

# Does the family care best? Ideals of care in a familialistic care regime<sup>‡</sup>

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## Introduction

To develop effective social policies to support older people in need of long-term care and their carers, it is highly important to understand the existing context in which the respective social policy should intervene. Countries differ in how care is organized. In the field of social policy, these differences are captured with concepts such as the care regime (Esping-Andersen, 1990), which identifies different countries sharing similarities in the distribution of responsibilities between the state and other actors. The family is a particularly important actor to look at, because of the extent of care provided and the significance of the distribution of care work for social inequalities – namely, gender and socio-economic status inequality. The care regime literature uses the concept of familism (Esping-Andersen, 1999; Saraceno and Keck, 2010) to differentiate if and how the family is seen as responsible for care when comparing different social policies. Different types of familism describe different ways of distributing care work between the family and other actors.

In the care regime literature, familism is discussed in relation to social policies. Caregiving and receiving is not only shaped by certain social policies, it is simultaneously also a lived experience. To understand familism in a more extensive way, we need to also understand the lived experience in more depth by taking on the perspectives of those who give and provide care – not least because transformation processes over time and the impact of specific social policies will result from the interaction of social policies with the perspectives grounded in experiences of caregivers and receivers. These perspectives are part of care cultures (Fine, 2015) and encompass among other elements different ideals of care. Care cultures,

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describing the meanings and organization of care, can be identified within and across countries. Previous research has shown how care cultures are shaped e.g. by gender and class (Kremer, 2007; Broese van Groenou *et al.*, 2006). An example is the difference in expectations regarding intergenerational caregiving based on different socio-economic backgrounds studied by Conlon *et al.* (2014) in Ireland. This difference results in higher expectations for women with lower socio-economic backgrounds to provide informal care. Research on the perspectives of caregivers and care receivers is scattered and highlights contrasting findings for the Austrian context (Schmidt, 2018), with higher expectations on middle and higher socio-economic groups to provide informal care. How gender and socio-economic status are embedded in particular care cultures is important, to know how to develop policy measures to reduce social inequalities. At the same time, a better understanding of care cultures and their subtleties is required to be able to describe familialistic countries in more detail and to use this knowledge for the development of social policies. With this paper, we aim to contribute to this goal with an in-depth analysis of the experiences of those who are caregivers and receivers in upward intergenerational care dyads and combine formal and informal care in Austria. We study individuals who use a care-mix (formal and informal care) whose ideals reflect the experience with both types of care and are not shaped exclusively by only one of them. Moreover, combining formal and informal care is increasingly becoming a more important care arrangement in Austria (Ilinca and Rodrigues, 2019). As reflected in our sample, it is also taken up by different population groups (e.g. women and men, urban and rural, with and without migration background, married and widowed, high and low socio-economic background) and thus less likely to be confounded with just one particular subgroup.

This paper aims to contribute to a better understanding of familialism through an investigation of the care cultures that are linked to it. It takes the example of Austria as a familialist country (Österle and Bauer, 2012) and here particularly the experiences linked to upward intergenerational caregiving among those who combine formal and informal care to examine if and how the key role of the family in familialism is mirrored in the ideals of care of caregivers and care receivers. Furthermore, it investigates whether the care culture is significantly shaped by social inequalities with the examples of gender and socio-economic status. Thus, we also examine whether ideals of care are patterned across gender and socio-economic status among those who practice a care-mix. A better understanding of the Austrian case can then also be used for comparison with other countries that are comparable in terms of familialism. Depending on the particular lens used to define familialism and the current development of care regimes, these are e.g. Belgium, France, Luxembourg and Germany (Leitner, 2003) or Germany, Italy, Spain and England (Le Bihan *et al.*, 2019).

### Types of familialism and the social policy context in Austria

Familialism is a concept that emerged in the tradition of research on welfare and care regimes which focuses on care and the relation between the family and the state (Esping-Andersen, 1990; Leitner, 2003; Le Bihan *et al.*, 2019). While the analysis of welfare regimes focuses on the distribution of resources, the study of care regimes is interested in the link between the state and the family to understand how care is provided based on the respective social policies in different countries (Bettio and Plantega, 2004). Over time, this field has developed a variety of typologies to characterize different forms of familialism in more detail. An early example is Leitner's (2003) typology which describes familialism in different degrees. As Leitner demonstrates, a country's categorization varies depending on which area of care one is studying: with childcare and care for older people as two cases in point.

Leitner (2003) also includes the ways in which policies impact gender relations in her typology and distinguishes between gendered and de-gendered familialism. The former enforces traditional gender roles; the latter weakens them. De-gendered and gendered versions of the same type of familialism are possible. Support for formal and informal care was often treated as two opposing options in the analysis of care regimes, but support for one type of care does not necessarily go hand in hand with less support for another type of care (Eggers *et al.*, 2020). Accordingly, some countries (England) support formal and informal care, whereas others (Italy) do not provide much support for any type of care.

Austria has been consistently depicted as a familialist country (Kreimer, 2006; Österle and Bauer, 2012). In Leitner's typology, it is described as explicitly familialist because of the existence of a care allowance. In Schmid *et al.*'s typology (2012) further reasons for this classification were at the time of writing a relatively limited access to public services and legal obligations to (co)-finance care. More recently, Le Bihan *et al.* (2019) described it as an example of optional familialism through the market, since the care allowance is thought of as compensating for informal care but options to buy services are increasingly available too. Care policies include the care allowance based on an assessment of hours of care needed, social insurance, care leave, respite care and options to reduce working hours to part-time work for informal carers (Bundesministerium Soziales, Gesundheit, Pflege und Konsumentenschutz, 2021). The care allowance is not meant to cover all costs of care but to contribute to covering them. Looking at Austrian care policy from a family care regime perspective (Frericks *et al.*, 2014), informal carers have some social rights but family care is not formalized similar to e.g. Denmark. Austria is an example of a country with high levels of intergenerational care, in which caregiving is particularly unequally distributed between women and men (Schmid *et al.*, 2012). The care allowance, cultural norms and the gendered division of labour are further strengthening the role of women in caregiving (Haber Kern *et al.*, 2015). Reforms such as the

TABLE 1. Sample description (number of participants): Age, Gender, SES

	Care receiver	Caregiver
<b>Age</b>		
36-39		1
40-49		4
50-59		10
60-69	1	6
70-79	4	3
80-89	10	
90-98	9	
<b>Gender</b>		
Female	19	17
Male	5	7
<b>SES</b>		
low	8	5
middle	11	10
high	5	9
<b>Frequency of care services received</b>		
Daily	17	
More than once a week	4	
Weekly or less	3	

introduction of the care allowance in, 1993, the regularization of migrant live-in carers in 2007 and increased availability of care services did not diminish the family orientation and importance of informal care (Österle and Bauer, 2012). While employment for migrant live-in carers and for care workers in residential facilities rose (Da Roit and Moreno Fuentes, 2019), the reforms in Austria did not lead to informal caregiving parity between women and men and the significance of the male breadwinner model persists (Kreimer, 2006; Sardadvar and Mairhuber, 2018). This seems to confirm the critique of cash-for-care schemes as policies that could act towards reinforcing gender inequalities (Rummery, 2009). The combination of care and work remains difficult and brings several disadvantages in different life domains and in terms of financial and social security for informal carers (Sardadvar and Mairhuber, 2018).

### **The lived experience of familialism and the diversity of ideals of care**

While research on welfare state policies often defines culture narrowly in terms of the ideas to which welfare state policies refer, we take a broader understanding (Pfau-Effinger, 2005). Culture is also important in terms of the values of caregivers and care receivers. Individuals are not only acting based on economic rationality, but also on moral rationality (Pfau-Effinger, 2005), and it is specifically the realm of cultural values, norms and ideals (Van Oorschot *et al.*, 2008; Budig *et al.*, 2012) we are interested in. Within the same care culture, these

different elements influence each other. The perspective we use focuses on beliefs about good care as part of a care culture in which social policies intervene. Such understandings will guide caregivers and care receivers in their practices of care alongside the options given to them through different social policies.

Hochschild (1995) distinguishes four different ideals (traditional, postmodern, cold-modern and warm-modern) which describe ways of distributing care and variations regarding the extent to which care is perceived to be needed (unpaid informal care by women, reduced need of care, only formal care, formal care through public institutions together with informal care shared between women and men). Thus, similar to the discussion of variations of familialism in social policy, we see a differentiation in terms of the role of the family which is also linked to different gender relations.

But there's not only variation regarding the role of the family in particular, ideals of care can also refer to different understandings of what care is about. Care has been described as a 'relationship-based process' (Fine, 2014), emphasising those aspects that go beyond the physical execution of tasks. If several people are involved in care and some care is also bought, the stress associated with upward intergenerational caregiving can be reduced (Kyungmin *et al.*, 2017). Previous research has conceptualized family solidarity as based on norms of familism of parents and children as well as affection (Bengtson and Roberts, 1991). In care research, this is also described with the difference between caring for (through the completion of individual care tasks) and caring about (as a demonstration of concern for a person's wellbeing) (Ungerson, 2005). Preferences for how much care should ideally be about carrying out a care task and how much it should focus on caring about the user are similarly varied (Rodrigues, 2019). The relationships developing around care are also relationships of power (e.g. Kittay, 1999). As Graham and Bassett (2005) argue, the co-constructed character of such relationships has often been overlooked due to a focus on the carer. Care relationships should not be conceptualized as one-directional. Care receivers might also teach carers (England and Dyck, 2011).

Care also comprises physical interaction, and help with personal hygiene is one particular example of such interactions. Women are more often providing support with personal hygiene. Following Twigg (2004), this is due to the closeness of personal hygiene and intimacy and general understandings of male sexuality. Twigg argues that since women are often viewed in a maternal and asexualized framework, they are preferred for this type of work. Others found preferences of same-sex caregivers regarding physical care (Arber and Ginn, 1994). Beyond the particular question of support with personal hygiene, research also demonstrates gendered understandings of a caring role. Finch and Mason (1993) discuss this in terms of how women and men negotiate social guidelines and relationships with their kin throughout their lives which lead to women providing more informal care than men. Research on the availability of

health and care services found that with the availability of services, informal care tends to specialize in those forms of support that are less demanding and more spontaneous, as opposed to support that is linked to physical care (Brandt *et al.*, 2009).

While ideals exist in the general population, we argue that the ideals of those who give and receive care, and are thus part of care convoys (Kemp *et al.*, 2013), are particularly interesting. Those who provide or receive care have to bring their general understanding of the role of the family in care, intergenerational relationships and good care together with their own practices of being part of a care arrangement and options in a particular care regime. In those instances, where people practice a care mix, they have chosen to include both formal and informal care and their ideals of care will thus be informed by the experience of both. While we have a good understanding of the details of the social policy dimension of familialism in Austria, we don't know so much about the details of familialism among those who are part of care arrangements. Our first research question is therefore: how is Austrian familialism depicted from the perspectives of caregivers and care receivers practicing a care mix through ideals of care?

In a study comparing countries from different care regimes regarding filial norms, participants in Germany did not hold the view that parents are entitled to care from their children or that children should live close to their parents as often as participants in Spain or Israel (Lowenstein and Daatland, 2006). Previous research highlighted the link between attitudes towards care homes and social inequalities (Sudha and Mutran, 1999). That ideals of care are not homogenous within a country, but further differentiated by social inequalities, is also shown by Dykstra and Fokkema's (2012) research on the strength of filial norms in the Netherlands – which highlights that those norms are stronger among those with fewer years in education, with religiosity and with migration experience. In their study, men also have stronger filial norms than women.

As demonstrated, culture encompasses more than the cultural values referred to in the discussion of social policies. Different roles of the family and different understandings of care as well as different filial norms describe aspects of the lived experience of care and care cultures. Based on these findings on the importance of social inequalities and particularly class and gender for care norms and ideals in other countries, our second research question is: how are the ideals of care among those practicing a caremix patterned across gender and class in Austrian familialism?

## Methods

The study employed semi-structured face-to-face in-depth interviews with care dyads. The dyads include an older person who is a beneficiary of the care

allowance (*Pflegegeld*) as the care recipient and their child or grandchild acting as the main informal caregiver. The Austrian care allowance is paid out based on seven levels depending on care needs (65 to more than 180 hours per month). The lowest level amounts to 162,5 Euros per month (Bundesministerium Soziales, Gesundheit, Pflege und Konsumentenschutz, 2021). All dyads received also some form of formal care. Qualitative methods were chosen to have a more in-depth understanding of the perspectives of dyads regarding ideals of care, prevailing norms and preferences and to be able to capture these concepts in their full complexity and nuances across different groups. The sampling strategy aimed to collect a diverse set of dyads including women and men and participants with different SES. The SES of care recipients was defined around housing ownership, educational background and income, while for informal carers, SES was defined around occupation and education.

To overcome the former focus on the perspective of caregivers (Lyons *et al.*, 2002), we studied care dyads, in line with recent calls for more relational data (Hudson *et al.*, 2018). We view care as encompassing a relational aspect that includes emotions (caring relationships) as well as power and reciprocity. To study these elements, dyadic research is the ideal setting. The study is based on 48 interviews with 24 care dyads. The dyads include the care recipient and their main informal caregiver. All care recipients lived in a private home, received *Pflegegeld* and also some formal care. The latter included mobile care and/or attendance of a day care centre and in one case live-in carers. By studying those dyads who use a caremix, we ensured that participants had experience with both formal and informal care. While we sampled for diversity of gender and SES (most dissimilar study design), we chose a most similar study design regarding the experiences with different types of care. This was done to allow us to isolate factors pertaining to care culture and ideals, which might have been obscured with more diversity in terms of the care arrangements. 21 caregivers were the adult children of the care recipients, two were their adult grandchildren and one was the son in law of the care recipient. In two dyads, caregiver and care recipient were co-habiting. Furthermore, 12 dyads included a mother and a daughter, 4 a son and a mother, 3 a daughter and a father.

Participants were recruited through snowballing, organisations offering mobile care services, GPs and local organizations (churches and community centres). Purposive sampling was used with the aim of having a diverse sample in terms of gender and SES. Participants who received care were aged 60 and older and their cognitive capacity allowed them to be interviewed. The study was part of a larger comparative study involving Austria and Slovenia and received ethical approval from the research ethics committee of the Faculty of Social Sciences of the University of Ljubljana. Written informed consent was gathered from each interviewee.

Interviews were conducted face-to-face between February and July 2019 and lasted between 20 and 70 minutes. The interviews were semi-structured using a prepared topic guide as a starting point, which included prompts and open-ended questions covering four areas: life-course decisions on care; the moment of needing care; providing care; and paying for care. All participants were interviewed individually, except for three interviews with care recipients in which caregivers or partners were present upon request of the care recipient. Most participants were interviewed in the home of carer or care recipient. Close to one third of the interviews took place in work places, cafes and day care centres. All interviews were audio recorded and transcribed verbatim. Socio-demographic information of each interviewee was gathered in a short questionnaire before each interview.

Data analysis was based on the framework method (Ritchie and Lewis, 2003). The transcripts were initially segmented by two of the authors (SK, RR) with regular discussions to solve differences in terms of the segmentation. From this, SK, RR and RK selected codes for the analysis of the research question. SK, RR and RK analysed the data, developing further subcodes and discussing the analysis in regular meetings. The different ideals of care were written up and further discussed with SH. After refining the ideals, their distribution according to gender and SES was analysed to identify patterns. Transcripts were analysed using the data analysis software MAXQDA and MS Office.

## Results

We identified four different ideals in interviewees' stories about caregiving and -receiving: an ideal viewing the family as the ideal provider, an ideal in which good care is primarily based on the care receiver's and carer's personal preferences, an ideal based on the involvement of the care receiver in decision-making and a gendered care ideal. We analysed the care ideals of all individuals interviewed separately, but also report the respective number of dyads describing an ideal. The ideals are not distinct – one individual often describes more than one care ideal.

### Family care ideal

The family care ideal appears in two different versions. In one, care is part of a history of exchanges within the family and thus to some extent conditional upon previous care from the care receiver. In the other version, it is linked to the special character of parent-child relationships, which is understood as including informal care. Care is thus provided unconditionally to the care receiver, independently of previous support. The first version highlighting reciprocity is much more frequent than the second version. The family care ideal was described by 24 individuals, who were part of 18 dyads.



A recurrent theme in the interviews of both care receivers and their family carers was care as part of broader intergenerational exchanges taking place within families. For the majority of dyads interviewed there was a history of previous exchanges within the family that were presented by some interviewees in an explicit way. In these cases, informal care was seen as part of reciprocal exchanges where parents/grandparent and children/grandchildren felt they were receiving/giving something back. In these narratives, interviewees offered examples of how relatives or themselves had been there for them in the past:

*“Yes, I raised him [grandchild] and that’s why he says ‘Yes, granny, you have done so much for me in my life, I will pay you back now. I’m here for you now.’”* – care receiver, female, 92 years

The interpretation of care as reciprocal support was particularly strong among the few dyads where grandchildren were the carers as in the above quote. The reciprocal nature of informal care could also be linked to the caring demeanour of the relative as when one daughter offered this explanation for caring for her mother: *“My mother really had no life of her own. She [has] always lived only for her children”* (carer, female, 63 years). Informal care was also described as a ‘family tradition’, literally passed on by example from one generation to the other.

*„[...] in our family it was always commonplace to help one another”* – carer, male, 40 years

The exchanges around informal care also involved directly rewarding care-giving, which further described the way reciprocity was defined by the dyads. For the most part, these exchanges were non-monetary rewards or gifts provided by parents to their children and grandchildren carers. Some of these gifts were given for Christmas and birthdays, although clearly meant as a token of appreciation for the care provided. Monetary exchanges linked to care were also present within the dyads, although they were an exception and usually took on a symbolic value (6 dyads). Some of these monetary exchanges were similar to tipping, as when parents rounded up the shopping bills of their family carers. Otherwise, monetary payments were given explicitly to the next generation (i.e. to grandchildren) and as such explicitly accepted by adult children carers, who otherwise frowned on being paid directly for care.

Among the dyads, the Austrian cash benefit (*Pflegegeld*) was overwhelmingly used to pay for the care services that supplemented or complemented the care provided by adult children. When this was not enough children paid out their own pocket for care for their parents – with one single exception these upward financial exchanges were confined to middle and upper SES carers. There were only two cases among dyads, where the cash benefit was explicitly used as ‘routed wage’ for the family carer. In both cases, the carer was of low SES.

We have seen how gift exchanges were overwhelmingly non-monetary. However, where monetary gifts to family carers were reported (such as tipping), these were pervasively concentrated among low SES care receivers or carers. For women, both carers and persons cared for, care was embedded in notions of reciprocity, even if these were sometimes less explicitly defined – such as in the previously provided example of care linked to the demeanour of the person cared for.

While reciprocity was evident in many narratives, there was also a small group of carers for whom family and in particular the parent-child relationship implied an obligation or duty to care that went beyond reciprocity. There were several facets to these narratives. For one, prior support was not deemed as a necessary condition for informal care to be provided. In fact, care could be provided despite recognition that in the past support and affection from the older relative had been found wanting:

*“My friend always said to me ‘put her in a home, she wasn’t friendly to you either’, isn’t it? I cannot do that, she is my mother after all” – carer, female, 63 years*

In the examples that describe this care ideal, the fact that the carer and the care receiver *get along* particularly well is never given as the reason for care provision in the family. The narratives are instead built around the view that informal care provision is part of relationships between parents and children. Even when care dyads include a grandparent and a grandchild, interviewees emphasised the parent-child-like character of their relationship when explaining the care arrangement.

The expectation of meeting relatives’ needs could also be understood as a form of peer pressure, sometimes linked to gender roles, that left interviewees uncomfortable:

*“and now he always says: ‘When are you going to retire?’ Because I think maybe his idea is that when I retire I’ll be there for him 24 hours a day” (carer, female 60 years).*

Conversely, there were concerns for the additional burden it could entail – a view expressed particularly by older relatives – as many children faced competing caring responsibilities such as caring for a partner with a chronic disease.

### **Personal preference ideal**

In contrast to the role prescribed to the family in the family care ideal, the personal preference ideal views good care as primarily fulfilling the preferences of the care receiver and the possible informal carer. The focus on preferences brings other aspects of care besides the question of the involvement of the family to the foreground: the preferences in the narratives of the care dyads relate to the care receiver being able to remain in their home and to the provision of bodily

care. Some of the preferences of care receivers and carers lead to the involvement of the family in care – if caregiving in the family enabled the care receiver to remain at home, or if the informal carer found it important that bodily care is provided in close relationships. The preference ideal focuses on general decisions on how care should be provided (e.g. where the care receiver lives, who provides bodily care). It was described by 26 individuals belonging to 20 dyads.

Many carers and care receivers referred to the care receiver's wish to remain in their home when explaining a care arrangement. This was sometimes related to the care receiver's home in a physical sense as the built environment and sometimes in the social sense of the social relations tied to their place of residency.

*“Well, the current arrangement is the ideal way. You have to say that. What we sort of put together, so to speak, what corresponds to my mother. And it is also where I can really identify with it. The “quick-quick, nursing home”, in my view, that would not have been it.” – carer, female 47 years*

Some care receivers primarily wanted to remain in their homes because they did not want to move to a care home. The care home was seen as a worse option because of restrictions imposed on the inhabitants, such as a prohibition on watching TV at night. This perception of care homes offering a lower quality of life was also echoed by some carers. Sometimes, the care home was seen as a threat to the care receiver's life:

*“[...] if I gave her to a home, I would not have her for long anymore” – carer, female, 70 years*

In contrast to place of residency, the preferences regarding the preferred type of carer when it came to bodily care were not homogenous. The topic of bodily care highlights the diversity of preferences – sometimes the family is seen as better suited due to the emotional bonds between informal carer and care receiver and the way in which bodily care was seen as being linked to ‘caring about’. Others would express preferences for bodily care being provided by formal carers and regarded it as too close for them to feel comfortable (6 caregivers of whom one is male).

### **Involvement ideal**

The involvement ideal defines good care around the involvement of the care receiver in decision-making. Thus, similar to the preference ideal, the involvement ideal focuses on decision-making. However, the involvement ideal emphasizes the involvement in everyday decision-making. In case the family is better able to facilitate and respond to the care receiver's decisions, this ideal could be seen as another indirect family care ideal, similar to some examples included in

the preference ideal. The involvement ideal was described by 17 individuals belonging to 17 dyads.

Being in control as an ideal of good care can be perceived in terms of the care recipients' control and/or coproduction over care decisions as well as in terms of their autonomy in daily life. The interviews show that family members follow the ideal of including the older person in the decision-making process of selecting among available care options. Ideally, the older person also would be able to make decisions in their daily lives. This includes how long to watch TV or when to make a coffee. Furthermore, for many older persons, it is still important to be capable of managing their money. Sometimes the involvement in everyday decision-making meant an increased burden for carers (for instance, regularly walking to the ATM machine for the care receiver rather than transferring money online). To gain more autonomy in their daily lives, older persons sometimes may choose to make adjustments tailored to their needs – for example, by increasing or decreasing hours of formal care. As an older person stated:

*“I just decided that. I said Nicole, I don't have any home help anymore, I cancelled that, I can go shopping for the money myself, I never need it”* – care receiver, female, 88 years

Involving the care receivers in decision-making processes sometimes meant making an extra effort on the side of the informal carer.

### **Gendered care ideal**

In the gendered care ideal, interviewees identified care with female gender and its perceived character traits. Mostly, this was brought up in relation to formal carers rather than in relation to family carers. In fact, caring and cared for family members do not strongly differentiate between the gender of their relatives and what care tasks are being performed. This indifference may also depend on the limited number of children or other available relatives (and their gender) within a family. For example, sometimes the older person has only children of one gender. If physical care was needed, this was mostly carried out by a formal carer. The gendered care ideal was described by 6 individuals from 6 dyads.

The gender of the carer seems more relevant for older persons when utilizing formal carers. The interviews reveal the prevalent perception that care – and bodily care in particular – is ideally performed by a person of the same gender. The reasons for this preference are feeling more comfortable and the same-gender carer knowing personal hygiene better for one's own gender, which was poignantly expressed by a daughter who cares for her father:

*“I would say a man should take care of a man and a woman should take care of a woman. When it comes to personal hygiene, I really think that's just something intimate*

*and special and that doesn't work particularly well across all genders, I think, frankly" – carer, female, 52 years*

However, some participants described links between gender and care that went beyond this preference for a same-sex carer. For them, character traits of men made them less fit for caring. The character traits that were seen as a hindrance to being a good carer were: to be hurried, to be badly organized, to be sometimes domineering (3 individuals).

*"The women that were here were much better than men because men (are) fast fast, and I need to go. I say 'I cannot so fast, it is a half hour' " – care receiver, female, 92 years*

Sometimes, the preference for women to provide care was not further explained, as in this case of a male care receiver: *"Well, I don't like it that much anyway, better with a woman"* (care receiver, male, 77 years). However, even in formal care relationships, many older persons learned to accept carers of the other gender after having experienced positive interactions with them. Thus, a gendered caring role was overridden by experiences with carers and the establishment of a relationship in these cases.

### **SES and gender**

In terms of SES, the ideals did not show a pattern of different SES groups describing different ideals in our sample. This suggests homogeneity of the ideals beyond different SES groups. However, within the family care ideal, the unconditional version of the ideal was described only by low and middle SES groups. However, we could find evidence of SES shaping practices that were linked to different ideals. Examples were that dyads including low SES individuals would in some cases use the Pflegegeld as a routed wage or that dyads with high SES individuals would organize formal carers for bodily care. Women and men also did not describe different ideals of care, but women described particularly the family care ideal and the involvement in decision-making ideal more often than men. Within the family care ideal, the version linked to reciprocity was described more often by women than men.

### **Discussion**

We demonstrate that the ideal of the family as a provider of care is anchored in different ways in the narratives of care dyads who practice a caremix, through a history of exchanges or because of the filial care duty associated with parent-child relationships. Moreover, we also describe alternatives to the family care ideal which were present in the data. These other ideals focus instead on other aspects of care or intrinsic characteristics of care, such as the importance of place (and continuity), bodily care, processes of decision-making and the significance of gender. Topics highlighting the specificity of care provision such as caring

about (Ungerson, 2005), the particularity of bodily care (Fine, 2005) and the care relationship as a relationship in which both carer and care receiver actively participate (Graham and Bassett, 2005) have an importance place in people's understandings of good care. The ideals that are alternatives to the family care ideal at times highlight the limits of the family care ideal (e.g. a preference for distant relationships in bodily care, particular genders being preferred for care or for bodily care) but these sometimes could also bring the family into care in an instrumental sense – because it could often also play an important role in fulfilling these other ideals.

Our research demonstrates that to describe familialism in Austria, ideals of care cannot be reduced to the family as a provider of care. Instead, alternative ideals such as individual preferences and involvement in decision-making are similarly important. It is likely that the central role of the family often emerges because the family is better able to achieve certain outcomes (e.g. ageing in place). This raises the question, whether this is also the case in other familialist care regimes. In contrast to existing literature on the importance of SES for the lived experience of familialism (e.g. Schmidt, 2018), we found that ideals are spread across low, middle and high socio-economic groups. Women and men also did not describe completely different ideals, although some ideals were described more often by women. We found evidence of a rare gendered care ideal, in which men are seen as less able to care because of ascribed male character traits. Thus, care ideals comprise an important role for the family, in some cases for those who identify as female, and simultaneously for individual preference and involvement in decision-making of care receivers.

While the gendered care ideal was rare for any type of care, gender could also be seen as a transversal element of all the care ideals. Similar to the intertwining of familialism and gender on the social policy side, the ideals have implications for the distribution of care work and gender relations. The ideals which are not explicitly gendered could still be seen as being implicitly linked with it. For example, the family care ideal, although not explicitly calling for women to provide care, could still often result in women rather than men taking up the role of the informal carer because they often earn less than men and have less secure jobs. Since the family can be instrumental in fulfilling the preference and involvement in decision-making ideal (enabling the care receiver to stay at home or empowering the care receiver in terms of decision-making), these ideals could also result in women providing more care than men because of women earning less than men (and therefore being more available for care) or perceived links between femininity and care. The gendered care ideal, which includes a preference for either women in general to provide care or same-sex bodily care, could (through the fact that more women than men receive care) again lead to women providing overall more informal care than men.

We could not find evidence of the importance of SES (Sudha and Mutran, 1999; Dykstra and Fokkema, 2012; Timonen *et al.*, 2013) for care ideals. This could be a particularity of the group we studied or be linked to different approaches to conceptualizing ideals and how much practices are taken as evidence of ideals in other research. We found evidence of SES differences regarding practices (e.g. how the care benefit is used, who carries out what type of care) but not in terms of ideals. This suggests that the differences in the practices aren't the result of diverging understandings of good care in different SES groups, but rather effects of the uneven distribution of resources.

### Conclusion

Among those who practice a caremix and therefore also have experience of formal care, the family continues to play an important role in the provision of good care. The ideals, which did not necessarily involve the family, sometimes again required it to be involved in care but less for normative and more for instrumental reasons. The family can be well positioned to allow the care receiver to continue living in their home, or better able to involve the care receiver in decision-making compared to formal care because of fewer time constraints. In both cases, the family might only be involved because of a lack of better alternatives that could be developed. We contribute to evidence on the various ways in which gender is intertwined with ideals of care and argue that the distribution of care ideals is similar across SES groups among those who practice a caremix. This adds to the literature on the role of ideals in caregiving (Timonen *et al.*, 2013; Schmidt, 2018).

The fact that the family care ideal is widespread demonstrates the willingness of adult children to take up the role of an informal carer, possibly even if care is overburdening the informal carer. Policies that can reduce the burden of informal carers could be particularly important here, particularly since the instrumental involvement of the family suggests that family care is often also provided because of a lack of better alternatives. The intertwining of the family care ideal with gender relations underscores the importance of policies that reduce gender inequalities in care. The homogeneity of the ideals across different SES groups highlights that differences in practices are likely to be linked to different resources, rather than different understandings of what good care looks like. From a policy perspective, this means that care receivers from lower SES need better access to community-based services to complement informal care and thus reduce the burden of informal carers.

This analysis is based on the narratives of care dyads who practice a care mix and further research is needed to explore possible differences related to different types of care arrangements (only informal care, only formal care) as well as changes over time and examine whether the ideals are similar across different

familialistic care regimes. Although we only study one example, the fact that we found nuances behind the family orientation in a familialistic care regime beyond the family care ideal also has implications for other familialist care regimes and the opportunities for policy development. This could be taken up in future comparative studies.

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### Competing interests

The authors declare none.

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