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You will take care of me when I am old: Norms on children's caregiver obligations – An analysis with data from the European Values Study

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Abstract

Objective: We explore gender differences in support of the norm that children must provide care for their parents.

Background: Society's values and norms play a crucial role in deciding whether to provide family care. We investigate these values and norms on family care by analyzing which individual and country level factors affect them.

Method: We use data from the European Values Study wave 5 and multilevel regression techniques. The question, "Adult children have the duty to provide long-term care for their parents", serves as our dependent variable. The explanatory variables at the individual level are gender and further socio-demographic variables. At the country level, we include expenditures on health care, and the female labor force participation rate.

Results: The results show that women, as well as those living in countries with high expenditure on health care and high female labor force participation rates, are less supportive of the norm that children have an obligation to provide care for their parents. Furthermore, the gender effect is stronger in countries with a higher female labor force participation rate.

Conclusion: Norms and values on family care are not fixed and can change, as suggested by the differences between countries. They are also not shared by all social groups equally, as the differences between women and men and along other socio-demographics show.

Key words: long-term care, informal care, gender, norms and values, EVS

1. Introduction

Increasing life expectancy and decreasing fertility rates are resulting in a growing number of older people in absolute and relative numbers (Harper, 2015) in Europe and many other parts of the world. With this increase in the number of older people, societies will face the challenge of providing more long-term care (LTC). According to projections by the European Commission, the proportion of people aged 65 and older will increase by 41% over the next 30 years. This will result in an increase in persons potentially in need of long-term care in Europe (EU-27) from 30.8 million in 2019 to 33.7 million in 2030 and 38.1 million in 2050. As a result of the development described above, spending on long-term care in the EU is also expected to increase from 1.7% of GDP in 2019 to 2.5% of GDP in 2050 (European Commission, 2021). These major challenges must be addressed by policymakers and other stakeholders at all levels, with a particular focus on vulnerable groups. Already today, many people in Europe do not have access to long-term care; financial reasons, in particular, play the largest role here (European Commission, 2021). Although the share of long-term care provided in institutions is increasing in many countries, the largest part still occurs at home by family members—especially women. Similarly to the professional care sector, in which the share of women is around 90%, the responsibility to provide (informal) care for older family members primarily falls to female household members (European Commission, 2021). Feminist scholars have repeatedly pointed out this gender inequality, not only regarding the unequal division of (care) labor but also concerning the societal values and norms that assign the responsibility of (family) care to women (Le Bihan et al., 2019; Pfau-Effinger et al., 2009).

The decision and obligation to take up family care is multifactorial and relates to individual, organizational, and societal factors. Frequently mentioned in this regard are health (Kaschowitz & Brandt, 2017), age (Berger-Schmitt, 2003), economic factors such as income and low socio-economic status (Schmitz et al., 2022), or the cost of professional care, that all play a role in care decisions (Quashie et al., 2022). Using European data, Rodrigues et al. (2018) found, for example, that people with low income and wealth have a higher probability of providing family care. One explanation might be monetary limitations in access to professional care, as Saito et al. (2018) showed for Japan.

The employment status of a potential family caregiver is an important factor as well. People with a lower labor market attachment have a higher probability of starting family care (Czaplicki, 2012, 2020). The opportunity cost of starting caregiving might explain this effect of labor market status. In addition to factors that relate to individuals, the organization of long-term care in a country and related welfare state policies—both factors at the meso and/or macro level of societies—have also proven to be crucial in the decision or obligation felt to start family care (Doty, 1986; Gori et al., 2015). Family care decisions are, for example, strongly related to the provision of (formalized) professional care, the establishment of policies fostering the reconciliation of care and work, and social security measurements that compensate for wage and retirement contributions lost when providing care (Attanasio et al., 2008; Geyer & Schulz, 2014).

Societal norms and values of how and by whom long-term care should be provided also play an important and crucial role in the decision to start family care. In this regard, societal norms might even have a double effect. On the one hand, they affect to whom a society ascribes care responsibility. On the other hand, they influence welfare state policies and the organization and availability of extra-familiar care settings, which in turn factor into an individual's notion of who is responsible for providing care. This is underlined by the theory of sociological institutionalism, which assumes that norms and values strongly affect the decisions of people who feel obligated to take care of older family members. Hall & Taylor (1996: 948) comment that "institutions do not simply affect the strategic calculations of individuals, as rational choice institutionalists contend, but also their most basic preferences and very identity."

Applying this argument to the question of care decisions, one would expect that children—and in particular women—in countries with strong norms will feel that they should or even must take care of their parents when they are old, and mainly daughters and daughters-in-law will feel strong pressure and provide family care. Hess et al. (2020: 665) explore how norms and values affect the decision to provide care in Europe and find that "the results show that the familiaristic-conservative values of a society correlated with the probability of older women doing care. The implication is that "Culture Matters" in care politics."

The question now arises of *how individuals agree with the highly gendered norms of family care obligations*, and how this differs between men and women and countries/societal contexts. Using data from the European Values Study (EVS), we explore these norms by analyzing the support for the norm that children have the duty to provide care for their parents. In doing so, the study makes several contributions to the

literature. First, we explore gender differences regarding family care norms. Second, we do this from a comparative perspective, as we expect differences in cultural and societal contexts. Finally, we add to the understanding of how gender and country differences interact in the context of family care norms.

The remainder of the study has the following structure. First, we provide an overview of the current literature, and we discuss central lines of argumentation in the discourse around care norms and obligations. Here we aim to highlight the complexity of care norms, and how they not only relate to the individual level, but are also embedded in the cultural context and present in institutional settings and welfare state policies. Then we present our data, our methodological approach, and the study's results. The study concludes with a discussion of our findings, followed by the limitations and future research needed.

2. Literature review and theoretical framework

2.1 Gendered care norms

In countries with growing numbers of older people, the question of how to provide them with adequate long-term care is at the center of societal discourse. When looking at care settings, research has shown that the decisions behind who takes on care responsibilities and who feels obliged to provide care are multi-factored and multi-level structured. This means that in addition to *whom society normatively ascribes care responsibilities to*, it is also very important *how individuals have internalized such a notion and agree with it* (Hess et al., 2020). Culturally shared norms and values have proven to have a dual effect in this regard: On the one hand, on the individual level they put pressure on certain members of society and/or families (traditionally women) to take on (unpaid) care responsibilities. On the other hand, they form institutional settings and welfare policies at the meso and/or macro level that might foster or hamper the availability of extra-familiar care services, and subsequently shape the options available to families and/or caretakers (Doty, 1986; Gori et al., 2015). These include, amongst others, the provision of care offered and care professionals available in each country (Ehrlich & Keller, 2019), support in the reconciliation of work and care (Busby, 2018; Ehrlich et al., 2019), and potential compensation for wages and retirement contributions lost when providing care for an older relative (Attanasio et al., 2008; Geyer & Schulz, 2015).

In countries with access to extra-familiar care services and payment schemes to pay or compensate for care, the responsibility to care for older relatives (theoretically) does not fall solely on the family, or more precisely on the women in the family (Gubermann et al., 1992; Spasova et al., 2018; Wagner & Brandt, 2018). Hence, they should feel less compelled to take on care responsibilities for their relatives. Even though institutional care is increasingly available in many countries, informal care in the domestic context, carried out by family members, remains the most prevalent and common care setting (Gentili et al., 2017; Geyer & Schulz, 2015; Wetzstein et al., 2015). This puts immense pressure on families—mainly women—to care for older relatives, while simultaneously being confronted with other societal obligations. The main obligation is the politically motivated high labor market participation, due to shrinking workforces, skill shortages, and the need to ensure the sustainability of welfare systems (Harper, 2015). For women aged 50+ this results in what Dallinger (1996, 1998), amongst others, has framed as the "second reconciliation conflict". This means that the clash of being gainfully employed at the same time as providing care for one's parents becomes necessary, which then might lead to women being opposed to highly gendered family-care norms. Furthermore, because of this conflict, women often reduce working hours or withdraw and retire (prematurely) from the labor market (Dow & Meyer, 2010; Forma, 2009). In doing so, as researchers have pointed out, women face several "new social risks" regarding their individual well-being or health, which might decline due to the pressure put upon them to reconcile work and care, or by weakening their current and future income situation (Ehrlich et al., 2020). Furthermore, care obligations and consequences of caregiving vary by socioeconomic status (SES), as socioeconomically disadvantaged groups have fewer opportunities to access privately paid extra-familiar care services. Hence, they are more likely to provide informal care which not only reinforces socioeconomic inequalities, but also reduces individual life-satisfaction (Brandt et al., 2022; Quashie et al., 2022). This is especially (but not exclusively) the case in the wake of the COVID-19 pandemic, which—as researchers have pointed out—increased caregivers strain due to the unavailability of social and professional support systems (Schmitz et al., 2022). In this regard, a generational effect might also come into play, as a study looking at the renegotiation of care across family

generations by Conlon et al. (2014) highlights. The authors found that, regarding care expectations, older women in higher socioeconomic positions are less likely to expect family support and are particularly attuned to potential care strains put upon younger female family members. They reflect critically upon the impact these gendered care-norms had on their own lives and in doing so initiate the "re-negotiate of care" within their own families.

Another "new social risk", as feminist researchers have pointed out, concerns traditional gender stereotypes, which—by women continuously providing care in most countries—are potentially being reinforced rather than overcome. As a result, women might adhere to and reinternalize traditional gender roles and the division of (care) labor which perpetuate their dependency on the so-called "breadwinner model" (Le Behina et al., 2019; Leitner, 2013; Theobald, 2020). When looking at the role of countries in regard to care decisions, Geissler & Pfau-Effinger (2005) note that while potentially creating or reproducing social and/or gender inequalities, this "re-familiarisation of care" might even be in the interest of a country and its welfare state policies, as it presents itself as a cheaper alternative to establishing costly extra-familial care and LTC services.

> "Family care, while seemingly in the background of major long-term care policy reforms, is therefore often brought in 'through the back door'. As a result of these policy patterns, demographic changes and of course also through explicit encouragement of family inputs in many countries, the role of family care is expanding" (Kodate & Timonen, 2017: 298).

As discussed, family care is an important pillar for countries trying to supply adequate and high-quality care to their increasingly ageing populations. If societies (morally) assign care responsibilities to families, welfare state policies or expenditures aimed at fostering informal care can be interpreted as a way¬—explicitly or implicitly—to semi-formalize, subsidize, and foster gender-specific divisions of care (Campbell et al., 2015; Eggers et al., 2020; Le Bihan, 2012). In doing so they also reflect upon how parent-child relationships might be understood in different countries and cultural and religious settings. A study by Ziettlow & Cahn (2015) demonstrates not only how the 'honor commandment' ("*Honor your father and your mother, so that your days may be long in the land that the Lord your God is giving you*") persists as a normative ethic in care practices in the US, but also how its influence can be traced back into current laws and regulations, e.g., filial responsibility laws, statutes that impose sanctions for failing to support parents or act abusively and/or neglectful towards them, or laws that provide support for children that take care of their parents.

How welfare states answer the question of 'how to care best for older people?' and 'whose moral duty it is to provide adequate care?' is therefore not only of immanent importance for care decisions and related norms, but also for reproducing gender inequalities, as repeatedly pointed out in feminist discourses. Differences between welfare states, e.g., in regard to how 'they answer' the above-mentioned questions, relate to 'basic principles' on which welfare states are founded that either implicitly or explicitly reflect upon societally shared culture and norms; "These principles can also be interpreted as fundamental 'values' of welfare state action" (Pfau-Effinger, 2005: 3). Diverging from Esping-Andersen typology, feminist welfare state researchers have shown that it is possible to distinguish welfare state regimes by the gender relation model they apply. Influential authors such as Bambra (2004) and Leitner (2003, 2013) highlighted this underlying normative orientation of welfare states by taking a closer look at the relationship between gender, family, and welfare state policies. In doing so, they classified welfare states according to whether women are encouraged to carry out child- and/or eldercare (familialistic) or—on the contrary—to participate in the labor market, e.g., by offering extra-familiar care services (de-familialistic) (Verbakel et al., 2019). Hence, welfare state policies are embedded in societal contexts and welfare values (e.g., ideas and norms that societal groups have agreed upon) that, instead of being rigid and immutable, are impacted, influenced, and modified by social interactions and individual behavior ("welfare arrangements") (Czyplicki, 2020; Ostner, 1996; Pfau-Effinger, 2005). This means that care decisions on the individual level are not only influenced by institutional settings and meso and macro level, but vice-versa are influential for welfare state policies, as they may result in re-traditionalization of gender roles and care patterns (Brini et al., 2021; Grunow et al., 2007; Leitner, 2013).

2.2 Theoretical framework and hypotheses

When exploring individuals' support of gendered family care obligations and their interaction with institutional settings and welfare policies, various theoretical frameworks can be applied. Amongst them, *Institutionalism* offers such a link, as it not only explains how individual preferences, opinions, and behavior constitute themselves at the individual level, but also how they relate to norms and policies on the societal level (De Tavernier, 2016). Within *Institutionalism*, three different (main) strands (rational choice, sociological, and historical institutionalism) exist, each with a different emphasis. The *rational choice institutionalism* focuses on the influence of incentives and constraints in the decision-making of a (rational) actor. In this understanding, institutions create the framework in which an individual chooses, in reference to his or her preferences (Shepsle, 2006; De Tavernier & Roots, 2015). If institutions change their framework, e.g., via bringing specific incentives forward or creating constraints that make certain options less desirable, the preference of the institutions may change, but not those of the individual (Hess et al. 2020). *Historical institutionalism* focuses more specifically on temporal aspects by looking at the reproduction and occasional change of norms over time. This approach, which is often described more as a perspective than a theory of its own, emphasizes how sequences and/or path dependencies affect institutions and shape social and welfare policies, and therefore individual behavior (De Tavernier, 2016).

Of special interest to this study is *sociological institutionalism*, which emphasizes the importance of institutions and country contexts, not only for individuals' behavior but also for their preferences and attitudes (Hall & Taylor, 1996; Knill & Lenschow, 2001). Pfau-Effinger (2005) and Hall & Taylor (2007) point out that as well as internalized values and norms expressed via institutional frameworks and welfare state arrangements, there are also social role expectations that result in gender role adherence. Sociological institutionalism is not deterministic in nature, rather it makes some options more attractive than others and frames what behavior is deemed appropriate or expected; "Institutions influence behavior not simply by specifying what one should do but also by specifying what one can imagine oneself doing in a given context" (Hall & Taylor, 2007: 178f.). In earlier works, the authors go even further and hold institutions responsible, not only for simply affecting "the strategic calculations of individuals, as rational choice institutionalists contend, but also their most basic preferences and very identity" (Hall & Taylor, 1996: 948).

In the study at hand, we explore these cultural values and norms regarding the duty of children to provide care for their parents. We expect the consent for such a value to differ between women and men. It could be expected that women adhere to role expectations and accept that care responsibilities lie with female household members (Le Behina et al., 2019), making them more supportive of the norm that children should care for their parents (H1a). However, as such norms put high pressure on women to provide care for their relatives (Hess et al., 2020), women might want to decrease this pressure, thus one could also expect that women support the norm of children's care obligations less than men do (H1b). On the country level, one would expect less support for the norm in countries with more extra-familiar care services available (H2), as families have alternative opportunities and, thus, feel less pressure to provide care (Sposava et al., 2018). Furthermore, it can be expected that in countries with a high female labor market participation, the overall support for the norm that children have the obligation to care for parents is lower than in countries with a low female labor market participation (H3). The argument is that traditional gender roles are at least partly substituted by a more egalitarian division of (care) labor (Hess et al., 2020). As with increasing female labor market participation, more women are confronted with the potential 'second reconciliation conflict' (Dallinger, 1996, 1998); we expect that in countries with a high female labor market participation, women are less supportive of the child's obligation to care than men are (H4).

3. Data & methods

To test these hypotheses, we used data derived from the EVS wave 5, for which the data was collected between 2017 and 2020. The EVS is a large-scale, cross-national, longitudinal survey, conducted previously in 1981, 1990, 1999/2000, and 2008. The 5th wave includes data from 34 countries, with more than 56,000 people. The focus of this survey is on basic human values (European Values Study, 2020).

The sample was restricted to those respondents with available data, meaning they had no missing variables from EVS used in the analysis, and for which data on the level of the country could be realized. An overview of the variables used is given below. The following countries were included in the analysis:

Albania, Armenia, Austria, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Czechia, Denmark, Estonia, Finland, France, Georgia, Germany, Great Britain, Hungary, Iceland, Italy, Lithuania, Montenegro, Netherlands, North Macedonia, Norway, Poland, Portugal, Romania, Russia, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, and Ukraine. The final sample included 54,880 respondents.

The main dependent variable is the attitude regarding the potential duty of children to provide care for their parents. It is based on the following question: "How would you feel about the following statements? Do you agree or disagree with them? Adult children have the duty to provide long-term care for their parents". Answers are given on a five-point Likert scale ranging from 1(=strongly disagree) over 2(=disagree), 3(=neither agree nor disagree), 4(=agree) to 5(=strongly agree). The data structure allows the use of explanatory variables at two levels—individual and country—as the individuals in EVS are nested in countries; thus, we conducted multilevel regression. At the individual level, we used several socio-demographic variables. These include gender (female and male) and age (18-39, 40-59, 60-83). Education is coded using the ISCED classification in three categories: low (ISCED 0-2), medium (ISCED 3-4), and high (ISCED 5-6). In addition, partnership (in a relationship and not in a relationship), parenthood (having children and not having children), employment status (in employment and not in employment), and religiosity (religious, not religious, atheist) are included in the regression models. Health (1=very good, 2=good, 3=fair, 4=poor, 5=very poor) was recoded into good (1-2) and poor (3-5). At the country level, we used health expenditures as a percentage of gross domestic product, and female labor force participation rate as the percentage of women in the labor force (of all women older than 14). Data for both variables were derived from the Worldbank World Development Indicators database.

To explain perceived care obligations, we estimated multilevel random slope models using the described variables on the individual and country level and allowing the variable gender to vary across countries. We included a cross-level interaction term between gender and female labor market participation to test whether the association between gender and perceived care obligations differs by the country's female labor market participation. Lastly, we used weights in every analysis to adjust our sample to the distribution of the target population.

Table 1 shows the percentage distribution of our sample as well as the average agreement with care obligations. In the following, we describe the percentages of the categories of our independent variables in our sample; the mean values of our dependent variable, 'care obligations', are described in the results section below. Our sample mostly consists of respondents aged 18-39 (36.01%) and 60-83 (35.50%). The majority are male (51.71%), employed (53.22%), in a partnership (53.40%), have a medium educational level (43.36%), and have children (70.10%). Most of them consider themselves religious (63.9%) and in good health (62.48%).

Figure 1 depicts the percentages of current health expenditure as the percentage of GDP, and female labor force participation by country. The highest current health expenditures can be found in western and northern European countries such as Germany (11.33%), Switzerland (11.48%), France (11.33%), and Sweden (10.79%). Female labor force participation, on the other hand, is highest among northern and western European countries—especially in Iceland (72.32%), Sweden (61.00), Norway (61.48%), and Switzerland (62.60%). Current health expenditure and female labor force participation are both lowest in southern and eastern European countries.

4. Results

Figure 2 depicts the average agreement with care obligations of children towards their parents by country. We find that in particular, people living in countries in eastern and southern Europe (Albania, Azerbaijan, Armenia, Bosnia and Herzegovina, Belarus, Croatia, Georgia, Italy, Montenegro, Serbia, and North Macedonia) support the statement that children should provide care for their parents. In contrast, Scandinavians in particular (Denmark, Finland, Iceland, Norway, and Sweden) and also people living in western European countries (Austria, Germany, Netherlands, and Switzerland) less frequently agree that children are responsible for providing care for their parents.

Table 1: Sample Overview (n=54,880)

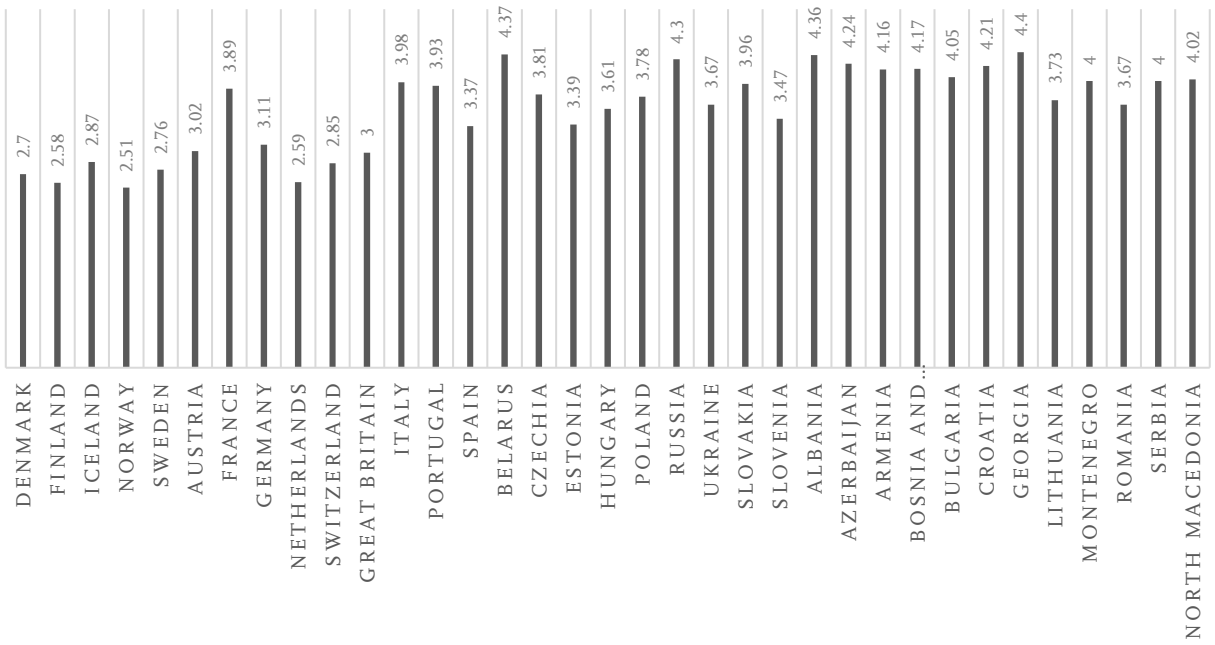
	Shares %	Care obligations (1-5) M
Age (18-83)		
18-39	36.01	3.62
40-59	35.50	3.47
60-83	28.50	3.61
Gender		
Female	48.30	3.54
Male	51.71	3.60
Health (1-5)		
Poor (1-3)	37.52	3.73
Good (4-5)	62.48	3.47
Education		
Low	30.50	3.70
Medium	43.36	3.58
High	26.20	3.39
Employment status		
Employed	53.22	3.44
Unemployed or inactive	46.78	3.72
Partner		
Yes	53.40	3.55
No	46.62	3.60
Children		
Yes	70.10	3.61
No	29.90	3.55
Religion		
Religious	63.91	3.76
Not religious	28.06	3.22
Atheist	8.03	3.22

Notes: weighted

Figure 1: Percentage of current health expenditure and female labor force participation (n=35)

Note: Source Worldbank

Figure 2: Mean values for norms on care obligation by country (n=35)



Notes: weighted

Without taking country differences into account, we generally find that gender is only weakly related to perceived care obligations (η2= 0.00; p=0.000) (see Table 1). However, especially religious respondents (η2= 0.05; p=0.000) support the statement of higher care responsibilities of children towards their parents compared to unreligious and atheist respondents. Furthermore, unemployed (η2=0.01; p=0.000) and lower educated (η2=0.01; p=0.000) persons favor higher care obligations of children compared to those in employment and with higher educational levels. Lastly, respondents with poorer perceived health (η2=0.01; p=0.000) more frequently agree that it is the child's responsibility to provide care for their parents than persons in better health do.

Table 2 shows the results of the multilevel random slope regression models. An empty model without explanatory variables (not presented here) showed that 25.2% of the variance in care obligations is located on the group level, whereas 74.8% of the variance is related to the individual level. This demonstrates that there is high variability between the countries. The inclusion of macro variables from M1 to M2 improves the model fit, and therefore contributes to the explanation of care obligations. Moreover, our models with gender as a random slope fitted the data better than random-intercept models (not presented here) did. Therefore, our first finding is that the association between gender and care obligations varies across countries.

Men are more likely than women to agree with the statement that the child must provide care for their parents. Middle-aged (40-59 years), healthier, employed, higher educated respondents, as well as those who are in a partnership and have children, are less likely to expect children to provide care for their parents. However, age is only weakly related to perceived care obligations. Moreover, non-religious (and especially, atheist) persons agree significantly less that children should have care obligations. The inclusion of macro variables in M2 shows that individuals living in societies with a higher female labor force participation and health expenditure are less likely to have social norms that expect children to provide care for their parents.

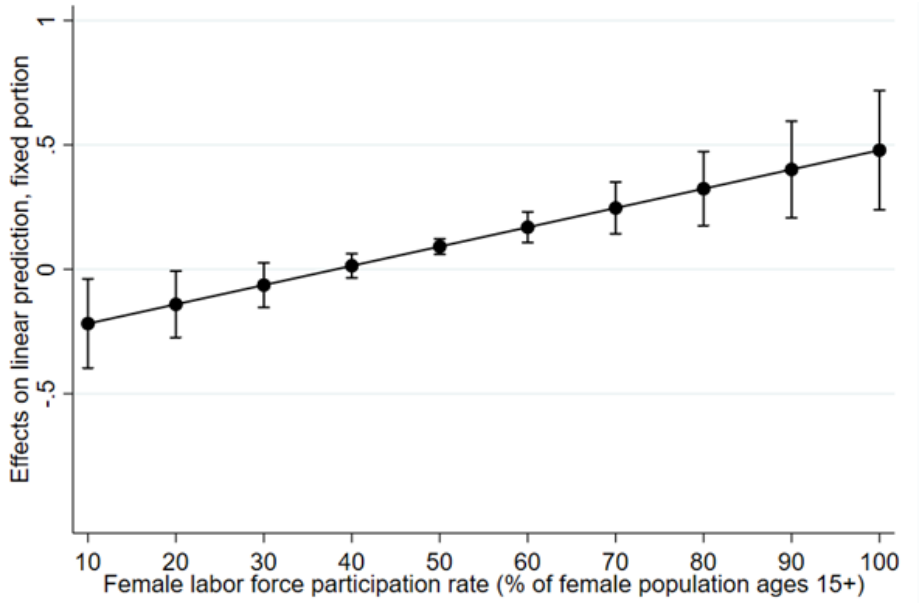
Lastly, the addition of the cross-level interaction of female labor participation and gender in M3 explains parts of the country differences. Men are more likely than women to agree with the care obligations of children in countries with a female labor force participation of over 40% (see Figure 3). However, in countries with an employment rate of under 40%, men are less likely than women to accord with the statement that it's the child's duty to provide care for their parents.

Table 2: Multilevel random slope analysis for care obligations

	M1 β (SE)	M2 β (SE)	M3 β (SE)
Constant	3.94*** (0.06)	5.64*** (0.30)	6.68*** (0.42)
Individual level			
Male (Ref. Female)	0.11*** (0.02)	0.11*** (0.02)	-.0.30* (0.11)
Age (Ref. 18-39)			
40-59	-0.08* (0.04)	-0.08* (0.04)	-0.08* (0.04)
60-83	-0.04 (0.06)	-0.04 (0.06)	-0.04 (0.06)
Good health (Ref. Poor health)	-0.04* (0.02)	-0.04* (0.02)	-0.04* (0.02)
Education (Ref. Low)			
Medium	-0.10*** (0.03)	-0.10*** (0.03)	-0.10*** (0.03)
High	-0.11*** (0.03)	-0.11*** (0.03)	-0.11*** (0.03)
Employed (Ref. Unemployed or inactive)	-0.06*** (0.02)	-0.06*** (0.02)	-.06*** (0.02)
Partnership (Ref. No partner)	-0.06*** (0.01)	-0.06*** (0.01)	-0.06*** (0.01)
Children (Ref: No children)	-0.11*** (0.03)	-0.11*** (0.03)	-.11*** (0.03)
Religion (Ref. Religious)			
Not religious	-0.26*** (0.02)	-0.26*** (0.02)	-0.26*** (0.02)
Atheist	-0.30*** (0.02)	-0.30*** (0.02)	-0.30*** (0.02)
Macro level			
Health expenditure	-	-0.09** (0.03)	-0.09** (0.03)
Female labor participation	-	-0.02*** (0.00)	-0.04*** (0.01)
Cross-level interaction			
Female labor participation x Gender	-	-	0.01** (0.00)
Variance (gender)	0.11 (0.01)	0.12 (0.01)	0.10 (0.01)
Variance (constant)	0.60 (0.05)	0.44 (0.06)	0.41 (.06)
Log pseudolikelihood	-77791.252	-77785.865	-77781.974
ICC	0.26	0.16	0.15
AIC	155614.5	155607.7	155601.9
Groups	35	35	35
N	54,880	54,880	54,880

Notes: weighted; *p < 0.05, **p < 0.01, ***p < 0.001

Figure 3: Average marginal effects of gender



Notes: weighted

5. Discussion

In this study, we investigated norms and values regarding children's obligations to provide care for their parents. Using data from EVS, we found a strong variation in the support for such norms, on the individual as well as country level. In line with H1b, we find that women agree less with care obligations for children than men do, supporting our argument that women—knowing that they will do the larger share of the family care—are more in favor of professional care. This is underlined by the finding that higher spending on health care is associated with decreased support for the norm, as expected by us in H2. Furthermore, the results are in line with H3, which expected that individuals are less likely to support children's care obligations towards their parents in countries with higher female labor force participation rates. And finally, H4 was supported by the results, as we found a cross-level interaction effect between gender and the share of female labor force participation rate. The higher the latter, the fewer the women who support the norm that children should provide care for their parents. Therefore, the strength of the relationship between gender and care obligations varies by the country's female labor participation rate. It can be assumed that women who are faced with the "second reconciliation conflict" (Dallinger, 1996, 1998) of working and providing care are less willing to do the latter. This also aligns with findings that show that older women who have experienced these gendered care-norms in their own lives are more active in renegotiation of them, and find alternative care arrangements to lessen the care strain for younger female family members (Conlon et al., 2014).

This study makes several contributions. Previous research has shown that norms and values are crucial in deciding if, and by whom, family care is provided (Brini et al., 2021; Hess et al., 2020). We went 'one step back' by exploring how agreement with these norms and values regarding care obligations of children towards their parents differs between men and women. We adopted a cross-comparative perspective and included countries in the analysis that are often neglected, such as Albania and Azerbaijan. The substantial differences between countries in support for the idea that children must provide care for their parents imply that these norms and values are not "set in stone", but can change (see also Heymann et al., 2019; Seguino, 2007). Furthermore, the differences within countries between social groups suggest that societal discussions and negotiations are taking place regarding how to provide care for older people.

When interpreting the results, some limitations must be acknowledged. First, the data used in the analysis are cross-sectional; hence, one must be very careful when making any causal interpretation (Diekmann, 2004), and the result in the analysis should only be interpreted as correlations. Second, only a limited number of data were available for all countries included in the analysis; they are not all members of the European Union, and therefore the relatively crude measures of expenditures for health care overall and female employment rate were used. Examples of better measures are: expenditures on long-term care, the share of long-term care recipients that are taken care of by families, measures of laws and regulations that children must provide care for their parents, and policies for the reconciliation of work and care and potential compensations for wage and retirement contributions losses (see also Verbakel et al., 2022). Third, a comparison of norms and values between countries can be difficult, as the understanding of what the question of the dependent variable means might differ between countries (Bjørnskov, 2007). In addition, the dependent variable does not differentiate between the gender of the child who is responsible for providing care to the parents.

From these limitations, implications for future research can be derived. Panel data on the attitudes towards care-obligation of children towards their parents should be collected to allow for more sophisticated analysis. In addition, it is necessary to build larger datasets, with country level information including more countries as well as more variables. Qualitative research, such as interviews with caregiving children, can help to explore the norms and values that revolve around family care in more detail, and disentangle country differences.

Overall, our results indicate that to understand individual social norms, it is necessary to take macro-level indicators into account. In particular, the finding that women are less supportive of children's care obligations towards their parents in countries with a higher female labor market participation stands out in our article. Although we cannot draw causal conclusions, the results imply that the trend of a growing share of women in the labor market is accompanied by decreasing support among women for the notion that it is the child's responsibility to provide family care. As this family care is mostly (still) done by women, this is a challenge for those countries which put care work on the shoulders of women, because it seems they are increasingly less willing to do it. Thus, societies should strive to improve the reconciliation of care and work

for women and men. In addition, they should recognize the importance and value of care work and compensate (more) for wage and pension losses.

Conflict of interest

The authors have no conflict of interest.

Data availability statement

The data used in this study are available for scientific usage after registration. For further information see here https://europeanvaluesstudy.eu/. The country context data is available from the website of the Worldbank.

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Information in German

Deutscher Titel

Du kümmerst dich, wenn ich alt bin: Normen und Wertvorstellung zur familiären Pflege älterer Angehöriger durch erwachsene Kinder – eine Analyse mit Daten aus der European Values Study

Zusammenfassung

Fragestellung: Die Studie untersucht geschlechtsspezifische Unterschiede in der Zustimmung zur gesellschaftlichen Norm, dass erwachsene Kinder ihre älteren Angehörigen pflegen müssen.

Hintergrund: Die Normen und Wertvorstellung einer Gesellschaft können eine wichtige Rolle bei der Entscheidung spielen, ob familiäre Pflege geleistet wird oder nicht. Wir untersuchen, wie Faktoren auf der individuellen und der Länderebene diese Normen und Wertvorstellung in Bezug auf familiäre Pflege beeinflussen.

Methode: Wir verwenden Daten der European Value Study (Welle 5). Die Zustimmung zur Aussage "Erwachsene Kinder haben die Pflicht, ihre Eltern zu pflegen" ist dabei die abhängige Variable. Erklärende Variablen auf der individuellen Ebene sind neben verschiedenen soziodemografischen Variablen das Geschlecht und auf Länderebene werden die Ausgaben für die Gesundheitsversorgung und die Erwerbsquote der Frauen mit in die Analysen einbezogen.

Ergebnisse: Die Ergebnisse zeigen, dass Frauen und Personen, die in Ländern mit hohen Gesundheitsausgaben und einer hohen Frauenerwerbsquote leben, die Norm – dass Kinder die Pflicht haben, für ihre Eltern zu sorgen – weniger unterstützen. Darüber hinaus ist der geschlechtsspezifische Effekt in Ländern mit einer höheren Frauenerwerbsquote stärker ausgeprägt.

Schlussfolgerung: Normen und Wertvorstellung in Bezug auf die familiäre Pflege sind wirkmächtig jedoch nicht einheitlich und unveränderbar, worauf die Variationen zwischen den Ländern hindeutet. Sie werden auch nicht von allen sozialen Gruppen gleichermaßen geteilt, wie an den Unterschieden zwischen Frauen und Männern und entlang anderer soziodemographischer Merkmale zu sehen ist.

Schlagwörter: Langzeitpflege, informelle Pflege, Geschlecht, Normen und Werte, European Value Study (EVS)

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