

Family Elderly Caregiving and Preferences for Family or State Responsibility in France (Paper Draft)

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Abstract

The rapid ageing of the European population in recent years has brought a significant increase in elderly care needs. While families still constitute the main care provider in most European countries, their capacity to care seems to have decreased in the face of these intensified pressures, calling for a strengthening of the state's role. In this context, the discussion on whether families or states should be responsible for elderly care takes relevance, and the preferences of family caregivers appear fundamental to ascertain whether families will continue to carry most of the weight or, on the contrary, states will need to step up. The present study addresses this issue by testing the existence of a causal link between providing elderly care to a parent or partner and preferences for family or state responsibility, under the hypothesis that caregiver burden and its impact on the caregiver's well-being increase demand for state responsibility. This hypothesis is tested with data from the Generations and Gender Survey for a 3-wave panel sample of 5435 respondents in France, which constitutes a prototypical case of explicit familialism in elderly care. Data are analysed through a causal mediation approach using linear within-effects and propensity score weights. Results suggest that caregiving actually increases support for family responsibility, but only when the caregiver is a man and the care receiver is an elderly parent. Moreover, there is evidence that well-being moderates rather than mediating this causal link, as caregivers with low well-being become less familialistic.

Introduction

In recent years, European countries have experienced a significant increase in elderly care needs due to sociodemographic changes, primarily the rapid ageing of the population and an increment in chronic illness (Bastawrous, 2013; Da Roit et al., 2007; Theobald & Luppi, 2018). This increase has intensified pressures on families and states and brought forward a discussion on which should be responsible for elderly care provision. Families, and within families most often women, continue to represent the main provider of elderly 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 state responsibility (Theobald & Luppi, 2018; Da Roit et al., 2007).

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; Kalmijn & Saraceno, 2008). However, in a context of increasing elderly 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 state responsibility for elderly care has become a relevant research topic for social scientists. Previous studies on elderly care preferences have explored individual predictors like gender, partnership, number of children, labour 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 old adults with care needs and whether they prefer to have those needs covered by their family, generally through informal care provided by a family member, or by the welfare state through the funding or provision of formal care (Mair et al., 2016b, Fang & Yang, 2023, Lu et al., 2021, Wielink et al., 1997; Eckert et al., 2004; Hajek et al., 2017).

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 providing elderly care to a family member might cause objective and subjective burden when it becomes difficult to balance care with other professional and personal responsibilities, leading to a preference for government-based assistance. However, no evidence has been provided of a causal effect of caregiving on preferences. Since the willingness of family members to care is essential to sustain a care system which remains strongly dependant on the family, and given the constant increase in elderly care needs across European countries, understanding the experiences of family caregivers and whether these have an impact on already pre-existing preferences for family or state responsibility has become a fundamental task in order to ascertain the future of elderly care systems in Europe.

The present paper intends to breach this research gap by testing the existence of a causal link between family elderly care provision and preferences for family or state responsibility for elderly care. The proper specification and test of a causal mechanism rather than a mere statistical association 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 choices and behaviour. To that end, the following research question is specified:

RQ: Does providing elderly care to a family member affect preferences for family or state responsibility for elderly care?

Following Mair and colleagues' (2016a) suggestion that caregiver burden might lead to a preference for greater state responsibility, a mediation model is proposed in which providing elderly care to a family member (elderly parent or partner) increases demand for state responsibility through its negative impact on the caregiver's well-being.

Indeed, research has shown that those who provide elderly care to a family member often experience objective and subjective burden leading to psychological strain and a decline in general well-being (Montgomery et al., 1985; Bastawrous, 2013; Schmid et al., 2012; Casado-Mejía & Ruiz-Arias, 2016; Savundranayagam et al., 2011). 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 labour market and income risks, even though the impact of caregiving on well-being depends on a number of other factors. From a self-interest approach to preference formation, it is logical to expect that those who experience caregiver burden demand that the state takes greater responsibility in elderly care in order to alleviate their own care duties.

The study employs data from the Generations and Gender Survey¹ (GGS) for a panel sample of 5435 French respondents, 376 of which provide elderly care in at least one wave, in the years 2005, 2008 and 2011. The reasons to conduct a case study in France are both theoretical and empirical. From a theoretical point of view, the French elderly care system constitutes a prototypical case of explicit familism 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 a higher degree of involvement by the state. In empirical terms, France is the only country in the GGS with longitudinal data for the key variables in three different time points, allowing for the application of causal inference methods.

The data are analysed using Imai et al.'s (2010a) Causal Mediation Analysis approach. Causal effects are tested by means of within-effects models using different binary caregiving indicators as treatments. To correct the non-random assignment to treatment the models are fit employing Propensity Score Weights (Olmos & Govindasamy, 2019; Zhou et al., 2020).

The findings indicate that providing care only affects the preferences of male caregivers of an elderly parent, while for women and caregivers of an elderly partner there is no causal effect. Against expectations, male caregivers of an elderly parent do not experience any changes in well-being. However, well-being does act as a moderator of the link between caregiving and preferences, as those caregivers who report low well-being levels become more supportive of state responsibility, while caregivers who experience high well-being become more familistic after providing care.

The next section provides a theoretical background on family care, care preferences and the concept of caregiver burden, and introduces the research hypotheses and the particularities of the French case. Subsequently, the methods and results are presented. A brief discussion of the findings concludes the paper.

¹ For a complete review see Vikat et al., (2007)

Theory

1. *Family caregiving: motivators and preferences*

In all current European societies, the responsibility for the provision of elderly care is shared between families and welfare states (Daatland & Herlofson, 2003). However, the degree of responsibility assigned to each of the parts varies cross-nationally depending on institutional and normative factors (Kalmijn & Saraceno, 2008). Institutionally, it has been observed that some welfare regimes 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). 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 elderly care provision. The first group, composed by Denmark, Finland and Sweden, is characterised 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 characterised by implicit familialism, meaning that policies do not explicitly support family care but neither offer state-based alternatives, 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 characterised 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 provide elderly care to their relatives moved by social expectations and individually held norms of family responsibility. The role of norms has been particularly stressed in the literature when it comes to intergenerational solidarity. In a seminal work for the field, Bengtson and Roberts (1991) proposed a six-dimensional model of intergenerational solidarity and 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, several studies have provided evidence that strong norms of filial responsibility translate into actual support behaviour, both at the individual level (Silverstein et al., 2006; Hwang et al., 2022) and in aggregate terms (Kalmijn & Saraceno, 2008; Dykstra & Fokkema, 2011). However, that institutional setting and social norms lead individuals to provide elderly 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 responsibility for the care needs of their elderly relatives. The difference is important, as it has implications for the social legitimacy of a familialistic social organisation of elderly care.

Scholarly research on the formation of preferences for family or state responsibility for elderly care considers several individual factors. First, gender has been found to play a relevant part. There is evidence that women tend to be less supportive of family responsibility than men (Mair et al., 2016a), a finding that appears to be connected

with the gendered division of care work. In terms of family composition, having children matters only conditionally to normative factors. Daatland & Herlofson (2003) observe that while the respondent's number of children is positively associated with support for family responsibility in familialistic countries, it leads to a higher demand for state responsibility in more individualistic cultures, and suggest that in countries with strong independence norms, parents' preference for state responsibility might have to do with a concern about the welfare of children. Moreover, individual labour market status, income and educational level are also associated with elderly care preferences. Mair et al. (2016a) find evidence that employed respondents are more supportive of family responsibility than those who are unemployed or outside the labour market, while Fang and Yang (2023) find that support for family responsibility is positively associated with family income but negatively associated with educational level. Furthermore, receiving family care is associated with increased support for family responsibility (Mair et al., 2016b; Daatland & Herlofson, 2003) although it is difficult to discern whether care experiences lead to preferences or previously held preferences crystallise into care.

From the perspective of caregivers, it has been suggested that caring for an elderly relative might reduce support for family responsibility 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 policies result from rational calculations of the potential benefits each individual can expect from the implementation of said policies (Meltzer & Richard, 1981; Blekesaune, 2007; Linos, 2003). In this sense, family caregivers can be seen as beneficiaries of the implementation of defamilialising care policies and programs that relieve their care responsibilities. In other words, when providing family elderly care leads to care burden, family caregivers might become more supportive of an increase in state responsibility to protect their well-being.

2. Caregiver burden

The term "caregiver burden" is well-established in the specialised literature (Montgomery et al., 1985; Bastawrous, 2013; Liu et al., 2020). 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; Bastawrous, 2013). 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 tasks. As a result, caregivers often experience conflicts between their caregiving role and other familial, social and professional obligations, which lead to a decrease in the quality of their relationships with family members other than the care receiver, 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; Casado-Mejia & Ruiz-Arias, 2016; Liu et al., 2020). On the other hand, subjective

burden refers to the emotional or psychological impact of objective burden on caregivers (Bastawrous, 2013). 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 a multiplicity of factors, the most prominent being the gender of the caregiver (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; Silverstein et al., 2006; Palriwala, 2019; Ganga-León, 2024). Women are not only more likely to become family care providers than men, but they take up roles that are more burdening than those typically performed by men. Schmid et al. (2019) find that while there are no important gender differences in terms of sporadic support across European countries, daughters provide intensive support to elderly parents much more often than sons, particularly in countries with familialistic care systems. This difference is important because while no link has been found between sporadic support and well-being, intensive caregiving is associated with lower mental and physical strain (Schmid et al., 2012) as well as reduced employment hours (Ehrlich et al., 2020). Similarly, Bastawrous (2013) observes that male caregivers typically provide mainly instrumental support, while female caregivers are more likely to provide emotional support in addition to performing instrumental tasks. As the provision of emotional support has a greater impact on the psychological well-being of caregivers, women are more vulnerable to subjective caregiver burden than men.

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 elderly care: adult children and partners (Pinquart & Sörensen, 2011; Bastawrous, 2013). While the latter are traditionally the first option to provide elderly 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 when it comes to providing care. While partners tend to provide care full-time, children are more likely to compatibilise care tasks with paid employment and other family and social obligations, which leads to a higher degree of caregiver burden (Casado-Mejía & Ruiz-Arias, 2016). In a similar line, Bastawrous (2013) suggests that caregiver burden in adult children arises from the non-normative character of the role transition they experience when the parent becomes dependent on the adult child at a point when children have their own spousal and parental obligations. Nonetheless, while the theoretical link between relation to care receiver and burden seems clear, empirical studies have provided mixed evidence. In this sense, Pinquart 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. Thus, the differences in caregiver burden among child and partner caregivers require of further exploration.

In line with the theoretical considerations above, the following hypotheses about the causal relations between family elderly caregiving, well-being and preferences for family or state responsibility are proposed:

H1: Providing elderly care to a family member decreases well-being.

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

H2: Providing elderly care to a family member decreases support for family responsibility for elderly care.

H3: The impact of providing elderly care to a family member on support for state responsibility is, at least partially, mediated by well-being.

- a) The mediated impact of providing elderly care to a family member on support for family responsibility is stronger on adult children than on partner caregivers.*
- b) The mediated impact of providing elderly care to a family member on support for family responsibility is stronger on female than on male caregivers.*

These hypotheses are tested using panel data from the Gender and Generations Survey for France in the years 2005, 2008 and 2011. The case of the French elderly care system and its adequacy for this study are discussed below.

3. The French Case

Like most European countries, France has seen since the end of the past century a considerable increase of the elderly population and, consequently, of elderly care needs (Martin et al., 1998; Le Bihan & Martin, 2012). In 2015, 4.4% of those aged 60 or over were dependant, with between 0.4 and 1.5 million dependent people over 60 living at home (Brunel & Carrère, 2017). 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 residencial facilities (Boneschuy & de L'Espinay, 2022, Or et al., 2023). Despite these developments, the family has remained the main provider of elderly 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).

The French social insurance system does not explicitly consider the risk of long-term elderly care dependency, which is instead addressed via social assistance. This situation has persisted despite political debates during the 2000s and 2010s regarding the potential coverage of long-term elderly care dependency risks under an independent social insurance branch (Kaufmann, 2018; Le Bihan & Martin, 2012). The main benefit provided to dependent elderly people by the French welfare state is the *Allocation Personnalisée à l'Autonomie* (APA), which was introduced in 2002 and is still in place nowadays (Da Roit et al., 2007; Kaufmann, 2018). Unlike its predecessor, the *Prestation Spécifique Dépendance* (PSD) of 1997, which was means-tested, the APA

is based on the principle of universality and is available to all persons 60 years of age or older who have difficulty performing everyday tasks (Morel, 2007; Da Roit et al., 2007; Boneschi & de L'Espinay, 2019). 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 institutionalised care (Da Roit et al., 2007; Kaufmann, 2018; Boneschi & de L'Espinay, 2019). In this sense, the APA has been understood as a defamilialising care policy, as it enables dependent elderly people to afford care from the formal market (Da Roit et al., 2007). Along the same lines, Morel (2007) argues that the main idea behind the APA has been to promote free choice for dependent persons while simultaneously fostering the creation of low-skilled, low-wage jobs in personal service. However, it is not clear that the APA has worked as a defamiliasing arrangement. First, despite an increase in the availability of long-term care services at home, there is still a shortage of specialised 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 elderly 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 elderly parents. This arrangement recognises the right of the family to care but it pushes caregivers, generally women, outside of the labour market, putting them at financial risk (Da Roit et al., 2007). Moreover, France, like many other European countries, has institutionalised 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). Morel (2007) points out that France's categorisation as a corporatist welfare state (Esping-Andersen, 1990) 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 children and the elderly at home. Similarly, 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. 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. All in all, despite a development of the care system towards a mixed family-state model, informal family care remains the principal source of elderly care provision in France (Da Roit et al., 2007).

According to data from Besnard et al. (2019), in 2015 there were 3.9 million family caregivers for citizens aged 60 or over living at home in France. Out of these, about half were adult children and a quarter were spouses. 99% of the spouse caregivers

cohabited with the care receiver, whereas only 15.5% of the child caregivers lived in the same house. However, among those child caregivers who did not cohabit with the care receiver, three quarters lived less than 40 minutes from the senior's home. Regarding the impact of caregiving on well-being, 64% of spouse caregivers and 45% of child caregivers declared at least one negative consequence on their health, like feeling lonely, depressed or anxious. Women reported negative impacts on their health considerably more often than men. Despite these negative effects, almost 8 out of 10 spouse and child caregivers considered that providing care was their duty. This contrasts with previous evidence reflecting comparatively low support for upwards intergenerational solidarity among the French population (Kalmijn & Saraceno, 2010). Of course, family caregivers are likely to hold particularly strong norms of family responsibility, as normative solidarity is a predictor of support behaviour (Bengtson & Roberts, 1991; Silverstein et al., 2006; Hwang et al., 2022). The question is whether, in turn, the experience of providing care and its negative impacts on well-being have the capacity to influence preferences for family responsibility.

The French case is particularly interesting for the study of elderly care preferences since its care system constitutes a mixed family-state model where families are still the main provider of elderly care but the welfare state complements them. Therefore, French citizens in general and informal caregivers in particular are acquainted with both family and state-based forms of elderly care provision, having a basis to form their preferences for family or state responsibility. Moreover, the debate about the need to strengthen state responsibility over long-term care has been around in French society since the 2000s, as different governments have discussed the possibility of covering care needs under an independent social insurance branch (Kaufmann, 2018; Le Bihan & Martin, 2012). Finally, as discussed above, informal caregivers in France are vulnerable to negative impacts on their well-being, which might lead to increased demands for a degree of state responsibility that goes beyond supporting family caregivers. These conditions make of France an ideal case to test the argument of this study.

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 survey, which is part of the Generations and Gender Program², offers two key advantages: First, the inclusion of detailed data on the provision of elderly care to family members, along with elaborate information on family constellations and dynamics and a questions on elderly care preferences and psychological well-being, allow for the joint measurement all the key variables in the study. Second, the panel format of the dataset enables the use of causal inference techniques, necessary to fulfil the purpose of this research.

The GGS constitutes an individual-level fixed panel, meaning that it takes repeated observations from individuals. The target population is composed by those individuals resident in the country where the interview takes place, non-institutionalised and aged

² For a detailed report on the Generations and Gender Program see Gauthier and Emery (2014).

18-79 and the time of the first wave. Respondents are selected through probability sample 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 in France 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 gross sample size in Wave 1 was 18009 with a response rate of 65.2% (Gauthier et al., 2018). The cumulative attrition across the three waves was of 43%, with 35% between waves 1 and 2 and 17% between wave 2 and 3. Régnier-Loilier and Guisse (2012) studied attrition in the GGS' French sample and found significant associations with gender, age, education and nationality and place of residence on attrition, as well as with low family trust and poor health. The impact of these sample biases can be corrected through the use of weights.

2. Variables and Operationalisation

The dependent variable of the study, preference for family or state responsibility for elderly care, is measured by means of 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. The values range from 1, *"mainly a task for society"*, to 5, *"mainly a task for the family"*. While the term "society" is not equivalent to the state, there are precedents of studies which have used this same GGS item to measure preferences for family or state responsibility, arguing that society can be taken to mean the welfare state in the context of the question (Daatland et al., 2009; Herlofson et al., 2011). Regardless, the ambiguous phrasing on the side of the dependent variable is admittedly a limitation, but is compensated by the high quality of the questions on the side of the covariates, and the benefits of the survey's panel format.

The main independent variable is whether the respondent is providing elderly care to a family member. The GGS asks if the respondent has 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, and as they are the ones who provide most intense support and experience burden more often, a binary variable was created indicating whether respondents had provided care to at least one parent or partner 60 years or older. Two additional indicators of care for parent and care for partner are used to evaluate the differences between both caregiver groups.

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 the well-being models are age, health, activity status, partnership status, educational level and household income, as well as gender at level 2 (individual). To predict preferences a similar set of control variables is employed, but instead of health two dummy indicators of whether the respondent lives with their parents and whether they have children are used.

3. Modelling Strategy

Two sets of within-between effects linear models are independently estimated, one of which predicts the mediator (well-being) based on the treatment (caregiving) and covariates, and the other of which predicts the outcome (preference) based on the treatment, mediator and covariates. An interaction between treatment and gender is included in both cases to assess gender differences in the treatment effects. These models allow to test Hypotheses 1 and 2.

In order to test the mediated causal effect (Hypothesis 3), the Causal Mediation Analysis approach proposed by Imai et al. (2010a) is employed. This approach allows to use a wide variety of regression models and types of variables, offers an array of sensitivity analysis to quantify the robustness of results and is easily implementable in R through the *mediation* package (see Imai et al., 2010b).

As GGS data are non-experimental, the assignment to treatment (caregiving) is strongly associated with factors that also affect the mediator and the outcome variables, like gender and age. To obtain robust estimations of the causal effects it is necessary to account for this fact by balancing those confounders across treatment and control groups. To do so, propensity score weights were estimated and used when fitting the regression models (Antonakis et al., 2010). Three sets of weights were fit for the three variations of the treatment: caring for an elderly parent, caring for an elderly partner or caring for either of them. The specification of the propensity score models is available in the Supplementary Materials. The weights were obtained by means of the *PSweight* R package (Zhou et al., 2022). Overlap weights were selected as they led to perfect balance of the potential confounders.

Results

1. Exploratory results

Table 1 reflects how family caregiving is distributed between genders and different age groups. Unsurprisingly, the bulk of elderly care (70%) falls on women. The gender gap is particularly pronounced for those who provide care to an elderly parent, where three fourths of caregivers are women. When it comes to caring for an elderly spouse or partner, gender differences are smaller.

In terms of age, practically all caregivers of the elderly are 45 years old or over. Among caregivers of elderly parents, almost two thirds are between 45 and 59 years old, whereas practically 9 out of every 10 caregivers of an elderly partner are 60 years old or over. The observed gender and age differences are consistent with previous theory.

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

	<i>Men</i>	<i>Women</i>	<i>Under 45</i>	<i>45-59</i>	<i>60 and over</i>	<i>n</i>
<i>Cares</i>	0.31	0.69	0.05	0.47	0.47	476
<i>Cares for parent</i>	0.26	0.74	0.07	0.63	0.30	341
<i>Cares for partner</i>	0.45	0.55	0.00	0.13	0.87	135

3-Wave pooled sample (group sizes in right column)

Table 2 shows the correlations between the key variables of the study. Surprisingly, being a woman is negatively correlated with age, meaning that higher shares of women are found in the sample among the younger age groups. In line with the frequencies observed in Table 1, women are more likely to provide elderly care to parents, but no significant gender differences are observed in terms of care to spouses or partners. Women also report lower psychological well-being. Age is positively correlated with care provision, especially with caring for a spouse or partner, which also matches the frequencies observed in Table 1. Surprisingly, there is no significant correlation between age and well-being.

Providing care to an elderly parent is significantly correlated with a higher preference for family responsibility. The direction of the correlation was to be expected, as more familialistic respondents are more likely to engage in care behaviour. However, preferences for family or state responsibility do not seem to be correlated with providing care to an elderly partner. Finally, providing family care is negatively correlated with a well-being, but once again this effect is only visible for those who care for a parent. This observation is compatible with Hypothesis 1a.

Table 2: Correlations between key variables

	<i>Gender (f)</i>	<i>Age</i>	<i>Cares</i>	<i>Cares for parent</i>	<i>Cares for partner</i>	<i>Preference for family responsibility</i>	<i>Well-being</i>
<i>Gender (f)</i>		-0.04 ^(***)	0.04 ^(***)	0.05 ^(***)	-0.01	0.01	0.20 ^(***)
<i>Age</i>	-0.04 ^(***)		0.10 ^(***)	0.04 ^(***)	0.12 ^(***)	0.06 ^(***)	0.00
<i>Cares</i>	0.04 ^(***)	0.10 ^(***)		0.84 ^(***)	0.53 ^(***)	0.02 ^(*)	0.02 ^(**)
<i>Cares for parent</i>	0.05 ^(***)	0.04 ^(***)	0.84 ^(***)		-0.01	0.02 ^(*)	0.03 ^(***)
<i>Cares for partner</i>	-0.01	0.12 ^(***)	0.53 ^(***)	-0.01		0.00	0.00
<i>Preference for family responsibility</i>	0.01	0.06 ^(***)	0.02 ^(*)	0.02 ^(*)	0.00		0.00
<i>Well-being</i>	-0.20 ^(***)	0.00	-0.02 ^(**)	-0.03 ^(***)	0.00	0.00	

3-Wave Pooled sample, $n = 16305$ *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$, + $p < 0.10$

2. Causal inference

2.1 Caregiving and well-being

Table 3 shows the estimated coefficients for the within and between effects of caregiving and other covariates on well-being. The within effects correspond to the changes in variables within individuals across time, and thus allow to test causal relations. The between effects correspond to the differences among individuals and reflect statistical associations.

Table 3: Within-Between Models for Well-Being

	M1 (<i>x=cares</i>)	M2 (<i>x=cares for parent</i>)	M3 (<i>x=cares for partner</i>)
Within Effects			
<i>Cares: yes</i>	−0.08*	0.02	−0.19
<i>Age</i>	0.00	0.00 ⁺	0.10***
<i>Health</i>	0.08***	0.12***	0.01 ⁺
<i>Not in paid employment</i>	−0.10***	−0.15***	−0.14***
<i>Partner: non-cohabiting</i>	−0.29***	−0.27***	−0.22***
<i>Partner: no partner</i>	−0.45***	−0.45***	−0.44***
<i>Edu: ISCED 3</i>	−0.47	−0.47	−0.01
<i>Edu: ISCED 4-5</i>	−0.01	−0.01	0.36
<i>HH Income: 1500-3000</i>	−0.00	−0.03 ⁺	−0.03
<i>HH Income: > 3000</i>	−0.04	−0.07***	−0.06*
Between Effects			
<i>Intercept</i>	2.44***	2.44***	2.53***
<i>Cares: yes</i>	−0.16***	−0.23***	−0.01
<i>Age</i>	0.01***	0.01***	0.01***
<i>Health</i>	0.24***	0.24***	0.23***
<i>Not in paid employment</i>	−0.04	−0.05 ⁺	−0.02
<i>Partner: non-cohabiting</i>	−0.16***	−0.17***	−0.15***
<i>Partner: no partner</i>	−0.18***	−0.18***	−0.18***
<i>Edu: ISCED 3</i>	0.07***	0.08***	0.08***
<i>Edu: ISCED 4-5</i>	0.04 ⁺	0.05*	0.06***
<i>HH Income: 1500-3000</i>	0.08***	0.07*	0.05 ⁺
<i>HH Income: > 3000</i>	0.04	0.03	0.45
<i>Gender: female</i>	−0.17***	−0.17***	−0.18***
Cross-Level Interactions			
<i>Cares * female</i>	0.07	−0.04	0.27 ⁺

3-Wave panel observations nested in individuals, N= 4908 *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$, + $p < 0.10$

When considering caregivers of parents and spouses together (M1), a significant negative causal impact of caregiving on well-being is observed, although the estimated effect is small. Therefore, H1 is accepted, but the influence of caregiving on well-being is much weaker than expected. The between effect is also negative and significant, supporting the idea that caregiving decreases well-being.

Taking the groups of child caregivers (M2) and spouse caregivers (M3) separately, no significant causal effects are found. This is probably due to the loss of statistical power, specially for the relatively small group of spouse caregivers. When looking at the between effects these reflect that caring for a parent is significantly associated with lower well-being, while caring for a partner is not. Nonetheless, H1a is rejected as no significant differences are found among caregiver groups in terms of causal effects.

Finally, there is only weak evidence of gender differences in the effect of care over well-being for the group of partner caregivers (M3). According to the results, the well-being of women seems to increase after providing care to an elderly partner, but the interaction is only significant with a confidence level of 0.9. Therefore, H1b is also rejected.

In conclusion, there is evidence that providing family elderly care decreases well-being but no reasons to assume that this effect differs based on the caregiver's relationship to the care receiver or gender. Moreover, health, employment and partnership status causally affect well-being in all models, and women consistently report significantly lower well-being than men.

2.2 Caregiving and preferences for family or state responsibility

Table 4 shows the estimated coefficients for the within and between effects of caregiving, well-being and other covariates on preferences for family or state responsibility for elderly care. First and foremost, the models strongly support the existence of a causal effect of caregiving on preferences (M1) but, contrary to expectations, respondents become more familialistic after providing care. Therefore, H2 is rejected.

Considering child (M2) and partner (M3) caregivers separately, the impact of caregiving in preferences is only visible for the first group. Those who provide care to an elderly parent become more supportive of family responsibility, while those who care for a partner experience no change in their preferences. This difference is visible both within and between respondents.

Furthermore, the familialising effect of caregiving seems to only affect men, as significant negative interaction effects are found for female caregivers in M1 and M2. A positive causal effect of well-being on preference for family responsibility is also found, as well as familialising effects of age and living with parents, and a defamilialising effect of having children. No significant gender differences are observed in terms of preferences.

Table 4: Within-Between Models for Preferences for Family Responsibility

	M1 (<i>x=cares</i>)	M2 (<i>x=cares for parent</i>)	M3 (<i>x=cares for partner</i>)
Within Effects			
<i>Cares: yes</i>	0.20***	0.48***	−0.01
<i>Well-being</i>	0.11***	0.07***	0.05 ⁺
<i>Age</i>	0.03***	0.04***	0.03***
<i>Not in paid employment</i>	0.03	0.05	0.03
<i>Partner: non-cohabiting</i>	0.17***	−0.11	−0.09
<i>Partner: no partner</i>	0.30***	−0.10	0.07
<i>Lives with parents: yes</i>	0.91***	0.93***	0.89***
<i>Has children: yes</i>	−0.36***	−0.13**	−0.10*
<i>Edu: ISCED 3</i>	1.20	1.05	0.57
<i>Edu: ISCED 4-5</i>	1.12	0.96	0.54
<i>HH Income: 1500-3000</i>	−0.06	0.01	0.02
<i>HH Income: > 3000</i>	−0.10 ⁺	−0.07	−0.10 ⁺
Between Effects			
<i>Intercept</i>	3.42***	3.34***	3.42***
<i>Cares: yes</i>	0.17 ⁺	0.32***	−0.25
<i>Well-being</i>	0.02	0.01	0.01
<i>Age</i>	0.00	0.00	0.00
<i>Not in paid employment</i>	0.05	0.06	0.02
<i>Partner: non-cohabiting</i>	−0.07	−0.06	−0.02
<i>Partner: no partner</i>	−0.00	−0.00	0.00
<i>Lives with parents: yes</i>	0.57***	0.55***	0.48***
<i>Has children: yes</i>	0.06	0.03	0.01
<i>Edu: ISCED 3</i>	−0.11***	−0.11***	−0.12***
<i>Edu: ISCED 4-5</i>	−0.21***	−0.21***	−0.21***
<i>HH Income: 1500-3000</i>	−0.11*	−0.09 ⁺	−0.08
<i>HH Income: > 3000</i>	−0.06	−0.05	−0.05
<i>Gender: female</i>	0.01	0.01	−0.01
Cross-Level Interactions			
<i>Cares * female</i>	−0.26**	−0.56***	−0.04

3-Wave panel observations nested in individuals, N= 4834 *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$, + $p < 0.10$

2.3 Causal Mediation

Table 5 shows the estimated Average Causal Mediation Effects (ACME) and Average Direct Effects (ADE) for a sample of women and one of men using each of the variations of the caregiving indicator. The evidence does not provide support for the existence of a mediated causal effect, which leads to rejecting H3. Only for the group of male caregivers of a partner is there a significant negative ACME, but given that the total effect is not significant and the proportion mediated is very small, the evidence is insufficient to accept H3.

Positive significant effects are found for the group of male caregivers of a parent, an observation that is coherent with the results obtained in Table 4. It can be concluded that, although caregiving is associated with lower well-being, it does not increase support for state responsibility. More specifically, it has no effect on the preferences of women, while men become more supportive of family responsibility when they take care of an elderly parent, but not if the care receiver is their partner.

Table 5: Causal Mediation Analysis

	<i>Female</i>			<i>Male</i>		
	<i>Cares</i>	<i>Cares for parent</i>	<i>Cares for partner</i>	<i>Cares</i>	<i>Cares for parent</i>	<i>Cares for partner</i>
ACME	0.00	0.002 ⁺	−0.01	−0.00	0.00	−0.02 [*]
ADE	−0.00	−0.01	0.08	0.16 ^{***}	0.33 ^{***}	−0.04
Total	−0.00	−0.01	0.08	0.16 ^{***}	0.33 ^{***}	−0.06
Proportion Mediated	0.00	−0.03	−0.00	−0.02	0.01	0.05

3-Wave panel observations nested in individuals N female sample = 1995, N male sample = 1429

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

Nonetheless, when interacting caregiving and well-being for different gender groups (Table 6), the results are compatible with the study's argument. While no significant causal effects whatsoever are found for women, among men we find that, although caregiving increases preference for family responsibility, the effect is highly dependent on the caregiver's well-being, as indicated by the sizeable interaction effects. When male caregivers of an elderly parent experience low well-being, they become more supportive of state responsibility.

Table 6: Preferences and the interaction of caregiving and well-being for gender groups

	<i>Female</i>	<i>Male</i>
<i>Within effects</i>		
<i>Cares: yes</i>	−0.08	0.42 ^{***}
<i>Cares for parent: yes</i>	−0.10	0.51 ^{***}
<i>Cares for partner: yes</i>	−0.02	−0.05
<i>Cares * well-being</i>	−0.16	2.27 ^{***}
<i>Cares for parent * well-being</i>	−0.15	2.21 ^{***}
<i>Cares for partner * well-being</i>	−0.76	2.09 ⁺

3-Wave panel observations nested in individuals, $N = 4830$ (2784 female, 2046 male)

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

Therefore, providing care has an impact on preferences for family or state responsibility but only when the caregiver is a man and the care receiver is an elderly parent. Moreover, the effect's direction (towards family or state responsibility) depends on the well-being of the caregiver. However, no evidence of causal mediation has been found, suggesting that a moderation model might be a more accurate representation of the causal mechanism at play.

Discussion

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

After analysing panel data from years 2005, 2008 and 2011 in France the results do not support the study's overarching argument. First of all, while there is a clear negative association between giving care to an elderly parent and well-being, the evidence for a causal effect is weak. For those respondents who provide care to an elderly partner, nor a within causal effect neither a between association were found. Second, providing elderly care does have a causal impact on preferences, but only for male caregivers of an elderly parent and, contrary to expectations, caregivers in this group become more supportive of family responsibility after providing care, not the other way around.

Well-being is also a causal predictor of preferences and, as expected, a decrease in well-being is associated with a stronger preference for state responsibility. However, the Causal Mediation analysis provides no support to the theory that the impact of caregiving on preferences is mediated by well-being. Instead, there is strong evidence that well-being functions as key moderator of the causal link between caregiving and preferences. When male caregivers of an elderly parent experience high levels of well-being, they become more supportive of family responsibility, while caregiving increases support for state responsibility in those cases where the caregiver's well-being is low. Thus, a moderation model appears to be a better fit to describe the causal mechanism connecting these three variables.

In conclusion, women and caregivers of an elderly partner do not experience changes in their preferences due to caregiving, but men who provide care to an elderly parent do and the direction of these changes strongly depends on their well-being. That only men's preferences change due to providing care to an elderly parent might have to do with a weaker influence of family responsibility norms on their opinion and behaviour. While there is evidence that daughters are more likely to feel an obligation to take responsibility for their parents' care needs (Ehrlich et al., 2020), the preferences of sons might be more often based on self-interest calculations of their own well-being. As sons tend to provide sporadic rather than intensive care, their well-being is generally not affected by caregiver burden, strengthening preference for family responsibility. However, in those occasions where caregiver experience a decrease in well-being, self-interest leads to increased demands for state responsibility.

Considering that male caregivers constitute only one of every four caregivers of an elderly parent in the study's sample, and that half of them report no well-being problems, the conclusion is that most family caregivers do not become more supportive of state responsibility after providing care. Therefore, based on this study's findings it is unlikely that pressures from French family caregivers for an increase in state responsibility will increase.

The study's conclusions must be treated with caution in light of some limitations. First and foremost, as discussed above the operationalization of the dependent variable is not ideal, as it cannot be assumed that "society" and "state" are equivalent terms. Nevertheless, it can be argued that "responsibility of society" as opposed to "responsibility of the family" represents a proxy for a greater degree of involvement of the state, which institutionally represents society as a whole. Moreover, 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, particularly in terms of studying family elderly care, and by the availability of panel data. In this sense, the GGS represents the most appropriate dataset to test the article's hypotheses. Moreover, the analyses have been conducted on a representative sample of the French population, and their conclusions can therefore not be generalised to a wider context, although the arguments exposed in the theoretical section of the paper are 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. 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.

References

- Antonakis, J., Bendahan, S., Jacquart, P., & Lalive, R. (2010). On making causal claims: A review and recommendations. *The leadership quarterly*, 21(6), 1086-1120.
- Bastawrous, M. (2013). Caregiver burden—A critical discussion. *International journal of nursing studies*, 50(3), 431-441.
- Bengtson, V. L., & Roberts, R. E. (1991). Intergenerational solidarity in aging families: An example of formal theory construction. *Journal of Marriage and the Family*, 856-870.
- Besnard, X., Brunel, M., Couvert, N., & Roy, D. (2019). Les proches aidants des seniors et leur ressenti sur l'aide apportée. Résultats des enquêtes «CARE» auprès des aidants (2015-2016)». *Les Dossiers de la DREES*, 45, 1-38.
- Blekesaune, M. (2007). Economic conditions and public attitudes to welfare policies. *European Sociological Review*, 23(3), 393-403.
- Boneschi, S., & De L'Espinay, A. M. (2022). Aides à l'autonomie des personnes âgées: qui paie quoi? L'apport du modèle Autonomix—Résultats 2019. *Les dossiers de la DREES*, (99), 2022-07.
- Brunel, M., & Carrère, A. (2017). Les personnes âgées dépendantes vivant à domicile en 2015. Premiers résultats de l'enquête CARE «ménages». *Études et Résultats, DREES*.
- Casado-Mejía, R., & Ruiz-Arias, E. (2016). Influence of gender and care strategy in family caregivers strain: A cross-sectional study. *Journal of Nursing Scholarship*, 48(6), 587-597.
- Daatland, S. O., & Herlofson, K. (2003). 'Lost solidarity' or 'changed solidarity': a comparative European view of normative family solidarity. *Ageing & Society*, 23(5), 537-560.
- Daatland, S. O., Slagsvold, B., & Lima, I. A. (2009). Population ageing, intergenerational solidarity and the family-welfare state balance: A comparative exploration. *United Nations Economic Commission for*

Europe (ed.), *How Generations and Gender Shape Demographic Change: Towards Policies Based on Better Knowledge*, Geneva, United Nations, 127-138.

Da Roit, B., Le Bihan, B., & Österle, A. (2007). Long-term care policies in Italy, Austria and France: variations in cash-for-care schemes. *Social Policy & Administration*, 41(6), 653-671.

Dykstra, P. A., & Fokkema, T. (2011). Relationships between parents and their adult children: A West European typology of late-life families. *Ageing & Society*, 31(4), 545-569.

Eckert, J. K., Morgan, L. A., & Swamy, N. (2004). Preferences for receipt of care among community-dwelling adults. *Journal of aging & social policy*, 16(2), 49-65.

Ehrlich, U., Möhring, K., & Drobnič, S. (2020). What comes after caring? The impact of family care on women's employment. *Journal of Family Issues*, 41(9), 1387-1419.

Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. Princeton University Press.

Fang, F., & Yang, X. (2023). Socioeconomic status, cultural values, and elderly care: An examination of elderly care preference in OECD countries. *Aging and Health Research*, 3(3), 100153.

Frericks, P., Jensen, P. H., & Pfau-Effinger, B. (2014). Social rights and employment rights related to family care: Family care regimes in Europe. *Journal of Aging Studies*, 29, 66-77.

Ganga-León, C. (2024, April). Emotion Work of Paid and Unpaid Caregivers of the Elderly in Chile. In *International Conference on Gender Research* (Vol. 7, No. 1, pp. 485-487).

Gauthier, A. H., & Emery, T. (2014). Generations and Gender Programme: A Research Infrastructure For Analyzing Relationships over the Life-Course. In *Facing the Future: European Research Infrastructures for the Humanities and Social Sciences* (pp. 99-108). SCIVERO Verlag.

Gauthier, A. H., Cabaço, S., & Emery, T. (2018). Generations and Gender Survey study profile. *Longitudinal and Life course studies*, 9(4), 456-465.

Herlofson, K., Hagestad, G., Slagsvold, B., & Sørensen, A. M. (2011). Intergenerational family responsibility and solidarity in Europe. *Norwegian Social Research*.

Hajek, A., Lehnert, T., Wegener, A., Riedel-Heller, S. G., & König, H. H. (2017). Factors associated with preferences for long-term care settings in old age: evidence from a population-based survey in Germany. *BMC Health Services Research*, 17, 1-9.

Hwang, W., Kim, J. H., Brown, M. T., & Silverstein, M. (2022). Are filial eldercare norms related to intergenerational solidarity with older parents? A typological developmental approach. *Journal of Family Psychology*, 36(4), 585.

Imai, K., Keele, L., & Tingley, D. (2010). A general approach to causal mediation analysis. *Psychological methods*, 15(4), 309.

Imai, K., Keele, L., Tingley, D., & Yamamoto, T. (2010). Causal mediation analysis using R. In *Advances in social science research using R* (pp. 129-154). Springer New York.

Janus, A. L., & Koslowski, A. (2020). Whose responsibility? Elder support norms regarding the provision and financing of assistance with daily activities across economically developed countries. *European Journal of Ageing*, 17(1), 95-108.

Kalmijn, M., & Saraceno, C. (2008). A comparative perspective on intergenerational support: Responsiveness to parental needs in individualistic and familialistic countries. *European Societies*, 10(3), 479-508.

Kaufmann, O. (2018). Long-Term Care Benefits under the French Social Protection System. *Long-Term Care in Europe: A Juridical Approach*, 93-119.

- Le Bihan, B. (2018). *ESPN Thematic Report on Challenges in long-term care. France* (Doctoral dissertation, European Commission. European Social Policy Network (ESPN)).
- Le Bihan, B., & Martin, C. (2012). Steps toward a long-term care policy in France: Specificities, process, and actors. In *Reforms in long-term care policies in Europe: Investigating institutional change and social impacts* (pp. 139-157). New York, NY: Springer New York.
- Leitner, S. (2003). Varieties of familism: The caring function of the family in comparative perspective. *European societies*, 5(4), 353-375.
- Linos, K., & West, M. (2003). Self-interest, social beliefs, and attitudes to redistribution. Re-addressing the issue of cross-national variation. *European Sociological Review*, 19(4), 393-409.
- Liu, Z., Heffernan, C., & Tan, J. (2020). Caregiver burden: A concept analysis. *International journal of nursing sciences*, 7(4), 438-445.
- Lu, J., Zhang, L., & Zhang, K. (2021). Care preferences among Chinese older adults with daily care needs: individual and community factors. *Research on aging*, 43(3-4), 166-176.
- Mair, C. A., Chen, F., Liu, G., & Brauer, J. R. (2016a). Who in the world cares? Gender gaps in attitudes toward support for older adults in 20 nations. *Social Forces*, 95(1), 411-438.
- Mair, C. A., Quiñones, A. R., & Pasha, M. A. (2016b). Care preferences among middle-aged and older adults with chronic disease in Europe: Individual health care needs and national health care infrastructure. *The Gerontologist*, 56(4), 687-701.
- Martin, C., Math, A., & Renaudat, E. (1998). Caring for very young children and dependent elderly people in France: Towards a commodification of social care?. In *Gender, social care and welfare state restructuring in Europe* (pp. 139-174). Routledge.
- Meltzer, A. H., & Richard, S. F. (1981). A rational theory of the size of government. *Journal of political Economy*, 89(5), 914-927.
- Montgomery, R. J., Gonyea, J. G., & Hooyman, N. R. (1985). Caregiving and the experience of subjective and objective burden. *Family relations*, 19-26.
- Morel, N. (2007). From subsidiarity to 'free choice': Child-and elder-care policy reforms in France, Belgium, Germany and the Netherlands. *Social Policy & Administration*, 41(6), 618-637.
- Olmos, A., & Govindasamy, P. (2019). A practical guide for using propensity score weighting in R. *Practical assessment, research, and evaluation*, 20(1), 13.
- Or Z., Gandré C., Seppänen A. V., Hernández-Quevedo C., Webb E., Michel M., Chevreul K. (2023). France: Health system review. *Health Systems in Transition*, 2023; 25(3): i–241.
- Palriwala, R. (2019). Framing care: Gender, labour and governmentalities. *Indian Journal of Gender Studies*, 26(3), 237-262.
- Pinquart, M., & Sörensen, S. (2011). Spouses, adult children, and children-in-law as caregivers of older adults: a meta-analytic comparison. *Psychology and aging*, 26(1), 1.
- Reher, D. S. (2004). Family ties in Western Europe: persistent contrasts. In *Strong Family and Low Fertility: A Paradox? New Perspectives in Interpreting Contemporary Family and Reproductive Behaviour* (pp. 45-76). Dordrecht: Springer Netherlands.
- Savundranayagam, M. Y., Montgomery, R. J., & Kosloski, K. (2011). A dimensional analysis of caregiver burden among spouses and adult children. *The Gerontologist*, 51(3), 321-331.
- Schmid, T., Brandt, M., & Haberkern, K. (2012). Gendered support to older parents: do welfare states matter?. *European journal of ageing*, 9, 39-50.

Silverstein, M., Gans, D., & Yang, F. M. (2006). Intergenerational support to aging parents: The role of norms and needs. *Journal of family Issues*, 27(8), 1068-1084.

Sowa-Kofta, A., Marcinkowska, I., Ruzik-Sierdzińska, A., & Mackevičiūtė, R. (2021). Ageing policies - access to services in different Member States.

Theobald, H., & Luppi, M. (2018). Elderly care in changing societies: Concurrences in divergent care regimes—A comparison of Germany, Sweden and Italy. *Current Sociology*, 66(4), 629-642.

Vikat, A., Spéder, Z., Beets, G., Billari, F. C., Bühler, C., Désesquelles, A., ... & Sola, A. (2007). Generations and Gender Survey (GGS) Towards a better understanding of relationships and processes in the life course. *Demographic research*, 17, 389-440.

Wielink, G., Huijsman, R., & McDonnell, J. (1997). Preferences for care: A study of the elders living independently in the Netherlands. *Research on Aging*, 19(2), 174-198.

Zhou, T., Tong, G., Li, F., & Thomas, L. E. (2020). PSweight: An R package for propensity score weighting analysis. *arXiv preprint arXiv:2010.08893*.