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## Intergenerational solidarity and caregiving

### Intergenerationelle Solidarität und häusliche Pflege

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■ **Summary** In this paper the topic of caregiving and intergenerational solidarity will be explored in four parts. First, relevant aspects of caregiving will be pointed out. Second, general theoretical models will be used to analyse the problem of caregiving. Third, the German situation and especially the still rather new long-term care insurance will be described. Fourth and finally, the basic outline of a European research project (OASIS), which is devoted to the topic of intergenerational solidarity and the use of service systems, will be presented.

■ **Key words** Solidarity – intergenerational relations – family – care – caregiving

■ **Zusammenfassung** In diesem Artikel wird das Thema häusliche Pflege und intergenerationelle Solidarität in vier Abschnitten behandelt. Zunächst werden relevante Aspekte der (häuslichen) Pflege diskutiert. Zweitens werden allgemeine Modelle herangezogen, um das Problem der (häuslichen) Pflege zu analysieren. Drittens wird die Situation in Deutschland, unter Berücksichtigung der Pflegeversicherung, beschrieben. Schließlich wird ein europäisches Forschungsprojekt (OASIS) skizziert, das dem Thema intergenerationelle Solidarität und Inanspruchnahme von Dienstleistungssystemen gewidmet ist.

■ **Schlüsselwörter** Solidarität – intergenerationelle Beziehungen – Familie – häusliche Pflege

### Definition of caregiving

Looking from the perspective of the recipient, caregiving can be defined as providing assistance or care to a family member, friend, or a client (4, 10). The intention of care is to enable the care recipient to maintain an optimal level of independence and quality of life. Hence, the goals of long-term care might be different from short-term care as for instance after an accident or an operation. Not “restitutio ad integrum” (restoring “normal” functioning), but

“restitutio ad optimum” (stabilising the state being or aiming at even “small” improvements) is the guideline for caregivers. The assistance of caregivers to care receivers can be instrumental (“hands on care”), affective, informational, and financial; and takes place within given contextual constraints. The effects of the caregiving situation on the caregiving person have been mostly analysed under the assumption of strain, stress and negative effects, but potentially positive consequences for both caregiver and care receivers should not be neglected. Finally, there is a clear gender bias in care giving: Family

and professional carers are mostly women at the moment, and also among care receivers there is a majority of women. In the families wives, daughters, and daughters-in-law most frequently take over the responsibilities of care giving, but with increasing female participation in the work force this situation could change in the future.

It is well known that ageing should not be equated with deteriorating health, but clearly there is an age-related increase in morbidity and handicaps. The prevalence rates for “being in need of care” (“Pflegebefähigkeit” is a legal definition in Germany) increase from about 2% between 65 and 69 years of age to 28% in the age group of persons 85 years and older (20). At the time being only about a quarter of all persons entitled to receive help from the long-term care insurance in Germany reside in institutions (19). The vast majority lives at home within a network of familial and other informal caregivers. Let me remark that the German long-term care insurance covers care not only for elderly persons, but also for children and younger adults as well.

Caregiving takes place within a cultural context which can be quite diverse – looking even only at Europe. Although one should not be as pessimistic as Rosenmayr (this volume) who points to “disjunctive” elements of the contemporary culture of ageing, it is clearly the case that old age needs a strong cultural framework of compensation for individual losses related to the process of ageing. In the context of caregiving two aspects of the cultural context are of special importance: Family culture and welfare systems. Family culture concerns the norms and attitudes within families regarding the responsibilities and preferences of caregiving. In a collectivist culture, family members feel obliged to step in as caregivers when the need to do so arises. In contrast, personal goals and commitments of family members gain higher importance in individualistic cultures, and the idea of negotiating and compromising between different interests comes in. However, one should be careful not to equate countries with only one underlying family culture. There are for instance eminent social changes in countries like Italy and Spain which are quite often associated with a strong family culture.

Another important aspect of the cultural context is the type of welfare state regime. Differences might exist in the extent of legal obligations for families concerning the care for elderly family members, and the type of support available under the specific welfare regime. In Germany, for instance, only the long-term care insurance has initiated infra-structure growth of social care services. However, as the coverage of the German long-term care insurance is fixed to an upper limit, utilisation of services are

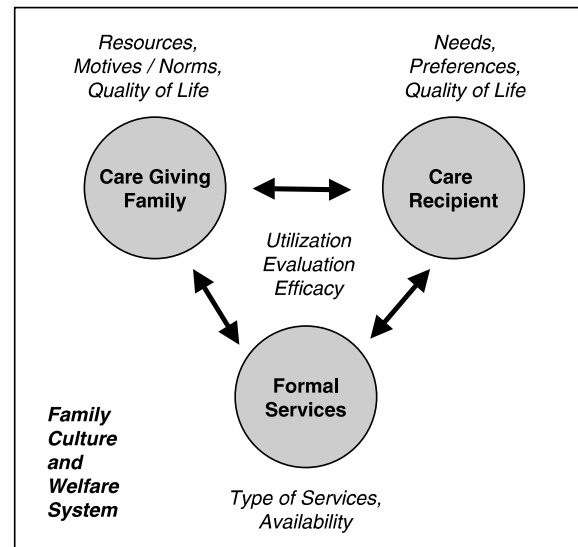


Fig. 1 A conceptual model of caregiving

still also influenced by financial constraints of the care recipients and their families.

### Theoretical models of caregiving

If we look at caregiving from a theoretical perspective, it seems useful to distinguish three different layers or levels of analysis (see Fig. 1): individuals, families and service systems (11, 21).

(1) Needs and preferences of the care recipient are responsible for type and sources of support and care. As most ageing individuals wish that close relatives care for them, the first institution to step into the process of caring are families. Important are the consequences of caring for the care recipient: Quality of life comprises not only subjective aspects (like satisfaction and emotional wellbeing), but also objective aspects like independence and agency. Especially difficult is the measurement of quality of life in the case of cognitive impairments and dementia. (2) Complementary to the needs and preferences of the care recipient, resources and motives of the care giving family influence the type care arrangement (see Perrig-Chiello in this volume). It is important to note that in most cases not all family members contribute equally to caregiving. Instead, there is a single main carer who takes over most of the responsibilities. Other family members belong to the main carers own resources. Also the quality of life of the caregiver should be taken into account, in both objective and subjective aspects. (3) Finally, the existence and availability of formal services has to be

taken into account. The interplay of care recipient, caregiver and service systems has to be analysed according to utilisation, evaluation, and efficacy of support.

Caregiving is not a static situation, but a process in time. This is true for both care recipient and caregiver. The process of caregiving is related to somatic, personal and social factors of the care recipient. Not only should somatic changes and deteriorating cognitive capacities be taken into account, but also decision making of the care recipient which might influence his or her own living situation in the future. For the caregiver several phases of the caring process can be distinguished. After acquisition of the role as caregiver, a phase of role enactment follows and – not rarely – also the “normalisation” of life after institutionalisation or the death of husband or parent. Formal services normally do not play a role in the caregiving situation from the very beginning. There is a decision process within the family concerning the involvement of “outsiders”, either as bringing social care services to the home of the care recipient or as moving the care recipient into a long-term care institution.

Caregiving can be analysed using theoretical concepts from different disciplines (psychology, sociology, social policy theory) related to the three levels of individual, family and service systems. An important conceptual task of the future will be the integration of these models (if this is possible at all). At the time being, it seems necessary to point out the need for theory, and the need for theory at different levels of analysis.

A first set of theoretical concepts refers to the individual level. Caregiving can be seen as stressful situation or experience which is potentially harmful to an individual. Coping means those individual behaviours, actions, and processes which intend to deal with harmful stressors (12). Several prominent coping models point to a similar dichotomy of coping strategies. Lazarus and Folkman distinguish between problem-focused and emotion-focused coping (13), Paul and Margret Baltes refer to selection and compensation (2, 3), Heckhausen and Schulz describe primary and secondary control processes (9), and Brandtstädter, Wentura and Greve introduce the dual-process model of assimilation and accommodation (8). Neglecting the important differences between these models, one could conceptualise the basic dichotomy as “changing the world” (primary control) and “changing the self” (secondary control). The effectiveness of these types of coping processes depend on the nature of the stressor and the criterion used to measure effectiveness. In the case of chronic health problems, tendencies of “flexible goal adjustment” could influence *subjective* quality of life

indicators like life satisfaction positively, while “tenacious goal pursuit” could increase the agency of the individual.

The next level of theoretical analysis concerns the family. One important theory in this respect is the model of intergenerational solidarity by Bengtson and associates (5, 6). There is an interplay of six dimensions of solidarity. Functional solidarity (which covers also caregiving) is influenced by opportunity structure, association of family members and quality of relationship. However, this model sharply separates the positive and harmonious aspects of solidarity from conflicts within families. Conflict is a conceptual construct independent from solidarity, and characterises only a minority of families (about 15% of “long-term lousy relationships”). In contrast, the model of intergenerational ambivalence proposed by Lüscher, Pillemer and Lettke (14, 16) takes into account conflicting tendencies, hence both positive and negative aspects of family life. For instance, families strive for both autonomy *and* dependency of family members, a conflict which is not easily solvable. Within the intergenerational ambivalence model, two dimensions are important. The tension between convergence and divergence constitutes the personal dimension of ambivalence, the tension between reproduction and innovation the institutional dimension. The situation of family caregiving increases intergenerational ambivalence. For instance, both positive *and* negative feelings are vivid in a caregiving arrangement between caregiver and care receiver. Individuals and families have to cope with this ambivalence, in order to preserve intergenerational solidarity within the family.

The third level of analysis concerns service systems under a welfare state perspective (see Attias-Donfut and Daatland in this volume). The main question can be formulated as follows: If the welfare state takes over the responsibilities of the family this could lead to substitution and, hence, a decrease of intergenerational family solidarity which could be socially inefficient in the long run (1). If on the other hand, the welfare state supports caregiving families, this would mean that the state functions complementary to family support. Hence, intergenerational solidarity should be stabilised or even increased. However, these effects depend on type and availability of service systems.

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### Long-term care in Germany

Some of these questions can be studied looking at the situation of long-term care in Germany. The main factor of change was the introduction of long-

term care insurance in 1994. Since April 1995 home care and since July 1996 residential care have been covered by long-term care insurance. The main goals of the German long-term care insurance are stabilising care arrangements, reducing individual poverty risks and public welfare spending, and enhancing the infrastructure and improving the quality of social care services. Although the long-term care insurance follows the already existing social security systems in Germany, there are specific unique and innovative aspects (18). There are ceilings in spending, hence not everything is paid for what the insured persons is in need of, but rather fixed amounts are paid (different for the three levels of “in need of care”). Persons who live at home may choose between cash payments and benefits in kind. The idea behind this option refers to increasing “reciprocity” between care giving families and care receiving elderly people who receive the chance to compensate for the effort of their relatives.

Interestingly, in 1998 about three quarters of all community dwelling individuals entitled to receive help from the German long-term care insurance chose cash payments (19). Only about 11% chose services and about 14% chose a combination of both cash payments and services. Only a very small proportion chose day care or respite care. However, since 1995 the proportion of persons choosing cash payments has decreased by about 10%, and the proportion of persons choosing combinations of payments and services increased by about 6%. Hence, the structure of utilisation of the long-term care insurance has not stabilised yet.

One of the goals, namely stabilisation of care arrangements, clearly has been reached by the long-term care insurance. If one looks at the main categories of carers – partners, parents, children, and others – there are only small differences in the proportion of carer types before and after introduction of the long-term care insurance (19). Again, women carry the main burden of care. If one includes parents of children and adolescents in need of care, more than 70% of all carers are women. However, there is one interesting tendency: With the long-term care insurance the proportion of other relatives, neighbours and friends has almost doubled (from 10% to 17%). It is too early, though, to decide if this is a true effect of the long-term care insurance. One can nevertheless assume that care arrangements involving non-family members point to processes of “individualisation” and “modernisation” and could increase in the future.

In a study by Blinkert and Klie, the effects of modernisation on care arrangements have been tested explicitly (7). “Modern family arrangements” were defined according to six – rather rough – crite-

ria (one can as always argue if this operationalisation is adequate). About 8% of the sample proved to live in a “modern” family arrangement. Characteristics of these modern family arrangements are lower participation of partners and children in the care arrangement, higher involvement of formal services and higher participation of friends and neighbours in the process of care giving. Hence, it might be necessary in the future not only to consider “intergenerational family solidarity”, but also solidarity outside the family.

Finally, the results of the empirical studies show that satisfaction with the long-term care insurance is very high. This is not very surprising given the fact that respondents did not compare alternatives of long-term care insurance, but a residual welfare solution with a completely new system. In the Blinkert and Klie study, approval of the long-term care insurance reach a level of about 90% (7). In the Schneekloth and Müller study, respondent’s approval also was very high: About three quarters agreed to the statement that the long-term care insurance had improved the living situation (19). However, in more sophisticated data analyses, the authors could show that *lower* satisfaction with the long-term care insurance was related to low provision level (“Pfleigestufe 1”), high cognitive impairment of the care recipient and high subjective strain of the caregiver.

Are all problems related to caregiving solved with the introduction of the long-term care insurance in Germany? One certainly cannot state that the contrary is true, but there are still a lot of open questions. (1) On the individual level, it is still unclear how care recipients’ quality of life is affected by new forms of social care. This is of special importance for elderly care recipients suffering from dementia. In the two studies mentioned so far, dementia was treated as a methodological problem only: Responses were recorded from caregivers only when care receivers were unable to answer. Evenly important are the consequences for working carers (which essentially points to the effects on female carers). (2) On the family level it is still unclear which factors influence the decision process of involving formal services outside the family. And since the German legal definition of “in need of care” (“Pflegebedürftigkeit”) heavily depends on the amount of hands-on care, but not on the extent of looking after a cognitively impaired family member, support for families caring for a relative with dementia is not adequate at the time being. (3) Finally, on the level of service systems there are also open questions: These concern mainly the standards and infrastructure of home care services.

## Old age and autonomy: The OASIS project

Not all, but some of these questions mentioned will be addressed in a European project with the title "Old Age and Autonomy: The Role of Service Systems and Intergenerational Family Solidarity" (the first letter of central words form the acronym OASIS). Funding comes from the European Union's 5<sup>th</sup> framework programme. Research institutes from five countries are involved in this study: Israel, Norway, UK, Spain and Germany (15, 17). The OASIS project pursues three research questions: The social construction of intergenerational relations is the first focus. In cultural and societal comparisons it will be analysed in which ways families deal with ambivalence and create solidarity facing the need for help and support as parents and grandparents grow older. Second, one of the aims is to analyse the relationship between family support and utilisation of service systems, again in regard to different cultural and welfare state contexts. And finally, the project will concentrate on how the quality of life – autonomy and emotional wellbeing – is affected by intergenerational solidarity and the use of service systems.

At the core of the underlying model individual, family and services are considered (cf. Fig. 1). In addition contextual variables will be taken into account: Individual resources and capabilities, living arrangements and family resources, and finally family culture and welfare regime at the societal level. As dependent variables the project will look at several dimensions of quality of life: Objective aspects of living conditions as well as cognitive and emotional aspects of subjective wellbeing.

There are two empirical parts to the project OASIS (Fig. 2). In each participating country a representative, cross-sectional survey involving 400 in-

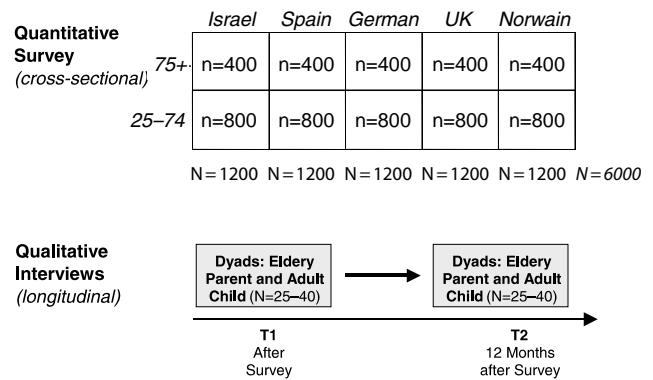


Fig. 2 Design of the European project "Old Age and Autonomy: The Role of Service Systems and Intergenerational Family Solidarity" (OASIS)

dividuals at 75 years and older, and 800 individuals between 25 and 74 years of age will be conducted. Hence in each country the sample will be N=1200, the total sample size will be 6000 in all five countries taken together. In addition to the quantitative survey a qualitative, in-depth interviews with 25 to 40 elderly who are identified as being "at risk for dependency" in the survey will be conducted. The aim is to interview not only the elderly person, but also one of the adult children (the potential main carer). These dyadic interviews will be repeated after 12 months, hence trying to capture the process of caring within families. The project OASIS is devoted to gather knowledge in order to improve the quality of life of caregivers and care recipients, to learn about family relationships (including both aspects of solidarity and conflict), and finally to increase information about the welfare state in order to enhance the interchange between families and service systems.

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