

Why Should I Care? Family Old-Age Caregiving and Preferences for Family or Public Care Provision in France

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Abstract

The rapid ageing of the European population in recent years has brought a significant increase in old-age care needs. While families remain the main care provider in most European countries, their capacity to care has decreased in the face of intensified pressures, calling for a strengthening of public care services. In this context, the discussion on whether families or the public sector should be responsible for providing old-age care gains relevance, and the preferences of family caregivers appear fundamental to ascertain whether families will continue to carry the main load or welfare states will need to step up. This study addresses the issue by testing a causal link between providing family old-age care and preferences for family or public care provision, under the hypothesis that caregiver burden and its impact on well-being increase demand for public services. This hypothesis is tested with data from the Generations and Gender Survey for a 3-wave panel sample of 4587 respondents in France. Data are analyzed through a causal mediation approach using linear fixed-effects and propensity score weights. Results suggest that providing old-age care increases demand for public services among women but makes men more supportive of family provision. These findings align with previous evidence of a gender gap in welfare attitudes.

Introduction

In recent years, European countries have experienced a significant increase in old-age care¹ needs due to sociodemographic changes, primarily the rapid ageing of the population and an increment in chronic illness (Da Roit et al., 2007; Theobald & Luppi, 2018). This increase has

¹ The term old-age care is preferred to elderly care given the ongoing debate about the negative connotations of the term “elderly” (Avers et al., 2011).

intensified pressures on families and the public sector and brought forward a discussion on which should be responsible for old-age care. Families, and within families most often women, continue to represent the main provider of old-age care in most European societies (Da Roit et al., 2007; Sowa-Kofta et al., 2021). Nevertheless, factors like the growth of paid employment among women aged between 40 and 65 and the higher occupational and residential mobility of adult children have reduced the capacity of families to care, calling for a strengthening of public provision (Da Roit et al., 2007; Theobald & Luppi, 2018).

The central role of the family in Continental, Southern and Eastern Europe is generally explained in the literature through institutional and cultural factors (Kalmijn & Saraceno, 2008). Institutionally, family care is either explicitly encouraged through policies such as cash-for-care payments and care leaves or implicitly supported by the absence of public care services (Leitner, 2003; Schmid et al., 2012). Culturally, it is generally assumed that norms of family responsibility are comparatively strong in Southern and, to a lesser extent, Continental and Eastern European countries, leading to higher family care rates than in the more individualistic Scandinavian cultures (Reher, 1998; Daatland & Herlofson, 2003, Calzada & Brooks, 2013). However, in a context of increasing old-age care needs and declining resources on the side of the family, normative aspects might not be enough to sustain public support for familialistic care systems.

In this scenario, the formation of individual preferences for family or public provision for old-age care has become a relevant research topic for social scientists. Previous studies on old-age care preferences have explored individual predictors like gender, partnership, number of children, labor market status, educational level or the respondent's experiences of care receiving (Mair et al., 2016a, 2016b, Daatland & Herlofson, 2003; Fang & Yang, 2023; Lu et al., 2021) as well as contextual variables like welfare state generosity, country-level gender equality and culture (Mair et al., 2016a; Janus & Koslowski, 2020). A considerable share of these

contributions focuses on the experiences and preferences of old adults in need of care (Mair et al., 2016b, Fang & Yang, 2023, Lu et al., 2021).

Less attention, however, has been given to the preferences of caregivers and how these might be affected by their caregiving experiences. In this line, Mair et al. (2016a) suggest that giving old-age care to a family member might cause caregiver burden when it becomes difficult to balance care with other professional and personal responsibilities, leading to demand for public services. However, a hypothetical causal effect of caregiving on preferences has not yet been tested. Since the willingness of family members to care is essential to sustain a system of care provision which remains strongly dependent on the family, and given the constant increase in old-age care needs across European countries, understanding the experiences of family caregivers and whether these impact their preferences for family or public provision becomes a fundamental task to ascertain the future of old-age care systems in Europe.

The present paper tests a causal link between family old-age caregiving and preferences for family or public provision of old-age care. The proper specification of a causal mechanism constitutes a relevant contribution to the field, given that there are solid theoretical reasons to assume that, while caregiving might lead to changes in preferences, preferences also explain caregiving behavior. To that end, the following research question is addressed:

RQ: Does giving old-age care to a family member cause preferences for family or public provision of old-age care?

Following Mair and colleagues' (2016a) suggestion that caregiver burden might lead to demand for public services, a mediation model is proposed in which giving care to an old-age parent or partner increases preference for public provision through its negative impact on the caregiver's well-being. Indeed, research has shown that those who give care to a family member often experience burden leading to psychological strain and a decline in general well-being (Montgomery et al., 1985; Bastawrous, 2013; Schmid et al., 2012). Family caregivers are more

likely to suffer from fatigue, stress and depression, experience role conflicts and a lack of work-life balance, and to face labor market and income risks. From a self-interest approach to preference formation, those who experience caregiver burden might demand an increase in public old-age care provision to alleviate their own care duties.

The study employs data from the Generations and Gender Survey for a panel sample of 4587 French respondents in the years 2005, 2008 and 2011. The reasons to focus on the French case are both theoretical and empirical. From a theoretical point of view, the French old-age care system constitutes a prototypical case of explicit familialism in which the predominant role of the family as the primary caregiver is supported by the state via income-tested dependency allowances and only limited access to public services (Leitner, 2003; Schmid et al., 2012; Morel, 2007). At the same time, there is evidence that social support towards norms of family responsibility is comparatively lower in France than in other conservative welfare states (Kalmijn & Saraceno, 2008). Therefore, family caregivers in France should be particularly supportive of an increase of public care provision. In empirical terms, France is the only country in the survey with longitudinal data for the key variables in three time points, allowing to properly model within-individual effects across time.

The data are analyzed using linear fixed-effects models and causal mediation analysis (Imai et al, 2010). Propensity Score Weights are used to correct the non-random assignment of respondents to caregiving (Olmos & Govindasamy, 2019; Thoemmes & Ong, 2016).

Theory

1. Family caregiving: motivators and preferences

In all European societies, the responsibility for old-age care provision is shared between families and the public sector (Daatland & Herlofson, 2003). However, the degree of responsibility assigned to each of the parts varies depending on institutional and normative

factors (Kalmijn & Saraceno, 2008). Institutionally, it has been observed that some welfare states rely on and actively support the caregiving role of the family, while others try to alleviate family care responsibilities (Leitner, 2003; Schmidt et al., 2012; Saraceno & Keck, 2010). In this regard, Leitner (2003) classifies European welfare states in three groups, depending on whether and how they address the role of the family in old-age care provision. The first group, composed by Denmark, Finland and Sweden, is characterized by optional familialism, meaning that family responsibility is strengthened via transfers, care leaves and regulation of intergenerational obligations, but family burden is partially alleviated through public services. The second group, including Greece, Italy, Spain, Portugal and the Netherlands, is characterized by implicit familialism, meaning that policies do not explicitly support family care but neither offer alternatives through public services, and families remain the primary caregiver by default. Finally, a third group composed by France, Belgium, Luxembourg, Austria, Germany, Ireland and the United Kingdom is characterized by explicit familialism, meaning that family responsibility is strengthened through care leaves, cash-for-care benefits and legal obligations, but there is a lack of public services to alleviate family burden.

In normative terms, it has been argued that family care is commonly perceived as the natural alternative (Daatland & Herlofson, 2003) and individuals give old-age care to their relatives driven by social expectations and norms of family responsibility. The role of norms has been particularly stressed in the literature when it comes to intergenerational solidarity. Bengtson and Roberts (1991) argued that norms and expectations of individual obligations to the family have a great impact on the actual patterns of instrumental support and resource sharing. Indeed, there is evidence that strong norms of filial responsibility translate into actual support behavior, both in individual and aggregate terms (Silverstein et al., 2006; Kalmijn & Saraceno, 2008). However, that institutional settings and social norms lead individuals to give old-age care to their family members does not necessarily mean that family care is their preference. In contexts

of scarce public provision and strong normative expectations of family responsibility, individuals might have no alternative but to take over the care needs of their old-age relatives. The difference is important, as it has implications for the social legitimacy of a familialistic social organization of old-age care.

Scholarly research on the formation of preferences for family or public old-age care provision considers several individual factors. First, gender has been found to play a relevant part. There is evidence that women tend to be more supportive of public provision than men (Mair et al., 2016a), a finding that appears to be connected with the gendered division of care work and the gender gap in welfare attitudes (Goossen, 2020). Family traits like having children or a partner also play a role in preference formation, although their influence seems to be dependent on cultural factors (Mair et al., 2016a; Daatland & Herlofson, 2003). Socioeconomic characteristics are also associated with old-age care preferences. Mair et al. (2016a) find evidence that employed respondents are less supportive of public provision than those who are unemployed or outside the labor market, while Fang and Yang (2023) find that support for public provision is negatively associated with family income but positively associated with educational level. Furthermore, receiving family care is associated with stronger support for family provision (Mair et al., 2016b; Daatland & Herlofson, 2003), although it is difficult to discern whether care experiences lead to preferences or previously held preferences crystallize into care.

From the perspective of caregivers, it has been suggested that caring for an old-age relative might increase support for public provision when the caring tasks generate incompatibilities with the caregiver's other professional and personal responsibilities, leading to objective and subjective caregiver burden and impacting their psychological well-being (Mair et al., 2016a). This argument aligns with the self-interest approach of preference formation, which posits that individual social policy preferences result from rational calculations of the potential benefits

each individual can expect from the implementation of said policies (Meltzer & Richard, 1981; Blekesaune, 2007). In this sense, family caregivers can be seen as beneficiaries of the implementation of defamiliarizing care policies that relieve their care responsibilities. When providing family old-age care leads to care burden, family caregivers might become more supportive of a strengthening of public provision to protect their well-being.

2. Caregiver burden

The term “caregiver burden” is well-established in the specialized literature (Montgomery et al., 1985; Bastawrous, 2013). In a systematic review of the concept, Liu et al. (2020) define caregiver burden as “*the level of multifaceted strain perceived by the caregiver from caring for a family member and/or loved one over time*”. As highlighted in the definition, caregiver burden entails a multiplicity of dimensions, which are generally grouped into objective and subjective burden (Montgomery et al., 1985). Objective burden includes the physical or instrumental provision of care and its interference with other aspects of the caregiver's life. In order to satisfy the care needs of care receivers, family caregivers must allocate a significant amount of time to caregiving. As a result, caregivers often experience conflicts between their caregiving role and other familial, social and professional obligations. These conflicts can lead to a decrease in the quality of their relationships with other family members, particularly spouses and children, a lack of social activities and consequent restriction of social networks, and negative financial and career impacts when the caregiver renounces to full-time employment to fulfil the care receiver's needs (Savundranayagam et al., 2011; Bastawrous, 2013). On the other hand, subjective burden refers to the emotional or psychological impact of objective burden on caregivers. Indeed, there is evidence that providing care to a family member increases the likelihood of experiencing emotional stress and anxiety, and is associated with a decrease in emotional well-being (Savundranayagam et al., 2011; Casado-Mejia & Ruiz-Arias, 2016).

The extent to which family caregivers experience caregiver burden depends on multiple factors, the most prominent being the caregiver's gender (Casado-Mejia & Ruiz-Arias, 2016). There is abundant evidence that in most contemporary societies the responsibility for family care falls disproportionately on the side of women (Schmid et al., 2012; Leitner, 2003; Chou et al., 2017). Women are not only more likely to become family caregivers, but usually take up more burdening roles as well. Schmid et al. (2012) find that while there are no important gender differences in terms of sporadic support across European countries, daughters provide intensive support to old-age parents much more often than sons, particularly in countries with familialistic care systems. This difference matters because, while no link has been found between sporadic support and well-being, intensive caregiving is associated with mental and physical strain. Similarly, Bastawrous (2013) observes that male caregivers typically provide mainly instrumental support, while female caregivers are more likely to provide additional emotional support. As emotional support has a greater impact on the psychological well-being of caregivers, women are more vulnerable to subjective caregiver burden than men. This last point has nevertheless been challenged by Russell (2007), who highlights that the emotional support provided by male caregiving has often been underplayed in the literature.

A second characteristic that influences the likelihood of experiencing caregiver burden is the relation of the caregiver to the care receiver. Two types of kinship are particularly salient in the provision of family old-age care: adult children and partners (Pinquart & Sörensen, 2011; Bastawrous, 2013). While the latter are traditionally the first option to provide old-age care (Pinquart & Sörensen, 2011), it has been suggested that the role of adult children will become increasingly important due to population ageing (Bastawrous, 2013). Children and partner caregivers differ in relevant aspects. While partners tend to give care full-time, children are more likely to compatibilize care tasks with paid work and other family and social obligations, leading to a higher degree of caregiver burden (Casado-Mejía & Ruiz-Arias, 2016). In a similar

line, Bastawrous (2013) argues that caregiver burden in adult children arises from the role transition experienced when the parent becomes dependent on the adult child at a point when children have their own spousal and parental obligations. Nonetheless, this argument has not been fully supported by empirical evidence. In this sense, Pinguart and Sörensen (2011) concluded after a meta-analysis of 168 empirical studies that partner caregivers report greater psychological strain and financial burden than adult children.

In line with the theoretical considerations above, the following hypotheses about the causal relations between family old-age caregiving, well-being and preferences for family or public provision are proposed:

H1: Giving old-age care to a family member increases support for public provision of old-age care.

H2: Giving old-age care to a family member decreases well-being.

- a) The impact of giving old-age care to a family member on well-being is stronger for female than for male caregivers.*
- b) The impact of giving old-age care to a family member on well-being is stronger for adult children than for partner caregivers.*

H3: The impact of giving old-age care to a family member on support for public provision is, at least partially, mediated by well-being.

- a) The mediated impact of giving old-age care to a family member on support for public provision is stronger for female than for male caregivers.*
- b) The mediated impact of giving old-age care to a family member on support for public provision is stronger for adult children than for partner caregivers.*

These hypotheses are tested using panel data from the Gender and Generations Survey for France in the years 2005, 2008 and 2011.

3. The French Case

Like most European countries, France has seen faced the end of the past century a considerable increase in old-age care needs (Martin et al., 1998; Le Bihan & Martin, 2012). In response to this increase, since the 1990s long-term care policies have become a relevant issue for the French welfare state (Da Roit et al., 2007; Le Bihan & Martin, 2012), which has addressed the matter mainly through cash-for-care benefits and co-financing of care residential facilities (Boneschy & de L'Espinay, 2022, Or et al., 2023). Despite these developments, the family has remained the main provider of old-age care at home, as care policies have focused on supporting and complementing family caregivers rather than relieving them from care responsibilities (Morel, 2007; Le Bihan & Martin, 2012), following a logic of explicit familialism (Leitner, 2003).

The French social insurance system does not explicitly consider the risk of long-term old-age care dependency, which is instead addressed via social assistance. The main benefit provided to dependent old-age people by the French welfare state is the *Allocation Personnalisée d'Autonomie* (APA), which is available to all persons 60 years of age or older who have difficulty performing everyday tasks (Morel, 2007; Boneschi & de L'Espinay, 2022). The benefit, which is partially co-paid by the care receiver depending on their resources and level of dependence, is granted to finance a specific care package determined by a team of professionals according to the recipient's needs and can be used to pay for care at home or institutionalized care (Da Roit et al., 2007; Kaufmann, 2018). In this sense, Morel (2007) understands that the main idea behind the APA is to promote free choice for dependent persons while simultaneously fostering the creation of low-wage jobs in personal service. However, it is not clear that the APA has worked as a defamiliazing arrangement. First, despite an increase in the availability of long-term care services at home, there is still a shortage of specialized workers due to the low salaries and hard working conditions in the sector, which often leads to

a poor coverage of care needs (Or et al., 2023; Le Bihan & Martin, 2012). Second, although it is not allowed to pay the APA to a spouse, other family members such as adult children can still be hired as caretakers (Da Roit et al., 2007; Kaufmann, 2018). Finally, since care needs are often not manageable by a single formal care provider, family members still tend to bear a significant amount of informal care work as well as supervise care activities and make care decisions (Da Roit et al., 2007; Le Bihan, 2018).

Other care policies put in place in the country have explicitly reinforced the responsibility of families for old-age care. In 2006, an unpaid care leave for informal carers was introduced, allowing adult children to leave their work for 3 to 12 months to provide care to their old-age parents. This arrangement recognizes the right of the family to care but it pushes caregivers outside of the labor market, putting them at financial risk (Da Roit et al., 2007). Moreover, France has institutionalized the obligation of parents, children, grandchildren and spouses to provide mutual assistance in case of need, either through instrumental help or economic contributions (Besnard et al., 2019; Le Bihan & Martin, 2012).

Leitner (2003) classifies the French care system as a case of explicit familialism, in which transfers, care leaves and the regulation of intergenerational obligations support family responsibility. Similarly, Morel (2007) points out that France's categorization as a corporatist welfare state has been historically reflected in its care system, based on the principle of subsidiarity and the normative belief that the family is the best possible provider of care, along with the defense of a male-breadwinner model in which women are expected to care for old-age relatives at home. Le Bihan (2018) highlights that 8 out of 10 care receivers in France obtain at least some support from their relatives, with half of them being cared for only by an informal carer. Overall, informal family care remains the principal source of old-age care provision in France (Da Roit et al., 2007).

Methods

1. Data Source and Sample

The study's hypotheses are tested using panel data from the three waves of the first Generations and Gender Survey (GGS). The GGS constitutes an individual-level fixed panel which a target population composed by those individuals resident in the country where the interview takes place and aged 18-79 at the time of the first wave. Respondents are selected through probability sampling and the sample size for each country in Wave 1 must be sufficiently high to achieve at least 8000 cases on Wave 3. These sampling criteria grant large sample sizes in each wave and country (Gauthier et al., 2018).

There are 19 countries which have been covered in at least one wave of the GGS I. Out of these, however, only France contains data on the key variables of these paper for all three waves. The data collection years for each of the waves were, respectively, 2005, 2008 and 2011. The sampling frame consisted of a combination of area and census information using names or dwellings as sampling units. Data were collected through computer-assisted personal interviewing (CAPI). The balanced panel sample for France contains 5435 respondents. After eliminating missing values for the key variables, the final sample used in the study includes 4587 respondents.

2. Variables and Operationalization

The dependent variable, preference for family or public old-age care provision, is measured using a 5-point Likert scale asking whether care for older persons in need of care at their home should be a task for family or for society. After inverting the order of the levels, values range from 1, "*mainly a task for the family*", to 5, "*mainly a task for society*". Here, "*a task for society*" is taken as a proxy for public care services, as opposed to private family-based provision. In this sense, previous studies have used the same GGS item understanding "*society*"

to mean “*the state*” (Daatland et al., 2009; Herlofson et al., 2011). The term “*public provision*” used in this paper captures collective responsibility for old-age care in a broader way.

The main independent variable is family old-age caregiving on the side of the respondent. The GGS asks if respondents have given regular help with personal care to anyone in the last 12 months and what the relationship of the respondent is with up to 10 care receivers. As adult children and partners constitute more than three-quarters of family caregivers in France (Besnard et al., 2019) and as they are the ones who provide the most intense support and experience burden more often, two separate categorical variables were created indicating whether respondents had provided care to a parent or partner 60 years or older. For both, the reference group is composed of respondents who have not provided old-age family care.

The mediator in the causal model is psychological well-being. The GGS includes a battery of 7 questions asking respondents how often in the previous week they have experienced certain types of psychological strain, like feeling depressed, fearful or lonely. The values for each question range from 1, “*seldom or never*”, to 4, “*most of the time*”. The mean of all 7 items was taken as an index of psychological well-being. Cronbach’s alpha was 0.90, supporting the internal consistency of the index. The variable has been inverted so that higher values reflect higher well-being.

The control variables in all models are age, health, activity status, partnership status, marital status, having kids and household income.

3. *Modelling Strategy*

As GGS data are observational, the assignment of respondents to caregiving is significantly associated with factors that also affect the mediator and the outcome variables, like age and income. To obtain robust causal estimates, these confounders can be balanced using propensity score weights (Antonakis et al., 2010). Since some of the confounders can change over time, weighting was specified differently for every time point following Thoemmes & Ong (2016).

This approach ensures that the estimated within-individual effects of caregiving on preferences and well-being are not biased by unaccounted time constant or variant confounders. Overlap weights were selected as they lead to an optimal balance of the potential confounders. These weights allow to estimate the average within-individual treatment effect among the population with the greatest degree of overlap between control and treatment groups. The specification of the propensity score models and complementary analyses using inverse probability weights and unweighted models are available in the Supplementary Materials.

After weighting, two sets of linear fixed-effects were independently estimated, one of which predicts preferences based on caregiving, well-being and controls, and the other of which predicts well-being based on caregiving and controls. Each of the sets includes four models, testing the effects of giving care to a parent and a partner separately for a sample of female and a sample of male respondents. The estimates can be interpreted as the average within-individual effect of giving care on preferences. These models allow to test Hypotheses 1 and 2. Robustness checks with alternative formulations of the models are available in the Supplementary Materials.

Finally, in order to test the mediated causal effect (Hypothesis 3), the causal mediation analysis approach proposed by Imai et al. (2010) was employed. The causal mediation effect is defined here as the change that would occur to preferences if well-being is changed from the value realized when not giving care to the value realized when giving care, while holding caregiving status constant.

Results

1. Exploratory results

Figure 1 reflects the distribution of family caregiving across genders and age groups. As expected, the bulk of old-age care falls on women. The gender gap is strongly pronounced for

those who provide care to an old-age parent, where three fourths of caregivers are women. Nonetheless, no gender differences are observed when it comes to caring for an old-age spouse or partner. In terms of age, practically all caregivers in the sample are 45 years old or over. Among caregivers of old-age parents, almost two thirds are between 45 and 59 years old, whereas practically 9 out of every 10 caregivers of an old-age partner are 60 years old or over. The observed gender and age differences are consistent with previous theory.

Regarding the distribution of the dependent variable across different caregiving groups (Figure 2), differences on average preferences are small and non-significant but suggest interesting patterns. First, caregivers are on average more familialistic than non-caregivers, with the exception of female caregivers of a partner. Second, while male and female respondents have practically identical average preferences when not giving care, the distances between them increase when giving care, with female caregivers showing higher support for public provision.

Figure 1: Distribution of caregiving across genders and age groups (pooled sample)

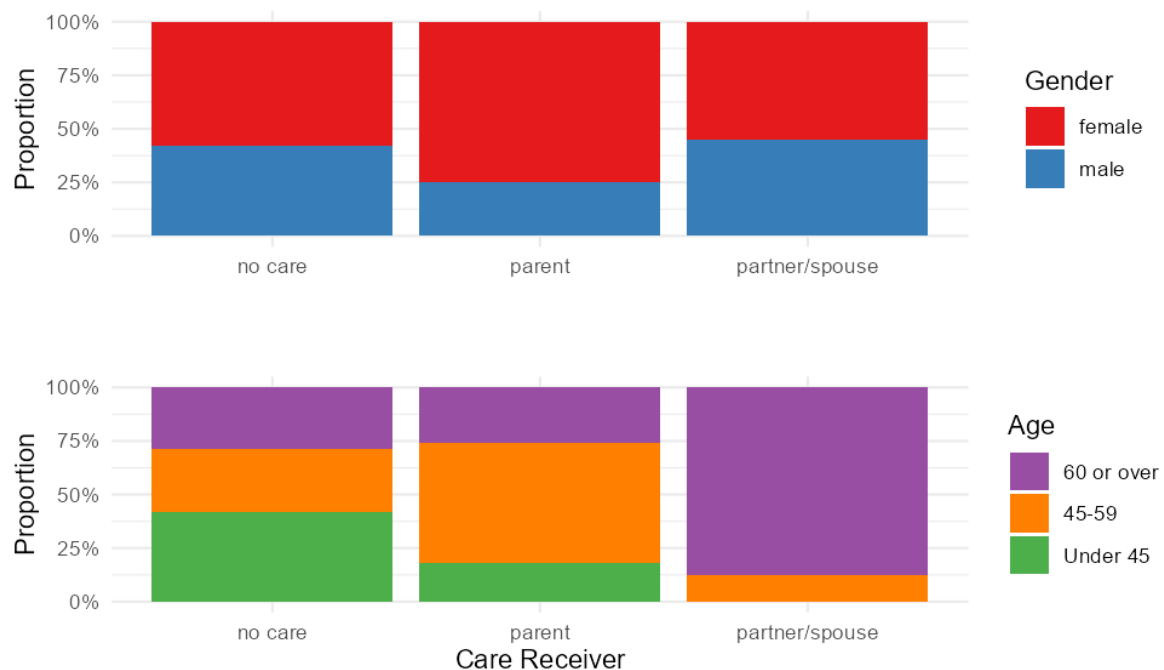
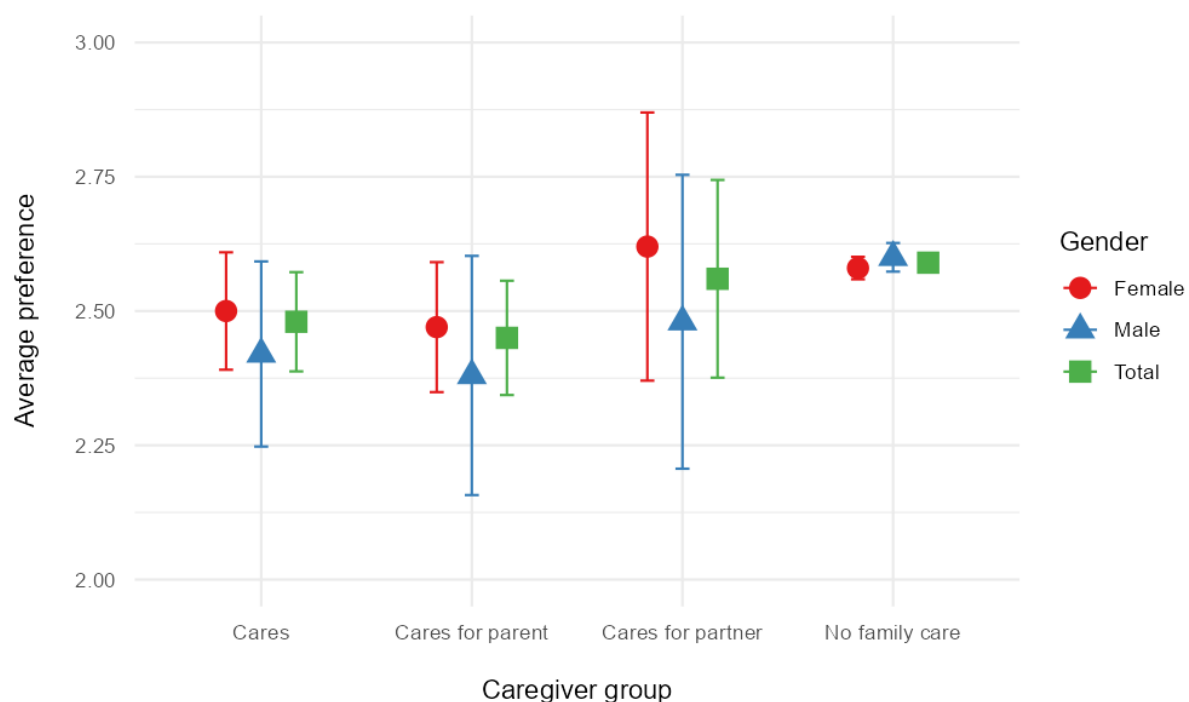


Figure 2: Average old-age care preferences across genders and caregiver groups



Y ranging from 1: “Mainly a task for the family” to 5: “Mainly a task for society”

2. Causal inference

2.1 Caregiving and preferences for family or public provision

Table 1 shows the estimated coefficients for the within effects of caregiving, well-being and other covariates on preferences for family or public provision of old-age care.

According to Hypothesis 1, giving care to an old-age parent or partner should increase support for public care provision. The models support the existence of a causal effect of caregiving on preferences, but the direction of the effect varies depending on the caregiver’s gender and relationship to the care receiver. Giving care to an old-age parent significantly decreases support for public provision among male caregivers (M1.2) but does not affect the preferences of female caregivers (M1.1) Conversely, when looking at the effect of giving care to an old-age partner, there is no effect for male caregivers (M2.2) but a significant increase in support for public care provision is observed among female caregivers of an old-age parent (M2.1).

Table 1: Linear Fixed-Effects Models for Preferences

	M1.1 (Female)	M1.2 (Male)	M2.1 (Female)	M2.2 (Male)
Cares for parent	0.02	-0.19 ***		
	(0.02)	(0.03)		
Cares for partner			0.14 ***	0.03
			(0.04)	(0.04)
Well-being	0.08 **	-0.18 **	-0.08 *	-0.10 +
	(0.02)	(0.06)	(0.03)	(0.05)
Age	-0.00	-0.04 ***	0.03 ***	-0.04 ***
	(0.00)	(0.01)	(0.01)	(0.01)
Activity: not in paid employment	0.07	-0.05	-0.33 ***	-0.04
	(0.04)	(0.06)	(0.06)	(0.11)
Partnership: non-resident	0.30 ***	0.53 ***	0.15	-0.33 *
	(0.06)	(0.09)	(0.10)	(0.14)
Partnership: co-resident partner	0.24 **	0.30 **	-0.27 **	0.81 ***
	(0.08)	(0.09)	(0.10)	(0.16)
Lives with parents	-0.34 **	-0.86 ***	-0.10	-0.19
	(0.10)	(0.18)	(0.26)	(0.32)
Marital: married	-0.31 ***	0.39 ***	-0.02	-1.67 ***
	(0.08)	(0.09)	(0.10)	(0.22)
Has kids: no	-0.03	-0.26 **	-0.00	-0.50 ***
	(0.06)	(0.08)	(0.06)	(0.06)
HH Income: 1500-3000	-0.04	-0.46 ***	-0.01	0.38 ***
	(0.04)	(0.06)	(0.05)	(0.06)
HH Income: >3000	0.07	-0.31 ***	-0.12 +	0.41 ***
	(0.05)	(0.07)	(0.07)	(0.08)
Health	0.08 ***	-0.02	0.04 +	0.05 +
	(0.02)	(0.03)	(0.03)	(0.03)
AIC	-26104.01	-10955.54	-5282.509	3867.747
Num. obs.	7764	5760	7353	5688
Num. groups: individuals	2588	1920	2451	1896

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$, + $p < 0.10$

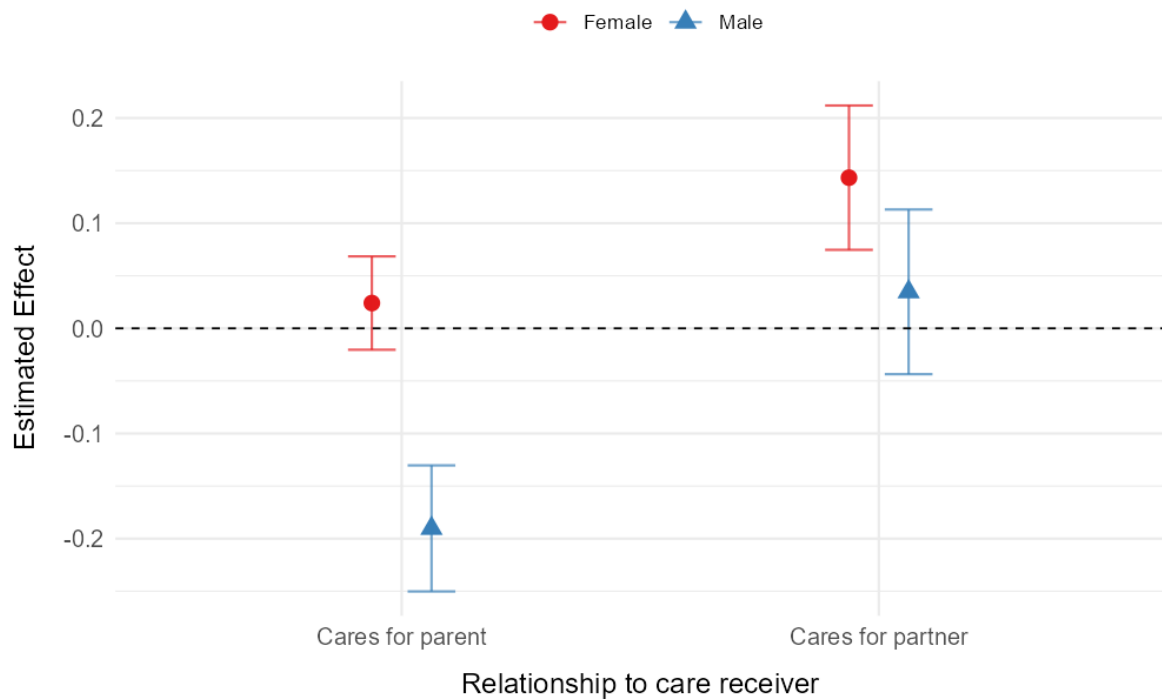
Thus, H1 is supported by the data only in the case of female caregivers of an old-age partner. In contrast and against H1, men become less supportive of public provision after giving care to an old-age parent and the preferences of female caregivers of a parent and male caregivers of a partner are not significantly affected by caregiving. These effects are depicted in Figure 3.

Regarding other variables in the models, well-being decreases support for public provision in all models except when considering giving care to an old-age parent among women (M1.1), where higher well-being seems to lead to higher support for public provision. Moreover, there is evidence that changes in family characteristics play an important role in the formation of preferences. Entering partnership increases support for public provision in all models that

consider caring for an old-age parent (M1.1, M1.2). In the models that consider care for an old-age partner (M2.1, M2.2), women become more supportive of public provision when they enter a co-residential partnership, but more familialistic when the partner is non co-resident. In turn, having children increases support for family provision among men (M1.2, M2.2) but has no effect on women (M1.1, M2.1).

Figure 3: Estimated Causal Effect of Caregiving on Support for Family Provision

Comparison by Gender and Relationship to Care Receiver



Y ranging from 1: “Mainly a task for the family” to 5: “Mainly a task for society”

2.2 Caregiving and well-being

Table 2 shows the estimated coefficients for the within effects of caregiving and other covariates on well-being.

According to Hypothesis 2, giving care to an old-age parent or partner should reduce well-being, and this effect should be particularly clear for female caregivers and caregivers of a parent. The observed results do not support this hypothesis. Negative causal effects of caregiving on well-being are found among male caregivers (M1.2, M2.2), which are slightly

clearer when giving care to an old-age partner. This finding resonates with Pinquart and Sörensen (2011), who concluded that the psychological impact of caregiving was stronger for spouse caregivers than adult children. However, no deterioration of well-being is observed among female caregivers (M1.1 and M2.1). What is more, giving care to an old-age partner actually increases the well-being of women (M2.1), a finding that contradicts previous theoretical expectations (Casado-Mejía & Ruiz-Arias, 2016; Schmid et al., 2012; Bastawrous, 2013). In sum, Hypothesis 2 only find supports for male caregivers, with all expectations about the role of gender and relationship to care receiver being rejected. These effects are depicted in Figure 4.

Table 2: Linear Fixed-Effects Models for Well-being

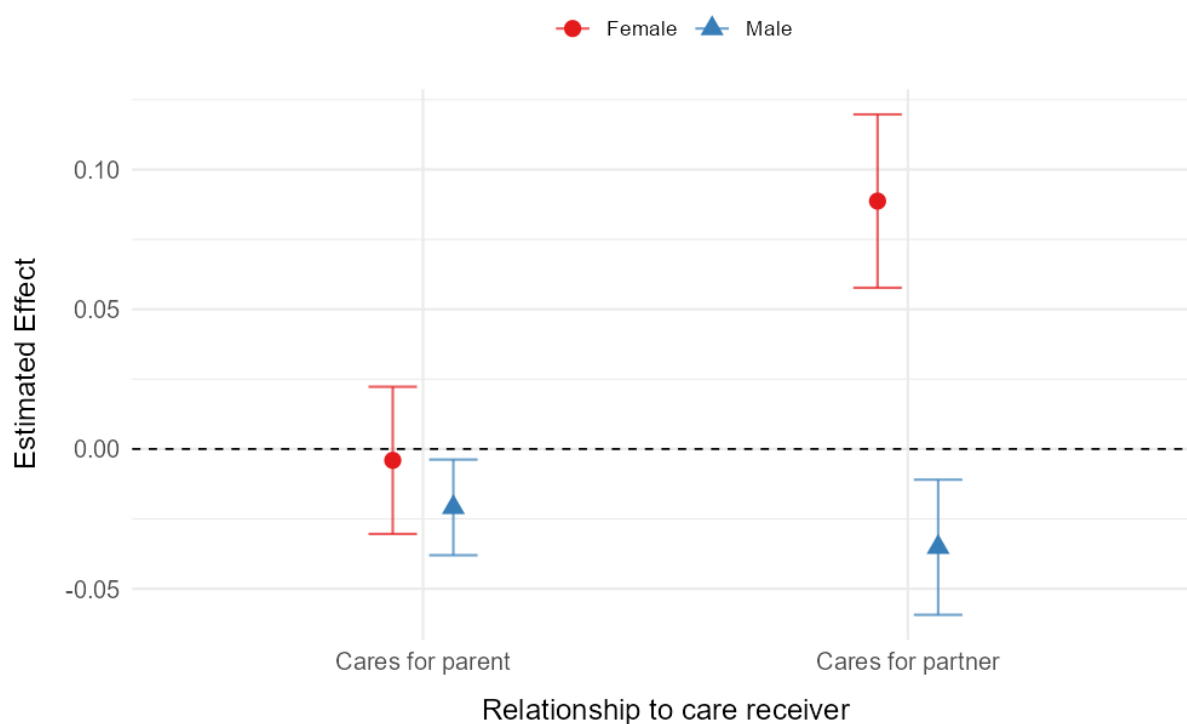
	M1.1 (Female)	M1.2 (Male)	M2.1 (Female)	M2.2 (Male)
Cares for parent	-0.00 (0.01)	-0.02 * (0.01)		
Cares for partner			0.09 *** (0.02)	-0.04 ** (0.01)
Age	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	-0.01 *** (0.00)
Activity: not in paid employment	-0.03 (0.02)	0.03 (0.02)	-0.10 *** (0.02)	0.05 (0.03)
Partnership: non-resident	0.27 *** (0.04)	0.14 *** (0.02)	0.42 *** (0.06)	0.12 ** (0.04)
Partnership: co-resident partner	0.43 *** (0.04)	0.26 *** (0.03)	0.30 *** (0.05)	0.51 *** (0.05)
Lives with parents	-0.05 (0.06)	0.02 (0.05)	-0.00 (0.15)	-0.01 (0.10)
Marital: married	-0.02 (0.05)	0.05 * (0.02)	-0.10 * (0.05)	-0.26 *** (0.07)
Has kids: no	0.08 * (0.03)	-0.02 (0.02)	-0.07 ** (0.03)	-0.13 *** (0.02)
HH Income: 1500-3000	-0.04 + (0.02)	-0.02 (0.02)	-0.00 (0.02)	-0.05 ** (0.02)
HH Income: >3000	-0.08 * (0.03)	0.01 (0.02)	0.08 ** (0.03)	-0.00 (0.03)
Health	0.12 *** (0.01)	0.01 (0.01)	0.06 *** (0.01)	0.02 + (0.01)
AIC	13253.86	3065.99	22249.99	17357.14
Num. obs.	7764	5760	7353	5688
Num. groups: individuals	2588	1920	2451	1896

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$, + $p < 0.10$

Concerning the rest of variables, entering a partnership increases well-being in all models, while entering marriage and having children affect well-being negatively in the models that consider care for an old-age partner (M2.1, M2.2). An increase in health significantly leads to higher well-being among female respondents (M1.1, M2.1) but does not clearly affect the well-being of male respondents.

Figure 4: Estimated Causal Effect of Caregiving on Well-Being

Comparison by Gender and Relationship to Care Receiver



Y ranging from 1 (lowest well-being) to 5 (highest well-being)

3. Causal Mediation

Table 3 shows the estimated Average Causal Mediation Effects (ACME) and Average Direct Effects (ADE) for each combination of gender and relation to care receiver. According to Hypothesis 3, giving care to an old-age parent or partner should increase support for public provision through its impact on well-being. Thus, the ACME should be positive and significant.

Moreover, the mediated effect should be particularly clear for female caregivers and caregivers of a parent.

The ADE match the estimations of the fixed-effects models for preferences, indicating that caregiving increases support for public provision among female caregivers of a partner and reduces it among male caregivers of a parent. Regarding the ACME, these are significant for all groups except for female caregivers of a parent (M1.1). The sizes of the mediated effects are, however, small, with the proportion mediated representing less than 5% of the total effect in all cases. Thus, Hypothesis 3 is rejected, meaning that the significant changes in support for public provision among male caregivers of a parent and female caregivers of a partner are not explained by a decrease in well-being.

Table 3: Causal Mediation Analysis

	<i>Cares for parent</i>		<i>Cares for partner</i>	
	<i>Female (M1.1)</i>	<i>Male (M1.2)</i>	<i>Female (M2.1)</i>	<i>Male (M2.2)</i>
ACME	-0.0004	0.004**	-0.01**	0.004*
ADE	0.03	-0.19***	0.14***	0.03
Total	0.02	-0.19***	0.14***	0.04
Proportion Mediated	-0.01	-0.02**	-0.04**	0.07
Num. obs	7764	5760	7353	5688
Num. groups: individuals	2588	1920	2451	1896

Discussion

The purpose of this study was to test the existence of a causal link between providing informal care to an old-age parent or partner and preferences for family or public provision of old-age care, under the hypothesis that caregiving increases support for public provision due to its negative impact on the caregiver's well-being.

After analyzing panel data from years 2005, 2008 and 2011 in France the results do not support the study's overarching argument. First, there is a causal effect of caregiving on preferences, but this is not always towards greater demand for public provision. Instead, the effect is conditional on the caregiver's gender and relationship to care receiver. As expected, women become more supportive of public provision after giving old-age care, but the evidence is only conclusive in the case of caregivers of a partner. Conversely, men become more supportive of family provision after giving care, but the evidence is only conclusive for caregivers of a parent. A clear and relevant conclusion of this analysis is that caregiving affects the preferences of women and men differently. This finding goes in line with the well-documented gender gap in welfare state preferences (Goossen 2020, 2023). That opposite effects are observed for female and male caregivers might be due precisely to the fact that family care arrangements are embedded in a gendered care provision system, characterized by social norms and expectations about the divergent duties of women and men. In this context, female caregivers might see in public provision a relief from socially imposed care obligations. Conversely, male caregivers might represent precisely those men who are willing to care regardless of social expectations, and caregiving might reinforce their pre-existing familialistic preferences.

Second, giving care causes caregiver burden as expected, but this effect is again dependent on gender. A negative causal impact of caregiving on well-being is only observed for male caregivers. In the case of female caregivers, their well-being is not affected by giving care to a parent and it even increases when giving care to an old-age partner. This finding challenges the conclusions of previous studies which found the association between caregiving and psychological burden to be stronger for women (Casado-Mejía & Ruiz-Arias, 2016; Bastawrous, 2012; Schmid et al., 2012). A plausible reason for the observed decay in well-being among male caregivers might be precisely that the act of giving care and the particular

tasks involved are socially constructed as feminine. In this sense, Russell (2007) found qualitative evidence that male caregivers struggle when engaging in caregiving tasks that they require socially gendered skills and confronting gender roles and expectations. Therefore, male caregivers might experience a greater decrease in well-being simply because they are faced with caregiving for the first time.

Finally, the described causal effects of caregiving on preferences do not seem to be explained by changes in well-being. While significant average mediated causal effects were found for female caregivers of a partner and male caregivers of a parent, the comparatively small size of the coefficients and their negligible impact on the total causal effect suggest that other mechanisms explain the causal relation. Relevant potential explanations include unobserved differences in the intensity and character of care tasks (Schmid et al., 2012) and the role of individually held family norms on the perception of care arrangements and caregiver burden. While these mechanisms are not explored in this paper due to data limitations, they constitute relevant avenues for future research.

The study's conclusions must be treated with caution considering some limitations. First, the operationalization of the dependent variable is not ideal, as it cannot be assumed that "*society*" and "*public sector*" are equivalent terms. Nevertheless, it can be argued that "*a task for society*" as opposed to "*a task for the family*" represents a sense of collective responsibility for care provision which is fulfilled by public old-care services. Furthermore, this limitation on the side of the dependent variable is compensated by the rich information that the GGS provides on the side of the covariates and by the availability of panel data. In this sense, the GGS represents the most appropriate data set to test the article's hypotheses. Second, there is no available information on the intensity of the care given by the respondents, and therefore the study cannot explore how the impact of caregiving on well-being and preferences might differ between contexts of intensive and supplementary support. This limitation is partially accounted for by

the use of gender as a moderator. Finally, the analyses have been conducted on a representative sample of the French population, and their conclusions can therefore not be generalized to a wider context, although the theoretical argumentation of the paper is meant to apply as well in other European countries, once policy differences are controlled for.

Despite these limitations, the paper makes a relevant contribution to the field by providing the first test of the causal link between caregiving and care preferences and offering important insights on the different impacts of caregiving on women and men. The use of propensity score weights allows to study the relationship between caregiving and preferences without the influence of potential confounders, increasing the reliability of the results. Future contributions on the issue should aim to provide evidence from different national contexts and explore how different care policies and systems might shape the link between caregiving and care preferences, ideally through cross-national analyses.

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