country characteristics:			
% 65+ in residential care	5.048	2.113	1.0 – 8.2

Notes: Data are from waves 1-2 of the Survey of Health, Ageing and Retirement in Europe (SHARE) and MULTILINKS; n = 1,214;

^a Values before log transformation.

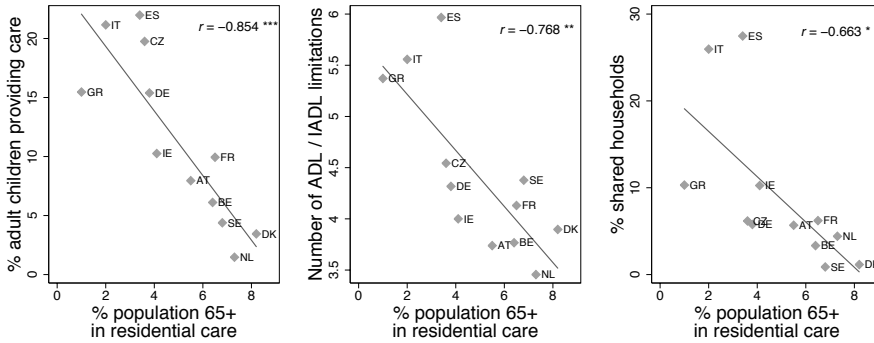


FIGURE 3.2: Intergenerational care, coresidence, severity of care needs and residential care.

Sources: MULTILINKS; Survey of Health, Ageing and Retirement in Europe (SHARE), Wave 1-2.

Results of the multilevel logistic regression analyses are presented in Table 3.2. Model 1 is the reduced form model that does not include the mediators. It shows a strong and statistically significant negative total effect of the availability of beds in residential care settings on the likelihood that an adult child provides care to an impaired parent. Keeping all other variables constant, every percentage point increase in the share of the population aged 65 and upwards living in residential care settings is associated with a 29 percent ($p < .001$) decline in the predicted odds for an adult child to provide care. Model 1 further predicts that the odds of providing care to a parent are a factor 3.414 ($p < .001$) higher for daughters than for sons. Adult children with offspring of their own are less likely than their childless counterparts to provide care (OR: 0.486, $p < .01$). Children of parents aged between 65 and 79 (OR: 3.313, $p < .05$) and of parents aged 80 or older (OR: 3.762, $p < .05$) have higher odds of providing care than children of parents younger than 65. The likelihood that a given child provides care is lower when the parent has a larger number of children (OR: 0.846, $p < .05$). The odds of providing care are a factor 1.711 ($p < .05$) higher for children of parents receiving formal home care than for children of parents who do not receive home care. None of the other parent and child characteristics included in Model 1 were significantly associated with adult children's provision of care.

The second model is a full model that includes the severity of parents' care needs and intergenerational coresidence. The model fit substantially improved with the addition of these two variables (LR $\chi^2(2) = 78.0$, $p < .001$). The model indicates that children are more likely to provide care to an impaired parent when

TABLE 3.2: Coefficient estimates of multilevel logistic regression models predicting intergenerational caregiving.

Independent variable	Model 1			Model 2		
	B	SE	Odds ratio	B	SE	Odds ratio
<i>Fixed part:</i>						
Constant	-1.304	0.787	0.271	-3.878***	0.928	0.021
Child characteristics:						
Female	1.228***	0.227	3.414	1.229***	0.240	3.419
Age (ref.: under 45)						
45 – 59	0.580	0.325	1.785	0.628	0.356	1.873
60 or older	0.597	0.408	1.816	0.552	0.450	1.737
Married	-0.207	0.250	0.813	0.183	0.291	1.200
Education level (ref.: low)						
Intermediate	0.111	0.234	1.117	0.391	0.258	1.478
High	-0.545	0.307	0.580	-0.095	0.333	0.909
Employment status (ref.: not employed)						
Part-time	0.010	0.426	1.010	0.084	0.459	1.088
Fulltime	-0.403	0.234	0.669	-0.361	0.251	0.697
Has children	-0.722**	0.278	0.486	-0.497	0.320	0.609
Shares household with parent				1.965***	0.340	7.132
Parent characteristics:						
Female	0.310	0.286	1.364	0.280	0.303	1.323
Age (ref.: under 65)						
65 – 79	1.198*	0.599	3.313	0.889	0.637	2.433
80 or older	1.325*	0.634	3.762	0.807	0.679	2.241
Divorced	-0.357	0.473	0.700	-0.429	0.499	0.651
Education level (ref.: low)						
Intermediate	-0.660	0.359	0.517	-0.495	0.378	0.610
High	-0.883	0.567	0.414	-0.856	0.598	0.425
Poor financial status	-0.360	0.214	0.698	-0.309	0.231	0.734
Number of children	-0.168*	0.073	0.846	-0.167*	0.077	0.846
Receives formal home care	0.537*	0.254	1.711	0.246	0.274	1.279
Receives professional household support	0.095	0.259	1.099	-0.016	0.277	0.984
Wave 2	-0.480*	0.210	0.619	-0.488*	0.241	0.614
ADL / IADL limitations (log)				1.008***	0.187	2.742
Country characteristics (level 2):						
% 65+ in residential care	-0.344***	0.067	0.709	-0.210**	0.079	0.810
<i>Random part:</i>						
σ level 2 (country)	0.121	0.263		0.246	0.195	
Log-likelihood	-348.4			-309.4		
Degrees of freedom	23			25		
Bayesian Information Criterion	860.1			796.3		

Notes: Data are from waves 1-2 of the Survey of Health, Ageing and Retirement in Europe (SHARE) and MULTILINKS; n = 1,214; Number of countries: 12;

* $p < .05$, ** $p < .01$, *** $p < .001$

the latter's care needs are more severe (OR: 2.742, $p < .001$). Furthermore, the odds of providing care are a factor 7.132 ($p < .001$) higher for adult children who share a household with the impaired parent than for children who do not live with the parent. As expected, the effect of the availability of beds in residential care settings is smaller in the full model than in the reduced form model. In Model 2, every percentage point increase in the share of the population aged 65 and upwards living in residential care settings is only associated with a 19 percent ($p < .01$) decline in the predicted odds for an adult child to provide care, when all other variables are kept constant. Furthermore, the coefficient estimates of adult children having offspring of their own and parents' age and receipt of formal home care are smaller than in the reduced form model and no longer statistically significant. This suggests that the effects found in the first model can largely be explained by the level of parents' care needs and intergenerational coresidence.

TABLE 3.3: Decomposition of coefficient of availability of beds in residential care settings.

	B	SE	Share of total effect	Share of indirect effect
Reduced form	-0.344***	0.078	100.0%	
Full model	-0.210**	0.079	61.2%	
Δ Reduced form model – Full model	-0.134***	0.023	38.8%	100.0%
Components of difference:				
ADL / IADL limitations (log)	-0.085***	0.019	24.6%	63.2%
Intergenerational coresidence	-0.049***	0.012	14.3%	36.8%

* $p < .05$, ** $p < .01$, *** $p < .001$

In Table 3.3, I decomposed the effect of the availability of beds in residential care on the likelihood of intergenerational care provision. Indirect effects make up 39 percent of the total effect. Of these indirect effects, 63 percent can be attributed to the natural logarithm of the number of ADL / IADL limitations of older parents ($\Delta b = -0.085$, $p < .001$) and 37 percent to intergenerational coresidence ($\Delta b = -0.049$, $p < .001$). The former indicates that, consistent with the *out-selection* hypothesis (H1), the lower likelihood of intergenerational care provision in countries where beds in residential care settings are more widely available can partly be explained by the lower severity of care needs of impaired parents in such countries. The latter indicates that the lower likelihood of intergenerational coresidence in countries with widely available residential care also partly explains the lower likelihood of intergenerational care provision. This is consistent with

the *in-selection* hypothesis (H2). Consistent with the *diffusion of responsibility* hypothesis (H3), a significant direct effect of availability of beds in residential care settings remains after the addition of the mediating variables to the model ($b = -0.210, p < .01$). This direct effect makes up 61 percent of the total effect.

3.7 Discussion

A large body of research is devoted to the way that the care that adult children provide to impaired parents is related to formal care services. In the bulk of this work, the focus is on formal home care services. Recent research suggests, however, that the availability of beds in residential care settings also has an impact on intergenerational caregiving. The underlying mechanisms are not well understood. In the current study, I described and tested three explanations for the negative association between the availability of beds in residential care settings and the likelihood that a given adult child provides care to a community-dwelling parent. I labeled these three mechanisms out-selection, in-selection and diffusion of responsibility. I focused on adult children's provision of care to community-dwelling parents lacking a spouse or partner, given the primacy of spousal care over intergenerational caregiving when spouses are present.

The analyses presented here indicate that adult children are less likely to provide care to impaired, community-dwelling, unpartnered parents in countries where beds in residential care settings are more widely available, (1) because parents' care needs are less severe in such countries (*out-selection hypothesis*) and (2) because adult children and impaired parents are less likely to share a household in such countries (*in-selection hypothesis*). Finally (3), adult children remain less likely to provide care in countries where beds in residential care settings are more widely available when differences in the severity of the parent's care needs and the prevalence of parent-child coresidence are accounted for (*diffusion of responsibility hypothesis*). Plausibly, being able to rely on residential care undermines adult children's sense of urgency to step in and provide care to their parents.

These results suggest that widely available beds in residential care settings directly and indirectly undermine the willingness of adult children to provide care to their impaired parents. It should be noted that adult children do not tend to stop providing support to impaired parents when the latter are admitted to residential care settings. Support to parents becomes more secondary after admission, however, and consists mainly of organizing, managing, and supervising care (Ross, Carswell, & Dalziel, 2001).

Although the key focus of the current study was on the association between

the availability of beds in residential care settings and adult children's provision of personal care to community-dwelling impaired parents, I also included measures for parental receipt of formal home care and professional household services in the models. I did so because countries where beds in residential care settings are widely available also tend to have relatively high shares of older adults receiving formal home care (Saraceno & Keck, 2010). Unlike what the substitution thesis and the models of complementarity described in the introduction would lead one to expect, the analyses show neither a negative nor a positive association between parental receipt of formal home care and the likelihood that a given adult child provides care. Possibly, competing mechanisms are cancelling each other out.

It has been argued elsewhere that legal obligations to support parents in need are positively associated with intergenerational caregiving (Haber Kern & Szydluk, 2010). Thus, the association between the availability of beds in residential care settings and adult children's care provision may be overestimated if countries where adult children are legally obliged to support parents in need also have relatively few beds in residential care settings. For that reason, I also estimated models that included a dummy variable for the presence of legal obligations to support parents in need at the country level. Models that included this indicator instead of or in addition to the indicator for the availability of beds in residential care settings did not fit the data better than the models presented in Table 3.2, and the presence of legal obligations to support parents was not significantly associated with the likelihood of intergenerational care provision in any of the models.⁶ Plausibly, I did not find an effect of legal obligations, because legal obligations generally pertain to financial support of parents in need rather than to the actual provision of care.

This study has a number of limitations. The measure of care provided by adult children was based on reports of parents, i.e. the recipients. It has to be borne in mind that recipients tend to report receiving less support than providers report giving (Mandemakers & Dykstra, 2008). In addition, the possibility that the associations between the availability of beds in residential care provision and the likelihood of intergenerational care provision may be confounded by culture should be considered. In his paper on family ties in Western Europe, Reher

⁶Country level information on the presence of legal obligations to support parents in need was taken from the MULTILINKS database of comparative social policy indicators (Keck & Saraceno, 2011) and, when MULTILINKS data were not available, from Mestheneos and Triantafyllou (2005). Bayesian Information Criterion scores for the models with a legal obligations dummy instead of the availability of beds residential care settings indicator were 879.0 (reduced form model) and 803.5 (full model). Bayesian Information Criterion scores for the models that included a legal obligations dummy and the availability of beds residential care settings indicator were 863.7 (reduced form model) and 800.0 (full model). Full results are available on request.

(1998) underlined the importance of cultural differences within Europe, with the south being characterized by “strong” family links and the northwest by relatively “weak” family links. He argued that these cultural differences are deeply rooted in the distinct histories of different European regions. In a cross-national study like the current one, it is difficult to disentangle the relative impact of the cultural context and of the policy context because they are heavily intertwined (Pfau-Effinger, 2005). However, recent longitudinal studies conducted in England (Pickard, 2012) and Sweden (Ulmanen & Szebehely, 2015) have shown that changes in the availability residential care in these countries were followed by changes in intergenerational care provision. Given that cultural factors tend to be highly resistant to change (cf. Reher, 1998), these findings suggest that the effects of the availability of beds in residential care settings on adult children’s provision of care to impaired community-dwelling parents as found in this study are largely exogenous.

A contextual factor that I did not take into account in the current study is the design of cash-for-care programs. Cash-for-care programs vary greatly across countries on a range of important dimensions, such as entitlement criteria, benefit levels and how the benefits can be used (Da Roit & Le Bihan, 2010; Le Bihan & Martin, 2012). When the use of cash benefits is limited to the purchase of services under a formal contract or labor relationship, they may encourage the use of professionally provided care and reduce the necessity of family members to provide care (Saraceno & Keck, 2011). When cash benefits can be used freely, they may encourage the purchase of care services on the informal (often migrant) market, as has been noted in Italy, or they may foster family caregiving, as appears to be the case in Germany and Austria (Rodrigues, Huber, & Lamura, 2012). The latter is also the likely outcome when the allowance is paid to family caregivers rather than to care recipients (Saraceno & Keck, 2011).

Finally, the extent to which residential care is available varies across regions and there are pronounced cross-national differences in the types of care that are offered in residential care settings, organizational structures (public, private non-profit, private for-profit) and the extent to which those in residential care have to contribute in the costs (Forder & Fernandez, 2011; Meijer, Van Kampen, & Kerckstra, 2000; Ribbe et al., 1997; Robertson, Gregory, & Jabbal, 2014). Due to data limitations, I could not take these kinds of differences into account. The analyses presented here show associations between the availability of beds in residential care settings in general and adult children’s provision of care to community-dwelling impaired parents. Future research is needed to provide insight in how various aspects of residential care may moderate the mechanisms underlying the negative association between the availability of beds in residential care settings

and adult children's provision of care to community-dwelling impaired parents.

Chapter 4

The impact of siblings on residential choice.

Do parental need and regional characteristics matter?

This chapter is co-authored by Pearl A. Dykstra. A paper based on this chapter is published as:

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In many countries that had traditionally adopted a universalistic approach to long-term care (LTC), more authority in determining the LTC services to be provided and their eligibility criteria has lately been delegated to lower level governments. This development has the potential to create regional differences in the availability of state supported LTC services. Germany, although not a country that had traditionally adopted a universalistic approach to LTC, is a country with substantial regional disparities in the availability of care services (Rothgang et al., 2009). In this chapter, I assess whether the regional availability of LTC services and other regional characteristics shape the extent to which adult children with and without siblings choose to live close to or together with ageing parents. To do so, I conduct analyses of German Ageing Survey data enriched with indicators at the district (NUTS3) level ($n = 1,989$).

4.1 Introduction

The willingness to relocate to a place with better employment opportunities is an important antecedent of occupational achievement (Mulder & Van Ham, 2005; Van Ham, Findlay, Manley, & Feijten, 2012). Individuals who are prepared to extend their job search area further beyond their locality of origin will find more, and possibly more promising, employment opportunities. Migration can thus be seen as “an instrument for investing in occupational careers” (Mulder & Van Ham, 2005, p. 184).

Although pursuing employment opportunities far from the locality of origin may benefit one’s success on the labor market, it also comes with a range of economic and non-economic costs (Sjaastad, 1962). Higher costs will induce individuals to constrain their residential choice, possibly resulting in sub-optimal labor market outcomes (cf. Rainer & Siedler, 2009). In this chapter, I explore the links between family composition – particularly the presence or absence of a sibling – and the constraints on residential choice.

Insofar studies of parent-child distance have taken family composition into account, they consistently show that the presence of siblings is associated with living at a greater distance from the parental home (cf. Hank, 2007; Malmberg & Pettersson, 2007; Rainer & Siedler, 2009; Shelton & Grundy, 2000; Van den Broek, Dykstra, & Schenk, 2014). It has been argued that parents value the close proximity of an adult child more than vice-versa (Konrad et al., 2002; Manacorda

and Moretti, 2006; cf. Bengtson and Kuypers, 1971). This would imply that adult children constrain their residential choice when they consider their parents' preferences. The need for a given child to constrain his or her residential choice in order to live up to the parent's desire for a child living nearby is reduced when a sibling is present, because the sibling may also be the one choosing to live close to the parent.

In most studies exploring the impact of the presence of siblings on residential choice, the qualitative difference between intergenerational coresidence and a situation in which parents and children live close to each other but in separate households have been ignored (e.g., Konrad et al., 2002; Rainer & Siedler, 2009, 2012). Compton and Pollak (2013) have recently argued that this can lead to bias in models estimating the distance between parents and adult children. In this study, I explore residential choice differences between only children and children with siblings while taking into account that intergenerational coresidence may be qualitatively distinct from independent living arrangements.

Furthermore, I assess whether parental need and the regional context shape the differences in residential choice between only children and their counterparts with siblings. Earlier studies assessed whether birth order (Konrad et al., 2002; Rainer & Siedler, 2009), sibling gender (Ibid.) and – at the national level – the organization of long-term care (LTC) (Rainer & Siedler, 2012) moderated the effect of the presence on siblings. Parental need has thus far not been considered as a potential moderator of the difference between only children and children with siblings. This is remarkable, because parents' needs and desires for a child living nearby are often considered to lead children – and particularly only children – to constrain their residential choice (Konrad et al., 2002; Rainer & Siedler, 2012). Whether or not regional characteristics also shape residential choice differences between only children and children with siblings has not been explored either, even though regional characteristics are known determinants of parent-child distance (Van den Broek, Dykstra, & Schenk, 2014; Van der Pers & Mulder, 2013).

4.2 Theoretical background and hypotheses

4.2.1 Linked lives

Point of departure of the current study is the notion from the life course perspective that lives are linked (Elder, 1994). In order to pursue ambitions, for instance in education or on the labor market, children may consider a life in a location far from the parental home. From the life course principle of linked lives it follows, however, that, when choosing a residential location, children may take

the needs and desires of their parents into account, in addition to those of their own. If parents value having an adult child nearby more than vice-versa, as is often suggested (Konrad et al., 2002; Manacorda and Moretti, 2006; cf. Bengtson and Kuypers, 1971), then children who let their parents' needs and desires guide their residential choice will live relatively close to their parents. The presence of a sibling will mitigate the constraint on residential choice posed by the adult child's wish to see parents' preferences fulfilled. When a sibling lives close to a parent this reduces the need for an adult child to do the same. This leads me to formulate a general sibling hypothesis: adult children with a sibling are less likely to share a household (H1A) and more likely to live far away (H1B) from their parents than only children.

4.2.2 Birth order

The geography of the family thesis (Konrad et al., 2002) holds that not only the presence of a sibling, but also birth order of siblings is relevant for the geographic distance between parents and a given adult child. Proponents of the geography of the family thesis, but also others (e.g., Maruyama & Johar, 2013; Rainer & Siedler, 2009), assume that adult children consider how to minimize their share in future caregiving tasks to older parents when choosing where to live. A large geographical distance to the parent is generally considered a legitimate excuse to refrain from taking on a large caregiving role (Finch and Mason, 1993; cf. Leopold, Raab, and Engelhardt, 2014). In a family with two children, the firstborn will typically be in a position to leave the parental home before the secondborn. Firstborns can capitalize on this by choosing residential location so far away from the parental home that they will be legitimately excused to refrain from providing care when the parent will eventually be in need of assistance. This entails a moral hazard, because the consequences of such a residential choice are not for the firstborn, but for the secondborn to deal with. Similar to the situation of an only child, a secondborn will have to consider that a choice to live far away from the parental home comes with the trade-off of the parent no longer having a child living nearby. This reasoning is reflected in the birth order hypothesis: firstborn children are less likely to share a household (H2A) and more likely to live far away (H2B) from their parents than secondborn children.

4.2.3 Gender composition

When assessing the ways in which lives are interdependent, it is important to take gender into account (Hagestad & Dykstra, 2016). Daughters and sons are typically expected to provide support to ageing parents in different ways (Finch &

Mason, 1991). The types of support for which daughters are deemed responsible, such as personal care and household help, often require close geographic proximity between parent and child. This is not the case for the types of support for which sons tend to be deemed responsible, such as providing financial assistance. Siblings more strongly expect sisters than brothers to respond to parents' needs that require close proximity to be met (Ingersoll-Dayton, Neal, Ha, & Hammer, 2003). Therefore, as has been stated by Michielin and Mulder (2007), "the presence of a sister (who could in principle take care of the parents in case of need) might lower the reluctance to move away from the parents" (p. 658). The considerations outlined here lead me to formulate a gendered geography hypothesis: children with a sister are less likely to share a household (H3A) and more likely to live far away (H3B) from their parents than children with a brother.

4.2.4 Response to need

The premise of the current study is that only children let their parents' needs and desires guide their residential choice to a stronger extent than children with siblings. In situations when parents' needs for a child nearby are greater – for instance when they are coping with frailty – residential choice differences between only children and siblings can therefore be expected to manifest themselves most clearly. This leads me to formulate a needs-induced geography hypothesis: the extent to which only children are more likely than children with a sibling to share a household with a parent (H4A) and less likely to live far away from their parents (H4B) is stronger when parents are coping with frailty.

4.2.5 Context

The hypotheses formulated up to here follow from the life course principle that lives are interdependent. However, life course theorists also emphasize that the way lives are linked is dependent on context (Hagestad & Dykstra, 2016). In earlier studies on the association between the presence of a sibling and parent-child distance, context has rarely been taken into account. An exception is a cross-national study by Rainer and Siedler (2012), who assessed whether the sibling effect differed across three types of countries with distinct institutional features of the eldercare system.

Research has shown that regional characteristics are relevant for the geographic distance between parents and adult children (Van den Broek, Dykstra, & Schenk, 2014; Van der Pers & Mulder, 2013). I assess whether regional factors also shape the difference between only children and children with a sibling in the distance to their parents. I take three regional factors into account: level

of urbanization, regional economic performance and the availability of beds in residential care settings.

Level of urbanization

The extent to which only children live closer to their parents than do children with siblings may depend on the strength of the factors pushing them to live farther away. When push factors are weak, the incentive to seize the opportunities that having a sibling provides is also relatively weak. When parents live in highly urbanized areas where amenities and opportunities are abundant, adult children may be less compelled to live farther away (Malmberg & Pettersson, 2007; Michielin & Mulder, 2007; Van den Broek, Dykstra, & Schenk, 2014; Van der Pers & Mulder, 2013), regardless of the presence of a sibling. I therefore expect that the extent to which only children are more likely than children with a sibling to share a household with a parent (H5A) and less likely to live far away from their parents (H5B) is weaker when parents live in more highly urbanized regions.

Regional economic performance

Residential mobility is also strongly related to economic circumstances at the regional level (Caldera Sánchez & Andrews, 2011). Like a low level of urbanization, a poor regional economic performance pushes young adults to move away, as Lamonica and Zagaglia (2013) have shown for Italians. Employment opportunities are meager in such regions, and the opportunity to get a new or better job is often a trigger for a residential relocation (Clark & Davies, 1999). A recent OECD study of residential mobility in 25 countries indicated that almost one in ten residential relocations was employment related (Caldera Sánchez & Andrews, 2011). In larger countries this share is generally greater than in smaller ones.

The urge to pursue employment opportunities far from the parental home can be expected to be smaller when parents live in economically strong regions that offer ample employment opportunities (cf. Van den Broek, Dykstra, & Schenk, 2014). Therefore, the presumed higher likelihood of only children to refrain from pursuing geographically distant employment opportunities may be less relevant for residential choice when parents live in economically strong regions. These considerations lead to the expectation that the extent to which only children are more likely than children with a sibling to share a household with a parent (H6A) and less likely to live far away from their parents (H6B) is weaker when parents live in regions with a better economic performance.

Residential care

As noted earlier, adult children, and particularly only children, presumably keep parents' future needs for intergenerational support into account when they consider where to live (Konrad et al., 2002; Maruyama & Johar, 2013; Rainer & Siedler, 2009, 2012). Considerations regarding parents' future support needs may, however, be less relevant when adult children know that the formal care system in the area where the parent lives is adequate. Van den Broek and Dykstra (2016) showed that coresidence of adult children and parents with care needs is more common in countries where beds in residential care settings are less widely available. They argued that families in which an older member is in need of care are selected into living arrangements that facilitate family caregiving in such countries, because a viable alternative in the form of residential care is lacking. Plausibly, only children are more prone to this form of in-selection than children with siblings (cf. Freedman et al., 1991). Rainer and Siedler (2012) make a similar argument, after concluding that the differences between only children and children with siblings in the geographical distance from the parent are relatively small in countries where the care responsibilities of the public sector are well defined.

The scholarly work summed up here implies that the pressure that particularly only children perceive to live close to their parents may be less pronounced when beds in residential care settings are more widely available. This leads to the expectation that the extent to which only children are more likely than children with a sibling to share a household with a parent (H7A) and less likely to live far away from their parents (H7B) is weaker when parents live in regions where beds in residential care settings are more widely available.

4.3 The German context

The current study is largely devoted to the exploration of regional differences in the impact of the presence of a sibling on geographic distance between parent and adult child. Germany makes a good case for this study, because there is substantial variation across regions on the characteristics of interest.

German districts range from sparsely populated rural areas with less than 50 inhabitants per square kilometer, to densely populated, large cities such as Berlin, Hamburg and Munich (EUROSTAT, 2014). With regard to GDP per capita, many regions outperform the EU average by over 25 percent. However, there is also a substantial number of regions where GDP per capita is over 25 percent lower than the EU average (EUROSTAT, 2014). These regions can mostly

be found in the East, but also, for instance, in rural areas of Lower Saxony in the West. Finally, regions also differ substantially with regard the availability of beds in residential care settings. The number of LTC beds per 100 inhabitants aged 75 or older is less than 1 in the bottom quintile and more than 30 in the upper quintile of German districts (Rothgang et al., 2009).

Germany's divided past also needs to be taken into account. Before the fall of the Berlin wall in 1989 and the reunification one year later, Germany had been divided for over four decades in the German Democratic Republic (GDR) in the East and the Federal Republic of Germany (FRG) in the West. Fertility patterns in the GDR differed from those in the FRG. Among women born in the early 1950s, the proportion childless but also that with a large number of children is lower in Eastern than in Western Germany. The odds of having one child versus having two children are somewhat higher for East German women than for their counterparts in the West (Goldstein & Kreyenfeld, 2011). This implies that not taking the East-West difference into account may lead to bias in the estimated association between the presence of a sibling and the distance between a child and a parent, because differences in parent-child distance between the former GDR and the former FRG are also likely to exist. On the one hand, Boenisch and Schneider (2010) have argued that residential mobility is lower in the former GDR than in the former FRG due to differences in acculturation and the strength of ties to local networks. On the other hand, the German reunification was followed by substantial economically motivated migration from East to West (Mai, 2008).

4.4 Data

I use data from the scientific release of the German Ageing Survey (DEAS) (Engstler & Schmiade, 2013; Lejeune & Engstler, 2014; Motel-Klingebiel, Wurm, et al., 2010), provided by the Research Data Centre (FDZ-DEAS) of the German Centre of Gerontology (DZA). DEAS is a nationwide representative cross-sectional and longitudinal survey of the German population aged over 40. I use the most recent baseline sample (wave 3). The third wave data were collected between April and September 2008.

In the scientific release of DEAS, information on the respondents' region of residence is limited to the *Bundesland* (state) in which they live. However, at special request FDZ-DEAS provided a set of additional district level indicators from the INKAR (Indicators, Maps and Graphics for Spatial and Urban Development) dataset of the Federal Institute for Research on Building, Urban Affairs and Spatial Development (BBSR). Micro-data and district data were matched

using non-retraceable district ID's, as a result of which district names remained unknown.

The baseline sample of the third wave of DEAS consisted of 6,205 respondents nested in 211 districts. I selected respondents with one or two children ($n = 3,860$) (cf. Konrad et al., 2002; Rainer & Siedler, 2009, 2012). I further restricted the analyses to parents of whom the youngest child was at least 30 years old ($n = 2,192$) (cf. Holmlund, Rainer, & Siedler, 2013; Konrad et al., 2002; Smits, 2010). At this age, children can be expected to have had the opportunity to leave the parental home. Almost nine out of ten German children have left the parental home by the age of thirty (Iacovou, 2011). I excluded 721 parents who relocated after at least one of their children left the parental home. Thus, I am confident that differences in parent-child distance in the data represent differences in the residential choices of children (cf. Konrad et al., 2002). Finally, I excluded 228 respondents with missing values on any of the child or parent characteristics of interest. This leaves a final sample of 1,243 parents, in which 1,989 child observations are nested. The parents are themselves nested in 190 different districts.

4.5 Measures

4.5.1 Dependent variable

In DEAS, six parent-child distance categories are distinguished: (1) in the same house or the same household, (2) in the same neighborhood, (3) in the same town, (4) in a different town that can be reached within two hours, (5) farther away, in Germany and (6) farther away, abroad. I collapsed these responses into three categories of parent-child distance. Adult children living in the same house or household as their parent were coded as coresident children. Those living in the same neighborhood or in the same town were coded as living nearby. Adult children in any of the remaining distance categories were coded as living far away from the parent.

4.5.2 Child characteristics

The main independent variable in this study is a dichotomous measure indicating whether a child has a sibling or not. To be able to test the birth order hypothesis, I coded separate dummy variables for children with an adult older sibling and for adult children with a younger sibling. I also coded separate dummy variables to distinguish adult children with a sister and adult children with a brother. These

enabled me to test the gendered geography hypothesis.

I controlled for a range of child-level characteristics to minimize bias in the estimates of the sibling effect. I included dummy variables in the models to distinguish daughters (coded as 1) from sons (coded as 0) and married children from their non-married counterparts. In addition, I created a dummy variable indicating whether or not the child had any offspring of his or her own. Research suggests that individuals with a larger number of siblings are less likely to remain childless (Parr, 2006). This is relevant, because adult children with offspring of their own are known to be relatively likely to move closer to their parents, plausibly because of childcare assistance that grandparents can provide (Pettersson & Malmberg, 2009; Smits, 2010).

4.5.3 Parent characteristics

The needs-induced geography hypothesis postulates a particularly strong sibling effect on parent-child distance when parents have severe health limitations. Respondents were asked whether they had been limited in doing normal activities during the past six months due to health problems, with the answering categories being (1) yes, limited a lot, (2) yes, limited a little and (3) no, not limited at all. Respondents who indicated that health problems had limited them a lot in doing normal activities were coded as having severe health limitations. Those who indicated that they felt only a little bit or not at all limited in performing normal activities were coded as not having severe health limitations.

I also controlled for a range of parent characteristics to minimize bias in the estimates of the sibling effect. I included dichotomous variables in the model to distinguish whether respondents were mothers (coded as 1) or fathers (coded as 0) and whether they were married or not. I also included the parent's age, which I centered on the grand mean for model interpretation purposes. The measure for the socioeconomic status of the parent was based on International Socio-Economic Index of Occupational Status (ISEI) scores provided by FDZ-DEAS. For the public release of the DEAS dataset, FDZ-DEAS generated ISEI-scores ranging from 0 to 100 based on information of the respondent and, if applicable, his or her partner (Lejeune and Engstler, 2014; cf. Ganzeboom, De Graaf, and Treiman, 1992). Because the distribution of ISEI-scores in the sample was multimodal, I recoded the scores into three categories. Respondents with ISEI-scores ranging from 0 to 40 were coded as having a low socioeconomic status. Those whose ISEI-scores were between 41 and 60 were coded as having an intermediate socioeconomic status and those with ISEI scores of 61 or more were coded as having a

high socioeconomic status. In addition, I included a dummy variable indicating whether or not the parent was a homeowner.

4.5.4 District characteristics

I used the population density of the district of residence of the parent to measure the regional level of urbanization. Given the positively skewed distribution of population density across districts in the sample, i.e. many districts with relatively low population density levels and a few very densely populated districts, I performed a logarithmic transformation. I used the average gross monthly wage in a district (in €1,000) as a measure of regional economic performance (cf. Porter, 2003; Van den Broek, Dykstra, & Schenk, 2014). The availability of beds in residential care settings was measured by the region's number of LTC beds per 1,000 inhabitants aged 65 and older. For model interpretation purposes, I centered the logged population density, district average wages and the number of beds per 1,000 inhabitants aged 65 on their grand means. Finally, I included a dummy variable to distinguish whether the parent's district of residence was located in the former GDR (coded as 1) or the former FRG (coded as 0). Berlin was coded as a former GDR district (cf. Goldstein & Kreyenfeld, 2011).

4.6 Method

Several scholars assessing the impact of the presence of siblings on adult children's residential choice have included children sharing a household with their parents in the analyses and regarded parent-child coresidence simply as the minimum value of parent-child distance (Konrad et al., 2002; Rainer & Siedler, 2009). Compton and Pollak (2013) warn that this may lead to biased estimates of the effects of predictors of parent-child distance. As Silverstein (1995) pointed out, "one can argue that intergenerational co-residence is qualitatively distinct from all types of independent living arrangements, even those in which the parties live near one another" (p. 32). Shared and independent households differ, for instance, with regard to the level of privacy and the opportunities for cost-sharing and exchange of functional intergenerational support (Dykstra, Van den Broek, et al., 2013). Given these qualitative differences, antecedents of coresidence may differ radically from those of a situation in which the child and the parent live nearby but in separate households. When this is the case, commonly used ordered logit or probit models are misspecified, because they constrain the effects of predictors for coresidence and for living independently but nearby to be in the same direction (Compton & Pollak, 2013). To test whether the a priori constraints of ordered

models are problematic, I estimate a model including the key independent variable, i.e. the presence of a sibling, as well as the control variables described above using an ordered logit specification and perform a Brant test (Brant, 1990). This test assesses whether the parallel regression underlying ordered logit models is violated. If this is the case, a multinomial specification is called for.

After determining whether models should be estimated with an ordered logit or a multinomial logit specification, I add predictors to test the formulated hypotheses. For every new model, I compare its Akaike Information Criterion (AIC) score with that of the model that best fits the data up to that point (Akaike, 1974). Subsequent models will only build on the new, more complex model when it fits the data better than the more parsimonious earlier model, i.e. when the AIC score of the new model is lower. The data have a nested structure, with observations of one or two children nested in parents, who are in turn nested in different districts. I account for the non-independence due to this nesting by estimating the models with robust standard errors (White, 1980).

I first estimate a simple model that includes a dummy variable for the presence of a sibling, as well as the control variables described above. In the second model, separate effects for the presence of a younger sibling and for the presence of an older sibling are estimated in order to test the birth order hypothesis. In the third model, I again split up the sibling effect, this time by estimating separate effects for the presence of a sister and for the presence of a brother. I do so to test the gendered geography hypothesis. To test the needs-induced geography hypothesis, I estimate a fourth model in which the sibling effect is moderated by whether or not the parent has severe health limitations. In models five to seven, I add interaction terms of the sibling effect with, respectively, level of urbanization, regional economic performance and the availability of beds in residential care settings.

4.7 Results

Table 4.1 provides an overview descriptive statistics. In the sample, about 1 out of every six adult children shared a household with the parent. One third lived nearby but in a separate households and half of the adult children lived far away from the parent. As illustrated in Figure 4.1, the distribution across the parent-child distance categories was different for children with and without a sibling, however. Compared to their counterparts with a sibling, only children in the sample more often shared a household with the parent and less often lived far away. A chi-squared test indicated that the residential choices of only children and children with siblings differed significantly ($\chi^2(2) = 30.0, p < .001$).

TABLE 4.1: Descriptive statistics.

Variable	M	SD	Range
Parent-child distance:			
Shared household	.141		0 – 1
Independent household, nearby	.337		0 – 1
Independent household, far	.528		0 – 1
Child characteristics:			
Has sibling	.750		0 – 1
Female	.478		0 – 1
Married	.608		0 – 1
Has children	.655		0 – 1
Parent characteristics:			
Female	.486		0 – 1
Age ^a	68.831	7.201	49 – 85
Married	.818		0 – 1
Has severe health limitations	.102		0 – 1
Socio-economic status:			
Low	.280		0 – 1
Intermediate	.487		0 – 1
High	.232		0 – 1
Home-owner	.733		0 – 1
District characteristics:			
Former GDR	.339		0 – 1
Population density (inhabitants / km ²) ^a	623.068	820.874	39.7 – 4,270.5
Average gross monthly wage (in 100 €) ^b	26.666	4.036	20.1 – 39.5
Residential care beds / 1,000 inhabitants 65+ ^b	47.714	9.895	25.2 – 94.8

Notes: Data are from Wave 3 (2008) of the German Ageing Survey (DEAS);
n = 1,989;

^a Values before centering;

^b Values before log transformation and centering.

To test whether the association between the presence of a sibling and parent-child distance persisted after taking relevant characteristics of child, parent and regional context into account, I conducted a series of multivariate analyses. I first estimated the effects of the presence of a sibling and the control variables described in the measures section on parent-child distance using an ordered logit specification. The Brant test ($\chi^2(15) = 96.0, p < .001$) indicated that the parallel regression assumption underlying ordered logit models was violated. I therefore estimated subsequent models using a multinomial logit specification.

Selected results of the multinomial logit analyses are presented in Table 4.2.

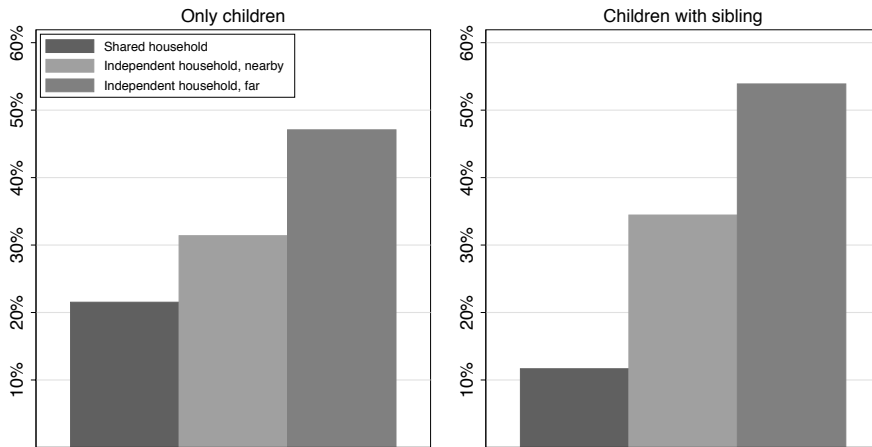


FIGURE 4.1: Distance between parent and child.
Source: German Ageing Survey (DEAS), Wave 3.

Given that coefficient estimates of a multinomial model are difficult to interpret, I chose to present marginal effects (Wang, 2004). The presented marginal effects can be interpreted as the predicted increase in the probability of belonging to a specific category of parent-child distance associated with a 1-unit increase in the independent variable when all other characteristics are set to the sample mean. In the first multinomial model I estimated, adult children with a sibling are predicted to be 7.7 percentage points ($p < .001$) less likely to share a household with a parent than adult children with siblings. This is consistent with hypothesis H1A. Contrary to the expectations formulated in hypotheses H1B, I do not find adult children are more likely than only children to live far away from their parents (marginal effect: 3.5%, not significant).

TABLE 4.2: Predictors of parent-child distance; Marginal effects of multinomial regression analyses.

Variable	Model 1			Model 4		
	Shared household	Nearby	Far	Shared household	Nearby	Far
Child:						
Has sibling	-7.7%***	4.2%	3.5%			
Has sibling, no severe health limitations parent				-6.5%**	4.7%	1.9%
Has sibling, severe health limitations parent				-0.7%	2.6%	-1.9%
No sibling, severe health limitations parent				13.5%***	6.8%	-20.3%**
Female	-6.3%***	-1.4%	7.7%***	-6.2%***	-1.3%	7.6%***
Married	-8.7%***	2.3%	6.4%**	-8.6%***	2.3%	6.4%**
Has children	1.8%	8.2%**	-10.0%***	1.7%	8.2%**	-10.0%***
Parent:						
Female	-1.7%	0.5%	1.2%	-1.7%	0.5%	1.2%
Age ^a	0.1%	0.0%	-0.1%	0.1%	0.0%	-0.1%
Married	-4.4%*	-2.1%	6.5%*	-4.4%*	-2.1%	6.5%*
Has severe health limitations	8.5%***	-0.6%	-7.9%*			
Socio-economic status (ref.: low):						
Intermediate	-2.5%	1.4%	1.1%	-2.5%	1.4%	1.1%
High	-6.1%**	-9.2%**	15.2%***	-6.0%**	-9.2%**	15.1%***
Home-owner	-1.9%	-4.9%*	6.8%**	-1.9%	-4.8%*	6.7%**
District:						
Former GDR	0.9%	-0.7%	-0.2%	0.8%	-0.7%	-0.1%
Population density (log) ^a	-1.6%*	8.1%***	-6.5%***	-1.6%*	8.1%***	-6.5%***
Average gross monthly wage ^a	-0.2%	-1.0%*	1.2%*	-0.2%	-1.0%*	1.2%*
Residential care beds / 1,000 inhabitants 65+ ^a	-0.1%	0.1%	-0.1%	-0.1%	0.1%	-0.0%
Log-likelihood	-1,841.0			-1,838.7		
Degrees of freedom	32			34		
Akaike Information Criterion (AIC)	3,746.1			3,745.4		

Notes: Data are from Wave 3 (2008) of the German Ageing Survey (DEAS); n = 1,989;

Models were estimated with robust standard errors;

^a Mean centered;

* $p < .05$, ** $p < .01$, *** $p < .001$.

A comparison of AIC scores indicated that the model with separate effects for the presence of a younger sibling and for the presence of an older sibling did not fit the data better than the first model presented in Table 4.2 (AIC: 3,748.4). Likewise, the inclusion of separate effects for the presence of a sister and for the presence of a brother did not improve the model fit (AIC: 3,748.8). The analyses thus do not provide support for the birth order (H2A, H2B) and gendered geography (H3A, H3B) hypotheses.

The model fit improved when I allowed the sibling effects on parent-child distance to vary as a function of parents' health limitations in the fourth model (see Table 4.2). Consistent with the needs-induced geography hypothesis, the results suggest that only children are more responsive to parents' need than children with siblings. Children with siblings are only slightly more likely to share a household with their parent (marginal effect: 5.9%, $p < .05$) and not significantly less likely to live far away (marginal effect: -3.8%, not significant) when the parent is coping with severe health limitations. For only children, parents' health limitations are associated with a substantially higher likelihood of coresidence (marginal effect: 13.5%, $p < .001$) and a substantially lower likelihood of living far away (marginal effect: -20.3%, $p < .01$).

The model further indicates that daughters are more likely to live far away (marginal effect: 7.6%, $p < .001$) and less likely to share a household with the parent (marginal effect: -6.2%, $p < .001$) than sons. Coresidence with a parent is also relatively unlikely when children are married (marginal effect: -8.6%, $p < .01$). Married children are more likely to live far away from their parents than their unmarried counterparts (marginal effect: 6.4%, $p < .01$). When children have offspring of their own, they are more likely to live nearby in a separate household (marginal effect: 8.2%, $p < .01$) and less likely to live far away (marginal effect: -10.0%, $p < .01$).

Adult children are more likely to live nearby in a separate household (marginal effect: 8.1%, $p < .001$) and less likely to live far away from the parent (marginal effect: -6.5%, $p < .01$) when the latter lives in a district with a higher level of urbanization. A better regional economic performance of the parent's district of residence is, in turn, associated with a lower likelihood of living in a separate household nearby (marginal effect: -1.0%, $p < .05$) and a higher likelihood of living far away (marginal effect: 1.2%, $p < .05$). Children of married parents are less likely to share a household with the parent (marginal effect: -4.4%, $p < .05$) and more likely to live far away (marginal effect: 6.5%, $p < .05$) than children of non-married parents. Compared to children of parents with a low socio-economic status, children of parents with a high socio-economic status are

more likely to live far away (marginal effect: 15.1%, $p < .001$) and less likely to share a household with the parent (marginal effect: -6.0%, $p < .05$) or to live nearby in a separate household (marginal effect: -9.2%, $p < .01$). When parents own their home, children are also more likely to live far from parents (marginal effect: 6.7%, $p < .05$).

4.8 Discussion

In this study I explored the residential choice differences between only children and their counterparts with siblings. Compton and Pollak (2013) have criticized a large share of the earlier research on the distance between parents and children for relying on models – for instance ordered logit models – that ignored the qualitative distinctness of intergenerational coresidence from living arrangements in which parents and children live independently. My findings corroborated their point: the Brant test indicated that the assumptions underlying ordered logit models were violated when estimating parent-child distance. Therefore a multinomial model which allowed the antecedents of intergenerational coresidence and of living nearby but independently to differ was called for.

The multinomial analyses indicated that, in general, children with a sibling are less likely than only children to share a household with a parent, but not more likely to live far away. Consistent with the needs-induced geography hypothesis, I found that differences in the residential choice of only children and their counterparts with siblings are most pronounced when parents are coping with frailty. Only children respond more strongly to parental need of having a child nearby than children with siblings: only children are substantially more likely to share a household with the parent and markedly less likely to live far away when the parent is coping with severe health limitations. Michielin, Mulder and Zorlu's (2008) analysis of administrative data from the Netherlands has indicated that the impact of parental needs on children's residential choice is generally rather small. The findings presented here suggest, however, that for only children the impact of parental needs on residential choice is substantial.

I did not find support for the birth order hypothesis. The analyses do not indicate that children with a younger sibling live farther from their parents than children with an older sibling. Given that Rainer and Siedler also did not find a birth order effect when they analyzed data from Germany (2009) and from ten different European countries (2012), there seems to be reason to question the birth order element of the geography of the family thesis by Konrad and

colleagues (2002). The analyses did not provide support for the gendered geography hypothesis either. Although gendered freeriding patterns among siblings have been noted with regard to caregiving to older parents (Tolkacheva, Broese van Groenou, & Van Tilburg, 2010), children with a sister do not appear to live farther away from their parents than their counterparts with a brother.

I did not find that any of the regional characteristics included in the models – level of urbanization, regional economic performance and the availability of beds in residential care settings – moderated the differences in residential choice between only children and children with siblings. Consistent with earlier studies, I found that children are more likely to live in separate households nearby their parents and less likely to live far away when the parents are living in regions with a higher level of urbanization.

Like Rainer and Siedler (2009) and Konrad and colleagues (2002) have done before, I focused on the case of Germany. Germany is a country where residential mobility is relatively low in comparison to other OECD countries (Caldera Sánchez & Andrews, 2011). The majority of children leaving the parental home remain within 10 kilometers from their parents (Leopold, Geissler, & Pink, 2012). Drawing on 2002 German Socio-Economic Panel Study data, Rainer and Siedler (2009) conclude that almost 6 out of 10 Germans live in the town of their childhood. Future research is needed to assess whether the patterns found in this study also apply to countries where residential mobility is higher.

In the current study, I focused only on families with one or two children. This is common in studies about the association between family composition and parent-child distance, because it becomes unfeasible to determine the combined impact of birth order and gender composition in larger families (cf. Konrad et al., 2002; Rainer & Siedler, 2009, 2012). As a consequence of the analytical approach, I cannot make statements about the geography of families with more than two children. Holmlund et al. (2013) have recently shown that in Sweden, there is no effect of having more than one sibling on parent-child distance. Future studies could assess whether having more than one sibling impacts parent-child distance under specific circumstances, for instance when the parent has severe health limitations.

Due to the cross-sectional nature of the analyses, I could not determine to what extent the differences in parent-child distance between only children and children with a sibling found in this study should be attributed to only children's inclination to remain near to the parental home and to what extent they should be attributed to their inclination to move back to a location close to their parents after initially having moved farther away. Plausibly, both mechanisms play a role.

Leopold, Geissler, and Pink (2012) do not find that a larger number of siblings is associated with a greater distance of initial moves out of the parental home in Germany, but children with more siblings are known to leave the parental home at younger ages (Mitchell, Wister, & Burgh, 1989). Studies conducted in the Netherlands and Sweden show that children with siblings are less likely than only children to relocate to a place close to their parents (Pettersson & Malmberg, 2009; Smits, 2010) and that a larger number of siblings is associated with a lower likelihood to move in with parents (Smits, Van Gaalen, & Mulder, 2010).

Regardless of the limitations summed up above, the current study allows me to conclude that family composition impacts children's residential choice and that the extent to which it does depends on parental need. Mulder (2007) has pointed out that scholarly attention for the impact of family on residential choice has been very limited. She argues that this may in part be related to ideology bias, stating that "the idea that we are now living in, or moving towards, a society in which achieved characteristics are more important than ascribed characteristics might have led researchers to overemphasize individual determinants of residential choice and underemphasize family determinants" (p. 270). The analyses indicate that only children constrain their residential choice more strongly than children with a sibling, particularly when parents have severe health limitations. As Rainer and Siedler (2009) have shown, these stronger constraints may very well result in sub-optimal labor market outcomes. The findings presented here thus suggest that only children face subtle barriers to occupational achievement that children with a sibling do not.

Chapter 5

Care ideals in the Netherlands: Early twenty-first century shifts

This chapter is co-authored by Pearl A. Dykstra and Romke J. van der Veen.

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Like in Chapter 2, the focus of the current chapter is on the Netherlands. The Netherlands is a country that is exemplary for the development in long-term care (LTC) policy that has been taking place countries that had traditionally adopted a universalistic model, in the sense that an ever stronger appeal to the family is made to take on a caring role. In this chapter, I assess how moral beliefs among the Dutch population about care for older persons in need changed in the first decade of the twenty-first century in response to LTC reforms. Drawing on the work of Hochschild, I adopt an approach in which three dimensions of moral beliefs about how care ought to be organized are taken into account conjointly: (1) the level of responsibility assigned to the family, (2) the level of responsibility assigned to the state and (3) the sharing of tasks between men and women in families. To do so, I conduct latent class regression analyses on two waves of the data from the Netherlands Kinship Panel Study ($n = 4,186$).

5.1 Introduction

With regard to the issue how to deal with the social risk of being in need of long-term care (LTC), countries like the Netherlands and the Nordic countries have traditionally adopted a so-called universalistic approach, i.e. they made state supported LTC services widely available for those in need. In the face of population ageing, many universalistic countries felt forced to implement LTC reforms in the late twentieth and early twenty-first century. One of the characterizing elements of these reforms was that they aimed to activate and maintain family members as caregivers. Ranci and Pavolini (2015) argue that the LTC reforms in universalistic countries can be viewed as an attempt to redefine how the family and the state share responsibilities for the care of those in need.

The question arises to what extent such a redefinition of responsibilities effectively can be prescribed. Public attitudes largely determine whether planned policy reforms achieve intended effects (Svallfors, 2010), particularly for policy issues that are highly salient (Burstein, 2003). 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). In this chapter, I therefore look into people’s moral beliefs about how LTC should be organized and assess to what extent the developments of these beliefs among the population fit with LTC policy

developments. I focus on the case Netherlands, a country in which LTC reforms have been implemented that are exemplary of those taking place in universalistic countries (see also, Chapter 2).

Scholars have examined specific aspects of moral 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 moral 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 moral care beliefs.

The first aim of the current study is to distinguish *care ideals* in an attempt to capture multiple dimensions of moral care beliefs simultaneously. Drawing on an essay by Hochschild (1995), I distinguish three key dimensions along which care ideals differ: a state dimension, a family dimension and a gender dimension. In a large sample of the Dutch population, I aim to identify care ideals with characteristic patterns for the three dimensions. The second aim is to assess shifts in these care ideals over time in the early twenty-first 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 arguably to be expected. However, Dutch LTC reforms, much like those in other countries that had traditionally adopted a universalistic approach to LTC, have encouraged family members to take on an active role in caring for dependent relatives. Dutch reforms prescribed that for an increasing number of support tasks, the spouses, partners and relatives of those in need, rather than the state, are the "normal" providers (Grootegoed, Van Barneveld, & Duyvendak, 2015; Morée et al., 2007; Van den Broek, 2013b). Should this prescription be embraced, then one would see a shift towards care ideals in which family members carry substantial caring responsibilities and in which the responsibility of the state is only limited.

5.2 Background

5.2.1 Hochschild's cultural ideals of care

Hochschild's (1995) typology of cultural ideals of care is unique in that it addresses multiple dimensions of moral 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 expected to be equally involved in family caregiving.

Hochschild’s typology has received criticism for being normative *a priori* (e.g., Kremer, 2006). Hochschild seems to have a preference for the warm-modern care ideal. I do not disagree with this criticism, but believe that it does not disqualify the typology of care ideals as a promising theoretical starting point for the study of multiple aspects of moral care beliefs in conjunction. In the following, I will therefore build on Hochschild’s labels, including their elements that may be considered value-laden, e.g. “cold” and “warm”. A simple schematic overview of Hochschild’s four care ideals is presented in Table 5.1.

TABLE 5.1: 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	–	+	+	+

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. The substitution of family caregiving by state supported LTC services is often spoken of in terms with negative connotations, such as “crowding out” (Schlesinger, 2012). However, as Greene (1983) has argued, whether this kind of substitution is negative or positive depends on what one

perceives to be the goal of state involvement in caregiving. Individuals adhering to a cold-modern care ideal believe reduction of family involvement in caregiving is desirable. 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 presumably 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 ideal, 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 do not expect women or 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).

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

Life course theory holds that changing times tend to be reflected in persons’ lives (Elder, 1994; Hagestad & Neugarten, 1985). As argued previously, I 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 twentieth century and the first decade of the twenty-first century (Janssen & Portegijs, 2011; Van Doorne-Huiskes & Schippers, 2010). The labor 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 twenty-first century the average number of hours worked has slightly increased (Janssen & Portegijs, 2011).

Women's rising engagement in paid work is arguably reflecting modernization of social norms regarding gender relations and the division of labor between men and women (Pfau-Effinger, 1998). 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. Although informal caregiving can be a positive experience for caregivers, for instance by giving a sense of satisfaction or through learning new skills (Cohen, Colantonio, & Vernich, 2002; Reinhard, Levine, & Samis, 2012), 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, Lucke, Hockey, & Dobson, 2008) and the United States (Lee, Tang, Kim, & Albert, 2015; 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 caregiving responsibilities, so-called "decommodified defamilialization" of care is called for. This entails widely available, affordable, state supported LTC

services (Saraceno and Keck, 2011; cf. Esping-Andersen, 1990; Esping-Andersen, 1999; Lister, 1994). The principle of reducing the responsibility to support those in need from the family through state supported LTC services is at the core of the universalistic approach to LTC, which had traditionally been adopted by the Netherlands, along with the Nordic countries.

As described more elaborately in Chapter 2, the Netherlands has, along with many other traditionally universalistic countries, been reforming its historically generous public LTC arrangements since the late 1990s (Pavolini & Ranci, 2008; Österle & Rothgang, 2010; Ranci & Pavolini, 2015; Swartz, 2013). 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). The usual protocol restricts the scope of state provided services for individuals with potential providers of what is considered “usual care”. Grootegoed, Van Barneveld, and Duyvendak (2015) argued that the usual care protocol is an instrument to shift the responsibility for an ever growing number of support tasks from the state to spouses, partners and relatives (cf. Morée et al., 2007; Van den Broek, 2013b).

The developments in Dutch LTC policy can be seen as manifestations of “re-familialization” rather than decommodified defamilialization. Given that family caregivers tend to be women, the LTC 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, 2013b). Assuming that moral care beliefs show changes that match policy changes (cf. Raven, Achterberg, Van der Veen, & Yerkes, 2011; Svallfors, 2010) and thus that the moral plausibility of LTC policy is sustained regardless of policy changes, one 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.

5.2.3 Socio-demographic predictors

Apart from examining shifts over time, I 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 Europe (Daatland & Herlofson, 2003; Daatland, Herlofson, & Lima, 2011; Herlofson, Hagestad,

Slagsvold, & Sørensen, 2011) and Japan (Van den Broek & Morita, 2016) tend to find the opposite pattern. 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 me 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, I 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, and McDonnell, 1997; cf. Daatland and Herlofson, 2003). Therefore, I 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, Herlofson, & Lima, 2011; Herlofson et al., 2011), possibly because parents do not want to burden their own children with demanding care tasks (Cahill, Lewis, Barg, & Bogner, 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, I expect to find the divorced, those with children and those who no longer have living parents to be particularly likely to adhere to care ideals in which family members have a restricted caring responsibility, such as a cold-modern care ideal.

5.3 Method

To distinguish care ideals among the Dutch population and to identify shifts over time in care ideals, I 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 (Hagenaars & Halman, 1989; McCutcheon, 1987). 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. An alternative method for categorization into classes is cluster analysis, but, contrary to LCA, this method relies on arbitrarily predetermined cut-off points and the choice of these cut-off points greatly influences results (Fonseca, 2013). In LCA, the relationship between the latent variable and the observed variables is furthermore probabilistic, rather than deterministic (Hagenaars & Halman, 1989).

To predict class membership, I 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, I 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 disadvantage 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).

I 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 (cf. 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 with different starting values.

I 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 I want to include in the model, a model with five or more classes would be unidentified (cf. Linzer & Lewis, 2010). For that reason, I 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, I compare the Bayesian information criteria of both models (Schwarz, 1978). When this procedure indicates that a four class model fits the data better than a model with fewer classes, I estimate LCA-models without covariates, starting with a four class model and, again, keep adding classes until an additional class no longer improves the model fit. Given the number of manifest variables and the number of these variables' categories it is possible to estimate LCA-models without covariates with up to seven classes before the model becomes unidentified (cf. Linzer & Lewis, 2010).

5.4 Data

I use data 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 (De Leeuw & De Heer, 2001).

I restricted the 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 (Merz et al., 2012). Women are overrepresented, with about 60 percent of respondents being female. With regard to the age distribution, the share of people in the middle age ranges in the sample is larger than the corresponding share in the Dutch population. The married and those living with children (except for single fathers) are overrepresented in the NKPS data, while those living alone or with their parents are under-represented.

I excluded respondents with missing values on any of the models' covariates in either of the waves, leaving a final sample of 4,186. I randomly selected one observation per respondent, effectively turning the panel data into a repeated cross-section. By doing so, I avoid violating the assumption of non-independence underlying the analyses. To check the robustness of the findings, I repeated the

procedure of randomly selecting one observation per respondent five times and estimated the models on each of the five additional samples.⁷

5.5 Measures

5.5.1 Manifest variables

I 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, I 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”. A similar question has been used in earlier studies on the relative responsibility of state and family for the care of older persons (Herlofson et al., 2011).

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”. Similar questions have been used in earlier studies of filial responsibility (cf. Dykstra & Fokkema, 2012; Gans & Silverstein, 2006; Herlofson et al., 2011). 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 the data matrix, I collapsed response categories (cf. Hageaars & Halman, 1989; Hogan, Eggebeen, & Clogg, 1993; Van den Broek & Morita, 2016). Though collapsing categories implies a loss of information, using all answer categories would produce unacceptably sparse data (cf. Van Gaalen & Dykstra, 2006). For each statement I 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.

Given the non-availability of a direct measure of gender attitudes with regard to caregiving, I used a measure indicating whether a respondent believed that,

⁷Results available on request. The results of the additional analyses did not differ substantially from the results of the analyses presented here.

within the family, it was the man's task to provide income to capture the gender dimension of care ideals. I did so, because ideas about gender and caregiving mirror ideas about gender and work in all four of Hochschild's (1995) cultural ideals of care. 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, I collapsed categories, merging "both equally" and "primarily the mother". It should be noted that less than one percent of the 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 served as control group 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).

5.5.2 Covariates

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

I 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. I 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. I 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. I 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).

5.6 Results

Descriptive information on the respondents is presented in Table 5.2. A comparison of Bayesian information criteria indicated that the model fit of the latent class regression model with four classes is better than that of the models with two or three classes. Estimation of LCA-models without covariates but with a greater number of classes further indicated that adding a fifth class does not improve the model fit.⁸

TABLE 5.2: Descriptive statistics.

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

Notes: Data are from waves 1 and 3 of the Netherlands Kinship Panel Study (NKPS); n = 4,186.

Estimated conditional probabilities of scores on the manifest variables on moral care beliefs are presented in Table 5.3. The most prevalent latent class is the one with a response pattern that is consistent with a *warm-modern* care

⁸Bayesian information criteria for the full models with two, three and four classes are, respectively, 25,650.8, 25,560.2 and 25,536.0. 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.

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.

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.

TABLE 5.3: Estimated class-conditional response probabilities.

		Observed total	Care ideals			
			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					

Notes: Data are from waves 1 and 3 of the Netherlands Kinship Panel Study (NKPS).

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 approximately 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%). I 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 5.4. 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: 0.729, $p < .05$).

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: 0.984, $p < .05$) or a traditional (OR: 0.941, $p < .001$) care ideal relative to a cold-modern care ideal. Compared to men, women have lower odds of having a warm-modern (OR: 0.760, $p < .05$), traditional (OR: 0.318, $p < .001$) or cold-traditional care ideal (OR: 0.438, $p < .01$) relative to a cold-modern care ideal. Those with a higher education degree are less likely than

TABLE 5.4: Results of latent class regression analysis predicting care ideals.

	Warm-modern		Traditional		Cold-traditional	
	B	(SE)	B	(SE)	B	(SE)
Constant	1.746***	0.339	4.165***	0.366	0.493	0.706
Wave 3	-0.315*	0.104	-0.094	0.134	0.000	0.267
Age	-0.016*	0.005	-0.061***	0.007	-0.000	0.010
Gender (female = 1)	-0.275*	0.108	-1.145***	0.132	-0.825**	0.199
Chronic illness / disability	-0.024	0.115	0.093	0.148	-0.343	0.202
Higher education degree	-0.146	0.102	-0.429*	0.133	-1.480***	0.275
Employed	0.188	0.125	-0.510**	0.152	-0.728*	0.241
Divorced	-0.057	0.144	-0.009	0.193	-1.399*	0.438
Has children	-0.193	0.119	-0.285	0.141	0.743*	0.298
Both parents deceased	0.113	0.138	0.007	0.192	0.074	0.245
Observations	4,186					
Fully observed cases	2,341					
Estimated parameters	62					
Residual df	9					
Log-likelihood	-12,509.5					
BIC	25,536.0					

Notes: Data are from waves 1 and 3 of the Netherlands Kinship Panel Study (NKPS); Reference category: cold-modern.

* $p < .05$, ** $p < .01$, *** $p < .001$

those without a higher education degree to have a traditional (OR: 0.651, $p < .05$) or a cold-traditional care ideal (OR: 0.228, $p < .001$) relative to a cold-modern care ideal. The employed are less likely than the jobless to have a traditional (OR: 0.600, $p < .01$) or a cold-traditional care ideal (OR: 0.482, $p < .05$) 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: 0.247, $p < .05$). I 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.

For easier interpretation of the findings, I calculated predicted probabilities for a “typical” woman or man in waves 1 and 3 to have each of the distinguished care ideals. I performed separate calculations for those with and those without a higher education degree. Age was set to the mean and the categorical predictor

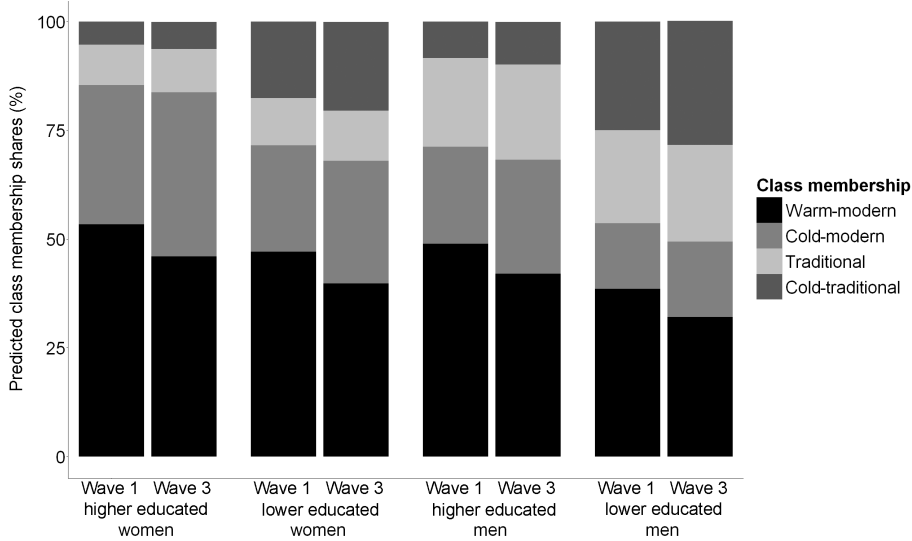


FIGURE 5.1: Predicted probabilities class membership.
Source: Netherlands Kinship Panel Study (NKPS), Waves 1 and 3.

variables were set to the mode.⁹ Predictions are depicted in Figure 5.1. 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.

5.7 Discussion

In this chapter, I looked into people's moral beliefs about how LTC should be organized and assessed to what extent the developments of these beliefs among

⁹Thus, 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.

the population fit with LTC policy developments. I focused on the Netherlands, a country that is exemplary for the development in LTC policy that has been taking place in countries that had traditionally adopted a universalistic approach to LTC, in the sense that an ever stronger appeal is made to the family to take on a caring role. I have argued that a multi-faceted approach is required to fully grasp moral care beliefs. The first aim of the current study was to distinguish care ideals capturing multiple dimensions of moral care beliefs simultaneously. The second aim was to assess how care ideals have shifted in the Netherlands in the early twenty-first century.

The analyses presented here 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. I 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, I find a care ideal not described in Hochschild's typology. I label this care ideal *cold-traditional*. Those adhering to this care ideal are traditional with regard to gender roles.

I 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 postmodern response pattern would furthermore 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 postmodern care ideal would also be unlikely to regard earning money as a task for men rather than for women.

I expected the rising female labor market participation in the Netherlands to be accompanied with shifts in care ideals. Consistent with my expectations, the

findings indicate that in the early twenty-first 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 LTC policy and people's moral care beliefs. Dutch policy makers increasingly aim to activate and maintain family members as caregivers, but the findings show a trend towards, rather than away from, care ideals in which the family only has a very limited caring role. In Mau's (2004) terminology, the moral plausibility of Dutch LTC 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 LTC policy changes that have taken place over the last decades (Smits, Van den Beld, Aartsen, & Schroot, 2014).

People who were younger than 18 or older than 80 when wave 1 data were collected were not present in the Netherlands Kinship Panel Study. Particularly the absence of the last group should be kept in mind when interpreting the findings of the current study. The 80-plus segment of the Dutch population is growing. It is expected that by 2025 almost 1 million inhabitants of the Netherlands will be in this age range, on a total population of 17.5 million (Wobma, 2011). With the findings indicating that it becomes more unlikely to adhere to a warm-modern relative to a cold-modern care ideal with increasing age, the absence of this growing group of oldest old in the sample implies that the shift away from warm-modern care ideals and towards cold-modern care ideals may be stronger than presented here. Future research is needed to assess whether this is the case.

Although the results of the current study suggest a discrepancy between the Netherlands' LTC policy and moral 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 former. Moral beliefs about lighter forms of care may therefore differ from moral 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.

Chapter 6

Long-term care reforms,
intergenerational support
and moral beliefs

6.1 Introduction

In the late twentieth and early twenty-first century, many countries that had traditionally adopted a universalistic approach to long-term care (LTC) have implemented largely similar reforms. Typically, these entailed increased targeting of services to those with the most severe care needs, de-institutionalization and the delegation to lower level governments of more authority in determining the LTC services to be provided and their eligibility criteria. Taken together, these reforms arguably shifted responsibilities for the care of those in need from the state to the family.

The aim of this dissertation was to shed light on the implications that these ongoing LTC reforms might have. A central question was whether a greater involvement of adult children in caregiving is effectively seen when state supported LTC services are less widely available. And if so, who provides more? More specifically, is the extent to which the involvement in caregiving of particular categories of adult children exceeds that of other categories greater when more responsibility rests with the family? Furthermore, I explored how public opinion responded to reforms.

In pursuit of answers to my research questions, I conducted longitudinal, cross-national, and cross-regional analyses, the results of which have been presented in the preceding chapters. In Chapter 2, I focused on the Netherlands. The reforms implemented in the Netherlands are exemplary of those taking place in countries with a universalistic LTC model. One of the implications of the reforms is that access to lighter forms of LTC services, such as household help, has been restricted. I assessed whether adult children responded by increasing their involvement in household help to ageing, community-dwelling parents living alone. Chapter 3 provided a cross-national comparison of a more onerous form of support: personal care, e.g. help with bathing or dressing. I linked cross-national differences in adult children's provision of personal care to impaired community-dwelling parents living alone to the availability of beds in residential care settings. The focus in Chapter 4 was on Germany, a country with substantial regional differences in the availability of LTC services. I conducted cross-regional analyses to assess the links between the regional availability of LTC services and the likelihood that adult children choose to live with or near ageing parents. In Chapter 5, I focused on the Netherlands again and looked into the question of how the moral beliefs of the Dutch with regard to how care ought to be provided changed in response to LTC reforms. In the current chapter, I briefly summarize the main findings and elaborate on their implications.

6.2 Implications for research

6.2.1 LTC services and adult children's support to ageing parents

Reverse substitution model

In the LTC literature, different models have been proposed on the association between state supported LTC services and the support that family members provide to ageing relatives in need. My findings largely corroborate the reverse substitution model developed by Johansson et al. (2003). The reverse substitution model posits that family members, in particular offspring, will increase their involvement in support to older relatives in need in response to cutbacks in state supported LTC services. Consistent with this model, I showed in Chapter 2 that Dutch adult children increasingly provided household support to impaired ageing parents living alone when state supported household services became less widely available.

This increase was not self-evident. Older people in the Netherlands are, on average, financially well-off (Smits, Van den Beld, et al., 2014). The net standardized income of people aged 65 and older has been rising for decades and the poverty rate is very low in this age group (Ibid.). This suggests that many older persons had the financial means to acquire care services on the market, rather than turn to family, in order to compensate for state supported services to which access became more restricted. However, the role of out-of-pocket paid private care services remains small in universalistic countries such as the Netherlands and Sweden (Lyon & Glucksmann, 2008; Ulmanen & Szebehely, 2015), and my findings indicate that the market for services did not render family support obsolete.

Earlier longitudinal studies conducted in England (Pickard, 2012) and Sweden (Ulmanen & Szebehely, 2015) provided evidence for reverse substitution in response to de-institutionalization, i.e. the reduction of beds in residential care settings. In these countries – which, like the Netherlands, traditionally adopted a universalistic LTC model – adult children's provision of personal care to ageing parents increased following a reduction in the availability of beds in residential care settings. Consistent with the findings of these longitudinal studies, the cross-national analyses presented in Chapter 3 showed a negative association between the availability of beds in residential care settings and adult children's provision of personal care to impaired community-dwelling parents. I extended on earlier work by looking into the underlying mechanisms. I showed that adult children

of impaired community-dwelling older adults were less likely to provide personal care in countries where beds in residential care settings were more widely available, partly because (1) the parents' care needs were less severe in such countries and (2) adult children and impaired parents were less likely to share a household in such countries. After accounting for these two factors, adult children remained less likely to provide care in countries where beds in residential care settings were more widely available. Plausibly, being able to rely on residential care undermined adult children's sense of urgency to step in and provide care to their parents.

Support with household tasks or personal care requires face-to-face contact and it is well-established that children who live nearby are more likely than their counterparts living far away to provide these forms of support to ageing parents (Knijn & Liefbroer, 2006; Leopold, Raab, & Engelhardt, 2014; Rainer & Siedler, 2012). It has been argued that adult children – in particular those without siblings – let their parents' expected future need for care guide their decision where to live (Konrad et al., 2002; Rainer & Siedler, 2009). It is conceivable that the perceived pressure to do so is lower when LTC services are more widely available, because such services make older persons less dependent on relatives to have their care needs met (cf. Rainer & Siedler, 2012). The evidence for a link between the availability of LTC services and residential choice provided in this dissertation is mixed, however. In Chapter 3, I showed that impaired community-dwelling parents were less likely to live with adult children in countries where beds in residential care settings were more widely available, but the cross-regional analyses for Germany presented in Chapter 4 did not show any association between the availability of LTC services in the district where the parent lives and the proximity of a child.

Complementarity and specialization models

My findings provide reasons to question two theoretical models proposed by scholars challenging the idea of (reverse) substitution: the complementarity model and the specialization model. According to the complementarity model (Chappell and Blandford, 1991; cf. Stoller, 1989), family members are encouraged, rather than discouraged, by state supported LTC services to provide support to parents in need. Proponents of this model argue that the barriers for family members to take on support tasks are lower when state supported services are also provided. This is because the possibility to share the overall care load with formal caregivers presumably reduces the potential burden associated with providing care for family members.

The findings presented in this dissertation are not consistent with the complementarity model. In Chapter 2, I found that children's involvement in household support to ageing parents in need increased in response to cutbacks. The complementarity model would have led one to expect a decrease, because cutbacks imply a reduction of the opportunities for family members to share the care load with formal caregivers. The complementarity model would also suggest that, after controlling for severity of needs, adult children would be more likely to provide personal care to impaired community-dwelling parents when the latter received formal home care services, because in situations like these the former can share the care load with formal caregivers. In Chapter 3, I found no positive association between parental receipt of formal home care and adult children's provision of personal care, however.

Proponents of the specialization model (Brandt et al., 2009; Igel et al., 2009) argue that when state supported LTC services are more widely available, the need for family members to provide the most onerous support tasks – e.g. personal care – to relatives in need is reduced, which, in turn, presumably makes family members more able and willing to provide lighter forms of support – e.g. household help. Cutbacks in services would, in this model, thus increase the pressure on family members to provide personal care, as a result of which family members' ability and willingness to provide household support would be undermined.

The reasoning of the specialization model might be plausible when cutbacks concern state supported services for the most severe care needs. However, cutbacks in universalistic countries largely concern lighter forms of services, e.g. household help. Although the reforms arguably increased the need for family members to provide lighter forms of support, the need to provide personal care was not increased substantially. The empirical findings presented in this dissertation are also not consistent with the specialization model. As described above, the model would lead one to expect a decline in adult children's involvement in household help – regarded as a lighter form of support by proponents of the specialization model (Brandt et al., 2009) – in response to cutbacks. In Chapter 2, I instead found an increase. The task-specialization model would also lead one to expect that adult children were less likely to provide personal care – deemed a demanding form of support (Brandt et al., 2009) – to impaired community-dwelling parents when the latter received formal home care services. This association was not found in Chapter 3, however.

My findings do not rule out that the ongoing LTC reforms in traditionally universalistic countries might yield specialization of a different kind than suggested in the model by Brandt and colleagues. Future research could explore the validity

of a refined model that I would tentatively label *specialized reverse substitution*. Specialized reverse substitution would imply (1) that the state's provision declines and families' provision grows with regard to both relatively onerous forms of support, e.g. personal care, and more basic forms of support, e.g. household help, but (2) that the shift would be stronger for the latter form of support than for the former. Thus, an increasing share of the shrinking package of state LTC supported services would be aimed at covering needs for demanding forms of care, while a declining share of adult children's growing provision of support would be aimed at addressing such needs.

6.2.2 Differences across categories of children

It is well-established that some categories of children are more likely than others to support ageing parents. Daughters are more involved than sons and only children's involvement exceeds that of children with siblings (Haber Kern & Szydlik, 2010; Knijn & Liefbroer, 2006; Ogg & Renaut, 2006; Rainer & Siedler, 2012). The analyses presented in this dissertation largely corroborate these earlier findings. I showed that, compared to sons, daughters are more engaged in the provision of household help (Chapter 2) and they also more often provide personal care to impaired community-dwelling parents (Chapter 3). Moreover, I showed that adult children are more likely to provide personal care when they have fewer siblings. Lastly, Chapter 4 showed that adult children without siblings are more likely than children with a brother or sister to choose to share a household with ageing parents, particularly when the latter have severe care needs.

It has been suggested elsewhere that the extent to which the provision of support by some categories of children exceeds that of others depends on the availability of LTC services. More than 30 years ago, Finch (1983) warned that shifting care responsibilities from the state to the community effectively implied shifting responsibilities to female family members of those in need. This concern for what I call gendered reverse substitution has since been echoed numerous times (e.g., Saraceno & Keck, 2011; Schenk et al., 2014; Van den Broek, 2013b; Van Hooren & Becker, 2012). It furthermore seems plausible that a shift of care responsibilities to the family could have particularly strong consequences for those who are an only child, because they do not have siblings to share these responsibilities with. This reasoning would lead one to expect that the differences in support provision between only children and children with siblings are more pronounced when state supported LTC services are less widely available (cf. Rainer & Siedler, 2012).

The analyses presented in this dissertation do not suggest that the concerns

described here are justified. In Chapter 2, I did not find that daughters' provision of support increased more than sons' in response to LTC cutbacks in the Netherlands. Neither did I find that only children's support increased more than support by children with siblings. In Chapter 4, moreover, neither the residential choice differences between daughters and sons¹⁰, nor those between only children and children with a sibling were found to depend on the regional availability of LTC services.

6.2.3 Care ideals

The reforms implemented in countries with a universalistic LTC approach can be characterized as ongoing efforts to change how the state and the family share responsibilities for the provision of support to those in need (Ranci & Pavolini, 2015). In the last part of this dissertation, I looked into the moral plausibility of this responsibility shift, i.e. the extent to which it corresponds with public opinion (Mau, 2004). Hochschild (1995) has argued that moral beliefs with regard to how care ought to be organized are best understood as images that reflect distinct models of care. These distinct ideal models vary on three dimensions: (1) the level of responsibility assigned to the family, (2) the level of responsibility assigned to the state and (3) the sharing of tasks between men and women in families. To truly grasp moral beliefs about care – and therefore to be able to assess the moral plausibility of LTC reforms – all three dimensions should be assessed conjointly.

Hochschild (1995) proposed a typology of four care ideals, i.e. distinct moral views of how care for those in need should be organized. In the *traditional* care ideal, care is first and foremost the responsibility of – in particular female – family members and the state only has a limited caring responsibility. People adhering to a *warm-modern* care ideal believe that the family and the state carry a joint responsibility for the care of those in need. People adhering to a *cold-modern* care ideal believe that family caregiving is undesirable. They expect women and men to focus fully on a career in paid labor, and believe that the state should enable this by taking on the bulk of care for those in need. Finally, people adhering to a *postmodern* care ideal believe that neither the state nor the family carries a large responsibility towards those in need. Having care needs met is, in their eyes, a

¹⁰In addition to the models presented in Table 4.2, I estimated a model in which an interaction term (child gender X residential care beds per 1,000 inhabitants 65+) was added to the best fitting model (Model 4). However, the interaction term was not significant and its addition did not yield a model fit improvement (AIC: 3,747.0, full results are available on request). I thus do not find support for the idea that residential choice differences between sons and daughters are contingent on the availability of LTC services in the district where the parent lives.

responsibility of individuals in need themselves.

Hochschild's empirical underpinning of her typology was largely anecdotal. Moreover, she explicitly stated that her essay concerned the United States and she made a plea for further research in other developed countries. The latent class analysis presented in Chapter 5 largely validated the typology of care ideals in the context of the Netherlands. I identified four distinct views about how LTC ought to be organized, three of which are consistent with care ideals formulated by Hochschild: traditional, warm-modern, cold-modern. Furthermore, I found a care ideal not described in Hochschild's typology. I labeled this care ideal *cold-traditional*. People adhering to this care ideal are traditional with regard to gender roles. They also believe that the state is primarily responsible for the provision of care to the frail old and that the family has only a restricted caring role. The cold-traditional care ideal is consistent with new conservatism, where high value is ascribed to maintaining a generous welfare state. Havenaar (2006) has argued that new conservatism is a continental European phenomenon. This may be the reason why Hochschild did not describe a cold-traditional care ideal in her typology. The finding of a cold-traditional care ideal implies that adherence to the male breadwinner model does not necessarily go hand in hand with the belief that the family carries an important role in the care for older persons in need.

A second discrepancy between Hochschild's typology and my findings is that I did not find a postmodern care ideal. In the postmodern care ideal it is the responsibility of persons in need themselves to have care needs met. Although Hochschild does not explicate how individuals with care needs should do this, an obvious way would be through out-of-pocket purchase of private services. As pointed out, however, the role of out-of-pocket paid private care services in addressing older persons care needs is only small in traditionally universalistic countries such as Sweden and the Netherlands (Lyon & Glucksmann, 2008), and there does not appear to be a substantial increase in response to reforms (Ulmanen & Szebehely, 2015). Thus, not only do I not find a postmodern care ideal among the Dutch population; behavior that fits with a postmodern care ideal is also uncommon in traditionally universalistic countries.

6.3 Policy implications

6.3.1 Adult children step in

The LTC reforms in traditionally universalistic countries have attempted to re-define how the family and the state share the responsibilities for the care of those

in need. One of the ways policy makers have sought to achieve this goal has been to make state supported services – in particular for less onerous tasks such as household chores – less widely available. The evidence from the Netherlands presented in Chapter 2 suggests that this approach yielded the envisioned response: Dutch adult children increased their involvement in household support to ageing parents with care needs considerably when state-supported services became less widely available.

Another key element of LTC reforms in universalistic countries has been de-institutionalization, i.e. the reduction of beds in residential care settings. It has been argued that shifting the locus of care from institutions to the home effectively increases family responsibility in caregiving, because state supported home care services do not suffice to address the care needs of impaired older adults without the presence of a family member willing to take on a substantial caring role (Levine, Halper, Peist, & Gould, 2010). Consistent with this argument – and with longitudinal work conducted in England (Pickard, 2012) and Sweden (Ullmanen & Szebehely, 2015) – the cross-national analyses presented in Chapter 3 showed that adult children were more likely to provide personal care to ageing parents when beds in residential care settings were less widely available. This is consistent with the idea that de-institutionalization yields re-familialization of care.

Given that the provision of household support or personal care require face-to-face contact, one could imagine that adult children and ageing parents might be more likely to choose to live close to each other or even in a shared household to facilitate the provision of support when LTC services are less widely available. As pointed out, however, I found only mixed evidence for links between the availability of LTC services and the extent to which adult children choose to live near or with parents. A recent study of the Netherlands, where the number of beds in residential care settings has been drastically reduced (as illustrated in Figure 1.1 in Chapter 1), shows that coresidence between older parents and adult children remains much more strongly driven by the needs from the younger generation rather than by those of the older generation (Smits, Van Gaalen, and Mulder, 2010; cf. Dykstra, Van den Broek, et al., 2013). In anticipation of an increase in the desire of older parents with care needs and their children to live in close proximity in order to facilitate informal caregiving, the Dutch government has facilitated the possibility of creating so-called “kangaroo housing”, i.e. family dwellings incorporating a self-contained apartment for the relative in need of care. Studies conducted by a coalition of the association of social housing corporations and an association of care organizations (Aedes-Actiz, 2011), as well as by the city of The Hague Gemeente Den Haag (2013) pointed out, however,

that demand for such housing is very small and that there is no indication of an increase. These findings and the mixed evidence in this dissertation suggest that the impact of LTC reforms on the living arrangements of adult children is limited. It should be noted that although intergenerational coresidence is relatively rare in the Netherlands, older parents and their adult children tend to live relatively near to each other (Mulder & Kalmijn, 2006).

Intergenerational coresidence and intergenerational proximity can result from different trajectories, each with their own, and sometimes contradictory, predictors (Dykstra, Van den Broek, et al., 2013). Ideally, longitudinal analyses of residential relocations should be conducted to disentangle who moves closer to (or in with) whom and for whose needs (cf. Choi, 2003; Smits, Van Gaalen, & Mulder, 2010). Given the rarity of needs-induced relocations of older people, analyses of long-running register data are called for to assess whether and, if so, how LTC reforms impact the propensity of parents in need and their adult children to relocate close to each other or, ultimately, to share a household.

My findings corroborated the established finding that the engagement of some categories of children, most notably daughters and children without siblings, exceeds that of others. A reason for policy makers to be hesitant about shifting care responsibilities to the family might be the concern that such a shift would amplify these differences. As described earlier, however, my findings do not suggest that such concerns are warranted. To some extent this may be attributable to ceiling effects. In Chapter 2, for instance, daughters were already markedly more engaged in the provision of household support than sons at baseline. Hence, there was less room for growth for daughters than for sons. For methodological reasons, I was furthermore not able to assess in Chapter 3 whether the links between the availability of LTC services and adult children's provision of personal care varied between daughters and sons and between only children and children with siblings.

6.3.2 Moral plausibility

As outlined above, my findings suggest that LTC reforms in traditionally universalistic countries contribute to an increase in adult children's involvement in the provision of support to ageing parents. Also, I did not find that the organization of LTC has an impact on the extent to which the support provided by some categories of adult children exceeds that of others. Nevertheless, my findings suggest that caution is warranted should policy makers aim to shift even more care responsibilities from the state to the family.

The universalistic approach to LTC is a manifestation of what Hochschild

(1995) has labeled a cold-modern care ideal. People adhering to this care ideal believe that the state should enable men and women to focus on work by making LTC services available that reduce the need to provide care to relatives. The ongoing reforms – as a result of which the scope of services to which persons in need are entitled has been reduced – imply a move away from an LTC approach that fits with this ideal. For this to be morally plausible, the adherence to the cold-modern care ideal would need to decline, but the results from the Netherlands showed the exact opposite. In the first decade of the twenty-first century, the Dutch became more likely to adhere to cold-modern care ideal. The surge of the cold-modern care ideal came most notably at the expense of the warm-modern care ideal, the proponents of which believe that family and the state are jointly responsible for the provision of care to those in need.

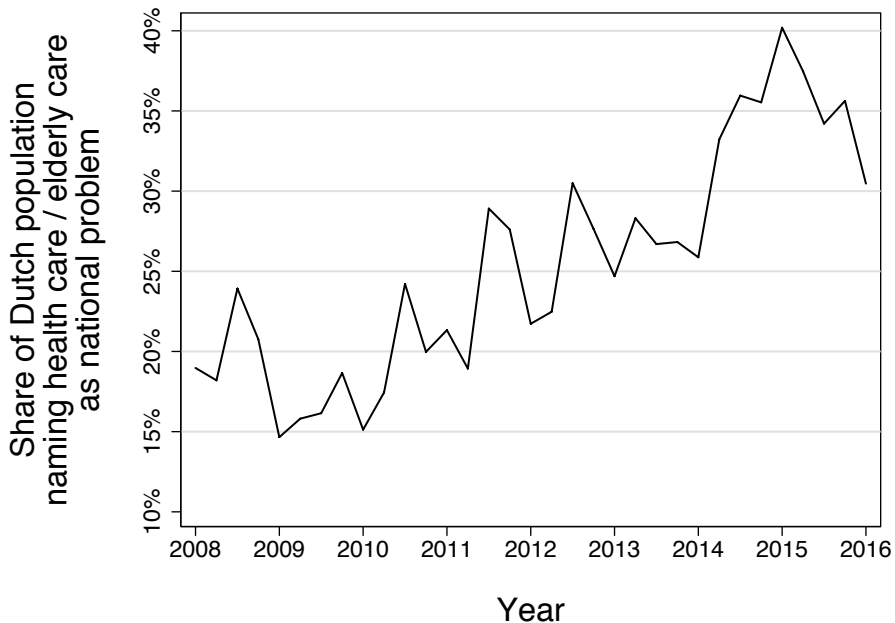


FIGURE 6.1: Elderly care as a perceived national problem in the Netherlands. Source: Continu Onderzoek Burgerperspectieven (COB), The Netherlands Institute for Social Research (SCP)

The discrepancy between trends in, on the one hand, moral beliefs and, on the other hand, the organization of LTC raises the questions about the appropriateness of shifting an even larger share of the responsibility for care from the state to the family. Public opinion can determine the borders to which reforms are

feasible (Svallfors, 2010), particularly for policy issues that are considered highly salient (Burststein, 2003). Only a few issues can be highly salient at a time, and the need for policy makers to be responsive to public opinion is largely limited to these few issues (Jones, 1994). That a large and growing share of people hold moral beliefs about LTC that are at odds with the direction that LTC in traditionally universalistic countries is heading is therefore relevant to the extent that LTC is considered a salient policy issue.

Since 2008, the Netherlands Institute for Social Research has periodically monitored public opinion of the Dutch on a wide range of issues. Among other questions, respondents were asked what they perceived to be the Netherlands' greatest problems. The share of persons who named health care / care for older people as (one of) the greatest problem(s) is presented in Figure 6.1.¹¹ The share of the Dutch population expressing concerns about these topics has gradually increased in recent years, rising from less than 20 percent in early 2008 to more than 40 percent in the beginning of 2015. Since this peak, a decline in the salience can be noted, plausibly because of the rising salience of issues related to refugees and migration (Dekker, Van Dijk, Van Houwelingen, Mensink, & Sol, 2015). Nevertheless, the figure shows that the organization of care is still a substantially more salient issue today than it was the recent past. The rising salience of LTC as a policy issue in combination with increased adherence to the cold-modern care ideal suggests that attempts to shift even more responsibilities from the state to the family may meet resistance.

The research presented in Chapter 5 roughly pertained to changes in the first decade of the twenty-first century. Given that established moral beliefs can be hard to change (Svallfors, 2010), this is a rather short period to study shifts. In the Netherlands and elsewhere, the issue of how to organize LTC in the future has been subject of intense political debate in the period of study. Plausibly, people increasingly emphasized the value of state supported services and stressed the limitations of what can be expected from relatives because of uncertainty about what further cutbacks in state supported LTC services might bring (cf. Pierson, 1996). The research presented in Chapter 5 therefore asks for future studies on how public opinion about how LTC ought to be organized develops over a longer time span. Such research would shed light on whether there is a persistent, and possibly even growing, discrepancy between people's moral beliefs about LTC and the direction in which LTC in traditionally universalistic countries is moving, or

¹¹I would like to thank Alice de Boer and Josje den Ridder at the Netherlands Institute for Social Research for providing me the data.

whether the former will adapt itself to the latter. Following up on this dissertation's research, I have recently estimated that in 2014 three out of every ten Dutch adults adhered to a cold-modern care ideal (Van den Broek, 2016), which is higher than the levels reported for 2011 in Chapter 5. First indications thus do not suggest that the attempts to redefine how the family and the state should share the responsibilities for the care of those in need are generally embraced.

6.4 Is cold-modern really old-modern?

In recent policy discourse, the traditional universalistic approach to LTC has often been presented as outdated (Da Roit, 2012; Newman & Tonkens, 2011). The view on LTC that Hochschild (1995) labeled cold-modern – of which the universalistic approach to LTC is a manifestation – has been dismissed as what one could call *old-modern*: a view that might have been considered modern decades ago, but that has become hopelessly antiquated. Illustrative is the following quote from the 2013 speech of the throne in the Netherlands. In this speech, the concept of the “participation society” was introduced, in which people are expected to take responsibility for their own lives and those of the people close to them and to rely less on the state.

“The shift towards a participation society has manifested itself in particular in social security and long-term care. In these policy areas, the classic welfare state from the second half of the twentieth century has produced arrangements that are unsustainable in their current form and that no longer fit with people’s expectations.” (own translation)

I would like to make two comments. With regard to the sustainability of welfare state arrangements, it should, first, be noted that, with their populations ageing, many universalistic countries have aimed to contain public expenditure not only by reforming LTC, but also by encouraging labor force participation of men and women in later midlife (OECD, 2013, 2014, 2015). It has been argued that these two policy efforts may clash (Putters, 2014; Sadiraj, Timmermans, Ras, & De Boer, 2009). Particularly for women, providing informal care is associated with an increased risk of reducing employment hours or quitting paid work altogether (Berecki-Gisolf et al., 2008; Lee et al., 2015; Pavalko & Artis, 1997). The detrimental impact of informal caregiving on the labor market participation of middle-aged women is most severe in countries where state supported LTC services are least widely available (Kotsadam, 2011; Naldini, Pavolini, & Solera, 2016). My findings corroborate earlier work that suggests that children increase

their support to ageing parents in need when state-supported LTC services are made less widely available. From a cost-containment perspective, these LTC reforms may nevertheless prove to be what Sieber (1981) called a fatal remedy. Policy makers should consider the potentially disruptive impact of redefining how the family and the state share caring responsibilities on the concomitant effort to keep welfare state arrangements sustainable through an increased labor market participation of middle-aged men and women.

Second, I would argue that is overly bold to state that the traditional universalistic approach to LTC no longer corresponds with what people expect. Although I do not dispute that some norms, most notably with regard to spending later life in residential care settings rather than at home, have likely shifted over the last decades in a way that corresponded with policy developments, the substantial and growing share of people holding a cold-modern view on LTC cannot be ignored. It indicates that more, rather than fewer, people believe that the principal responsibility for the care for older people with care needs rests with the state, and that family members carry only limited caring responsibility. The universalistic approach to LTC, in which state supported LTC services are made widely available for those in need, fits best with these people's expectations.

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Curriculum Vitae

Thijs van den Broek (Ammerzoden, 1977) obtained his Master's degree in Sociology at Erasmus University Rotterdam with distinction (*cum laude*) in 2011. The Dutch Gerontological Association (NVG-knows) awarded him the Prof. Joep Munnichs Prize for the best master thesis in gerontology in the academic years 2010-2011 and 2011-2012.

From November 2011 until October 2015, Thijs worked as a doctoral researcher at the Department of Sociology at Erasmus University Rotterdam. He was involved in the international research project *FamiliesAndSocieties – Changing families and sustainable societies* funded by Seventh Framework Programme of the European Union and the COST Action *INTERFASOL: Intergenerational Family Solidarity across Europe* funded by the European Union's Framework Programme Horizon 2020. He published research articles on intergenerational support and long-term care in national and international peer-reviewed journals. In February and March of 2015, Thijs was a visiting researcher at the German Centre of Gerontology in Berlin. This research visit was partly funded by Erasmus Trustfonds and COST.

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