OASIS

Old Age and Autonomy:
The Role of Service Systems and Intergenerational Family Solidarity

Final Report

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The Project OASIS: Old Age and Autonomy: The Role of Service Systems and Intergenerational Family Solidarity

Preface

Demographic changes in the last decades of the 20th century and in the coming decades of the 21st century caused and will cause an increase in the ageing populations. It will, thus, impact the size and age profiles of the populations in all EU countries. Combined with these we also witness changes in family structures, norms and behaviours like decrease in fertility rates, increased rates of divorce and a growing participation of women in the labour force. All of the above pose significant challenges to societies, families and individuals. Considerable gains to social policy could be achieved from analysing these issues in a comparative EU perspective. The major goal of the OASIS cross-national study is, thus, to provide a knowledge base of how to support autonomy in old age to enhance well-being of elders and their family caregivers and improve the basis for policy and planning. The project was funded under the 5th Framework Program – Quality of Life and Management of Living Resources Program (1998-2002) of the European Commission, Contract number: QLK6-CT1999-02182 and QLK6-2000-30102.

The five countries participating in the project, represent a diverse range of welfare regimes and different family cultures, where the issue of family solidarity and its interaction with service systems is central to the future development of social care and support to the elderly. The five countries include: Norway, England, Germany, Spain and Israel.

This report is the final report of the work undertaken in the last three years that began in February 2000 and ended in January 2003. The report presents the theoretical, conceptual and methodological aspects of the project together with the empirical findings and their implications for policy. The three years of collaboration between the five research teams and the service organisation was a challenge that has produced fruitful products and valuable working relations.

The main issues covered within the project and reflected in this final report include themes on three levels: on the macro/societal level, comparing welfare states as managing risk and opportunities, and examining the question of substitution or complementarity between families and services; on the meso level, intergenerational family solidarity, conflict and ambivalence, norms and ideals regarding elder care and patterns of service use by elderly and families; on the micro/individual level, quality of life of elders and their family caregivers. The report also outlines the conceptual framework and the quantitative and qualitative research methods used in the study.

During the life-time of the project several publications have appeared: two monographs, conceptual and empirical articles and book chapters in international publications. A special issue of the French journal – *Retraite et Societe* – has been devoted to the OASIS project (January 2003). Each team authored an article in this issue. The editor is Claudine Attias-Donfut, and the guest editor of this issue is Clemens Tesch-Roemer. International policy oriented publications based on the OASIS study were also produced e.g. as expert contributions to the preparations of the International Action Plan of Ageing that were presented to the UN Commission for Social Development. The OASIS findings were also published in national publications and presented in a variety of national and international scientific conferences. The findings were presented to national policy makers in the five countries and will be disseminated in a closing conference in Brussels for European and Israeli policy makers in May 2003.

Ariela Lowenstein
Co-ordinator of the OASIS project

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List of OASIS Selected Publications

Bazo, M.T. (2003) "Intercambios familiares entre las generaciones y ambivalencia: Una perspectiva internacional comparada", *Revista Española de Sociología* (num. 2, in press).

Bazo, M.T. (2003) "Dar y recibir: análisis comparativo de las prácticas de intercambio entre generaciones, preferencias, y valores en las familias españolas", *Revista Interuniversitaria de Formación del Profesorado* (in press).

Daatland, S.O. & Herlofson, K. (2003, forthcoming). 'Lost solidarity' or 'changed solidarity': a comparative European view on normative family solidarity. *Ageing & Society.*

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Abstracts

SECTION 1 – Conceptual Framework

Chapter 1. Theoretical perspectives and conceptual framework

The theoretical and conceptual frameworks of the OASIS study are based on the 'ecology of human development' approach that distinguishes three levels of analysis: the macro level (welfare regimes and family cultures), meso level (family intergenerational relations) and micro level (quality of life of elders and family caregivers). One of the central and innovative aspects of the OASIS project is the advancement of a theoretical knowledge base through the use and empirical study of two conceptual frameworks: intergenerational solidarity and conflict versus intergenerational ambivalence. The OASIS project represents one of the first attempts to compare these two theoretical paradigms in a European context. The methodology used offers a fruitful avenue for exploring how cultural, social and economic factors, as well as external structural-environmental conditions, shape care-giving behaviours and influence the quality of life of older people and their family care-givers. The findings can improve our understanding of family relations within and between different countries.

Chapter 2. Comparing welfare states

The five OASIS countries have different welfare regimes. Empirically based typologies are presented that distinguish groups of European countries according to how they implement social welfare policies. The welfare regimes in the OASIS countries are discussed in the context of *settings for managing risks and opportunities.* A set of social indicators identifying dominant family models within countries are developed and presented. These indicators provide the context for the analysis of the OASIS empirical data. It is also suggested that they can be used as a context for new research questions that emerge from the OASIS project findings.

SECTION 2 - Methodology

Chapter 3. The quantitative survey

Cross-national comparisons depend upon data quality. This chapter introduces the quantitative survey of approximately 6,000 adults in the five OASIS countries. It covers the concepts, questionnaire design, sampling methodology, sampling selectivity and different perspectives of the analyses. The field-work schedule in the five countries is critically assessed, focussing on sampling and the work of the survey organisations that undertook the interviews. The important process of data cleaning, file merging and creation of derived variables is presented. Sample selectivity is examined for each country. Despite facing several obstacles, the OASIS survey is an integral data set that can improve knowledge about influences on the quality of life in old age within a cross-national perspective.

Chapter 4. The qualitative phase

Families are increasingly confronted with the challenge of maintaining independence and a sense of autonomy in old age. These challenges are examined through the qualitative phase of the OASIS project. Fifty parent and adult child dyads were extensively interviewed. The parents (10 in each country) are aged 75 and above with health problems. The chapter outlines the process of identifying and accessing the sample, ethical issues encountered in designing and undertaking the fieldwork, the details of the fieldwork phases and the analysis process resulting in key codes and categories. Challenges in designing cross national qualitative research are highlighted. The qualitative interviews show how older people and their families in the five OASIS manage and negotiate the changes associated with the onset of illness or disability in old age.

SECTION 3 - Findings

Chapter 5. Norms and ideals about elder care

Filial obligation norms to help and support elderly parents are still strong in each of the five OASIS countries, although they are generally higher in Spain and Israel compared to Norway, England and Germany. But supporting older parents is neither absolute nor unconditional. A substantial minority do *not* subscribe to such norms, and both the substance of the norms and the level of support vary from country to country. Country differences reflect preferences of how filial norms

should be enacted The preferred model for elder care is a combination of family and welfare state responsibility. This can be achieved with the welfare state in a more central role than at present, togehter with moral and practical assistance from the family.

Chapter 6. Intergenerational solidarity

The intergenerational family solidarity model has proved to be a useful conceptual tool in examining family relationships. This model is applied to the cross-national perspective of the OASIS project. The quantitative data, as reported by older people, are used to test the links between demographic, familial and health variables on the different dimensions of solidarity. The results show that family solidarity is strong in all five countries, although there are variations in the degree of strength. Also, the factor of country was found to have main effects on all solidarity dimensions, except proximity, implying that there are national and cultural idiosyncrasies

Chapter 7. Exploring conflict and ambivalence

Conflict between older parents and their children is rare in all OASIS countries. However, the results generally show that low levels of conflict between parents and their adult children can co-exist with harmonious and positively affective family relations. A typology of four groups of parent-child relationships is presented and analysed in view of the conflict and ambivalence perspectives: the *affective*, *steady*, *ambivalent* and *distant* types of relationships. The qualitative analysis of the data attempts to unravel these four family types. They show that ambivalence can be a normal state as parents and adult children struggle to negotiate a path between autonomy and dependence. Rather than focusing attention on whether or not ambivalences are unsolvable it would appear to be more fruitful to attend to the ways in which ambivalences emerge in family relationships and the processes and strategies family members make use of to address these issues. This approach would appear to have potential in terms of considering implications for practice and policy in respect of inter-generational ties and family relationships.

Chapter 8. Families and services

Formal (services) and informal (family) support have an unequal weight in the five countries and there are different levels of complementation influencing caring situations. changes in the traditional family role of women in family roles are slow to develop. The stability of values and family models characteristic of premodern

societies continues to be observed despite transformations in socioeconomic structures and other cultural values regular and familiar interaction with services leads to more demands and expectations. Where there is more choice of different caring arrangements, there is more satisfaction and a sense of autonomy Two different dynamics in care models have been identified. A close, familiar interaction with services linked to the availability, normalisation and positive image of services, and a distant, uncertain interaction, characterised by lack of knowledge and limited access to services. It is clear that individual pressures and expectations have an impact at the structural level on the development of more public and private services to fill the gaps that stop people from maintaining their independence for as long as possible. Changes in this direction are expected to reinforce the patterns observed in caring and tending activities – a division of labour between families and services, and less demands on the family to provide physical or constant instrumental support. A broad network of social services is needed on the basis of the different needs that persons experience as they age. Service accessibility and flexibility, together with quality, are also necessary to improve user satisfaction. Bureaucratic organisations usually make it difficult to achieve these aims. This means that women's traditional commitment to their families has not significantly changed, despite their increasing participation in the labour market. Updated family policies, as well as financial, fiscal and employment policies, are needed to promote women's feeling of self-fulfilment.

Chapter 9. Quality of life

Two aspects relating to the subjective quality of life are analysed - cognitive evaluations (*domain specific life satisfaction*) and emotional states (*positive and negative affect*). The results show that functional health, income and education have a strong impact on most dimensions of subjective quality of life for all of the OASIS countries. The existence of children (parenthood) has an additional positive impact on subjective physical health and psychological well-being. Analyses in respect to support from families and services show mostly *negative* correlations with subjective quality of life. This finding is not interpreted as a direct effect of support *per se*, but rather as an indication of needs associated with support, since only older people with special needs get extensive help from families and/or services. However, in a cross-national perspective, Germany and Spain show a substantial negative correlation between service help and subjective quality of life, but not Norway, England, Israel. This finding is interpreted as being due to the lower levels of service provision in Germany and Spain compared to Norway, England and Israel. The social policy implications focus on the need to strengthen the resources of elderly individuals (especially health) and to improve the infrastructure and culture of services.

SECTION 4 – Policy Implications

Chapter 10. Families and welfare states: substitution or complementarity?

The chapter presents the arguments for the substitution versus the complementarity approaches to elder care, using data on the receipt of help by elders at risk of dependency from family and formal services. The results show elements of both substitution and complementary at work. Family help tends to be higher in countries with low service levels, but when needs are met by the formal system, some families do not retreat from their obligations altogether. The OASIS project data favours complementarity between services and families rather than substitution, even though there is some evidence of substitution effects. Older people receive a higher overall level of help and support in high-service countries compared to low-service countries, indicating that a partnership between services *and* families meets the needs of elders better than a family dominated care system. Services do *not* seem to discourage family help, and are more likely to help families spread their resources in meeting other needs. Services may even be a stimulant for intergenerational exchanges. Hence all welfare states are encouraged to invest more in services to elders. The slightly lower rates of family help found in high-service countries are more likely to be a response to the availability of family members than to a lower threshold of family willingness to support their elders. Modern families seem to be inclined towards more independence between generations, and they may have adopted many characteristics more commonly found in friendships. Whether this independence is a threat to intergenerational solidarity or a flexible adjustment to new social realities remains to be seen. But the fact that families can and do change has been one of the keys to their strength and resilience, and this pattern may continue to be a long-term trend.

Chapter 11. Social policy implications

Welfare state expansion has *not* eroded filial obligations. Younger and older generations alike tend to agree on norms of filial obligation. Moreover, younger generations appear to be *more* family orientated than older generations. Overall, the preferred model is towards some mix of informal family care and formal service provision. The ideal seems to be one where the welfare state has a more central role than at present. Families do *not* downplay their responsibilities. But it seems they are shifting the focus from *providing* practical instrumental care to *managing* care, a process dependent on the relative development of services in each country. social policies that improve the life of women and empower them are a key element, both in the context of family and the workplace.

1

Theoretical Perspectives and Conceptual Framework[1]

Ariela Lowenstein and Ruth Katz

Introduction - Ageing populations and changing family structures: a cross-national perspective

The broad aims of the OASIS project are to provide a knowledge base of how autonomy in old age can be promoted to enhance the well-being of elders and their family caregivers and to improve the basis for policy and planning. Specifically, the OASIS project has three main objectives:

- to analyse the interacting roles of family care and service systems on the quality of life in old age. Elder care has both formal and informal elements, but the actual balance differs between countries according to family culture and the availability and accessibility of service systems.
- to study variations in family norms and transfers (intergenerational solidarity) across age groups within various countries.
- to learn how individuals and families cope when elderly members are at risk of dependency (intergenerational ambivalence). Population ageing and changing family structures mean that it is important to know how different family cultures and welfare regimes promote quality of life and delay the onset of dependency in old age.

Ageing populations are made up of three factors. First, a growth in the proportion of people aged 65 and above. Second, an increase in the absolute number of older people. Third, improvement of life expectancy at birth. These factors are present today all across Europe (Kinsella 2000). Population projections for the year 2020 show that in most Nordic countries, and in England, and Spain up to 18% of the population will be aged 65 and above, and about 4% aged 80 and above (OECD 1996). Israel is a relatively young country, and people aged 65 and above will constitute about 12% of the population by 2020, and about 3% of people age 80 and above (Elders in Israel: Statistical Yearbook, 2000). Population ageing raises questions about the definition of old age, about the experiences of older people and their place in society, and about appropriate ways in which the need of elders with health and welfare difficulties can be met. The family orientation of social life is strongly influenced by parenthood .The value attached to sociability makes the

[1] The OASIS study is supported by the European Commission, Quality of Life and Management of Living Resources Programme (1998-2002), Fifth Framework Programme, Contract number: QLK6-CT1999-02182.

family a main reference point in the ageing process, and the needs of older people are best understood within the context of the family. It is important to know what these changes mean for the family relations of older persons and their caregivers in Europe. How do European societies perceive and respond to the psychological, social and health needs of their older populations within their respective service networks?

A parallel process to ageing societies can be seen to occur in changing family structures, in social networks, and in the living arrangements of the elderly. Several structural changes have had an impact on the lives of older people and their families. These include the growing number of elderly one-person households, increased distances between parents and adult children, smaller numbers of children in families, and the changing labour force participation of women (the traditional caregivers). Combined with these transformations in family structure and family life, we are witnessing the impact of broader societal and technological changes, such as internal and external migration, shifts in social policy direction, and changing preferences for care. These changes force us to analyse and question the more traditional patterns of family intergenerational solidarity and to focus also on the needs of caregivers. Long-term care services will have to respond quicker and differently to the growing needs of ageing societies and the inevitable financial consequences. A critical step in tackling these problems is to adopt an empirical approach, focusing on diverse social, familial and cultural contexts. This approach was taken in the OASIS project, a cross-national study including the five following countries: Norway, England, Germany, Spain, and Israel. These countries have a diverse range of welfare regimes (institutional, conservative, residual) and familial cultures (family-oriented and individualistic). They also contain elements of a north-south divide as suggested by Reher (1998). This chapter attempts to analyse on the macro, meso and micro levels the trends cited above and how the implications they raise for theories of ageing and the family can be explored through the OASIS project.

Theoretical and conceptual background

A theoretical framework provides '*conceptual tools to interpret complex events and critically evaluate the current state of ageing*' (Biggs et al. in press 16). In addressing the theoretical paradigms that guide the OASIS project, we must bear in mind the existence of complex processes and the interaction of micro-interpersonal and small group dynamics with multiple levels of social macro-forces. Moreover, studying private spheres of social life, especially family life, is where the greatest complexity is encountered. The OASIS project is based on the concept of the '*ecology of human development*' proposed by Bronfenbrenner (1979). This concept distinguishes macro, meso and micro levels of analysis and their importance for understanding the complex interplay between individuals, families and social structures. The theoretical and conceptual perspectives chosen for the study are:

- the Welfare Regime and Family Culture, on the ***macro*** level.
- the paradigm of Intergenerational Family Solidarity/Conflict versus the recent paradigm of Intergenerational Family Ambivalence and Service Use on the ***meso*** levels.
- the quality of life on the ***micro*** level.

The macro level – welfare regimes and family cultures

Welfare regimes have been described and classified using different normative models. The earliest model classified welfare on a spectrum from the least developed to the most developed systems. The most well-known example is the distinction between 'residual' and 'institutional' models of welfare which was developed by Wilensky and Lebeaus's (1958), and later by Titmuss (1974) and others. The second model classified welfare systems according to their distinctive approaches to the delivery of social welfare, through 'industrial-achievement and performance' or 'institutional-redistributive' means (Titmuss 1974). Esping-Andersen (1990) developed further Titmuss's classification (1990) and in a later work (1999) he proposed a typology of welfare regimes relating to country differences in social policies based on citizen rights and the organisation of work. According to his typology, three models of welfare regimes can be differentiated: the *social-democratic*, the *liberal*, and the *conservative-corporatist*. The social-democratic model is characterised by a universalistic approach to social rights, a high level of decommodification, and an inclusion of the middle classes in social programmes. The liberal model, at the other extreme, provides only limited social insurance and its social programs are directed mainly toward the working class. In the conservative-corporatist model, social principles prevail in most areas, although they are not based on egalitarian standards but on eligibility according to social status and tradition. Esping-Andersen's typology is relevant for the countries participating in the OASIS project. Germany and Spain belong to the conservative welfare model, Norway to the social democratic model, and England to the liberal model. Israel may be categorised as a '*mixed model*', with liberal, conservative and social democratic features.[2]

All welfare states have expanded into areas where the family once held total responsibility. But some have done so earlier and more than others. Consequently, there are differences of perception regarding the reasonable balance between public services and private, family support. In conservative, liberalist and residual welfare societies, the state is more reluctant to introduce services traditionally provided by

[2] A more detailed description of the social indicators of the participating OASIS countries is given in Chapter 2.

the family than in universalistic and social democratic welfare regimes. The latter have removed legal responsibilities between adult family members, and they base their social policies on the needs of the *individual*, not the *family*. They have consequently developed higher levels of social services in general, and higher levels of home care services in particular (Daatland 1997). The more *familistic* welfare states operate under the principle of subsidiarity. They still place the primary responsibility for help and support on the family, and government responsibility is activated only when family care is missing or professional competencies are needed.

The expansion of the welfare state into areas where the family was previously responsible shifts the boundary between public and private spheres of social life. The limits of each become uncertain and there are many relationships and circumstances that do not fall neatly within either the public or the private spheres. In these cases, state and family are merged. As a result of these uncertainties, family ethics are changing. Therefore one of the objectives of the OASIS project is to examine filial obligation norms and what people consider to be the 'right' balance between the family and the state.

The relationship between family networks and service systems are part of the equation in retaining autonomy in old age. How different welfare states support the family is particularly important. Previous research has shown that elder care is a shared responsibility between the public and private spheres. But the balance differs between countries, depending upon three factors: family norms and preferences for care; family culture, which guides the level of readiness to use public services; and the availability, accessibility, quality and cost of services. Research has shown that in most Western societies family care is substantial. But in those countries where collective responsibility through public services is more available, family care has *not* been discouraged. In fact, families are *more* willing to use public services when an older member becomes dependent, (Daatland 1997; Katan and Lowenstein 1999).

So although the family still undertakes a wide range of care tasks, some responsibility for elder care is now entrusted to the welfare state. This applies particularly to the duties of children toward elderly parents (Sgritta 1997). Among attitudes to intergenerational relations are those relating to the balance between family and state responsibility for the welfare of older people. Social care has come to mean both formal and informal care networks existing side by side (Cantor 1991). One of the basic policy debates in this area is whether formal services *substitute* or *complement* informal family care. Social policies for older people in most countries tend to treat families and service systems as alternatives which counteract (substitute) each other (Hooyman 1992). Public opinion also seems to support the substitution idea (Daatland 1990). But research has largely supported

the complementarity approach (Litwak 1985; Chappell and Blandford 1991; Lingsom 1997; Litwak et al., forthcoming).

In an analysis of changes to the structure of society and the family, Sussman (1991) pointed out that many functions of the traditional family have been taken over by social institutions. Some researchers believed this decline of the traditional family to be an unavoidable outcome of modernisation and the modern economy. For example, they pointed to geographical separation as evidence that the intergenerational family was in decline and that older parents were isolated from their children in the modern family (Parsons 1944). For others, the disengagement and isolation of older people were perceived as adaptive and functional strategies, not only for younger generations but for the older one themselves. Another factor influencing this debate is that the ability of women (the traditional caregivers) to provide care for older family members has been undermined by their massive participation in the labour market. Changes in family structure, particularly high rates of divorce and single parenthood, are further dimensions of the perceived decline of the family (Popenoe 1993).

These reports of the demise of the extended family were, however, premature (Silverstein and Bengtson 1998). Studies of intergenerational family relationships have revealed that adult children are *not* isolated from their parents but frequently interact with them and exchange assistance, even when separated by large geographic distances (Lin and Rogerson 1995). Feelings of family obligations and affective relationships spanning the generations have *not* been weakened by geographic separation. Family sociologists have empirically shown that the contemporary extended family maintains cross-generational cohesion (Bengtson 2000). The nuclear family has also kept most of its functions in partnership with formal organisations (Litwak 1985; Litwak et al. forthcoming). On the basis of this evidence, one of the main theoretical paradigms in the OASIS project is the Intergenerational Solidarity Model.

The meso level – family relations: intergenerational solidarity, conflict and ambivalence

In society, the family is located somewhere at the centre, below the collective but above the individual. It holds a crucial position at the intersection of generational lines and gender. The study of intergenerational family relations in later life is based on an integration of knowledge from the sociology of the family and gerontology. But there are inherent difficulties in this integration. First, there is a gap in knowledge bases between the two disciplines, with gerontology much less developed than family sociology. Second, sociological theories tend to focus on the nuclear family rather than on the complex multi-generational family. Third, the emphasis in gerontology is on the process of personal ageing, whereas in sociology it is on family development. Finally, sociological knowledge of the family is based

on the 'normal' family structure**,** whereas in gerontology it tends to be based more on family problems (Klein and White 1996).

Bearing in mind the above difficulties, the OASIS project attempts to understand the meanings of societal and familial changes as they impact on intergenerational family relations. Solidarity between generations is seen as an enduring characteristic of families (Brubaker 1990). Researchers have found that because individuals live longer and share more years and experience with other generations, intergenerational bonds among adult family members may be even *more* important today than in earlier decades. However, some basic questions still need to be addressed (Lowenstein 2000). These are:

- How much help and support is actually exchanged between family generations?
- How strong are the bonds of obligations and expectations between generations?
- What accounts for differences in contact, closeness, similarity of opinions, expectations and patterns of help and support?
- Is there a potential for intergenerational family ambivalence?
- What is the economic value of the intergenerational transfers that occur within families?
- What is the role of society, through its service systems, regarding the enhancement of family relations?

The term 'solidarity' reflects various theoretical traditions. These include classical theories of social organisation, the social psychology of group dynamics and exchange theory, and the developmental perspective in family theory (McChesney and Bengtson 1988; Bengtson and Roberts 1991).[3]

Intergenerational relations within families consist of complex social bonds. Family members are linked by multiple kinds of solidarity that can be contradictory. Bengtson and his colleagues have developed a conceptual framework for studying intergenerational relations: the 'Intergenerational Solidarity Model' (Bengtson and Mangen 1988; Bengtson and Roberts, 1991). The model conceptualises intergenerational family solidarity as a multi-dimensional phenomenon with six components reflecting exchange relations: *structural* solidarity, *associational* solidarity, *affectua*l solidarity, *consensual* solidarity, *functional* solidarity and *normative* solidarity. These six dimensions can be further reduced to three (Bengtson and Harootyan 1994). These are the *structural and associational* elements of solidarity, giving opportunities for interaction; *affectual* solidarity,

[3] For an extensive review of the theoretical background, which shaped the perspective of the intergeneration solidarity concept, see Lowenstein et al. 2001.

which is the closeness and warmth felt between individuals; and *functional* solidarity, which includes a range of helping behaviours.

The conceptual framework of intergenerational solidarity represents one of several enduring attempts in family sociology to examine and develop a theory of family cohesion (Mancini and Blieszner 1989). The intergenerational solidarity paradigm has guided a large part of research on family integration over the past 30 years. There are several advantages of using this conceptual framework in research. It focuses on family solidarity as an important component of family relations, particularly where successful adjustment to old age is concerned (McChesney and Bengston 1988; Silverstein and Bengtson 1991). Family solidarity is conceived as a multi-dimensional construct (White and Rogers 1997). A reliable and valid research instrument, based on the dimensions of solidarity described above, has been designed to evaluate the strength of family relationships (Bengtson and Roberts 1991). The structure of intergenerational solidarity is wide enough to include extant latent forms of solidarity (Silverstein and Bengtson 1998) Finally, the intergenerational solidarity paradigm has been widely used by family researchers to study parent-child relations (Bengston and Roberts 1991; Kauh 1997; Katz et. al. 1999).

The existence or absence of intergenerational solidarity has an impact on self-esteem and psychological well-being, as well as the giving and receiving of help and support. Intergenerational relationships generally contribute to psychological well-being throughout the life course (Roberts and Bengtson 1988; Rossi and Rossi 1990). Studies of the effects of family solidarity on coping in situations of stress, such as widowhood or immigration, show that higher family solidarity contributes to better adjustment in these situations (Silverstein and Bengtson 1991; Katz and Lowenstein 1999). Several studies have also found negative effects of intergenerational solidarity. High levels of family solidarity, for example, can create heavy demands on time and family resources in families of low economic status (Belle 1986). In some families, very close relationships can suppress individuality (Beavers 1982).

Research on intergenerational solidarity has tended to emphasise the existence of shared values across generations, as well as normative obligations to provide care and enduring ties between parents and children. Empirical data, though, do not provide equivocal results on the benefits and costs of intergenerational family solidarity to different generations. Thus, in recent years Bengtson and others have incorporated *conflict* into the study of intergenerational family relations. They argue that conflict is a normative aspect of family relations, and that it is likely to influence how family members perceive one another and consequently their willingness to assist each other. But conflict can also mean that some difficult issues eventually get resolved, and the overall quality of relationships improve rather than deteriorates. Conflict, therefore, should be integrated into the

intergenerational solidarity framework (Parrott and Bengtson 1999). However, the two paradigms of solidarity and conflict do not represent a single continuum ranging from high levels of solidarity to high levels of conflict. Intergenerational solidarity can exhibit *both* high levels of solidarity and conflict, and low levels of solidarity and conflict. The combination depends on family dynamics and circumstances. Bengtson and colleagues see conflict as a natural and inevitable part of human life, a view which is the basic assumption of conflict theory (Bengtson et al. 2000). Social interaction always contains elements of harmony and conflict, and the family is no exception to this pattern. Groups cannot exist in total harmony, since they would be completely static (Klein and White 1996).

The theoretical framework of ageing and family solidarity is currently being challenged because of the normative underpinnings of the solidarity paradigm (Marshall et al. 1993) and issues related to care-giving (Cicirelli 1992) New concepts are being introduced such as 'family ambivalence' (Luescher and Pillemer 1998) or the 'postmodern family' to refer to '*the contested, ambivalent, and undecided character of contemporary gender and kinship arrangements*' (Stacey 1990 17).

Intergenerational ambivalence has been proposed as an alternative to the solidarity paradigm in studying parent-child relations in later life, especially in situations of elder care (Luescher and Pillemer 1998). It is suggested that intergenerational relations may generate ambivalence between family members. This approach is based on post-modern and feminist theories of the family. It contends that family life today is characterised by plurality and a multiplicity of forms**,** such as divorce, remarriage, or 'blended' families, all of which have an impact on family relationships. The term 'intergenerational ambivalence' is proposed to reflect the contradictions in relationships between older parents and their adult children that exist on two dimensions: contradictions at the macro-social structure in roles and norms; and contradictions at the psychological-subjective level, in terms of cognition, emotions and motivation.

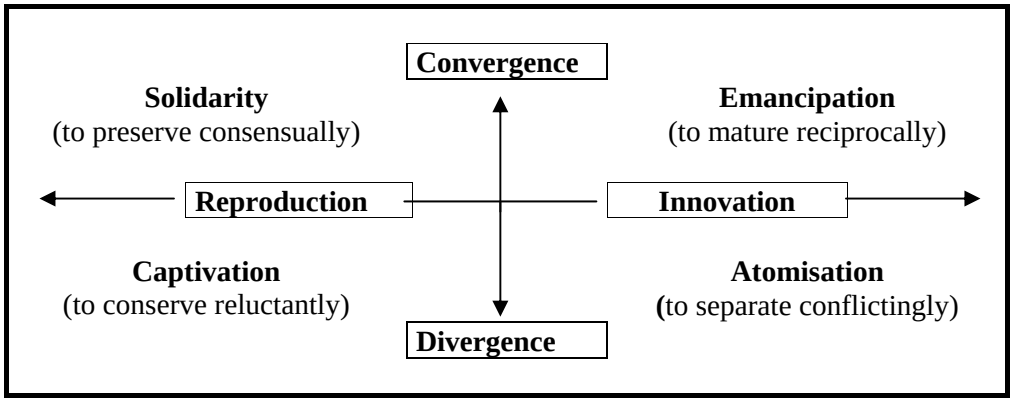
Three aspects of family life are suggested as being likely to generate ambivalence (Luescher and Pillemer 1998 417).

- ambivalence between dependence and autonomy - in adulthood the desire of parents and children for help and support and the countervailing pressures for freedom from the parent-child relationship
- ambivalence resulting from conflicting norms regarding intergenerational relations - for example, conflicting norms of reciprocity and solidarity in care-giving which become problematic in situations involving chronic stress
- ambivalence resulting from solidarity - for example, the '*web of mutual dependency*' which exists in cases of elder abuse. Where there is a conflict

between norms and roles in the social structure, this can lead to feelings of ambivalence. These feelings in turn have an impact on psychological well being and on decisions made to relieve the ambivalence

Luescher (1999 2000) has proposed a heuristic model to combine presuppositions of ambivalence with the two basic dimensions implied in the concept of generations. In this model, intergenerational relations are institutionally imbedded in a family system which is characterised sociologically by structural, procedural, and normative conditions. These institutional conditions are, on the one hand, reinforced and reproduced by the way people act out their relations. On the other hand, they can also be modified and lead to innovation. Reproduction and innovation are two poles of the social field in which the family is manifest as an institution. These two poles may be conceived as referring to structural ambivalence. A further aspect of the model is that parents and children share a degree of similarity that is reinforced by the intimacy of mutual learning processes. There is therefore a potential for closeness and subjective identification. At the same time similarity is both the cause and effect of distancing. Consequently, Luescher postulates an ambivalence polarity on this inter-subjective dimension as well.

Figure 1. The schema of intergenerational ambivalence model (Luescher 1999)



Other research attempts to operationalise ambivalence have focused on the interplay between structural and individual ambivalence and the negotiation between the two. Very recently, the theoretical debate concerning solidarity, conflict and ambivalence received greater visibility in articles published in the Journal of Marriage and Family (August, 2002). In this issue Connidis and McMullin examine 'sociological ambivalence and family ties'. Luscher presents a paper on 'intergenerational ambivalence' and other authors introduce the ambivalence perspective, arguing that it provides a link between social structure and individual action (Marshall 1996). Connidis and McMullin (2002) suggest that

ambivalence can be viewed as a brokering concept between the solidarity model and the problematisation of family relations. These authors, using their own research, offer a critical perspective on the impact of divorce on intergenerational relations. Bengtson et al., in their response to the above, discuss 'solidarity, conflict and ambivalence' and point out that these conceptual paradigms are not competing. They maintain that in close family relations, solidarity comes first and conflict follows, and '*from the intersection of solidarity and conflict comes ambivalence, both psychological and structural*' (575). Taking this debate into consideration, we have included these competing paradigms in the OASIS research so as to examine their impact on the quality of life of elders and their family caregivers.

Family relations and social structures are changing (Popenoe 1993; Lowenstein 1999; Bengtson 2000; Lavee and Katz, forthcoming). Hence, studying the associations between quality of life and intergenerational family exchanges and support (solidarity, conflict and ambivalence) within the broader societal context can serve as an indicator for the success of different help and support systems. This is one of the basic goals of the OASIS project.

The micro-level: quality of life

Quality of Life (QOL) is an important component in research on the balance between family care and service use. Much of the existing research on QOL has focused on health aspects (De Vries 1999). But QOL is a multi-dimensional concept and it is difficult to measure, since it contains objective as well as subjective aspects of well-being. Liu (1976) has argued that QOL has as many definitions as the people asked to define it. A review of 80 articles has revealed little agreement between authors writing on the topic (Felce and Perry 1995). Despite these measurement difficulties, there is a general agreement on five domains that contribute to personal quality of life. These domains are physical, social, emotional and material well being, personal growth, and activity (Felce and Perry 1995).

One of the main disagreements concerning QOL definitions is the contribution and relevance of *objective* versus *subjective* variables, the former focusing on objective dimensions of life, the latter on subjective perceptions. In the objective approach, QOL is defined as the level of control of resources that an individual obtains in order to consciously manage life conditions (Erikson 1974). Different scholars have criticised the objective definition of QOL, because it is based primarily on values and moral assumptions (Katz and Kravetz 1996). Moreover, research findings show that the percentage of explained variance in objective QOL measures is low (Evans 1994). Findings which show that people can stay optimistic and satisfied under very difficult conditions indicate the importance of the subjective measurement of QOL (Flynn 1989; Holland 1990). One of the

limitations of using objective measures of QOL is that the impact of culture, values and ideologies is not considered (Evans 1994).

Haycox (1995) defined QOL as a measure of well-being. The basic assumption underlying this approach is that a subjective evaluation of objective living conditions is required. Various subjective measures have been formalised using this approach, covering satisfaction, emotional state and freedom from stress (Campbell 1976). Traditional QOL studies were concerned with levels of *general* life satisfaction and psychological well being. However, later psychological studies have shown that these subjective variables are not adequate (Smith et al. 1996), and that negative and positive aspects of QOL can exist as independent dimensions (Diener 1994).

In gerontology, the term QOL was initially defined as life satisfaction, which in turn was the outcome or consequence of 'successful ageing' expressed in various theoretical approaches (Stewart and King, 1994). Empirical findings tend to support this approach more than others (Michalos 1991). Life satisfaction is therefore an important component in the definition of QOL (Frich 1998). Developmental changes in old age affect QOL. These changes can have negative effects on objective QOL. But simultaneously there are inner changes that can improve subjective QOL. In comparison with young people, elders achieve more balance in self-perception, which then strengthens a realistic evaluation of self-capacity, helping to maintain QOL (Atchley 1991).

The societal perspective is not usually considered in approaches that place the individual's personal point of view or their experience of life at the centre of QOL perception. Tesch-Romer et al. (2001) note that '*it is important to know which opportunities societies create for their members. Necessary preconditions for taking the societal perspective into account are, first comparative designs (comparing at least two societies or cultures) and, second, the detailed description of the opportunity structure of the societies to be compared*' (p. 71). Thus in the OASIS project, the variables that influence the quality of life of elders and caregivers in five countries are investigated, and links between family support, professional services and well-being are examined.

OASIS research questions, model, and research design

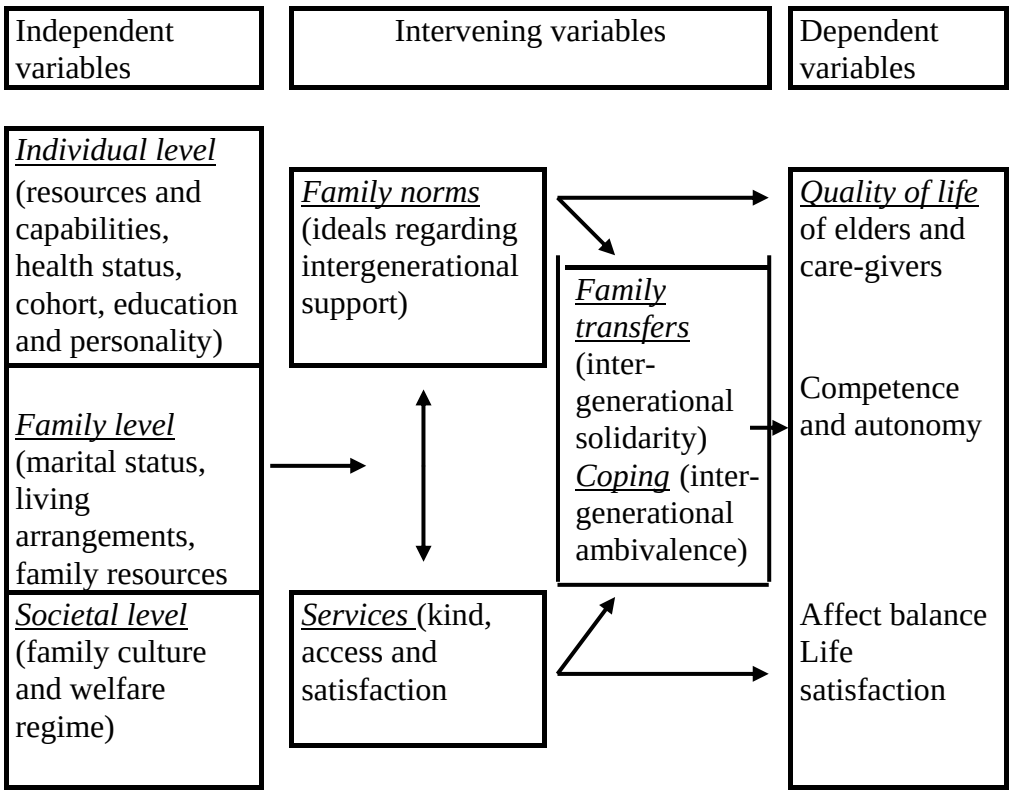
The following research questions based on the theoretical frameworks outlined for the macro, meso and micro levels and the general objectives of the study were posed:

1. What is the actual and preferred balance between families and formal service systems?
2. Do families and services substitute or complement each other in care systems?

3. How do family norms and practices (family culture) influence service systems, and vice versa, how are they influenced by welfare regimes?
4. How do these behavioural and normative patterns vary between countries and generations?
5 What are the normative ideals of intergenerational care and living arrangements in the different countries?
6. To what extent are these norms shared across cohorts/generations, and what changes are to be expected in the future?
7. How do families handle intergenerational ambivalence, and how is ambivalence related to quality of life?
8. Can intergenerational solidarity and ambivalence exist together? Is there a balance between them, and how does this reflect on quality of life in care-giving situations?

In order to answer the above research questions, a conceptual-heuristic model was developed (Figure 2). As can be seen from the model, family norms and preferences, service use, and family solidarity and ambivalence are groups of intervening variables in the study. They are linked to three clusters comprising the independent variables (individual, familial and societal levels). The combination of the independent and intervening variables influence the quality of life of elders and their caregivers.

Figure 2: The OASIS conceptual model



The five countries in the OASIS project differ in several ways. These differences include cultural and social contexts, population size, and the degree of economic development and urbanisation. Among the most important differences relevant to the OASIS project, are 'family culture' and 'welfare regime' in the five countries. Examining these differences can help to unravel the complex relations between the concepts of solidarity, conflict and ambivalence. A further objective of the study is to examine how the two concepts of family solidarity and intergenerational ambivalence influence the quality of life of elderly people and family caregivers. Solidarity and ambivalence are also examined in the context of countries at different stages of modernisation, and with different family cultures and welfare development.

Research design

The OASIS project was based on a two-stage, multi-method design of quantitative and qualitative methods. The quantitative survey consisted of face-to-face structured interviews with urban representative samples of 1,200 respondents in five participating countries – Norway, England, Germany, Spain and Israel. The samples were stratified by age groups to ensure that a sufficient number of older people would be selected for detailed analyses. The total survey included approximately 6,000 respondents, about one-third of whom were aged 75 and above and the remaining two-thirds aged between 25 and 74. A basic protocol (in English), was translated and adopted to target languages. The questionnaire included modules on the Quality of life (WHOQOL-Bref)[4], intergenerational solidarity and ambivalence, values and preferences, use of formal health and welfare systems, socio-demographic characteristics and health variables (for a detailed description see Lowenstein et al. 2002).

The qualitative sample was an extended sub-sample from the survey. It consisted of in-depth interviews with 10 elderly parent-adult child dyads in each country. In each case, the elderly parent had health problems that posed a risk of dependency. The in-depth interviews were partly constructed to validate the survey data, and partly to explore feelings of personal obligations and emotions relating to care-giving demands, dependence, coping and overall quality of life.

Conclusion

One of the central and innovative aspects of the OASIS project is the advancement of a theoretical knowledge base through the use and empirical study of two conceptual frameworks: Intergenerational solidarity and conflict versus intergenerational ambivalence. The OASIS project represents one of the first attempts to compare these two theoretical paradigms in a European context. It therefore has the potential to improve our understanding of family relations within and between different countries.

A second innovative aspect of the project is the combined application of groups of societal/macro level variables with meso and micro level variables. These groups are welfare regimes and social services, familial/meso level variables, family intergenerational solidarity/ambivalence and the changing role of women. The context of the older person's autonomy and quality of life are included for the individual/micro level group of variables. This methodology offers a fruitful avenue for exploring how cultural, social and economic factors as well as external

[4] The WHOQOL-Bref covers a range of questions on the perception of quality of life and cognitive evaluations of satisfaction with life in four domains: physical, psychological, social and environmental.

structural-environmental conditions shape care-giving behaviours and influence the quality of life of older people and their family care-givers. The results provide a basis for making policy recommendations. A third innovative aspect of the project is the use of a multi-method design of quantitative and qualitative methods, where the focus is on different age groups ranging from younger adults aged 25 to 74 to the 'old-old' aged 75 and above.

There is a wide variety and diversity of welfare service regimes in European countries. Answers to some of the OASIS research questions are not uniform. But the OASIS cross-national project provides new frameworks and contains insights to help us understand these idiosyncratic and intriguing differences, as well as sometimes the unexpected similarities between the five countries. The answers to the OASIS research questions should facilitate the development of theory and applied social policy.

As far as social policy is concerned, the OASIS survey can help to inform policy makers about the promotion of autonomy and reduction of 'the risk of dependency'. Examples include the needs of older people without children, the needs of carers (especially working carers), and evaluating community services and service use. The role of the family versus the state in care provision to the frail elderly is also an area of interest to policy makers. In summary, it is hoped that policy makers will pay attention to how the quality of life of older people and their carers can be improved.

Contents of the report

The report has four sections: The first section includes this introductory chapter and a chapter on welfare regimes, both devoted to establishing the theoretical and conceptual frameworks of the study. As the OASIS project is a cross-national study of countries with diverse welfare systems and family cultures, the second chapter describes and analyses different models of welfare states as institutions for managing risk and promoting opportunities for older people. This chapter focuses on the political cultures of the OASIS countries, and it examines the discourses on the different typologies of 'welfare regimes'. These discourses are discussed in their relation to feelings of obligation in providing support to elderly family members. Additionally, specific social indicators of the countries involved are presented in this chapter.

The second section of the report includes two chapters which describe the quantitative and qualitative methods of data collection and sampling procedures. Basic descriptive information of the samples is included here. The third chapter focuses on the survey data collection, outlining the conceptual framework of the study and assessing the overall process and structure of the project. This chapter presents the OASIS research instruments, the quantitative and qualitative sampling

strategies and the methods of analysis. Some basic descriptive statistics of the five samples are presented. The fourth chapter, on the qualitative methods, outlines the long process of developing the in-depth interviews. It also presents the different guidelines for conducting interviews and examines the process of analysis. The analysis was based on an agreed coding frame, supported by CAQDAS (Computer Assisted Qualitative Data Analyses). Throughout this process data from different interviews and across teams was compared. As a result, new configured coding frames, narratives and memos were constructed. These were then collated by the team co-ordinating the qualitative interviews and subsequently forwarded to each country team.

The third and main section of the report is the results section. This has five chapters, each dealing with the main domains of the OASIS model. Chapter 5 on 'Norms and Preferences about Elder Care' deals with the first and fifth research questions of the study: ***what is the actual and preferred balance between families and formal service systems? What are the normative ideals of intergenerational care and living arrangements in the different countries*****?** The chapter focuses on the normative bases for family care and the personal perceptions of respondents in the study. The data indicate that filial obligation norms are still strong in each of the five countries, but support for filial norms follows the geographically north-south axis, being in general higher in Spain and Israel and lower in Norway, England and Germany. Additionally, country differences reflect preferences of how these norms should be enacted. The chapter concludes that differences to norms and preferences about elder care are related to the family cultures and social policies of the OASIS countries.

Chapter 6 deals with 'Intergenerational Solidarity', attempting to answer the following research question: ***how do these behavioural and normative patterns of care vary between countries?*** Intergenerational solidarity is a multi-dimensional phenomenon with six components, expressing the behavioural, emotional, cognitive and structural aspects of family relations: structural solidarity, contact, affect, consensus, functional transfers/help and normative solidarity. The chapter presents descriptive results of the solidarity dimensions. These show that family solidarity is considerably strong in all five countries, although there are variations in the strength of dimensions. Links between demographic, familial and health variables on the different dimensions of solidarity for the elderly population (75+) were also examined. The factor of country was found to have a main effect on all solidarity dimensions, except proximity, implying that there are national and cultural idiosyncrasies which need to be explored further.

The seventh chapter, 'Ambivalence and Conflict in Intergenerational Relations' addresses the following research questions: ***how do families handle intergenerational ambivalence, and how is it related to quality of life? Can intergenerational solidarity and ambivalence exist together?*** Ambivalence has

become an important concept in the light of increasing dissatisfaction with the polarity of the solidarity and conflict models. Ambivalence has also been seen as a useful concept at times of life-course transitions, when roles and relationships are renegotiated. The results generally show that low levels of conflict between parents and their adult children can co-exist with harmonious and positively affective family relations. A typology of four groups of parent-child relationships is presented and analysed in view of the conflict and ambivalence perspectives: the *affective*, *steady*, *ambivalent* and *distant* types of relationships. The qualitative analysis of the data attempts to unravel these four family types. They show that ambivalence can be a normal state as parents and adult children struggle to negotiate a path between autonomy and dependence.

The eighth chapter in this section deals with 'Family Help and Service Use' addresses the following research question: ***how do family norms and practices (family culture) influence the service system, and vice versa, how are they influenced by the welfare regimes?*** In the OASIS project, family help and service use are viewed as key elements in delaying dependency. Formal (services) and informal (family) support have an unequal weight in the five countries and there are different levels of complementation influencing caring situations. Data presented include different sources of help in areas such as household chores, transport and shopping and personal care provided by different types of formal services: the public, voluntary and commercial sectors. Also health and welfare service use by the people aged 75+ is analysed.

The last chapter in this section, Chapter 9, deals with 'Quality of Life' and the determinants of subjective evaluations and affective states. This chapter addresses the research question: ***how do familial relations reflect on quality of life in care-giving situations?*** Theoretical considerations regarding the concept of quality of life are discussed, and the psychometric properties of the research instruments are presented. The analysis covers the influence of family support and service use on the quality of life of elders facing functional impairments. The 'buffer-hypothesis' of social support is tested in the data. The results indicate that subjective quality of life decreases with age. Gender differences are also consistent, with women scoring lower than men. Family structure and some elements of family support had limited relevance on quality of life. The important predictors were need factors such as physical functioning, and individual resources such as income and education.

The fourth and final section contains two integrative chapters: the first chapter, Chapter 10, deals with the issue of families and services as substituting or complementing each other. This chapter covers the following research questions: ***are families and services substituting or complementing in the care system; to what extent are these norms shared across cohorts/generations, and what changes are to be expected for the future?*** Families and services are the main agents for elder care, but the public-private mix takes different forms. Sustaining

existing patterns in the future may be problematic given population ageing and the rapidity of social change. The chapter presents the arguments for the substitution versus the complementarity approaches to elder care, using data on the receipt of help by elders at risk of dependency from family and formal services. The results show elements of both substitution and complementary at work. Family help tends to be higher in countries with low service levels, but when needs are met by the formal system, some families do not retreat from their obligations altogether. Instead, they find other avenues of support.

The last chapter of the report, Chapter 11, covers the social policy implications which arise from the results of the study. Although differences between countries exist, and bearing in mind the complexity of social care, similarities still remain. For example, family solidarity is strong in all the participating countries and family norms are prevalent in their urban populations. But these norms are neither absolute nor conditional. Welfare state expansion has *not* eroded filial obligations. Younger and older generations alike tend to agree on norms of filial obligation. Moreover, younger generations appear to be *more* family orientated than older generations. Overall, the preferred model is towards some mix of informal family care and formal service provision. The ideal seems to be one where the welfare state has a more central role than at present. Families do *not* downplay their responsibilities. But it seems they are shifting the focus from *providing* practical instrumental care to *managing* care, a process dependent on the relative development of services in each country.

Gender has a particular influence in areas of ambivalence and conflict, as well as upon the quality of life of family members. Women are still the main caregivers and given their increased participation in the labour force, social policies that improve the life of women and empower them are a key element, both in the context of family and the workplace.

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2

Comparing Welfare States

Hans-Joachim von Kondratowitz

Similarities and differences in cross-national research

Any comparative perspective of research has the problem of setting the *main perspective* for analysis. An emphasis can be placed either on *similarities* of social phenomena, or on *differences* of the social formations under investigation. The choice depends partly on the subject under investigation and the specific nature of the topic. But assumptions derived from explicit or implicit theoretical considerations also influence the choice of perspective. Gauthier, following the arguments of Alex Inkeles and Peter Rossi (Inkeles and Rossi 1956), has clearly pointed out two theoretical approaches in comparative cross-national research – 'structuralism' and 'culturalism': '*While the structuralist theory suggests that similarities are to be expected across countries sharing similar 'structures' (for example, a similar level of industrialization or similar occupational system), the culturalist theory instead suggests that cross-national dissimiliarities are to be expected as a result of intrinsic country-specific characteristics'*. In other words, *'while the structuralist thesis assumes that social structure has a uniform effect on individuals, regardless of other national characteristics, the culturalist thesis assumes that culture (societal values) modifies the effect of social structure on individuals and therefore results in country-specificities'* (Gauthier 2000 7).

This contrast, between looking on the one hand for potential generalisations and on the other hand for specificities, (or using the terms of Ragin: to follow the 'variable-oriented' or the 'case-oriented' perspective) has been an enduring, crucial and controversial element within comparative research. Recently, the debate over these two perspectives has become visible in the context of research on ageing (cf. Daatland et al. 2002). Ragin has summarised the main issues eloquently and appropriately by posing a dilemma in research strategies: '… *an appreciation of complexity sacrifices generality; an emphasis on generality encourages a neglect of complexity. It is difficult to have both*.' (Ragin 1987 54). Despite this dilemma, research projects should develop a theoretically legitimated way of addressing data that allows some balancing out of the two approaches. This does not mean arguing on the ground of theoretical and empirical *alternatives* alone. The idea is to consider both lines of research strategy as *complementary* and to shed light on developments made under diverse research strategies. Thus this chapter begins by directing attention to key *similarities* between all the five countries in the OASIS project and presenting social indicators to discuss the validity of such an approach. But the bulk of the chapter concentrates on the *differences* between the five OASIS countries and their dominant welfare regimes.

Confronting the existence of a 'European model'

European sociologists and historians have spent considerable time debating whether there are essential qualities that collectively constitute a specific and consistent model for a European society. This debate has important consequences for evaluating the five countries in the OASIS project, especially given that one of the countries, Israel, is arguably not part of Europe. But by referring to the five countries as 'European', we have decided to treat Israel as a society predominantly shaped and characterised by European socio-economic and societal developments and discourses. In the context of the OASIS project therefore, we do not refer simply to Israel's legal status as an associate member of the European Union. Historical traditions are equally important, as well as conceptions of welfare models stemming from a broad European background. These factors continue to shape socio-political dominant administrative strategies which in turn determine patterns of social life in Israel. At the same time, we clearly realise that as far as political and social life in Israel is concerned, the continual process of integrating culturally diverse groups of immigrants has produced new social constraints and challenges. Accordingly, new political groupings and coalitions have appeared in Israel which in the long run will certainly alter and transform the European traditions. Israel therefore represents an ideal case to examine the anticipated strong impact of a 'migration society' on dominant modes of socialisation. It also provides the opportunity to examine patterns of the societal distribution of opportunities which might be seen in the domains of intergenerational social support and care. Throughout the report, we draw attention to clear differences in the way that Israel has adopted and implemented the traditional European welfare model when these differences arise as an important factor of the analysis.

As the discussion of the inclusion of Israel shows, there are several dimensions to be critically considered when attributing structural qualities to a generally homogenous type of societal model. This problem is also apparent in the wider scientific debate concerning the existence of essential *structural similarities* between European countries arising from early modernity. Several social scientists and social historians, following the pioneering work of Stein Rokkan, have focussed on the question of whether there is a distinct European pattern or model of development which would allow, for the purpose of comparison, the identification of certain social arrangements as distinct elements of this unity (Kaelble 1987; Crouch 1999; Therborn 2000). These authors have tried to distinguish central characteristics of this model and weigh them against each other in respect to their potential impact over time. Although these authors disagree on the existence of a single unifying and specific pattern of European development in modernity, it is remarkable that they tend to agree on basic trends and patterns. Generally speaking, these authors have identified the presence of at least the following *societal similarities of modern European societies* developing over time:

- the dominance of certain *family models* (nuclear family) with the implication of a characteristic *gender-specific division of labour*

- a dominance of *social inequality* in forms of *social stratification*, especially in the existence of a *class structure*

- the apparent dynamics of spatial *social mobility* which result in *urbanisation*, with increasing agglomerations of residential settings, and accordingly a necessity to establish new planning procedures locally (cf. Kaelble 1997)

- *structures* of *industrial development* with accompanying *labour relations*, especially mechanisms of conflict management (cf. Therborn 2000)

- a relatively high degree of *homogeneity* in respect to *religion*, *ethnicity* and *political culture* (although this is at present under debate because of the effects of trans-national migration)

- the existence and increasing social impact of some *conception of a welfare state* (though its respective premises are differently elaborated and legitimised)

Evidently, these similarities (as well as other characteristics) do not help to clarify the uniqueness of the European societal model because they are now valid for many countries in the world. Moreover, an approach distinguishing common characteristics immediately provokes criticism, as most researchers of European societies tend to focus on important *differences* and how they develop over time. Finally, and most important, apparent similarities in modernity can be deciphered as the *historical products* of colonisation, where dominant cultures have imposed their ideologies on resistant minority groups. This is an observation that particularly applies to the topic of the homogeneity of religion, ethnicity and political culture. For the OASIS project countries, certainly Spain and England have colonial histories that compromise the building of harmonious ethnic-cultural relations. But although these historical factors influencing relations between ethnic groups are less evident in Norway and Germany, conflict still exists in these countries. The religious preferences of minorities in European nation states is one example where the consequences of confrontation can lead to social exclusion. And as the national-socialist regime with its open racism in Germany has demonstrated, even historical phases of less conflict characterised by implicit colonisation do not rule out the possibility of rigid exclusion mechanisms later on.

The overall conclusion of these observers is that a balance of similarities and differences only makes sense if a unique and specific quality of European societies is identified. This quality is that European societies possess the ability to bridge

these disparate processes of social change and can *manage* diversity through institutional devices. By introducing the concept of management, Colin Crouch has directed attention to '*the way in which diversity is handled*' as an '*ordered, limited and structured diversity'* (Crouch 1999 404). In a comparative perspective, a specific characteristic of European societies is that the *structures of management of diversity* are successfully institutionalised within each nation state.

However, these structures are manifestly different in each country and it is these differences that the OASIS project seeks to identify. In order to reassess *institutionalisation effects* cross-nationally, it is possible to group differences according to how diversity is managed within each nation state. This is precisely what has been done in the field of *comparative welfare state research* and one has to return to this important topic later in much more detail. But as a first step, it is important to describe the general features of the management of diversity, focusing on how it influences social policy in the OASIS project countries. This is done in the context of the above discussion regarding the genuine characteristics of a European model. Empirically based typologies are presented that distinguish groups of European countries according to how they negotiate and implement social policy.

Negotiations, political decision-making and political cultures

The central question is how the institutional devices for managing diversity within and between nations have been implemented in accordance with the democratic value systems of European societies established in the second half of the twentieth century. Parallel to this question, is whether these devices and the negotiations that lead to their implementation have been able to revitalise the structural basis of democratic procedures and to develop different policy strategies accordingly (cf. Castles and Mitchell 1993; Alber 1998; Lessenich 2002.) In other words, understanding what constitutes *modern democratic rule* in the context of (Western) Europe is the main issue. The debate about the connections between state activities and corresponding forms of democracy has convincingly been put on the agenda in the seminal work by Arend Lijphardt. Lijphardt contrasts two models of democracy: the 'majoritarian' and the 'consensus model'.

These models address the question of whether the decision-making structure of a given political system advances or limits the impact of majoritarian rule (Lijphardt 1984 1999). Based on a comprehensive investigation of numerous indicators, Lijphardt concludes that in the long run the group of consensus oriented democracies in Europe possess a larger capability to solve socio-economic problems than majority oriented democracies. This observation though, has been challenged by researchers who maintain that consensus oriented democracies have to cope with a variety of 'veto players' resulting in reform blockages and making them 'slow' to act (Tsebelis 1995 1999; Czada 2000 2002). This criticism points to

the need to consider the effects of a much wider constellation of actors and institutional forces. Lijphardt's dichotomy then transforms into a continuum of models of democracy, ranging from strictly 'majoritarian oriented' through a variety of 'consensus-negotiation oriented' models to more 'concordance oriented' models with strong and stable corporatist features (cf. Schmidt 1998 2001).

Thus it becomes possible to generate a theoretical link (as well as empirical connections) to international comparisons of democratic decision-making processes. Such a perspective would also allow socio-political themes to be considered in the OASIS project. However, this task would constitute a separate research project, and there is only the space here to summarise the results of several lines of empirical comparative research on democracies as they apply to the OASIS project. Therefore, the chapter presents a typology which is grounded in this comprehensive discourse, allowing a dynamic and flexible interpretation of the political decision-making structures in the five OASIS project countries.

The key issue at the centre of discriminating between types of political cultures (Figure 1) is what kind of *central orientation* exists in the structure of democratic decision-making: towards supporting the majority decision or controlling and limiting the majority impact. Majority oriented democracies are orientated by the principle of supporting and buffering majorities. In some democracies, the majority orientation is mellowed by incorporating decision-making processes grounded in additional *federal structures* where policies are negotiated (presented in Figure 1) as only one example from several possible elements of differentiation). The same considerations might apply to *consensus-oriented* types of democracy. Here, federal structures may be given more power by including a larger proportion of actors in the making of social policy. The fifth position, '*concordance-orientation'* refers to intensively corporatist structures of decision-making processes, such as those that exist in Austria and Switzerland. In summary, there are only a few nation states where the typology mirrors actual political processes precisely. In most cases, the 'pure' type does not exist and there are mixed forms of democratic styles, some of which even differ between themselves.

Figure 1. Political cultures of the countries in the OASIS project

Lijphardt models	**"Majority oriented"**			**"Consensus oriented"**	
Continuum of models	*majority*	*majority-federal*	*consensus-federal*	*consensus*	*concordance*
	◄	———	———	———	►
OASIS Countries	**England**		**Norway**	**Germany** **Spain**	**Israel**

The five OASIS project countries also show signs of overlap between the different democratic styles. Although most commentators agree that the UK represents a comparably 'pure' example of majority-orientation, it could be argued that recent changes in the political participation of provinces (Wales, Scotland, Northern Ireland) has shifted the UK into the 'majority-federal orientation' domain. Equally, whereas Germany and Spain are often regarded as similar, Spain has experienced a 'transformation democracy' where the relation between consensus-orientation and federal decision-making structures is characterised by especially strong tension between the central and federal decision-making bodies (the problem of 'autonomous entities'). In contrast, although Germany's democratic structures can be classified as occasionally conflict-ridden, most of the time they operate smoothly in common with strategies of consensus. Finally, while it is uncontroversial to attribute *Israel* to the consensus oriented democratic model, the particular decision-making structure of Israeli politics and the formal and informal negotiation bodies within its political system reveal some similarities with countries who have a dominant concordance orientation. The Israeli inclination to concordance may be seen most clearly in the implementation of new social policy strategies.

The emergence of new directions in social policy is a good example of the importance of organising the OASIS countries into a *grid of political cultures*. In studying how diversity is handled within decision-making processes and their accompanying negotiation bodies, it may be possible to determine the concentration and speed of emerging options in new areas of social policy. Countries at the 'extremes' are, at least in the short-term, in a more favourable position as they can rely on a clear-cut structure when handling diversity. Disagreements and conflicts that subsequently emerge are treated separately, but at least this can be done on the basis of a management result. In contrast to these 'accountable patterns' (following Liphardt's argument) the more consensus-

oriented countries have to activate time-consuming counter-forces, make compromises, and establish new networks. But this extensive negotiation process makes solutions much more 'conflict-proof' in the long run. The influence of mediating bodies as integral to social policy formation will increase within nation states and extend to an 'inter-organisational' level of multi-national policy co-ordination. The possible impact of 'multi-level' and 'multi-actor governance' is currently widely discussed in the context of an emerging European social policy. It may be important for Europe's future, particularly in respect to achieving a multi-level subsidiarity principle. A central message of recent reforms is indeed the emergence of co-operative, public-private partnerships (cf. Falkner 1999). These are essential developments at the European level, which have led some commentators already to speak of the appearance of 'semi-sovereign welfare states' (Leibfried and Pierson 1998).

Confronting and differentiating typologies of 'welfare regimes'

The welfare state is one of the essential components of the 'European Model' described above. Therefore, this section compares different welfare states in Europe, focussing on how this well developed debate informs the objective of the OASIS project. Indeed, one of the premises of the OASIS project is to incorporate the results of this debate when identifying similar countries and to use the results as a platform for further research. The five European countries were chosen as units of research and as points of reference for analysis. They were selected under the following premises:

- All five countries represent *complex welfare state arrangements* in modern societies where the issue of *family solidarity* and how it interacts with existing *service systems* are currently under discussion for a variety of reasons, among them the future development of social care and support to people in need.
- At least four of the European countries belong to one of the types of welfare states distinguished in the international literature. The fifth country, *Israel*, presents particular challenges because Israeli society has diverse family cultures due to its unique multi-cultural population. Israel also has a wide range of social services backing up family provision.

There is currently a rich and diverse array of approaches distinguishing welfare states. These are briefly covered here as they relate to the OASIS project objectives.

The most well known typology of 'welfare regimes' has been developed by Esping-Andersen building on the work of Richard Titmuss (Esping-Andersen 1990). Esping-Andersen distinguishes welfare states by the degree to which they have institutionalised processes of 'de-commodification' - the extent to which individuals are able to survive without selling their labour - and the degree to which de-commodification is institutionalised in different countries. This

differentiation brings him to the three types of welfare states: '*market liberal*', '*conservative-corporatist*' and a '*social-democratic*' welfare state. The typology provides a solid base for comparing social security transfers in countries with different welfare regimes (employment centred vs. universalistic; or the 'Bismarckian' vs. the 'Beveridgian model'). But it is extremely weak in explaining family transfers and not at all useful to analyse the dynamics of service delivery. The analytical weight of Esping-Anderson's typology is on labour markets and the principles underpinning social security arrangements. The UK, Germany and Norway are examples of each respective type of welfare regime.

In order to analytically situate Spain (and possibly Israel) within the OASIS project, it is necessary to reactivate another discussion revolving around the comparison of welfare states. There have been intensive debates over whether it is justified to distinguish a separate 'southern-European welfare state' or 'Mediterranean welfare state', with several distinctive characteristics:

- a high relevance of transfer payments coupled with a high level of occupational status and institutional fragmentation, but a low level of protection for non-institutionalised labour markets.

- an unbalanced distribution of social protection across standard risks. This is manifest in an *over-protection* of risks associated with old age (through a larger share of public pensions), an *under-development* of family benefits and services, and an under-development of public housing. Looking at recent indicators on public social security expenditures, Table 1 shows that at least with respect to the share of public pensions, Spain (but not Israel) could on the one hand still be attributed to the 'Mediterranean model'. But it is already leaning towards the middle and northern European welfare states. However, Italy and Greece have higher levels of public pension expenditure and fairly limited health care services, so they too fit the 'Mediterranean model'.

Table 1: Public social security expenditures 1990 and 1996

	Total social security expenditure*		Pensions*		Health care*		Total social security expenditure as proportion of total public expenditures	
	1990	**1996**	**1990**	**1996**	**1990**	**1996**	**1990**	**1996**
Norway	27.1	28.5	9.1	8.9	6.7.	7.0	52.7	57.7
UK	19.6	22.8	8.9	10.2	5.4.	5.8	45.8	56.7
Germany	25.5	29.7	10.3	12.4	6.7	8.3	54.3	52.1
Spain	19.6	22.0	9.4	10.9	5.4	5.8	45.8	56.7
Israel	14.2	24.1	5.9	5.9	2.7	7.6	27.5	47.4
Italy	23.1	23.7	13.5	15.0	6.3	5.4	42.9	45.9
Greece	19.8	22.7	12.7	11.7	3.5	4.5	57.8	67.4

Notes. * proportion of GDP.
Source: International Labour Organization, World Labour Report 2000, Géneve ILO Office, Tab.14
Total social security expenditures covers expenditures on pensions, health care, employment injury, sickness, family, housing and social assistance benefits in cash and in kind, including administrative expenditures. *Pension expenditures* includes expenditures on old age, disability and survivors pensions. *Health care expenditures* covers expenditures on health care services.

A similar picture appears in figures for 'social protection expenditures' available for the OASIS countries through Eurostat. The figures in Table 2 show basically the same picture as Table 1, but with Spain developing into an even clearer middle and northern European pattern of welfare delivery in respect to old age benefits (again in contrast to Italy and Greece).

Table 2. Social protection expenditures and old age benefits

		Social protection expenditure as a percentage of GDP	0ld age benefits as a percentage of total social benefits
Norway	1998	27.9	42.7
UK	2000	26.8	47.7
Germany	2000	29.5	42.2
Spain	2000	20.1	46.3
Israel	2001	n a (31.1)*	n a
Italy	2000	25.2	63.4
Greece	2000	26.4	49.4

Notes: Social protection expenditures comprise the following groups: old age, survivors, health care, family and children, invalidity, impairment, unemployment, housing, social exclusion etc. These figures add additional health costs as well as unemployment benefits to the 'social protection expenditures' but they are not available for countries outside of the European Community (except Norway, Iceland and Switzerland); * the value comes from a recent white paper; otherwise equivalently calculated Israeli data not available
Source: EuroStat 2001, 16; EC-EuroStat 2000, 1.1.12, p.52; Eurostat (2001): Social Protection Expenditures and Receipts 1980-1998, Luxembourg; Statistics Norway 2001.

But there are more characteristic elements of the Mediterranean welfare state model which deserve attention in connection with the OASIS project:

- a low degree of regulating welfare production by not actively supporting a mix of public and private actors, especially in the institutional sector.
- a universalistic design of the health domain by institutionalising national health services. In this respect, Spain again fits a 'Mediterranean model', as shown in Figure 2.

Figure 2 shows that all OASIS welfare states have a potentially universalistic perspective in securing health care. But organisational devices differ. These differences have consequences for the domain of personal care where there are two basic models of public health delivery. *National health services* are considered to be more cost-controlling but with lower quality standards and 'waiting lists' for service delivery. In contrast, *insurance based solutions* are more cost-expanding and they are regulated intensively through negotiations between health care actors (cf. Immerfall 1993).

Figure 2. Prevailing health care provision

Country	***Type of Provision***
Norway	Universal Health Insurance Coverage
UK	National Health Service
Germany	Universal Health Insurance Coverage
Spain	National Health Service
Israel	Universal Health Insurance Coverage

In summary, Spain *seems* to have many characteristics of the southern European welfare state. But even if one could demonstrate this conclusively, Spain does not seem to represent a 'clear cut model', but a rather reduced version with strong connecting points to central European welfare states. And the expectation that Israel might correspond with this 'Mediterranean' type is even less justified on the basis of the data examined so far. Although disagreement about the existence of the 'Mediterranean welfare state' remains, simply recognising its absence means that the important issue of family support and service delivery is brought to the centre. And it is exactly at this point that gender issues regarding the welfare state have been taken up.

The latest development in typologies of welfare states is the contribution of feminist researchers (Lewis 2000). Here, the analytic weight is put on family work as *unpaid women's work*. The classifying principles of welfare states are thus redefined. Researchers such as Lewis, Sainsbury, Orloff and O'Connor emphasise

the importance of unpaid women's work and focus on 'caring/care regimes' that revolve around a male 'breadwinner', the children and the elderly. Such a typology juxtaposes welfare states in which the 'male breadwinner family' is dominant and those where a 'parental model' is enforced (concentrating benefits on children and thereby acknowledging women as 'workers' as well as 'carers'). Finally this typology distinguishes welfare states where a 'two breadwinner family' is encouraged. A more developed version of such a perspective is presented later for organising the available indicators.

It is clear that these feminist perspectives for discriminating between welfare states are strongly influenced by debates on child care and their societal support dimensions. As far as the care of the elderly is concerned, there is little in the way of suggestions and the number of studies that treat child and elder care simultaneously and systematically are few. This clearly shows that it is difficult for one typology alone to address *all* the domains of the OASIS project and the perspective of elder care in particular. Instead, the central elements from the available typologies should be selected according to the particular analysis being undertaken. This can be done, even though there is a risk of throwing the baby out with the bath water - that the obvious advantage of a typology (helpful and convincing attributions and groupings for the sake of a long term analysis) cannot be sustained without introducing further classifications and reducing substantially the ability of the typology to discriminate between different groups.

Esping-Andersen himself has contributed to a more dynamic perspective of welfare states in his last book, where he critically reassesses his earlier work and advocates considerably modifying his original concept of 'welfare regime' (Esping-Andersen 1999). He now conceives of such 'regimes' as institutional devices pooling social risks and, reacting to feminist critics, he distinguishes '*three radically different principles of risk management*': *state*, *market* and *families*. Moreover, welfare states can be differentiated according to the way they make risks socially manageable and how the relation between the principles underpinning these risks are institutionally defined. Social risks are therefore essential and core elements of welfare regimes and they can '*be internalised in the family, allocated to the market, or absorbed by the welfare state"*. And '*where the state absorbs risks, the satisfaction of need is both "de-familialised" (taken out of the family) and "de-commodified" (taken out of the market)'* (Esping-Andersen 1999 40). 'De-familialisation' is now an equal partner of the category of 'de-commodification' within his analysis. However, this essential conceptual enlargement did not bring him to revise completely his original typology which he still considers to be a valid analytical tool.

Esping-Andersen's reformulation has consequences for comparative analyses. The OASIS countries are therefore now examined as *settings for managing risks and opportunities* and this set of indicators are examined later within a perspective

which tries to arrange indicators of *dominant family models* in each country which influence the how social care is organised.

Risks and opportunities in European welfare states

Socio-political processes and the social construction of risks and opportunities in modern welfare states can be approached on different levels of analysis. In this section, the welfare dynamics on the macro level are considered by discussing the impact of some indicators of state activity on general welfare conditions. The section is divided in two. First, information about the general socio-economic conditions of the OASIS welfare states is compared. These conditions partly constitute the frame of reference in which policy options are processed and institutionalised. Second, some indicators are presented from the *vital statistics* of all the countries concerned. Here, 'life course markers' are discussed, since in a comparative perspective demographic dimensions play a key role in determining the nature of debates about social care and the potential of intergenerational help and support. These indicators represent somewhat contingent developments which are influenced and moulded by different policy options over service arrangements and implementation strategies.

The distribution of social benefits provides a familiar (but controversial) indicator to examine further the five welfare states under investigation (Table 4).[1] The three indicators in Table 4 are regarded as controversial in a cross-national context because they are based on proportions only, meaning that they have little explanatory power. This is because the indicators are sensitive to the evolution of the GDP itself, and therefore they give more information about the general socio-economic situation in *each* country rather than providing differences *between* countries. More importantly, any ranking disregards different historical stages of development. Also, rising social expenditure does not mean that welfare states are well equipped to solve socially defined problems. On the contrary, they might turn out to be also *causing* social problems connected to the very concept of the welfare state. Finally, cross-national data bases can often misleading, because government statistics tend to give higher and more ambitious values which often result from different methods of calculating statistics. In addition, the premises on which these calculations are based often differ between countries, a fact which makes cross-national research additionally problematic (cf. Schmidt 2001, 34). It is therefore generally accepted that the comparison of these indicators does not allow a ranking of countries in respect to standards of social performance.

[1] These figures also complement those on social security expenditures shown in Tables 2 and 3.

Table 4. Quota of social benefits as proportion of GDP (1995)

	Public social benefits	Public and private compulsory benefits	Price-adapted per-capita social expenditures for public expenditures only*
Norway	27,59	28,48	5236
UK	22,52	22,79	3779
Germany	28,01	29,61	5451
Spain	21,49	21,49	2771
Israel	19,14* (27.44)**	n a*	n a*

Notes. * in Geary-Khamis Dollars; *the Israeli calculation uses other values and price adaptations (as PPF). **if health expenditures are added.
Source: OECD 1999; Column 4 calculated: OECD 1999; Madison 1995, Appendix D; from: Schmidt 2001, 35.

Social benefits are predominantly useful to identify major differences between countries and to demonstrate that different social policies result in historically different performance levels and outcomes (for example in different standards of living). However, differences between the OASIS countries are slight, pointing to the generally high performance of European welfare states (cf. Wagschal 2000). The differences between the higher values of Norway, Germany and Israel on the one hand and the lower values of Spain on the other hand say more about important historical divergences in the pace of evolving welfare states in these countries. Also, it is well known that in all countries, expenditure on social benefits is overwhelmingly made via the public sector. Although Spain and the UK are normally classified as having different welfare regimes, compulsory benefits paid through the private sector particularly do not seem to play a decisive role, at least not according to the data of 1995. Whether the pattern in Table 4 holds in the light of more recent data, reflecting particularly UK privatisation strategies in the late nineties, remains to be seen.

The ability to manage the personal care needs of the elderly in the future depends upon long-term changes over the life course. These include trends in life expectancy patterns, and in particular the projected increase in the number of older people who will need personal care as well as changes in the future availability of caregivers, particularly women. Therefore it is necessary to contrast different social indicators in the OASIS countries concerning the life course.

Table 5 shows the development of life expectancy figures for the OASIS countries. By comparing life expectancy at birth for 1950 with 2000 it is clear that all countries are subject to the epochal demographic changes characteristic of ageing societies. In Norway, already in 1950 the general life expectancy at birth was relatively high and by 2000 it is women who gained greater increases in life

expectancy compared to men. The available figures for the other countries are fairly similar for life expectancy at birth (with Spain having the lowest levels). By 2000 this had clearly changed, with Spain having made the most gains in life expectancy, confirming it's reputation of developing modern life course patterns at a quicker pace than other European countries. The 'frontrunner' position of Spain is also reflected in the figures for life expectancy at age 65 in 1999. At this age, the middle and northern European OASIS countries are fairly close to each other for both men and women, but with Norway among the lowest levels.

Table 5. Life expectancy at birth and at age 65

		At birth* 1950	At birth* 2000	At age 65** 1999
Norway	Male	70.3	75.7	14.2
	Female	73.8	81.6	17.9[2]
UK	Male	66.2	75.0	14.6
	Female	71.1	80.5	18.3
Germany	Male	64.6	74.3	14.7
	Female	68.5	80.8	18.6
Spain	Male	59.8	75.3	16.0
	Female	64.3	82.5	19.9
Israel	Male	NA	76.2	15.8
	Female	NA	79.2	17.8

Source. * US Census Bureau (Kevin Kinsella, An Aging World 2001); ** US Bureau of Statistics

Table 6 shows the proportion of the elderly population in the OASIS countries for 2000, and the projected proportion for 2005. These data demonstrate again the general acceleration in life expectancy, particularly for Spain (together with Germany and, to a certain degree, also the UK) with Norway leading the field and Israel staying behind.

Table 6. Proportions of the population aged 60+ and 80+

	Percentage 60+		Percentage 80+	
	2000	**2005**	**2000**	**2005**
Norway	19.6	20.3	4.5	4.9
UK	20.6	21.4	4.1	4.5
Germany	23.2	24.8	3.6	4.5
Spain	21.8	22.8	3.8	4.5
Israel	13.2	13.2	2.1	2.5

Source: United Nations Population Division Database 2001

The HALE model of the WHO statistics provides another way of looking at increases in life expectancy. This model includes an adjustment factor for periods of poor health throughout the life course based on health indicators for each country. The figures in Table 7 show that poor health does not change the picture drastically. But the population in Spain, Norway and Israel once again (at least for men) has a longer life expectancy than in the UK and Germany.

Table 7. Healthy life expectancy estimation for 2000

Indicator HALE	Total pop. at birth	Healthy life expectancy at birth (years)		Health Life expectancy at age 60 (years)		Expectation of lost healthy years at birth		Percentage of total life expectancy lost	
		Male	Female	Male	Female	Male	Female	Male	Female
Norway	70.5	68.8	72.3	15.8	18.2	6.9	9.1	9.2	11.2
UK	69.9	68.3	71.4	15.3	17.4	6.5	8.5	8.7	10.6
Germany	69.4	67.4	71.5	14.8	17.6	6.9	9.2	9.3	11.4
Spain	70.6	68.7	72.5	15.8	18.3	6.6	9.8	8.8	11.9
Israel	69.9	69.3	70.6	16.2	17.1	7.3	10.0	9.6	12.4

Note. Healthy Life expectancy (HALE) is based on life expectancy (LEX), but includes an adjustment for time spent in poor health. This indicator measures the equivalent number of years in full health that a new-born child can expect to live based on the current mortality rates and prevalence distribution of health states in the population.
Source: WHO Statistics - HALE Annex Table 4 (Confidence intervals not presented).

The role of health throughout the life course needs be followed in more detail by examining *mortality patterns*. Table 8 compares selected mortality causes between the OASIS project countries.[2] A comparison of the figures for 'malignant neoplasms' shows that men have higher mortality rates than women. The closest country to the calculated life expectancy for men being Israel, followed by the UK. For the category of 'heart diseases' men tend again have higher rates, but with the remarkable exception of Germany and Spain where women have higher rates. Germany figures high for 'diseases of the circulatory system'. For 'cerebro-vascular diseases' there are also important gender differences, with women in all countries most likely to die of these diseases. Finally, there are no substantial gender differences for 'diseases of the respiratory system'. But the large differences between Germany and Israel on the one hand, and the UK on the other hand, are remarkable.

[2] The selection criteria are influenced by the well known epidemiological debates about the future prominence of chronic diseases over the life course. It is regrettable that the WHO statistics do not go beyond the conventional 65+ age cut-off point to allow a more differentiated picture of mortality causes among the elderly.

Table 8. Life expectancy and chances per 1000 of eventually dying from specified and selected causes

Country/ Year	Sex	Age	Years of life expec-tancy	Malignant Neoplasms	Diseases of circulatory system	Heart diseases	Cerebro - vascular diseases	Diseases of the respira-tory system
Norway 1995	*Male*	45	31	247.2	457.8	321.3	96.1	111,2
		65	15	235.6	469.9	323.0	104.9	123.1
	Female	45	37	205.6	459.4	288.8	136.2	121.8
		65	19	174.5	482.0	302.2	143.7	128.1
UK 1996	*Male*	45	31	266.3	443.9	313.5	89.9	162.2
		65	14	250.5	450.1	310.6	96.9	179.2
	Female	45	36	221.4	438.4	269.0	134.1	169.4
		65	18	192.1	457.3	278.8	141.9	179.2
Germany 1996	*Male*	45	31	263.2	475.2	329.2	100.7	79.3
		65	14	245.8	507.6	345.5	112.6	87.3
	Female	45	36	210.6	548.0	344.8	139.5	54.5
		65	18	184.8	577.7	362.4	147.9	56.5
Spain 1995	*Male*	45	32	287.2	364.2	219.0	106.1	129.7
		65	18	261.0	383.3	224.5	116.3	143.4
	Female	45	38	173.8	482.6	267.4	156.6	85.1
		65	20	151.1	501.1	276.2	163.3	88.4
Israel 1996	*Male*	45	33	242.0	402.5	268.7	111.1	75.7
		65	16	229.6	414.2	272.7	118.0	81.2
	Female	45	36	219.4	421.4	252.7	133.3	75.6
		65	18	195.1	439.8	262.6	139.9	79.7

Notes. Norwegian and Spanish data only available for 1995 as last entry.
Source: WHO health statistics 2000, Table 3 (includes data received since publication of 1996 Edition)

The final table in this section (Table 9) shows dependency ratios. As far as old age dependency ratios and parent support ratios are concerned, Norway again has higher rates but the UK and Spain following closely, with Germany and especially Israel lagging behind. These values point to the trends that have repeatedly been emphasised. The rapid demographic changes that Spain is currently experiencing will shape the social life of this country considerably putting the issue of the balance between professional services and family care on the political agenda.

Table 9. Elderly dependency ratio, total dependency ratio and parent support ratio (2000)

	Elderly	Total	Parent Support
Norway	24	54	26.18
UK	24	53	23.77
Germany	24	47	19.09
Spain	25	46	23.42
Israel	16	62	17.86

Note. Elderly Dependency Ratio is the ratio of the population aged 60 years + to the population aged 15-59. The total dependency ratio is the ratio of the sum of the population aged 0-14 and that aged 60+ to the population aged 15-59. Both ratios are presented as number of dependants per 100 persons of working age (15-59). The parent support ratio is the ratio of the population aged 50-64 to the population aged 80+ x 100.
Source: United Nations Secretariat: *World Population Prospects: The 2000 Revision* and *World Urbanization Prospects: The 2001 Revision.* Further reference (without Israel): EuroStat 2001, 16; EC-EuroStat 2000, 1.1.12, p.52; Parent support ratios calculated based on data from: *World Mortality in 2000: Life Tables for 191 countries*. WHO 2002. N: p.376-377; UK: p.484-485; G: p.256-257; Sp: p.442-443; Isr: 290-291.

Risks and opportunities in European welfare states: individual dimensions and outcomes

Individuals and families are confronted with risks and opportunities which are often mediated by the welfare state. Several indicators of these risks and opportunities are discussed here to demonstrate how they are distributed in the OASIS countries. Three main themes are presented: '*social participation via employment*', '*available income resources*' and '*risky life situations*'. Table 10 shows figures for 'social participation via employment .

Table 10. Labour force participation (2000) (%)

	15-64 years	55-64 years	65+ years	Unemployment	Long term unemploy-ment
Norway	75.2**	63***	8.1	3	5
UK	75.9	49	4.4	6	2
Germany	70.1	38	2.3	9	5
Spain	61.2	35	2.0	16	7
Israel	68.5	50	10.5	9	11***
Year	2000	2000	2000	2001	2001

Note. *unemployed for at least one year; **(16-66); ***(55-66); ****Israel estimates: Statistical Abstract if Israel 2002, based on 12.24, 12.24.
Source: EuroStat 2001, 16; Statistics Norway-Webpages; International Labour Organization, World Labour Report 2000, Géneve ILO Office.

Regular employment is an important indicator for social integration into the culturally transmitted achievement structure of an industrialised society. Participation in the labour market over the life course is particularly instructive for evaluating social status. In this respect, the selected indicators in Table 10 are sufficient for a comparison between the OASIS project countries. These indicators show that the 'institutionalisation of the life course', with its age-related markers is still a dominant feature of social organisation for all countries, especially for the beginning of the retirement phase. Nevertheless, there are still considerable differences to be taken into account. Norway is by far the most advanced country, in so far as it has greater opportunities for higher age groups to continue in paid employment (63 % for the age groups 55 – 66). Moreover, Norway has even higher participation rates for the age groups of 67-74 than all the other OASIS countries, although the effects of the institutionalisation of the life course shown by the notable decrease in employment rates after the age of 55 do show for Norway as well.

The participation of women in the labour market shows even more dramatic differences between the OASIS countries (Table 11). It is well known that these figures reflect the changing role of women and that the welfare state is forced to invest in measures to make family work and employment more compatible for both sexes. A rise in female employment rates also implies a relinquishment of the traditional role of women as exclusive carer in the domestic arena. This trend has clear consequences for the future availability of women as carers.

Table 11. Labour force participation rates of population at age 15-64 (%)

		1980	1990	1995	2000
Norway	*Men*	84.79	81.17	80.34	79.50
	Women	60.79	68.52	70.16	71.81
UK	*Men*	89.80	85.21	83.87	82.53
	Women	56.87	62.51	63.88	62.25
Germany	*Men*	84.98	80.54	79.69	78.84
	Women	54.76	59.17	60.19	61.21
Spain	*Men*	85.19	79.87	78.79	77.72
	Women	31.40	39.99	42.42	44.84
Israel	*Men*	84.31	82.09	81.32	80.55
	Women	40.71	48.39	51.72	55.04

Source: International Labour Organization, World Labour Report 2000, Géneve ILO Office

The figures in Table 11 give a clear message that female labour force participation rates are increasing in all OASIS countries. For men, although rates are (not surprisingly) considerably higher, there has been a slight decrease over this twenty year period. On the one hand, countries such as Norway have had relatively high rates of women in the labour market for some time. But even in Norway, further

increases can be seen. On the other hand, Spain and Israel have seen a massive rise in female labour force participation rates, a phenomenon which will have considerable socio-political consequences. The UK and Germany also show rising female employment rates, but they still are considerably lower than the Norwegian level.

Table 12 differentiates these overall patterns according to age groups. The figures show similar trends in all countries. Rates of men in the labour force show recent signs of decreasing drastically in the last two age groups (55-59 and 60-64). But Norway, Israel and also the UK still have a considerable proportion of men in the labour force among these age groups. This trend is contrary to Germany where rates for men fall substantially, particularly in the 60-64 age group which over a twenty year period reflects the 'German early exit-model'.

Table 12. Labour force participation rates of population for selected age groups (%)

		1980				1990				2000			
		45 - 49	**50 - 54**	**55 - 59**	**60 - 64**	**45 - 49**	**50 - 54**	**55 - 59**	**60 - 64**	**45 - 49**	**50 - 54**	**55 - 59**	**60 - 64**
N	***M***	93.68	91.02	88.17	74.69	93.44	88.96	82.12	63.80	93.22	86.97	79.38	59.42
	W	79.20	70.00	50.00	25.00	82.26	75.09	62.72	46.04	88.33	77.19	65.26	45.35
UK	***M***	97.10	95.40	91.75	75.00	93.87	89.71	80.73	58.08	93.09	87.90	77.68	53.11
	W	67.95	65.00	55.85	24.70	73.73	66.71	52.86	22.21	80.12	71.09	51.36	20.97
G	***M***	96.05	92.89	83.24	47.82	96.82	93.43	75.95	32.24	96.81	93.17	74.48	29.84
	W	59.04	52.35	42.82	17.97	70.38	62.98	40.47	10.26	75.44	67.58	42.78	8.93
S	***M***	94.98	91.01	84.96	64.53	93.92	88.90	76.16	47.24	93.82	86.93	72.54	42.03
	W	28.31	26.17	24.09	17.67	34.59	29.30	23.18	15.57	41.35	34.37	22.72	14.53
I	***M***	93.70	91.40	85.00	72.40	93.70	91.40	81.42	64.13	92.95	90.18	79.16	60.87
	W	45.07	39.83	30.00	18.00	58.59	50.18	37.20	20.16	67.45	57.28	41.97	22.12

Note. N=Norway, UK=United Kingdom, G=Germany, S=Spain, I=Israel; M=Men, Women
Source: International Labour Organization, World Labour Report 2000, Géneve ILO Office

The same pattern can be seen in the figures for women - a clear fall in rates of labour force participation, beginning in the age group 50-54 and continuing with increasing pace until the age group 60-64. Women exit the labour market earlier than men, perhaps because of special exit rules. But again the fall has to be seen relative to the level (for age as well as time) where it started from. Norway still has a high proportion of women in the labour force among the age groups 55-59 and 60-64. The same applies for the UK and Israel, although both somewhat lower. A steep fall can be seen in the German figures for 1990 and 2000, while the decrease in countries with lower proportions of women in the labour force (for example Spain) are less dramatic.

Another social risk factor is poverty, particularly among higher age groups. Definitions of poverty are however controversial. EuroStat calculates poverty rates as a percentage of the population with an income less than 60% of the national median.[3] Table 13 contains Eurostat figures, but only for three countries of the OASIS group (UK, Germany and Spain).

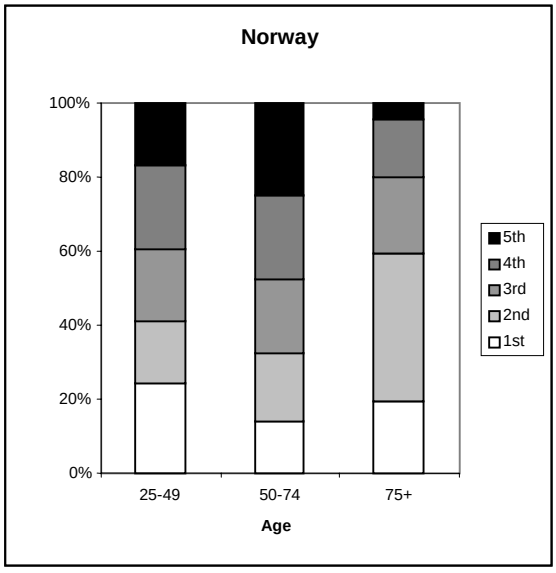
Table 13. Poverty rates in 1996 (%)

	Poverty rates*	Continuous low income**
UK	19	8
Germany	16	7
Spain	18	10

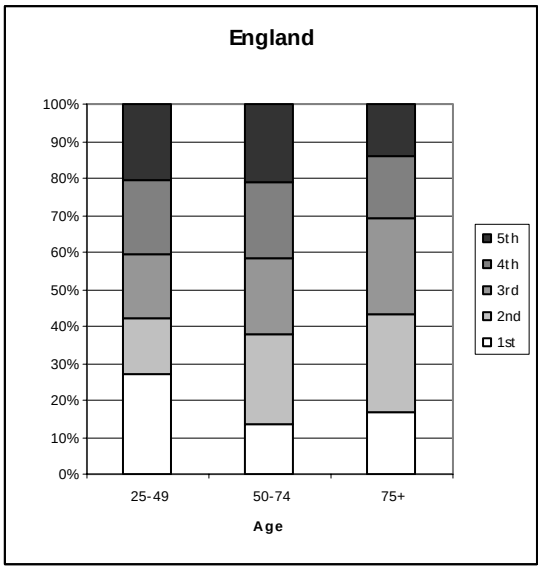
Note. * Proportion of the population with an income less than 60% of the national median 1996; **proportion of population with an income less than 60% of the national median from 1994-1996.
Source: EuroStat 2001, 16; ECHP-User data bank, Version 2001/9

The figures in Table 13 also include an indicator for continuous low income. Since comparable data for Norway and Israel are not available, the income of the OASIS survey respondents (using the age groups 25-49, 50-74 and 75+) are shown in Figure 3 to allow some general comparison to be made, even though the age group of 75+ is reported in the Eurostat figures.[4]

Figures 3a-3e. Quintiles of equivalent income by country



[3] The latest available data are from 1996.
[4] Because the OASIS survey was stratified by age, the data are weighted (see Chapter 3 for details)


England
100%
90%
80%
70%
60%
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40%
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20%
10%
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25-49
50-74
75+
Age
5th
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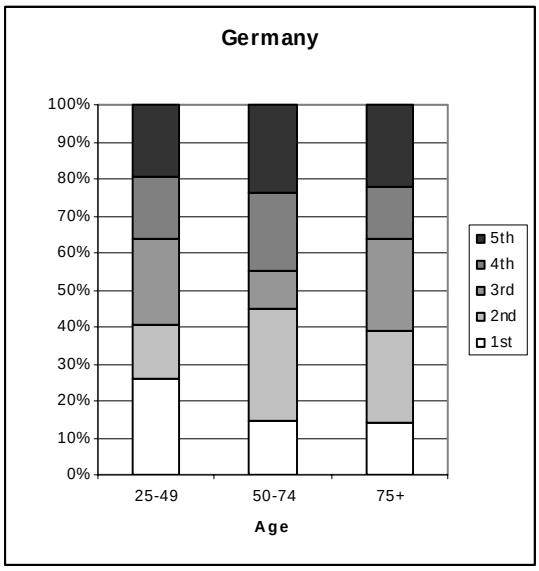
3rd
2nd
1st


Germany
100%
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50-74
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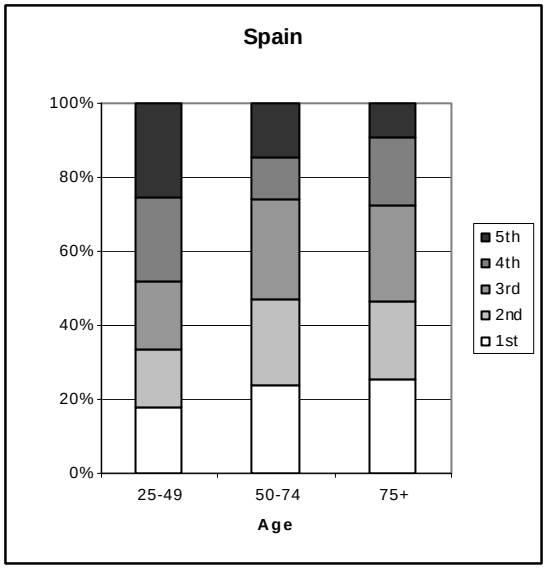

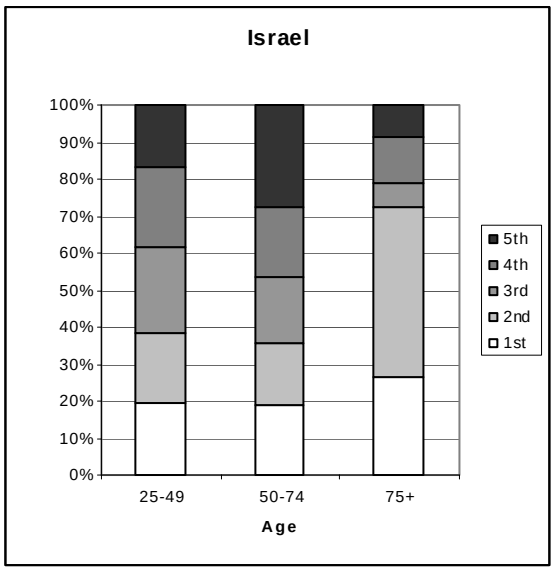

Notes. Quintiles of equivalent income by country as the per household income deflated for household size and composition defined by the old OECD scale of equivalence weights to adjust for effects of the economies of scale (Faik, 1995; Figini, 1998; Merz et al., 1993)

Source: OASIS 2000, n=4684

The lower rates of poverty in Germany shown by the EuroStat figures in Table 14 are confirmed in Figure 3. Norway now enters the picture with relatively high incomes among the elderly. Spain appears to have the lowest level of incomes, but is comparable to England. Elderly Israelis show a peculiar pattern, with most of the population in this age group among the top two quintiles and its levelling out in the lower and middle income groups.

Risks are not only negotiated and processed at the level of the welfare state. They also emerge as an expression of constraints encountered in real life situations and by an accumulation of specific needs. Two types of risk life situations can be identified: *emerging and still unregulated situations*, and situations which have been *already regulated by welfare state interventions* (although remaining an important feature of the socio-political agenda). In the context of elder care, two indicator sets describing both types of risk are presented. For the emerging but unregulated type, indicators of living alone are presented, and for welfare state regulated situations, health in daily living which has been a topic for socio-political interventions in all OASIS countries, but which serves also as an important discourse in the area of care policies.

Research has shown that living alone in old age presents risks for emotional well-being and accessing help and support when in need. The figures in Table 14 confirm the patterns already described throughout the life course. Norway, (followed at a certain distance by Germany and the UK) has a higher proportion of people living alone than couples with children. Spain is the country with the lowest proportion of people living alone. But the proportion of Spanish couples with children households is relatively smaller than in Israel. In any case, the strong service orientation of the Norwegian welfare state is certainly justified and quite comprehensible under these demographic conditions.

Table 14. Household composition, 1997 and 2001

	One person	Couple with dependent child(ren)	Three or more adults and dependent children	Couple only
Norway	38	23	10	24
UK	12	35	8	41
Germany	15	31	12	39
Spain	4	33	28	33
Israel	17	49	9	20

Note. For Norway and Israel 'One male/female person with children to be cared for' not presented.
Source: ECHP-User data bank, Version 2001/9; Norway: Population and Housing Census 2001 Tab.6; Israel: estimates for 2001, based on Statistical Abstract of Israel 2002; Tb. 5.3.

Family and gender cultures

By introducing the concept of 'family and gender cultures' some researchers of comparative welfare states have intended to point to a *complexity* of cultural definitions. 'Gender cultures' are the cultural constructs of a gender specific division of labour in the private and public spheres. Important cultural constructs include the social construction of age, concepts of generations, the social roles associated with being a 'father' and 'mother', and norms and preferences for being care for on the individual as well as the societal level.

Within this debate researchers have identified six *family and gender cultures*. These models are represented as a continuum, ranging from more 'traditional' to more 'modern' forms of combining paid work and caring tasks within families. The principles on which the models are based undoubtedly depend on historical research on family structure. Within this debate, 'care' mostly means 'child care', and that is why it has important implications for research on gender roles. But recently, the necessity of integrating elder care into these models has been increasingly discussed, although empirical research has yet to be undertaken (cf. Bang et al. 2001; González López and Solsona Pairó 2001). This is a work programme which clearly exceeds the possibilities of the OASIS project, although its results could have a place in such a programme. Notwithstanding these difficulties, the OASIS data can provide some information on how different family models relate to the availability of child and elder care services.

The six *family and gender cultures* are presented below, complemented with commentaries about possible changes in the utilisation of home and institutional care for the elderly.

Family models

A. Family economic gender model

- co-operation between men and women in a family economy context with flexible attribution of roles according to situation
- children as well as the elderly are seen as an integral part of the conditions of production within a family economy
- institutional care arrangements for elder care are developed only in case of being unable to participate in this economy

B. Male breadwinner/female home carer model

- distinct separation of private/public spheres. The role of women is seen as complementary in household

- children are treated as family-elements to be supported within a dominant female care perspective
- elder care in the domestic sphere is seen as a predominantly female task to be covered by their (unpaid) work. Institutional care arrangements are utilised only when being unable to cover needs sufficiently within the domestic sphere

C. Male breadwinner/female part-time carer model

- a modernised version of the breadwinner model. There is limited equal participation in the employment market as long as children remain in the household.
- part-time labour markets allow to take over child and elder care obligations. (There exist quite remarkable differences in Europe concerning part-time work which need to be taken into account).
- home elder care is based on such labour market options. Institutional elder care arrangements are seen only as a second choice in the case of increasing incompatibility with this model.

D. Dual Breadwinner/State Carer Model

- full integration of men and women in the labour market, defined as individuals who as who are both breadwinners.
- childhood is constructed to be an independent phase of life, but increasingly seen as a public as well as family responsibility.
- elder care is seen more via services of home care or institutional care. This model allows a variety of different social dominant value orientations ('gender equality' in Scandinavian welfare states; 'maternity' in France, etc.)

E. Dual Breadwinner/Dual Carer Model

- full integration into the labour market for both sexes
- child care is seen as a family task only if the working environment is organised in a family friendly way. Domestic work is secured by direct family benefits and complex transfer systems.
- elder home care services is the norm. Institutional elder care is seen in ambivalent way - violating values of family friendliness but being attractive as a short or long term discharge of responsibilities.

F. Dual Earner/Market Female Carer Model

- full integration of men and women into full-time waged work
- increasing possibilities of child and elder care in markets

- provision of additional possibilities to outsource family tasks (additional man/women-power in the household; combined self-organisation on local level etc.)
- because of market provision, possible increases in attractiveness of institutional elder care, but provision arranged in a more flexible and need-oriented way

In the OASIS countries, these models do not exist in a pure form. Each country has aspects of the six models but with different patterns. For example, it is difficult to identify an exhaustive set of *indicators* for living arrangements in each country which neatly fit the six types of models and which then can be compared cross-nationally. Some important dimensions, such as family size, are also missing in the models, and these would give a more dynamic picture of family development in the OASIS countries and enhance the comparative perspective. Finally, in addition to capturing the complexity of cultural definitions, the six models may also be particularly important for a comparative analysis of specific regions within the OASIS survey data.

Family policies

The five OASIS countries are all making important changes in legislation and family policies, particularly in the area of social care. Figure 3 summarises different legal definitions and family support policies. It can be seen that intervention into family life via social policy is not unanimously accepted by all countries. Such intervention is often justified by wider social concerns, as for example, gender equality in Norway or the importance of marriage in Germany. The same applies to discourses justifying country specific family policy. Wider social concerns, such as anti-poverty measures also have a major impact.

Figure 3. Determinants of family policy

	Norway	UK	Germany	Spain	Israel
Legitimation i.e. the legally resp.constitutionally grounded legitimacy to intervene socio-politically into the realm of family	yes (but only legitimised by gender policy)	no	yes (oriented toward marriage)	no	yes
Explicitness i.e.. the existence of an explicitly formulated family policy	no	no (basic pro-vision policy)	yes	no	yes
Justification i.e..the existence and differentiatedness of societally central discourses on family policy	orientation toward women's movement and toward emancipation	anti-poverty and children policy orientation	traditionally securing the family as institution, in the presence stronger formulated as gender policy	antifrancqui-stic resp.-antinatalistic orientations	securing the family as institution, natalistic justifications possible
Presence of social-political points of reference I: Improvement of the economic situation of families	yes	yes (concentration on families in need)	yes (equalization of burdens of families)	no (beginning to develop in recent times)	yes
Presence of social-political points of reference II: compatibility of family work and labour participation of women	yes (as national policy objective)	yes	yes (in present times more apparent in public debate)	no (recently more debates about compatibility)	yes
Presence of social-political points of reference III: Change of legal definitions of the concept "family"	Intensive debate	Intensive debate	Intensive debate, but still controversial statements and legal decisions	Existing debate; controversial statements and legal decisions	Existence of debate; controversial statements and legal decisions
Legal obligation to give the aged familial economic support	no	no	yes (though LTCI)	yes (but first debates about possible LTC measures)	yes (though LTCI)

Notes. developed from a presentation by Kaufmann 1993 and Lessenich/Ostner 1996)

All the OASIS countries have three core socio-political points of reference that currently determine public discourse on the family. These are the *improvement and the security of the socio-economic situation of families*, the *issue of the*

compatibility of work in public and private domains, and the *increasing participation of women in the labour force*. In Germany and Spain, where the employment rate of women has been traditionally rather low, the issue of women in the paid labour force has a special prominence. Also, in all OASIS countries there are clear signs that the concept of the 'family' is being redefined in legal and public discourses, and that this process is driven mostly by child care issues. The meaning of 'family' is shifting from the previously dominant notion of the nuclear family with its emphasis on marriage towards a more fluid definition which includes a variety of intergenerational networks with responsibility for bringing up children. This can be seen in all the OASIS countries, but in different degrees of intensity and with different levels of consensus. Only Norway and the UK seem to consider the impact of the rapidly changing nature of family life in a concerted way, by attempting to link these changes to legal measures and social policy. In Germany, Spain and Israel these debates do not only differ in intensity, but due to mostly religiously founded objections, they also expose contradictions in legal decisions and in the general approach to these issues.

Another side of this remarkable shift in legal and public attention concerning the 'family' can be seen in the area of elder care: One of the key issues is whether there is a legal obligation to give the aged familial economic support in the line of the 'subsidiarity principle'. Originally from catholic social teaching, the subsidiarity principle implies that all smaller entities of support as families and social networks have to be utilized before the state is asked to cover the needs from public means. Thus respective family members have a legal obligation (which would be means tested) to pay for the care of their elders. Here it is remarkable that not all welfare regimes in the OASIS countries have care policies based on such a legal obligation. But more importantly, those countries, who originally had such an obligation, are now partly 'mellowing down' this principle by defining care as a societal risk and by introducing long term care insurance or other ways of granting funds for care, thereby somewhat discharging the family of financial strain in order to allow the taking over of care responsibilities (cf. Schulte 1996).

The renewed interest in family matters, particularly as they apply to elder care, is placing pressure on social policy formulation. It has already resulted in considerable developments (and often overlooked) in the enlargement and re-conceptualisation of the role of 'care' in most European welfare states. Figure 4 presents the different available typologies of European welfare regimes and the dynamics of change in care policies.

Figure 4. Models of welfare states and care policies

	Norway	**UK**	**Germany**	**Spain**	**Israel**
Type of welfare state acc. to R. Titmuss	'meritocratic model'" ?	residual (Beveridge type)	contribution based (Bismarck type)	---	---
Welfare regimes acc. to Esping-Andersen	social democratic	market liberal	conservative-corporatist	---	---
Welfare state models acc. to the debates on alternative typologies	Scandinavian countries- model	Market liberal model with subgroups: ('liberal', 'radical')	central-west European model	'Mediterranean' model	coexistence of different regime options
Present developmental stage of **care policies**	Marketisation of existing structures of public provision	Reorganisation of community care programs	Further necessities to reform the existing LTCI (integrated care)	Experimenting with different care options without legal regulation	Reforms of existing LTCI into the direction of more cash benefits

Different '*developmental patterns in care policies for old age'* can be seen in Figure 4 (cf. Alber 1995; Schölkopf 1999). The Scandinavian countries, first Finland and Sweden, but now also Norway and Denmark, have tried to retain their former position, where community based elder care policy is mostly characterised by public services and a low rate of private services. Despite the dominant political direction towards public services, Sweden and Finland have recently followed a policy of restricting funds and concentrating benefits on certain groups of older people in need. Recent suggestions for reform in Norway and Denmark provide evidence of a political discourse which emphasises mixed economies of care, and this seems to apply to most Scandinavian countries. They are following similar paths in social policy but at a different pace. For example, the traditional social care policies in Northern European countries have dissolved into a variety of strategies and new service arrangements to complement former public structures. The same pattern applies to the Mediterranean countries. Although generally they lag behind the rest of Europe in terms of elder care policies, Spain (and Greece) have now cautiously incorporated gerontological expertise into their political agenda. They are currently putting in place at least some supportive public services in the care sector (probably tax-financed rather than an insurance based solution).

One consequence of these changes seems obvious. In both Northern European and Mediterranean welfare state models, it has been the appearance of *new groups within each model* that seems to shape how these societies develop and implement

their overall legal and policy responses. This emergence of new groupings is particularly evident in the case of the 'central West-European model' or 'conservative-corporatist' regime of welfare states (Germany, Austria, France). In these countries, the previous unifying elements that defined them has almost disappeared. Although the ideology of the family as the main provider of care still holds (although in different degrees), diverse social care policies and practices are being implemented. Each country in this 'central West-European model' begins to look unique, even if they all have some comparable elements.

Directions for the research strategies in the OASIS project

This chapter has focussed mainly on demonstrating *diversity* between the OASIS countries. It concludes with some remarks concerning how the issues raised can be integrated into a strategy for the analysis of the OASIS project data. Table 16 summarises some of the main themes according to social indicators. These indicators should be viewed as components of 'country portraits' which are comparable. But they can also be used as an empirical basis for new research questions which emerge from the results of the OASIS project.

Table 16. Characteristics of the OASIS countries

	Norway	UK	Germany	Spain	Israel
Political Cultures	More consensus	More majority	Consensus	Consensus	Strong consensus
Public Social Security Expenditures	quite strong	strong	strong	less strong	less strong
Social Protection Expenditures	quite strong	strong	quite strong	less strong	n a
Health Care Provision	Insurance	NHS	Insurance	NHS	Insurance
Increases in general female life expectancy at birth	fair	fair	fair	considerable	fair
Projected increase in higher age groups (80+)	fairly strong	fairly strong	quite strong	quite strong	less strong
Employment rate in old age (65+)	high	middle	low	low	high
Female labour force participation	high, slow increases	middle, slow increase	middle, slow increase	low, strong increase	middle, slow increase
Income Position of the Aged (75+ OASIS based)	favourable	Relatively favourable	favourable	Relatively favourable	Relatively favourable

Table 16. Characteristics of the OASIS countries (continued)

Percentage of living alone	high	middle	middle	low	middle
Discourse on improvement of economic situation of families	present	present	more present than in former times	more present than in former times	more present than in former times
Discourse on compatibility of family work and female labour force participation	present	present	more present than in former times	more present than in former times	present
Discourse on necessary legal changes of concept of "family"	present	present	more present than in former times	more present than in former times	more present than in former times
Determinants of care policies	potential rationalisation and marketisation strategies with consequences for private public mix	potential rationalisation and marketisation strategies with consequences for private public mix	Reorganising public benefits by creating integrated provision and supporting implementation of quality measures	conceptual and experimental considerations about appropriate care provision	Reorganising public benefits with the consequence of reducing services and increasing cash benefits

Following the theoretical line of this chapter, at least *three interlocking domains of research* are examined. Central to these three domains are the degree of 'defamilarization' and 'de-commodification' in its mutual dependence in the OASIS countries and here the indicators distinguished can do their service. It should be attempted to complement this by more differentiated data concerning the service structure in each country. The publication of Pazolet (Pazolet et al. 1999[2]) unquestionably has been for quite some time a highly valuable source of information but several dimensions of this comprehensive compendium would have to be adjusted to more recent developments, as the case of Germany after introducing the long term care insurance and its explosion of social services in the area of home care easily proves. This general dimension of confronting both processes should be followed first in a *political vein* using the different models of democratic representation. Secondly it ought to be complemented by an analysis of the *welfare state side* of these processes. Here it might be possible to distinguish shifts in different indicators (as f.i. the transfer-services ratio; as impacting on different indicators from the life time regime; as restructuring the employment area; as designing strategies for risky life situations etc.). Thirdly, the field of

family and gender cultures which is made easy insofar as the models implicitly follow already the line of ‘de-commodification’ and ‘defamilialisation’ as could be demonstrated above in the commenting remarks. Out of these components along the country line ought to follow a comparison and its relation to the survey results of the OASIS project.

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3

The Quantitative Survey

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Introduction

The main objectives of the OASIS project are to explore how family cultures and service systems support autonomy and delay dependency in old age, to promote quality of life, and to improve the basis for policy and planning. The OASIS project aims to add to current scientific debates on family solidarity and conflict, norms and values in areas such as preferences for care, use of services, coping strategies and quality of life. More precisely, the project aims to examine how these concepts can be measured and predicted under different societal macro conditions, such as welfare regimes and family cultures. The OASIS project provides a unique knowledge base which can help to enhance the quality of life of elders and their family caregivers. It shows how family roles, service systems and individual styles of coping interact and influence the quality of life in old age. The project also shows how different family cultures and different welfare systems promote quality of life and delay dependency in old age. In summary, the OASIS project scientifically studies older people's quality of life, analysing the balance between family care and service systems and their relation to welfare regimes. It describes variations in family norms, expectations and transfer behaviour across age groups and between countries, and it examines the individual's and family's coping strategies when an elderly parent is at risk of becoming dependent.

These questions are examined extensively on an empirical basis in two stages the - OASIS quantitative survey followed by the qualitative study. This chapter concentrates on the quantitative survey, while the qualitative research phase is discussed in Chapter 4. First, the collection of the quantitative data is described in the context of the OASIS conceptual framework. The focus here is on assessing the processes and structures established by the project. Second, the quality of OASIS data is examined and some empirical analyses are presented. These analyses focus on differential sample selectivity as one of the most important threats to data validity in international comparative research. Third, strategies for analysing the data are examined and discussed in the international project context of OASIS.

Time schedule and process

The OASIS project began in February 2000 and ended in January 2003. The project is characterised by three innovative aspects: its *conceptual framework, multi-level perspective* and *research methods*. The conceptual framework is based on the 'Intergenerational Solidarity Model' developed by Bengtson and others (Bengtson and Dowd 1981; Bengtson and Mangen 1988; Roberts and Bengtson 1990; Roberts et al. 1991) and on the model of 'Intergenerational Ambivalence' by Lüscher and others (c.f. Lüscher and Pillemer 1997). The ambivalence paradigm, which suggests that intergenerational relations generate ambivalence between family members, was proposed as an alternative to the frequently used solidarity perspective for studying parent-child relations in later life. The simultaneous study of societal or macro level variables (social services) and individual or micro level variables (personality traits, intergenerational family solidarity/ambivalence and the changing roles of women) and their application to the context of the older person's quality of life is a second innovative aspect of the project. This multi-level perspective offers a fruitful avenue for exploring how cultural, social and economic factors, as well as external structural-environmental conditions, can shape people's behaviour and their quality of life. The third innovative aspect is the research method. The project adopts a cross-cultural, cross-generational perspective, comparing different welfare regimes (institutional, conservative, residual), and three 'generations' (younger, middle and older). In addition, the project combines quantitative and qualitative methodologies.

The combination of these innovations had to be achieved during the implementation of the research project. The original time-table soon proved to be inadequate if the objectives of the project were to be achieved and the schedule had to be changed. The survey data collection was restricted to three months at the end of the year 2000 and the time available for the development of the questionnaire extended. A new task, 'data cleaning', was introduced and the time scale for the survey analysis was extended. In fact, these adjustments did not extend the overall length of the project. Time delays of 6 months were balanced in other areas by gains of 5.5 months.

After an initial phase working on developing concepts and building the questionnaire, pilot studies were undertaken between early and late summer of 2000. The field phase of the survey began in October 2000 and officially ended in December 2000. In Norway, approximately 200 additional respondents were interviewed in early spring 2001 because it was discovered that this number of interviews had been forged by some of the interviewers from the sub-contracted survey research organisation. In Germany, an additional 60 respondents were interviewed form the outset in order to reach a sufficient number of cases for analysis in different age groups. In Spain, the data collection began in January 2001 and finished in March 2001 because of a delay caused by the sub-contracting

research organisation (see below for more information on the national sub-contractors). The English data was mainly collected in late spring 2001, because the first sub-contractor went bankrupt after interviewing only 200 respondents in autumn 2000. A second research organisation was sub-contracted to finish the interviewing. Although this change of sub-contractors was implemented immediately after the problem was identified, the English field phase still had to be put back until spring 2001.

After the field phase ended in each country the data was cleaned. A first draft of a four-country data set was available in mid 2001. This data set became the basis of preliminary analyses which were presented at research seminars and conferences. The cleaning of the English data was delayed and finally became part of the data set in July 2002. During the process of preliminary data analysis, the data set was constantly improved and extended by adding derived variables. Inevitably, inconsistencies were identified and the country teams added standard constructs as a basis of shared analyses (see below). A final version was sent to team members undertaking the analyses in December 2002.

Questionnaire, instruments, and sampling

The OASIS questionnaire has two sections: the standardised international survey instrument and some specific country context questions (add-ins). The questionnaire was compiled with the co-operation of all the country teams and co-ordinated by the Norwegian team which prepared the final version of the questionnaire. The design of questionnaire includes well-known scales that have been frequently used and validated. Nevertheless the process of questionnaire design lasted almost one year. Seven revisions of the questionnaire were carried out in each country, including a full pre-test of Version 4 and a partial test of Version 6. The results of these pre-tests were fed back into the design process. They indicated that the early versions of the questionnaire were too long and in some places too complicated. The 8th version of the questionnaire was accepted as the final master version. A basic English language master questionnaire and an operational manual were developed. The master questionnaire was then translated into the languages of the participating countries and back-translated to double check for translation problems. If available, previously tested translations were used, for example the WHOQOL-Bref (WHOQOL Group 1994b; World Health Organization 1996 1998; WHOQOL Group 1998), the PANAS instrument (Watson et al. 1988) and other scales.[1] The country teams decided to choose, wherever possible, instruments that were already well established and had been tested in different countries, cultures and research contexts. The number of instruments was reduced to those that directly related to the conceptual model. Shortened versions of research instruments, if existing, were preferred over long

[1] See Lowenstein et al. (2002) for details of scales.

versions. The production of questionnaires (lay-out and printing) was done by the sub-contracted survey research organisations in each country.

Table 1. Content of the survey questionnaire

▪ Socio-demographic data	▪ Social relationships
▪ House and environment	▪ Norms and values
▪ Occupational activity and socio-economic status	▪ Preferences
▪ Health and functional ability	▪ Coping
▪ Help and services	▪ Quality of life
▪ Children	▪ Income
▪ Parents	▪ Miscellaneous
▪ Other family members	

The survey instrument contains questions in 15 research areas listed in Table 1. The main instruments included in the OASIS questionnaire are: the scale on physical functioning taken from the SF36 Health Survey instrument (Ware and Sherbourne 1992; Gladman 1998); The Family Solidarity and Conflict scales (Mangen et al. 1988); Intergenerational Ambivalence (Luescher et al. 1999); Flexible Goal Adjustment scale (Brandstädter and Renner 1990); Filial Responsibility Scales (Lee et al. 1994), the WHOQOL Quality of Life scale (WHOQOL Group 1994a, WHOQOL Group 1994b, WHOQOL Group 1998; World Health Organization 1996; World Health Organization 1998), the PANAS - Positive and Negative Affect scale (Watson et al. 1988), as well as scales developed especially for the project, such as the Help and Use of Services.

The construction of the questionnaire and the selection of the instruments reflect the advantages of working in a cross-national study, where a wide range of cross-cultural comparisons can be achieved. In such a study a diversity of comparisons can be accomplished within one theoretical framework. The research instruments are therefore tools to provide comparable data for cross-national purposes. They are also a framework for the design of the qualitative phase (for details see Lowenstein et al. 2002.). The country teams added some questions to adjust for specific country situations. This was restricted to a very limited number of additional indicators.

- *Norway*. The Norwegian team added questions about age identification which had been developed for a study on the integration of older people in 1969 (Helland et al. 1974). These questions were also used in a Statistics Norway omnibus study for the Norwegian Institute of Gerontology in 1993. Three questions were developed specifically for the OASIS survey although they had been used in a number of other studies in different ways: subjective age, and preferences regarding contacts which people of certain

age groups. In addition, the Norwegian team included two questions about the number of generations in the family.

- *England.* The English team included an instrument called the Work-life Balance Checklist, devised by the Industrial Society in its Work-life Manual (Daniels and McCarraher 2000).
- *Germany.* The German team added some questions on the most important institution in the context of social care and long-term care insurance (von Kondratowitz et al. 2002). Respondents were asked whether they had long-term insurance, applications for assistance under this scheme and the receipt welfare state transfers offered by them. A set of instruments about social care developed and used by infratest were also added (Schneekloth and Müller 2000). Finally, some minor questions on intergenerational ambivalence (Lüscher 1998; Lüscher and Lettke 2000) that were not covered in the international questionnaire, and some questions on media use and on life-styles of the elderly were added (Spellerberg 1996).
- *Spain.* The Spanish team included questions on self-perception of chronological age, a question on the number of family generations the respondent had, and a question on feelings of generational belonging. Due to the country specific housing issues, especially in the historic centres of many Spanish towns, an additional question on the availability of a lift was added, since accessibility is an important issue for older people.
- *Israel.* Only two questions were added to the Israeli questionnaire. First, a question on years of education, which was seen as a common parameter in the Israeli context. Second, in the services section, a question on future preferences for regular help was asked in the thematic areas of household chores, transport/shopping and personal care.

Field work, sample and the study population

The OASIS sample was drawn as a representative, stratified (ages 75+ over-represented) and random sample of the urban population of individuals aged 25 and above in private households in each of the five countries. The sample therefore explicitly excludes individuals living in institutions. In addition, people were not interviewed if they appeared to be demented or if there was any doubt about their ability to give informed consent. This procedure may have produced a selectivity bias, but it was necessary because people living in residential institutions have very different life situations compared with the general population of older people. The decision to restrict samples to urban areas was based on the premise that potential country differences depend in part upon stages of urbanisation. Urban areas, defined as cities with more than 100,000 inhabitants, were identified as primary sampling units in each country. In Norway, Spain and Israel all of these urban units were included, while in England and Germany a selection of urban areas was made. In England urban areas were defined as six major regions with 120 wards, which

the research team assumed to be representative for the English urban areas in general. In contrast the German gross sample was drawn as a self-weighting double random sample based on the municipal registries. A random sample of municipalities with at least 100,000 inhabitants was established randomly to select the sample units on the individual level. The number of addresses in the gross sample was weighted by the size of the municipality.

The next stage was to draw a sample of individuals within all the available or selected regional units, with an approximately equal probability of including eligible individuals. The sampling strategies on the individual level also differ slightly between the countries according to the national conditions. While in Spain and Israel a pure random route strategy was chosen, the Norwegian team decided to use this method for the 25 to 74 year old age groups only and to exploit registry data for the sample of the 75+ age group. This process allowed letters to be sent announcing the visit of the interviewers and improving the control over the interviewer field. In England, electoral registers combined with the Monica coding system (using first names to identify the age group of the target person) were used to sample addresses and to identify respondents by age and gender – a prerequisite of the sample stratification. In Germany, the municipal registries of residents were used to sample individuals as level two units.

Both procedures, the English and the German, allow respondents to be identified in advance and permit an analysis of respondent participation so, that sample selectivity can be controlled on the basis of the (electoral or municipal) registry data. Of course, the differences in sampling procedures in each of the countries may have introduced uncontrollable deviations between the final samples. But the different strategies described above were chosen because they represent the best research practice in each country. Selectivity processes are discussed in more detail later in the chapter by illustrating sample selectivity via differences between the OASIS and official EuroStat data. This discussion also includes aspects of potential selectivity for the different measurement points of respondent participation, the willingness to participate again, and re-participation in the qualitative OASIS study.

The field work was undertaken by sub-contracted survey research organisation.[2] It should be noted that some of the survey research organisations lacked high standards in certain areas. The OASIS teams therefore had to push hard to ensure that the data was reliable. There were problems in each of the participating countries. The German sub-contractor considered the contract terms to have been met once 1,200 interviews were reached, even though the stratification objectives

[2] These were the Norsk Gallup Institutt, Oslo, Norway; Marketing Sciences, Winchester, England; INFAS – Institut für angewandte Sozialwissenschaft, Bonn, Germany; Demoscopia, Madrid, Spain; Gallup Institute, Jerusalem, Israel.

had not been completely achieved. This problem was easy to solve, but it caused a delay of three weeks as an additional 60 interviews with respondents aged 25-74 had to be done. The Norwegian sub-contractor had problems with the reliability of some of their employees so that the quality of the data was questionable. This problem was identified during data cleaning, and it was solved by replacing the interviews of negligent employees with new interviews. In Spain, the sub-contractor was slow in starting the interviews which lead to data being delivered significantly behind the time schedule. The Israeli sub-contractor, Gallup, withdraw from the market shortly after the field phase so that no field report was ever prepared. In addition, this sub-contractor faced problems reaching the required numbers of cases in each age strata, and this also lead to a delay in the data delivery. In the English case, the initial survey research organisation went bankrupt after having done less than 280 of the 1,200 interviews, so a new sub-contractor had to be found.

This problems resulted in the field phase being delayed by approximately six months. In addition, the data cleaning and editing process was also delayed. All of these problems resulted in the final international data set being 12 months behind schedule. Intensive co-operation between the OASIS country teams helped to handle these problems with the sub-contractors and despite the delay, the data collection phase was successfully completed. An initial data set from four countries, allowed strategies of analyses to be developed. Preliminary results were presented to peer groups of researchers. The English data were added to the four-country data base in June 2002. This flexible strategy of approaching problems in a co-ordinated way led to the creation of a final robust data set from which the analyses were undertaken.

The structure of the survey sample

The survey sample was designed to be a representative sample of the urban population in the participating countries of individuals aged 25 and above. The sample was stratified by age groups to ensure sufficient numbers of cases for detailed analyses of older people. Respondents aged 75 and above are therefore over-represented[3].

[3] Descriptive analyses with no age differentiation are adjusted for the age stratification of the sample by using weights based on population data.

Table 2. The Quantitative OASIS sample

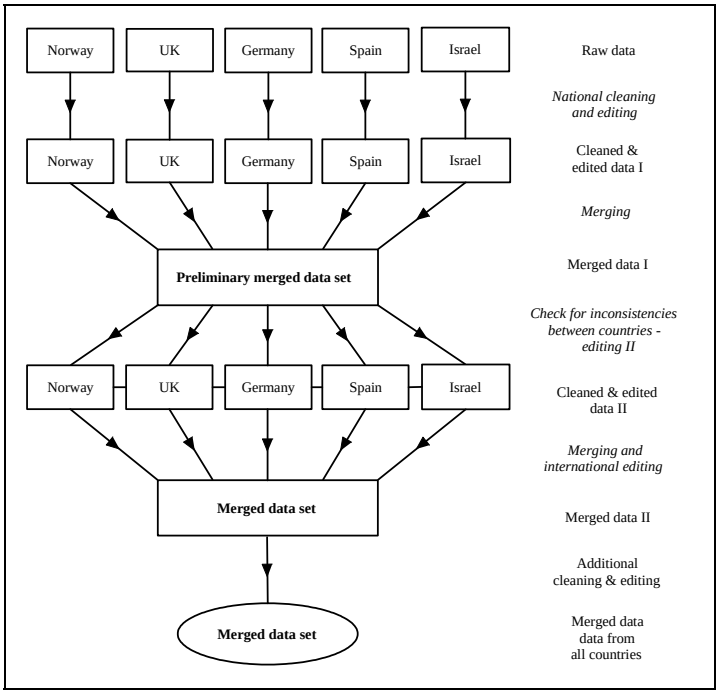
	Norway	England	Germany	Spain	Israel	Total
25-74	790	799	798	816	840	4.042
75+	413	398	499	385	368	2.064
Total	1.203	1.197	1.297	1.201	1.208	6.106

Source: OASIS 2002.

An age-stratified representative sample of the urban population was drawn n each country. Generalisations of the findings to the total population on the basis of urban samples can only be made under certain assumptions. So on the one hand, the focus on urban areas restricts the descriptive results to the urban populations of the five countries. But on the other hand, an urban sample substantially improves the basis for international comparisons, because a contrast of urban populations allows different levels of urbanisation to be controlled when analysing the data. In Norway (Oslo, Bergen and Trondheim), Spain (33 cities with more than 100,000 inhabitants), and Israel (Tel Aviv, Haifa and Jerusalem), each main town or city has more than 100,000 inhabitants, so they were included in the sample frame. In England and Germany, a sample of municipalities before a sample frame of individuals could be identified. In Germany, a random sample of municipalities with at least 100,000 inhabitants was drawn, while in England the sample of urban areas was pre-selected (Birmingham, the West Midlands, West Yorkshire, London, Manchester, and Liverpool). The final OASIS sample has 6,106 respondents, with n=1,197 to n=1,297 cases per country. About two thirds of the respondents are aged 25 to 47, and one third aged 75 and above.

In addition to the quantitative survey, 50 parent-child dyads were also interviewed with a qualitative instrument. Respondents with health limitations aged above 75 (10 in each country) were selected from the OASIS survey sample described above. One of their adult children was also interviewed with an open instrument (see Chapter 4). The participating children were not part of the OASIS survey sample and were contacted by arrangement with their elderly parents. The qualitative sample is therefore an extended sub-sample of the OASIS survey sample. As with the quantitative sample, some comparisons can be made to analyse differences between the true population and the OASIS's sample. This is done later in the chapter by examining sample selectivity over different measurement points.

Figure 1. The process of data editing and merging



Descriptive information on the study population

Descriptive information is restricted to the urban populations in Norway, England, Germany, Spain and Israel with their well-known distinctive features. The potential for generalisation of the results for the whole societies is limited. The reasons for this selection of urban areas and the questions of representativity or selectivity are discussed elsewhere in this chapter. Nevertheless a stocktaking of basic indicators of living situations in different countries seems to be useful as a basis for understanding and analyzing connections and processes in the OASIS countries. The goal is to deliver a brief overview of living conditions on the micro level of the societies – a breakdown that serves to embed the following chapters of the OASIS report. Consequently, the range of the variable presented in such an overview will be focused since much of this information is given elsewhere in this report anyway. Socio-demographic measures as well as information on the existence of families and wider social networks, socio-economic status, health and services as well as

overall quality of life is included. The descriptive information is presented as tables by age, gender and country in the appendice at the end of this report.[4]

Data cleaning and merging

The data cleaning and merging process was a complex and interactive process. On the one hand it soon became apparent that although the project had established an integrated survey instrument for use in all the participating countries, country specific field versions differed because of subsequent changes made by teams and their sub-contractors. On the other hand, even though a guideline for the establishment of the national data sets had been produced, each final country data set still differed substantially regarding variable names and definitions. These problems required additional data cleaning and the organisation of merging the five-country data sets had to be completely reviewed.

During the first phase of data cleaning, each country team edited its own data to fit a standard data scheme based on a blueprint by the German team. This process formed the basis for the data merging. The merged data files were then centrally tested for structural inconsistencies by the co-ordinating German team and returned to the country if errors were found. In the next step, the improved data sets were merged again. The final merged data set was again checked by the German team and sent out to the country teams for analyses (see Figure 1). This reliable standardised procedure was hampered because the data collection, cleaning, editing and delivery by each country team was not simultaneous. The process of testing data structures against each other became even more complicated and time consuming and it extended considerably the time needed for this part of the project. The end result was that the delivery of the final data set was way behind schedule. Nevertheless, seen from a methodological perspective, the final OASIS survey data set, as a result of this standardised process of collecting, cleaning, editing and merging of the data, can be considered reliable and unique for comparative cross-national analyses.

Once the final data set was completed, the OASIS country teams then built a set of Micro Indicators to add to the original variables. The goal was to establish a framework for the international analyses for all the teams. Each country team took responsibility for certain conceptual areas and delivered the indicators to the German team where the variables were checked. A set of approximately 200 derived indicator variables is available in the OASIS data base. These variables

[4] The authors would like to thank Katharina Herlofson, Norwegian Social Research (NOVA), Oslo, for her support in working on the appropriate selection of variables show fully in the appendices.

include complex measures and groupings of chronological age, measures of household and family structure, aggregated variables on health status, education, social strata, income, service use, types of support and relations between family generations, and quality of life. In addition an SPSS program to produce standard tables by age, gender and country was sent to the country teams in the summer of 2002. The program gives weighted and unweighted percentages, means and standard deviations. Useful information on variable definitions and the number of cases in particular analyses was also passed on to country teams. The goal was to provide a practical program to give basic descriptives which can be used by team members who are not familiar with quantitative data, as well as to standardise the output of basic descriptive information between country teams.

Data quality – selected analyses on sample selectivity

The remaining section of the chapter deals with data quality. Sample selectivity is one of the major threats for the validity of quantitative data (Cronbach 1970; Wainer and Braun 1988; Kühn and Porst 1999; Motel-Klingebiel and Gilberg 2002).[5] An important distinction needs to be made between *sample* selectivity and *item* selectivity.[6] While the former is caused by selective participation in surveys (Heckman 1979; 1990) the latter is based on differences in the willingness to answer certain questions (Colsher and Wallace 1989). Sample selectivity is particularly an issue in cross-sectional analyses, where the validity of descriptive results is threatened by diverging criteria of selectivity in each country. The risk is that observed country differences may simply result from different selection processes – or may be overridden by them.

[5] Others are the reliability of answers or age specific answering behaviour (Herzog and Dielman 1985; Rodgers and Herzog 1987; Jobe and Mingay 1991; Schwarz et al. 1998; Wagner and Motel 1996.

[6] The problem of *item selectivity* is not covered, but the validity and reliability of certain measures is discussed more thoroughly in the chapters where these measures are used.

Table 3. Gender comparisons between OASIS survey and public data

Gender	OASIS				*EuroStat*			
	25-49	50-74	75+	Total	*25-49*	*50-74*	*75+*	*Total*
Norway								
male	43,0	50,0	40,4	45,0	*51,0*	*49,1*	*36,9*	*48,7*
female	57,0	50,0	59,6	55,0	*49,0*	*50,9*	*63,1*	*51,3*
gender proportion[(1)]	133	100	148	122	*96*	*103*	*171*	*105*
England								
male	37,1	42,5	31,7	39,4	*50,8*	*48,5*	*36,0*	*48,4*
female	62,9	57,5	68,3	60,6	*49,2*	*51,5*	*64,0*	*51,6*
gender proportion	170	135	216	154	*97*	*106*	*178*	*107*
Germany								
male	51,2	45,7	30,8	46,7	*51,2*	*48,1*	*29,7*	*47,9*
female	48,8	54,3	69,2	53,3	*48,8*	*51,9*	*70,3*	*52,1*
gender proportion	95	119	225	114	*95*	*108*	*237*	*109*
Spain								
male	48,5	47,2	34,5	46,6	*50,4*	*47,4*	*37,2*	*48,0*
female	51,5	52,8	65,5	53,4	*49,6*	*52,6*	*62,8*	*52,0*
gender proportion	106	112	190	115	*98*	*111*	*169*	*109*
Israel								
male	37,2	44,4	45,8	40,4	–	–	–	–
female	62,8	55,6	54,2	59,6	–	–	–	–
gender proportion	169	125	118	148	–	–	–	–

[(1)] The gender proportion is the number of women in a certain age group related to the corresponding number of men in this age group. It is defined as the number of women per 100 men.

EuroStat data refers to the entire population of the countries while OASIS data is based on the populations of urban areas only.

Source: OASIS 2000 and *EuroStat Data Base NewCronos, 15.October 2002, special counting.*

Table 3 shows the composition of the OASIS samples by gender and compares it with data from the EuroStat NewCronos data base.[7] The table shows large differences between the countries. The OASIS distribution for Germany and Spain seems to be generally plausible. German OASIS data show a gender ratio of about 225 for the 75+ age group while the EuroStat data indicate a value of about 237.[8] The German OASIS value for the age group 50-74 (25-49) is 119 (95), and the EuroStat values are 108 for the 50-74, and 95 for the 25-49 age group. For Germany therefore, the OASIS data corresponds well with EuroStat data. The

[7] EuroStat figures not available for Israel.

[8] This corresponds with more detailed analyses with data from the Federal Statistical Office in Germany which show a ratio of 235 for the 75+ age group.

situation is similar in Spain, with a minor deviation in the highest age group, where OASIS reports a ratio of about 190 while EuroStat gives a value of 169. The difference however is small, and can be accepted methodologically.

But in Norway and England, the difference between the OASIS and EuroStat data is very large. In England, there is an *overestimation* of the proportion of women in England, while in Norway there is *over-representation* of young women and an *under-representation* of older women (and vice versa for men). Also, in Israel the gender/age distributions are distinct because of the declining gender ratios with increased age, resulting in a comparably small number of women in the oldest age group. For age distribution, Israeli OASIS respondents follow a similar pattern of gender ratios as described above for Norway. But the degree of *overestimation* resembles the English gender bias.

The problem of gender biases in sampling are well known. Normally, they can be remedied by the careful organisation of the field phase and strict control of the sample. Evidently, some of the sub-contractors did not make the necessary effort to avoid such sampling biases. Descriptive analyses for the entire population therefore must be interpreted with care because country differences may result from a gender bias in a particular country. Similarly, country similarities may be an effect of unequal gender distributions. In summary, a mixture of effects must be expected when interpreting the data. All effects that are associated with or moderated by gender may be influenced by this structural bias and interpretations should be made with caution.

The OASIS *weighted* age distributions show only minor differences compared with the EuroStat figures. But some exceptions to this encouraging result should be mentioned. In England, there is a slight underestimation of the youngest age groups (25-44) while the middle age groups (55-74) are slightly overestimated. In the German sample, the proportion of the 65-74 age group is a little higher than the EuroStat figures, while Spain somewhat underestimates the proportion of the 35-44 years old. Again there are no comparable data from Israel in the EuroStat NewCronos data base from which to make comparisons.

Table 4. Age comparisons between OASIS survey and public data

Age	OASIS unweighted	OASIS weighted	EuroStat
Norway			
25 to 34	20,1	27,2	23,0
35 to 44	14,5	19,6	21,9
45 to 54	13,7	18,6	20,7
55 to 64	9,1	12,3	14,3
65 to 74	8,3	11,3	11,2
75 to 84	26,9	8,6	8,9
85 and over	7,4	2,4	2,8
Total n (25+)	1.203	1.203	2965560
England			
25 to 34	9,9	13,5	22,3
35 to 44	13,1	17,8	22,4
45 to 54	12,6	17,1	19,6
55 to 64	12,2	16,5	15,3
65 to 74	18,9	23,9	12,3
75 to 84	24,0	8,4	8,1
85 and over	9,3	2,9	2,9
Total n (25+)	1.197	1.197	39964756
Germany			
25 to 34	12,0	17,3	19,8
35 to 44	14,5	20,8	22,4
45 to 54	10,8	15,5	17,4
55 to 64	12,3	17,6	17,9
65 to 74	11,9	17,0	12,7
75 to 84	29,6	9,4	7,0
85 and over	8,9	2,4	2,7
Total n (25+)	1.297	1.297	60166290

Table 5. Age comparisons between OASIS survey and public data (continued)

Spain			
25 to 34	19,1	25,3	24,3
35 to 44	13,0	17,2	21,6
45 to 54	13,1	17,3	17,6
55 to 64	11,2	14,9	14,5
65 to 74	11,6	15,3	13,9
75 to 84	27,0	8,4	8,1
85 and over	5,1	1,6	2,4
Total n (25+)	1.201	(1)1.200	27631778
Israel			
25 to 34	22,9	30,3	–
35 to 44	12,7	16,7	–
45 to 54	14,0	18,5	–
55 to 64	9,6	12,7	–
65 to 74	10,3	13,7	–
75 to 84	26,0	6,9	–
85 and over	4,5	1,2	–
Total n (25+)	1.208	1.208	–

(1) The difference between weighted and unweighted n of cases is caused by rounding.

EuroStat data: annual average 2000.

EuroStat data refer to the entire population of the countries while OASIS data is based on the populations of urban areas only.

Source: OASIS 2000 and EuroStat Database NewCronos, special counting, 09. January 2003

There are some differences in the distribution of educational levels between the OASIS and EuroStat data. Both sources however, use slightly different interpretations of educational levels. The OASIS survey defines three levels of schooling as follows: low = primary level (or less), intermediate = secondary level and higher (without university degree) and high = higher levels. This three category variable is useful for cross-national comparisons, but it is a crude measure. EuroStat uses the International Standard Classification of Education (ISCED 1997) (UNESCO - United Nations Educational Scientific and Cultural Organization 1997; OECD - Organisation for Economic Co-Operation and Development 1999) to define different educational stages: low = ISCED 0-2 (primary and lower secondary level), intermediate = ISCED 3-4 (secondary and post-secondary level) and high = ISCED 5+ (fist and second stage of tertiary level). Both variables are more or less similar and contain only minor differences.

Table 5 compares the OASIS education variable with the EuroStat figures containing the corresponding ISCED variable. It shows that there is:

- an *overestimation* of the proportion of respondents with higher levels of education in Norway
- an *overestimation* of intermediate levels (with an equal underestimation of high and low levels) in England
- an *overestimation* of lower education (especially among the elderly) in Germany
- an *underestimation* of lower education, corresponding with an *overestimation* of intermediate (but not of higher levels) in Spain

Collectively, there are unequal patterns of *over* or *under*-estimating educational levels in each country. In Norway and Spain, the mean levels are higher than in the EuroStat data. But in Germany they or lower and similar, and in Britain the variance of education levels is underestimated. However, the EuroStat data are for population totals while the OASIS data is representative of urban areas only, and this undoubtedly accounts for different distributions of educational levels. Taking this into account there are only moderate differences the OASIS project can cope with.

Table 6. Levels of schooling comparisons between OASIS survey and public data

Levels of schooling		OASIS				EuroStat			
		25-49	50-74	75+	Total	25-49	50-74	75+	Total
Norway									
	low	2,0	14,9	43,7	10,7	9,5	31,5	*	18,1
	intermediate	34,5	46,1	38,5	38,7	55,8	47,4	*	52,5
	high	63,5	39,0	17,8	50,5	34,7	21,1	*	29,4
England									
	low	2,3	11,7	27,9	9,5	14,4	32,1	*	19,6
	intermediate	79,4	80,5	69,6	78,9	55,8	44,1	*	52,3
	high	18,3	7,8	2,6	11,5	29,9	23,8	*	28,1
Germany									
	low	21,0	53,6	75,5	41,0	15,8	29,1	49,1	24,0
	intermediate	58,5	32,5	16,7	42,8	59,2	51,4	40,5	54,5
	high	20,5	13,9	7,8	16,2	25,0	19,5	10,4	21,5
Spain									
	low	12,2	56,9	82,0	36,7	53,3	85,6	94,3	69,0
	intermediate	55,9	37,7	15,4	44,7	19,6	5,6	2,3	12,8
	high	32,0	5,4	2,6	18,6	27,2	8,8	3,4	18,2
Israel									
	low	4,0	21,5	39,9	13,2	–	–	–	–
	intermediate	61,4	47,1	51,5	55,4	–	–	–	–
	high	34,7	31,4	8,6	31,4	–	–	–	–

(1) low = OASIS: primary level (or less) – EuroStat: ISCED 0-2
intermediate = OASIS: secondary level or higher without university – EuroStat: ISCED 3-4
high = OASIS: higher levels – – EuroStat: ISCED 5-7

* data not available or imprecise because of small n of cases.

EuroStat data refer to the entire population of the countries while OASIS data is based on the populations of urban areas only.

Source: OASIS 2000 and EuroStat Database NewCronos, special counting, 09. January 2003

Sampling and realisation of the sample – analyses with the German data

In this section, the German sample is used as an example to demonstrate the sampling process and to discuss the problems of obtaining a sample of elderly persons. As previously discussed, it should be noted that the sampling strategies of the other four countries were different. The German sample was the only one drawn exclusively from population registries and therefore it is also the only sample where the relation between the respondents and the corresponding

population can be examined in detail. In the other countries, either a random route method was used for sampling or registry data was not available. In addition, the strong co-operation between the German OASIS team and sub-contractor, INFAS[9] meant that information about the field data collection process was freely available, thereby facilitating an examination of the sampling process (see Motel-Klingebiel and Gilberg 2002).

About 12% of the gross sample were 'natural' drop-outs. These included faulty addresses, people living in institutions, deceased persons, persons unknown at the reported address, and those who were too young (see Table 7). Most of these errors appeared in the registry and therefore they are unsystematically distributed over the population. The analysis of systematic drop-outs shows a distribution that is typical for surveys. Disability and illness was a prime reason, accruing with age. The total proportion of refusals is high (37%) but typical for urban populations. This rate is comparable with similar studies such as the German Aging Survey in 1996 (approximately 30% among the 40-69 year age group) (INFAS; Kohli and Künemund 1998; Kohli et al. 2000). Although 30% is slightly lower than in the OASIS survey, the German Aging Survey includes both urban and rural populations. German rural populations generally show higher participation rates than urban populations. Refusals are also more frequent in younger than older age groups. Both of these factors mean that systematic drop-outs are in fact *less* common among the urban elderly than among urban middle age groups. Despite having higher rates of disability and illness, the elderly have *lower* rates of registry errors and refusals and are easier to access since they are more likely to be present at home than younger age groups (Lindenberger et al. 1996). The hypothesis of an age effect, in the sense that elderly people have a lower probability to participate in survey studies, is not supported by comparing the German registry and OASIS sample data. Health related problems are compensated by greater accessibility and willingness to participate.

[9] Institut für angewandte Sozialwissenschaft, Bonn

Table 7. Sampling – OASIS Germany

Sample	Total		Age groups: 25 - 44		45 - 64		65 and higher	
	n	%	n	%	n	%	n	%
Gross sample (missing data on age group: n=561)	3.487	100,0	807	100,0	719	100,0	1.400	100,0
Neutral drop-outs:	338	9,7	102	12,5	67	9,3	101	7,1
Faulty address	108	3,1	22	2,7	23	3,2	33	2,4
Study person unknown, new address	152	4,4	67	8,3	33	4,6	27	1,9
Study person institutionalised	18	0,5	0	0,0	1	0,1	17	1,2
Study person not in the focus group	39	1,1	12	1,4	8	1,1	7	0,4
Study person died	21	0,6	1	0,1	2	0,3	17	1,2
Adjusted gross sample (missing data on age group: n=493)	3.149	100,0	705	100,0	652	100,0	1.299	100,0
Systematic drop-outs:	1.842	58,5	412	58,4	396	60,7	730	56,2
No contact to household	451	14,3	135	19,1	106	16,3	118	9,1
Study person is ill	153	4,9	11	1,6	11	1,7	103	7,9
Study person ment./physic. impaired	44	1,4	0	0,0	0	0,0	42	3,2
Study person refused	1.163	36,9	259	36,7	270	41,4	452	34,8
Interview prevented by others	31	1,0	7	1,0	9	1,4	15	1,2
Realised oral interviews	1307	41,5	294	41,7	256	39,3	577	44,4
Unusable interviews	9	0,3	1	0,1	0	0,0	8	0,6
Realised usable oral interviews	1.298	41,2	293	41,6	256	39,3	569	43,8
missing data on age group	1	0,1	0	0,0	0	0,0	0	0,0
Realised analysable oral interviews	1.297	41,2	350	*)	301	*)	646	*)
Willingness to participate again	*677*	*52,2*	*166*	*47,4*	*180*	*59,8*	*331*	*51,2*

The sample statistics by age groups are based on those cases with valid information on the study person's age in the registry data only (exception: rows 19 and 20).

The cut of the age groups differs from the OASIS standard conventions. Since the field data was taken from the INFAS contact protocol data base, which is mainly established for methodological analyses and internal use, the INFAS standard groupings had to be adapted for the OASIS analyses based on this data.

*) Percentages can not be computed since the adjusted gross samples for the age brackets can not be computed because of missing age information in the delivered registry information. Realised interviews classified after the interviewing.

Source: OASIS 2002, contact protocol data, INFAS - Institut für angewandte Sozialwissenschaft taken from Motel-Klingebiel et al., 2002.

The figures in Table 6 do not suggest selectivity problems specific to the OASIS survey.[10] A multivariate analysis (whether or not the target persons, chosen by drawing a random sample from the German registry data, participated in the OASIS survey) shows mainly very small and not significant effects, with only small P^2 values of about 0,03 (McFadden's Pseudo-R^2) and 0,05 (Nagelkerke's Pseudo-R^2).[11].(Table 7)

Table 8. Participation in the German survey (logistic regression)

		Odds Ratios
Gender	female	1,04
Age	35-44 years	0,8
	45-54 years	0,7*
	55-64 years	0,8
	65-74 years	1,3
	75-84 years	1,0
	85+ years	0,8
Region	East Germany	0,58***
Size of municipality	100.000-500.000 inhabitants	1,0
Number of contacts		1,2***
n		3.009
P^2	McFadden's	0,03
	Nagelkerke's	0,05

*p<0.10, **p<0.05, ***p<0.01.
Source: OASIS 2000, Motel-Klingebiel and Gilberg, 2002.

Table 7 shows that only the difference between east and west Germany indicates a possible sample selectivity bias. The probability for participation of East German respondents is approximately one half (58%) compared to West German respondents. This result was expected since it is well known that east German respondents are much less likely to participate in surveys from the mid-1990s onwards. Although this was known in advance, the German OASIS team decided not to stratify the sample accordingly because this would have compromised the cross-national objectives of comparability. As a result, the German OASIS data underestimate the proportion of the east German population.

[10] See Knesebeck and Lüschen 1998; Kühn and Porst 1999; Knäuper et al. 2002; Motel-Klingebiel and Gilberg 2002).

[11] See Hartmann 1991; DeMaris 1992; Vogt 1993; Gujarati 1995.

Table 7 also shows that there is no overall age effect of participation in the German OASIS survey, although there are slightly lower participation rates in the middle age groups. There are also no gender effects, or effects according to the type of municipality. The effect of the number of contacts shows the success of the survey organisation in locating respondents. It also shows the importance of a sufficient time-frame for implementing a qualitative field phase - the more often the potential respondent was contacted, the higher the probability of participation. In summary, the German sample does not appear to be characterised by any specific selectivity bias (Motel-Klingebiel and Gilberg 2002).

The willingness to participate again

In contrast to sample selectivity, the willingness to participate again can be analysed for each country sample. This analysis is based on information collected during the OASIS survey interview. At the end of the interview the respondents were asked whether they agreed or disagreed to participate in a next wave of the study.[12] Table 8 shows that the willingness to participate again was highest in Israel and lowest in Germany with different age distributions in each of the countries. For the oldest age group, Spain has the lowest rates and Norway the highest. These rates have important implications for the qualitative field phase of the OASIS project.

[12] In Norway this question was asked to respondents of age 75 and above only.

Table 9. Willingness to participate again

Further participation		25-49			50-74			75+			Total		
		male	female	total	male	female	total	male	female	total	male	female	total
Norway													
	no	–	–	–	–	–	–	31,9	39,3	36,3	–	–	–
	yes	–	–	–	–	–	–	68,1	60,7	63,7	–	–	–
England													
	no	28,1	31,2	30,0	38,3	31,6	34,4	43,0	44,0	43,7	34,6	33,0	33,6
	yes	71,9	68,8	70,0	61,7	68,4	65,6	57,0	56,0	56,3	65,4	67,0	66,4
Germany													
	no	52,8	44,8	48,9	42,0	44,5	43,3	45,7	51,6	49,7	48,4	46,1	47,2
	yes	47,2	55,2	51,1	58,0	55,5	56,7	54,3	48,4	50,3	51,6	53,9	52,8
Spain													
	no	42,9	42,1	42,4	48,0	48,6	48,3	42,1	59,7	53,3	44,9	46,6	45,8
	yes	57,1	57,9	57,6	52,0	51,4	51,7	57,9	40,3	46,7	55,1	53,4	54,2
Israel													
	no	30,7	28,8	29,5	25,2	31,0	28,4	42,0	42,5	42,3	29,4	30,5	30,1
	yes	69,3	71,2	70,5	74,8	69,0	71,6	58,0	57,5	57,7	70,6	69,5	69,9

Source: OASIS 2000, weighted data.

Logistic regression models were estimated using the dichotomous information of willingness to participate again (yes/no) as the dependent variable and gender, education, income situation, household type and physical health status as independent variables. Five-country and country specific models have been computed for the entire sample as well as for the 75+ and the 25-74 age groups. As expected, the models show a strong effect of the respondent's level of education (with England as an exception). It is well known that respondents with higher education are more likely to participate in surveys. A significant effect of gender can only be found in Spain where women were underestimated. In the younger age group, there is an effect of the household composition: respondents living alone have a lower likelihood of participating again than others.[13] But the fit of all the models is not very high, bearing in mind that the McFadden's Pseudo R^2 statistic is a very conservative estimation of the model fit. England is once more an exception, with relevantly higher P^2 values of 0,08 (McFadden) and 0,14 (Nagelkerke). Although unobserved sample selectivity can not conclusively be evaluated from these results, the analyses do show overall processes of selectivity and differences between countries (or more precisely, between the different sub-contracted survey organisations).

[13] Norwegian data were not available for the younger age group.

Table 10. The willingness to participate again (logistic regression;75+)

		Total I	Total II	Norway	England	Germany	Spain	Israel
Gender	female	0,83*	0,86	0,74	1,08	0,97	0,43***	1,14
Education	intermediate	1,06	1,05	1,04	0,64*	1,27	0,68	2,52***
	high	2,04***	1,94***	2,49***	0,95	3,35***	0,79	2,23***
Income	2nd	1,15	1.17	0,88	1,85	1,62	0,77	1,20
	3rd	1,15	1.26	0,97	1,73	1,18	1,58	0,91
	4th	1,23	1,31	0,79	6,02***	1,67	1,26	0,72
	5th -highest	0,79	0,94	0,69	1,39	0,91	0,79	0,91
	missing	0,66***	0,62***	0,89	0,55**	1,03	0,57*	0,64
Household type	lives with partner	0,99	1,06	1,07	1,18	0,73	1,01	1,31
	lives with partner and others	0,00	1,11	2,18	0,73	2,06	1,27	0,93
	lives without partner but with others	0,93	1,02	0,88	1,26	0,98	1,11	0,62
Physical health status (/10)		1,01	1,01	0,97	1,03	1,07*	0,93	1,03
Country	Norway	–	1,56***	–	–	–	–	–
	England	–	1,75***	–	–	–	–	–
	Spain	–	1,10	–	–	–	–	–
	Israel	–	1,53***	–	–	–	–	–
n		1879	1879	384	365	479	310	341
P^2	McFadden's	0,03	0,04	0,04	0,09	0,05	0,05	0,04
Nagelkerke's		0,05	0,06	0,06	0,16	0,08	0,09	0,07

*p<0.10, **p<0.05, ***p<0.01

The model 'Total I' shows the complete model without the country indicators while the model 'Total II' includes these country information and presents estimations for the difference in the participation between countries.

The SF-36 physical health status measure was divided by ten to present more vivid values. This transformation has no effect on the results as such.

Reference groups:
gender: male, income: lowest quintile, household type: living alone, country: Germany

Source: OASIS 2000.

Table 11. The willingness to participate again (logistic regression; 25-74)

		Total I	Total II	England	Germany	Spain	Israel
Gender	female	1,13	1,08	1,24	1,17	0,84	0,98
Age	50-74	1,16	1,13	1,14	1,47**	0,60***	1,42*
Education	intermediate	1,08	0,95	1,65*	1,38	0,57***	1,46
	high	1,65***	1,55***	4,25***	1,59	1,00	2,07**
Income	2nd	0,86	0,86	0,88	0,72	0,66	2,17**
	3rd	1,14	1,11	1,67	1,13	0,94	0,95
	4th	1,05	0,98	1,28	1,18	0,70	0,97
	5th –highest	1,19	1,10	1,99*	1,08	0,52**	2,15**
	missing	0,56***	0,48***	0,52**	0,31***	0,44***	0,86
Household type	lives with partner	1,41***	1,42***	1,53*	1,54*	0,84	1,76*
	lives with partner and others	1,60***	1,44***	1,48	1,92***	0,92	2,11***
	lives without partner but with others	1,46***	1,28*	1,33	0,93	0,72	2,90***
Physical health status (/10)		0,97*	0,99	1,01	0,93	0,88***	1,03
Country	England	–	1,83***	–	–	–	–
	Spain	–	0,76**	–	–	–	–
	Israel	–	1,79***	–	–	–	–
n		3020	3020	746	769	720	785
P^2	McFadden's	0,03	0,05	0,09	0,05	0,05	0,04
	Nagelkerke's	0,05	0,09	0,15	0,09	0,08	0,06

*p<0.10, **p<0.05, ***p<0.01

The model 'Total I' shows the complete model without the country indicators while the model 'Total II' includes these country information and presents estimations for the difference in the participation between countries.

The SF-36 physical health status measure was divided by ten to present more vivid values. This transformation has no effect on the results as such.

Reference groups:
gender: male, income: lowest quintile, household type: living alone, country: Germany.

Source: OASIS 2000.

Table 12. The willingness to participate again (logistic regression; total)

		Total I	Total II	England	Germany	Spain	Israel
Gender	female	1,05	1,04	1,24	1,11	0,71***	1,01
Age	50-74	1,17*	1,17*	1,06	1,67***	0,65**	1,39*
	75+	0,92	0,96	0,89	1,62**	0,40***	1,04
Education	intermediate	1,09	1,03	0,89	1,26	0,60***	1,95***
	high	1,70***	1,65**	2,10***	1,91***	1,02	1,35***
Income	2nd	1,01	1,01	1,15	0,94	0,70	1,88**
	3rd	1,18	1,22	1,76**	1,07	1,08	0,94
	4th	1,17	1,15	1,92**	1,28	0,84	0,90
	5th -highest	1,09	1,11	1,84**	0,98	0,58**	1,70*
	missing	0,61***	0,53***	0,53***	0,45***	0,50***	0,82
Household type	lives with partner	1,23**	1,25**	1,35*	1,21	0,94	1,55**
	lives with partner and others	1,34***	1,30***	1,30	1,65**	1,03	1,61**
	lives without partner but with others	1,20*	1,15	1,28	0,94	0,82	1,79**
Physical health status (/10)		0,99	1,01	1,02	1,03	0,91	1,04
Country	England	–	1,76***	–	–	–	–
	Spain	–	0,81**	–	–	–	–
	Israel	–	1,69***	–	–	–	–
n		4515	4515	1111	1248	1030	1126
P^2	McFadden's	0,03	0,05	0,08	0,03	0,05	0,04
	Nagelkerke's	0,05	0,08	0,14	0,06	0,08	0,07

*p<0.10, **p<0.05, ***p<0.01

The model 'Total I' shows the complete model without the country indicators while the model 'Total II' includes these country information and presents estimations for the difference in the participation between countries.

The SF-36 physical health status measure was divided by ten to present more vivid values. This transformation has no effect on the results as such.

Reference groups:
gender: male, income: lowest quintile, household type: living alone, country: Germany.

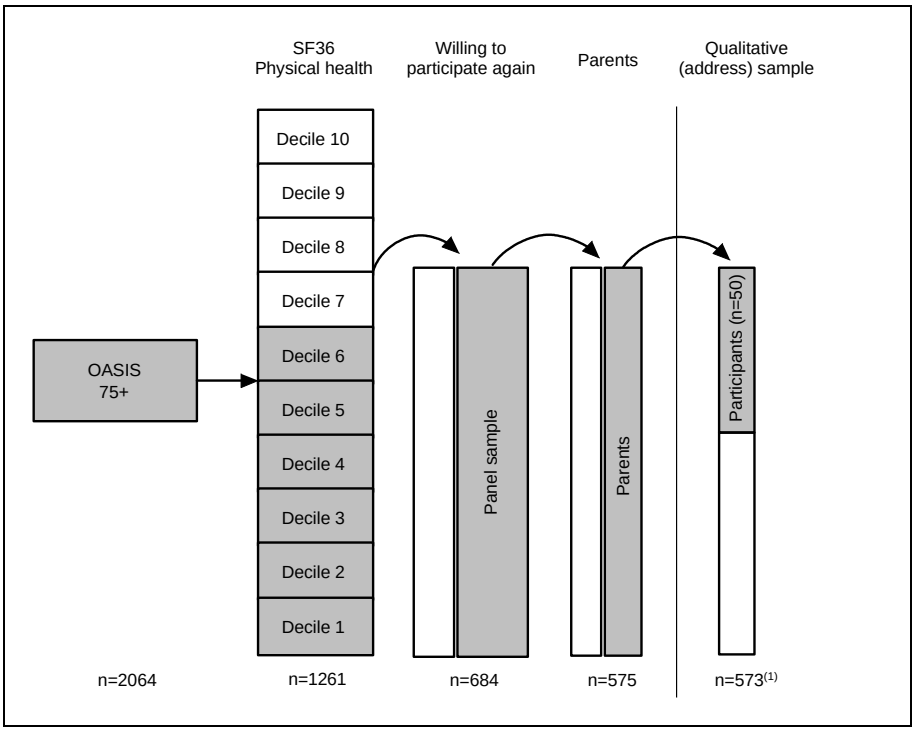
Source: OASIS 2000.

The participation in the qualitative interviewing

Sample selectivity can also be examined in relation to participation in the qualitative field phase of the OASIS project. The qualitative address sample was defined on the basis of the oldest sample strata in the OASIS survey sample (Figure 2). Potential respondents aged 75+ who agreed to participate again and who had at

least one living child were selected from the lowest six deciles on the SF36 physical health scale.

Figure 2: The process of selecting cases for the qualitative interview sample



(1) The difference of two cases between the estimated and the real address sample is caused by the delayed delivery of additional cases after the establishment of the qualitative address sample which was done on the basis of preliminary data

The analysis that follows relates to differences between this sample frame and the final achieved sample of qualitative interviews. Tables 12 and 13 show some key characteristics of the final qualitative sample. Table 13 compares indicators of the overall survey sample, the address sample and the final qualitative sample. The average respondent in the achieved sample is slightly older than in the sample (address) frame, but healthier, with a higher disposal income and, most importantly, with a higher level of education. Although this selectivity bias is not a fundamental problem for the qualitative sample (see Flick, 1995), it might be important for cross-national interpretation of the results. This would be particularly important if the selectivity bias is one *between* countries. Table 14 shows that this is the case in the OASIS qualitative sample. Logistic regression models were estimated to test the descriptive results in the light of multivariate analyses. The overall results confirm the relevance of levels of education for the probability to

participate in the qualitative study as well as showing diverging predictors of sample selectivity between countries.

Table 13. Qualitative Sample – parents only

	Gender	Age	Family status	Household	Education	Income pos. Quintiles	Physical health
Norway	female	84	widowed	living alone	high	4th	intermediate
	female	78	widowed	living alone	high	5th	low
	male	75	married	with partner	low	3rd	low
	female	87	widowed	living alone	low	2nd	low
	female	87	widowed	living alone	low	2nd	intermediate
	female	80	widowed	living alone	intermediate	3rd e	low
	male	90	widowed	living alone	missing	5th	intermediate
	male	86	widowed	living alone	intermediate	2nd	intermediate
	male	84	widowed	living alone	high	3rd	intermediate
	male	88	widowed	living alone	high	3rd	low
England	male	88	married	with partner	high	2nd	low
	female	80	married	with partner	intermediate	4th	low
	male	91	married	with partner	high	4th	intermediate
	female	78	widowed	living alone	intermediate	4th	low
	female	80	widowed	living alone	missing	Missing	intermediate
	female	86	divorced	living alone	low	3rd	low
	female	79	married	with partner	high	Missing	intermediate
	female	80	married	with partner and others	low	1st	low
	female	76	divorced	living alone	intermediate	4th	intermediate
	female	86	widowed	living alone	intermediate	3rd e	low
Germany	female	78	widowed	living alone	high	5th	low
	female	78	widowed	living alone	high	5th	intermediate
	male	82	married	with partner	high	Missing	intermediate
	female	79	widowed	living alone	high	5th	intermediate
	male	76	married	with partner	high	4th	intermediate
	male	86	married	with partner	high	2nd	intermediate
	male	77	married	with partner	high	4th	intermediate
	male	82	married	with partner	high	Missing	intermediate
	female	86	married	with partner	low	1st	low
	female	85	widowed	living alone	low	2nd	intermediate

Table 14. Qualitative Sample – parents only (continued)

	Gender	Age	Family Status	Household	Education	Income Pos. Quintiles	Physical Health
Spain	female	81	widowed	with others (no partner)	low	1st	low
	female	76	widowed	with others (no partner)	low	2nd	low
	female	82	widowed	with others (no partner)	low	1st	intermediate
	male	85	married	with partner and others	low	4th	intermediate
	female	90	widowed	with others (no partner)	low	2nd	low
	male	75	married	with partner and others	intermediate	1st	intermediate
	female	88	widowed	with others (no partner)	low	2nd	low
	female	84	widowed	living alone	low	3rd	low
	male	75	married	with partner and others	high	missing	intermediate
	female	86	widowed	living alone	low	5th	intermediate
	female	82	widowed	living alone	intermediate	2nd	low
	female	82	widowed	living alone	intermediate	missing	intermediate
Israel	female	81	widowed	with others (no partner)	high	1st	high*
	female	76	widowed	living alone	intermediate	2nd	intermediate
	male	77	married	with partner	high	4th	intermediate
	female	82	widowed	living alone	high	2nd	intermediate
	male	87	married.	with partner	intermediate	1st	intermediate
	female	86	widowed	living alone	high	2nd	intermediate
	female	80	widowed	living alone	high	2nd	low
	female	76	widowed	living alone	high	2nd	intermediate

Table 15. Comparisons between quantitative sample, qualitative address sample and sample of qualitative interviews – OASIS sample

	Total sample (75 years and older)	Qualitative address sample	Qualitative interview sample
n	2064	573	50
Age (mean)	81,1 years	81,6 years	82,6 years
Physical health status (mean)	56,1	38,6	41,8
Proportion of males	36,3 %	32,7 %	34,0 %
Proportion married	36,0 %	34,0 %	34,0 %
Proportion living alone	52,7 %	52,4 %	54,0 %
Proportion high education	20,9 %	21,0 %	45,8 %
Income quintiles (median) (1)	2nd quintile	2nd quintile	2nd/3rd quintile(2)

(1) Equivalent income (old OECD scale).

(2) The threshold for the qualitative interview sample is exactly between the 2nd and 3rd quintile of the country specific overall distribution.

Source: OASIS 2002.

Table 16. Comparisons between quantitative sample, qualitative address sample and sample of qualitative interviews by country

	Total sample (75 years and older)					Qualitative address sample					Qualitative interview sample				
	N	E	G	S	IL	N	E	G	S	IL	N	E	G	S	IL
n	413	398	499	385	369	88	113	119	116	137	10	10	10	10	10
Age (mean)	81,5	82,3	81,3	80,4	80,0	83,0	83,0	81,8	80,5	80,5	84,4	82,9	81,3	82,8	81,4
Physical health (mean)	29,0	33,1	29,6	30,3	28,9	41,5	30,5	41,6	39,7	39,9	36,0	36,5	50,0	40,0	46,5
Proportion of males	40,4	31,7	30,8	34,5	45,8	35,2	23,0	32,2	30,2	41,6	50,0	20,0	50,0	30,0	20,0
Proportion married	34,6	35,6	35,9	38,7	35,3	26,1	31,9	37,8	33,6	37,8	10,0	50,0	60,0	30,0	20,0
Proportion living alone	63,9	51,9	58,7	31,9	54,5	70,5	53,1	55,5	29,3	56,9	90,0	50,0	40,0	20,0	70,0
Proportion high education	35,9	13,1	24,0	3,9	26,4	38,4	11,0	30,8	1,7	26,2	44,4	33,3	80,0	10,0	60,0
Income[1)] quintiles (median)	2nd	3rd	3rd	3rd	2nd	2nd	3rd	3rd	2/3[2)]	2nd	3rd	3/4[2)]	4th	2nd	2nd

[1)] Equivalent income (old OECD scale).

[2)] The threshold for the qualitative interview sample is exactly between theses quintiles of the country specific overall distribution.

Rows 4-7 (proportions): %

Table 17. Participation in the qualitative interviewing (logistic regression; basis: qualitative address sample)

		Total I	Total II	Norway	England	Germany	Spain	Israel
Gender	female	1,39	1,38	0,44	1,45	0,52	1,06	7,20*
Age	85+	1,63	1,65	2,25	2,11	1,10	4,08	1,67
Education	intermediate	0,84	0,99	–	–	–	–	–
	high	3,23***	4,51***	–	–	–	–	–
Income	2nd	1,53	1,43	–	–	–	–	–
	3rd	1,25	0,96	–	–	–	–	–
	4th	1,44	1,09	–	–	–	–	–
	5th -highest	1,51	1,25	–	–	–	–	–
	missing	0,57	0,44	–	–	–	–	–
Household type	lives alone	0,99	0,90	–	–	–	–	–
	lives with partner	4,18**	2,90	–	–	–	–	–
	lives with partner and others	1,30	1,00	–	–	–	–	–
Physical health status (/10)		1,03	1,04	0,91	1,24	1,30	1,02	1,11
Country	Norway	–	1,07	–	–	–	–	–
	England	–	1,61	–	–	–	–	–
	Spain	–	1,94	–	–	–	–	–
	Israel	–	0,80	–	–	–	–	–
n		557	557	88	113	118	116	137
P^2	McFadden's	0,08	0,09	0,05	0,03	0,05	0,05	0,07
	Nagelkerke's	0,10	0,11	0,07	0,04	0,06	0,07	0,09

*p<0.10, **p<0.05, ***p<0.01

Complete and more detailed models have not been estimated because of limitations in the number of cases.

The model 'Total I' shows the complete model without the country indicators while the model 'Total II' includes these country information and presents estimations for the difference in the participation between countries.

The SF-36 physical health status measure was divided by ten to present more vivid values. This transformation has no effect on the results as such.

Reference groups:
gender: male, income: lowest quintile, household type: living alone, country: Germany.

Source: OASIS 2000.

Perspectives of analyses

As described in Chapter 1, the theoretical model of the OASIS project implies a hierarchical strategy analyses, beginning with simple country and domain specific descriptions and ending with more complex analyses of variance and multiple group analyses. The main focus of most of the analyses in the following chapters is to test hypotheses by estimating regression models and analyses of variance. The OASIS project therefore uses a cross-national approach to compare solidarity and ambivalence in more traditional societies with more modern countries. The project analyses structural differences between various welfare regimes according to the perspective of three age groups.[14] The OASIS project is based on theory to give insights on the conditions of autonomy and quality of life. Theory guided hypotheses regarding the single dimensions of the model are discussed individually in the following corresponding chapters of the report.

The OASIS model can be understood as heuristic device set in a cross-national welfare state perspective. This means that not only are different types of welfare regimes compared, but also infrastructures of services (sometimes called 'service systems') are examined. Different types of family solidarity and their meaning emerge from these comparisons. But the model also is relevant in a country specific perspective, and it is this perspective that provides the basis for a broader and conceptually more elaborated examination of the comparative data.

The model therefore provides a *hierarchical* agenda for quantitative OASIS analyses with the following stages:

- Definition and construction of basic variables and empirical constructs.
- Description and bivariate analyses within the research areas on the basis of national data.
- Description and bivariate analyses within the research areas in a comparative perspective.
- Multivariate analyses within the research areas on the basis of national data.
- Multivariate analyses within the research areas in a comparative perspective.
- Multivariate analyses for national data on the basis of the complete theoretical model.
- Multivariate analyses on the basis of the complete theoretical model in a comparative perspective.

[14] These age groups can be interpreted as actual age groups, age cohorts or even different generations.

All of the project's research questions can be related to one of the steps of the analyses listed above. After the theoretical definition and construction of variables was completed, a structured description within the respective national data sets was produced. The third stage extends the country specific results into a cross-national perspective of descriptive analyses. The country analyses are then contrasted with respect to comparative theoretical considerations and hypotheses regarding country differences. Stage four is multivariate analyses performed within each country. This stage includes regression analyses (ordinary least squares regressions, logistic regressions, multinomial logistic regressions and sometimes ordinal logistic regressions) and analyses of variance to explain distributions and probabilities of main indicators within each country and within certain domains[15]. In this stage the main goal is to test hypotheses that do not need a comparative perspective, such as those relating to family sociology and social inequality of age dependency, continuity, homogenisation and differentiation of social inequalities over age groups. All of these analyses focus on the distribution of relevant indicators such as quality of life and on the age dependent quality of life predictors which is an argument concerning the structural dimension of inequality.

Stage five broadens the analyses to a cross-national perspective. This mainly results in selecting 'country' as an explanatory variable in regression models or analyses of variance. These models are constructed from the OASIS project hypotheses and analysed to determine interaction effects between countries (which has to be extended by social indicators illustrating its meaning) and other predictor variables. In this way, the simple model within country differences are then examined between countries (which can be technically interpreted as a integration of a complete interaction between all predictors and the country variable) but were also extended by a independent variable 'country' and certain interactions. Stage 6 introduces the more complicated part of the analyses. It is based on a theoretical model which is translated into formal models – a structure of manifest indicators (e.g. number of children, health indicators, help given and received, subjective statements in different quality of life dimensions, social strata) and of latent constructs (social inequality, family cohesion, family culture, transfer types, quality of life). In stage 6 this is undertaken on the basis of country data to describe the situations under certain welfare regimes and to interpret how the models work in a cross national perspective.

Stage 7 extends the models beyond a cross-national perspective. This means including macro indicators of the different welfare states and their development into the theoretical and empirical model. Since the cross-national perspective is designed for clustered data with individuals nested in different countries, it follows that this stage involves hierarchical data with more complex modelling than the other stages.

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[15] For an example see Motel-Klingebiel 2001.

The structure of the OASIS data therefore is based on two hierarchical levels: individuals and society. Such hierarchically structured data usually arises in a variety of research areas. Having two or sometimes three levels is very common, but beyond this number analyses become very complex and can be confusing to interpret. The OASIS project therefore mainly concentrates on individuals nested in their respective countries. An interaction between predictors on the individual level and the respective country need therefore to be tested. The examination of individual and country level data entails information on different levels. These type of analysis can be done with the OASIS data (for example as means or proportions) but they also require external data sources such as national systems of social indicators (see Chapter 3). In the end, an appropriate way has to be found to deal with these hierarchies since the OASIS project is primarily concerned with the interaction between predictors, countries and individuals.

Summary

In summary, any evaluation of the methodological aspects of the OASIS project needs to take into account the enormous complexity of the task and the decisions made by the OASIS teams. Methodological analyses too often place an accent on the problems of conceptualising and analysing the data. Despite the inevitable problems, a coherent strategy was devised by the OASIS teams. The result is a unique data base which can help to answer questions regarding the relation between the family and the welfare state in elder care in a cross-national perspective. Notwithstanding this successful result, it should also be acknowledged that that the process of the empirical implementation of the quantitative OASIS concept could certainly be improved.

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4

The Qualitative Phase

Judith Phillips and Mo Ray

Introduction

This chapter discusses the method and fieldwork undertaken in the qualitative phase of the OASIS project. The outcome of the analysis is also introduced, although the detailed results are presented in subsequent chapters. Broadly speaking, the key elements of qualitative research may be summarised as:

- a focusing on multiple methods, involving an interpretive and naturalistic approach to subject matter
- research undertaken in natural settings, with an attempt to interpret phenomena in terms of the meanings that people bring to them (Denzin 1994)
- the structured use and collection of a variety of empirical materials
- the production of richly detailed material which allow conceptual and experiential meanings to be given to social events, experiences and process in individual, group and community live.
- An open-ended, flexible means of creating hypotheses for structured analysis

A combination of quantitative and qualitative methods in social science research is increasingly common. This approach offers an alternative to the 'paradigm war', which argues that different epistemological positions cannot be appropriately combined (Kelle 2000 2). There were three main aims of using a mixed method in the OASIS project. First, to uncover and illuminate some of the complexities of intergenerational relationships that were perhaps less easy to interpret within a purely quantitative methodology. Second, to explore and expose cultural differences. Third, it was envisaged that the qualitative data would validate and illustrate the quantitative data.

There were significant challenges for the OASIS project in using a qualitative approach. Language issues are fundamentally important in both quantitative and qualitative cross-national research. But these issues surprisingly, have been relatively neglected in the literature on cross-national research process and outcome (Mangen 1999). Qualitative methods, with an emphasis on narrative, bring the challenges and dilemmas associated with linguistic equivalence into sharp relief. Hantrais (1999), for example; comments:

'Many concepts do not travel well and the question of equivalence of concepts in different contexts has become a central issue in cross cultural comparisons…'

Language, cultural background and diverse methodological orientations make the management of data collection and analyses a significant challenge. Clear planning and project management were therefore an essential part of doing the qualitative research and the subsequent analyses. This chapter begins with a discussion of the importance of decision-making in the research planning and fieldwork phases. Specifically, it addresses:

- the rationale for a mixed method design
- research questions and areas of exploration in a qualitative context
- research methodology
- analysis – the process of undertaking team analysis

The chapter then presents the key codes and categories that emerged from the analysis process. Many of these themes and ideas are taken up and discussed in subsequent chapters of the report. The chapter concludes with a discussion of dissemination issues and the relevance of this type of research to the policy context and the gerontological research agenda.

Project planning

The combination of research methods to extend ways of seeing and interpreting the complexities of social life has received considerable support (Mason 1996; Wenger 1999). Combined methods are certainly worth considering in general terms. But in cross-national research, they can offer vital support in contextualizing qualitative materials. Nevertheless, it is important to state why mixed methods are useful, how they contribute overall to research, and how different methods can be combined (Mason 1996).

This section outlines the design, planning and preparation of the qualitative phase of the OASIS project. First, the qualitative research goals are identified. Second, the process of devising an appropriate research schedule is reviewed. Third, sampling decisions and the process of accessing the sample is discussed. Complexities of drawing samples are highlighted, such as gaining access to the adult child via a third party. Ethical issues which influenced the research are also reviewed. Finally, consideration is given to the strengths, resources and challenges of undertaking qualitative research experienced by the OASIS research team.

The qualitative phase of the OASIS project had two primary goals. The first was to explore some of the issues raised in the quantitative survey. For example, the 12 item SF36 index provides information on the numbers of older persons

experiencing difficulties in activities of daily living and the severity of these difficulties. The qualitative phase then explores the challenges emerging from chronic illness and its day-to-day management. The aim is to examine in detail how these difficulties are manifested and the coping strategies of the people concerned. Moreover, the qualitative phase aimed to uncover processes between older parents and adult child dyads which were not directly addressed in the survey instrument but which remain connected to the overall OASIS model. For example, how do normative expectations influence notions of duty and responsibility among adult children? How does family biography influence the management of change associated with the onset of disability. How is seeking help negotiated? What is the balance between achieving ideal care preferences and making use of existing resources?

To achieve these goals, it was decided that the qualitative phase would involve in-depth interviews of older parents (who had participated in the survey) and who were defined as being 'at risk of dependency'. Each parent would then nominate an adult child to form a parent-child dyad. Each dyad would be interviewed, with a follow-up interview 12 months later. The aim of this longitudinal element was to track change and the management of change over time.

Research schedules

The most common qualitative method is that the unstructured or semi-structured interview. Kaufman (1994 123) has defined in-depth interviews as appropriate when:

'the goal is to collect detailed, richly textured, person-centred information from one or more individuals. It is used when the researcher wants to investigate what is meaningful to the individual…the investigator initiates a dialogue with a real person and engages with the interviewee as a human being, not as a study subject. This approach differs significantly from that used in surveys, pre-worded or structured questionnaires, and other fact-finding data-gathering tools. Thus conceived, in-depth interviewing carries special expectations and responsibilities.'

Mangen (1999) warns against using completely unstructured interviews unless linguistic competence is high and the accompanying disadvantage of limiting the potential for interpretive analysis. This observation has been supported by Chamberlayne and King (1996), Ungerson, (1996) and Schunk (1996). But even if linguistic competence is high, there are other good reasons for giving serious consideration to the potential difficulties or costs associated with completely unstructured interviews. These considerations were relevant to the OASIS project. Firstly, not all the research teams had experience of undertaking unstructured interviews. Secondly, the resource implications associated with unstructured

interviews were likely to be too high given the resources available and timeframes. Thirdly, it was essential to achieve a mutual understanding in each country of the concepts being explored. This can be enhanced by using semi-structured interviews when there is team agreement on the conceptual relevance of the areas explored. With these factors in mind, semi-structured interviews were considered to have particular potential benefits for the OASIS project:

- the opportunity to agree on the linguistic meaning of key concepts (for example, 'family duty and obligation', 'formal and informal help')
- the provision of a framework for interviews ensuring that each team pursues broadly similar themes; accompanying prompts were included to develop and enlarge the interview process
- a framework for researchers less familiar with qualitative interviewing

Research questions for the qualitative phase focused on:

- How is help and support to older people patterned and provided? (triggers for help-seeking; mix of help and support; how help and support is decided or negotiated, evaluating the mix of help and support)
- To what extent are family relationships grounded in intergenerational exchanges (continuities over time; change in existing patterns and management of change)
- How do older persons and their families construct and make sense of the experience of dependency? (narrative of dependence; discussions about competence; involvement in decision making; how definitions of dependence change with health changes)
- To what extent does the family culture (values and norms) influence perceptions about expectations/duties and responsibilities to provide care and support (moral duty; solidarity; conflict; ambivalence)

The interview schedule (see Appendices) was developed around these substantive issues. Table 1 provides an overview of the topic areas covered and the rationale for each area. These were devised in team meetings, and following feedback and discussions on draft schedules and a draft qualitative manual produced by the English team.

Table 1. Areas and rationale of the qualitative interviews

Topic area	**Rationale**
Who the older person currently relies on for help and support (*prompts: type of help, how help came about; mix between family, others, formal)*	Obtaining a more detailed picture of the type of help and support received, mix of help, frequency and recall on how help came about (e.g. formal help seeking; as a result of a critical incident)
How managing in life right now *(prompts: views on maintaining independence; evaluations of current coping, met and unmet needs)*	Understanding views on maintaining autonomy – what is important, what has changed stayed the same. Gaps and unmet needs and views about how and whether they should be met.
Celebrating a family event *(prompts: how are events celebrated, how often, ways, who takes charge/organises? Have things changed recently or has it always been like that? Views on family contact and times together)*	Solidarity. Changes in direction of power/authority – who makes decisions? Evidence of maintaining continuity / autonomy.
Change event *(negative or critical change event; what happened; who was involved and why; how was it resolved; how did people get involved (choice/preference/default); ongoing issues resulting from event*	Experience and management of change; use of family, social and formal networks; negotiation of help; meeting needs and preferences; management of ongoing issues resulting from change
Conflict *(experience of conflict; examples; reasons; manifestation; resolution/ongoing – strategies)* `	Use of conflict as functional aspect of family communication/negotiation; family culture around negotiation; management of change; existence of long-standing or unresolved conflict and impact on family care and support/solidarity
Mix of help received *(Prompts: satisfaction / critique of help received; gaps in help received; match of actual help to preferences; notions of duty and obligation to provide help – formal / informal)*	Preferences for help against actual help received; role of duty and obligation re: provision of family help and/or formal help; evaluation/satisfaction of help received
Independence/dependence: *(prompts; views of coping; feelings about current levels of autonomy – dependency; changes in continuity; future issues – help seeking and likely preferences*	Maintenance of autonomy and views about that; management of need for help and assistance; possible plans/ideas for future; what is most important in management of change/continuity

The same interview schedule was used for parents and adult children (with appropriate adjustments in the way the questions were asked).

The use of vignettes has been identified as a useful method of investigating attitudes, beliefs and behavioural outcomes in cross-national research (Mangen 1999). Vignettes have certainly been used to good effect in facilitating family members to discuss notions of family duty and obligation in a hypothetical situation (e.g. Finch and Mason 1993). They can also provide opportunities for participants to relate to their own situation and context. A single vignette to the interview schedule exploring family duty and obligation between mother and daughter was included in the qualitative interviews (see appendices).

Interview schedules and vignettes were translated and back translated alongside discussions with the OASIS teams. This strategy was employed to ensure that the concepts were the same in each language and areas to be pursued in the interviews would be the same in each country. Country teams piloted the interview schedule and minor amendments were made. This phase allowed researchers to try the schedule 'in the field'. The pilot were also an opportunity for teams to discuss how topics could best be framed and to discover any cultural issues in interview approach. For example, formal help in the Spanish interviews had to be addressed with sensitivity, because sometimes older participants did not fully understand the purpose of the interview and feared that the real reason was about the possibility of going to a nursing home.

Identifying and accessing the sample

The OASIS qualitative interview were with a parent, who had already participated in the survey, aged 75 or over, defined as 'at risk of dependency' and, with at least one living adult child. The definition 'at risk of dependency' was operationalised by identifying persons recording decile 6 and below on the ADL scale (SF36) (see Appendices). The rationale for defining 'at risk of dependency' at decile six was twofold. Firstly, we wanted to interview older people (and an adult child) who were likely to be experiencing change in their health and to need assistance or care. Secondly, the original methodology included a longitudinal follow-up interview. A relatively low point on the SF36 scale was used to prevent a very high attrition rate. Hence, relationships, values, expectations and experiences could be looked at in depth in the context of a transition from poor to ill health, and from autonomy to dependency – a transition which can radically influence relationships between older people and their families.

The methodology required each parent to nominate an adult child who could be interviewed (the second half of the dyad). Ideally, this child was the one they felt they could depend on in some way (or depend on most in comparison to other children). Seeking permission from potential participants was therefore a two stage process. Older respondent from the quantitative survey who had indicated that they would be prepared to be re-interviewed were contacted first. Where they agreed to participate in the qualitative phase, they were asked to provide information about a named adult child whom the OASIS team could approach. This process clearly takes longer than seeking consent from both parties at a single point of contact. Parents and children were interviewed separately.

A list of potential participants from each country was generated with sufficient numbers of people to account for attrition, refusal to participate from the older person and refusal to participate from the adult child. In addition, the practicalities

of travel time and distance in terms of reaching both the parent and the adult child needed to be taken into account, given that the adult child could live a considerable distance from their parent. Pragmatic decisions were reached based on each individual team's resources concerning the distance they were able to travel to make interview contact with an adult child.

Ethical issues

The issue of 'informed consent' was an essential consideration in re-contacting respondents from the quantitative survey. Informed consent is essentially a process of a potential participant making '*…a voluntary, uncoerced decision…on the basis of adequate information and deliberation*' (Butler 1990 165). Kimmell (1988) has highlighted the importance of ensuring that participants know how they came to be selected and to provide them with information about the possible uses of the research data. Permission was sought during the OASIS survey stage from older respondents that they could be re-contacted to discuss the possibility of participating in the qualitative interviews.

Prior to the qualitative interviews, letters were sent to potential interviewees reminding them of their earlier participation, outlining the overall goals and purpose of the OASIS project and giving them an explanation of the qualitative phase. It was made clear that the project's aim was to interview one of their adult children. The letter therefore stated that the project wanted to contact an adult child and would need to discuss the research with them in order to seek their consent to participate. The voluntary nature of participation was highlighted in all written contact with potential participants along with freedom to withdraw at any time. The high drop-out and refusal rate (see below) suggests that participants did feel able to choose whether they wanted to take part in the second stage of the research.

Other ethical issues which needed to be taken into account included respect for privacy, safeguarding the confidentiality of data, potential harm to participants and the consequences of research dissemination (Bulmer 2001). Privacy rights were addressed by ensuring that participants had control over the information they gave to interviewers. Participants were told that they could refuse to answer questions. Team discussions highlighted the importance of respecting the participant's right to withhold information. Safeguarding the confidentiality of data was addressed at several levels. It was possible that participant would not want their views, perceptions and biographical information passed on to another family member. The interviewers were clearly not in a position to decide safely or confidently whether information about family members should be freely exchanged. It was therefore agreed with each participant that all the information they gave would not be passed on to the other member of the dyad (parent/adult child).

The confidentiality of the data was also dealt with in other ways. These included:

- appropriate anonymsisation of survey instruments. Each country had different rules governing the preservation of anonymity of survey respondents. In Germany for example, only the survey research organisation held names and addresses of respondents form the quantitative phase of the research.
- the qualitative interviews were made anonymous. Specific details which could identify participants were change (e.g. place names and organisational names)
- interview tapes were separated from other material identifying the participants

Finally, we were aware that in the context of an in-depth interview, interviewers could possibly encounter participants who were perhaps at serious risk or in an abusive relationship. We agreed that each team would devise their own protocols for addressing those issues should they arise in the interview situation.

Researchers

The qualitative phase involved several fieldworkers. A team understanding of the approach to data collection and subsequent analysis was therefore important. A range of experience, disciplinary background and research interests among team members is a strength in a project of this nature. On the whole, research associates involved in the OASIS project primarily took responsibility for the qualitative interviews. But in Norway, they were conducted by a clinician who was temporarily appointed to do the qualitative interviews and in Spain, some interviews were conducted by the original sub-contractors for the quantitative survey phase. In both Norway and Spain however, the OASIS project teams were responsible for briefing interviewers, quality control, and analysis. In England, Germany and Israel, the qualitative interviews were conducted by permanent OASIS team members. Information about the requirements of qualitative interviewing was discussed at OASIS team meetings and a written qualitative manual covering key issues in the overall design was compiled by the English team.

All interviewers were supplied with guidelines on how to undertake the pilot interviews as well as the actual interviews. Attempts were made to code the pilot interviews so as to develop concepts and to begin work with the WinMax Qualitative Analysis data base (see below). A workshop was organised at Keele University to help research associates familiarise themselves with the WinMax system. This workshop provided further opportunities to discuss the development of the schedule and to discuss the potential for a ‘whole team’ analysis of the qualitative data.

Fieldwork

Cultural factors can influence the willingness to participate, as can other factors such as the perceived value or relevance of the study, understanding its aims, and the perceived or actual sensitivity of the topics being researched. Participants aged 75 and above defined as 'at risk of dependency' were drawn from the quantitative sample and asked if they would be prepared to take part in a further aspect of the study with high numbers of people in all countries, in principle, agreeable to further participation. There were significant difficulties in accessing the appropriate sample of dyads for the qualitative phase. Accessing older people who had initially agreed at the survey stage to participate in the qualitative follow-up was problematic due to ill health or death of the respondent. Accessing children was also difficult for the following reasons:

- parents were reluctant to involve their children in the research (the most frequently stated reason was that their children were busy and that they did not want to disturb them)
- parents and adult child lived large distances from each other
- children refused to participate and in some cases also insisted that their parents should not take part in the study.

It took a long time to find a small number of dyads and to set up the interviews. The country teams developed their own approach to seeking selecting the dyads. In England for example, the potential parent participant was sometimes interviewed first and then asked whether a child could be approached. But this method caused difficulties if subsequently the adult child did not want to participate. In Israel and Spain, the greater likelihood of close geographical proximity (or co-residence) between parent and child meant that gaining consent was conducted on a face-to-face basis rather than via letter and/or telephone. Overall, the Norwegian team experienced the least difficulties. Feedback from Norwegian participants appears to show that because parents felt they had already made a commitment to enter the research project at the survey phase, it was reasonable for them to participate again. Access to dyads was most problematic in Germany for the reasons already stated. Germany had a high refusal rate.

The interviewers were generally flexible over the timing of interviews because adult children were often busy at work. Interviews with adult children were for example, often conducted in the evenings and at weekends. Arranging interviews with parents and children was time consuming, especially when they lived in different areas or a large distance from the interviewers. Careful planning was required as a minimum time delay between each interview of the dyad was felt by the OASIS team to be important.

Given the detail in qualitative interviews, decisions needed to be made about how to capture the essential content of the narratives. One obvious approach was to tape record interviews and then transcribe them in detail afterwards. But not all researchers agree. Mangen (1999 117) comments that '*recording can inhibit respondents or cause them to decline to participate; some cultures are not attuned to non-official interviews at all, especially when they are being recorded….*'. The OASIS project teams decided that the benefits of taping interviews outweigh the disadvantages and that consent to record interviews would be sought before they took place. In reality, participants were generally happy to have interviews taped.

One issue that arose, particularly in Spain, was separating parent and child to conduct individual interviews. In two cases, where the elderly parent and adult child lived together, this was impossible. The elderly parents were too anxious about the interviews to allow separate interviews. Interviewing the dyads concurrently does effect the data. But it is not always possible and flexible decisions have to be made in the field. In fact, flexibility was often needed because of the difficulties experienced by teams to find parent-child dyads willing to take part.

Soon after the interviews, the individual teams transcribed them into their country language. This process was an opportunity to reflect on the content and to start work on the analysis (see analysis section below).

Despite the difficulties of finding parent-child dyads all were willing to participate, once access was achieved the interviews generally proceeded well. Overall, participant gave detailed, thoughtful and relevant accounts of the issues relating to the interview schedule. They maintained interest in the project, and evidently recalled their earlier participation. The outcome and analysis of the qualitative interviews are discussed in detail in subsequent chapters.

Profile of participants

Demographic details of the dyads interviewed are given in Chapter 1 (Table 13). Given the size of the project and the amount of narrative material collected, it was important to keep track of the interviews. Each interview therefore had a record sheet containing details of process and progress. These record sheets provided an 'audit trail' (Lincoln and Guba, 1985) for topics such as:

- the management of ethical issues
- use of interviews and development of transcripts
- interviewing techniques used and addressing topics identified by the project
- theory generation and analysis

The use of the record sheet was an important dimension of the reliability and validity of the qualitative phase of the OASIS project.

Analysis

In addition to general complexities associated with qualitative analysis, language and context issues need to be managed at this stage of the research process. Although there is no single approach, the analysis of qualitative data should be inductive and systematic. The way in which the analysis proceeded depended upon the aspirations of the qualitative phase:

- to provide a deeper understanding of family processes when an older parent is at risk of illness and disability
- to generate theory about these processes
- to verify or challenge the quantitative survey findings

A number of issues crucial to the analysis were identified:

- the management of a large data set in five languages
- the different abilities and interest in qualitative method among the country teams
- strategies for developing concepts that are grounded in the interview material and the methods of communicating these developments between teams
- the integration of qualitative and quantitative findings.

Large qualitative data sets can be managed in a number of ways. One of these is Computer Assisted Qualitative Data Analysis (CAQDAS). The cost-benefit analysis of software packages is an essential part of the planning process. The goals, aspirations and analysis requirements of the research all need to be taken into account. Software packages for analysing qualitative data have a number of advantages (Fielding and Lee 1998; Kuckhartz 1998; Lewins 2000; Silverman 2000):

- they can handle large amounts of data quickly
- they provide a consistent approach to analysis
- whole transcripts and projects can be stored for secondary analyses
- links with quantitative data are possible
- consistency of coding
- they encourage a consistent approach to the management of memos from potentially diverse theoretical and professional perspectives (Fielding and Lee 1998)

The disadvantages include:

- a ‘mechanical’ and over-descriptive and superfluous generation of categories that are not grounded in a reflective and questioning approach (Richards and Richards 1994)
- the need to find soft-ware suitable for a multi-site and multi-lingual teams
- erroneous assumptions that qualitative software somehow ‘do the work’ for you (Lewins 2000)
- training and resource implications arising from purchasing unfamiliar soft-ware
- computer analysis does not offer ‘*simultaneous visual access to materials that makes ideas happen’* (Padgett 1998 82)

The cost-benefit analysis confirmed that CAQDAS was the best option for a team approach. The WinMax soft-ware (Kuckartz 1998) appeared to offer particular benefits in terms of team-based analyses and the management of a large data set. It can:

- exchange files across and between teams (this includes texts, codes, coded work and memos)
- transfer of individual pieces of work (e.g. individually coded text and specific coding frames)[1]
- to merge archives across teams to create a key master coding frame
- support different languages

[1] The original and final coding frames are appended to this report. An example of interview narrative, it’s coding and memos is also attached in the Appendices to this report in order to give readers insight to the actual process of doing analysis.

Co-ordination and analysis procedures

As already discussed, the production of rich data from qualitative research undertaken by several teams in a cross-national setting creates specific challenges. In addition, the integration and co-ordination of the analysis presents additional issues. These include:

- difficulties in fully understanding the meaning of terms which have a cultural loading within a particular national context. This makes direct comparison a daunting prospect
- the corruption of data by translation. The reduction of interview material from many languages to one gives only a partial account of the process and outcomes of the research
- when a research project is the product of several researchers, then comparability of data is a major concern

Although there are difficulties associated with several researchers in different sites, it was important to integrate the data and not to exploit it separately. This would have obscured the richness of a large project and the research objectives of the OASIS project would not have been met.

Figure 1 shows the process of analysis, and conceptual development of the qualitative research component. At the planning stage, the cross-national team of OASIS researchers agreed a coding framework based on concepts integral to the OASIS project model. Each team undertook their own analysis and worked with the coding framework in their own language. The coding frame allowed for flexibility to add concepts from each country, after consultation with the co-ordinating team (i.e. the English team). Memos were then sent with the codes to enable each team to understand and contextualise the concept and to further analyse their own country's data applying this code if appropriate.

Figure 1. The process of analysis and defining emerging categories

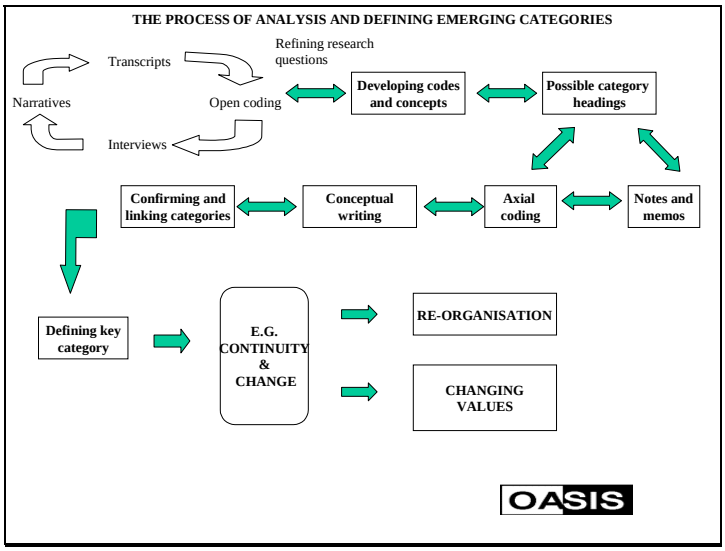
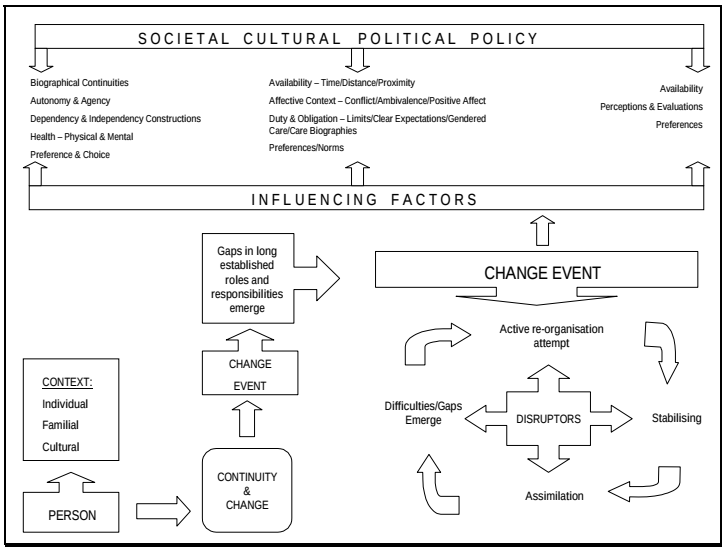


Figure 2. Key categories of analysis



During the analysis of the data, feedback was given to the English team. Inevitably, the feedback was in English and this poses difficulties in cross-national research. In addition, extracts from interviews (and a sample of complete interviews from each country) were translated into English to illustrate how concepts were being defined. Crucially however, each team would continue to undertake their own

analysis and coding work in their own language and context. It was hoped that this would prevent some of the limitations associated with a strictly defined and rigid coding frame. It remained our stated intention to explore qualitative materials inductively and to generate and develop concepts to aid understanding of the complexity of the relationship between family cultures, informal care and formal care arrangements.

At the end of the process each country had their own analysis and coding frame in their own language. In addition a coding frame amalgamating the key codes from each country was developed. The approach also draws on Ungerson (1996) and her strategy of ensuring that team members worked in their own languages.

It was hoped that the availability of both an overarching coding frame (achieved by team discussion, feedback and critical comment and associated individual frames) would provide an important opportunity for triangulation of the data. Furthermore, this would provide the opportunity for writing up in each team's own language. In addition, as well as comparative possibilities across the whole OASIS team, units of comparisons within and between some teams were possible. Finally, the qualitative research component would complement the quantitative data and lead to contextual analyses of the participating countries.

This method of analysis presented challenges which were eventually resolved by the OASIS teams. For example, the difficulties of accessing parent-child dyads delayed interviewing and subsequently feedback. This was resolved by each team giving feedback as soon as they were able to start interviewing. Also, the feedback period was extended to ensure that all the teams had a chance to develop the coding.

Language difficulties were generally resolved by team discussion. For example, an older Norwegian woman spoke about moving to a 'nursing home' with her own 'cooking plate'. This led to a discussion about the range of residential provision available in Norway, their facilities and clarification for terms such as 'nursing home care' compared with other forms of supported housing. Idiomatic language needed clarification. In Spain, for example, the research associate explained to the other teams by way of memos the meaning of various expressions in interview narratives and also made comments about the likely 'strength' of meaning if she felt the meaning could be construed differently in English.

Coding (see reference manual) took place with country teams working on their own narratives (produced in their own languages). Some narrative fitted with the original coding frame (for example, incidences of solidarity). Other material needed new codes (for example, duty and obligation; methods of family communication). Memos were generated by individual team members and sent to

the English team as the central point for circulating across all teams. These memos had several uses:

- a means of defining concepts added to the coding frame
- a way of exchanging ideas with teams (for example, is the same theme emerging in their data?)
- the translation of examples and extracts of narratives into English
- clarifying meaning, coding, data translation and idiomatic language
- cross referencing to other interviews which had similar and importantly, different examples or experiences.

Throughout the analysis, data was compared between interviews and across teams. Differences as well as similarities were important, and the interview schedules or areas of questioning were developed and updated during the analysis. This process is similar to the comparative method (Strauss and Corbin, 1998) and some important issues emerged. One example is different notions of autonomy among the older Spanish participants. Whereas older participants in other countries tended to stress independence, the importance of home and retaining important skills, Spanish older people focused much less on these issues. They talked about the importance of getting help from children, mostly daughters and often living with their parents. Preserving autonomy in Spain was perceived as something to do with the right to give up independence and choices about whether to live with or near other family members.

At each feedback point, the newly configured coding frame, interview narratives and memos that had been collected by country teams were merged by the English team and redistributed. This process meant that country teams could add emerging codes and concepts to their own coding frames whilst still having an overall view of other team's interviews, codes and memos. It also allowed ongoing dialogue between team members, generating interesting theoretical possibilities for developing the analysis.[2]

As well as using the soft-ware, further analyses of the interviews was undertaken by country teams working on particular topics and concepts. Researchers were therefore able to get very 'close' to the data. They could work with narratives across dyads, analysis data within countries and make comparisons across countries. This process helped the integration of the qualitative and quantitative data.

[2] There were problems merging Israeli data because the original Winmax system did not support Hebrew. The Israeli team therefore bought the latest Winmax package (which does support Hebrew) but a further problem arose, since the two versions were incompatible and data could not be merged. So the Israeli team sent their data as a Word document to the English team and it was merged into the coding frame

In June 2002 an Accompanying Measures meeting was convened to discuss the qualitative phase of the research. It was funded by the EU and experts in qualitative data collection and analysis were present. The meeting focused on issues of analysis and the process of the qualitative research phase within the OASIS project. A number of issues emerged from this meeting:[3]

- evaluating the quality of qualitative research processes
- the role of triangulation in mixed-method research
- the experience of cross-national research processes and analysis in other European funded research
- the re-conceptualisation of ambivalence utilising interpretive approaches (Connidis and McMullen 2002)

Dissemination

There are crucial questions to consider for the dissemination of cross-national qualitative research. These are:

- issues of linguistic equivalence and the management of reporting multi-lingual projects
- reliability and validity of the research
- avoiding the worst excesses of a universalist or culturalist approach and therefore appropriately contextualising the research
- the method employed and the challenges or pitfalls associated with it
- the visibility of the researcher in reporting the research

Epistemological, ontological and methodological differences in qualitative research should not mean a lack of concern for the pursuit of rigour (Silverman 1993). Padgett (1998:88) has argued that qualitative research has '*…the unappealing double bind whereby qualitative studies can't be verified because researchers don't report on their methodology, and they don't report on their methodology because there are no established canons or conventions for doing so'* Qualitative research can be criticised for unrepresentativeness of its findings.

Other potential issues for dissemination include viewing data through preconceptions and filters, and ignoring data that does not support conclusions. Lincoln and Guba (1985) suggest that the issue of *trustworthiness* in qualitative research provides a suitable alternative to reliability and validity. Trustworthiness can be evidenced via questions addressing:

[3] Papers presented at the Accompanying measures meeting are appended to this report.

- Credibility – how credible does the analysis appear given the current state of knowledge about the topic? The results of the OASIS qualitative interviews support for example, research findings on the role of solidarity between the generations and the how ambivalence may be used to manage change. Furthermore, the findings provide evidence of how older adults make use of biography and identity to shape the decisions they make in the context of maintaining continuity. Biography and identity are also used for strategies to manage change.
- Transferability – can the findings be transferred to other similar research contexts? The OASIS qualitative findings can be transferred to other situations, such as exploring the management of change caused by chronic illness and disability. For example, the analysis on service preferences, maintenance of autonomy and the impact of conflict can be applied to marriage and long-standing partnerships.
- Auditability – is it possible to audit the research process? Is there a satisfactory audit trail to follow? The OASIS qualitative project has a clearly defined and transparent process in terms of project planning, data collection and analysis. The use of the Computer assisted analysis software provides an easily auditable trail.
- Confirmability – can these findings be confirmed via further study, repeated studies or, comparison with existing data? Repeated studies have not yet taken place but it is anticipated that the OASIS project will be repeated by other researchers.

The problem of linguistic equivalence and diversity of language was an issue throughout the research process. Ungerson (1996 65) reflects on the difficulties associated with data being altered by the process of translation: '*Where qualitative methods, leading to grounded theory, are used, the loss of meaning and nuance arising from the translation of direct quotations can be an insuperable difficulty. Publication will lock the culturally loaded meanings of interview material from many languages into a single language where they can only provide a partial key*'. This is an issue that the OASIS project has only partially been able to solve. Encouraging researchers to work in their own language manages the problem from the perspective of individual analysis. But funding bodies require cross-national research to be written up in a single language. Peer review, feedback and triangulation can help to overcome bad translation, but the issue still remains. In addition, reporting the findings in the context of social and welfare policies can help to weave analysis with an appropriate contextual back-cloth.

Finally, consideration has to be given to the final stages of qualitative and quantitative cross-national research. Often, the two approaches are written up separately and presented independently. Padgett (1998) suggests that an integrated study should ideally interweave findings in a synthesised comparative analysis. Such an integrated approach would enable readers to make judgements about how

outcomes converge, complement or contradict each other. The OASIS project has attempted both approaches, and the qualitative findings have been used to illustrate and illuminate key arguments and findings of the quantitative data.

Key concepts and categories

The key concepts and categories of the qualitative interviews are based on the management of change and transition in the context of real or potential chronic illness and its day-to-day management by the individual. They are explored from the individual and intergenerational perspectives and cover family and formal care options. Figure 2 provides an overview of the key categories in the analysis. Basic information about the individual's situation provides data for an analysis:

- individual biographical features
- family contexts. For example, affective contexts; presence of conflict; proximity of family; quality of contact between family members

The 'management of change' refers to how older people address the changes they experience as a result of ill health and disability. This concept addresses a number of issues which influence how older people perceive and experience the transition from good to poor health:

- the perception of biographical continuities and which continuities they want to preserve compared to choosing new one or abandoning old ones. This issue relates to a key finding that older people often make difficult decisions about what they will forego in order to preserve important aspects of their lives. For example, older people may decide to socialise less in order to preserve energy and remain independent in their own home.
- individual perceptions of autonomy and agency. People have different perceptions of autonomy and these influence how help is sought from within or outside of the family. Moreover, aspects of older people's lives might resonate more clearly with their perception of autonomy. In the qualitative interviews, older people acknowledged that they might not be able to remain independent and that ill health could might lead to re-negotiating and reconstructing ideas about autonomy.
- the older people interviewed tried to *manage* the changes and uncertainty caused by illness and disability. They reorganised previously held routines and basic activities of daily living. Family members helped out, as well as formal services. But in some case, there were difficulties in managing these changes. Some older people using formal services found their lives were disrupted and that the benefits of professional services did not outweigh the costs. The help of other family members was heavily influenced by ideas about what was right

or appropriate to ask. In all the OASIS countries except Spain, parents were worried about expecting too much of their children, particularly in the area of personal care.

- the presence or absence of on-going disruptions (e.g. further events associated with the change from poor to ill health, or uncertain and unpredictable health). All the older people interviewed in the qualitative phase had uncertain health. They were aware that they could become ill or disabled at any time. They knew that further disruption to their lives would be caused by fluctuating health and that they would be required once again to manage these change.
- individual perceptions of dependence and independence. The clearest difference to emerge in this category was that Spanish elders did not perceive co-resident care (with adult children) as a loss of independence. Independence in other countries focused on being able to maintain oneself at home and dependence was perceived overwhelmingly as moving into a care home. In Spain, the idea of moving into a care home was not seen as a loss of independence but rather, as a form of family abandonment.

It is important to take into account the family contexts when assessing the potential of individuals to support older people in their management of change. These contexts are influenced by:

- affective relationships and on-going and unresolved conflict. As shown in the quantitative data, older parents and their children generally expressed considerable affection and concern towards one another and provided mutual support. Where conflict was serious or unresolved, it was not surprising to find that adult children were less willing to provide support and practical help. Nevertheless, these adult children often continued to provide a level of support necessary to maintain their parent at home.
- proximity to an older parent. This clearly had an impact on the provision of support and help to parents. Children who lived close by were often critical of their siblings who lived further away and who were perceived as providing less help and support to their parents. In Spain, close proximity often meant an absolute expectation that co-resident care would be provided and this had the potential to create ambivalent feelings about this expectation.
- notions of duty and obligation to supporting parents. The management of change and involvement of family members was mediated by notions of appropriate levels of duty and obligation. In Germany, Norway and England there was a clear message that children had a duty to support their parents, but mainly in areas of practical help, social and emotional support. In Norway, people held the state more responsible for the care of older disabled people. In Spain, most people believed that it as the duty of children to provide *all* types of help and care if necessary. In Israel, there were strong feelings of filial obligation to support older parents in need. However, the older parents highlighted the importance of autonomy (defined as managing independently)

and therefore they wanted to avoid involving children in areas such as personal care.

Formal services were also identified as a crucial factor in the management of change. Decisions concerning the use of services were mediated by a number of factors:

- availability and acceptability of formal services. In Spain, services were generally perceived as unacceptable and they represented family abandonment. Moreover, Spanish services are less developed and not as available as in the other OASIS countries. It was not unusual for the Spanish older parents to express considerable ambivalence about the possibility of involving formal services. Issues such as being cared for by strangers and the limitations of what formal services could do were often highlighted. In England for example, there was anxiety about the availability of services given the considerable publicity directed at factors such as eligibility criteria and insufficient funding of community care services.
- ability of formal services to meet need.
- the relation between formal services provided and how they corresponded to people's aspirations for autonomy.
- the maintenance of continuities and perceptions of the quality of services. Older parents evaluated formal services on the basis of how they fitted in with their lives. Some older Norwegian parents and children found services unsatisfactory because these services were not flexible enough to accommodate their daily routines. The continuity and standard of care was also identified as an issue. When there was a consensus between individual need and service provided, families generally received services positively and regarded them as an essential component in maintaining independence.

The processes of negotiation in the management of change is very important. For example, older parents were ambivalent in their attempts to negotiate resolutions to their difficulties when their expectations did not accord with what was available, affordable, or acceptable. Uncertainty about potential future care needs is a significant feature of the narratives, highlighting a number of issues:

- on-going ability to manage autonomously
- availability of support should needs become more complex
- children's views on future solutions to complex needs
- parent's views on future solutions to complex needs
- acceptability of possible services (for example, greater input from community formal services; admission to a care home)
- views and perceptions about appropriate levels of obligation from children to parents and their role in supporting and caring for parents

Societal, cultural and political contexts also mediate the process of negotiating change. For example, the availability of formal services, whether these services are acceptable, and attitudes towards the balance of formal and family care, are all highly relevant to older parents and their children. The pattern of service availability, policies and practice responses to the care of older disabled people are all shaped by these considerations.

Conclusion

This chapter has outlined the process of undertaking a qualitative research phase as part of the mixed method project in the OASIS project. The research design contained several challenges in terms of cross-national research. However, this design has also created the possibility of understanding how older people and their adult children manage change and the transition to disability and chronic illness. Some cross-national comparisons have been possible within the context of the qualitative research, particularly for example, with reference to preferences and orientations over resolving events associated with change. These themes and issues that emerge in the qualitative phase have been discussed alongside the findings from quantitative data. The chapter has identified the key themes which underpinned the analysis of the qualitative phase of the OASIS project.

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5

Norms and Ideals about Elder Care

Svein Olav Daatland and Katharina Herlofson

Background

Ageing populations present challenges to both governments and families. A changing balance between older and younger generations puts more pressure on families, and raises doubts about the feasibility of the current balance between public and private provision of elder care. Structural changes leading to competing obligations have added to these challenges. A growing number of older people live alone, and multi-generational households are on the decline. Adult daughters, who with spouses are the dominant family care providers, are increasingly joining the paid labour force, and it is unreasonable for them to carry double burdens. In addition, reduced fertility rates and less stable families mean that fewer family members will be available as caregivers in the future.

These changes are common to most modern countries, but with differences of timing and degree. Some countries are at earlier stages of demographic transition than others, and they have faced the consequences for some time. Countries also vary in cultural values. Not only do they have different responses to the challenges brought about by demographic changes, but they also have different priorities. Ultimate goals may be similar, but views and policies about how to get there can differ considerably. New policies must therefore not only accommodate new realities, but also already established traditions. What people perceive as the reasonable and fair thing to do is vitally important for a sustainable model of elder care. These issues are the subject of the present chapter, where the focus is on the cultural basis for family care and what people *themselves* see as desirable.[1]

Focus

Norms and ideas about elder care are important for pragmatic as well as theoretical reasons. In all modern countries, responsibility for elder care is shared in some form between the family and the welfare state. But is there a sustainable balance between these two parties when populations are ageing and equality of opportunity for women is increasingly acknowledged? In order to develop just policies we need to know more about what people see as 'the right thing', and what they find is a

[1] See research questions 1 and 5 of the OASIS project: What are the normative ideals of intergenerational care and living arrangements? What is the (actual and) preferred balance between families and services systems?

reasonable balance between the family and the welfare state. What people are *actually* doing is obviously important to know. But so is what they *would* like to do, given the power of choice. Perceived norms and personal taste are premises for a good quality of life and for that matter, a good quality of care. We are usually happy when our preferences are rewarded, and unhappy when they are not. High quality care should therefore respond to psychological as well as physical needs.

Knowledge about norms and attitudes are important, because given the opportunity and resources, people tend to act accordingly. On the one hand, attitudes and preferences are relevant for policy makers, as they point forward and are push-factors towards new life styles and policies. On the other hand, norms and obligations are backward looking, representing continuities over time and resistance to change. What people *actually* do is always some form of compromise between the two. The same holds for social policies which, attempt to balance conflicting considerations.

The *theoretical* relevance of these issues has roots in the controversy over the 'isolated nuclear family' - whether or not the link to older generations has weakened in modern society, as suggested by Talcott Parsons (1955). Ethel Shanas and other researchers on ageing in the 1970s were critical of Parsons. They suggested the term 'modified extended family' as more appropriate (Shanas et al. 1968). Empirical studies in the 1960s and 1970s showed that high levels of contact and support across generations were still in place, and the breakdown of family solidarity could be considered a myth (Shanas 1979). Theses studies however, were not totally critical of Parsonian functionalism. The position of elders in the family was still seen as rooted in their utility. These researchers simply pointed to *alternative* emotional roles and functions, which had gained importance as instrumental and economic tasks of families were transferred to other institutions and relationships.

The intergenerational solidarity model of Bengtson and Roberts (1991) followed in the footsteps of the Shanas tradition. This model measured solidarity along six dimensions – *structural*, *associational*, *consensual*, *affectional*, *functional*, and *normative* solidarity (see Chapter 6 for details). The early formulation of this model assumed that these dimensions were expressions of a common, latent solidarity factor. Later revisions have stressed the truly multi-dimensional character of intergenerational relationships. Conflict has been added as an independent dimension, and not simply indicating a low level of solidarity (Silverstein and Bengtson 1997). These revisions came in response to criticism that the earlier model was normatively biased towards family harmony (Marshall, Matthews and Rosenthal 1993).

More recently, ambivalence has been introduced as a concept for exploring family relationships (Lüscher and Pillemer 1998, Connidis 2001). Intergenerational

ambivalence refers to contradictions in parent-child relationships, both on the structural (sociological) and personal (psychological) levels. Ambivalence is, so to speak, the 'normal' state of affairs. The ambivalence perspective allows solidarity and conflict to co-exist as features of family relationships, and stresses the dynamics of these relations. The focus of this approach is how contradictions are socially constructed, and how conflicting obligations and mixed feelings are continuously negotiated in the day-to-day life of families (Connidis and McMullin 2002). In fact, this is a very similar approach to the one adopted by Janet Finch (1989) some years earlier. She too pointed to the inherent contradictions of family relationships, and how family members adjust their commitments to fit with other obligations and aspirations. According to Finch and Mason (1990, 1993), family norms are more appropriately seen as general guidelines rather than concrete prescriptions for behaviour. In this view, commitments can take new directions when circumstances change. In the past, such changes may mistakenly have been taken as a breakdown of family solidarity. A more promising hypothesis might be to see intergenerational obligations as stable, but striving to be more adaptive. A cross-national analysis of how filial obligations are related to personal preferences for care, and public opinion about the role of families and the welfare state, may help to clarify this possibility.

The questions examined in this chapter are as follows:

- are filial obligation norms prevalent in Europe today, and if so, what is the nature of these obligations?
- what do contemporary Europeans see as the proper balance between the family and the welfare state in elder care?
- what are the people's preferences for long-term care and living arrangements in old age – do people want family care and shared housing with children, or do they prefer services and residential care?

The cross-national perspective

Most empirical studies have an ethnocentric bias as they are normally carried out in one country only. The present chapter takes a comparative perspective and draws on data from five countries, Norway, England, Germany, Spain and Israel. The five countries represent different family cultures and welfare state regimes. According to the Esping-Andersen typology (1990), Germany belongs to the *conservative* welfare state regime, Norway to the *social democratic*, and England to the *liberal*. Some observers have identified a southern, or Mediterranean, welfare state as a separate category (Leibfried 1992; Ferrera 1996), but Esping-Andersen (1999) has suggested that Spain (and other southern-European countries) could also be

included within the conservative regime. Israel may be seen as a *mixed* model, with both liberal, conservative and social democratic features.[2]

As far as family legislation is concerned, England and Norway have no legal obligations between adult generations. These two countries base their social policies on individual needs and rights. Germany, Israel, and Spain belong to a more familistic tradition, although differently rooted (in conservative, Judaic, and Catholic traditions) and with varying degrees. Formal family obligations are most apparent in Spain, where the wider family has legal obligations and not only the parent-child relationship as in Germany (Millar and Warman 1996) and in Israel (Lowenstein 2000).

The extent to which Europe is characterised by distinct family systems is a matter of controversy. Reher (1998) suggests a north-south divide, with deep historical roots in Western Europe. The more central and dominant position of the family in southern Europe pre-dates the modern welfare state. Over time, the family has developed in a form consistent with already established cultural practices. Some convergence can be expected in response to pressure from demographical change and other external factors, but the nature and meaning of family life will probably *not* converge. Convergence in the external indicators of family life will '… *not undermine the deep disparities that have always characterized the family in the different regions and cultures of Europe'* (Reher 1998 221).

Are such cultural and political characteristics reflected in filial norms, public opinion and personal preferences observed in the OASIS data? If so, then family care should be particular attractive to people in Spain, and welfare state services to people in Norway. Consensus and contrast *within* the five countries is also interesting to investigate. Do women support filial obligations and family care more than men as might be expected from a traditional gender role perspective? If so, is the female dominance of family caring that has been firmly documented in a number of studies (Dooghe 1992, Dwyer and Coward 1991, Sundström 1994, Twigg 1996), 'legitimised' by a corresponding difference between women and men in their personal and normative ideals? And finally, are family norms so deeply rooted in the culture of a country that they represent stable and distinct patterns, or will they converge in response to the weight of demographic transitions and related structural changes? The latter outcome is more likely if younger cohorts hold similar, and less collectivistic, attitudes than older cohorts. If this is the case, important signals about changes to come will have been found.

Comparative studies often follow one of two approaches. The first observes general patterns of similarity in different countries. The second approach looks for

[2] For more details see Chapter 2.

distinctiveness and idiosyncrasies. These different strategies are characterised by Ragin (1987) as the *variable-oriented* vs. the *case-oriented* approach. Gauthier (2000) points to the same contrast when she identifies *structuralism* and *culturalism* as two different paradigms in comparative research. The structuralist position assumes that similar macro characteristics will produce similar outcomes on the micro (individual) level. Social structure is then expected to have a uniform effect on institutions and individuals, regardless of differences in culture. Culturalists, on the other hand, assume that social values can modify the effects of social structure, and hence lead to different outcomes of similar inputs. Kohn (1989) indicates that both perspectives have something to offer and, '… *the critical issue is how to interpret similarities, and how to interpret dissimilarities, when you find them'* (p. 78). Finding cross-national similarities is an avenue to acquiring more general sociological knowledge. Cross-national differences are often difficult to interpret, as they can be produced by idiosyncratic conditions. In this chapter, Kohn's positions on these issues is followed, and attention is directed towards *both* similarities and differences. If the contrasts between the countries are dominant, they will point in the direction of culturalist explanations. If the similarities are more salient, they may indicate more general mechanisms at work.

The data for the analysis are based on parallel surveys undertaken in 2000 and 2001 in the five participating countries of the OASIS study. A representative age-stratified sample was drawn consisting of non-institutionalised persons aged 25 and above in larger urban areas (100 000+). About 1,200 respondents (400 aged 75+, 800 aged 25-74) were interviewed by a standardised questionnaire in each country – a total of 6,106 respondents. Persons aged 75 and older were over-sampled in order to have sufficient representation among the oldest (see Chapter 3 for details).

The study also included qualitative interviews in each country with around 10 dyads of 'elders at risk' and the 'primary care person' among their children (see Chapter 4). The present chapter is based mainly on the survey data, but illustrated also with excerpts from qualitative interviews in two contrasting countries as far as family and welfare state tradition is concerned - Norway and Spain.

The analysis is based on four sets of variables: filial obligation norms, attitudes to the family-welfare state balance of responsibilities, public opinion about future elder policy, and personal preferences for care and living arrangements. The chapter now turns to the measurement of these constructs and a discussion of how they are related.

Filial obligations

Filial obligation norms refer to the expectations on adult children to provide support for their ageing parents. Based on a scale developed by Lee, Peek and

Coward (1998), support for filial obligations is measured as the number of agreements with four propositions:

> **Do you *strongly agree, agree, disagree, strongly disagree* with the following statements**:

1. Adult children should live close to their older parents so that they can help them if needed.
2. Adult children should be willing to sacrifice some of the things they want for their own children in order to support their ageing parents.
3. Older people should be able to depend on their adult children to help them do the things they need to do.
4. Parents are entitled to some return for the sacrifices they have made for their own children.

Respondents score 1 if they agree with a proposition. Scores therefore range from 0 to 4 - the higher the score, the more supportive of the norm of filial obligation. For the purposes of the analysis, each question was adjusted from the original four response categories to include a fifth, *neither/nor* option placed between the strongly agree and agree on the one side, and the disagree and strongly disagree on the other. This was done so that ambivalent attitudes could be measured. Lee et al. (1998), in a similar analysis, used an additive index ranging from 4 to 16. The dummy index used here (counting number of agreements) correlates highly (around 0.90) in all five countries with Lee et al.'s scale. The scale used by Lee et al. is also reported to have a high internal consistency (Cronbach's alpha = 0 .79). This is also the case for the dummy index used in this analysis of the OASIS data (0.73 for the total sample, varying between 0.67 in Israel and 0.80 in Germany).

The propositions regarding filial support are phrased in broad terms so that general cultural norms can be tapped equally for persons with and persons without children (or parents). Two of the propositions relate to the adult child's perspective (what adult children ought to do), the other two from the older parent's perspective (what older parents might expect). Note also that the propositions differ in nature and address separate domains of the relationship (living close-by, depending upon, etc.). They also represent different strengths of commitment. Therefore the final scale should cover a broad range of filial responsibility expectations, and far better so than any of the single items by themselves. Each item may, however, be a useful source of information in its own right to examine the substance of the norm in more detail. A weakness of the scale, however, is the bias towards agreements. This is common to many scales aiming to measure familism. All four items are phrased in *support* of filial obligations and the responses are therefore biased in this direction. However, this should not affect the relative differences between the countries.

The family/welfare state balance

Attitudes to the family/welfare state balance of responsibilities are measured with reference to help in three domains - *financial support*, *instrumental help*, and *personal care*. These three domains cover the main areas of policy towards supporting elders. The items and scale were developed specifically for the OASIS study.

1. About how much responsibility should in your opinion the family on the one hand, and the welfare state on the other, have to provide *financial support* for older persons in need?
2. About how much responsibility should in your opinion the family on the one hand, and the welfare state on the other, have to provide *help with household chores* for older persons in need?
3. About how much responsibility should in your opinion the family on the one hand, and the welfare state on the other, have to *provide personal care* for older persons in need?
   Responses possible: totally family, mainly family, both equally, mainly welfare state, totally welfare state

The scale used from these three items sums the responses in the following way: '*welfare state totally*' (score=2), '*welfare state mainly* (score=1), '*family totally*' (score=-2), '*family mainly*' (score=-1), '*both equally*' (score=0). The scale therefore ranges from -6 to +6. Negative scores indicate an inclination towards the family as being mainly responsible and positive scores indicate a welfare state orientation. Scores around zero represent support for an equal division of responsibility between the two.

Public opinion about policies for older people

Public opinion on policies for older people concerns the distribution of the needs and costs of care for elder care. This is assessed by one direct question on primary responsibility, and five related questions about the increasing costs of care:

1. In the years to come there will be more old persons in need of care, help and nursing. In your opinion – who should take the primary responsibility for meeting these increased needs? Should it be the *family, public services, voluntary organisations, the private sector, or others – like friends or neighbours*
2. In your opinion – how should we cover the increased costs for the care of the aged in the years ahead? Answer by saying how much you *agree* or *disagree* with the following statements

a. Care for older people should increasingly be financed through the private sector.
b. Elderly people ought to pay somewhat more for the help and services they receive.
c. Adult children should pay more for help and services to older parents.

d. Taxes should be increased somewhat and be used for the care of elderly people.
e. A larger proportion of the public resources should be used for the care of elderly people, but without raising taxes
Responses possible*: strongly agree, agree, neither agree nor disagree, disagree, strongly disagree, none of this apply*

Personal preferences

Personal preferences are measured in two domains - preferences for long-term help, and preferences for housing. Both domains relate to the preference for family care over professional services. The questions were phrased as follows:

1. Turning now to your own personal preferences – supposing you should come to need long-term help on a regular basis with household chores like cleaning, washing clothes etc? From whom would you prefer such help – from *family, from organised services, or from others*?
2. If you could no longer live by yourself in older years, and had to choose between living with a child or in residential or institutional care, what would you prefer? (*This question was relevant only for parents*)

Analytical perspective

It is not self-evident how each of the four domains described above are interrelated. Beliefs and preferences can be rationalisations for already performed behaviours, or they can be prospective motivators for behaviour. In fact, probably both will be present for intergenerational relationships, because they are characterised by a long stream of events. Given this difficulty, a particular perspective must be selected, and an analytical logic imposed on the data.

Filial norms are taken as general guidelines for behaviour and as part of the fabric that binds families together. Norms indicate what is the right thing to do, and regulate (but not dictate) the *who* and *what* of family obligations. They are motivators for behaviour. We are inclined to do what is considered as 'the right thing'. If not, competing obligations or attractions prevent us from doing so. On the whole, norms are stable and inflexible. But this means that there are often legitimate reasons to escape from them or to find easy ways out. Besides, norms usually have more in common with general guidelines than prescriptions for specific behaviours (Finch 1989, Finch and Mason 1990). People may agree with prevailing norms, but *disagree* about how they should be enacted. It is important to know about how norms operate because they represent a push in a certain direction. If people identify with a norm, they will usually try to respect it or suffer a bad conscience if they do not. If outside pressure is strong, they may even adopt extrinsic norms. Therefore norms about filial obligation need not necessarily make

people actually provide help. But it is assumed that such norms are motivating factors towards an *intention* to act, providing that needs exist and that competing obligations or attractions are not stronger than the motivating factors. The '*right thing to do*' is therefore a matter for negotiation. For some, the acceptance of norms may be the driving force behind actual care provision, while others may carry out their obligations via care management (for example by helping older people to link with professional services). The latter course of action seems to be expanding in modern, urban settings, particularly when men are involved and in communities where services are an established alternative to family care (Daatland 1983).

Norms are, however, not the whole story. Family care may, of course, also be motivated by emotional attachment and identification. One may feel close to parents (in some cases perhaps *too* close if original attachments have not fully matured into autonomy). For this reason, the love of one's parents can also be a factor in providing support. Most people probably have mixed motives for providing care. For example, they combine reciprocal obligations (the repayment for earlier services) with emotional attachments.

Personal preferences, as for example types of care and accommodation following the loss of independence, may be seen as a compromise between normative considerations and personal desires. The same is true for *opinions about social policy* and *attitudes to the family/welfare-state balance*. Both preferences and attitudes are pragmatic conclusions arising from mixed motivations and opportunities. Therefore they can be seen as future indicators of behaviour, both in the public sphere through policy orientations, and in the personal domain through preferences for social care and housing. When we are interested in how people *would* act more than in the combination of motivations behind their intentions, then a standardised questionnaire like the one employed here may be an appropriate research strategy. This approach 'hems in' the respondent, requiring any mixed motives and opportunities to be placed in a *single* response - what one would probably do. Underlying motives are also of interest, but the data contain only partial information on them. These motives can be normative ('what *ought* to be done') or attitudinal ('what one would *like* to be done'). The former motive is indicated by the filial obligation scores. There are no independent indicators of what people would 'really want' other than those that can be inferred from the qualitative interviews.

The four focus domains may therefore be seen as influencing the chain of events that lead to the final response of adult children to the care needs of their older parents. Other factors will also influence this flow of events, such as the personal resources of adult children, whether or not they have competing obligations, and the extent to which there are alternative sources of help. These factors are known as 'the opportunity structure' and they are included among the independent

variables in the analysis which closely follows Ajzen's models of '*planned behaviour'* (Ajzen 1988). This model assumes that 'personal attitudes', 'subjective norms' and 'perceived personal control' (perceived opportunity) have an impact on 'behavioral intentions', but not the other way around. Filial obligations, which may be seen as subjective norms within the Ajzen model, will therefore be included among the factors to explain attitudes to the welfare state and personal preferences for care and housing following the loss of independence. All of these attitudes are taken as behavioural intentions in the Ajzen sense of the term.

Equally important as the factors motivating adult children to provide (or not provide) help are those motivating their older parents to *accept* (or not accept) such help. It tends to be forgotten that there are two active parties in a helping relationship - the giver *and* the receiver. How people state their preferences for care gives some indication about the parent's role in the relationship. It should not be assumed that parents will automatically choose the solution of the family, as the 'hierarchical compensatory' model indicates (Cantor and Little 1985). Both autonomy norms and norms of parental concern may prevent parents from turning to their children if they have other options. In fact, studies from countries with comparably generous service levels such as those in Scandinavia (Daatland 1990) and the Netherlands (Wielink et al. 1997) indicate that when older people have a choice they increasingly prefer services over family care.

The analysis begins by showing descriptive and comparative patterns for each of the four focus domains: Does the urban population in each of the five study countries support filial norms? What do people see as the proper role of the welfare state? From whom would they prefer to receive help if they should come to need it? Following these descriptive results is a section on multivariate analyses of within-country variation and between-country differences in norms and opinions. This analysis is based on the issues outlined above. Are there parallel patterns in the five study countries as the structuralists would assume, or do the norms and orientations primarily respond to country-specific factors, as expected from a culturalist position? And finally, what is the greater story behind the observed patterns? Is indeed the normative basis for family solidarity much stronger in some countries than in others? Or, as suggested by Finch and Mason (1990, 1993), are these ties a common heritage which seeks different forms of expression when circumstances change?

Filial obligation norms

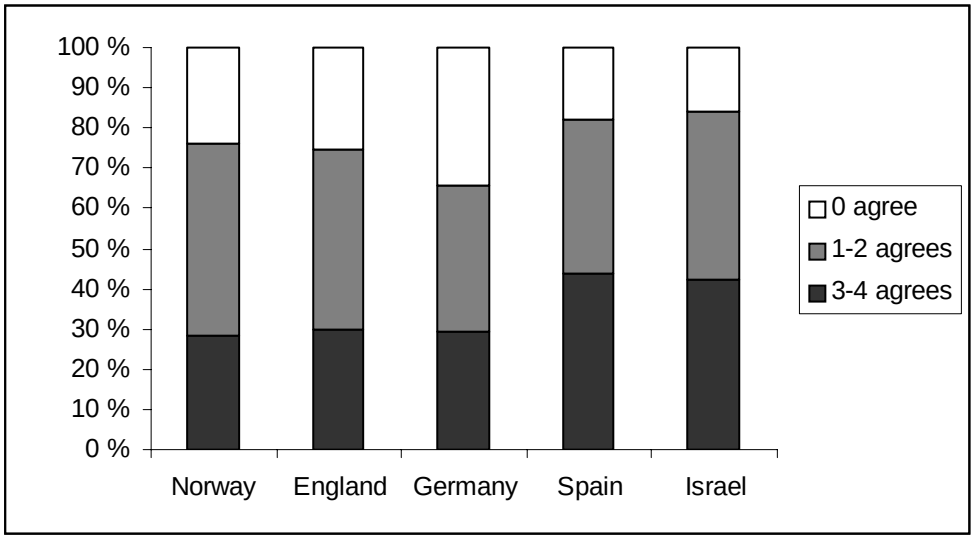
North American studies have generally found strong support for the presence of filial responsibility norms. But the influence of gender, class, and ethnicity on these norms is less clear (Finley et al. 1988, Hamon and Blieszner 1990, Rossi and Rossi 1990, Burr and Mutchler 1999). There is seemingly no systematic variation based

on gender. Younger people, in most (but not in all) cases, have been found to be more in agreement with filial norms than older people (Cicirelli 1981, Hanson et al. 1983, Blieszner and Hamon 1992, Logan and Spitze 1995). Adult children and grandchildren therefore tend to express a greater degree of filial responsibility than their older parents or grandparents expect of them.

Comparisons between studies are difficult, as they often use different instruments to assess filial responsibility. But in a study based on the same scale as that used in the OASIS analysis, Lee, Peek and Coward (1998) found African-americans more supportive of filial norms than whites. The authors attributed this finding to a more collectivistic, or familistic culture among blacks due to a long history of discrimination. They also found a more collectivistic attitude in rural compared to urban areas. The latter finding is relevant for this analysis, as the OASIS data are drawn from urban populations only. They are therefore probably biased towards the *less* familistic attitudes.

The results shown in Figure 1 indicate that in all five countries the majority acknowledges at least some degree of filial obligations, in the sense that they accept at least one of the items of the scale. Agreement with one or two statements is the modal response in Norway, England, and Germany, while three or four (all) agreements are the most common responses in Spain and Israel. Hence Spanish and Israeli people seem more family-oriented than Norwegians, English and Germans. The observed pattern is more or less congruent with the north-south division of family types suggested by Reher (1998), with the possible exception of the unexpectedly low filial obligation scores found in Germany.

Figure 1. Filial obligation index[a] by country.[b]



a) The index counts the number of agreements to the following four statements: (1) Adult children should live close to their older parents so that they can help them if needed, (2) Adult children should be willing to sacrifice some of the things they want for their own children in order to support their ageing parents, (3) Older people should be able to depend on their adult children to help them do the things they need to do, and finally (4) Parents are entitled to some return for the sacrifices they have made for their own children.
b) Weighted sample.
Source: OASIS 2000, N=5713

The variation between the countries is, however, not very large. The similarities seem equally striking as the differences. All five countries, for example, have a substantial minority who do *not* accept filial obligations. This is the case for 24 to 25 per cent of the population in the two northern countries (Norway, England), and 16-18 per cent in the two southern (Spain, Israel). Germany is the deviating case, with more than one-third (34 per cent) that do not accept filial responsibilities. But even Spain and Israel have no national consensus on filial norms.

There is no standard to assess the level or strength of filial obligations. As previously noted, the scale is biased towards supportive responses because all four items are phrased in support of the norm. Additionally, if familistic Spain is assumed to represent the benchmark, the results indicate that filial obligation norms are also rather strong in northern European countries, and even in a universalistic welfare state like Norway. Welfare state expansion does not seem to have eroded filial obligations as suggested by the moral risk hypothesis of Wolfe (1989).

Gender and age differences (see Appendix 3 Table 5A) are modest or inconsistent. Only England and Israel follow the earlier reported pattern of stronger filial norms among younger people (aged 25-49) than among older people (aged 75+). No age differences are observed in Norway, while *the eldest* seem more inclined to support filial obligations in Germany and in Spain. As for gender differences, there is no indication that women hold more familistic norms than men. In fact, the contrary is found in Norway and England, while there is no gender differences in support for filial norms in Germany, Spain, and Israel. The possible impact of gender and age will be explored further in the multivariate analysis below.

Are there national profiles in the *substance* of filial norms? This can be examined via a comparison of responses to each of the items of the scale (Table 1). Item 1 (adult children should live close to their old parents) follows the north–south division, meaning that support for this norm is the highest in Spain and Israel and the lowest in Norway. Whereas the majority of people in Spain and Israel agree that adult children ought to live close to older parents, English and Norwegians seem to subscribe to a norm of independence. Only a minority in these two countries support the idea that adult children and older parents should live close-by.

Table 1. Per cent in agreement (agree or strongly agree) to filial obligations by item and country (n). [a]

	Norway	**England**	**Germany**	**Spain**	**Israel**
Item 1 (should live close)	28.5	30.7	40.2	57.1	55.4
Item 2 (should sacrifice)	41.0	46.6	35.5	43.6	37.0
Item 3 (able to depend on)	58.3	41.0	55.2	59.8	51.1
Item 4 (entitled to returns)	37.9	47.9	26.1	55.4	63.8
(n)	*(1179-1193)*	*(1153-1170)*	*(1193-1222)*	*(1152-1169)*	*(1183-1196)*

[a]Weighted samples, age 25+. Items: (1) Adult children should live close to their older parents so that they can help them if needed, (2) Adult children should be willing to sacrifice some of the things they want for their own children in order to support their ageing parents, (3) Older people should be able to depend on their adult children to help them do the things they need to do, and finally (4) Parents are entitled to some return for the sacrifices they have made for their own children.

The contrast between Norway and Spain can be illustrated with excerpts from the qualitative interviews. A Norwegian older mother says '*you shouldn't interfere in adult's lives, even if they are your own children*'. And similarly, from another Norwegian parent: '*Everyone should manage for themselves and not be a burden to others*.' In contrast, a Spanish daughter concludes that '*… it's a normal thing that children take care of their parents. What else are they going to do? Put them*

in a home? No, I'm not for that!' A Spanish son agrees, but has less faith in the family: '*They* (children) *have the obligation to care for them* (parents), *but many throw them in a nursing home. They don't care… '*

Countries also differ in the degree of support given for *reciprocity* as a guide for parent-child relationships (Table 1, item 4). Again Spain and Israel have a majority in favour, while Norwegians and Germans in particular give little support to the reciprocity norm. '*It's natural for me to take care of my parents, because as they looked after us when we were children, we have the same obligation towards them when they are old… '* says a Spanish daughter. A Norwegian mother does not agree: '*One should be happy to have children, but you shouldn't demand anything from them*'. Another Norwegian joins in: '*Children should help their old parents, but not out of duty or obligation. They should do so voluntarily, because they want to.'* Indeed several of the Norwegian respondents downplayed any normative obligations between generations. They were, so to speak, hiding the ugly face of duty behind a more gentle mask of love*: 'I think it's a pleasure. I like to help her. The fact that she* (the mother) *is not expecting help makes it nice to help her. If she had been demanding, then I doubt she would have seen me for some time'* (Norwegian son). Some people also added a quality argument for this attitude: '*Caring should be voluntary, otherwise it's no good for any of the parties*' (Norwegian daughter).

The variation between the countries is less for items two and three. Norwegians, for example, are equally supportive as the Spanish to the idea that older people should be able to depend upon their children for help (item 3). Variations are also small for perhaps the strongest commitment to filial obligations, namely supporting ageing parents to the extent that one may have to sacrifice benefits for their own children (item 2). Between 36 and 47 per cent agree with this statement in the five countries. The top of the range is represented by England and the bottom by Israel. But variations between countries are moderate.

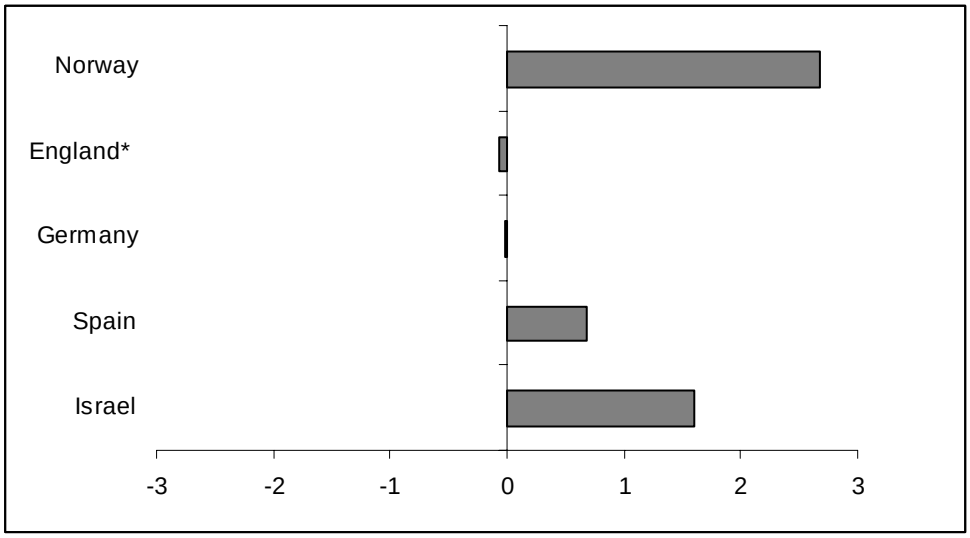
In summary, filial norms are supported by the majority of the urban population in all five countries, but by a larger majority in the south (Spain, Israel) than in the north (England, Norway) of Europe. Germany deviates slightly from the north-south trend, having the least support for such obligations. Deviations from the general pattern are also found for individual items of the scale, indicating that differences between countries may be larger in norm *profiles* than in norm *levels.* This could be an indication that basic normative obligations are rather similar but take on different expressions.

The family/welfare state balance

Public opinion about how responsibilities should be divided between the welfare state and the family vary considerably between the countries. At a first glance, this variation seems much larger than for the filial obligation scores. This difference is to be expected on theoretical grounds, because general values, such as filial obligations, should be more stable than opinions which are concrete and factual.

Generally, public opinion tends to favour welfare state responsibility in all countries except Germany, with Norway as the extreme case (86 per cent in favour of the welfare state) followed by Israel (Figure 2 and appendix 3, Table 5B). Even in Spain, where the provision of care is mostly a family affair, more people see the welfare state as the main responsible agent than those favouring a family responsibility.

Figure 2. Family-welfare state balance index [a] by country. Mean scores by country[b].



[a] Mean scores of an additive scale from –6 to 6, adding up responses («totally welfare state» (=2), «mainly welfare state» (=1), «both equally» (=0), «mainly family» (-1) and «totally family responsibility» (=-2)) in the three domains – financial support, help with household chores and personal care.

[b] Weighted samples

*The data from England are biased (towards the family), because the response scale by mistake had only one option for the welfare state side (mainly), not two (mainly and totally).

Source: OASIS 2000, N=5875

Older people seem *more* oriented towards the welfare state than younger people in all countries except Spain. (Gender differences are small and inconsistent. Women seem *more* welfare state oriented than men in Norway, and *less* welfare state oriented than men in Spain. No gender differences are found in the other three countries.

Only a few cases are close to the extremes of the scale, where -6 is maximum family orientation and +6 is maximum welfare state orientation. Most people favour some mix of responsibilities - some partnership and some complementarity - between the welfare state and the family. Complementarity does, however, take different forms. Germany and England have mean scores around zero, indicating an equal division between the two. This could also mean that the family, supported by the welfare state, should be primarily responsible.[3]

Norwegians and Israelis tend to see the welfare state as the main responsible provider, with the family in a supportive role. As a Norwegian daughter puts it in the qualitative interview: '*The society has the larger duty, but the family can add up with other things (types of help). Old people have contributed their share to society, and have the right to get something back.'* Spaniards tend to favour family help, sometimes because they see this as the normal thing, or because they lack alternatives: '*Going to a nursing home could be a good thing, but I don't have the means for it. The government… the state… they are not going to do anything. Old people are nothing more than a drag.'* (Spanish father).

Looking at the *substance* of these attitudes in more detail, it can be seen that that the great majority of Norwegians favour a welfare state responsibility in all three domains, but slightly more so for financial support and personal care than for instrumental help (Table 2). Israel has more moderate majorities in the same direction, while the welfare state is expected to assume a more modest role in the other three countries. The strong welfare state position in Norway is more or less as expected. More surprising is the stronger inclination towards the welfare state in Spain relative to Germany.

[3] English data are, however, biased towards the family option in this particular measurement, because the response scale had by mistake only one option (=mainly) for the welfare state side, not two (=mainly and totally) as in the other four countries.

Table 2. Per cent in favour of total or mainly welfare state responsibility by help domain and country (n). [a]

	Norway	**England**	**Germany**	**Spain**	**Israel**
Financial support	79.0	35.0	33.9	40.1	50.1
Instrumental help	66.9	35.7	22.8	36.3	49.3
Personal care	77.0	40.0	23.8	31.4	56.8
(n)	*(1185-91)*	*(1167-86)*	*(1246-62)*	*(1170-72)*	*(1178-87)*

Note. [a] weighted samples

The other side of the coin is the responsibility ascribed to the *family* (not shown here). Only a few Norwegians and Israelis place the main responsibility on the family (around 10%). Germans and Spaniards are much more likely to choose family responsibility. Differences between countries are considerable. Norwegians are about ten times more likely to place the main responsibility on the welfare state rather than the family. In Germany responsibility is evenly divided, and in Spain there is a slight balance towards the welfare state.

It should be stressed that very few people see the family as *totally* responsible for the care of older people - only around 1% in Norway and Israel, and less than 10% in Germany and Spain. Total welfare state responsibility is, however, a more common response, particularly in Norway and Israel (around 25-30%). Also Germans and Spaniards are more inclined to favour total welfare state responsibility rather than total family responsibility.

It is interesting to note that support for filial responsibility norms need *not* imply that the family is seen as the natural care provider. For example, nearly half (48%) of Norwegian respondents with *top* scores on filial responsibility still choose the welfare state as having the main responsibility in *all three* domains. The correlation coefficients for filial obligation scores and the family/welfare state responsibility index range between -0.24 and -0.26 in Germany, Spain, and Norway (somewhat lower in Israel). As expected, high scores on filial expectations are related to low scores on the family/welfare state index. But the coefficients are moderate, and filial obligations explain only a small part (less than 10%) of the variation in opinions about how responsibilities should be divided between the family and the welfare state.

Public opinion on elder policy

Public opinion about how the needs and costs for elder care should be distributed is more or less in line with attitudes to the family/welfare state balance of responsibilities. If anything, there is a perhaps an even greater inclination towards the welfare state. In all five countries, the urban population (with a possible exception of England) points to the welfare state as the main responsible provider for meeting increased needs associated with an ageing population. This is particularly the case for Norway. But it is also true for countries like Germany and Spain, which today have family dominated systems of care provision (Table 3). Quite a few people are willing to pay additional taxes if these taxes are targeted at providing care. The favourite option for financing future care, through public redistribution *without* a tax raise, comes as no surprise.

Table 3. Policy opinions regarding the coverage of the increased needs and costs of elder care in the future by countrya.

	Norway	England	Germany	Spain	Israel
Who's responsibility for *the increased needs*[b]					
The family	7	9	34	35	26
The public services	89	40	58	61	70
Voluntary organisations	4	21	4	1	2
The private sector	1	18	3	2	2
Others	---	13	1	---	---
Increased costs should be covered by[c]					
(1)... the private sector	16	15	29	19	16
(2)... user pay by elders	17	16	21	7	8
(3)... adult children	9	43	16	14	13
(4)... higher taxes	29	75	15	20	22
(5)... public redistribution without a tax raise	77	84	75	85	88
(n)	*(1179-1195)*	*(1146-1183)*	*(1215-1263)*	*(1078-1157)*	*(1170-1182)*

[a] *Totals are weighted.*

[b] «In the years to come there will be more old persons in need of care, help and nursing. In your opinion – who should take the primary responsibility for meeting these increased needs. Should it be the family, public services, voluntary organisations, the private sector, or others – like friends or neighbours?»

[c]«In your opinion – how should we cover the increased costs for the care of the aged in the years ahead?». Per cent in agreement with the following statements: (1) Care for older people should increasingly be financed through the private sector, (2) Elderly people ought to pay somewhat more for the help and services they receive, (3) Adult children should pay more for help and services to older parents, (4) Taxes should be increased somewhat and be used for the care of elderly people, and (5) A larger proportion of the public resources should be used for the care of elderly people, but without raising taxes.

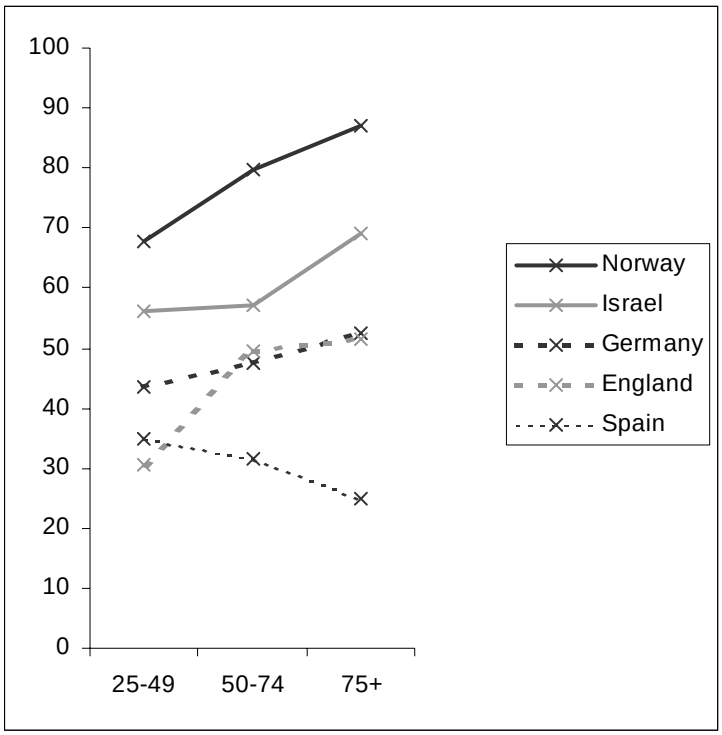
Although the welfare state is seen as the primary responsible provider for the future increase in costs and caring, this view appears to be held in a form congruent with already established country patterns. The English, Germans and Spaniards still place more responsibility on the family and private sectors than the Norwegians and Israelis. The majority of the population in all countries are, however, reluctant

to push responsibilities on to adult children (with the possible exception of England) or on to older people themselves.

Personal preferences

Personal preferences for care vary considerably between the countries and in a direction more or less the same as views on family traditions and welfare state regimes (Figure 3). These preferences are not necessarily what the respondents would 'really want', but some compromise between personal wishes, cultural norms and perceived opportunities. Notwithstanding this difficulty of measuring 'true' preferences, the majority of Norwegians and Israelis prefer help from services, while the Spanish tend to prefer family care. Germans and English are in intermediate positions.

Figure 3. Preference for services by age and country (%).[a]



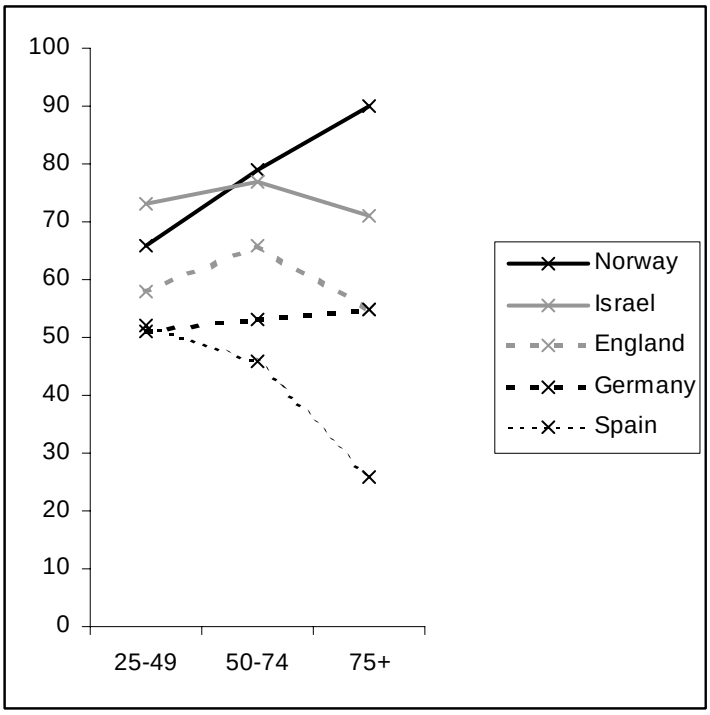
a) Per cent with preference for «organised services» in response to the following question: «Turning now to your own personal preferences – supposing you should come to need long-term help on a regular basis with household chores like cleaning, washing clothes etc? From whom would you prefer such help? From family, from organised services, or from others?»
Source: OASIS 2000, N=5568

These preferences are probably adapted to the opportunity structure of each country. Countries with high levels of service provision also rate high in preferences for the services option. In the OASIS data, variation in service levels (opportunity) between countries differed substantially. Nearly one third of the 75+ age group in Norway and Israel received home care assistance (instrumental help) during the past 12 months. The corresponding rate for England was 15%, and for Germany and Spain not more than 8 per cent (Daatland and Herlofson 2001). In fact the balance of preferences (between services and families) in Norway and Israel seems to correspond more or less with the actual balance in care provision. England, Germany, and Spain - all with lower service levels - have lower rates of preferences for services, but higher rates than the actual provision of services in these countries. There are clearly unmet wishes for services in these countries, at least in the urban population. This push towards services as being the main providers of care is confirmed by attitudes to the future balance of responsibility between families and the welfare state. As already mentioned, the majority of the population in all five countries place the primary responsibility for future growth in provision on the welfare state (Table 3).

The need for more services can also be illustrated using the qualitative interviews. A Spanish daughter states that '*I wish they (the services) could help more old people to remain at home. A person coming to the house would be an ideal thing; it would be marvellous!*' Most Spanish informants tended, however, to agree with a son stating that '*No, no, no – the state is not helping old people enough*'. Quite a few Spanish elders indicated that they rely on the family because there is no alternative: '*Of course it's an obligation (to take care of old parents), because otherwise, what was I going to eat, where was I going to be?*' (Spanish mother).

Preferences for housing if at risk of dependency show a similar pattern. A majority of older Norwegian gave a preference for residential (institutional) care over living with a child, particularly the eldest respondents. Nine out of ten older Norwegian parents prefer a residential setting if they can no longer live by themselves (figure 4). This reluctance towards living with children is also present in Israel, England, and Germany - and among younger people in Spain. Only among older Spaniards is there a majority who would prefer living with a child.

Figure 4. Preference for *residential care* by age and country (among persons with children) (%)a



a) Per cent with preference for «residential care» in response to the following question: «If you could no longer live by yourself in older years, and had to choose between living with a child or in residential or institutional care, what would you prefer?» («Don't know/It depends» responses are left out).
Source: OASIS 2000, N=3680

Country differences in preferences for both care provision (Figure 3) and housing if at risk of dependency (Figure 4) are more pronounced among older cohorts. This could mean that values, or opportunities, are converging and that they will result in more similar patterns in the future. From the available data, it is difficult to explain the reasons behind these patterns. On the one hand they could be the consequence of increasing opportunities for adult generations to put into practice basic values of independence. On the other hand, they could be a product of more recent changes in values towards greater individualism.

Preliminary conclusion

The descriptive results discussed so far lead to a preliminary conclusion. Filial obligation norms are prevalent in contemporary urban Europe, but a substantial minority do *not* subscribe to such norms. In general, support for filial norms is higher in southern countries (Spain, Israel) compared to northern European countries (England, Norway). Germany however, deviates from this pattern having the lowest support for filial norms. But country differences are moderate and seem far less than differences in public opinion about the respective roles of families and the welfare state. Filial norms could be a source of common ground for all these countries. If so, they seem to take form according to local and situational circumstances. Spain and Norway contrast strongly. The former displays familistic characteristics, the latter more individualistic, with the welfare state as the preferred provider. This Norwegian preference reflects current policies. There is, however, not a perfect match between policy and opinion. Public opinion and personal preferences seem to be push factors for *more* services and welfare state initiatives than are presently in place in all five countries. This is particularly the case in countries having low service levels and dominated by family care. Older people themselves may be among the most active in pushing this trend forward, as in most of the five countries they seem more inclined than younger people towards services provided by the welfare state. Family care may be influenced as much by what older parents prefer and find reasonable to accept, as by what their adult children are willing to offer.

MULTIVARIATE ANALYSIS

Previous research has collected a substantial amount of data on filial responsibility and intergenerational relations. Findings are however mixed, and there is little consensus on how patterns and variations can be explained. The theory of 'planned behaviour' (Ajzen 1988) is chosen here as an analytical framework to study norms and ideals of intergenerational relationships.

How can the observed variations in norms and ideals, opinions and preferences be explained? Do they follow the same logic in all countries, thereby indicating some general mechanisms? If so, what are these mechanisms? Or alternatively, are these variations country-specific? The latter finding would point in the direction of culturalist and idiosyncratic explanations.

To explore these questions, a series of multiple regression analyses were undertaken. Filial obligations are here taken to mean 'subjective norms'. In the Ajzen model of planned behaviour, 'personal attitudes' and 'perceived control' (opportunity) combine with subjective norms of filial obligation and lead to 'behavioural intentions'. If not distracted, they can eventually lead to 'behaviour'

itself. Personal preferences for care and housing, and opinions about the role of the welfare state, are taken here as 'behavioural intentions'. Personal preferences are located in the personal domain, while public opinions about the role of the welfare state are located in the public sphere. Filial obligation norms are seen as more general normative orientations. They can then be included among the explanatory factors for preferences and welfare state orientations, but not the other way around.

The other independent variables included in the multiple regression analyses are demographic factors (such as gender and age) and indicators of opportunity (such as functional ability, family resources, access to formal services, and financial resources). Opportunity structure should have an impact on the more concrete intentions (preferences and welfare state orientations), but not (or less so) on more general filial norms. For example, shared households and parenthood should lead to a stronger *family* orientation in policy opinions and preferences. Generous access to *services* should have an impact in the other direction. Financial resources may work in both directions. Affluence may represent independence from the family or an opportunity for family exchanges. Levels of education and religiosity are included in the analyses as indicators of traditional (familistic) value orientations. Religious people and less educated people are assumed to be more traditional.

Some of the variation in norms and attitudes by age and gender have already been shown in the descriptive section. The true effect of age and gender when other variables are controlled is, however, not obvious. On the one hand, given that filial obligation norms depend in part on socialisation and that such normative expectations are stronger for daughters than sons, it is expected that women are more family oriented than men. It could also be argued that older cohorts are more traditional (familistic) than younger ones, because older people have been socialised into more traditional values and norms than younger people. On the other hand, wanting to be independent, having parental worries about the children, or a fear of being a burden to the family, may all prevent older people leaning on the family. If so, then older people should be *less* family oriented than younger people.

Without access to longitudinal data, norms and ideals can only be studied under present circumstances. It is not possible to know if they are more deeply rooted in personal experiences and cultural trends. The impact of such deeper structures and longer time-scales is included within the unexplained variance of the multivariate analyses. As such, the long-term evolution of norms and ideals is necessarily a subject for speculation.

Within-country differences

The multivariate analyses are restricted to three of the focus domains - support for filial norms, public opinion about the family/welfare state balance, and personal preferences for care. First, the within-country variation is examined. This part of the analysis explores whether the variation is general or country-specific. The focus here is on the potential effect of gender and the opportunity structure on the three domains. Opportunity structure is indicated by several factors - the functional ability of the respondent's family and financial resources, and the availability of services. Functional ability (risk of dependency) is assessed via scores on an ADL-scale. Family resources are measured by comparing shared with single households, being parents or not, and the receipt of help from family members during the past 12 months. Financial resources are measured subjectively by asking respondents whether or not they have a comfortable financial situation. The receipt of help from services indicates opportunity vis-à-vis the welfare state. Details about the indicators are given in the notes to Table 4.

This section of the analysis is restricted to respondents aged 75+, because most of the explanatory factors are relevant for older people only. Religious orientation and education level, as possible indicators of traditional value orientations, are also included in the regression analysis. The filial responsibility score is included in the regression of welfare state orientations (Table 5) and preferences for care (Table 6) as explained above.

Turning now to the results, and starting with gender differences, women are *not* found to be more supportive of filial obligations than men (Table 4). On the contrary, in Norway and England it is *men* who appear to be more supportive of filial obligations than women, while in the other three countries there are no significant gender differences in filial obligations. Gender has an impact on family/welfare state orientation only in Germany, with German women being more oriented towards the family than German men (Table 5). There is otherwise no indication that female dominance in *actual* care provision is a response to women's own norms and preferences.

Table 4. Regression of filial responsibility[a] for the 75+ by country (standardised coefficients)

	Norway	England	Germany	Spain	Israel
Gender (1=female)	-.176**	-.167**	.051	-.019	-.037
Risk of dependency (1=at risk)	-.066	-.034	.139**	-.035	-.077
Have children (1=yes)	-.181***	-.138*	.367***	.034	.062
Household (1=with others)	.066	-.024	-.034	.061	-.018
Help from family (1=yes)	.086	.085	.074	.236***	.206***
Help from services (1=yes)	.121	-.031	-.052	.066	-.077
Religious (1=yes)	.068	.055	.108*	.058	-.133*
Education (1=low)	.137*	-.022	-.044	.130*	.127*
Financial situation (1=comfortable)	-.062	-.094	.030	.063	.040
R^2	.089	.063	.194	.092	.094
(n)	(350)	(323)	(386)	(327)	(302)

*p<.05, **p<.01, ***p<.001.

[a]Ordinary least square regression; missing cases are left out. Filial responsibility scale ranging from 0 to 4 according to the number of agrees (or strongly agrees) to the four items in the scale. Explanatory variables are included as dummies. Children (1=yes) means at least one living child. Household separates those living singly from all others. Risk of dependency means the lower 6th percentile of an ADL scale included in SF36 (Short form 36 scale), varying from 41 per cent of the 75+ in Norway to 65 per cent in England. Help from services (and family) refer to help received to household chores, transports/shopping and/or personal care during the last 12 months. Help from services among the 75+ varies from 7 per cent of the 75+ in Spain to 41 per cent in Norway. Likewise for family help, which varies from 24 per cent in Israel to 40 per cent in England. Religiosity means considering oneself being from somewhat to very religious – varying from 56 per cent among the 75+ in Israel to 92 per cent in Spain. Low education means primary level of schooling (or less) – varying from 13 percent in Germany to 81 per cent in Spain (75+). A comfortable financial situation means considering own financial situation as very comfortable or comfortable and varies from 29 per cent of the 75+ in Spain to 67 per cent in Germany.

Table 5. Regression of family-welfare state balance[a] for the 75+ by country (standardised coefficients)

	Norway	England	Germany	Spain	Israel
Gender (1=female)	-.001	-.024	-.125*	.059	-.052
Risk of dependency (1=at risk)	.076	.028	.184***	-.001	.105
Have children (1=yes)	-.011	.013	-.148**	-.113*	-.056
Household (1=with others)	-.044	.000	-.043	-.016	-.114
Help from family (1=yes)	-.041	-.119*	-.173***	-.056	-.093
Help from services (1=yes)	-.013	.130*	.100*	.037	-.035
Religious (1=yes)	.023	-.018	.028	-.082	.017
Education (1=low)	.065	-.186***	-.097*	-.045	.049
Financial situation (1=comfortable)	-.128*	-.122*	-.019	-.135*	-.162**
Filial responsibility	-.218***	-.285***	-.236***	-.256***	-.141*
R^2	.078	.146	.228	.132	.095
(n)	(344)	(310)	(367)	(313)	(285)

*p<.05, **p<.01, ***p<.001.

[a] Ordinary least square regression; missing cases are left out. For remarks about the family-welfare state balance index, see figure 2. For other information about the analysis and variables, see footnote, table 4.

Table 6. Multiple regression of preferences for services[a] for the 75+ by country (standardised coefficients)

	Norway	England	Germany	Spain	Israel
Gender (1=female)	.036	-.076	-.076	-.060	.051
Risk of dependency (1=at risk)	.025	.059	.056	-.053	.043
Have children (1=yes)	-.058	-.192***	-.207***	-.073	-.042
Household (1=with others)	-.064	-.062	.049	.039	-.045
Help from family (1=yes)	.041	-.163**	-.233***	-.131*	-.132*
Help from services (1=yes)	-.003	.130*	.151**	-.025	.164**
Religious (1=yes)	-.060	.035	.133**	-.033	.003
Education (1=low)	-.024	.007	-.012	.123*	.128*
Financial situation (1=comfortable)	.024	-.004	.157**	-.036	-.125*
Filial responsibility	-.207***	-.111	-.024	-.279***	-.096
R^2	.062	.112	.192	.141	.117
(n)	(341)	(299)	(354)	(311)	(289)

**p<.05, **p<.01, ***p<.001.*

[a] *Ordinary least square regression; missing cases are left out. Preferences for services (versus family help or help from others). For other information about the analysis and variables, see footnote to table 4.*

Being a parent seems to increase filial expectations only in Germany (Table 4 and 6), and represents a tendency to be more family oriented in Spain (Table 5). This contrasts with Norway and England, where parenthood *reduces* filial expectations (Table 4). One reason for this difference could be concern for the welfare of children in countries with a strong emphasis on independence norms. The English do, however, join the Germans in a tendency to prefer family care when children are available (Table 6). Parenthood does not seem to affect preferences in the other three countries.

Other family resources (shared household, family help) have no consistent effects within each of the five countries, except that family help seems to be associated with high levels of filial responsibility in Spain and Israel (Table 4), and a less supportive attitude to the welfare state in Germany and England (Tables 5 and 6). Receiving help from services has a corresponding effect towards stronger welfare state orientation in Germany and England (Tables 5 and 6), and to some extent Israel (Table 6). Receipt of help (from family or services) has *no* effects on any of the focus variables in Norway.

A religious inclination does *not* seem to have any systematic effect on the three domains, while as expected, less educated older people seem to be more familistic in norms than the better educated in Norway, Spain, and Israel (table 4). This is, however, not the case in England and Germany. But low levels of education in these two countries is associated with a strong family orientation in welfare policies (table 5). There is therefore some evidence for the hypothesis that the better educated are less family orientated, although this evidence is not consistent.

The need for assistance (risk of dependency) does *not* seem to have any impact on the three domains, with the possible exception of Germany. Older Germans at risk of dependency are more inclined to support filial norms (Table 4) *and* to support welfare state responsibility (Table 5). Financial resources (a comfortable economic situation) seems to stimulate a family orientation in policy opinions (Table 5). Otherwise they do not seem to have any impact on support for filial norms (Table 4). Affluent Germans are inclined to prefer services, which may be a response to these services being available on the market. In contrast, affluent Israelis indicate a preference for family care (Table 6). In the other three countries, the level of financial resources has no effect on preferences. The stronger family orientation found among the better off may be part of a more general scepticism towards the welfare state among higher classes. Alternatively, it may simply be an indication that family exchanges are stimulated by the resources that promote them. In this sense, a generous welfare state has the effect of stimulating intergenerational solidarity, as suggested by the crowding-in hypothesis (Künemund and Rein 1999) rather than undermining it, as suggested by the moral risk hypothesis of Wolfe (1989).

Finally, and almost consistent in all five countries, is the relationship between support for filial norms on the one side, and welfare state orientation (Table 5) and personal preferences (Table 6) on the other. As expected, the higher the support for filial norms, the more family oriented are policy opinions. Filial norms are also positively related to personal preferences for care, but only in Norway and Spain. The correlation coefficients between filial norms and policy opinions, and filial norms and personal preferences are modest. Less than 7% of the variation in preferences and welfare state orientations is related to filial norms.

Looking across all three Tables (4, 5 and 6), the model seems to have a low explanatory power in four of the countries ($R^2<0.15$), somewhat higher in Germany ($R^2\approx0.20$). There is occasional, but not consistent, support for the expected impact of the opportunity structure. The idea that women should be more familistic than men is clearly *not* supported by the data in any of the countries, while there is an almost consistent (but moderate) relationship between support for familistic norms and an inclination towards actual family involvement.

It is hard to find parallel patterns across *all* five countries. The only consistent finding beyond the correlation between norms and intentions is that household structure (single or shared) has *no* impact on any of the dependent variables among the 75+ age group. The variation in filial norms, welfare state orientations, and preferences for help may follow a somewhat different logic in the five countries. If so, this points in the direction of culturalist explanations. This is to say these orientations must be understood within the specific context of each country.

Between-country differences

It has already been noted that the *between* countries differences may be more prominent than the *within* country differences according to gender, opportunity and personal resources. Table 7 addresses this issue more directly for the total sample (all age groups), with country and age included as explanatory variables. Factors specific to the older population, like risk of dependency and access to help, are excluded in the model. But whether or not the respondent has living parents (a variable relevant to younger people) is added. This procedure is similar to the inclusion of being a parent for older respondents. Age and country are included as dummy variables, with younger respondents (age 25-49) and Norway as reference groups.

As the samples in all five countries are now pooled, any direct effect of a particular factor in one country may be outweighed by an opposite effect in another. The discussion that follows therefore focuses on the effect of *between*-country differences relative to the *within*-country variation. Some comments about the effect of other factors are mentioned, particularly the two new variables that are included - age and having living parents. The specific impact of the remaining factors is better explored in the separate analysis for each country, as has been done above.

Table 7. Multiple regression of filial responsibility, family-welfare state balance, and preferences for care[a] (standardised coefficients)

	Filial responsibility	Family-welfare state balance	Preferences for services
Gender (1=female)	-.047***	-.023	.001
Have children (1=yes)	-.029*	-.034*	-.030*
Have parents (1=yes)	.095***	-.003	.016
Household (1=with others)	.022	-.034*	-.033*
Religious (1=yes)	.041**	-.022	-.001
Education (1=low)	.099***	.005	-.015
Financial situation (1=comfortable)	-.011	-.047***	.010
Filial responsibility		-.232***	-.162***
50-74	-.018	.028	.064***
75+	.027	.051**	.068***
England	.024	-.411***	-.257***
Germany	-.008	-.436***	-.245***
Spain	.115***	-.278***	-.293***
Israel	.124***	-.130***	-.108***
R^2	.049	.229	.120
(n)	(5390)	(5259)	(4954)

**p<.05, **p<.01, ***p<.001.*

[a] *Ordinary least square regression; missing cases are left out. Reference category for age are those aged 25-49. Reference category for country is Norway.*

Having parents still alive seems to make filial obligations more salient, but has no effect on family/welfare state orientations and personal preferences for care. Age (or cohort) does not affect the support for filial norms, indicating that such norms may be rather stable over cohorts and time. Age does, however, seem to have an impact on the more concrete personal preferences and policy opinions on the role of families and the welfare state. The relationship is not very strong, but older people are *more* inclined to favour services over family care than younger people. This appears to be true both in a political and a personal capacity.

Women seem to be *less* supportive to filial obligations than men. But as far as older people are concerned, this is the case only in Norway and England (Table 4). There are otherwise no gender differences in attitudes to the welfare state and in personal preferences for care. The hypothesis that filial obligation norms are stronger in

traditional orientated cultures is given some support by the findings, if religiosity and low education are taken as indicators of a less modern orientation. But this pattern is not consistent across countries (see tables 4-6), and such values have seemingly no impact on policy opinions and preferences. Household structure (living along or with others) has no impact on norms and ideals in the 75+ age group (tables 4-6), but when all age groups are included in the analysis shared households are associated with a slightly stronger family orientation in policies and preferences (table 7). The relationship between filial responsibility norms and the more concrete political and personal orientations towards care provision for older people is in the expected direction. But filial norms seem to have a modest explanatory power (3–6%) for the more practical orientations. Strong filial norms are not incompatible with a welfare state orientation in policy and practice.

Finally, Table 7 confirms that the between-country differences seem more salient than the within-country variation. Between-country differences are moderate in support for filial obligation norms, but are considerable for welfare state orientations and preferences for care. Norway, England and Germany seem to constitute a northern cluster in filial responsibility norms. For welfare state orientation, Israel and Norway stand out and cluster with a stronger orientation than Germany, Spain, and England. This finding is most likely a response to the differences in the availability of services. Norwegian and Israeli welfare states have more generous care services for older people than the other three countries.[4]

The finding of a lower between-country variation for filial obligations than for welfare state orientations and personal preferences is yet another indication that filial norms may have a rather robust and general character. In contrast, policy opinions and personal preferences tend to vary according to local circumstances.

Conclusions and recommendations

Filial obligation norms are still prevalent in the urban populations of Norway, England, Germany, Spain, and Israel. But supporting older parents is neither absolute nor unconditional. A substantial minority (between 16 and 34%) do *not* subscribe to such norms, and both the substance of the norm and the level of support vary from country to country. Support for filial norms follows the geographically north-south axis, and is generally highest in Spain and Israel, and lower in Norway, England and Germany.

Country differences are even more prominent in preferences and opinions about how filial norms should be acted out. Filial solidarity is not incompatible with

[4] These results and conclusions are similar when one of the other countries is chosen as the reference in the model.

generous welfare state arrangements, nor does holding strong views about filial obligations have to imply that the family is the natural care provider. The expansion of the welfare state has therefore not eroded filial obligations as has been suggested by the moral risk hypothesis (Wolfe 1989). In fact, many respondents with top scores on filial responsibility also believe the welfare state should have the main responsibility for care provision. Filial norms are, however, correlated to familism in preferences and policy opinions. But these associations are neither strong nor consistent, indicating that filial solidarity may be differently expressed under different circumstances (Finch and Mason 1990, 1993).

Personal preferences for care and living arrangements in old age vary considerably between the five countries. This variation is consistent with their respective family and social policy traditions. Norwegians are more inclined to favour welfare state arrangements than Spaniards. Tradition is, however, only part of the story. There is also a drive towards more welfare state responsibility in all countries. In Norway and Israel, the preferred balance between services and families generally corresponds to the actual balance in care provision. In the other three countries preferences for services are far higher than what is actually available, a finding implying an unmet need for services. The same pattern emerges in opinions about the balance of responsibility between the family and the welfare state. Norway and Israel again lean heavily towards the welfare state, the other three countries less so. But they too tend to favour the welfare state as the more responsible party. Otherwise, public opinion in all five countries is in favour of some form of partnership between the family and welfare state. The preferred mix takes different forms. Norwegians and Israelis (and to a lesser extent the Spanish) place the welfare state in the dominant role, supported by the family. The other two countries tend to favour an equal split or a family dominance supported by the welfare state.

The OASIS survey does not include time series data and so changes over time can only be the subject of speculation. Given that families were almost the unique provider of care to the elderly before the modern welfare state, it is reasonable to assume that access to services has been increasingly welcomed by both younger and the older generations. In fact, older generations seem more reluctant to receive help from the family when alternatives are available than adult children are to provide such help.

The OASIS survey does not reveal any consistent gender differences in norms and preferences. Thus the often reported dominance of women in providing care is something that is most likely imposed on them rather than a result of their own inclinations.

Young people are as supportive of filial obligations as older people. In fact, younger people seem *more* inclined towards family care provision than older people. But Spain is an exception, as the older generation still clings to traditional

(family) solutions, while young people tend to favour welfare state arrangements. Thus they become more similar in their orientations to the (older and younger) populations of the other four countries. This pattern indicates some convergence among the Spanish population towards the orientations of more developed welfare states. A converging trend between countries is also indicated by the fact that differences in preferences are stronger among older people than among younger.

Multivariate analyses of the variation in filial norms, welfare state orientations, and preferences for care indicate that these norms and attitudes follow a somewhat different logic in the five countries. As far as preferences for care and welfare state orientations are concerned, country differences are more distinct than within-country variation. Support for filial norms seems to be more generally rooted and distributed. The low explanatory power of the multivariate models indicates that deeper layers and longer lines of cultural and personal experiences must be included in future models to capture more of the variation in family orientations. This would accomplish more than the cross-sectional survey and standardised questionnaire of the OASIS study.

Theoretically, the findings can be interpreted as lending support to Finch and Mason's suggestion that family obligations are generally stable, but expressed differently according to circumstances. The familistic orientation grows stronger from the north to the south of Europe. But as Reher (1998) has suggested, this trend may be rooted in structures that long pre-date the modern welfare state. Besides, familism as a normative orientation is *not* incompatible with a welfare state orientation in policy and preferences.

Paradigmatic changes in the social fabric of families and networks are possible, for example from stronger to weaker intergenerational ties, or 'from family groups to personal communities' (Phillipson et al. 2001). The main story that emerges from the present study is, however, one of stability as far as normative solidarity is concerned. But are there changes in how these norms are translated into policy opinions and personal preferences - and eventually also into actual behaviour? This is another topic.

As far as policy recommendations are concerned, the results indicate strong support among the urban populations of all five countries for welfare state responsibility in care provision for the elderly. Where the family has the main role and women the main responsibility within families, these patterns are more likely created by lack of alternatives rather than driven from within. Older people are themselves among those that are most eagerly urging governments to take more responsibility in their welfare. They seem more reluctant to receive family care than their adult children are to provide it. The preferred model is, however, not a single case solution, but a mix of family and welfare state responsibility. This can be achieved with the

welfare state in a more central role than at present, but with moral and practical assistance from the family.

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6

Intergenerational Family Solidarity

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Introduction

The aim of this chapter is to explore similarities and differences in intergenerational family relations between the five participating countries of the OASIS study (Norway, England, Germany, Spain and Israel). The chapter begins with a presentation of the Intergenerational Solidarity framework and an outline of its six dimensions. Each of these dimensions are then described for the five countries. Next, an analysis of the relationship between the various dimensions of family solidarity and socio-demographic, health and familial variables is undertaken in a cross-national perspective. This analysis addresses one of the central objectives of the OASIS survey, which is to study variations in family norms and transfers. A central question is how do behavioural and normative patterns vary between countries and generations? To date, there have been few cross-national studies on this topic (Bengtson and Martin 2001; Hollinger and Haller 1990; Silverstein et al. 1998). In order to fill this gap, the OASIS survey compares countries with different (and similar) styles of family cultures, but at various stages of welfare development. The findings do not unconditionally confirm the validity of the family solidarity paradigm to explain the complexity of intergenerational family relations. Further studies are thus required, especially in a comparative perspective.

It has frequently been stated that intergenerational solidarity is an enduring characteristic of families (Brubaker 1990). Moreover, researchers have found that intergenerational bonds among adult family members may be even *more* important today than in earlier decades, because people today live longer and share more years and experience with other younger generations.

Intergenerational family solidarity

The conceptual framework of intergenerational solidarity represents one of several enduring attempts in family sociology to examine and develop a theory of family cohesion (Mancini and Blieszner, 1989). Intergenerational relationships are one of the most important elements influencing subjective well-being (Silverstein and Bengtson 1991). Attempts to understand parent-child relationships in later life are often based on the *Intergenerational Family Solidarity* model (McChesney and Bengtson 1988). This model has guided a large part of research on family

integration over the past thirty years. The approach perceives parent-child relationships as a primary source of mutual emotional and instrumental support.

The term 'solidarity' stems from various theoretical traditions. These include classical theories of social organization, the social psychology of group dynamics, and developmental perspectives in family theory (Bengtson and Roberts 1991; McChesney and Bengtson 1988).[1] 'Intergenerational relationships' can be seen as important components of family relations, particularly for older people and their ability to cope or remain socially integrated (McChesney and Bengtson 1988; Silverstein and Bengtson 1991). Previous research on intergenerational family relationships showed that reports of the demise of the extended family were premature (Silverstein and Bengtson 1998). This research also demonstrated that adult children were *not* isolated from their parents. Parents and adult-children helped one another regularly, even if they were separated by large distances (Lin and Rogerson 1995). Feelings of obligation and close emotional bonds between generations continued to be present despite different generations living far from each other.

Bengtson and Schrader (1982) defined intergenerational solidarity as a multi-dimensional structure with six dimensions - *associational*, *affectual*, *consensual*, *functional*, *normative*, and *intergenerational.* These six dimensions reflect the behavioural, affectual, cognitive and structural components of the wider family. They can be divided further into two general aspects of intergenerational solidarity. The first is '*structural-behavioural*', combining the associational, functional and intergenerational dimensions of solidarity. The second is '*cognitive-affective*' combining the affectual, consensual, and normative solidarity dimensions (Bengtson and Roberts 1991).

Since the early seventies, Bengtson and his colleagues have continued to develop and expand this model within the Longitudinal Study of Generations (LSOG) research programme[2]. Replication is an important indicator of the generalizability of findings. Patterns and consequences of intergenerational solidarity based on regional and national samples have been replicated in several US studies (Rossi and Rossi 1990; Bengtson and Haarootyan 1994; Umberson 1992) and in a rural Welsh sample (Silverstein et al., 1998). However, until now they have not been replicated in a comparative European context, and this is one of the innovations in the OASIS study. The solidarity model was selected for the OASIS study because it has two important advantages. First, measures based on the dimensions of solidarity provide a reliable and valid instrument to evaluate the strength of the

[1] For an extensive review of the theoretical background, which shaped the perspective of the intergeneration solidarity concept, see Lowenstein et al. (2001), as well as the relevant parts in Chapter 1 of this report.

[2] Intergenerational Family Solidarity and Conflict Measures for Survey Assessment (Bengtson and Schrader 1982; Bengtson and Harootyan 1994; Silverstein and Bengtson 1997).

relationships in the family (Bengtson and Roberts 1991). Second, the structure of intergenerational solidarity is wide enough to include latent forms of solidarity (Silverstein and Bengtson 1998).

Bengtson et al. (2002) have remarked that because the solidarity model is multi-dimensional, '*configurations of aspects of family relationships are virtually unlimited*'. In the OASIS study, it is expected that higher solidarity (on most dimensions) will be found in more 'familistic' countries 'familistic' like Spain, than in more 'individualistic' countries like Norway and England. Furthermore, it is expected that important sources of diversity have an impact on family solidarity. The focus for the analysis is on personal resources such as age and gender (Rossi 1993), familial variables such as marital status (Amato et al. 1995) and living arrangements (Lawton et al. 1994; Silverstein and Bengtson 1997) and health variables (Field et al. 1993). All of these factors have been found in previous research to be key factors influencing family relations.

Methods

The OASIS project is a cross-sectional study that includes both quantitative (cross-sectional) and qualitative methods of data collection. The quantitative data collection was based on face-to-face structured interviews with an urban representative sample of 1,200 respondents (800 aged 25-74 and 400 aged 75+) in each of the participating five countries, totalling 6,000 respondents. The qualitative data collection was based on in-depth interviews with 10 dyads (an older parent of 75+ and one of his/her adult children), in each country, totalling 50 dyads. The analysis in this chapter is based on the reports of the 75+ age group in the five countries who are not living in institutional settings. The analysis focuses on the six dimensions of solidarity.

Intergenerational Solidarity. The items for the solidarity dimensions in the OASIS project were selected by Bengtson and Silverstein from their LSOG. Some items were adapted to the goals and constraints of OASIS. Those that best explained variability were also included. The final OASIS instrument has 54 questions for respondents about relationships with their children, parents and other family members.[3] In the qualitative phase both parents and adult children were asked the same questions. Most of these questions were about changes in intergenerational relationships over time.

The six dimensions included:

(1) *Intergenerational Structure*. This dimension is the geographical distance between older parents and their children. Close proximity facilitates

[3] For a detailed review of the Oasis Research Instruments see Lowenstein et al. 2002.

intergenerational contact, whereas large distances inhibit interaction. Geographical proximity was measured by the travelling times between parents and children. A six point scale was used, ranging from living together to living 3 hours or more travelling distance.

(2) *Association*. Association was measured by the frequency of face-to-face contact and contact by phone/mail between older parents and their adult children. A seven point scale was used, ranging from once a day or more to less than several times a year. Correlation coefficients between face-to-face contact and other forms of contact were low in all countries (0 .44 for the five country sample). Therefore the two variables were used separately in the analyses.

(3) *Affection*. Affection is the emotional relationships between parents and children. It was measured by three questions on emotional closeness, getting along together and communication. A six point scale was used ranging from 1 = extremely close to 6 = not at all close.

(4) *Consensus*. Consensus was measured by the degree of similarity on opinions and values between older parents and their children. The scale ranged from extremely similar to not at all similar.

(5) *Normative*. This dimension concerns attitudes to filial responsibilities, measured by the following 4 statements:

- adult children should live close to their older parents so they can help them if needed.
- adult children should be willing to sacrifice some of the things they want for their own children in order to support their aging parents.
- older people should be able to depend on their adult children to help them do the things they need to do.
- parents are entitled to some return for the sacrifices they have made for their children.

Each item was coded on a 5 point scale ranging from strongly agree to strongly disagree. Correlation coefficients between the four items in all countries were low (ranging from 0.293 to 0.494). Therefore the four items were used separately in the analyses.

(6) *Function*. This dimension measures instrumental assistance *provided* by parents to at least one child, and *received* by parents from at least one child. Six items of instrumental support were measured:

- house repair and gardening

- shopping and transportation
- household chores
- personal care
- financial assistance
- emotional support

Correlation coefficients were low in all countries (ranging from 0.111 to 0.482). Therefore each item of the instrumental support domains was used separately in the analyses. Additionally, functional solidarity was computed, counting the help received in the different 6 domains coded as: 1 = help received in one domain to 6 = help received in all domains, 0 = not received any help.

Personal and familial resources include the following:

- gender (male/female).
- marital status of older parents (married/not married).
- number of living adult children (older than 21 years).
- education, measured by the highest level attained on a three point scale: primary level, secondary level and higher.
- self-assessed financial situation (comfortable/not comfortable).
- ADL functioning, measured by the shortened version of the SF-36 with 12 items (Ware and Sherbourne 1992). The cores of the scale range from 1 to 100, a higher score indicating better functioning.

All of these variables were selected because of their possible impact on an older person at risk of becoming dependent.

Data analysis

The analysis begins with a presentation of the descriptive data on the various solidarity dimensions and differences between the five countries. Then covariance analyses are undertaken to test the influence of the personal and family resource variables on the solidarity components.[4] The qualitative interviews were analysed by using an agreed coding frame, supported by CAQDAS (Computer Assisted Qualitative Data Analyses). Qualitative data from the five countries was compared and new configured coding frames and narratives were developed. The narrative from the interviews in the five countries were merged by the English co-ordinating team. Further analyses have been conducted by us on particular topics and concepts regarding intergenerational solidarity in the five countries.

[4] As the models of the covariance analyses include more than 1,500 observations, .01 levels of significance was used

Data in Tables 1-7 show the distribution of the six solidarity dimensions in each of the five countries.[5].

Table 1. Structural solidarity: distribution of geographic proximity between parents' and children's' place of residence, by country

	Norway	England	Germany	Spain	Israel
Live together	4.5	8.9	8.4	22.9	4.0
< 10 minutes	18.5	16.4	17.0	19.1	13.7
10 – 29 minutes	31.5	33.2	30.1	24.8	39.1
30 – 59 minutes	17.3	13.4	18.4	17.6	22.0
1 – 2.9 hours	10.9	17.5	12.3	9.1	11.8
≥ 3 hours	17.3	10.6	13.9	6.6	9.3
Base	*330*	*292*	*359*	*319*	*322*

f (df, 4) = 12.90***

*** p < .0001

Values in percent. Totals sum up to 100%

Structural Solidarity (Proximity) The country with by far the highest rate of cohabitation between parents and adult children is Spain (23%). In all the other countries rates are low (about 9% for England and Germany, 4% for Israel and Norway. About half of the parents in all countries live between 10 minutes and half an hour from their children. But in Norway and Germany, 17% and 14% respectively live 3 hours or more away from their parents, and these rates are noticeably higher than in the other three countries.

[5] Differences on all dimensions are indicated by F tests for one-way ANOVA that were significant at least at the .001 levels

Associational Solidarity (Face to face and phone/mail contact) –

Table 2. Associational solidarity: distribution of face to face and phone contact between parents and children, by country

	Norway		England		Germany		Spain		Israel	
	(1)	(2)	(1)	(2)	(1)	(2)	(1)	(2)	(1)	(2)
Once a day or more	9.5	21.7	9.7	18.9	10.3	7.6	21.4	25.6	7.3	3.9
Several times a week	17.8	30.7	23.5	41.9	19.4	34.8	32.7	40.2	28.4	45.3
Once a week	23.5	27.2	28.0	21.5	20.3	24.8	25.4	19.1	35.0	13.2
Once in two weeks	13.7	8.3	8.6	6.4	19.4	15.2	6.5	3.3	10.4	2.5
Once a month	11.4	6.1	7.1	4.2	8.2	5.8	2.8	2.0	6.6	2.2
Several times a year	16.8	1.9	14.2	3.4	18.8	6.1	6.9	2.8	5.0	.6
Less than that	7.3	4.2	9.0	3.8	3.6	5.8	4.4	6.9	7.3	1.3
Mean	3.8	2.7	3.6	2.6	3.7	3.2	2.8	2.5	3.2	2.0
SD	(1.79)	(1.50)	(1.84)	(1.47)	(1.72)	(1.58)	(1.62)	(1.64)	(1.59)	(1.09)
Base	*315*	*313*	*268*	*265*	*330*	*330*	*248*	*246*	*317*	*318*

(1) Face to face contact with study child; f (df,4) = 16.28***

(2) Phone contact with study child; f (df,4) = 27.44***

*** p < .0001

Values in percent. Totals sum up to 100%

Table 2 clearly shows the difference between face-to-face and phone/mail contact. In all countries there is less face-to-face than phone/mail contact. Spain again shows high rates of regular face-to-face contact (54% of parents seeing their study child at least weekly). In the other countries this rate is around a third. For contact by phone/mail, Spain and England have the highest rates, with about 60% of parents having this type of contact with their study child several times a week, followed by Norway (52%), Israel (about half) and the lowest in Germany (42%).[6]

[6] Phone and mail contact were asked as separate questions However, it is almost certain that rates apply mostly to phone contact.

Turning to *irregular* contact, in Germany 19% of parents see their study child only several times a year, followed by Norway (17%), and England (14%). In Spain and Israel these rates are much lower (7% and 5%) respectively.

The qualitative data clearly show that proximity has the largest effect on associational solidarity. Face-to-face contact is daily for some parent-child dyads. Tracy (daughter, England): '*I see her more or less every day because I pop over and says hello'.* This pattern of daily visits is very similar to Geula (daughter, Israel) who lives five minutes drive away from her parents: '*I see them every day, sometimes even twice a day if they need something'.* Collette from Germany sees her mother once a week but '*I call her every day*'. For other daughters intimacy is kept at a distance, using strategies such as phone calls and monthly visits. Kathryn (daughter, England) is an example: '*Oh we speak, well, we always speak twice a week…but it is always agreed, we always know when the next time we are going to speak will be…'* Helga (daughter, Germany) is another example: '*I call her daily. I ruled it this way because I can't travel to her every weekend as I have a full time job.*

Patterns of associational solidarity begin to change with the onset of old age. Widowhood and a decrease in functional capabilities have an impact on previously stable family relationships. Often the family keeps the close contact routine, but the stability and continuity represented by the parent's home is lost. Christine (German parent): '*when my husband was alive we celebrated Christmas Eve at home. Now we have dinner at my son's house…and once we celebrated at my daughter's house. That means our family sticks together'.*

Florence (English parent) mentions a change in the relationships with her children since she lost her husband: '*Both of them come together and sometimes I have a friend or a couple in and we all have dinner together. But that's only being going on since their father died'.* Gunhild, (parent, Norway) does not have as many family Sunday dinners as before: '*In the old days it happened often. Because I had them a lot. I had them for Sunday dinners and things like that. But that's many years ago.* When asked if she goes to her children's home for Sunday dinner, she replies, '*Oh yes, not very often'.*

Finally, celebrations, holidays and special events were described by all respondents as 'family gathering' occasions.

Affectual Solidarity (Emotional Relations)

Table 3. Affectual solidarity: distribution of emotional closeness between parents and children, by country

	Norway	England	Germany	Spain	Israel
Extremely high	20.7	29.7	11.8	12.2	47.5
Very high	50.8	46.6	35.2	55.0	39.2
High	21.9	14.1	42.0	27.5	9.8
Intermediate	4.2	5.6	8.8	5.0	2.4
Low	2.1	2.8	1.6	.3	.6
Very low	.3	1.3	.5	0	.6
Mean	2.18	2.06	2.53	2.24	1.72
SD	(.86)	(.98)	(.88)	(.70)	(.82)
Base	*333*	*320*	*364*	*320*	*337*

f (df, 4) = 41.89***

*** p < .0001

Values in percent, rounded. Totals do not sum up to 100%

Correlation coefficients between the three questions, as mentioned in the methods section earlier, were high in each country (ranging from O.633 to 0.745). A mean score of the three items was therefore used in the analyses. The data show that affectual solidarity was the highest in Israel (M = 1.72; SD = .82) followed by England (M = 2.06; SD = .98), Norway (M = 2.18; SD = .86), Spain (M = 2.24; SD = .70) and in Germany the lowest (M = 2.53; SD = .88). This is also revealed in the Table where about 87% in Israel felt extremely high to very high affection to the children whereas in Germany only 47% expressed these feelings.

The qualitative interviews show that there is high affectual solidarity in each country. They reveal different ways of expressing emotions (direct and indirect), different types of contact with close family (such as in-laws, grandchildren), and different perceptions of parent-child relationships ('friendly', 'generational gap', 'authoritative'). But in each case showed elements of affectional solidarity.

Emotions are not always expressed in direct words and some of the findings were drawn from general patterns of care and support. These patterns derive from the 'music' that accompanies conversations about mutual help. A good example can be found in Ray (son, England). Affection, respect and attention to his mother's needs can be heard in his account of how he gave her support at a particular moment in time:'…*she is a very strong person. A very warm person as well…she needed a lot*

*of support at that particular time (*emotional*) and I like to think that my younger brother and myself did provide her with…if there was anything similar I'm sure we do it again'.*

Lisa, an Israeli widow, gets a lot of self-confidence from the warm relationship with her only daughter's family. Warm feelings are expressed towards different people in her family. In the case of in-laws these feelings are heightened, indicating that affection to children is perceived as natural but affection to in-laws can be something really special: '*When I moved here, the neighbours were sure that he* (the son in law) *was my son…he is very dear to me, sometimes he understands me better than my daughter.* Similarly, Maisie (parent, England) talks about her daughter-in-law and the special place she has in her life, despite all her other family relationships being good:*…if I'm upset or anything like that, she's always been there or she'll deal with the person if they've upset me. Maureen's always done kind of things like that for me. We talk quite a lot as well.* Warm feelings are sometimes attached to special roles and life events that various members perform. Lili, the Israeli daughter of a holocaust survivor, describes her husband's relationship with her mother: *My husband sits for hours and listens to her stories about her lost family and the holocaust…I can't hear it anymore, but he is really interested and supportive.*

Grandparents showed a great deal of affection towards their grandchildren. This affection takes different shapes and forms, depending on characteristics such as proximity and the age of both the grandparents and their grandchildren. But whatever the form, it is interwoven in almost all the narratives of respondents from each country. For example, Sigrid (grandfather, Norway) has a close relationship with his grandson: '*He is 23 and if I call him about anything he comes. Like if I'm upset then I call him and ask if they want to come over for dinner…'.*

The interviews provide evidence of a generation gap. This is reflected in different lifestyles, perceptions and attitudes of the generations. But it does not prevent closeness. Molly (parent, England) describes typical conversations with her daughter: '*We talk about anything. Of course, I don't mean sex subjects because I'm a different generation. I don't come out with things that I presume younger mothers do nowadays. We can talk to one another.* Molly summarizes her warm feelings in the following way: '*Well, she'd always be there to listen to you.'*

Svein (son, Norway) shows a lot of interest in what his mother is doing as well as showing feelings of closeness, despite his perception of emotional reciprocity between parent and child *necessarily* entailing distance and separation because of a generation gap: '*It is not easy to go to a child and talk about emotional problems'.* But he understands and respects his mother's point of view: '*You are a parent for life and you are a child for life….if it gets too emotional she is not in anymore'.* These emotional characteristics do not prevent Svein and his mother having a

warm and close relationship: '*And then there is the thing with the telephone. I call her. She expects me to do so. It's like…it's like a lot more fun to call every day than just once in a while… because then you, in a way, then you can have conversations, it can be a regular conversation…as if you talk to your friend or something like that'.*

The Spanish interviews show that looking after elderly parents, even in a society with strong traditional values, is derived not only from feelings of filial obligation and social norms, but also from a deep sense of closeness and warm feelings within the family. In many cases, parents mentioned not only feelings of obligations shown by their children, but also a lot of love and care. Saturnina (parent, Spain): '*They love me very much…they call me in the morning. This one calls in the morning, in the evening, the other one calls me when she comes at night. Very good granddaughters, very good son-in-law, I'm very happy…the only thing they do to me is love me a lot'.* Anna, a Spanish daughter who looks after her mother on a full-time basis, says: '…*whatever I do, I do with pleasure for my mother…my family is my life'.*

Interestingly, Israeli parents and their adult children both reported that they did not perceive emotional support as being just another form support (compared with functional support for example). Instead, they saw emotional support as a natural and self-evident component of their relationships. In other countries, emotional support tended to be very easily identified by respondents. For example, in answering a question about the key people her father relied upon, Anthea (Spain) says:*…he doesn't rely on us…it's more emotional than anything…it is really emotional support than practical support…'*

The German qualitative interviews were not much different from the other countries, despite Germany being relative relatively low on this dimension in the quantitative survey. Emotional reciprocity is reflected in Collette's (daughter, Germany) interview:*…She is a lovely mother and she cares a lot…it's my mother who I talk to. And she helps me then, I get some help back.*

In most cases, older people, their children and grandchildren experience strong feelings of solidarity. Older people often stressed that these warm feelings also exist towards daughters-in-law and sons-in-law. Despite a general awareness and acceptance of the generational gap, feelings of solidarity bring self-confidence and enhance friendships in addition to fulfilling basic human needs. Older people feel safe and secure because of these reciprocal positive feelings.

Consensual Solidarity

Table 4. Consensual solidarity: distribution of similarity of opinions / values between parents and children, by country

	Norway	England	Germany	Spain	Israel
Extremely similar	6.4	8.8	6.6	1.6	17.9
Very similar	22.8	34.6	23.4	14.9	20.6
Pretty similar	46.2	28.3	42.3	34.6	31.2
Somewhat similar	13.1	16.0	20.6	33.3	19.7
Not too similar	7.3	10.1	6.3	13.6	8.2
Not at all similar	4.3	2.2	.8	1.9	2.4
Mean	3.0	2.9	3.0	3.5	2.9
SD	(1.14)	(1.21)	(1.02)	(1.02)	(1.29)
Base	*329*	*318*	*364*	*309*	*330*

f (df, 4) = 12.90***

*** p < .0001

Values in percent. Totals sum up to 100%

Table 4 shows that with the exception of Spain, between 30 to 40% of parents reported having opinions and values that were extremely similar or very similar to their study child. In Spain, the rate was much lower (17%). There were no corresponding questions in the qualitative interviews. But the topic emerged indirectly, mostly through the respondents. The subject that nearly always reflected familial consensus or different views was religion. Mrs. B. (Israeli widow) states: '*I knew that my children would always agree with everything the Rabbi says…*'. One exception to this pattern was Steiner (son, Norway): '*And we do have completely different opinions and values. My father is very religious and I am an atheist . But we get along really well*.'

In Spain, 94% of the elderly are Roman-Catholics, many of them practicing. (Castiello, 2002). Holding a religious belief is more common in the parent's generation than in the adult child's. Religion, although not always explicit, was in the background of many topics raised in the interviews. The apparent low rates of consensus between Spanish parents and their adult children can be explained by the rapid social change Spain experienced during the 1980's. Other reasons include the substantially *lower* educational level and *higher* religiosity of older Spaniards compared with younger generations.

Functional solidarity –help received

Rates of functional support *provided* by parents to children were quite low in all countries. Data presented here will therefore focus on help *received*. The data show that emotional support was most frequently received in all countries ranging from 47% in Norway to 62% in Spain. The second frequent help domain was shopping/transportation ranging from 37% in Israel to 56% in England. The third was house repair/gardening where Israel was the lowest (16%) and then between 28% in Spain to 44% in Germany. The least frequent help received were in the areas of personal care, where the lowest was in Norway (2.4%) to 16% in Germany, and in the domain of financial assistance, where the lowest was again in Norway (2.7%) and the highest in Spain (13%).

Table 5. Functional solidarity: help received from children according to six domains, by country

	Norway						**England**					
	(1)	(2)	(3)	(4)	(5)	(6)	(1)	(2)	(3)	(4)	(5)	(6)
Yes	34.1	41.5	15.6	2.4	2.7	47.0	34.8	56.1	31.2	9.8	8.9	55.7
No	65.9	58.5	84.4	97.6	97.3	53.0	65.2	43.9	68.8	90.2	91.1	44.3
Base	*337*	*337*	*334*	*336*	*334*	*334*	*328*	*328*	*327*	*327*	*327*	*327*
	Germany						**Spain**					
	(1)	(2)	(3)	(4)	(5)	(6)	(1)	(2)	(3)	(4)	(5)	(6)
Yes	44.1	51.5	38.3	16.3	3.3	57.3	27.7	42.2	38.8	14.2	13.0	62.5
No	55.9	48.5	61.7	83.7	96.7	42.7	72.3	57.8	61.2	85.8	87.0	37.5
Base	*363*	*363*	*363*	*363*	*363*	*361*	*325*	*325*	*325*	*325*	*324*	*325*
	Israel											
	(1)	(2)	(3)	(4)	(5)	(6)						
Yes	15.8	37.0	15.0	6.5	12.0	56.3						
No	84.2	63.0	85.0	93.5	88.0	43.7						
Base	*341*	*341*	*341*	*341*	*341*	*341*						

(1) House repair / gardening (2) Shopping / transport (3) Household chores (4) Personal care (5) Financial assistance (6) Emotional support

Values in percent. Totals sum up to 100%

Data in Table 6 regarding the number of domains in which help had been received shows that very low proportions of parents received help from the 'study child' in all six domains (between 0% in Norway to 5% in Spain). Between 19% (Germany) and 25% (Spain and England), and almost a third in Norway and Israel, did not receive help in *any* domain. Help received in 4 or 5 domains is relatively low in Norway and Israel (about 7%), with Germany having the highest rate (21%).

Table 6. Functional solidarity: help received from children according to number of domains, by country

	Norway	England	Germany	Spain	Israel
All six areas	0	4	1	5	2.6
4 – 5 areas	6.9	15	21	17	7
3 areas	15	17	19	12	11
2 areas	21	20	18	16	17
One area	27	20	21	25	31
No area	31	25	19	25	31
Base	*331*	*325*	*361*	*324*	*341*

f (df, 4) = 15.01***

*** p < .0001

Values in percent, rounded. Totals do not sum up to 100%

Normative Solidarity

Table 7. Normative Solidarity: Agreement with filial obligation norms, by item and country

	Norway				England				Germany			
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)
Strongly agree	5.0	4.1	9.5	2.0	4.2	3.7	4.2	12.3	7.5	3.9	15.6	5.8
Agree	30.3	36.8	55.4	24.7	20.8	35.6	28.4	33.0	43.6	37.0	48.8	31.4
Neither nor	18.7	19.3	13.0	12.2	16.4	18.8	18.0	18.5	25.8	27.3	20.3	25.9
Disagree	39.8	35.3	19.8	42.6	36.1	28.8	30.2	24.1	17.6	27.3	12.3	23.8
Strongly disagree	6.2	4.6	2.3	18.5	22.4	13.1	19.1	12.1	5.5	4.6	3.4	13.2
Index	3.03				3.23				2.77			
SD	(.78)				(.8.3)				(.81)			
Base	*402*	*394*	*399*	*401*	*379*	*382*	*377*	*373*	*438*	*433*	*443*	*433*

	Spain				Israel			
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)
Strongly agree	13.6	9.2	12.0	10.9	7.8	4.0	6.5	7.9
Agree	58.7	42.2	49.9	49.4	49.9	30.3	35.8	44.5
Neither nor	18.6	26.3	23.4	23.5	12.0	21.2	21.1	19.8
Disagree	7.8	17.6	13.1	13.7	23.7	38.5	31.5	25.5
Strongly disagree	1.4	4.7	1.7	2.5	6.7	5.9	5.4	2.3
Index	2.46				2.86			
SD	(.75)				(.78)			
Base	*361*	*358*	*359*	*358*	*359*	*353*	*355*	*353*

(1) Adult children should live close to their parents so that they can help each other. (2) Adult children should be willing to sacrifice some of the things they want for their own children in order to support their aging parents. (3) Older people should be able to depend on their adult children to help them do the things they need to do. (4) Parents are entitled to some return for the sacrifices they have made.

Values in percent. Totals sum up to 100%

The five countries show different patterns of filial expectation norms. Spain has the highest rates of agreement with the four statements, whereas England has relatively low rates. Norway shows relatively low rates on two of the statements. As far as the option of cohabitation is concerned, more than half of the respondents in Spain, Israel and Germany support this statement. In Norway and England, the 'norm of independence' appears to be stronger and older people seem to prefer living

separately from their children. As far as the proposition that '*parents are entitled to some return for the sacrifices they have made to their own children*' is concerned, about half of the only Spanish population support this statement, while in the other countries the support is much lower. In Norway, Germany and Spain, about two thirds of respondents are highly supportive to the proposition that older people should be able to depend on their adult children for help when in need. In England and Israel, support on this item is much lower. For the fourth proposition, reflecting the reciprocity norm ('*parents are entitled to some return for the sacrifices they made*'), Spain and Israel stand out as strongly supporting this norm, whereas in Norway, England and Germany, rates of agreement are much lower, the lowest being in Norway.

Defining normative solidarity in the qualitative interviews was more problematic. It could be that the very words 'obligations' and 'duties' sound wrong in an individualistic society., Both parents and children and responded negatively to these expressions. But life styles and everyday living situations showed high levels of normative solidarity in both generations. In other words, adult children do not feel that they *have* to take care of their parents, but they do. As shown below, many older parents and their children preferred to describe their behaviour towards each other as voluntary, performed out of free will and inner need rather than fulfilling an obligation. Gunhild (parent, Norway): '*One can't expect everything. One has to be happy if the children do something. But not demand or expect them to do so.* Maria (parent, Germany): *It is completely out of the question that they will care for me. And I don't expect them to either.*

Most parents stressed that they would ask their children for help only if it became really necessary. Stan (parent, England): '*No I don't want to bother the family…how can you tie a daughter or a son down when they should be enjoying their own life?* Aviva (parent, Israel) supports this view: '*I have always been a very independent person. I believe everyone has to live his life, I wouldn't ruin my children's life by expecting them to take care of an old mother…I would call them only if it is an emergency'.* Gunhild (parent, Norway) summarizes this sentiment in the following way: '*…when I'm in need of course I have to ask for help…but you're not supposed to hassle the children.* All of these parents talks about support from their children based on choice and not arising from a sense of obligation or duty.

A second, smaller group of elderly parents has completely the opposite view. They are totally convinced that it is child's duty and obligation to support and take care of parents in old age. Sara, a religious Israeli mother, is one of these parents: '*My husband and I, we made sure that one of our children will live close to us so she will be able to take care of us in our old days.* Amelia (parent, Spain) responded: '*Of course it is an obligation, because otherwise what was I going to eat, where was I going to be…'*

The children also have diverse opinions and perceptions. A first group are very similar to their parents. They believe that giving support to parents should be a matter of choice. Ami (son, Israel) expressed his wish to support his mother in the following way: '*I love her, she is a great person and she has been a great mother. Now I want to help her as much as I can and as much as she will let me…'.* A second group, although sometimes ambivalent, believe they have an obligation. Amelia, (daughter, Spain: '*…all my brothers take it for granted…that my mother has to go to my house…when tomorrow comes, I'll have to take her to me…I don't want to do it as an obligation…I'll have to take care of her by force because she is imposing that obligation on me…she's convinced that she's going to live with me…'.* Carmen Garcia from Spain puts this view forward very simply, emphasizing the reciprocal nature of filial obligations: '*I take care of her because I've got to, she's my mother, I have no choice…Yes, I have no other choice than to care for her. She took care of me when I was a child. She cared about me and about my brother. Now she has to be taken care of herself…'.* Steiner (son, Norway) also has a sense of obligation: '*I feel that taking care of your family is something you ought to do'.*

The impact of background characteristics on the solidarity dimensions

Covariance analyses were performed for each dimension of support across the five country samples of the survey. This analyses are multifactor one way analysis of variance (ANOVA) that were used in order to select the variables that independently predict each of the dimensions. Additionally, two way interactions for the variable 'country' only with all the other factors were computed. The data are provided in Tables 6a-6g in the Appendices. Table 8 presents summary results of the significant and non-significant covariance analyses of Tables 6a-6g

Table 8. Summery results of covariance analysis

Main Effect	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Country	-	+	+	+	+	+	+
Functional health (SF 36)	-	-	-	-	-	+	-
Number of children	-	-	-	-	+	+	-
Gender	+	-	-	-	-	-	+
Marital status (married vs. not married)	+	-	-	-	-	+	+
Level of schooling (3 levels)	+	-	+	+	-	-	+
Financial situation (comfortable vs. not comfortable)	-	+	+	-	-	-	-
Two Way Interactions							
Country × Functional health	+	-	-	+	-	-	-
Country × Number of children	+	-	-	+	-	-	-
Country × Marital status	+	-	-	+	+	+	-
Country × Level of schooling	+	-	-	-	-	-	-
Country × Financial situation	-	+	-	-	-	-	-

1) Proximity (2) Affectual Solidarity (3) Consensual Solidarity (4) Associational Solidarity – face to face (5) Associational Solidarity – phone or mail (6) Functional Solidarity (7) Normative Solidarity

The figures in Table 8 show that there are significant main effects of the factor country on all dimensions except for proximity. Level of schooling had significant main effects for four of the dimensions – proximity, consensus, association face-to-face and normative. The more educated have a greater degree of consensus with their adult children, whereas the less educated live closer to their children, have more face-to-face contact and report higher levels of filial obligations (normative solidarity). Marital status shows significant main effects for proximity, normative and functional solidarity. The non-married elderly (who were mostly widowed) live closer to their children, report higher levels of filial obligations (normative solidarity) and receive more help from their children. The number of children has significant main effects for association by phone contact and functional support. The more children a parent has, the less contact and the less help received from each child. Gender has significant main effects for proximity and normative solidarity. Women tend to live closer to their children than men and report higher levels of filial obligations. The financial situation of respondents has significant main effects for affection and consensus. Those that perceived their financial situation as more comfortable tend to feel higher levels of affection and share more

similar views with their children. Levels of physical functioning have significant main effects for functional help only. More disabled respondents, as expected, received more help.

The significant two-way interactions show that the variable of country has an impact on the dimensions of solidarity differentially for certain background and health variables. For example, functional health had no main effect for proximity and association. But in the two-way interactions it was significant, meaning that it is only in Norway that parents with better health live closer to their children and see them more often. In Germany and Spain, the picture is reversed. And in England and Israel, the differences are very small although in the same direction, e.g. those with a lower level of functioning live closer to their children and see them more often. Significant two-way interactions were also found between country on level of physical functioning for proximity and associational solidarity, face-to-face as well as significant two-way interactions between country on number of children for these two dimensions. Significant two-way interactions were obtained between country on level of education to proximity and between country on financial situation for affection.

Discussion and conclusions

This chapter has presented, in a comparative perspective, the similarities and differences of intergenerational family relations and their determinants for older cohorts (75+) in the five countries of the OASIS study. This cohort was selected because they are more 'at risk for dependency'.

The first stage of the analysis showed the distribution of the six dimensions of intergenerational solidarity using both quantitative and qualitatively data, The second stage examined the impact of country and background (demographic, familial and health variables) on solidarity.

A general conclusion is that family solidarity is considerably strong in all five countries, although there are variations in the strength of dimensions. A large percentage, in all countries, reported high levels of affectual solidarity (emotional relations). Even if rates in the quantitative data were relatively low for Germany, similar forms of solidarity to the other countries was found in the qualitative data. A high level of consensus between older parents and their adult children was generally found (relatively low in Spain), as was having quite frequent face-to-face and phone/mail contact. Regarding living arrangements, Spain is the exception, with about a quarter of older parents living with one of their children. In all countries more than one half of older parents live quite close to at least one of their children. Norway and Israel have lower rates for functional help provided by children. This could be related to the level of needs and/or service development for older people in these countries. The other three countries show patterns of *more*

help received from children. The domain where most help was provided was emotional support, and the domains with the least support was personal care and financial assistance.

Normative solidarity was measured using filial expectation norms. The results show different patterns for the five countries. Spain has the strongest expressed filial norms. The qualitative data revealed only small differences between the remaining four OASIS countries, both older parents and children perceiving filial obligations very similarly. Normative solidarity means knowing that a child is there when in time or real need or emergencies. The first choice for everyday help and support is a paid worker. Sometimes, a child is expected to organise support or act as a care manager. In most cases, children accepts and appreciate this interpretation of the filial duty.

Spain (and in one case a religious family in Israel) was the exception to this pattern. Normative expectations there are very high for both parents and most of their children. Although norms and attitudes have been changing recently, traditional feelings of duty and obligation are very strong. Older people are unanimous that it is the child's duty to take care of an ageing parent. Adult children are somewhat ambivalent about their obligations towards their parents, especially daughters who are expected to become the main carers.

These findings are similar to previous research on intergenerational solidarity. Family sociologists have shown that the extended family has maintained cross-generational cohesion (Bengtson 2000). The nuclear family has kept most of its functions, while working in partnership with formal organizations (Litwak 1985; Litwak et al. forthcoming).

The results of the co-variance analyses indicate the importance of country, level of education, martial status, gender, number of children, perceived financial situation and physical functioning as having main effects on one or more of the solidarity dimensions. These variables have also been found in other studies to be linked to dimensions of solidarity. The discussion that follows first examines the influence of personal, familial and health factors across all countries on intergenerational solidarity. Then the each country is discussed in turn.

As far as level of education is concerned, findings are equivocal. Lawton, Silverstein and Bengtson (1994) found that people with higher levels of education have more social contact with their fathers than their mothers (controlling for distance). But the OASIS data show the *les*s educated as having higher levels of solidarity (proximity, face-to-face contact and normative), whereas the better educated have *more* likely to have similar opinions and values to their children (consensus). Other researchers have reported no association between level of education and receiving instrumental assistance (Hoyert, 1991).

Findings on the impact of marital status show differences between married and non-married persons. Several studies have found an association between marital status and intergenerational relations. Widowed people, for example, have more contact with their children and receive more help (Amato et al. 1995; Katz and Lowenstein 1999; Silverstein and Bengtson 1994). The OASIS data from the over 75 sample confirms this pattern. Crimmins and Ingengneri (1990) found that divorced or separated parents who are highly educated are likely to experience *low* levels of contact with their children. Ganong and Coleman (1998) also found that normative solidarity was lower for divorced parents (or stepparents) and similar results have been found by Lawton et al. (1994) and by Silverstein and Bengtson (1997), especially for divorced fathers.

The literature suggests that gender influences intergenerational relations. Rossi (1993) and Rossi and Rossi (1990), for example, found that women express higher levels of affectual and normative solidarity than men. They also found that affectional ties between mothers and daughters are the strongest. Mothers have been found to receive more support than fathers (Ikkink et al. 1999). The OASIS data reveals similar patterns, showing for example that mothers tend to live closer to at least one of their adult children than fathers.

The OASIS data show that the greater the number of children, the *less* likely regular contact and help given to parents. This finding is similar Hoyert's research (1991) where the more children there were in the family, the *less* likely were elderly parents to provide or received household assistance. But Rossi and Rossi (1990) did not find this pattern. They reported parents with a larger number of children receiving more support than those with few children.

As far as financial situation is concerned, our findings indicate that those with a *higher* perceived socio-economic status felt closer to their children and shared similar views. However, other research has shown different patterns. Richlin-Klonsky and Bengtson (1996), for example, found that a higher socio-economic status *weakened* affectual solidarity. Silverstein and Bengtson (1997)also found that income was inversely associated with having tight-knit relationships with mothers.

For physical functioning, the OASIS findings are similar to previous research. Parents in declining health tend to receive more help from their children than healthy parents (Field et al. 1993; Hogan et al; 1993; Silverstein and Bengtson, 1994).

In summary, it is difficult to draw firm conclusions about the effect of socio-demographic characteristics on intergenerational solidarity. This could be a methodological problem, as these characteristics are sometimes measured

differently. For example, financial situation is sometimes measured by *actual* income and sometimes by *perceived* financial situation. Another problem is that dimensions of solidarity are measured or analysed differently. For example, in several studies by Bengtson and others the solidarity dimensions were dichotomized. But in other related studies these dimensions were used as continuous variables. Moreover, cultural and social contexts might also explain the differences between the OASIS findings and other studies, since most of these studies were from the United States.

The chapter has shown how 'country' was one of the factors with significant main effects for all solidarity dimensions, except proximity. Family legislation in the five countries reflects these differences. In Norway and England, legal obligations between adult generations have been abolished and social policies are based on individual needs and rights. In Germany, despite a relatively new Long-Term Care Insurance Law that was implemented in 1995 for home care services and in 1996 for institutional services, elder care is still assumed to be a family commitment. In Spain the family also plays a central role in elder care, more so than in Norway, England or Germany. Spanish reforms in welfare services for the elderly reflect this family culture by attempting to reinforce the traditional emphasis on family care (Twigg 1994). Israel can be described as a 'mixed model' where the family is central (Lavee and Katz, in press), and services for the elderly are highly developed. The OASIS findings reflect this unique combination, where Israeli familial norms are relatively strong but people tend to rely for instrumental assistance more on the State, especially since the enactment of Long-term Care Insurance legislation in 1988. Today, about 120,000 older people (20% of the elderly) receive benefits under this law (Katan and Lowenstein 1999).

Norway is one of the most advanced welfare states, as are the other Scandinavian countries. However, the OASIS findings indicate that even with high levels of public assistance older people in Norway are embedded within the family system (Daatland 1990). More than half of older Norwegians live close to at least one of their children, feel emotionally close to their children and share similar views. These findings are similar to the results of a Swedish longitudinal study (McCamish-Svensson et al. 1999). In the OASIS survey however, Norway showed a mixed picture on the solidarity dimensions. On the one hand, as indicated above, Norwegians have quite high levels of proximity, affectual and consensus solidarity. But on functional solidarity, they are relatively low regarding help received from children. Norwegians also have relatively low levels of normative solidarity, although similar to the English.

England had relatively high levels of all solidarity dimensions, except for normative solidarity which was relatively lower. Although legislation was introduced in 1990 which "*spearheaded far-reaching changes in welfare provision and delivery to older people…. still where the need for social care arises it is met*

primarily by the family" (Phillips 1995 4-6). The OASIS findings are similar to those by Phillipson et al. (2001), both studies confirming the importance of the family and especially immediate family like partners, children and grandchildren. The generational chain these authors observed show that complex issues are raised when people talk about 'family life' or 'family support'. Even though support continues to be reciprocal it is more within the context single generation as opposed to multi-generational households and relationships are managed more by telephone contact than face-to-face contact. Phillipson et al. noted that there was '*a sense in which family life has to be "worked at" and "managed"'* (160).

Germany is a country where there are extremes in some dimensions of solidarity. For affectual and associational solidarity (phone contact) they have the lowest levels. But on functional solidarity they rate high, and on normative moderate. As stated in Katz et al., (forthcoming): '*In Germany, on many of the attitudinal aspects, regarding state-family balance, the respondents chose the option of co-responsibility between the two'*. In general, family policy in Germany is characterized by '*programmatic uncertainties and strong discontinuities and, despite an explicit family policy, has a social welfare system that remain unfavourable to the family*' (Kaufmann 1997 91).

Spain emerged as a country where a larger proportion of respondents scored high on proximity. About a quarter elderly Spaniards were living with one of their adult children. Spain also had the highest rates of face-to-face and phone contact, as well as on the normative dimension of solidarity. But for consensus, it had the lowest levels. It could be that these findings support the notion that Spain is still a more traditional-familistic society, with less well-developed formal services for the elderly. This is clearly expressed in an OECD (1996) publication where it was noted that "*one aspect of the Spanish reforms is the way in which they try to reinforce the traditional emphasis on family care, while accepting that it will change in nature… The support of family care is likely to be a continuing high priority in Spain, independently of the economic capacity to achieve particular service targets*" (p. 163). The issue of why respondents scored low on consensus might be related to the fact that Spain is undergoing rapid modernization (reflected, for example, in the lowest fertility rate in Spain). Younger generations are more exposed to this process as well as being better educated and more well-off than their parents. This could result in the emergence of a large generation gap.

Israel is still a 'familistic' country, as reflected for example in the total fertility rate (2.8 children per family) and relatively low divorce rate. Israel has also developed a nation-wide network of community and institutional services for the elderly. This duality is a marked finding of the OASIS survey. Israeli families live close to each other, have frequent daily face-to-face and phone contact, share similar views, and express the highest levels of affectual solidarity. Levels of normative solidarity are moderate in Israel, and levels of functional solidarity are relatively low (except for

the provision of emotional support by children to their parents). The findings on normative and functional solidarity reflect the feelings of elderly parents. They believe that they are 'overprotecting' their adult children, who are experiencing economic difficulties and the consequences of security problems (issues which were clearly expressed in the qualitative interviews). Additionally, as there is a broad availability of formal services that the elderly can rely on they do not necessarily consider turning to their children first. Another possible explanation for low levels of functional solidarity stems from the literature showing the negative impact of receiving support from family members in later life on well-being of the elderly (Umberson 1992; Silverstein and Bengtson 1994; Lee et al. 1995; Antonucci et al. 1996; Ingersoll-Dayton et al. 1997).

In conclusion, the five OASIS countries have similarities and differences on the dimensions of intergenerational family solidarity. This variability could reflect cultural-familial norms, patterns of behaviours and social policy traditions in the five countries. On the micro level, families may select different emotional and support behaviour patterns. These patterns are based on family values and norms, and they are responses to new tasks and the needs of ageing family members. On the macro level, countries develop different health and welfare service networks to meet the needs of elders and their families.

The findings show that Spain and Israel are more 'familistic' societies, Norway, England and Germany are more individualistic. But even in these 'individualistic' societies, family ties and intergenerational support continue to have a central role. Variations in the strength of the solidarity dimensions in the five countries may be related to how familial norms are enacted in different cultural contexts and in different welfare regimes (Daatland 1990; Finch and Mason 1993; Katz and Lowenstein 1999; Lowenstein and Katz, 2000).

These results emphasise the importance of cross-national analyses to give new insights into the idiosyncratic and intriguing differences between countries, as well as the sometimes unexpected similarities. Given rapid changes in family structures, population ageing and the growing number of women entering the labour force, a process of growing similarities in family relations might be expected in the future. Further research is needed on the different age cohorts in the OASIS survey, including triangulating the quantitative and qualitative data and examining it in a longitudinal perspective.

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7

Exploring Conflict and Ambivalence[1]

Judith Phillips, Jim Ogg and Mo Ray

Introduction

The concepts of conflict and ambivalence are receiving increasing attention in research on intergenerational relations. Overt family conflict, such as child abuse, domestic violence and elder abuse, has been by and large comprehensively researched and many findings have been incorporated into social policy and practice (Bennett and Kingston, 1997). Lesser forms of conflict, those which might be referred to as being 'part of life', have however received much less attention. This is changing as it is now recognised that these features of family life may have important consequences for intergenerational flows of support. Ambivalence, although not a new concept within sociology (Coser 1966), has recently been reformulated because of dissatisfaction with the polarity of two prominent models of the family – the solidarity and conflict models (Lüscher and Pillemer 1998; Lüscher 2000, Connidis and McMullin 2002). Whereas these models have been influential in demonstrating that the majority of families operate complex forms of solidarity, they are less useful in identifying those aspects of social action that concern uncertainty or risk and their outcomes.

Although every family has aspects of conflict and ambivalence within it, there are clearly difficulties in defining and measuring these concepts. Issues of definition and measurement, as Lüscher and Pillemer (1998) acknowledge, have yet to be clarified. Notwithstanding these complications, there is a growing sense that contemporary society is characterised by rapid social change and uncertainties over the nature of social relationships. Individuals are unsure over the roles they have in family life, perhaps especially those which relate to intergenerational relations. These uncertainties threaten previously held norms about family relationships and mutual obligations, particularly for women. With lower fertility rates and increasing participation in the labour force, many of the roles that were previously taken for granted as a woman's duty are being undermined. This has led to uncertainty about who will (and who should) provide care for vulnerable family members in the future. The unforeseeable consequences of current socio-demographic changes are a renewed source of anxiety over contemporary family life and the limits of intergenerational solidarity and traditional models of care giving are currently being questioned.

[1] The authors would like to thank Sylvie Renaut for help with the typology dervied from the quantitative data and Delia Spangler for her contribution to the qualitative analyses.

Among recent commentators who seek to place the concepts of conflict and ambivalence within a theoretical framework of intergenerational relations, Connidis and McMullin (2002), drawing on critical theory and symbolic interactionism perspectives, propose a re-conceptualisation of ambivalence. They argue that:

'ambivalence is created by the contradictions and paradoxes that are embedded in sets of structured social relations (e.g. class, age, race, ethnicity, gender) through which opportunities, rights and privileges are differentially distributed. Individuals experience ambivalence when social structural arrangements collide with their attempts to exercise agency when negotiating relationships, including those with family member' (21).

The emphasis that the authors place on the link between individual agency and social structure implies the need for a greater understanding of how parent-child relationships are negotiated. Whereas intergenerational conflict studies have tended to report on the existence and levels of conflict in families, the re-conceptualisation of ambivalence focuses on how conflict is experienced, managed or negotiated between family members (Williams and Nussbaum, 2001). Connidis (2002) has suggested that viewing ambivalence as a possible analytical framework for family research calls for a more interpretive approach to investigation, by for example exploring in family narratives the meaning of exchanges and support between parents and adult children and how roles are negotiated. To date, much of the research on conflict and ambivalence has focused on empirical attempts to measure these phenomena. Using single item questions, these studies provide good evidence of the existence of ambivalence in parent-child relationships. However, they have much less to say about the causes of such ambivalence – or indeed whether such sentiments should be treated as an independent or dependent variable to explain intergenerational relations (Lüscher and Pillemer 1998).

The main area of interest in this chapter is therefore to investigate how concepts of solidarity, conflict and ambivalence are experienced in parent-child relationships within the five study countries, particularly during periods of change and transition in the lives of older people in the study. The context is relationships between older parents and their adult children, and the focus is upon elderly parents (aged 75+) who are in need of care and support. The hypothesis is that different styles of parent-child relationships will exist within countries and between countries, reflecting both the influence of individual agency and social structure. In the absence of any previous comparative research in this area, no a priori assumptions are made concerning the hypothetical inter-country differences in parent-child relationships.

The quantitative data show that for each of the five study countries, there is no evidence of *high* levels of conflict between parents and children. On the contrary,

there is a strong demonstration of harmonious relationships. However, conflict is clearly an important dimension of family life, since between one-third and a half of parents in the study countries recognised the existence of some conflict and tension in the relationships with their children. Ambivalent relationships are more elusive to capture in the quantitative data. Whereas conflict is clearly linked to behaviours that can be identified by respondents, ambivalence, by its very nature, requires more interpretation of the data. Some of the key components of ambivalent relationships, such as contradictions in relationships that cannot be reconciled or the simultaneous presence of positive and negative perceptions by an individual, become more apparent in the qualitative data. The qualitative interviews show how older parents, in their attempts to negotiate, manage and reorganise their lives as a result of chronic illness and disability, often identify an experience of ambivalence at an individual level. Ambivalent feelings are expressed in parent-child relationships when managing major life changes. In this context, conflict need not have an inevitably deleterious effect on family relationships, but rather, it can promote the conditions necessary to manage transitions through life stages and shifts in social roles.

The chapter begins by examining the main findings from the quantitative survey concerning ambivalence, conflict and styles of parent-child relationships within the five study countries. The focus in this first part is to explore ways of identifying the presence of conflict and ambivalence between parents and children. Different styles of parent-child relationships are proposed and then examined in relation to the five study countries. These findings from the quantitative survey are illustrated with narratives from the qualitative survey. Secondly, the experience of ambivalence in relation to managing change and transition is discussed in relation to the qualitative data, where dyads of parents over 75 and one of their children were interviewed. The chapter concludes with some reflections on how different types of parent-child relationships relate to social policy.

Basic indicators of affection, conflict and ambivalence in parent-child relationships

In order to explore these issues further, the OASIS survey used ten questions based on Bengtson et al.'s (2000) model of solidarity and Lüscher's (1998) work on ambivalence. These questions were chosen not only as empirical indicators of conflict or ambivalent relations between parents and their adult children, but also to provide indicators of different styles of family relationships that are present within countries and between countries. Each of the questions contained a range of five or six graded categories, allowing respondents a choice of several responses (see below). Two sub-samples within the survey responded to these questions. The first group were *parent respondents* with at least one child aged 18 or above, where the parent was asked about their relationship with a randomly selected child (study child) if they had more than one child above this age (n=3,494). The second sub-

sample was *adult child* respondents who were asked the same set of questions about a living mother (n=2,255).

The full set of questions and the concepts they are designed to measure are reproduced below:

Conflict, ambivalence and relationship quality questions

	Questions asked to parents about their relationship with an adult child and to an adult child about their relationship with a parent(s)	**Concept measured**
1.	Taking everything into consideration, how close do you feel to this child (parent)	***Affection***
2.	Overall, how well do you and this child (parent) get along together?	***Affection***
3.	How is communication between yourself and this child (parent) – exchanging ideas or talking about things that really concern you at this point in your life?	***Affection***
4.	In general, how similar are your opinions and values about life to those of your child (parent)?	***Consensus***
5.	Taking everything into consideration, how much conflict or tension do you feel there is between you and this child (parent)?	***Conflict***
6.	How much do you feel this child (parent) is critical of you or what you do?	***Conflict***
7.	How much does this child (parent) argue with you?	***Conflict***
8.	Sometimes, family members can have mixed feelings in their relationships with one another. Thinking about (study child) (parent), how often do you have mixed feelings in your relationship with him/her?	***Mixed feelings***
9.	Every relationship can have both pleasant, and unpleasant aspects. All things considered, how would you evaluate your relationship with (study child) (parent)?	***Quality***
10.	In every family there are situations when family members do everything possible to preserve family harmony, or allow conflicts to occur. What about you and (study child) (parent) when such situations arise?	***Style***

Table 1 summarises responses to these questions by parent respondents in relation to their study child and adult child respondents in relation to their mother. The first point of note is that in all countries, levels of affection are high, both from the parent's perspective and from the adult child's – for example, the majority of parents feel very or extremely close to their children and, with the exception of Germany, the same applies for adult children. This finding is a strong indication of the persistence of close family ties, although the lower rates found in Germany require some explanation, especially when compared with the highest rates that are found in Israel. Secondly, in each country the parent generation persistently rate levels of affection higher than the adult children. Since this finding applies equally to all age groups of parents and children (from 'young' parents with teenage or young adult children through to the elderly with middle-age children), it seems likely that the respective position of the generations is the key to the stronger bonds felt by parents towards their children. By the same token, levels of conflict appear to be relatively low since only a small minority of parents and adult children in all countries respectively report high levels of conflict. Notwithstanding this finding, conflict clearly exists, especially from the adult child's perspective. Again, in all countries, adult children perceive higher rates of conflict with their mother than parent respondents with their children.

The question on consensus (4) follows a similar pattern in all countries, with only a minority of respondents who report having the same or very similar views as their parents and with parents giving higher rates than adult children. Generational differences on this item appear the strongest in Spain. Question 8 (mixed feelings) shows similar trends for all countries, with the majority of parents and adult children expressing having sometimes mixed feelings in their relations towards one another. Question 9, measuring the quality of relationships suggests some strong inter-country differences. Germany in particular, following the same pattern as the other questions shows signs of intergenerational tensions as reported by both the parents and the adult child respondents. The final question (10), a single item measure of relationship style, shows the largest inter-country differences of all items. Whereas less than one in three parents and adult children in Norway try to preserve harmony in their relationships, these rates are tripled for Spain and England.

Table 1. Parent-child relationships by country

	Norway		Germany		England		Spain		Israel	
	P	**C**	**P**	**C**	**P**	**C**	**P**	**C**	**P**	**C**
Mean age	63	39	64	*40*	63	*41*	63	*38*	61	*38*
% of respondents who:										
1. Feel extremely or very close	73	57	55	49	76	68	68	56	82	71
2. Get along extremely or very well	77	61	50	48	80	68	63	55	82	68
3. Communicate extremely or very well	59	45	45	40	71	58	54	45	76	58
4. Hold very or extremely similar views	28	19	33	21	41	34	17	14	34	24
5. Feel some conflict or tension	43	60	34	42	30	42	32	42	52	59
6. Feel some criticism from child	56	59	51	53	33	43	38	37	61	63
7. Argues sometimes with child	37	43	43	45	34	37	51	47	63	64
8. Sometimes have mixed feelings	61	74	53	56	51	62	58	62	54	65
9. Have almost always pleasant relationship	61	44	42	37	75	63	64	61	67	53
10. Always try to preserve harmony	33	26	44	44	74	67	78	78	56	46
Base	*645*	*514*	*708*	*400*	*697*	*355*	*694*	*447*	*740*	*531*

Note: $p<0.01$. P=parent respondent towards adult child; C=adult child towards mother.

The descriptive results in Table 1 provide some clues to the cross-cultural styles of parent-child relationships. On the one hand, from both the perspective of parents and adult children, ties remain very strong and there is no evidence to suggest any large scale intergenerational conflict within families. On the other hand, inter-country differences are more difficult to explain. The frequencies seem to suggest relatively large differences in levels of solidarity, particularly between Israel and Germany. Before any interpretation to these findings is advanced, it is necessary to explore the responses to the ten questions in a more systematic way, rather than examining each question individually. This is done in relation to the parent sample only (n=3,494).[2] Since the variation of responses for each country shows a similar pattern, this detailed exploration of how parents responded overall to the ten questions begins with an examination of the correlations between them – that is,

[2] The pattern of correlations between the parent/child and child/mother respondents is very similar.

using data from the entire sub-sample of parent respondents answering about their study child and not initially making any distinction between country differences.

The first three questions (***affection***) are strongly correlated. In other words, parents who feel close to their children generally communicate and get along well with them. Those parents who feel distant are more likely to have problems in communicating with their children as well as finding that they do not get along well together. The fourth question in the series concerns the similarity and differences of opinion between parents and children (***consensus***). This question stands apart from the others. It is weakly correlated with the three questions above (***affection***) and not at all with any of the other questions.[3] For example, parents who hold similar views to their children tend to feel close to them and communicate well. But their relationships could be equally harmonious or conflictual. Conflict and tension do not seem to be dependent upon whether parents and children hold similar views. The fifth, sixth and seventh questions in the series are concerned with conflict between parents and children (***conflict***). These three questions are correlated – so that parents who feel their child criticises them a lot also feel that their relationship with their child is characterised by conflict and tension, and perhaps naturally they tend to argue a lot. However, there is little association between these three variables and the others. This is important to note, because it implies that parents who feel very close to their children can equally feel conflict and tension. For example, Israeli parents, as previously noted, also report high levels of conflict.

The correlation between the final three questions is not very strong. For example, there is only a low correlation between ***mixed feelings*** and ***quality*** of relationships. Over half of the parents who report an unpleasant relationship with their child also report that they *never* have mixed feelings. In these cases, presumably their feelings are clear and the relationship is a conflictual one. Similarly nearly half of parents who very often have mixed feelings about their child almost always have a pleasant relationship. The correlation between ***mixed feelings*** and ***style*** is also low. About half of parents who very often had mixed feelings almost always try to preserve harmony. Similarly about one third of parents who never have mixed feelings almost always allow conflict to occur. The correlation between ***quality*** and ***style*** is however stronger than between ***mixed feelings*** and ***style***. Most parents who stated that they have almost always a pleasant relationship with their child also nearly always try to preserve family harmony. Also most parents who try to preserve harmony almost always have a pleasant relationship (over three-quarters in both cases). But this correlation breaks down somewhat when the relationship is unpleasant – almost half of these respondents (who are very few) nearly always try to preserve family harmony.

[3] A stronger association for the consensus question and affection questions is found among the over 75s.

Defining relationship types

The next stage of the analysis attempts to categorise parent-child relationships in a more comprehensive way. This was done by first performing a correspondence analysis. Correspondence analysis is a weighted principal component analysis of a contingency table which locates all categories of the ten variables in a Euclidean space.[4] The dimensions of this space were then plotted to examine the associations among the categories. Two significant dimensions emerge from the correspondence analysis of the ten variables. These two dimensions are then used to regroup the parents into 'classes' or 'types' by means of a cluster analysis using the co-ordinates from the correspondence analysis of the ten variables. Euclidean distances between respondents were calculated to obtain the clusters. Each parent began in a cluster by itself and then the two closest clusters of parents are merged to form a new cluster that re-laces the two old clusters. In other words, the technique identifies the groups of parents whose responses to the ten questions are as closely related as possible *within* each group, and as different as possible *between* each group, with no *a priori* assumptions about the number or nature of classes that might emerge. The result of these procedures are a four category type of parent-child relationship (24%, 32%, 27%, 17%) that is shown in Table 2.

[4] The analysis was carried out using the Proc Corresp and Proc Cluster procedures in the software package SAS.

Table 2. Relationship types by indicators (%)

	Harmonious (24%)	**Steady (32%)**	**Ambivalent (27%)**	**Distant (17%)**
Indicators				
1. Very and extremely close	98	90	47	38
2. Get along very/extremely well	97	95	43	37
3. Very/extremely good communication	92	87	28	26
4. Very/extremely similar opinions	53	40	10	12
5. No conflict or tension	65	94	40	32
6. No criticism from child	50	87	28	28
7. No arguing with child	51	88	32	29
8. No mixed feelings	55	66	26	21
9. Almost always pleasant r/ship	80	84	39	29
10. Always try to preserve family harmony	65	79	43	31
Base	*849*	*1213*	*867*	*564*

Note: $p<0.01$

Table 3 crosstabulates each of the four relationship types with the selected categories of the ten original indicator questions. In general, the direction is decreasing levels of solidarity between parents and children from the first to the fourth group. However, this is not the case for the second group (steady), who have higher rates on questions 5-10 than the first group (affective). Possible interpretations for this exception to the general pattern of diminishing solidarity from the first to the fourth group are given below. Firstly however, we look at the key characteristics of each relationship type and illustrate them with case study examples from the qualitative analysis.

Unlike any of the other relationship types, **harmonious relationships** are characterised by parents feeling extremely close to their child. The parent and child are much *more likely* to get along extremely well together and communication is *more likely* to be extremely good. Parents and children are *more likely* to have similar views than in the other three groups. This group allows conflict in the relationship, but not too much. The conflict does not have a negative effect on the affective nature of the relationship, so it seems to be a 'healthy' type of conflict, where parents and children argue a little and disagree about certain issues in an engaging way. There is room for mixed feelings in the relationship, but again these mixed feelings do not seem to 'harm' the relationship in any substantial way. These parents also acknowledge that at times their relationship with their child might not always be very good and that occasionally they might fall out over some issue or

another, although on the whole they have a good relationship. Family harmony is important for these parents, but they do realise that it can be difficult to maintain all the time. Just under a quarter of the parent-child relationships fall into this category.

Case study: harmonious family image

Stan and his daughter, Sarah (England) identify their relationship as a positive, affective and harmonious one. It is characterised by shared interests, enjoyment in being together and, effective and open communication:

'When she comes up here she might be here for 3 hours and we talk and talk and we laugh and she's got the same sense of humour that I've got….it's funny because there was a cartoon in the paper I was laughing at and she said "I laughed at that too but nobody else did.' (Stan, parent, England)

'Well I see him every week once a week socially and then if there's anything that I think I need to do or deal with for him then I pick it up there. I ring him most days as well so we have a lot of contact. Sometimes I visit more…'. (Sarah, daughter, England)

Conflict in their relationship is identified as virtually absent or, focusing on unimportant issues and daily hassles. They both feel able to have discussions on 'serious' or important issues without becoming conflictual:

'We don't have many disagreements. In fact I can't think of any. We disagree about going out to meals and restaurants but that is a mini thing (laughs). I was trying to think of something. No we don't disagree on things in general.'

'You've got to have serious conversation of course but not to the extent that it worries you. We always try to find a joke and I think that's a big asset. But we get on very well, she's a lovely girl.'

Nevertheless, Sarah discussed a critical incident in which she experienced serious mixed feelings about her father's remarriage following the death of her birth mother. This was, in part, promoted by difficult feelings about her father replacing her mother but worsened by her perception that her step-mother did not want Sarah and her family to continue with their usual levels of association. Sarah says that she hid these feelings from her father as he was, she felt, happy and unaware of any difficulties. Instead, Sarah resolved the difficulties by reinstating her regular contact with her father and his wife and avoiding discussing her difficult feelings with her father. She continues to regret however, that the break in contact created a separation between her sons and their grandfather which was never properly

reinstated and has now been further reinforced by them growing up and leaving home:

'When my mother was alive we were always on the phone to each other as the two families. When she died and he remarried there was a big break in communication 'cos his second wife wasn't really as keen on seeing the family. But I decided that was daft so I said "right I'm coming to see you" and I started going to see them every Sunday. And that's how the sort of regular visits started. And once she went into the home, then I kept going and I phoned a lot to see how he was doing…"I handled that my way. Because I knew he wanted to do it (remarry) and he was happy then that was right. If I didn't like it, then it wasn't for me to say. Because that would give cause for conflict. But the children didn't like it and worried that they wouldn't see him anymore which was right.'

The **steady relationship** is the largest category, representing 32% of the parents. These parent-child relationships are more emotionally distant than the first group, although they can still be distinguished as close. Parents generally get on well with their children, but perhaps they like to keep some emotional distance. The striking characteristic about this group is that parents and children don't seem to talk much with one another, since unlike the first group they do not register much in the way of conflict. It could be that conflict avoidance is the golden rule in these families and that parents and children do not want to rock the family boat for fear of emotionally distancing themselves from each other. But it may equally be that these are really 'happy families' where no emotions (affection or conflict) are strongly expressed. Everything seems to be more or less ok for these parents– a 'happy family' where either there is really no conflict or where if there is, it is hidden and not acknowledged:

Case study: steady family image

Halvard (Norway) expresses himself as being happy with and generally close to his children, despite the fact that he is aware of conflicts between his children. These are areas that he does not get involved in and, he believes, does not alter the overall harmony in the family:

(Interviewer): 'What if you were to characterise your family, would you say it is a harmonic family or a family with many conflicts?'

(Parent): 'well, I would say both ……I don't have any conflicts with any of them. But between them, my children, it is not always so easy. But I don't have problems so I ask who I want to for help'.

Steinar, his son would concur with his father's view about family harmony (apart from specific conflict with one sibling) but comments too on the fact that they do

not discuss potentially difficult issues. He commented, for example, on his father's tendency to be critical of his efforts but that he avoided reacting to this in order to maintain or preserve relative harmony. In this example, he highlights the tendency not to discuss difficult matters relating to his father's commitment to spending money on maintaining his family home at great financial expense:

'He could have built a new house for that money, in his opinion. It was impossible to discuss it with him. Ok, you might be able to build a new house, but what about painting, the floor and all that stuff, he just didn't get that part. He doesn't care about having a nice house…'

'I would say it is a harmonious family with many conflicts (laughs). We do have some conflicts but not like we become enemies'.

The **ambivalent group** is the second largest, representing 27% of the parents. This group shows signs of a generational gap emerging between parents and their children. These parents tend to feel neither emotionally close nor distant from their study child. Everything seems to be *pretty* good or *pretty* well. They get on pretty well with their child and also communicate pretty well. Things seem to tick over ok, nothing more nothing less. There is conflict in these relationships which seems to result more from the distancing of their relationship rather than from the closeness of it. Mixed feelings begin to show significantly when compared to the ***harmonious*** and ***steady*** groups, although the majority say they seldom or never have mixed feelings. Occasionally the relationships in this group can have their unpleasant moments but there are generally attempts to keep the family harmonious.

Case study: ambivalent family image

Fabiana (Spain) lives with her daughter, her daughter's husband and grandson. She feels that the relationship with her daughter is generally good:

'(I say I) can still help you on something, nothing, she doesn't want me to, and well, I'm feel ok here and we get on well and that's it.'

Throughout the interview, Fabiana hints at potential and actual conflicts with other family members, but states that she does not say anything to preserve family harmony and avoid interfering in the relationship between her daughter and son-in-law. Once again, the satisfactory nature of relationships is highlighted in this discourse:

'I behave with them very well and they do with me and that's it, that's the only thing, well, there are many things, but what can be done?'

'Ok, well with them, they don't behave wrong with me either, as me, and if I see anything I keep my mouth shut and that's it, I don't have to tell anything to anybody and that's the story.'

Fabiana's daughter also identifies a generally satisfactory relationship but comments openly about the existence of conflict and argument between her mother, herself and her son-in-law:

'For example I argue with my mother and I shout a bit at her, because if I don't shout at her she blows my top, and from time to time if you shout a bit at her, she calms down.'

'No, it doesn't affect our relationship, I argue with her and the next day I continue talking to her and caring for her, those arguments, but then they're forgotten, my husband or my 16-year old boy shouts at her sometimes.'

Further analysis of this interview suggests strong ambivalences on the part of Fabiana and her daughter. Fabiana, appears to have to negotiate a path through maintaining relative harmony as she lives with her family, set against key areas of potential open conflict or disagreement. Carmen reflects ambivalences in relation to notions of filial duty and responsibility to care for her mother and her feelings about her brother's reluctance to offer help. Moreover, she has an acknowledged difficult relationship with her husband. The issue of ambivalences created by the onset and management of challenges associated with physical illness and disability are discussed below.

The ***distant*** group is the smallest, representing 17% of parents. This is clearly the group where relationships show signs of emotional distancing and where there is more likely to be conflict, mixed feelings and differences of views – more than one third of these parents report holding opinions and values that are not similar to their children. These parents and children are very different from the ***affective*** group and analysis of the small sample of distant dyads in the qualitative research suggests tentatively that factors such as ongoing and unresolved conflict or differences of opinion are crucial. Moreover, failed attempts to resolve difficulties seem to create a sense of 'learned helplessness' in terms of the dyads ability to make a positive difference. Finally, in a few of the cases from the qualitative interviews, resistance to talking about differences or underlying conflicts can also create emotional distance, characterised by for example, reluctance to associate with or be involved in the life of the other.

Case Study: distant family image

The predominant theme in Maria's (Germany) narrative is disappointment. Social networks often do not satisfy her and she focuses on her daughter who, also

disappoints her standards and expectations. They remain in frequent contact (usually by telephone) but their relationship is characterised by difficult conversations and arguments. Maria is critical of her daughter's husband and this is a source of conflict. She is also critical of her daughter's working life and life style. The locus of this dissatisfaction appears to rest with a feeling that her daughter now has insufficient time for her and, that things were better 'in the past'. She blames her daughter's marriage for creating the emotional distance between them and further, assumes that her daughter suffers in the marriage:

'To cut a long story short, I can't expect anything from them and I don' t know how problematic it really is for my daughter. I told you she is a real workaholic. She is in her surgery all day long and there she always finds something to do. Maybe she takes refuge in work? I don't know how things are with her husband, so I don't know.'

'Once, I had told (my granddaughter a little story, because she calls me, or well she rings and I ring her back so it doesn't get too expensive for her, right (laughs). Err and I wanted to tell this story to my daughter too a few days later but she said, but it happens often that she says: "You know, I don't have the time anymore to listen to that too now. That's it, she never has the time to listen to anything.'

Helga echoes her mother's experience of a difficult and conflictual relationship. Similarly, she reflects on her mother's criticisms of her lifestyle, work patterns and jealousy of her relationship with her husband. Helga highlights her mother's critical stance in their communication and, as a result of unresolved and ongoing conflict, a reduction in emotional closeness:

…she is unpredictable in every action, what she does…and what she makes. Perhaps it sounds too negative, but that´s the relationship, in conclusion I would say it is not easy with my mother.

Or she says: 'I don´t understand, why do you always stay for so short, you can return on Monday", then I say: "Mum, I have the consultation hour on Monday, I cannot decide not to do that : "Well, you have a husband who earns money." Well then she absolutely misjudges the situation. That´s my work and whether I do it or not, but I can´t say I don´t do any consultation hour, because I am in town". And that makes it enormously difficult with her.'

At the time of the interview, Helga was increasingly ambivalent about spending time with her mother and enduring what she perceived as ongoing and unresolved battles predicated around her mother's dissatisfaction with her marriage, family and working life. But, feelings of obligation and bad conscience prohibit Helga from doing anything other than continuing to maintain contact and support. She has tried a number of strategies to improve the relationship with her mother (for example,

trying to encourage the mother to engage with a wider range of social contacts) but feels that these are again, criticised or misunderstood by the mother.

Inter-country differences in parent-child relations

The above analysis illustrates the different styles of relationships between parents and their adult children and provides evidence of different levels and forms of conflict and ambivalence. Turning now to inter-country differences, Table 3 shows that there appear to be important differences in relationship styles between the five study countries. One half of Israeli respondents report their relationships as harmonious compared to only one in eight German and Spanish parents. The harmonious relationship seems to be characteristic of the Israeli parents and their children. Spanish and English parents report the highest rates of 'steady' relationships – those that combine affection with little conflict. Ambivalent relationships are most evident in Germany, Spain and Norway and distant relationships in England. German parents differ from all other countries in so far as a majority of parent-child relations are either ambivalent or distant.

Table 3. Cluster parent-child relationships by country (%)

	Norway	Germany	England	Spain	Israel
Relationship type					
Type1: Harmonious	21	12	27	11	51
Type 2: Steady	32	29	40	41	16
Type 3: Ambivalent	32	41	11	35	16
Type 4: Distant	15	18	23	13	17
Base	*645*	*708*	*697*	*694*	*740*

Note: $p<0.01$

In order to explore further some of the factors that may influence parent-child relationships, a multinomial regression analysis is presented in Table 4 for each of the five countries. This form of regression equation assesses the impact of categories of independent variables upon those of a dependent variable. The independent variables selected were the age of the parent, sex of parent, sex of child, whether the child is living at home and whether the parent receives some form of help from the child.[5]

Table 4. Multinomial regression of cluster parent-child relationships

	Norway	Germany	England	Spain	Israel

[5] This means that during the previous 12 months, the child has either done house repairs or gardening for their parent, or has helped with transportation and shopping, or has helped with household chores, or has helped with personal care tasks, or has helped with financial assistance, or has given emotional support.

R^2 (Nagelkerke)		0.12	0.67	0.12	0.05	0.87
% of variance explained in regression equation		42.30	48.00	44.00	46.10	50.10
Relationship type	**Parameter**			**Odds ratio**		
STEADY	Age	**1.03**	1.02	1.01	1.01	**1.02**
	Father	**0.61**	1.29	0.80	1.06	1.46
	Son	**2.02**	0.91	**2.05**	1.11	1.43
	Not living at home	1.05	0.83	1.56	**1.82**	1.33
	Not receiving help	**2.20**	1.74	**1.63**	1.03	0.81
AMBIVALENT	Age	**0.98**	1.01	**0.96**	0.99	0.99
	Father	1.15	1.10	1.18	1.44	**1.59**
	Son	**2.04**	1.21	**2.54**	1.30	0.98
	Not living at home	1.21	1.55	1.44	1.05	1.26
	Not receiving help	1.66	**2.15**	1.16	0.88	1.18
DISTANT	Age	1.00	0.99	0.99	1.01	0.98
	Father	0.95	1.01	0.98	1.29	**1.60**
	Son	1.23	1.07	**2.31**	1.39	1.57
	Not living at home	0.89	2.53	1.17	0.85	0.94
	Not receiving help	**2.93**	**4.01**	**3.47**	1.52	**1.87**

Notes : Reference category for dependent variable 'harmonious'. Age continuous variable, sex of respondent dichotomy (father/mother), sex of child dichotomy (son/daughter), not living at home dichotomy (not living at home, living at home), not receiving help dichotomy (receiving help/not receiving help). Main effects model.

Table 4 compares the 'steady', 'ambivalent' and 'distant' parent-child relationships with 'harmonious' one. The figures provide further evidence of different parent-child relationship styles between the five countries. Norwegian and English parents have many similarities. Older parents are more likely to have steady than harmonious relationships and less likely to have ambivalent than harmonious relationships. Having a son rather than a daughter increases twofold the likelihood having a steady or reserved relationship rather than a harmonious one in the two countries (a gender effect that is even more pronounced in Norway, since being a father rather than a mother decreases the likelihood of having a steady relationship rather than a harmonious relationship by about 40%). If Norwegian and English parents do not receive any help from their children, they are three times more likely to have a distant relationship than a harmonious one. One key explanatory variable

for the Israeli parents seems to be the sex of parents, since fathers are more likely to have ambivalent or distant relationships with their children than harmonious ones. Spanish parents have only one significant parameter – having a child not living in the home increases the likelihood of having a steady rather than a harmonious relationship. The strongest parameter effects, with the exception of Spain, are to be found when no help is received from children. There is approximately a twofold or more increase in the likelihood of having a distant relationship with a child if this child does not help out in some way, and in Germany this increase is approximately fourfold.

Two tentative conclusions can be drawn from the above analysis. On the one hand, it is clear that there are both intra and inter country differences in styles of parent-child relationships. In all of the study countries, there is good evidence that parents and children differ qualitatively in the way that they relate to one another. These differences are important enough to have an impact on flows of intergenerational support, although it should be remembered that the majority of families show strong signs of intergenerational solidarity. In this respect, the analysis confirms findings from other researchers who have used typologies to characterise parent-child relations (Wenger 1989; Silverstein and Bengtson 1997). On the other hand, explaining these different family styles is more problematic, particularly in the context of a comparison between the five study countries. As Silverstein and Bengtson suggest, this heterogeneity can almost certainly '*be attributed to historical trends over the last century*' (1997:454). Thus the higher rates of harmonious parent-child relationships found in Israel may have as much to do with this country's recent history and the current geo-political situation. Similarly, the apparent generation gap between current cohorts of older parents and their adult children in Germany may also have something to do with the polarisation (along generational lines) of traditional/radical attitudes that occurred in the 1960s. To take another example, the low rates of harmonious parent-child relationships found in Spain my be due to enduring norms of traditional respect for elders common to Mediterranean cultures, where 'low-key' forms of conflict and high levels of affection are traditionally absent in family relations. These wider historical influences on intergenerational relations may be important indicators on how future patterns may evolve, but they do not explain the link between contemporary aspects of rapid social change and the conflicts and ambivalence that may arise from these changes. To examine these aspects in more detail, the following section of the chapter focuses upon the qualitative interviews of elderly parents (aged 75+) who are in need of care and support.

Sources of conflict and ambivalence

The qualitative phase of the OASIS project had two primary goals. Firstly, to illuminate in more depth and illustrate some of the issues raised in the survey instrument. For example, the experience and impact on day-to-day management of

challenges emerging from chronic illness builds on the data obtained from the 12 item SF36 (see Chapters number and number). Secondly, the qualitative phase aimed to uncover processes between parent-child dyads which were not directly addressed in the survey instrument but which remain connected to the overall OASIS model. For example, how normative expectations might influence notions of duty and responsibility amongst adult children; the ways in which family biography influences the management of change associated with the onset of disability; the process of negotiation in help seeking and establishing the balance between meeting care preferences and resorting to making use of what was available to meet care needs.

Historical ambivalences

Analysis of transcripts between dyads suggests that sources of ambivalence are reflected in the relationship in a number of ways. Firstly, ambivalences may manifest as a long-standing historical feature in the relationship between parent and adult child. Long-standing ambivalent feelings between parent and child are most likely to result in a 'distant' family image (see above) as any attempts to resolve these issues have been unsuccessful. Maria (Germany) for example, appears unable to integrate any positive qualities of the relationship with her daughter in the context of the predominantly negative image of the relationship she conveys now. She marks her daughter's marriage as the starting point of a negative development which implies difficulties within the context of changing mother-daughter ties. Helga is confronted with the ambivalence of feeling obliged to maintain contact with her mother even though this results in negative consequences for her.

Similar aspects of long-standing and unresolved ambivalences can be traced in other dyads who find it difficult to integrate positive or functional qualities or aspects of their relationship. Sisimo (Spain) for example, is critical of his daughters lifestyle and his associated assessment that she is unable to provide him with the help he may need:

'No, if I needed some help because of my health she won't give it to me, she won't give it to me, because she's a helpless person, useless, when you're young, if you're thin you bend down easily, she has woken up at 12.30 or 1 pm, then what kind of support she's going to give me, if I need a coffee and she won't give it to me? The only thing that can be good for me is that my wife lives because she's really good, having my wife, I have my things sorted out, if she dies today, I better die tomorrow, because my daughter's help is going to be like that…'

Maria and Sisimo's daughters discuss the impact of their parents disappointments in them. In this example, Mari-Mar says how she experiences her fathers contact with her:

'Don't do this, don't smoke, he's very active, and I'm not as active as he is and then he says to me, you're that fat because you don't move, you eat too much, and always, always, always nagging me so.'

They are confronted with associated ambivalence in terms of feeling obliged to maintain contact with their parents, despite the negative reactions and consequences that this implies. Long lasting features of the relationship seem to have gained a negative power over the years and both women have become increasingly entangled in the dilemma between filial obligation and the negative consequences of the relationship.

The failure of the dyad to accommodate to each others perspectives or to satisfactorily address the difficult feelings they have may lead to an experience akin to learned helplessness (Seligman, 1975). When people have experiences which show that whatever they do, positive change does not occur, their capacity to develop useful behaviour continues to reduce. Of course, long-standing ambivalences grounded in the biography of the dyad are likely to be overlaid and made more complex by ambivalences emerging from newly experienced problems or dilemma's caused by the changing health of the parent. A difficult and ambivalent relationship history is unlikely to contribute positively to successful attempts to resolve challenges that emerge from a parent developing chronic illness and associated disabilities. When dyads in this situation reach back into their biographies for successful or effective problem solving strategies, they have little in the way of positive outcomes to draw upon. The children in the study whose relationships were characterised by long-standing ambivalences and new problems to resolve responded by trying to achieve a balance between meeting their sense of obligation against maintaining emotional, practical and physical distance. In this example, Violet (England) expresses a desire to see more of her daughter. Janet on the one hand, acknowledges her obligations and tries to meet them and on the other, does what she can to limit contact with her mother:

'I knew we ought to go. My conscience made me go.'

(Interviewer): 'So you still feel you have a duty as a daughter to perhaps support in spite of...?'

'Oh definitely…..I left it to the last minute, to be honest, in the hope that she had alternative arrangements but she didn't.'

'I don't go as often as we should to be honest. I do come up with excuses. limited to school holidays etc, and then if I'm lucky I might get some adults that need escorting so that breaks into the school holidays. Generally I'm pretty well covered. I do try and get out of it as often as I possibly can.'

Janet's ambivalence is acutely focused on the issue of support for her mother and the possibility that her mother's health will deteriorate and more help will be required from her. Again, meeting her obligations against wishing to maintain distance and separation are the major issues Janet juggles with:

'I dread the possibility of her coming to live in this area. I will care for my mother within this area but hopefully I won't be asked to deal with it in my own house.'

(Interviewer): 'In the area?'

'I'm more than willing to do that but I don't want her living here.'

At present, Janet's ambivalent relationship with her mother is managed by her maintaining as much emotional, social and practical distance as she can from her mother. Her mother may ask for more contact and desire it, but ways are found by Janet (for example, work and family commitments) to avoid this until it is evident that her mother needs particular help, and then Janet's notions of filial obligation come to the fore. Long-standing ambivalence for Janet focuses on her mother's difficult social behaviour and critical approach to her family. For Violet however, the whole issue of any potential difficulties within her relationship with her daughter remains a silence. This represents a point of comparison between the other dyads discussed in that in these examples, ambivalences spilling into conflict were clearly expressed by both members of the dyad. In Janet's experience, she is very happy to discuss her relationship difficulties with anyone but her mother.

Problem centred issues

A second source of ambivalence focuses rather more on problem centred issues. That is, ambivalence may be created and experienced by individuals and manifest within a dyad as a result of some specific problem or issue; in this discussion, the onset of chronic illness and disability. At an individual level, older people in the study managed the dilemmas associated with increasing levels of disability by reorganising their usual range of roles and activities. A process of reorganisation may take the form of adapting existing activities to accommodate changed abilities; relinquishing activities or responsibilities or, even ignoring activities and roles. This process would often mean making decisions about those roles or activities that were most important to the individual's definition of autonomy and their aspirations about maintaining important life-style continuities. There are clearly complex contexts at play in terms of the strategies that an individual may adopt. For example:

- Biographical continuities that individuals wish to preserve or maintain in some form or other

- The potential individual resources that a person can bring to bear on managing the change
- The potential external resources that a person can utilise to manage change, for example, family support, formal help, alterations to the built environment
- Structural factors such as class, gender, age

For instance, Gunhild (Norway) relinquished many of her usual roles and activities as her mobility reduced but, she has been able to maintain important aspects of her life-style which represent important biographical continuities and appear fundamental to her notions of autonomy:

(Parent): 'I have to say that I only do five things.'

(Interviewer): 'Yes, that is?'

(Parent): 'I read. I have a fantastic offer from the library. It's called something like the book arrivesö. And I get twelve books a month. Fantastic. A unique service. I read and I drink and I smoke and I play cards and I do the crosswords.'

(Interviewer): 'Yes (laughing), so you're quite busy?'

(Parent): 'Oh yes.'

Her son acknowledges on the one hand, that his mother should continue with a lifestyle that provides enjoyment and continuity, but is on the other hand, concerned about the impact that it might have on her overall health:

'And she has become so incredibly thin, and she is also a very, she smokes a lot. Has lost her taste, doesn't eat much, got very thin. It is like..., if you have to ask me whether I worry about anything, then I have to say that I'm very worried about this. That it doesn't improve. It has been going down the slippery slope for three-four years. And it is getting worse...'

Parents reflected often on the number of ways in which they renegotiate their lives to manage the dilemmas that they may face as a result of changing health. For many participants, this involved altering the routines and roles of their daily lives often, substantially. At one level this may construct a picture of loss and potentially, disengagement. However, whilst this may create ambivalent feelings regarding the loss of continuity in daily lives, participants continued to demonstrate satisfaction with the roles and activities that were maintained. Christine (Germany) highlights the importance of continuing to maintain her independence in as many domestic roles and routines as possible. She has developed strategies for managing and makes limited use of home care services:

(Interviewer):' Mhm. Do you go shopping yourself?'

(Parent): 'Yes, I still do it myself, for the time being!'

(Interviewer): 'And how do you carry heavy things, like bottles or a bag of potatoes?'

(Parent): 'Yes, I've had a faithful servant till now, (laughs) the shopping trolley!'

Christine seems to be struggling with contemplating different future alternatives (family help versus nursing homes; autonomy versus dependency):

'I stay in my apartment. I am in my 80s and how long should I stay in my apartment? And then I say: "As long as I want to, I decide it myself…..So and (laughs) I am honest and sincere, as long as I manage it myself, I will do it myself.'

Whereas her daughter, Collette perceives ambivalence between a wish to help her mother and for her to receive more help and a wish to respect her mother's aspiration for autonomy:

'But then she has to, err, when I go there and see the dishes and see this and that, I get sick of it. SHE decides what the home help does because she thinks she can do the rest alone. I tell her quite often I have a home help, too, since I work full time again. She does the basics and I give her additional work now and then: 'It would be nice if you could clean the windows today', after three months or something. Or I didn't manage to do the ironing in this particular week. These are the things my mother believes to be able to do alone. Ironing, things like that.'

Moreover, she expresses considerable ambivalence about her role in both encouraging her mother to take help and the extent of her own obligation to provide it. Collette for example, sees her own employment of a cleaner as an essential and normal part of preserving her own autonomy as a full-time working woman whilst her mother perceives a similar service as loss of identity and autonomy. At the same time Collette struggles between her acknowledgement that she cannot and does not wish to provide complex care for mother set against an anxiety that she, as a daughter, demonstrates an appropriate level of support and concern.

'On the one hand, I don't want to make any mistakes, on the other hand I don't want to be told by outsiders afterwards, especially outsiders: 'You should have cared more!' outsiders, I don't mean her friends. But people, well actually I don't care what they say anyway. Honestly, neighbours or persons like that. They are not of interest to me. But still I do think about it.'

This is an area of some conflict between mother and daughter as they struggle to negotiate a path through Christine's determination for independence and her daughters wish for more support for her mother.

Management of change

Differences concerning the management of change and constructions of autonomy were apparent in the Spanish narratives. It was overwhelmingly adult children (predominantly daughters), usually in a co-residential setting, who provided support and care needs. Older participants generally viewed the support of their families as acceptable and, as a result, did not appear to experience the same struggle for autonomy as independence. Instead, autonomy is perhaps maintained through their ongoing role as the matriarch or patriarch of the family who is receiving appropriate care and attention from their adult children. Thus normative expectations focusing on filial obligation are maintained. In this context, there is a rich potential for long-standing biographical ambivalences to have a very significant impact both on the experience of co-residential care and, on the ability of the dyad to cope effectively with problem centred issues as they arise.

In this example from Spain, Carmen acknowledges that caring for a parent is a sacrifice but sees it as a clear duty or obligation grounded in filial responsibility:

(Interviewer): 'Do you think children should make sacrifices for their parents?'

(Child): 'Yes, well, I think so, it's clear that you cannot abandon her or leave to her own devices a person who is your father or your mother, that's the way I think, and you have to sacrifice, because, well, we're talking about those who are married, each of them have their own houses and their children and they have their obligations and it's clear, it's not like sometimes mothers take it and say, well, if they have to come and so... that's the way it is, it means a sacrifice because they have to leave their house, those who have to come, they have to leave her children and that means a sacrifice, of course.'

Once again however, it is in the context of more in-depth and unstructured discussion that ambivalences and conflicts emerge. Fabiana (Spain) lives with her daughter which she believes is an appropriate and preferable arrangement:

'I'd prefer my daughter had me at home and I only have a daughter in law, if my daughter in law was good to me and all that, but well, if she wanted to come, and my son, if something happened to me I know he would run to see me, because he's fond of me, now, he lives in Móstoles and see, he can't come every day, he calls me.'

This is echoed by her daughter who clearly identifies it as a filial obligation, reinforced by a history of care received by her mother:

'… I have no other choice (but) to care for her, she's taken care of me when I was a girl, she's cared about me and about my brother, now she has to be taken care of, I don't take her anywhere, while I can, she'll be with me.'

But neither Fabiana or Carmen's experiences are unambiguous. Fabiana has to negotiate her way through conflictual relationships between her and her son-in-law. Moreover, Fabiana is reluctant to spend time with her son who neither does, or is expected to, provide care for his mother. The constellation of ambivalences for Fabiana appear to rest on managing her difficult feelings about her son-in law whilst preserving a safe place for herself in his home and, in relation to her son, maintaining a positive relationship with him, whilst maintaining a suitable distance from him out of fear of the possible consequences:

'Because my son wants to take me to a nursing home and I don't want to, I don't want the nursing home, I don't…'

Carmen expresses considerable ambivalence as on the one hand, she perceives care of her mother as a duty but on the other, is resentful of the impact this has on her life and the additional stresses it engenders. She reflects on the difficulties of achieving her own independence by for example, working and is trapped inside a house where conflict is a feature of life. The gendered nature of this ambivalence is exacerbated by her brother's reluctance to involve himself in the care of his mother and marital tensions between her and her husband. There have been unresolved conflicts between the brother and sister about financial arrangements in favour of Carmen because she cares for her mother:

'…my brother doesn't stand my mother and well, I see myself alone to take care of her, I could be working and I'm not, I don't need it, but psychologically I do, go out, work, meet people, get out of here, because I say to myself many times, I'm here, I don't go out at all and this becomes a well without bottom, tensions with my husband, they argue, with my husband she doesn't keep quiet, well, she does many times, but she does argue with my husband sometimes.'

This example illustrates a potential long-standing biographical ambivalence as daughters are likely to be aware throughout the life course, that they will be expected or required to care for their parents almost regardless of their own aspirations, wishes and circumstances. However, the expectation that care will be provided by, predominantly daughters, are increasingly set against the belief that these expectations are changing. It was common in the narratives that parents perceived a 'lack of care' for older people by the 'younger generation'. In Spain particularly, adult children commented consistently on the notion that their own

children would not provide care for them when they aged and that alternative care arrangements would need to be developed:

'I think children will continue to care about their children, you have of all types, but as much as be responsible for their parents, take them to their house, no, I don't think so, but we are not going to allow it to happen.'

However, this was also set against the reality that care services were not perceived or experienced as readily available and, facilities such as nursing homes were consistently identified as an undesirable and unwanted option. This went so far in the Spanish narratives as constituting a form of abandonment and public evidence that children were not fulfilling their filial obligations.

Negotiating formal help

A key feature in the lives of participants was the need to have negotiated forms of help or assistance to meet needs they were no longer able or had difficulty fulfilling. Participants who had not yet needed to engage with this process discussed the potential need for this in the future. All participants, both parents and children, reflected on and often revealed significant uncertainty and worries about future care needs. Clearly, the provision of help is influenced by cultural norms concerning the acceptability of different types of help, together with the availability and range of help potentially available to older people.
Norway has a strong orientation towards formal services and participants clearly reflected an awareness that it was the state, rather than the family, that had an obligation to provide care for people who need it. This clearly influences perceptions of the acceptability of service based solutions and is in opposition for example, to the perceptions of participants in Spain, where formal help continues to be seen as largely unavailable or, unacceptable.

In Norway, participants were keen not to over-involve their children and focused rather more on children 'caring about' rather than 'caring for'. This does not of course, preclude the reality of children providing practical, emotional and social assistance and support. Solveig's response illustrates this point when discussing the issue of duty and obligation in relation to the vignette:

'No, that is not to expect when she has three children to take care of and a demanding job. Then she has MORE than enough. She can support her mother, of course, by visiting her. But no! This is something for the public services to take care of. Isn't that what most people think?'

Formal help in England is considered a possibility for people who have complex needs. Family help is considered an acceptable option but again, there is a concern to avoid over-involving families in personal and complex care. Ambivalences are

created around uncertainty as to whether formal help will be available to participants should they need it. Iris comments on her daughter's availability for practical help and social contact against the availability of public services:

'I would never let her give up her job. I will say that um it's a job for her to get time off but she does get time off when I've gone into hospital for an operation or for her dad or anything so we're lucky with that. But you hear how much the city is overspent and you do wonder whether the care will be there should you need it. Although I have been assessed by social services and they have said to get in touch if I need too.'

In Germany the situation was similar to that of England with a slightly stronger emphasis on family support. This perhaps reflects the legal obligation that children have to support their parents. Fritz comments on the role that his family play in supporting him but also emphasises that this should not be a duty necessarily and, that formal services should play a role for those persons in need:

'I have 5 children and also grandchildren and great grandchildren who come and support me even if they are not asked to. But we try to do everything we can for ourselves.'

'There is one provider of social services who I know pretty well and trust. I could imagine using them if necessary although I think my children might feel offended.'

In Israel, participants focused on the maintenance of self with associated ambivalence about the potential of making use of formal care and asking families for help beyond their (usually very high) level of contact and involvement:

'First of all, cleaning the home, there is a woman coming once a month. I do not want her more often, because I want to do things on my own.'

'The truth is, that they tell me all the time, that if I need a drive to any place, they have a car. The son, my grandson, has a drivers license and my granddaughter has a drivers license too. But my character is such, that I do not want to bother and I say - as long as there is public transportation, I do not ask for help.'

These generally boundaried expectations by parents and children of appropriate levels of involvement in care and support can constitute complexities in terms of how much help to ask for and also, how and when to involve formal services. In all countries, with the exception of Spain, support from children focused far more on practical help and social and emotional support. Participants spoke about regular forms of practical assistance, such as help with shopping and household chores. In this example, Kristin from Norway illustrates a picture of regular and sustained

help which appears to provide a genuine amelioration of some of the practical difficulties her mother experiences:

'I have every other Friday off and we spend some of my Fridays doing things she needs, like go to the bank etc. And I take her to the hairdresser because there are too many stairs for her to go there by herself. And I go shopping while I wait for her. And when she has to go to the doctor or dentist we take her. She is worried about taking a taxi in case it arrives late and so on. My brother takes her a lot of the times and she takes a taxi home. My husband can take her too.'

A picture emerges in the qualitative interviews of children generally providing regular and sustained, mostly practical support. This either provides sufficient help for their parents to continue to manage independently or, in some way complements or adds to the formal help and assistance their parents may receive. In all countries, there are generally low incidences of intimate and physical care being provided and the highest incidence appears in Spain, where care is more likely to be co-residential.

Children's attitudes to providing support to their parents is generally positive but there is too evidence of problem focused ambivalence as children (England, Germany, Norway) struggle at times to manage multiple demands on their time (for example, work, children, family life, personal life). Anthea (England) reflects feeling 'torn' by competing priorities and an awareness that her parents want to see her and spend time with her:

'They are not in a hurry anymore see and that's what I find difficult because I am always in a hurry to be places and they're not……But I think in reality, because they don't do it anymore they have lost sight of the fact that I still have got to do it. They say things like "You haven't got to go yet" when I have such a lot to do and it makes me feel very torn.'

Parents who received formal care services at home were generally aware of the real contribution it made to their ability to preserve their independence in their own homes. For all of the participants with the exception of Spain, remaining in one's home was a fundamental goal of parents. Ambivalences in this area of provision from both parent and children perspectives focused on:

- the amount of help a parent would accept against the amount of help children felt they needed (see above)
- the amount of help available against perceptions of the amount of help needed
- the quality of the care provided and it's ability to map onto the aspirations for maintaining autonomy or standards of living identified by parents and/or children

- expectations of formal services

Children, particularly in Norway expressed satisfaction that on the one hand, formal services provided care for their parents but on the other, frustration when home care assistance failed to provide care that they felt was needed or, that they thought had been agreed as a care plan. This frustration was exacerbated when they felt that they had to then fill the gaps left by home care services:

'They come here every week and there is not that much to do. The daughter, that is I, does all the grocery shopping so they don't have to do that. And I clean some of her clothes too. But I've told them many times to take a look at the kitchen sink because my mother spills coffee and all that. And they need to look over the dishes she has done. But they never do, they just leave it as it is. And then I have to do it when I come by because I'm not able to just leave it like that. I'm a home helper myself, but not in this area.'

A number of parents expressed ambivalence about the need for services and support in relation to their actual experience of it. For example, if services did not meet their standards or aspirations:

'You can get meals from the home services too. But I've tried once and I didn't like it. I've been used to make real dinners.'

'… there are so many different ones coming, but they're mostly boys. They are very clever. But you know, the home helpers today aren't like us old housewives. They don't look in the corners and behind the sofa, they don't even move this armchair if I don't ask them to do so. You know they're in a hurry. And they don't dust.'

Similarly, children were critical too of services which they perceived as inadequate for their parents needs. This exacerbated ambivalence in terms of negotiating a path between their own ideas of appropriate levels of involvement against perceived or actual gaps emerging in their parents' care. In these situations, children often mediated between their parents experience of services and the organisation providing those services. Anna reflects on this role:

'Well, for example, my father has huge, well he has colostomy, and up to one year ago he managed to changed those bandages etc. himself. There is this kind of ring that has to be kept clean and he is saying that he is managing himself, but he doesn't. Because it is not clean and it is not placed properly and then he has some accidents. And we wanted them to say that they would check every week or every second week, because these bags that have to be changed every day, he manages that himself. And we have made them help him with the cleaning, but I can't trust that they do it.'

A further complexity in this story, is that Anna's father believes that he can manage satisfactorily and so there is a difference of opinion between father and daughter about what should be done by formal services and the standard that should be achieved.

Future care also reflected as an issue of uncertainty, particularly for the respondents from England, Norway and Germany. In Spain and Israel, it was more likely to focus on family obligation. In the remaining countries, all participants identified a 'cut off' point in their quest for autonomy which would result in admission to some form of institutional care. For some participants, this was being actively considered as a more positive choice. For others, it was most definitely seen as the 'end of the road' or, the collapse of autonomy, with an accompanying hope that it would not happen:

'I dread going into an Old Folks Home, but maybe I will have to. I don't know. That's about all I can think of but I do hope I shall be one of these people who has a heart attack and wow, that would be it but I can't see that happening as there is nothing wrong with my heart.'

Children reflected similar notions; that a time would come when a residential admission would be inevitable or necessary. For some, as in this example from Norway, there at least appears to be a more pragmatic approach to future care:

'We have talked about it, if the day comes that he can't get out of bed himself and has to sit in a chair the whole day. The best thing in that case would be that he moves to a nursing home. He knows that. But I think he is better off living at home now, the way he is right now. Because he wouldn't have the same freedom in a nursing home, so I'm happy as long as he can stay at home.'

For other children, considerable ambivalence was reflected in potential future care needs. This was partly focused on the potential impact of realising a parent is moving towards the end of their life and partly, focused on concern about the availability and quality of residential care provision:

In this extract, Anthea (England) grapples with the range of possibilities. She considers having her father live with her, the worry of him being admitted to a nursing home and, the impact on her. This juggling of potential problems is set alongside her husband's mother being alive and also requiring possible care in the future:

'You know on the face of it, I have the right facilities. I have got a 5 bedroom house but my husband is looking to retire and we are thinking about coming down in size so that we don't have the upkeep of the place. His mother is still alive too and you just don't know… .and it's all according to what's wrong as to whether I could

manage. I couldn't do manoevering for example. If it was a case of being on hand that would be a different matter but I am not a nurse and if things needed nursing.'

'… It is something that I dread and I just hope that I can manage when the time comes.'

'But what would happen I just don't know. I dread to think really…'

'Um I really am of the opinion that people are sometimes better off in a home with people of their own age and interests providing they're not all sitting there gaga.'

This again reflects a strongly gendered orientation to informal care. Anthea sees this dilemma and possibility as entirely her concern and responsibility and is set against a range of other family responsibilities which she manages.

In conclusion, the qualitative narratives reflected considerable uncertainty about the provision of formal care. Formal care when it was provided was often highly appreciated and valued. It appeared to make the difference between managing independently and failing to manage. Uncertainty in interviews from Norway, England and Germany focused on the availability of care and especially, the availability of care in the future. Awareness of eligibility criteria and a tightening of both the amount and type of community care being provided exacerbated this in Norway and England particularly. The Spanish interviews reflected uncertainty too in terms of the ongoing expectation to provide family care for relatives set against the expectation that these values were changing. A tension existed between parents feeling that young people no longer cared for elders and adult children struggling to meet normative expectations often set against significant mixed feelings about doing so.

Conclusion

This chapter has focused on an investigation of how concepts of solidarity, conflict and ambivalence are experienced within the five study countries in the OASIS project. Specifically, it was hypothesised that different styles of parent-child relationships exist within and between countries, reflecting both the influence of individual agency and social structure.

Correspondence analysis of the ten questions relevant to inter-generational conflict, ambivalence and solidarity resulted in categorising parent-child relationships into four distinct styles. Harmonious relationship styles were categorised for example, by getting along extremely well but with an acceptance that conflict and ambivalent feelings could and did occur but without altering the essentially positive relationship experience. Distant family styles were conversely evidenced by emotional distancing, differences in view and the experience of conflict and

ambivalent feelings in a way which could or did have a deleterious effect on family relationships.

In the qualitative data, dyads who experienced their relationships as effective and essentially harmonious tended to identify ambivalence or conflict as a part of the process of their relationship. Transitions created by changes in parental health for example, brought about the possibility of negotiating or redefining roles and responsibilities without impinging on participants' views of the overall quality of the relationship. That is not to say that dyads would inevitably embark on a process of negotiation and management that unerringly resolved a transition to both parties satisfaction. But it did seem that both parents and children were more able to accept or live with the actions that their parent or child took in their efforts to manage a transition or event. The case study between Christine and Collette highlights this point. Collette experiences ambivalence between the wish to help her mother against the desire to respect her aspiration to maintain her independence and autonomy despite the significant challenges associated with that passage. Despite her wish to encourage her mother to accept more help, she is able to accommodate to her mothers strategies and actions.

Conversely, dyads who experienced their relationships as emotionally distant were very much more likely to identify long-standing and unresolved conflicts and ambivalences. Transitions created by for example, changing health in the parent served to reinforce relationship difficulties and sharpen ambivalence and conflictual experiences. This does not mean that individuals did not act with agency to attempt to resolve ambivalences. But there appeared to be a paradox in the case studies examined in that actions taken both managed the ambivalence (for example, maintaining emotional distance) and reinforced ambivalent feelings (for example, reinforcing the dichotomy between duty and a desire for emotional distance). The case study between Janet and Violet highlighted this process. Janet's ambivalence is centred on her sense of filial duty against a wish to keep her mother emotionally, physically and practically at arms length. Changes in Violet's health serve to reinforce and sharpen the dichotomy between Janet meeting her perception of her obligations and wishing to keep her mother separate. In these situations, the dyads appeared to have fewer positive or functional resources to draw on in the history of their relationship.

Interviews between dyads highlighted the complex contexts at play both in terms of dyadic interaction and in respect of the strategies that individuals adopt in their attempt to deal with transition and change. The importance of individual agency informed by individual and family biography was a key factor. Other issues such as the external resources that people can make use of to manage change was also pertinent. It was clear that there was often a strong relationship between biographical factors and the use of external resources. For example, the chapter has illustrated how some individuals prefer to forego the possibility of formal help

because it does not meet their need to preserve and maintain key biographical continuities. Of course, social and cultural norms will also influence the strategies that people adopt. The chapter has highlighted for example, the strong orientation towards filial obligation in Spain amongst parents who often perceive the use of formal services as a form of family abandonment. The paradox in this example, focuses on the fact that children increasingly perceive the current orientation towards family care as unworkable in the future against a powerful expectation that they themselves should provide care to their parents. This ambivalence is set against an awareness that formal service solutions in Spain remain sparse and relatively undeveloped.

Structural issues are also informative in terms of how families negotiate paradoxes and dilemmas. The chapter has illustrated for example, the impact of gender on perceptions and experiences of filial obligation. Spanish interviews for example, clearly highlighted the general expectation of parental care by a daughter who was often positioned in this role earlier in her life course by her physical proximity. Individual older people often exercised power by for example, taking decisions about what continuities, roles and responsibilities they wished to preserve when ill health threatened their ability to manage their usual range of activity. The issue power and inter-generational relationships in the context of ageing and disability is an area which deserves further exploration.

It is clear from analysis of the survey data that both intra and inter country differences in the style of parent-child relationships can be demonstrated. For example, participants from Israel have the highest incidence of harmonious relationships; Spanish and English countries have the highest incidence of steady family relationships. Ambivalence is most evident in the quantitative data from Germany, Spain and Norway. It is however, problematic to explain different family styles and the chapter has discussed the impact that historical trends prevalent in participating countries may have had on this issue.

A combined methodological approach has illuminated a number of features in relation to the experience of ambivalence and conflict in parent-child dyads. The definition of family relationship types has provided useful insights into the ways in which ambivalence and conflict feature in parent child relationships. Qualitative interviews highlight the importance of considering the dynamic of the origin of ambivalence. Dyadic interviews provided important insights into the ways different actors perceive and experience a change and transition. However, it would be of benefit to consider how inter-generational dyads operate within the whole context of family networks and roles (e.g. Connidis and McMullin, 2002) This chapter has highlighted the importance of individuals in an inter-generational context actively negotiating and renegotiating solutions or management strategies as a response to change and transition. Little support has been found for the notion of dyadic strategies to deal with ambivalence (Luescher, 2000). Whilst the dyad might

discuss the same experience of transition and change, they do so from their own individual contexts and in relation to their perception and experience of the other. Individual strategies rather than dyadic strategies were evident in processes of dealing with or resolving the transition. This leads to a further observation that resolution of ambivalences is possible, albeit temporarily. Rather than focusing attention on whether or not ambivalences are unsolvable it would appear to be more fruitful to attend to the ways in which ambivalences emerge in family relationships and the processes and strategies family members make use of to address these issues. This approach would appear to have potential in terms of considering implications for practice and policy in respect of inter-generational ties and family relationships.

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8

Family and Service Support

María Teresa Bazo and Iciar Ancizu

The provision of services to older people has become a major concern of governments all over the world. The growing numbers of old people living longer, particularly the rapid rise of the 'older-old', along with changes in working life, family structures and life-styles are currently posing new demands on families and on health and social care systems. These patterns are common in all advanced industrial societies and they have brought about different responses in terms of policy developments and service provision.

There is a general consensus about the need to make collective efforts to adapt the structure and management of services, as well as the benefits offered, to these changes. As outlined above, this new situation presents two key features. First, all countries are confronted with *demographic change*, in particular with a growing number of very old people in need of care. It is clear that changes in the demographic structure of a society create new social needs and lead to adjustments in social protection systems. There are, however, significant variations in the timing, impact and solutions to these changes between countries, and this can be clearly seen in the OASIS project. In general, such solutions seek a balance between assessed needs and available resources in a context of pessimistic economic and political projections and discourses about scarcity.

Secondly, *over the past few decades family life, and, in particular family arrangements have undergone significant changes*, which are closely connected to demographic transitions and increasing numbers of women in paid employment. Such changes form part of the gradual transformation of social expectations regarding old age and the family in different societies. The diversity of family forms, norms and behaviours has increased. This has lead to greater variation in family relationships. In fact, individuals are currently living in intergenerational families that are qualitative and quantitatively different from the past. Consequently, family and care policies need reforms that touch upon social dimensions connected to the care of older people, the conciliation between family and work responsibilities, and the development of services in response to a growing demand. In this context, long-term care emerges as the most important challenge facing governments, mainly due to new implications for families and services. In countries like Germany and Israel, long-term care insurance programmes have recently been established. Similar schemes have been studied in Spain and in Norway they are already in a comprehensive medical and social system. Finally, England has not opted for this solution to growing demands for long-term care. This demonstrates that despite historical differences in traditions, values and policy developments of care arrangements for older people, the challenges facing the

OASIS project countries have important structural similarities. However, the resources employed and the solutions implemented vary from one country to another, adding further to their differences. The aim of this chapter is to establish links between the different processes in the OASIS countries and to draw conclusions for policy and practice.

Within the present research framework as described in Chapter 1, family help and services are viewed as key elements that contribute to a good quality of life for older people by maintaining and increasing their autonomy and by delaying dependency. Family (informal) and service systems (formal) are the two main providers of care for older people. But their contribution varies between countries and there are different levels of complementation. In fact, at each level of analysis there are important country differences that influence caring situations.

Conceptualising service and family dimensions

Modernisation brings changes to the family roles characteristic of pre-industrial societies. Perhaps the most significant change in family life since the beginning of industrialisation is the emergence of the 'housewife' role versus the 'breadwinner' role. Family relations were transformed by different social and economic factors and this led to gender divisions in household responsibilities. With industrialisation, men/husbands have the fundamental responsibility of providing income whereas women/wives are responsible for care and services. These changes in the division of household work stem from other social changes occurring at a particular historical moment. But they are viewed as something natural more than socially imposed.

Today, the trend towards women's paid employment in general, and of married women in particular, is increasing. Despite their considerable participation in providing family income, women have to make this role compatible with their responsibilities as a spouse/housewife, mother and daughter. This situation provokes conflicts between the domestic and paid work spheres of labour. It is a phenomena that occurs even where women are concentrated in certain 'feminine' types of paid employment. But these so-called 'feminine' jobs do not have the qualities that women need: flexible hours and working facilities (Glass and Camarigg 1992).

In the last few decades, important changes affecting the family and the labour market have occurred. The increasing involvement of women in the labour market has severed the duality of gender roles that characterised industrial society. States have developed policies where the family is perceived as either traditional or modern. These differences are evident in the OASIS project countries. Norway and Spain represent these two models, as can be seen by their different service structure

for children, disabled persons and frail older people. In Spain, a transition process is taking place towards a model where family responsibilities, both financial and caring, are shared by both partners. However, men have not got involved in caring as much as women have got involved in financial provision. It is recognised that in the European Union women try to balance work and family life through part-time work and other atypical forms of employment (Drew et al. 1998). In particular, when faced with the care of an older relative, it is women who stop working. They do so not only because of ideological factors, such as feelings of obligation, but also because of structural factors, since their paid work is poorly remunerated. Both ideological and structural factors are closely connected and reinforce each other, and this has an important impact on individuals.

Caring is a socially constructed concept. It is socially accepted that caring tasks are women's work due to their supposed natural instinct for this type of work. Furthermore, caring is not perceived as skilled work. From a sociological perspective, caring is an activity built up by social patterns. These patterns affect both family care and paid care and justify low wages for workers who are mainly women. Women are then seen to take on care work not only because of socialisation processes and social expectations, but because of '*their restricted opportunities in better paying, more prestigious and more powerful "men's jobs"… the same beliefs and practices that make caregiving appealing to women also devaluate it as paid work'* (Cancian and Oliker 2000 89). The consequences of these beliefs are the overburdening of women because of the different demands of work and family, the devaluation of caring activities, and lack of policies to support carers. Moreover, the devaluation of caring is considered to be '*linked to the devaluation of women'* (Cancian and Oliker 2000 10).

Currently, the discourse about the future of social protection in relation to social services is, acquiring a conservative overtone. It is said that older men and women wish to remain in their family and social environments, even when health problems lead to dependency. But this mostly means keeping younger generations of women at home and in some cases encouraged by social policies.

Social policy can be defined as '*the actions and positions taken by the state as the overriding authoritative collective entity in society*' (Hill and Bramley 1986 2-3). These authors take the definition of public policy offered by Jenkins as '*a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specified situation where these decisions should, in principle, be within the power of these actors to achieve*'. This definition is useful because it emphasises some crucial features of public policy such as decision-making, the political actors who make them, policy direction as both means and ends, the authority of the state, and the feasibility of the eventual policy measures.

There are some criteria that distinguish social policy. Consensus exists that a series of policies are necessary in different areas: social security, health services and welfare or personal social services, although this traditional schema impedes the development of other aspects of policy. In relation to social services, the public provision of care interacts with private (commercial) activities as well as with the family provision of care. There is currently a trend to perceive formal help as *additional* to help provided by informal services such as family, friends or neighbours. Chronically ill and disabled people as well as frail elderly persons, are usually cared for at home by relatives, mostly women. This situation clearly shows the relationship between the state and the family, and the 'anxious call' for family and friends as carers (Abel 1989). The boundaries between formal and informal care are inflexible (Hill and Bramley 1992 122). There is not enough support for carers and it is possible that people in real need of care do not receive it and some carers overburdened by the responsibilities of caring.

Today, there is no longer the expectation that public care should supplant private care or vice versa, and commercial services are increasingly developing. In the OASIS project, different trends have been observed in the five countries. But a mixed economy of welfare seems to exist more or less in each of them, probably as a result of similar cultural and socio-economic changes.

In this diverse context, the unifying principle to analyse different social protection measures for older people is *the response to dependency situations*. Since the beginning of the 90s, dependency has been conceptualised as a 'new social risk' (Guillemard 1992). Current theoretical, political and applied developments have evolved in this direction, considering dependency as the most important challenge for social policy in the next decades (Rodríguez Cabrero 1999). In the Oasis project, dependency is not explicitly conceptualised as a dependent variable, since the research is concerned with how autonomy and competence are promoted in old age by both families and services. Consequently, dependency is not of interest *per se*, but in how it relates dynamically with autonomy. The focus is then on the onset of dependency, and particularly, on the 'risk of becoming dependent', which is defined in functional terms. Thus the dimensional range of dependency is restricted and other dimensions such as the psychological, social and economic are omitted. By adopting this approach, the objective is to concentrate on how families and services respond to the risk of becoming functionally dependent and, more specifically, on the interconnection between these macro-structural factors, such as the service organisation of a country, and the micro factors, such as family culture and individual expectations of care. The aim is to answer the following research question: how do family norms and practices (family culture) influence the service system, and vice-versa, how are they influenced by different welfare regimes?

The initial macro and micro conditions as well as the social-policy measures implemented in the OASIS countries are in a sense unique. They reflect cultural

and normative traditions, and they are grounded in different concepts and organisation of social protection and welfare. There is evidence that different traditions lead to different *care models*. From a conceptual perspective, the different care models can be understood as variable combinations of the role given to the family - the state and the market in each country (Casado Marín and López i Casasnovas 2001 75). The concept of a care model has been traditionally applied to long-term care in an attempt to understand, and in the long run assess, the role played by the different sectors in long-term care strategies for older people. The increasing importance of the voluntary sector as a care provider makes it necessary to incorporate this sector in the model, so as to offer a comprehensive analytic tool. However, the relevance of the voluntary sector differs between the OASIS countries, with Germany and England having a rather stronger voluntary sector promoted by policies of subsidies and government support.

In the last few decades, a *social economy of mixed care* has been promoted, characterised by the reinforcement of the social side of the economy and a greater emphasis on more complex organisation of care provision. The potential benefits of this new orientation lies in the acknowledgment of new demands and needs in the field of care and support to older people, not only at the service level, but also at the family level. Therefore, innovative measures are being taken to develop social protection systems. But there are also important difficulties. Resources are scarce and fragmented, the functions and limits of responsibility between agents are not clear and this causes problems of co-ordination. These problems are a key challenge to be dealt with by organisations the provide care to older people (whether private, public or voluntary).

Current care models

The Oasis project recognises the crucial role played by services and family transfers in the well-being of older people and their carers. The caring dimension is central to the Oasis project. Services and family support are conceptualised as intervening variables in the model, and in practical terms they are considered as instruments or means to maintain autonomy and delay dependency. Consequently, family help and service support have positive connotations since they are aimed at fulfilling older people’s interests and needs. But they may be also a source of tension and conflict, becoming a disservice with negative consequences for the well-being of older people and their families.

In order to explore the care model structure in each of the Oasis countries, data on service use and family help are presented. The Oasis questionnaire has a section on Help and Services provided by different sources (Family, Services and Others) in three different tasks (household chores, transport and shopping and personal care). These three tasks are combined into several indicators that summarise the

information obtained. The indicators produced are designed for a comparison among the OASIS countries.

Table 1 shows figures for the use of home help and home nurse services. These services are used most frequently in Israel, followed by Norway. In Spain and Germany they are used less frequently, with England holding an intermediate position. The use of one or these two services alone is more common than the use of both, although in Israel the difference between the proportion of people who use both services and only one is small. Women tend to use these services more than men, although differences are not important. The largest gender difference is found in Norway (13%).

Table 1. Use of home help and home nurse among (75+) (%)

	Norway			**England**			**Germany**			**Spain**			**Israel**		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
None	76	57	65	79	69	72	94	88	89	92	89	90	62	56	58
One	17	30	24	17	23	21	4	7	7	8	10	9	20	24	23
Both	7	13	11	4	8	7	2	5	4	0	1	1	18	20	19
n	*167*	*246*	*413*	*126*	*272*	*398*	*151*	*339*	*499*	*133*	*252*	*385*	*169*	*200*	*369*

Note. M=Men, W=Women, T=Total.

As shown in Table 2, the use of home help, home nurse and transport services is higher in Israel, followed by Norway. Again it is in Spain and Germany where these services are used the least, with England in an intermediate position. Most older people use only one service, although 16% of Israelis and 15% of Norwegians use both services. Finally, although the proportion does not reach 10%, some people use three services (Israelis 8% and Norwegians 6%). Women use these services slightly more than men (except in Norway), and they are also more inclined than men to use two services at the same time.

Table 2. Use of home help, home nurse and transport/shopping (75+) (%)

	Norway			**England**			**Germany**			**Spain**			**Israel**		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
None	70	50	58	76	63	67	92	84	86	92	86	88	55	50	52
One	21	21	21	20	22	21	3	7	6	7	11	10	22	26	24
Two	5	21	15	2	13	9	3	6	6	1	2	1	13	18	16
Three	4	8	6	2	2	2	2	3	2	0	1	1	10	6	8
n	*167*	*246*	*413*	*126*	*272*	*398*	*151*	*339*	*499*	*133*	*252*	*385*	*169*	*200*	*369*

Note. M=Men, W=Women, T=Total.

Considering the total help received from any source for household chores, transport and shopping, and personal care, the majority of older people receive help for household chores. Help with personal care is the least common. As shown in Table

3, the proportions of persons who receive help in these activities are higher than in previous cases. In the all countries, elders receive this type of support in, at least, half of the sample interviewed. The country profile remains the same as in Tables 1 and 2. A higher proportion of women receive support than men.

Table 3. TOTAL help received for household chores, transport and shopping and personal care (75+) (%)

	Norway			**England**			**Germany**			**Spain**			**Israel**		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
None	54	37	44	57	40	45	56	46	49	39	45	50	38	28	33
One	26	24	25	17	17	17	13	14	13	24	24	24	28	27	28
Two	14	28	22	14	29	25	22	23	22	11	21	17	19	25	22
Three	6	11	9	12	14	13	9	17	15	6	10	9	15	19	17
n	*167*	*246*	*413*	*126*	*272*	*398*	*151*	*339*	*499*	*133*	*252*	*385*	*169*	*200*	*369*

Note. M=Men, W=Women, T=Total.

Table 4 shows that help received from family for household chores, transport and shopping and personal care is less in Israel, followed by Norway, than Germany, Spain and England. The proportion of older people who receive only one type of help is higher than those who receive two or three types. Women are more likely to get support from family than men, particularly in England. However, in Germany, women do not receive as much help from family as men (when considering only one type of help). In Norway, Spain and England, women receive even more help than men when they get two different types of help at the same time.

Table 4. Help received from FAMILY for household chores, transport and shopping, and personal care*(75+) (%)*

	Norway			**England**			**Germany**			**Spain**			**Israel**		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
None	77	66	71	69	57	61	65	66	66	70	59	62	79	72	75
One	19	21	20	12	20	18	13	9	10	17	21	20	14	19	16
Two	3	11	8	12	18	16	15	17	16	7	13	11	5	6	5
Three	1	1	1	7	5	6	7	8	7	6	7	7	2	3	3
n	*167*	*246*	*413*	*126*	*272*	*398*	*151*	*339*	*499*	*133*	*252*	*385*	*169*	*200*	*369*

Note. M=Men, W=Women, T=Total

Table 5 shows figures for help received on these activities from services. Spanish elderly receive the least amount of help, followed by Germans. Norwegians get the highest amount of help, followed by Israelis, with the English in an intermediate position. In the three countries where services are used the most by elders, support received for one task is higher than support for two or three tasks. Women tend to receive more help than men, although in Israel support received is somewhat less when for two tasks at the same time.

Table 5. Help received from SERVICES for household chores, transport and shopping, and personal care (75+) (%)

	Norway			England			Germany			Spain			Israel		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
None	68	51	58	82	72	75	92	81	84	95	91	93	70	65	67
One	22	29	26	15	17	16	1	6	4	4	4	4	15	17	16
Two	5	13	10	2	7	5	4	5	5	1	4	4	8	5	6
Three	5	7	6	2	5	4	3	7	7	0	1	1	6	12	9
n	*167*	*246*	*413*	*126*	*272*	*398*	*151*	*339*	*499*	*133*	*252*	*385*	*169*	*200*	*369*

Note. M=Men, W=Women, T=Total

Help from *public services* (Table 6) for household chores, transport and shopping, and personal care is higher in Norway than in the other countries (36%) followed by Israel (20%) and England (17%). Less than 10% of Germans and Spanish elders get support from public services (7% and 6% respectively). In the three countries where the amount of help received from public services is larger, the proportion of elders getting support on one task only is higher than the proportion of persons receiving help on two or three. The differences in favour of women are small, but in Israel men get more help.

Table 6. Help from PUBLIC SERVICES for household chores, transport and shopping, and personal care (75+) (%)

	Norway			England			Germany			Spain			Israel		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
None	72	58	64	89	80	83	97	92	93	96	92	94	80	80	80
One	19	22	21	9	11	11	0	2	1	3	4	4	9	7	8
Two	5	14	10	2	5	4	1	2	2	1	3	2	6	5	5
Three	4	5	5	1	4	3	1	4	3	0	1	1	4	8	6
n	*167*	*246*	*413*	*126*	*272*	*398*	*151*	*339*	*499*	*133*	*252*	*385*	*169*	*200*	*369*

Note. M=Men, W=Women, T=Total

Looking at voluntary services, the proportion of elders who receive help for household chores, transport and shopping, and personal care is very low (only the percentages in Germany and England have any relevance (6% and 4% respectively). However, the general trends in the use of commercial services suggest an increase in the near future. The proportions by country range from 9% in Norway –a country with a wide network of public services- to 29% in Israel (where public services are very extended), and from 12% in Spain and Germany to 13 % in England. The fact that the two countries that enjoy the highest amount of public services utilise, in Israel above all, private services may be revealing a failure to meet needs or showing that those who can afford it, complement or substitute public services by private ones due to their inefficiencies. The fact that the proportion of private services in Spain is the same as in Germany and England,

both which benefit from more social services provisions, may be an indicator of the important changes occurring in Spain, such as the population ageing, the gradual transformation of the occupational status of women, and higher incomes for pensioners and their families.

The data explored above can be used to make a typology of the importance that each components of the care model has in the provision of care and support to older people (Figure 1). The value of this typology is that it provides a basis to identify the care structure of each country. Only in Norway do public services appear as the main providers of help, with the family ranking second. This reflects the policy of public social investment developed in the last few decades. The private and voluntary sectors play only a minor role in the support of elders aged 75 and over living in urban areas. In England, the family is the main provider of care, whereas the public and private sectors share the care provision in similar proportions. This is mostly a result of community care policies and the creation of a private internal market with evident consequences on care funding and provision. Looking at the situation in Germany, Spain and Israel, it is notable that they have the same structure. The combination of family and service provision varies among countries. Israel appears as a clear example of a mixed economy of care where all the agencies involved have a rather equal weight as far as the care of older people is concerned. The potential benefit of this 'balanced' distribution is that there are more alternatives to choose from and that, in fact, people take them. But there are also problems, common to all systems, such as lack of co-ordination and funding, and a failure to respond to the demands of elders and carers. Such a balanced distribution is a result of new initiatives and efforts made through partnerships between private and public agencies. The aim of offering services and improving them to meet the needs of elders lies behind the reforms undertaken in the 90s. In Germany, the family is still the main provider of help to older people, but services run by private insurance systems and companies are also rather relevant and hold a second position. Finally, the Spanish caring context is dominated by the family. The relevance of other sectors is rather insignificant, although increasing steadily over the years. Attempts to develop services and create wider networks to make services accessible to older citizens have increased in the last decade, but regional differences are sometimes large due to decentralisation policies, and services are still not regarded as trustworthy and desirable either to replace or supplement the family.

Figure 1. Use of services: comparative typology

Norway	England	Germany	Spain	Israel
Public services	Family	Family	Family	Family
Family	Public services	Private services	Private services	Private services
Private services	Private services	Public services	Public services	Public services
Voluntary services	Voluntary services	Voluntary services	Voluntary services	Voluntary services

The cross-national analysis carried out highlights the differences among countries on the basis of their macro characteristics. But it is difficult to asses the quality of the models or their impact on the well-being of elders and their families with this type of data. However, the qualitative analysis it is possible to investigate the influence of certain services and family dimensions on autonomy and well-being. The aim is to provide general country patterns illustrative of how individual interactions may have an impact on the structural level.

In all countries (except Israel) the proportion of 75 and older who do not get support on household chores is higher than those who receive it. The highest proportion of those not receiving any support in observed in Spain (61%) and the lowest in Israel (37%). Also in all countries (although with certain percentage differences) women receive more help than men. Examining help for transport and shopping, the numbers of elders not receiving help is higher than the those receiving it, being the amount of support higher among women than men. The proportion of elders who receive help with personal care is small in all countries. A large majority of elderly people do not get this type of help, with proportions ranging from 80% in Israel to 88% in Norway, and men appearing somewhat more independent than women.

Daughters are the main helpers with household chores. Among elders who get family support for these tasks, 69% in Spain are helped by a daughter and 38% in Germany and Norway, with the other countries holding intermediate positions. Higher proportions of women get help from daughters than men, and the largest gender difference is in Germany 24% of men compared to 46% of women. The exception is Norway, where the proportion for men and women receiving help from daughters is quite similar (41 % and 37 %). The proportion of people receiving help from a son is similar to the proportion of persons who report receiving help from a spouse or partner. But there are gender differences. Among older people who receive help from their spouse, there are disproportionately more men than women. This is due to men’s shorter life expectancy. However, it is

mostly women who receive help from a son than men, except in Israel where the proportion of men (39%) is twice that of women (17%).

Exploring help with transport and shopping from a spouse or partner, the proportions are lower than those of help provided by daughters and generally somewhat smaller that support given by sons. However, men also get more help from their spouses than women.

These support exchanges can also be examined in the data from the perspective of children who help their parents (as opposed to older respondents who answered questions about the support they received). The occupational status of children who having parents alive and who help them on with the three tasks discussed above has been analysed by gender. As observed in Table 7, among those adult children with parents in the sample, a large majority (between 75% and 83%) do *not* help their parents with household chores. Among those adult children who do help, most of them are daughters (ranging from 67% in Norway to 77% in Germany). These women are mainly employed (ranging from 50% in Spain to 70% in Norway). Sons who help their parents are also mostly employed, but at generally higher rates than daughters. Among daughters, between 6% and 21% declare themselves to be 'housewives'. It is also noticeable that daughters help their parents with household chores more than men, even when they have paid employment.

Table 7. Proportion of children who help their parents with household chores by gender and occupational situation (%)

	Norway	**England**	**Germany**	**Spain**	**Israel**
Do not help	57	64	72	67	68
Help	43	36	28	33	32
Men	51	36	40	44	39
Women	49	64	60	56	61
Employed men	84	66	72	66	78
Employed women	76	65	62	48	76
Housewives	4	21	22	22	8
Total	*543*	*468*	*367*	*551*	*409*

As far as helping parents with transport and shopping is concerned, Table 8 shows that approximately two thirds of children in Norway and three quarters in Germany do *not* help their parents. Among adult children who do help their parents with these tasks, gender proportions are similar only in Norway. In the other countries, a higher proportion of daughters help out than sons, with the largest difference in England (28 percentage points). Family helpers with transport and shopping are generally in paid employment rather than in other situations. They are also mainly sons, with gender differences ranging from 18 percentage points in Spain to 10 percentage points in Germany. The proportions of housewives among daughters providing help are low in Norway and Israel, achieving two fifths in the other three

countries. In this type of help -with the exception of Norway and with smaller differences than in help received with household chores- it is also women who help with transport and shopping more than men. This finding corroborate the analysis carried out above which showed that daughters are more involved in helping and supporting their elderly parents than men.

Table 8. Proportion of children who help their parents with transport and shopping by gender and occupational situation (%)

	Norway	England	Germany	Spain	Israel
Do not help	76	75	83	75	77
Help	34	25	17	25	23
Men	33	32	23	32	26
Women	67	68	77	68	74
Employed men	79	61	69	61	67
Employed women	70	50	66	50	65
Housewives	6	21	21	21	20
Total	*543*	*468*	*367*	*551*	*409*

As already noted, few elderly respondents received help with personal care, and only a small proportion received this type of help from their relatives. Certain patterns observed previously are repeated, such as the predominance of women in caring tasks. However, gender differences in paid employment of these carers, although small in Norway, differ between countries. The number of sons providing personal care and who are larger than daughters in Israel, and in Spain employed sons who are carers are twice the proportion of daughters. There are higher proportions of daughters who are carers in paid work than sons who are carers in England. The same pattern, although with smaller differences is found in Germany. The proportions of retired persons and housewives are generally high for this type of help. Nevertheless, it is necessary to be cautious when drawing any conclusions from this data because numbers are small.

From the above analysis of the three types of help provided by sons and daughters to their parents, several remarks can be made. First, the great majority of elderly persons do not receive help from family, mainly due to the fact that they do not need it. On the other hand, help with household chores is still a matter for women in all countries, although these gender difference narrow a little in Norway and Spain. Despite different modernisation rates for the five countries in diverse material and non-material aspects, there is a common cultural element that can be seen in the distribution of family roles, and which shows the continuity of a traditional model in modern societies.

This traditional model is clearly demonstrated in the OASIS data. Adult children who provide help are mostly employed, and sons who are carers are more frequently in paid employment than daughters who are carers. But the majority of

daughters undertaking caring tasks are employed. This finding demonstrates women's special commitment to household work and family care, which continues even when they are in paid employment. And one can presume that these dual work loads of women in economically developed societies are due to the continuity of their traditional role as family care-givers. It is therefore necessary to make important efforts in public policies to promote greater equality among men and women.

Interaction dynamics in caring relationships

The qualitative interviews reveal different dynamics in the organisation of care between the five OASIS countries. This is crucial for understanding how family norms and practices affect service systems and vice-versa, how care structures affect family care. The qualitative analyses reveal four key categories concerning services that may uncover connections between the country care model at a structural level and how different models are experienced by individuals. These are *knowledge, image, availability, and use of services.* Each category has different dimensions that can be seen in different types of interactions with services and the expectations families have of them. These categories also allow a typology of service interaction to be elaborated. Only services seem to be relevant here, since it is obvious that elders are aware of their family resources and networks. The following case examples illustrates these differences, but as it will be shown later, they also demonstrate that older people's interactions with services at a micro level have common features despite stemming from distinct care models.

Norwegian case example

Reidun is a widow who lives on her own, in the same house as her daughter, but not in the same household. She lives on the ground flour and her daughter's family on the first and the top floor. She has been getting home help since her husband died six years ago and has a very positive image about services. But she also has clear demands concerning the services she receives every second week. She decides together with the home helper what needs to be done and organises things accordingly. But she is also aware of the limitations:

I: I understand. Can you decide what the home-helper should do?
R: We decide together. She vacuums and takes the bathroom… I would have liked her to do other things do but you can't expect that.
I: What things?
R: Like clean the windows, and do some heavy cleaning.

A clear characteristic of this type of interaction is that services should not be seen as something distant but as accessible if needed. This leads to expectations that go beyond the purely instrumental side of support and acquire an emotional

dimension. Not only *what* is done, and *how* it is done are important, but also *who* does it. Thus, demands become more personal and not so task-related:

I: I'm thinking about the home services, would you call them, or the home nurse?
R: I might, it depends on whether or not my children are home, or what it is. But I don't think it is difficult to call the home-helpers because they are really nice and willing to help. It is good as long one does not need more help, because they think that I have a lot to do.
I: The home-helpers think so?
R: Yes. I think so. I think it is wonderful that I try to manage myself for as long as possible. Of course it is nice if someone comes and talks a little. That's nice.
I: But do you feel that the home-helper has time to talk?
R: We do talk a little, we have to (laughs). But the one who comes now is so busy, she hardly ever has time for a cup of coffee. I used to have one, the first one I got, you see I used to have the same one until last year. And she always had time.

The fact that services are available and are being used does not mean that Reidun does not get support from her family. On the contrary, she has a close relationship with them, but she makes every effort not to be a burden. In fact, a relevant finding emerging from the narratives is the high levels of *empathy* parents show towards their children. They are totally understanding of their children's situation, knowing they are busy and that they have their own families. This is clearly illustrated in Rediun's words:

I: So you don't think Kari [woman in the vignette] has a duty to help her mother?
R: No, I don't think so. I don't even think you can demand it…. I'm sure that they would, both my son and my daughter, that they would help me, but...
I: But what do you feel about that? If you were to receive a lot of help from them?
I: I doubt that I would like it.
I: No?
R: No, I wouldn't.
I: Why wouldn't you like it?
R: No, because they shouldn't have to struggle with me
I: But maybe they're thinking that you've helped them so much?
R: That might be, but they're so busy, they're busy all the time you know... But my son- and daughter-in-law are very nice too. So it is not difficult to ask them neither. I am very lucky. I am.

As seen above, Rediun has a strong sense of autonomy and does not expect her family to provide constant care, but mainly to be around for a talk and to keep her company. Maintaining her independence is a struggle she regards as positive not only for her, but for her whole family. Because of these feelings, her relatives help her out of love and choice and not because they feel they have an obligation or a duty towards her:

I: And you try to manage on your own as much as possible?
R: Yes, I do, that is better. And nicest when they come to me to sit down and talk.
I: So you see your grandchild every day and your daughter, do you talk with her every day too?
R: Oh yes, if she's not away travelling. And I talk with my son on the phone almost every day. So that is good.

This pattern observed in the Norwegian narratives appears to be related to country values and norms. The importance of family and services as mediating factors and as a way of maintaining autonomy is confirmed here. Norwegian elders' experience with services appears as self-assuring and positive. This does not mean that there are not tensions and conflicts over formal care arrangements. Nevertheless, the relevant finding to highlight here is that the more interaction with services, the more expectations are placed on them, and the more effort has to be made by welfare agencies to meet older people's needs and aspirations.

In Norway, the interactions older people have with services can be defined as *familiar*. They are characterised by a wide knowledge of the types of services available, a positive image of these services, an easy access to them and a high use. Thus, Norwegian elders have a close and familiar experience with services. They know which services exist, and these services are promoted mostly through the public sector. The private and voluntary sectors play a much less important role. Most Norwegians expect and want public services to be provided to older people who need them. As found in the narratives, older people interact with services, arrange their own care and do not expect their children help them, except when they are very ill or disabled. Services are considered as an asset, a way of maintaining autonomy, something that can be depended upon. There is, one can say, a *special relationship* between the old person and service provides. Services are *familiar* to older Norwegian people and their families. People have strong views about services, praising and criticising whilst at the same time having clear expectations. Norwegian older people also know exactly what to expect from their families. Public services are preferred because they respond best to the needs of older people and their families.

Israeli case example

Mrs. H. is a widow and lives close to her daughter. She considers herself as a hard working and very independent person. It is very important for Mrs H. to maintain her independence. Despite her difficulties, she tries hard to keep active (she goes to the local pensioner's club) and not to depend on her daughter and son-in-law for help. She has privately paid home help once a month. Mrs. H is a good example of the pattern in Israel, where older people prefer to remain in their own homes for as

long as possible, to buy the care they need in the private sector, and not to expect their children to provide any physical support. As Mrs. H. sees it:

R: It's the same, yes. No, in my opinion, I want to feel her [daughter's] warmth, but to receive physical help from her? I think different… I, I do have a plan, I… to be modest.
I: Modest.
R: It's always enough for me, my pension and I even make gifts, some savings to have the possibility to buy some help, and I helped my neighbours a lot when they have been ill and I think they would help me if I was in need.

The important role of children in providing emotional support is once more evident Mrs. H. expects little practical help from her family, because it is emotional support she needs most. Her daughter offers help and she is there if needed. But Mrs. H. does not want to be burden on her daughter and therefore she does not ask for help. The family plays a very important role in this cultural context. This role is not so instrumental, but more affective and supervisory. It is enough for Mrs. H to know that the family is around and cares for her:

I: Fine, ok, that means that there is almost not help at all.
R: If you do know, that there is help, that if you do not feel well, you do know that there is someone who can help, that helps.
I: Psychologically.
R: Yes, psychologically.
I: Fine, that means you say that knowing that you have somebody.
R: that there is somebody, yes.
I: That already is a kind of help.
R: Yes, yes.
I: That means, we would call this emotional support, right?
R: Yes, yes.

As seen above, in Israel, there seems to be strong family ties, a strong network of confidence, and feelings of trust that in times of need adult children will be there to provide support. Filial norms are important in people's lives and religiosity plays a significant role. But as found also in the quantitative data, the Israeli definition of filial norms seems is similar to the Norwegians. Children are not expected to provide round-the-clock care but to supervise and to make sure parents have what they need. This view emerges from the narratives and it is reinforced by the availability of services and the possibilities they offer to maintain independence.

As shown in the quantitative findings, services and families are the main providers of help and support to older people in Norway, but also in Israel. There are, however, two structurally distinct elements in the Israeli context. These are

stronger feelings of religiosity and children's feelings of obligation to help their parents financially when they are old. In Israel, the relationship between families and services seems to be more influenced by the adult children of elderly parents. As observed in quantitative data, Israeli family, public and private services share the care and support of older people. This is reflected in their interaction. People generally know about the services that exist and they have a positive image of community services. The use of services is rather high and, due to the policies implemented in the last decade (for example, the introduction of Long-term care insurance), services are readily available. There is a pattern of greater involvement by services and greater efforts on their part to offer formal support. This leads to older people accepting community and private support as a solution to maintaining their independence.

English case example

Molly is married and has always had problems with her legs. After her husband retired six years ago, they moved to a flat adapted for disabled people in another part of the city. Molly is a very independent person:

I: Why is the support important to you that Susan [daughter] gives you?
R: Well, it isn't really cause I've always been very independent even though I've been, I suppose you'd say I was disabled all my life. But I've always been very independent, I'm only glad that Susan is near because she needs somebody near her too, do you know what I mean?

As Molly points out, she is not a passive receiver of care. She also provides different types of material and non material support (emotional in particular) to her daughter and her son's families. In every interview, intergenerational relations are reciprocal. Molly has been getting home care for some years and values this support. Despite the fact that her husband and her daughter could help her, she has chosen to accept services because they allow her to maintain her independence and continue with her personal routines. Her relationship with service providers is expressed as something normal and acceptable. She makes the arrangements and decides on the type of service. She found out about services not through her children, but through other formal institutions, like the hospital. Her children act as supporting elements, supervising the whole process. But it is Molly who decides and manages the carers' work.

I: Do you have any formal support, any support from social services?
R: Oh yes, I have carers in twice a week to help me shower because three years, nearly four years ago, I had a mastectomy. I didn't think I needed them, mind you I was stronger on my legs then and it was the hospital arranged it when I came home I had these carers to help me shower. I was glad of them at the time. Then gradually my legs got worse so I was, I kept them on but just two days a week and I

got the allowance for that. They still come in and I mean I know Susan could help me but rather late at night or first thing in the morning and it'd be an awful rush. Peter at a pinch I suppose, he could help me, anyway I've got used to the carers.
I: Are they the same people all the time?
R: They are now, at the beginning no, because I had two come you see because I was kind of weak and that. They were different ones which I found very distressing at the time but the last two years or so the same group that have come in. I have one, one week the two days and the other one the other week. So I'm used to them now.

A clear characteristic of this regular and familiar relationship with services is that once the need is covered by a certain service, the relationship between the service and the person becomes more personal. Therefore, the person who performs the tasks gains importance. There is, in a way, a need to go beyond the instrumental help and to get to know the person. Having the same group of carers on a regular basis is therefore another important aspect that adds familiarity to the support given. Thus, the service stops being an abstract concept, which is distant and generally stressful. It becomes a caring relationship between the service provider and the user that has an additional impact on the old person's well-being and sense of autonomy. Autonomy is a very important value for Molly. She regards social services as means not to depend on her family and not to become a burden to them. This fits with her character and her recent major life decisions, such as moving into her adapted flat so that she can manage her environment and daily tasks.

I: in terms of the formal support that you receive from the carers that come in, do you think that's the right balance between family care and formal care?
R: Oh yes, I'd rather have the formal care I think because I've always been one, I wouldn't like to put on my children for anything, do you know what I mean?
I: Yes
R: Cause I think they have their own life and I wouldn't like to be a burden on them anyway.
I: If you needed more support you could look perhaps to social services to help out a bit more?
R: Yes, probably if I needed it, I could have cleaners in and that kind of thing, yes, I could have that. I wouldn't expect my family, immediate family, to do it because one has young children and the wife is working part-time anyway so they couldn't do it. Neither could Susan cause she's working full-time. So if I had to have help I would have to have social services I suppose.

Molly's words reveal feelings of empathy towards her children and the willingness to rely on services in the future if needed. At the same time, she want to stay at home for as long as possible.

It seems that the community care policies recently introduced in England may have created a more accessible image of community services as well as placing more demands on them. Without considering gaps in formal care services, the English interviews show that people interact with services and know about them. English people have a positive image of services, but do not use them all the time. This confirms the quantitative finding that the care model in England is still dominated to a greater extent by the family.

German case example

Christine is a widow and lives on her own. She has privately organised and privately paid help with household chores. She manages all her financial matters and arranges the help she needs privately since it is cheaper than help she can get from the Red Cross. Christine knows all about the services on offer and that she can choose what is convenient for her. Her independence is very important and she thinks that old people who depend on their children to take any kind of decision are 'helpless because they do absolutely nothing without their children's permission. She has clear views on her situation and aims to maintain her independence:

Now the matter is for instance: How long will I stay in my apartment? I am in my 80s and how long should I stay in my apartment? And I say: As long as I want to, I decide it myself. And my children don't. The apartment belongs to me, it's my property. In case I would go to JS [a nursing home] and I rented a room there for me and my pension was not enough, then I would use my apartment for getting some money. Both of my children they have a high qualification and both of them work. In this respect, I wouldn't consider what my children think about it. They will get what will be left.

A key aspect emerging from the interview with Christine is the importance of being able to choose between different alternatives and to take decisions without the approval or help from her children. Christine sees the future as holding various options, and of course she does not think that relying on her children is one of them. She knows what she needs and she is able to buy it. Money does not seem to be an issue, and this also reinforces her sense of autonomy:

I: Have you talked with your children or have you thought about what will happen if you need help?
R: I think old people shouldn't be burden for their children, I haven't done it yet, but if I won't be able to care for myself anymore, I would not like meals-on-wheels, in this case I would like to go to the nursing home JS.
I: Would you prefer a nursing home rather than asking your children to care for you and also…?
R: Both of my children work.
I: Yes, and would you consider this rather than home care?

R: Well, I could also consider home care.

The feeling of control over her life and the good relationship she has with her children are two key elements that help her to maintain a sense of life balance. Her family is important and she experiences relationships with family members as rewarding. But Christine would not expect to receive any physical care from them. Instead, she expects other types of support. Further analysis of German narratives reveal that this pattern is frequent.

The recent macro-transformation introduced in the German caring system (Long-term care insurance) is an attempt to respond to people's expectations of care and support. This reform is designed to give people a choice of care options by allowing older people themselves to decide on the most appropriate care arrangement. Despite these efforts, the family is still the main provider of help and support to older people. This is reflected in the greater proportion of application for cash benefits compared to benefits in kind. This picture contrasts with the wish of elders not to be a burden on their children and to continue managing their own situation. German elders conceptualise services as something normal. They neither have a positive nor negative image about services. German elders have a use services moderately. Education and social status seem to have a greater impact in this country than in the other OASIS countries.

The four country-cases presented above have two common themes that shed light on the dynamics behind the typology of service use identified. Nevertheless, it is important to point out that the objective of these examples is not to reduce individual variation. The aim is to show country patterns and how different structural contexts lead to distinct personal expectations and different types of interaction with services. A first theme to highlight is that *older people are familiar with services and use them*. In certain contexts, they have a close relationship with service providers. However, country differences in models of care do not seem to have an impact on the solutions taken by old people who are at risk of dependency. As illustrated through the country case examples, there are significant similarities between countries in the interaction older people have with services. It is difficult to assess what promotes autonomy more effectively. The family continues to play a salient role, but there are differences that stem from country specific structural conditions.

The second and related theme to emerge is that *services and family help and support are guided by different expectations and norms*. There seems to be a *division of labour* around caring and tending activities, where services and families are expected to do certain things but not others. The family is by no means expected to care for an old relative. In fact, we have seen that children offer their parents the possibility of moving in with them, helping them or offer themselves to arrange or pay for a service, but parents most of the times refuse. Old people do not

turn to family for personal care or practical support, but to services (public or private). This is grounded on a strong norm of autonomy supported and strengthened by the general availability of services.

Being autonomous is supported, encouraged and highly valued in these countries. Families play a supervisory role that involves mainly emotional and social support, transport and shopping, financial advice and doing small quality things for parents. Four main aspects have been identified in old people's definitions of independence: *self-perception,* they perceive themselves as independent because they are able to do what they need or want to do alone, with private or public help and/or minimum families' help; *children's perceptions,* their children view them and treat them as independent despite their own concerns and opinions*; independent living,* they live autonomously, enjoying their own space which they have control over; and *financial self-sufficiency,* they have their own financial resources and not depend on their children to manage daily life. Independence is then constructed through the interaction of these factors that become especially important in old age, when autonomy appears as seriously threaten by functional and general health limitations. Defining autonomy like this favours and strengthens a particular social and cultural climate that leads to policy solutions orientated to maintain not only old people's sense of independence but also their families' perception of it. It seems quite evident then that independence constructions cannot be improvised: they arise from a society's effort to offer the means and the backup to old people's endeavour of not feeling a burden on others, which appears as their main concern in all countries.

Spanish case example

Rosario has been living with her daughter since her husband died 18 years ago. She moved in as soon as she became widow. She receives regular instrumental and personal help form her daughter. As she acknowledges*:* '*she helps me on everything, she washes me…'*. Her severe leg problems prevent her from moving around without her crutches or her walking frame. She has been a very hard-working person all her life and regrets not being able to help out her daughter more and be more autonomous:

R: Well, I do all she's telling you, I cook sprouts, all those things, but considering what I've done in the past, now I think I'm not useful
I: And how do you deal with that?
R: How do I deal with it?
I: Yes
R: Protesting and complaining, I complain a lot.

All the help she receives comes mainly from her daughter One of her sons who is retired and lives close by runs errands for her and visits on a daily basis. Rosario's

relationship with her daughter is very close and they spend a lot of time together. As Rosario sees it: '*I don't, I can't be without her either, my children want me to go with them and I like to be with her*'. This creates tensions in the relationship, although they seem to get sorted out eventually. Her daughter, Isabel, points to this: *She still likes ruling, she thinks I'm 8 or 10 and she likes telling me what to do, what I have to do, what I don't have to do. This strikes a bit some times, some others I don't care.*
Rosario thinks that children have an obligation to care for their parents when they are old. She does not want to be a burden, but she has no option. Further analysis of the interview reveals that she feels ambivalent about the possibility of moving to a nursing home. On the one hand she would like to do so as to not bother her daughter. But on the other, she views this as a last option, because she wants to be with her daughter and she would not be able to afford a place in the home:

Yes, I'd like to go to a home, because to do nothing at all, a nursing home would be ok, although maybe the next day I'd say, I don't want to be here, but well, I'd get used to it, because if you get used to it… If I had no option…, of course, the home costs a lot of money, I don't have money to pay for that.

Caring is viewed as a normal obligation, accepted and assumed by her daughter. This appears to be the pattern in many of the Spanish narratives. Caring is done whatever the task. The need to share caring responsibilities is also an issue that does not occur in practice. As Isabel says:

I understand this [caring] as an obligation, you see, in this case, because she's with me, and let's say, it's been like this all my life and I'm used to it, but well, I acknowledge that all [sons and daughters] have the same degree of obligation

Contact with services is non-existent, and they do not have any knowledge about services either. The family is the only resource:

I: Talking about help from the State, do you think it's ok? Have you had the experience of dealing with social services?
R: No, I'm little informed about that, I don't know neither if…
I: There is something or not
R: Well, I know there are services, but I don't know anybody getting them, I haven't gone through it, I'm not very informed about that

The analysis of the Spanish interviews reveals a different pattern of interaction in caring relationships, with distinct characteristics in line with the two emerging themes identified above. First, as illustrated in the quantitative survey, in Spain the family is the most important source of care and support for older parents. There is also a strong filial norm. In addition, expectations are clearly placed on family members. In fact, it is children who assume caring responsibilities and if any

service is to be arranged, it is the children who do it. Older parents hardly ever get in touch services (neither do children). Older parents do not have a positive image about services nor clear expectations of them. Furthermore, using services has a negative connotation. There is an unspoken norm that services should only be used when family care is not available. This is assumed by both older parents and adult children and it has an impact on the development of services and the relationship with them. In Spain, it is necessary to achieve a normalisation of care services. They must be seen in the same way as other elements of the welfare state, such as health care, which is considered a citizen's right. Research has shown that the use of services in old age is perceived as stigmatising (Bazo 1993). Therefore, the fact that services are available for older persons in need and their families is fundamental. But the image and connotation of using certain services appears more important. So the information that potential users and their families hold about services is particularly important. This leads to an important difference between those citizens who consider services as a right and those who do not have information on the availability of services, because they do not regard them as something useful. How services are accessed and experienced is also crucial. As previously discussed, in countries like Norway older people have a direct experience with services and make their own arrangements for care In Spain children seem to assume the role of mediators between older people and bureaucracies (Gibson, 1982). This, of course, has to do with different service provision organisation which in turn is closely link to norms and values.

Secondly, a certain division of labour can also be identified in Spanish families where caring takes place. The family is expected to always care for older parents. All family members are expected to get involved, although the bulk of care and the main responsibilities are assumed by women, especially daughters (Ministerio de Asuntos Sociales & INSERSO 1995; Bazo 2001). In the Spanish qualitative sample, eight out eight out of ten children caring for an older parent were daughters. If a main carer is available as in the case example presented above, the rest of the family assumes a secondary role because all responsibility is taken by the primary carer. For example, Carmen, a widow living with her daughter, recognises that her daughters would care for her: *Well, if it was needed, my daughters would put up with me.* Her daughter's words reinforce this view: *but well, if she didn't have anybody, but if right now she… for example, I'm here, I do everything for her, what does she need a home helper for? Do you understand? If it came the day in which she couldn't manage, even more than now, then I'd call one of my sisters, as for example if you say, she's prostrated in bed and she can't move, that's what my sisters are for, they would come, I know.'*

How is the concept of independence constructed in a strong familistic country like Spain? It is clear that there are several answers. A sense of independence is not something which is uniquely constructed by the individual. It is also influenced by family support and interaction. Older parents living with adult children appears to

be an important pattern that hinders a sense of independence. Adult children feel that they need to protect and care for their parents and they have strong feelings of filial responsibility. Independent living is not regarded as important. Even when older parents are healthy and able to live independently, they may decide to move to a child's home or to have children live in their own household to keep them company. Spanish older people feel that this is 'the natural way for things', especially when they do not have adequate financial resources. Until recently, as shown through the OASIS interviews, co-habitation has fulfilled both generations' sense of responsibility and continuity. On the one hand, parents feel secure and well looked after by children. On the other hand, children feel they are doing the 'right' thing, paying back their parent's efforts and sacrifices. Feelings of duty and obligations to care are reciprocal and strong in the Spanish sample. They were strong also the other OASIS countries, but in Spain these obligations have practical consequences for the care of older parents. Children are pushed into family care through the lack of services, by mutual feelings of responsibility and filial obligation, or by the shortage of personal resources.

According to the four themes analysed above, the self-perception of Spanish elders is mostly of that they are a burden and that they not able to perform all the tasks they would like to independently. Their children have frequently ambivalent feelings about their role towards their parents. On the one hand, they try to constantly to promote their parent's independence, by giving them certain tasks and encouraging them verbally. But on the other hand, a change in the relationship occurs and the balance of power shifts. Important things the parent used to do begin to be done by the child, and this often causes conflict. Co-habitation is the most common living arrangement. Most of the people interviewed (mostly women) have low pensions that would not allow them to live independently without their children's help. Financial resources have emerged as the most important mediating factors in promoting the autonomy of elderly parents. It is evident that being wealthy or having savings allows older people and their families to consider several types of care arrangements, even if the service structure is weak or under-developed. Obviously, Spanish elders who can buy private care do so, and it is becoming very common among well-off classes to employ Latin American girls to live with and them and provide 24 hour care. This is Saturnina's situation. She lives in her flat with a Latin American girl she has employed to keep her company and to provide round-the-clock care. She found a way to maintain her independence by spending her savings on private care. But it needs to be pointed out that it was her daughter who arranged everything and who manages the payments. This caring arrangement seems to fulfil both the mother and daughter's expectations. Saturnina feels happy, supported and calm because she is not being a burden on her daughters. But still she thinks that children have a clear responsibility towards their parents: '*they do have a responsibility and my daughters are ready to do it*'. Her daughters now play a different role. They supervise the carer's work and make sure their mother feels emotionally supported.

But they do not provide any practical or instrumental help. This change in the relationship between daughters and their ageing parents is in the direction of more service orientated countries.

Thus in Spain, where services are underdeveloped and not valued by elders and their families, a transformation is taking place that will bring about changes in caring arrangements. Also, it seems that younger generations may not be expected to provide constant and daily care in the future. Instead, they will be expected to keep in touch and care *about* their parents and not for them. In other words, they are gradually assuming a 'care manager' role. The analysis of Oasis quantitative data on family values shows a clear generational change taking place. This is a very important difference with the past that is reflected in Vicenta's words:

I: What is the change you foresee?
R: To start with, I think we have a different mentality, because you [young generation] work and I think that if you don't stop working to care for your children, because my daughter is now going to give birth and she's not going to bring her child up, she's going to leave the child to me, at least until he/she goes to the nursery, if my daughter doesn't stop working to care for her child, do you understand me? She's not going to stop working to care for me, then, I think my mentality is that my children are not going to care for me, it's not that they don't love me, it's that they are not going to be able to care, because it's the same with my sister, she's working and, even though she would like to, she can't, then it's like you, your generation, you're all going to work, then even though you would like to care for us, you won't be able to'

Saturnina's daughter had important psychological problems when she realised she would not be able to care for her mother herself and that they would have to find another solution. Her sense of filial obligation made her feel guilty and depressed. Eventually, a different caring arrangement - employing a carer to be with her night and day - has ended up being more positive for the whole family. Saturnina does not want her children to physically look after her and expects only emotional support, as found in countries with more familiar and close relationships with services. The final Spanish example illustrates the importance of changes in attitudes towards achieving better services. Isabel's views reflect the role of family as a form of 'care insurance' in old age and the generational change taking place:

I: Do you think your expectations are different to those of your parent's generation?
R: Most of the people do not think…because before you had a daughter, you had sons, but you had a daughter, ah! Since my daughter is going to care for me… that was before, well, I have neighbours and it's also the same for them, they have brothers, but it's them who have their mothers at home.
I: Would you call that an insurance…?

R: A care insurance, more or less, but well, we're talking about times with other mentality […] now old people stay more on their own before moving in with a child, they maintain their independence longer, a period of ten years makes a difference, ten of fifteen years make a difference, it's the difference between saying I move in with you or I stay in my house while I can manage.

Finally, it is important to briefly highlight older parents and their children's views on *formal nursing support*. Nursing care can be public or privately financed. The process of moving towards nursing care as an option is difficult. Most people consider nursing care as a last option and it is also the most costly. Thus when confronted with the beginning of dependency, elders and their families consider available resources and take decisions accordingly. Complex decisions are made in the context of personal, familial and structural factors, and they are characterised by uncertainty and ambivalence. As indicated above, elders in all the OASIS countries want to be near their families and supported by them, to live independently, and not to be a burden on their children. Formal nursing support is not the preferred option in any of the countries, since it involves a lack of independence and important changes by elders but also by their families. This common finding is experienced differently between countries, that is between those with a familiar relationship with services compared with countries where services are distant and less widespread. The analysis has revealed that in the former nursing care is seen as a possibility, although it is not desired and elders fear having nursing care because they think that they are not going to receive good quality care. Consequently, they prefer to have care from their children in most cases. Reidun expresses this view talking about the future:

R: No, not if she has to manage her job and the mother gets sick [vignette]. I think it is better that she moves to a place [institution] then.
I: You're thinking about a nursing home?
R: Yes.
I: But if the mother really wants to come home. What if she doesn't want to go to a nursing home?
R: No, that is something we all prefer, to be able to live at home as long as possible, you know. That's for sure. But in my opinion one can't demand them [the children].
I: No? We can't demand them to?
R: No, I don't think so.
I: Have you thought about your future, your own situation?
R: You know the thoughts cross my mind, you can't avoid that.
I: And what thoughts do you have?
R: No, I hope that I get to stay here at home, till it's over. That it's, that it ends fast. When the time comes… I hope I can manage myself till the end.

The wish to stay in one's own environment and to keep all meaningful elements is a very important factor in the decisions of older people and their children. Helga talks about her mother's expectations and the feeling of being rootless if she has to go into a residential care home:

'Well, then she will engage some nurses who will take care for her at home all around the clock. She doesn't want to go to a nursing home, in no way, she doesn't want to leave her apartment. And in case she doesn't want to come to us, that we bring her in – what has she said? That we let her rot way in a nursing home.'

On the other hand, in countries with less developed services, nursing care is rarely discussed When it is, then it is normally rejected by elders and their children. The motivations for rejecting nursing care are different. In countries where older people have close and regular contact with services, they do not want nursing care because it involves losing independence. A more community-based solution is sought, seeking the advice of the family. For example, Mrs.H. plans to stay at home and take a woman in to care for her and keep her company. This is her choice, but also strengthened by her daughter's opinion:

R: […] but I think that until my very end I prefer to live in my own home, maybe with some woman.
I: To help you?
R: Yes, but no, our lives are not the same. And my daughter doesn't want to hear about a nursing home. Do you mean she doesn't see the possibility of a nursing home in the future, in any case…
I: No
R: Ok
I: And if I had the money to take some woman to live with me, and if not, we will see then.

The views of children carry an important weight on their parent's decisions in all countries, whatever the type of service structure. What makes a difference is the possibility to choose alternatives to depending on children for care. In countries where services are less valued and distant, nursing solutions are seen not only as a loss of autonomy, but as abandonment. This is clear in Carmen's words:

Are they going to put them [old people] in a home? I don't agree with that, well, since each one has their own, I don't know, their reasons, because they work, but well, particularly me, I don't agree with that, with the fact that having children, parents are put in home, I don't know, I'm not for that.

It is not only the parent's generation that express these views, but also their children. Feelings of filial duty and obligation are behind this attitude. In fact, admission to a nursing home is viewed as a decision outside of the control of the

older parent and being taken by children. Parents are then seen to be 'put in a home and left there. These attitudes, of course, have an impact on how older people view formal services, and particularly the difficulty of differentiating community services and nursing homes. Negative evaluations of formal care in general abound, which reinforce the family's role as the main source of care.

Conclusions and recommendations

The conclusions drawn from the analyses carried out can be summarised as follows:

- a large majority of persons aged 75 and over who live in the community do not have major needs for care and support and so they do not receive help from any of the usual sources such as the family or services
- where an older person has needs, the family continues to play an important supportive, either practically or through affective support
- the existence of comprehensive service networks, mainly formal, reduces demands on families to get involved in direct and daily care of people with caring needs
- women continue to be the main providers of help and support in family settings, even where they are in paid employment
- changes in the traditional family roles of women are slow to develop. The stability of values and family models characteristic of industrial societies continues to be observed despite transformations in socio-economic structures and other cultural values
- regular and familiar interaction with services leads to more demands and expectations. Where there is more choice of different caring arrangements, there is more satisfaction and a sense of autonomy
- services are mediating factors that have an influence on the well-being of older people and their families well-being. But this well-being depends of accessibility and perception of services. The more services are offered, the more positively they are valued and the more satisfied elders feel
- existing formal services may be insufficient to cover current needs for care. The analyses undertaken, both quantitative and qualitative, point to inefficient and rigid formal service structures
- when services are accessible, families can assume different roles and pay attention to providing emotional support
- the pattern towards the use of private services (and to a lesser extent voluntary services) may indicate a range of care provision options, even though the main responsibility lies still with the family and formal services.

Two different dynamics in care models have been identified. A close, familiar interaction with services linked to the availability, normalisation and positive

image of services, and a distant, uncertain interaction, characterised by lack of knowledge and limited access to services. It is clear that individual pressures and expectations have an impact at the structural level on the development of more public and private services to fill the gaps that stop people from maintaining their independence for as long as possible. In this sense, the inter-connection between family practices and service systems has been established and how this may influence welfare systems. In order to promote autonomy and delay dependency both families and services are needed, and different patterns with distinct dimensions have been illustrated. Changes in this direction are expected to reinforce the patterns observed in caring and tending activities – a division of labour between families and services, and less demands on the family to provide physical or constant instrumental support.

Future developments in service provision need to consider that a key to autonomy is the choice between different caring options. Such a choice can only be achieved through determined policy action. Briefly, some general recommendations can be made. A broad network of social services is needed on the basis of the different needs that persons experience as they age. Service accessibility and flexibility, together with quality, are also necessary to improve user satisfaction. Bureaucratic organisations usually make it difficult to achieve these aims. In this sense, the family is considered to adapt better to a person's needs. Due to the population ageing, the numbers of older-old will increase in the next decades. Demographic changes come with significant shifts in the status of women and other family members. At present, a large majority of people helping and caring for the elderly are women, most of them employed. This means that women's traditional commitment to their families has not significantly changed, despite their increasing participation in the labour market. Updated family policies, as well as financial, fiscal and employment policies, are needed to promote women's feeling of self-fulfilment.

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9

Quality of Life

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Introduction

The goal of the OASIS project is to analyse how families and service systems support autonomy and delay dependency in old age, in order to promote quality of life among the elderly and their caregivers and improve the basis for policy and planning. Specifically, the project studies the balance between family care and service systems and its relation to the quality of life of the elderly and their adult children and grandchildren. This chapter deals with concepts and findings relating to *subjective quality of life*. First, theoretical considerations are presented.[1] It is argued that, among other influences, support from families and services are relevant indicators for the subjective quality of life of older people. Second, the instruments used to measure subjective quality of life and the variables used in the analyses are described. Third, descriptive and theoretically guided results are presented, comparing the quality of life of older people in the OASIS project countries. The main question addressed through these analyses is whether family support and service use influences the quality of life of elderly persons facing functional impairments. Finally, the implications of the results are discussed and suggestions are made for future social policy directions.

Theory

It has often been argued that the subjective interpretation of objective living conditions have real consequences. Individual behaviour is influenced not so much by objective resources and living conditions, but by beliefs about one's own ability to control environmental factors (Schwarzer and Born, 1995). In other words '*the quality of life must be in the eye of the beholder*' (Campbell 1972). In an ethical perspective, one could argue that asking people themselves what they think constitutes a 'good life' gives each individual the right to decide whether his or her life is worthwhile (Diener 2000). These arguments demonstrate the need to look at subjective evaluations of objective living conditions.

In the past, research on subjective quality of life has relied quite often on indicators of general life satisfaction. However, psychological research has shown that subjective well-being understood as 'general satisfaction' or 'happiness' appears to be an over-

[1] The terms 'subjective quality of life' and 'subjective well-being' are used interchangeably.

simplification (Smith et al 1996; Diener et al. 1999; Diener 2000). Hence, in addition to general indicators of subjective well-being, empirical research has analysed domain specific evaluations. Thus, there are a number of different components of subjective well-being relating to a diversity of life domains, for example satisfaction with health, self, or social relations. Moreover, it has been suggested that psychological well-being is more than life satisfaction, and includes areas such as personal growth, meaning in life, self-acceptance and positive relationships (Ryff, 1989). Although domain specific indicators of subjective well-being tend to correlate, it is necessary to isolate these different domains to get an adequate picture of the multifaceted quality of life.

However, even domain specific evaluations do not cover the breadth of the concept 'quality of life' completely. In addition to cognitive judgments and evaluations, *emotional expressions* reflecting affective states are regarded as important aspects of subjective well-being (Smith et al. 1999). Cognitive components refer to judgements regarding one's own life (e.g. life satisfaction), while affective components refer to the experience of pleasant or unpleasant emotions and moods (e.g. happiness). It has been demonstrated empirically that positive and negative emotions are not opposite poles of one underlying dimension, but rather two independent dimensions (Diener, 1994). Hence, the emotional component of subjective well-being can be characterised by positive affect (experiencing pleasant emotions) and negative affect (experiencing unpleasant emotions). In summary, all the approaches mentioned above are based on the conviction that the subjective view of a person - the individual experience - is central to a good life.

However, when analysing quality of life, objective living conditions cannot be neglected. Objective quality of life has been defined as the degree to which '... *individual's command over ... mobilizable resources with whose help s/he can control and consciously direct her/his living conditions'* (Erikson, 1974). Individuals are seen as active and creative beings who strive towards autonomy in reaching goals. The resources used to reach personal goals include income and wealth, social relationships, and mental and physical capacities. These resources increase individual agency - the ability of the individual to actually influence or change their own living situation. In the present context – analysing subjective quality of life – resources and other aspects of objective settings are considered as conditions of subjective well-being.

It has been shown that a variety of sources influence subjective quality of life. 'Bottom-up' and 'top-down' theories of psychological well-being can be distinguished (Diener, 1996). Bottom-up theories suggest that subjective well-being is derived from a summation of positive and negative experiences in different life domains. As a consequence of experiences in daily life (e.g. success or failures) general life satisfaction increases or decreases. Top-down theories, alternatively, maintain that individuals are predisposed to experience events in positive or negative ways, because of certain personality traits like neuroticism. People with a positive basic attitude experience life positively, and people with a negative attitude experience life

negatively. Empirical evidence does indeed show that personality traits are important predictors of subjective well-being. However, personality is not enough to explain several basic and recurrent findings. For instance, intra-individual variation in subjective well-being over time cannot be explained by (presumably stable) personality characteristics. Instead, changing environmental aspects should be responsible for intra-individual variations in subjective well-being. Moreover, overall cross-national differences in subjective quality of life have been found which seem to be related to societal wealth (Diener 2000).

Hence, it is necessary to look very closely at the specific characteristics of objective living situations. Health status and functional ability, income and wealth, age and gender are correlated with life satisfaction in old age (Mannell and Dupuis 1996). The combination of economic and somatic risks have an especially profound negative effect on psychological well-being in old age, even when resilience resources like life investment or coping styles are taken into account (Staudinger et al. 1999). Gender differences – women quite often report subjective quality of life more negatively than men – seem to be mediated by gender specific opportunity structures that are disadvantageous for women (Tesch-Römer et al. 2002). The relationship of subjective well-being with age seems to vary in different domains of subjective well-being. Positive affect declines with age, while negative affect and general life satisfaction remain stable even in old age (Diener and Suh 1998; Okun, 2001).

The influence of social network characteristics and social support is of special interest to the OASIS project. Contrary to middle adulthood, social involvement is correlated with subjective well-being in old age (Mannell and Dupuis 1996). Social relations and social activities correlate positively also with health related quality of life (George 2001). The family is central to the social networks of elderly persons. Marital status is important in this respect. Married older adults typically have higher levels of life satisfaction compared with non-married persons (Mannell and Dupuis 1996). But horizontal family ties are not the only significant factor influencing quality of life. Vertical relationships also have an impact. The existence of children apparently prevents loneliness in old age (Wagner et al. 1999). In the context of the project OASIS, however, not only the structure of the social network is of interest, but also the effects of help and support on the quality of life of elderly persons.

The 'buffer' hypothesis of social support, well established in empirical research on stress and health, holds that stress is reduced by social support systems (Krause 1987; Schwarzer and Leppin 1997). Following this hypothesis, the social support network 'buffers' the quality of life experienced by individuals against the negative impact of stress. It should be noted that the buffer hypothesis predicts that social support has positive effects especially in situations of stress – e.g. a decline in physical functioning – but *not* in situations without stress. In contrast to this assumption, a general social support hypothesis predicts positive effect at *all* times ('main effect hypothesis'). Hence, this main effect hypothesis would predict a positive influence of social support,

regardless of individual needs. However, intergenerational support from children, although expected by ageing parents in need, may not straightforwardly influence subjective well-being and quality of life in a positive way. Parent-child relationships can be both a source of support *and* a source of conflict (Antonucci 2001). Hence, the effects of intergenerational support might depend on the relationship quality between parents and their adult children. However, it might be assumed that older people experiencing a functional decline would be better off when they get support from family members, especially from children, compared to those older people without such a support. But empirical analyses suggest that the fact that older people receive help may serve as an additional indicator of poor health and frailty not captured by a simple ADL scale (such as the SF 36). Hence, despite a positive effect of help on the well-being of older people, this is covered by the correlation between support received and poor health (which in turn is related to low levels of subjective well-being). Although family or service support do improve an elder's living situation, need factors cannot be completely controlled (even in a multivariate analysis) because help and support are always correlated with these need factors. Notwithstanding this methodological problem, the relationship between family and service support should show a clear effect on quality of life.

One of the main objectives of the OASIS project is to determine how families and services interact in terms of support for the elderly, and how this interplay of support from family and services influences the quality of life of elderly people. Following (and extending) the debate about 'substitution versus compensation' (see Chapter 8), two alternative hypotheses can be formulated. If on the one hand, services are able to *substitute* families in terms of support, one could assume that the quality of life of people with support from services is not different from those with support from families (i.e. services substitute the 'buffer effect' of families). If on the other hand, services *compensate* for certain functions of family support (e.g. 'hands-on-care', household chores), enabling families to focus their efforts on types of support most suited to them (e.g. emotional support, joint activities), this would mean that persons who get both types of support (from family *and* services) are better off than persons who get only one type of support (either from family *or* from services). This would mean that the combination of support from both families and services would be the most effective way of positively influencing quality of life. The OASIS project offers an exceptionally rich data base to test these questions empirically in a cross-national perspective.

A cross-national perspective means that behaviour and the experience of individuals can be analysed within different social contexts. The hypotheses and assumptions outlined above can be tested to see if they apply equally to different societies and cultures or if they have to be modified by taking into account specific societal and cultural circumstances. In other words, a cross-national research design like the one used in the OASIS project makes it possible to examine if hypotheses are universal or culture specific. Cross-national analyses can be executed in different ways. First, *levels*

and distribution of quality of life in different societies – in this case the five OASIS countries - can be compared. Differences in the mean level of quality of life could be interpreted as being due to societal or cultural differences (e.g. different types of welfare state). However, it should be noted that 'real' differences could be confounded with methodological circumstances (e.g. language specific interpretations of measurement instruments). Hence, any interpretation of mean level differences between countries/cultures should be made with caution.

Additionally, it seems reasonable to look instead at *patterns of relationships* in a cross-national perspective. Here, the similarity or difference of relationship patterns are of theoretical interest (e.g. the influence of income and wealth on quality of life might be different in different societies). Hence, the pattern of influences on quality of life are examined to see if they are similar in the five OASIS countries.

The following analysis therefore covers four broad research questions.

- *Descriptive comparisons between countries*. Are there differences in the subjective quality of life in the five OASIS countries? Here influences on a macro perspective are taken into account.
- *Correlates of quality of life*. Which aspects of living conditions influence subjective quality of life? Are patterns of influences similar or different in the five OASIS countries?
- *Family structure and quality of life*. Do family relations and structural influences on family life (i.e. existence of children) influence subjective quality of life? Again, this analysis is undertaken in a cross-national perspective.
- *Effects of support on quality of life*. Do functional aspects (i.e. support from children or services) influence the quality of life of elderly people? Additionally, it was asked if services substitute or compensate for the role of families in terms of quality of life.

Method

Subjective quality of life was measured by using instruments capturing cognitive evaluations and affective states.[2] For measuring domain specific evaluations of the subjective living situations, the survey instrument WHOQOL-BREF was used (WHOQOL Group 1994b, 1994a). The instrument has been developed by several centres in each continent, and is meant to be used in cross-cultural and cross-societal research. The WHOQOL-BREF is a multidimensional measurement instrument with

[2] Extensive information about the design of the project OASIS can be found in Chapter 1 while complete methodological information on the OASIS survey study is provided in Chapter 2. For the exact English wording of the instruments, see Lowenstein et al. 2002.

four sub-scales, “physical health” (7 items), “psychological well-being” (6 items), “satisfaction with social relationships” (3 items) and “satisfaction with the environment” (8 items). Two single items are related to overall quality of life and satisfaction with health. Additionally, single-items for general life-satisfaction and loneliness from the extended WHOQOL instrument form part of the set of indicators. In the analyses of the present chapter, only scales are used. All items are rated on a 5-point Likert scale and relate to the previous two weeks. Reliability and validity of the WHOQOL-BREF is good (WHOQOL Group 1998a, 1998b).

For measuring affective states, a short version of the instrument “Positive Affect Negative Affect Scale” (PANAS) was used (Watson et al. 1988). The PANAS measures positive and negative affect presenting positive mood adjectives (like ‘excited’ or ‘alert’) and negative mood adjectives (like ‘nervous’ or ‘afraid’). The respondent has to indicate on a 5-point Likert scale if s/he felt this way (from ‘not at all’ to ‘an extreme amount’) during the last two weeks. The scales are internally highly consistent, largely uncorrelated and stable over time. In the project OASIS, a 10-item version was used with 5 positive and 5 negative items (Kercher 1992). This shorter version of PANAS is found to have an appropriate factor structure, high discriminant validity and reasonable reliability for its sub-scales (Hilleras et al. 1998; Mackinnon et al. 1998).

Reliability of the WHOQOL-BREF (4 scales) and the PANAS (2 scales) was examined for the OASIS survey. Reliability coefficients are presented in Table 1. Results are similar for the total sample and for the specific analyses of all countries. In most cases, reliability coefficients (Cronbach’s Alpha) are good (Alpha above .80) or reasonable (Alpha above .70). However, for the WHOQOL-BREF sub-scale ‘satisfaction with social relationships’ reliability coefficients are lower than for the other scales. These results may come from the low number of items in this scale (three items).

Table 1. Reliability coefficients (Cronbach’s Alpha) for WHOQOL-BREF and PANAS (short version)

	Norway	England	Germany	Spain	Israel	Total
WHOQOL-BREF						
physical health (7 items)	.84	.88	.90	.90	.85	.87
psychological. well-being (6 items)	.75	.79	.83	.81	.77	.80
social relationships (3 items)	.54	.55	.69	.72	.72	.65
environment (8 items)	.72	.77	.78	.78	.74	.77
PANAS (short version)						
positive affect (5 items)	.91	.77	.80	.80	.75	.79
negative affect (5 items)	.79	.83	.80	.80	.79	.81

Inter-correlation coefficients between scales can be seen in Table 2 (computed for the total sample, i.e. collapsed over the five countries). The correlation between the scales measuring domain specific life satisfaction (WHOQOL-BREF, scales 1 to 4) are moderate to high (correlations between r=.44 and r=.68). The correlation between the two scales measuring emotional states – 'positive affect' and 'negative affect' – is rather low (r=.14). The correlation coefficients between the cognitive indicators (1 to 4) and the affective indicators (5 to 6) are, as expected, moderately low (between r=-.21 and r=.40). It should be pointed out that the pattern of inter-correlation coefficients are in most cases similar for all five countries. However, differences between countries can also be observed. For instance, correlations between positive and negative affect range between r=–.11 and r=.50 (Norway. r=.25, UK. r=.06, Germany. r=–.11, Spain. r=.22, Israel. r=.50).

Table 2. Intercorrelation coefficients between quality of life indicators and scales

	Psychological well-being	Satisfaction with social relations	Satisfaction with environment	Positive affect	Negative affect
Satisfaction with physical health	.64	.45	.53	.29	-.34
Psychological well-being		.51	.68	.38	-.40
Satisfaction with social relations			.44	.21	-.21
Satisfaction with environment				.31	-.30
Positive affect					.14

Note. Pearson correlations for total sample, collapsed over all OASIS countries, n between 5,821 and 5,998; all correlation coefficients significant at p<.01

All in all, the reliability of the instruments is high and the structure of inter-correlation coefficients corresponds to the assumptions specified in the theoretical considerations. Although the domain specific satisfaction scales are correlated quite substantially, there is no complete redundancy in these four scales. Hence, all of them are used in subsequent analyses. The two sub-scales of the PANAS instrument are only weakly correlated and should be treated separately as well. Hence, in the analyses that follow, there are six indicators used as dependent variables - four domain specific satisfaction scales (physical health, psychological well-being, social relationships, environment) and two scales measuring emotional states (positive affect, negative affect).

As independent variables, three sets of indicators are used as independent variables. General background indicators (age, gender, health, income and education), indicators of family structure (partnership, existence of children and grandchildren) and

indicators of support (from family and services). Specifically, these independent variables are:

- chronological age
- gender
- functional health (using the scale on physical functioning taken from the SF 36 Health Survey instrument, ranging from low [0] to high [100], (Gladman, 1998; Ware and Sherbourne, 1992)
- income (using the equivalent income based on the so called old OECD equivalence scale (see Fingini, 1998; Piachaud, 1992) in quintiles per country, from low [1] to high [5])
- overall educational status (ranging from low [1] to high [3] based on both, the information on schooling and vocational training, with 'low'=primary level of schooling without vocational training (primary level of education), 'intermediate'=primary level of schooling with vocational training or secondary level of schooling without additional training (lower secondary level of education), and 'high'=secondary level of schooling with vocational training and tertiary levels (upper secondary and tertiary level of education) (see UNESCO - United Nations Educational Scientific and Cultural Organization, 1997).

For family relations, the following variables are used:

- Partnership status (partner versus no partner)
- number of children (none, one, two, three and more)
- number of grandchildren (none, one, two, three and more)

For support, there were two questions in the OASIS questionnaire. Respondents were asked:

- if they had received help with household chores, transport/shopping and/or personal care in the last 12 months
- whether this help was from family, services or other sources (or any combination if them).

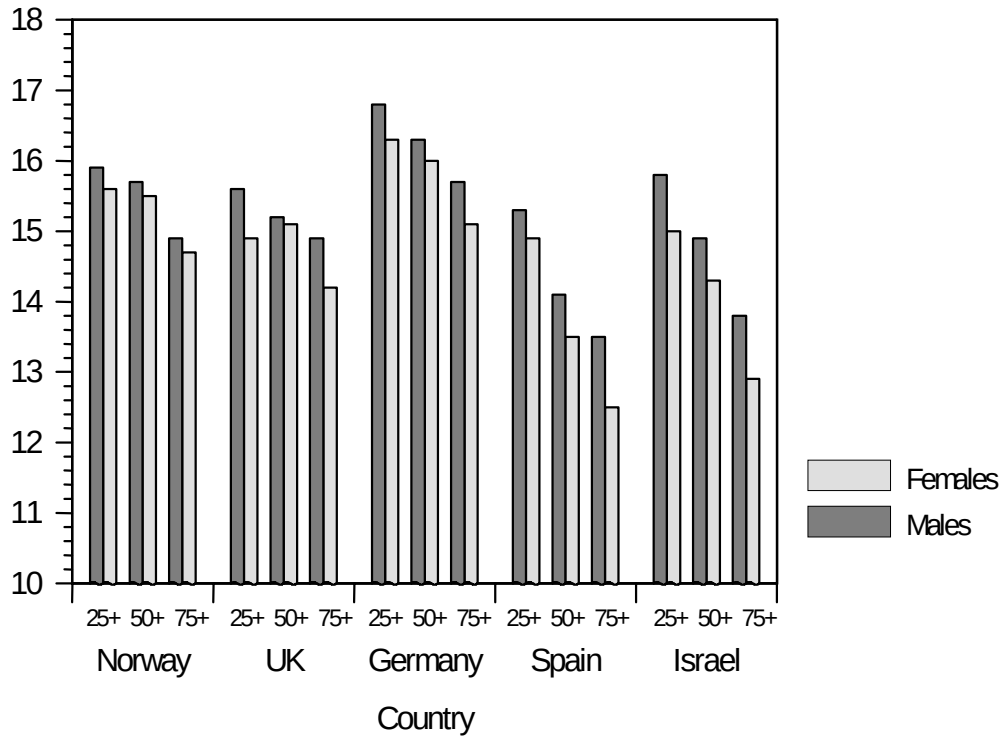
Hence, there are two comparable indicators for help from family and for help from services (number of areas help received, ranging from low [0] to high [3]) that are used in the analysis.

Results

Four broad areas of analyses are presented. Descriptive comparisons between countries, correlates of quality of life, influence of family network and family support on quality of life, test of the extended substitution versus compensation hypotheses. In the first two sections, data from the whole sample are analysed; in the last two sections, data from the oldest sub-sample of the respondents 75 years and older are used only.

As a first step, descriptive analyses for the dependent variables were performed. This allows tests for differences according to country, age and gender.[3] As the patterns of results are similar for all dependent variables, only one of them – 'satisfaction with physical health' (WHOQO-BREF sub-scale) – is presented in more detail. In Figure 1, mean levels of this scale – differentiated for age and gender – are presented graphically.

Figure 1. Satisfaction with physical health by age and gender



[3] The complete descriptive information for all six dependent variables is given in the Appendices.

As can be seen, there are differences between countries. Germany and Norway have the highest scores, Israel and the UK the lowest scores, and Spain is in between. For most indicators, there are also clear gender differences. Regardless of country and age. Men seem to have better subjective health than women. Marked differences can be found for age. Across countries and gender, the youngest respondents (25-49 years) have the highest subjective physical health, the oldest respondents the lowest subjective physical health (75 and more years) and the middle group (50-74 years) is in between. However, it should be pointed out that age differences in subjective health are not the same in all countries. For instance, they are much higher in Spain than in Norway. For the other scales, descriptive analyses yield similar results. But there are two exceptions. For the 'satisfaction with social relations' and 'positive affect' scales there is no overall gender effect. Men and women are equally satisfied with their social relations and show the same level of positive affect. Additionally, it should be pointed out that the country differences in 'negative affect' are very large in this domain. Israeli mean levels are significantly higher than in other countries.

Although these results are discussed thoroughly below, two methodological implications should be pointed out here. First, there are pronounced differences between countries. These differences could be due to different welfare levels in the five countries. But they could also be due to country specific language use. Second, the pattern of results regarding age and gender differences are rather similar across these countries (although the magnitude of these differences varies from country to country) and these patterns are compatible with previous research findings. Hence, it should be possible to analyse patterns of relationships *within* countries and compare these patterns *between* countries. It is necessary to compare cross-national differences to gain insights into the role of families and services in terms of quality of life of older people.

In the second stage, the role of individual living conditions are analysed. For the moment, the following characteristics are considered: age, gender, functional health, income, and education. In Table 3, first order correlation coefficients for the total sample (collapsed over countries) are presented. Coefficients for within-country analyses are similar. While there are moderate to high (negative) correlations between age and subjective physical health, psychological well-being, satisfaction with social relations and positive affect, there are only small (negative) correlations with negative affect and satisfaction with environment. Gender differences are rather small across all dimensions of quality of life, but disadvantageous for women. Functional health is strongly correlated with all dimensions of subjective quality of life. Poor functional health affects not only satisfaction with physical health, but also the evaluation other life domains. However, the 'spill over effect' of functional health is only moderate to small in the dimensions of positive and negative affect. Finally, both income and education show moderate correlations with all aspects of subjective quality of life, except for negative affect.

Table 3. Correlation coefficients between characteristics of living situation and quality of life scales

	Satisfaction with physical health	Psychological well-being	Satisfaction with social relations	Satisfaction with environment	Positive affect	Negative affect
Age	-.45 *	-.22 *	-.27 *	-.09 *	-.24 *	-.03 *
Gender	-.13 *	-.11 *	-.04 *	-.08 *	-.02 .	.13 *
Functional Health	.74 *	.42 *	.31 *	.34 *	.22 *	-.18 *
Income	.19 *	.18 *	.11 *	.26 *	.16 *	-.08 *
Education[1)]	.34 *	.31 *	.19 *	.31 *	.28 *	-.02 .

Note. Pearson correlations, except for [1)] Spearman correlations, (for total sample, collapsed over all OASIS countries, n between 5,821 and 5,998; all coefficients significant at p<.05are marked with asterisks *)

Since aspects of living situation tend to be correlated, it is necessary to look at the independent contributions of these variables in terms of predicting subjective quality of life. Hence, for each quality of life indicator a multiple regression was calculated with age, gender, functional health, income, and education as predictors. The results are shown in Table 4. There are similarities and differences with Table 3 (first order correlation). First, functional health, income and education remain moderate to strong predictors for the (statistical) explanation of variance within quality of life indicators. Across all quality of life dimensions, health is the most relevant predictor. In addition to health, both income and education significantly explain variance in the dependent variables. Secondly, the situation for age and gender differs when taking into account health, income, and education. Gender differences become negligible when taking into account control variables (an exception is negative affect). The influence of age varies across domains. Taking all other independent variables into account, the formerly large negative age correlations are reduced (for the scales on 'satisfaction with physical health' 'social relations' and positive affect) or even reversed. Controlling for other influences, psychological well-being and satisfaction with environment seem to *increase* and negative affect seems to *decrease* with age. Finally, for four dimensions the explained variance is only moderate. The adjusted R^2 coefficients range between 7% (negative affect) and 21% (psychological well-being). Only for the variable 'satisfaction with physical health' (54%) the explained variance is high. Hence, this points to the fact that there are other relevant influences in respect to subjective quality of life.

Table 4. Standard regression coefficients for multiple regressions of quality of life scales on characteristics of living situation

	Satisfaction with physical health	Psychological well-being	Satisfaction with social relations	Satisfaction with environment	Positive affect	Negative affect
Age	-.01	.11*	-.12*	.24*	-.13*	-.24*
Gender	-.01	-.03	.01	-01	.02	.09*
Functional Health	.69*	.41*	.24*	.36*	.09*	-.27*
Income	.05*	.06*	.05*	.14*	.08*	-.03
Education (med)	.06*	.19*	.00*	.21*	.09*	-.06
Education (low)	.09*	.25*	.05*	.34*	.21*	-.05*
R^2	.54	.21	.12	.21	.11	.07

Note. for total sample, collapsed over all OASIS countries, coefficients significant at p<.05are marked with asterisks *

The role of health becomes even stronger for respondents aged 75 years and above. Among these older respondents, there seems to be no interaction between age and health. Within-country coefficients show that in all countries, health is an important predictor across all dimensions of subjective quality of life. Although there are some country differences in respect to the influence of other predictors (which are not analysed in the present context), the results show that the characteristics of living situations are relevant for subjective quality of life in similar ways across all countries.

As a next step, the relationship between network variables and subjective quality of life is analysed. In this and the following section, the role of family and services on the quality of life of respondents aged 75 and above are examined. Three indicators of family structure are considered: the existence of a married or unmarried partnership, number of children, and number of grandchildren. As the correlation between number of children and number of grandchildren is very high (r=.74), only the analyses for the first two indicators are reported here.[4]

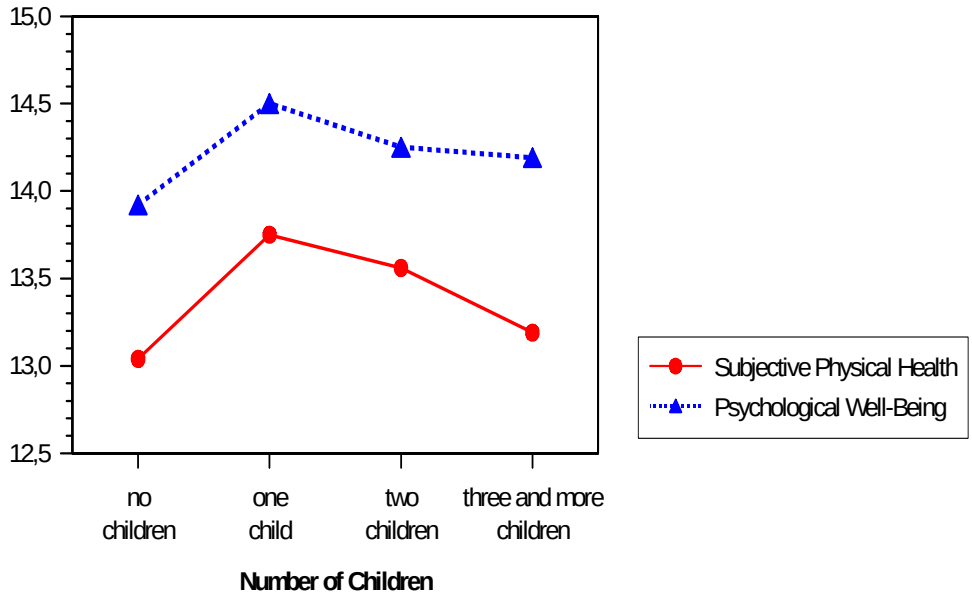
Elderly individuals with a partner, i.e. married persons or persons living with a partner, seem to be better off in respect to quality of life as compared to persons without a partner (i.e. widowed, divorced, separated, or never married persons). In all dimensions of subjective quality of life (except for positive affect) respondents with partners have more positive values than those without partners (in the four domain specific satisfaction scales persons with partners have higher scores and in the scale 'negative affect' persons with partners have lower scores). However, when the control

[4] Analyses involving the variable 'number of grandchildren' very similar to the findings from the variable 'number of children'.

variables analysed above (age, gender, functional health, income, education) are taken into account, the advantage of partnership status disappears. Although older people with a partner are obviously younger, more often males, healthier, better educated and have higher levels of economic resources than those without a partner, there is no significant independent effect of partnership as such. In multiple regression analyses, the partnership variable does not explain additional variance when taking into account control variables in a first step. Because of this finding, further analyses do not involve the role of partnership in a cross-national perspective.

Considering parenthood, a different and somewhat complex picture emerges. First, there is apparently an overall positive effect of parenthood, although one has to take into account the number of children. Figure 2 shows the mean level differences for subjective physical health and psychological well-being for four groups of elderly respondents: those without children, parents with one child, parents with two children, and parents with three and more children. In both dimensions of quality of life, a similar picture emerges. Elderly respondents without children have the lowest subjective physical health and the lowest psychological well-being of all four groups. However, there is no linear effect of the number of children. Those respondents with only one child score highest in both dimensions, with a slight decrease of the two sub-dimensions of quality of life in the groups with two and three or more children.

Figure 2. Satisfaction with physical health and psychological well-being by number of children



It should be stressed that these differences between elderly parents could be due to other variables such as income or education. Hence, multiple regressions analyses are undertaken to control for age, gender, health, income and education (Table 5). Two findings are of relevance here. For two dimensions of quality of life - subjective physical health and psychological well-being - there are independent positive effects of children (Figure 2) although the additional explained variance is rather low (about 1%). Again, as shown in Figure 2, it is mainly the fact of having one child (versus being childless) which produces the statistical effect (the beta-weights are .09 and .10, respectively). In the dimension 'negative affect' there is a significant increase of explained variance, although none of the relevant beta-weights is significant. For the other three dimensions, there is no significant effect of parenthood.

Table 5. Standard regression coefficients for multiple regressions of quality of life scales on characteristics of living situation and number of children

	Satisfaction with physical health	Psychological well-being	Satisfaction with social relations	Satisfaction with environment	Positive affect	Negative affect
Age	.04	.03	.00	.04	–.07	–.09*
Gender	.03	.02	–.01	.01	.06	.07*
Functional health	.70*	.44*	.29*	.39*	.11*	–.29*
Income	.01	.05	.01	.09*	.10*	.00
Education (med)	.10*	.21*	.02	.27*	.12*	–.07*
Education (high)	.08*	.22*	.06	.31*	.17*	–.05
1 child	.09*	.10*	.01	.05	–.02	–.04
2 children	.01	.02	–.02	–.01	–.05	.05
3+ children	.01	.06	.06	.01	–.03	.04
R^2	.51*	.28*	.10*	.29*	.07*	.11*
R^2 change (children)	.01*	.01*	.00	.00	.00	.01*

Note. For respondents 75 years and older, collapsed over all OASIS countries, coefficients significant at p<.01 are marked with asterisks *

In a cross-national perspective, although there is a general positive trend in all countries, it is only in Israel that the additional variance explained by the existence and number of children is substantial (for the dimension 'subjective physical health' and 'psychological well-being' the additional explained variance by the variable 'parenthood' was 3% and 6% respectively). Hence, it can be stated that the overall (weak) effect of parenthood could be replicated (strongly) in one of the five countries only. However, it should be emphasized that that there were no country specific results showing reversed effects in respect to the influence of parenthood.

The effects of help and support from families and services to the well-being of elderly persons under different societal conditions are central to the OASIS project.

Contrary to the main effect hypothesis of social support (outlined above), first order correlations show negative relations between help from family and most aspects of quality of life (see Table 6). For the total sample, family help shows low negative correlations with all dependent variables (except for positive affect). The highest correlation is r=–.31 (between help from family and subjective physical health). In further analyses, the interaction between family help and health status was analysed (testing the buffer hypothesis). Similarly, the correlations between help from services and subjective quality of life were negative, and somewhat stronger in comparison to the correlations between family help and dependent variables. The highest correlation is r=–.34 (between help from services and subjective physical health).

These findings could be due to the fact that this relationship captures the need of the elderly person for help, not the effects of support from family or services. Hence, partial correlations were computed controlling for health (Table 6). In the case of family help, four out of six partial correlation coefficients are around zero and not significant, and the remaining two significant coefficients are very low. However, evidence for the buffer hypothesis of family help is weak, and only shown for positive and negative affect. If health is controlled, there is a positive impact on positive affect, and the negative correlations between family help and quality of life are turned into (insignificant) positive ones in the case of psychological well-being, social relations and environment. In contrast, in the case of services, four out of six coefficients are still significant (although also significantly lower than the first order correlations). This means that the buffer hypothesis cannot be confirmed, but the data show a difference between the effects of family help and support from services.

Table 6. Correlation and partial correlation coefficients (controlled for health) between help from family and service and quality of life scales

	Satisfaction with physical health	Psychological well-being	Satisfaction with social relations	Satisfaction with environment	Positive Affect	Negative Affect
Help from family (first order correlation)	–.31*	–.14*	–.07*	–.14*	.00	.10*
Help from family (controlled for health)	–.09*	.02	.03	.01	.06*	.01*
Help from services (first order correlation)	–.34*	–.24*	–.19*	–.13*	–.11*	.10*
Help from services (controlled for health)	–.10*	–.07*	–.09*	.04	–.05*	.00

Note. Pearson correlations, n=1866-1966 (for respondents 75 years and older, collapsed over all OASIS countries, coefficients significant at p<.05 are marked with asterisks *)

In a cross-national perspective, the pattern of partial correlations is similar for the variable 'family help' across all countries (calculated separately for each country, almost all of the correlations are low and not significant). However, there are clear country differences for the variable 'service support'. In Norway, England, and Israel, partial correlations between help and services and indicators of subjective quality of life are low (and mostly not significant). However, in Germany and Spain most of the partial correlations are substantial and significant. Results for the variable 'help from services' are presented in Table 7. Hence, there are country differences in the relationship between support from services and subjective quality of life. Alternative interpretations of this finding are presented below.

Table 7. Partial correlation coefficients (controlled for health) between help from service and quality of life scales for five OASIS countries

	Satisfaction with physical health	Psychological well-being	Satisfaction with social relations	Satisfaction with environment	Positive Affect	Negative Affect
Norway	–.17*	–.06	–.09	–.03	–.03	–.03
England	–.04	–.05	–.03	–.04	.03	.00
Germany	–.21*	–.23*	–.16*	–.09*	.14*	.03
Spain	–.06	–.13*	–.11*	–.07	–.06	.14*
Israel	.03	-.02	.00	.09*	–.01	–.04

Note. for respondents 75 years and older, collapsed over all OASIS countries, coefficients significant at p<.05 are marked with asterisks *

Finally, the interplay between families and services is analysed using multiple regression analyses, first entering the control variables (age, gender, health, income, and education) and in a second step three dummy variables for 'family help only', 'service help only' and 'help from family and services' (the reference category is always 'no help'). The results are shown in Table 8. Similar to the analyses reported above, the variable 'help from families only' had no significant effect in five out of the dependent variables (there was only a low effect for 'subjective physical health'). However, there was a negative effect of the variable 'help from services only' in five out of the six dependent variables. Interestingly, for the combined help of families and services, the pattern looks more like the result in respect to 'family help only' (there are two significant negative coefficients for the dimensions 'subjective physical health' and 'psychological well-being'). In cross-national analyses, no clear picture emerged regarding country specific interplay of families and services. In analyses performed within country data sets, results were similar to the overall results reported in Table 8. However, there were small, but unsystematic variations of results between countries.

Table 8. Standard regression coefficients for multiple regressions of quality of life scales on characteristics of living situation and help from family and services

	Satisfaction with physical health	Psychological well-being	Satisfaction with social relations	Satisfaction with environment	Positive Affect	Negative Affect
Age	.06*	.05	.00	.05	–.05	–.10*
Gender	.03	.01	-.01	.01	.07*	.07*
Functional Health	.64*	.40*	.27*	.37*	.08*	–.27*
Income	.02	.05	.00	.09	.10*	.00
Education (med)	.12*	.22*	.02	.27*	.13*	–.08*
Education (high)	.09*	.24*	.06	.31*	.19*	–.05
Family Help only	–.07*	–.02	.00	–.01	.03	.03
Service Help only	–.12*	–.12*	–.08*	–.02	–.11*	.01
Family and Services	–.12*	–.05*	.00	–.04	–.04	.05
R^2	.52*	.28*	.10*	.29*	.08*	.10*
R^2 change (Help)	.02*	.01*	.01*	.00	.01*	.00

Note. for respondents 75 years and older, collapsed over all OASIS countries, coefficients significant at $p<.05$ are marked with asterisks *

Discussion and recommendations

This chapter has discussed the theoretical considerations on factors influencing subjective quality of life and reported empirical findings in a cross-national perspective. Subjective quality of life was defined as cognitive evaluations in respect to various life domains (physical health, psychological well-being, social relations, and environmental conditions) and as emotional states (positive and negative affect). The results appear to show that there are clear country, age, and gender differences relating to these dimensions of quality of life. In order to deal with the possible problem of language and culture specific interpretation of questionnaire items, the focus was on an analysis of patterns of relationships between variables. Age and gender differences were reduced substantially when controlling for variables indicating the health status, income and education levels of respondents. Physical functioning was the most important predictor of subjective quality of life for all age groups within each of the OASIS project counties. This finding was the case for all analysed dimensions of quality of life. However, independent of health, income and education levels were substantial predictors of subjective quality of life. Hence, a first summary conclusion relates to the *available resources* of individuals. In the European societies and cultures considered here (Norway, England, Germany, Spain, and Israel), health, income and education are universally important for the subjective quality of life of persons,

regardless of their age. This is especially true for the evaluations of all the domains of quality of life, but also (although to a lesser degree) for emotional states.

As far as older individuals are concerned, the finding seem to show that intergenerational relations (measured by the existence of children or parenthood) are positively related to two dimensions of subjective life quality, namely 'subjective physical health' and 'psychological well-being'. This finding remains the case, even if the above mentioned resources (health, income, and education) are taken into account. This effect seems to be especially strong when elderly parents have one or two children compared to none, while three and more children appear to be not only additional sources of support but also a potential burden to ageing parents. However, it should be mentioned that this result was found in the total sample (collapsing all countries) only. In single-country analyses, it could be replicated only for Israel.

Contrary to expectations, support from families and services was not positively, but *negatively* related with subjective quality of life. According to the 'main effect hypothesis of social support', support should have been *positively* related to subjective quality of life. And following the 'buffer hypothesis of social support' there should have also been a *positive* effect of social support when needs were high (in other words, an interaction between need and support). But none of these hypotheses is supported by the findings. This unexpected result can be explained in two ways. First, it is reasonable to suppose that support given by families and services does respond to genuine needs. Hence, the negative correlation between support and subjective quality of life could be explained by the assumption that 'support received' captures those aspects of poor health undetected by the indicator for physical functioning used in the OASIS project (SF 36). This assumption is supported by further analyses that also included additional health measures, such as the duration of being ill and hospital visits in the last year, as well as self-rated changes in health status during the twelve months prior to the interview. These analyses show family help in a more positive light. Second, support by families and services may have mixed consequences. For instance, while support from family members may lead older people to feel social integrated, it could also symbolise a threat to their autonomy and identity, and this could lead to negative subjective evaluations of the quality of life. Moreover, services could be seen as *more* acceptable in societies with a strong emphasis on personal services, and *less* acceptable in societies with a strong cultural disapproval of the role of professional services. The results presented here may be compatible with both explanations. However, the fact that in countries with a strong infrastructure of services (Norway, England, Israel) the correlations between service support and quality of life are zero, while in countries with a low infrastructure of services (Germany, Spain) the correlations are substantial and negative, points to the second explanation as the most plausible.

Before discussing the theoretical implications of these findings, some methodological cautions are presented. It has to be asked whether (a) the quality of life indicators

(WHOQOL, PANAS) measure quality of life adequately, (b) whether the measurement of help and support from family members and services is made with a sensibility for *all* types of help received in the relevant dimensions and (c) whether the relevant need factors can be controlled in a way that allows appropriate analyses of the net effects of support from different sources.

(a) Methodological analyses show a high reliability of the scales and a plausible regularity of their interaction. Only the WHOQOL dimension 'social relationships' shows a partial lack of reliability in some of the countries (with comparably low values also for other countries). In any case, this does not come as a surprise because the number of items for this indicator is very low. For the PANAS instrument, there are rather high correlations in some countries between the positive and negative affects, and this is not at all in line with previous research findings that show no (or at least low) correlations between them. This could be due to an exceptional effect for certain countries (Israel) and populations (urban). But whatever the explanation, these findings suggest that the results should be treated with caution. As discussed at the beginning of the chapter, the choice of indicators for the research questions seems to have been an appropriate one.[5] It should also be mentioned that all the indicators have strong (single order) correlations with independent variables (such as age, health, income, and education). This is in stark contrast to general life satisfaction indices which are known to be stable across the life course and insensitive to changes in living situation.

(b) The OASIS project measured support and its sources in three dimensions – 'household chores', 'transport and shopping' and 'personal care'. This inevitably reduces the global nature of support and all its associated aspects considerably. In addition, the questions for these indicators were posed directly after the questions on physical functioning (SF36), thereby focusing respondents on certain types of help that they may have received (see Lowenstein et al., 2002). Both of these factors may have resulted in respondents identifying support associated with poor health and age specific declines in physical functioning. Moreover, this influence may have been exacerbated by the omission of questions dealing with reciprocal exchanges of help and support - respondents were not asked to identify help they provided to other people in this part of the questionnaire. If they had been, this could have helped them to focus on other types of help. In addition, the correspondence between these three dimensions with the help reported in the section on children is surprisingly low ($p=.65$, $p<0.01$, for help on household chores provided by children). It seems therefore that only selected aspects of support are measured on these three dimensions. These methodological difficulties may have an impact on the results. It needs to be asked whether the variables provided by the OASIS data do give a complete picture of help and support provided by the family and services systems to older people.

[5] See also Tesch-Römer et al., 2001; Motel-Klingebiel et al., 2002; Motel-Klingebiel et al., 2002.

(c) The possibilities of control need factors are limited in the OASIS data set. Health can be controlled by the SF36 sub-scale in physical functioning and partly by single items such as the self rated changes of health status, and the duration of being ill and in hospital in the recent past. All these indicators focus on more or less severe needs related to strong limitations of health and independence. Controlling need factors for help and support on lower or different levels is difficult with the OASIS data set. So it needs to be questioned whether need factors can be controlled in a way that allows the net effects of support of different sources to be properly analysed.

The findings have theoretical implications for (a) the relevance of family structures, (b) the buffer hypothesis of family help and support and (c) the debate on substitution or compensation between family support and welfare state services.

(a) The results show that family networks have a somewhat limited relevance for quality of life, regardless of which dimension or aspect of quality of life is analysed. Instead, need factors such as physical functioning and individual resources such as income and education determine to a greater extend the quality of life of the elderly. Considering the results from the OASIS data, the family is not as important as these other dimensions. In addition, the analyses do not show significant differences between the countries taking part in the OASIS project. It seems that, contrary to the hypothetical expectations, the low relevance of family structures or family help is *not* connected systematically with different types of welfare state institutions or different family cultures. Instead, a uniform picture appears showing the impact of the family for a good quality of life in Western European countries should not be taken for granted. However, Israel seems to be an exception, as a positive effect of the family structure on quality of life was found in this country. These findings have implications not only for the psychological and sociological perspectives of research on ageing and family life, but also for the policy recommendations which are discussed below.
(b) Following the results of the OASIS survey, family help and support evidently does *not* appear to buffer the impact of stress (decline in health and need for help) in a significant way. Instead, family help appears to have no significant positive effect on quality of life in most of the domains, even where the analyses control for physical functioning as a need factor. Most of the effects are small or nearly zero. Satisfaction with physical health is an exception, since here a negative effect can be shown even if physical functioning is controlled. Another exception is the positive affect measured by the PANAS instrument, where there is a low positive effect of help and support.
(c) The analyses also provide only weak evidence regarding the questions of substitution and compensation – a debate of relevance for the efficiency of welfare state intervention. On the one hand, the hypothesis of compensation (as defined above) is not supported by the OASIS data, because higher levels of quality of life are not found for older people with mixed forms of support from family and

services. This remains the case even if health variables are controlled. On the other hand, there is some evidence to reject the substitution assumption, since older people with family help are at least slightly better off than those with services in most of the domains and aspects of quality of life. But the difference in quality of life between the receivers of family or service help is small and it varies between domains. It is strongest for the psychological well-being (WHOQOL) and the positive affect (PANAS). There is only weak evidence for the impact of a 'service culture' as a macro indicator varying between countries.

Policy recommendations should take into account these empirical results, and the methodological considerations and theoretical reflections that arise from them. The most relevant predictors of quality of life are physical functioning, economic situation and education levels of older people. The present results show that family structure – as compared to these resources – has a less dominant role in respect to subjective quality of life. Hence, policies that aim to increase quality of life in old age must concentrate on the building, protection and maintenance of individual resources, in respect to (a) material resources, (b) education related resources, and (c) health related resources.

(a) *Material resources*. The consequences of pension schemes and the redistribution of economic resources that are linked to them are often underestimated. Pensions are not only important to make the ends meet. Both relative and actual levels of income have a significant effect on the well-being of the elderly. Hence, the protection of old age pension schemes and the levels of resources provided by them is – especially in times of permanent welfare state reforms – an important task in maintaining a good quality of life in older age.
(b) *Education related resources*. Education is important not only for improving labour force participation and income levels for individuals and a general societal productivity at the macro level, but also for the maintenance of a good quality of life in old age. This finding emphasises the importance of education to younger generations as well as opportunities for education throughout the life course and of course for older people.
(c) *Health related resources*. Last, but most important, the role of individual health must be stressed. Policies that focuses on the improvement of health in earlier and later life-stages will obviously have the most important effects on quality of life on old ages. This policy relevant perspective is in line with earlier results that show an increase in the relevance of perceived individual health for quality of life over all age groups (c.f. Motel-Klingebiel 2002).

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10

Families and welfare states

Svein Olav Daatland and Katharina Herlofson

Context and questions

In all modern countries, elder care is undertaken in some form of partnership between the family and the welfare state. Other actors, such as volunteers, neighbours, friends usually only have a modest role. Depending on the country, the welfare state may take a larger or smaller share of the responsibility for elder care. It may assume direct provision through services or adopt a more indirect role through financial support and monitoring. In the latter case, services are contracted out to non-governmental organisations or private companies.

Hence the public-private mix of care differs between countries. But it remains to be seen which, if any, of the models can be sustained in a future characterised by population ageing and rapid social change. Understanding how families and services react to these changes, and how they interact and influence each other, is therefore vital. How do social policies and services affect families? What is a sustainable and reasonable mix of responsibilities between families and the welfare state? How can a supportive relationship between the two be built?

These questions lead to the issue of ***substitution***: Do services *supplant* or *supplement* family care? Is family solidarity *discouraged* or *encouraged* by an expanding welfare state? Popular opinion often takes the former position, namely that family solidarity declines when services are introduced. In contrast, most research find services to be a complement to family care (Daatland 1990). Some researchers argue for an even stronger case of complementarity, suggesting that a generous welfare state is a stimulant to family solidarity and exchange (Künemund and Rein 1999).

Public debate is, however, characterised by a deep concern over family solidarity – a concern which has followed us through history. The image of a family in crisis seems to have popular appeal. Although the notion of family decline may be latent for some time, it is reactivated in times of rapid social and political change. The persistence of this issue is probably rooted in the deep emotional investments that are characteristic of family relationships. But it also testifies to the importance of the family as a societal institution. The focus of the debate is often articulated on the boundaries between the individual and the family at the micro level, and between the family and the government (local and central) at the macro level. At each introduction of a new social policy, from the early Poor Laws to the modern welfare state, the public-private debate and the issue of substitution is re-activated.

Resistance to expanding public responsibility has often taken the guise of support for the family. Public intervention is then perceived as a threat to the very nature and basis of family solidarity. But is this so? This ongoing dispute is one reason why the interaction between families and services and the substitution issue are high among the principal OASIS research questions: are families and services substituting or complementing each other? And more generally: how do family norms and practices affect service systems, and vice versa, how are families influenced by different welfare regimes?

Theoretical formulations

The substitution controversy is also reflected in theoretical formulations of the family-welfare state relationship. The *hierarchical compensatory hypothesis* (Cantor and Little 1985) sees the family as the apogee of hierarchical preferences over who should provide care. More distant helpers – and the organised services among them – are expected to be activated only when helpers higher in the hierarchy are not available. A social policy formulation of this idea is *the principle of subsidiarity*, where family responsibility is assumed to be primary, while the welfare state takes a residual role and functions only as a safety net. Among the arguments advanced against expanding or developing new services is the idea that services may discourage family and civic responsibility. The moral obligation to provide mutual support within families will, so to speak, be corrupted if alternative forms of support outside the family are made available. Wolfe (1989) describes this outcome as '*the moral risk of the welfare state*' - services should not expand beyond the minimum required to make family and civic responsibility necessary. In this view, solidarity is seen as being driven by norms and circumstances external to individuals, and not as an attraction in itself.

This argument assumes that needs have a final character, while care-givers are seen as functionally equivalent and therefore substitutable (Lingsom 1997). Help given by one party can be re-placed by another, and neither family members nor service professionals have specific qualities that are non-replaceable. The underlying assumption in this model of care-giving is that both families and welfare states are reluctant contributors. A weakening of family ties has made it necessary for the welfare state to step-in, in turn encouraging families to withdraw even more. The result is a self-sustaining spiral of increasing public support and declining family engagement in caring (Daatland 1992).

A contrasting paradigm sees needs as socially defined, and the welfare state as an active, not only a reactive, agent. The development of welfare states is seen as expanding from within and adapting to social change. Needs are modified according to advances in medicine and the ambitions of professionals. In this paradigm, needs and responsibilities are constantly re-negotiated, so that new needs

and higher standards are accepted by both the public and professionals alike. Increases in living standards raise expectations and aspirations in the population, and for that matter also among professionals and policy makers. An expansion of services is not seen as a response to a breakdown in family solidarity, but as a policy response to welfare innovation. The expansion may, however, in turn affect the family, but how is not self-evident. Will a more generous level of services decrease, increase or simply change family commitments?

The first scenario, the decline of family solidarity, is a feature of the substitution hypothesis. The other two (increase or change) are variants of the complementarity thesis. Complementarity has two formulations: the *family support* and the *family specialisation* hypothesis. The former (family support) derives from social exchange theory, and suggests that families are more willing to provide help – and elders more willing to accept it – when burdens are not too heavy. Services then strengthen family commitments by sharing the burden. A heavy workload on the family may, in contrast, make family care-givers withdraw. When services are introduced as a supplement, then the recipient feels less of a burden, and hence is more willing to accept family help. Family care-givers can also combine care with other commitments if they are supported by services. Chappell and Blandford (1991) have found empirical support for such mechanisms in a Canadian study. Attias-Donfut and Wolff (2000) have done likewise in France, while Lingsom (1987) finds mixed evidence in the Norwegian case.

The task specificity model (Litwak 1985) is a variant of the family specialisation hypothesis. It suggests that formal and informal networks each have specialised competencies and their own internal logic, meaning that they can often be in conflict with each other. Families and services therefore function best when tasks are divided between them and contact is low. There are other formulations of the family specialisation hypothesis that are less strict and do not assume that the two parties need be in conflict (Lyons et al. 2000). The common feature in both cases is that families and services are seen as having different roles in the care system. Each has its own qualities that cannot easily be replaced by the other. Public services (and for that matter pensions and other cash benefits) are therefore not a substitute for families. Instead, the role of public services can shift to those domains where the family has special competences and qualities, such as meeting emotional needs. Hence, the family specialisation model is based on the Parsonian idea of structural differentiation in the modern family. According to this logic, socio-emotional needs have replaced instrumental functions as the core content of the family in late modernity. It may need pointing out that the term ‘family’ here goes beyond the nuclear unit and primarily points to intergenerational relationships between older parents and adult children.

The modern welfare state has not only moved into (substituted or complemented) traditional family functions. It has also introduced new roles to the family, for

example that of ‘case manager’. The primary role of the case manager is to ensure that elders get the help they need (or deserve) from the welfare state. This is as an example of how family solidarity has not been eroded by the welfare state, but may find new forms of expression.

Explorative ambition

Differences between substitution and complementarity are not always clear and they may be partly a matter of perception. Where one person may see services as a supplement to family care and hence a case of complementarity, another might point to a possible decline in family care, and hence an instance of substitution. Therefore, rather than treating substitution or complementarity as simple contrasts on one dimension, the factors and circumstances that influence the ‘push’ and ‘pull’ of these two opposing patterns need to be studied.

A further problem lies in the definition of ‘substitution’ and ‘complementarity’. It is not clear whether the two concepts refer to motivation, to actual behaviour, or to both. The original formulation of the substitution hypothesis - that the introduction of welfare state services may weaken family commitments to care - suggests the key issue is why people are *motivated* to help, and that actual exchange behaviours are of less importance. The behavioural component may have been reduced for reasons other than the availability of services, around which the substitution thesis is constructed. Thus low levels of family support need not imply declining obligations. Other factors external to levels of service provision may play a large part in determining family involvement in mutual help and support. For example, the increased geographical dispersion between parents and their adult children mean that families are less able to provide regular help and support. Competing obligations, such as those experienced by the increasing numbers of women participating in the labour force, is another reason which can influence the level of support exchanged within families. Besides, older people themselves may increasingly prefer professional services to family help. So even if adult children are motivated and willing to provide help and support, their older parents may now be more reluctant to accept their services.[1]

These considerations make it difficult to directly test the two theories of substitution and complementarity and to determine empirically whether the evidence supports one explanation rather than the other. This large task is not the objective of this chapter. Here, the aim is to explore actual help patterns, and to evaluate the role of families and services in these patterns. The OASIS study has only indirect information about how the patterns in each country have emerged and whether they have been stable or have changed over time. This limitation, common

[1] See Chapter 5.

to most studies in this area, is due to the absence of longitudinal data. A true test of substitution requires observations over time, as for example how families respond to higher or lower levels of service provision. The causal chain can only be the subject of speculation in cross-sectional data. This is also true for the motivations that lie beneath observed help patterns, although the OASIS study contains some information about norms, attitudes and preferences that may indicate which motive, or other factor, is the more probable explanation. Despite these limitations, one strength of the OASIS study is the cross-national data set. Previous studies addressing these issues were mostly restricted to one country only. Conclusions can then hardly be generalised to countries with different family cultures and welfare state regimes. A comparative study allows us to explore if, and to what extent, the interaction between services and families follows the same logic in different countries. This should make it possible to separate general patterns from those that are more country-specific.

Notwithstanding the above limitations, the aim of this chapter is to explore the patterns of family help and services in the five OASIS study countries. If family help levels are low when service levels are high (and vice versa), such a pattern should favour the substitution hypothesis. And conversely, if high service levels are found with high levels of family care, this would point towards the complementarity of family support. And finally, if family help takes different directions in countries with different service levels, this would support the family specialisation hypothesis. It needs to be restated that this exploration of outcomes using the OASIS data does not represent an all inclusive test of the three hypothesis, for the reasons given above. The results should simply point to patterns that might be compatible with each of the three hypotheses. Other observations must be added in order to judge which explanation is more reasonable.

Earlier studies

An EU observatory study in the early 1990's among Europeans aged 60 and above makes it possible to test whether services and family care levels are negatively correlated, as suggested by the substitution thesis: is family care low in countries with high service levels, and vice versa? The data indicate that substitution effects, in this meaning of the term, are indeed likely. Although by no means a perfect relationship, countries with the highest level of home care services were found to have the lowest family help rates (Walker 1993). The family was, for example, the overwhelmingly dominant source of help in Germany, Greece, and Portugal, all of which were countries with very low levels of home care at the time of the study. Denmark and the Netherlands represented the other extreme, with a (slight) majority balance for services over family help. Andersson (1993) has found the same results in the case of Sweden. All these are countries with comparably generous levels of home care services.

It needs to be stressed however, that services did not supplant family help, even in countries with the highest levels of services. According to the EU study, help to elders living at home was distributed more or less equally between families and services in the high-service countries. The low-service countries on the other hand were totally dominated by family care.

The EU data cannot provide evidence on whether levels of services influenced family involvement in other support domains as suggested by the family specialisation model. Contact frequencies between elderly parents and adult children were somewhat higher in the low-service countries (80% with at least weekly contact), but also high in the high-service countries (65-70% with at least weekly contact), indicating that access to services had not discouraged family contacts. Besides, the high frequency of *daily contact* in low-service countries like Greece, Spain, and Portugal (around 60%) relative to high-service countries like Denmark and the Netherlands (around 15%), indicates that a substantial part of the country difference in contact levels is simply explained by differences in cohabitation rates. Cohabitation is however, mostly due to a lack of alternatives rather than a matter of choice. Both older and younger generations value 'intimacy at a distance' (Rosenmayr and Köckeis 1963).

While actual contact and exchange patterns show rather high levels of intergenerational solidarity, public opinion tends to believe otherwise. The majority of the population in all of these EU countries believed that families are less willing to care for older relatives than they used to be (Walker 1993, Daatland 1997). Interestingly, and perhaps paradoxically, these beliefs were most widespread in the Mediterranean countries, where families were the overwhelmingly dominant care providers. But they were equally present in countries with developed welfare systems. A Norwegian study from the early 1990s found that the public attribute lower family solidarity as a direct consequence of the expanding welfare state. Between 80 and 90 per cent of the population agreed to the following statement: '*When the welfare state expands, family solidarity declines*' (Asbjørnsen 1991). But this very same population was extremely supportive of public services. The direction of these two views seems to be a paradox, since a presumably *undesirable* outcome - the loosening of family ties - arises from a preference for the development of public services.

Cross-sectional data, such as the EU data, cannot show whether observed patterns are stable traits or a response to changes in welfare states. A better test of stability versus change is to study developments over time: does family care tend to decline when service levels increase, and conversely, does family care increase when service levels decline? Susan Lingsom (1997) has studied the Norwegian case, where home help and care services were introduced in the 1950s. Services expanded greatly during the 1960s and 1970s, levelled off during the 1980s, and

declined rather moderately in the 1990s. According to substitution theory, the period of increase should either be a response to a decline in family care, or should itself produce such a decline. But Lingsom found that family care has been remarkably stable over the whole period, both during the period of service expansion and when service levels eventually declined. To be more specific, Lingsom found an *increase* in the number of family carers, but a decline in the average volume of help from each family member. Hence family care has been distributed among more hands, but each of them carry a smaller burden. The total volume has therefore remained more or less constant.

These trends do *not* support the substitution thesis. In the Norwegian case, families were not crowded out, nor did they withdraw, when alternative sources of help were made available. Neither is there any evidence of reverse substitution when services were cut back. Lingsom concluded that the home care services supplemented family care, but did not replace it. Complementarity was also found in individual relationships. When needs were substantial, an older person usually received help from *both* the family *and* the social services. In fact, older parents with home help services received *more* help from their adult children than parents without such services, even after controlling for their needs and the availability of filial care. Controlling for a wide range of variables, these parents also had more frequent contact with their children than parents without services. Hence Lingsom, concluded that in the Norwegian case, there is no indication that family care was withdrawn when home services were provided. She suggests that home help services could even generate additional efforts by the family to support older parents, as suggested by family support theory. Kohli (1999), and Künemund and Rein (1999) add support for this model but from a different angle. They suggest that generous state pension schemes enable older generations to reciprocate support from younger generations. A highly developed welfare state therefore strengthens the older person's position in the family and stimulates reciprocal exchanges.

In more extreme cases, when needs are either very small or very large, social services can replace or substitute family care provision. Lingsom (1997) for example found that when needs were modest, nearly half of the Norwegian home-help clients in her study had no additional help for household chores from their families. This may simply (and trivially) be a case of one party not needing to redo what the other has already done. At the other extreme, when needs are very large, responsibilities may be transferred more or less in full to the service system through institutionalisation. This need not, however, imply that families withdraw altogether. In fact, family support often continues after an older person moves into residential care, but it takes on a different form, such as visiting or emotional support.

Descriptive patterns

What are the patterns of help observed in the OASIS study countries? Is there any evidence to favour either the complementarity or substitution hypotheses, or do both patterns exist simultaneously? These issues are explored step by step using the OASIS survey data, firstly through a comparison of help levels and profiles, and then by assessing how differences in these patterns should be explained. To restate the main research questions:

- Are family help levels low when service levels are high and vice versa, are family help levels high when service levels are low? If so, this would be evidence supporting the substitution hypothesis in the sense that the development of services has weakened the family's commitment to care.
- Alternatively, do welfare state services support and encourage family help, and is it possible that services direct the family towards arenas of intergenerational exchanges other than elder care? This finding would support the complementarity hypothesis or one of its variations, the family specialisation hypothesis.

The presentation of results from the OASIS survey data begins with simple descriptives of help levels and help profiles, gradually building up to multivariate analyses.

Help levels

The giving of help can be measured in many ways, and the results may include elements of how help is defined and measured. The help levels presented here are based on the responses of adults aged 75+ to questions posed on help received in three domains. These domains are equally relevant for family helpers and professional services. They include help with *household chores*, help with *transport and shopping*, and help with *personal care*.[2] 'Help' is indicated by whether or not the respondent has received any of these three items of help during the last 12 months, and from whom.[3]

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[2] Respondents were asked: 'During the last 12 months – have you received any *help with household chores* like cleaning, washing clothes etc. from family (inside or outside the household), from organised services (public, charity, or commercial), or from others, such as friends or neighbours. (If yes) Who have you received this help from? From family, from services, or from others?' (The procedure was then repeated for help with *transport or shopping*, and *personal care* like nursing or help with bathing or dressing).

[3] Reports from adult children about help *provided* might have produced a different picture, for example if family help is taken for granted and then underestimated in a help received approach. This eventuality is dealt with later in the chapter.

It is important to note that help is recorded simply with the receipt and source of help as indicators. There is no assessment of the volume, regularity or perceived importance of these help items. Thus interpretation of the results should be made with this caveat in mind. If family helpers on average provide *more* help than service professionals, then this approach will underestimate the role of families, and vice versa if service providers provide more help. There is no good reason to assume a bias in either direction, or hypothesise a difference between the five countries. It is therefore assumed that comparisons between help sources and countries are unbiased. In other words, if half of the reported helpers are family and the other half service providers, the assumption is that 'help' – including the volume, regularity and perceived importance, - is divided equally between family and service providers.

Bearing these limitations in mind, the data show that total help levels (for at least one type of help from any source) are in fact fairly similar in the five countries, with the possible exception of Israel (Table 1). Between 50% (Spain) and 56% (Norway) of the 75+ respondents report having received help in at least one of the three domains during the last 12 months. Israel stands out with a somewhat higher help rate (67%). Differences between countries are moderately larger when the data are broken down to each of the three types of help. Note that Israel deviates primarily in the higher receipt of help for household chores. Help with transport, shopping and personal care is fairly evenly distributed. Personal care, in all five countries, has the lowest rate, which is almost certainly due to fewer people having a need for such help.

Table 1. Receipt of help among 75+ with household chores, transport/shopping, personal care during the past 12 months by country and physical health (%)

	Norway	**England**	**Germany**	**Spain**	**Israel**
Household chores	48	43	43	40	63
Transport/shopping	37	46	41	33	40
Personal care	12	15	18	13	20
At least one type of help	**56**	**55**	**51**	**50**	**67**
– at risk	86	71	63	63	73
– not at risk	35	26	31	32	55
n	*412-413*	*396-397*	*499*	*384-385*	*368*

Notes: Physical functioning is measured by scores on the SF36 sub-scale of functional abilities. Respondents in the lower 60% of the distribution are regarded as 'at risk' of dependency and more in need of help/support than those not at risk.

The receipt of help naturally varies with needs. Table 1 shows that there are higher levels of help among respondents at risk of dependency than by those not at risk. These differences are particularly high in Norway and England, implying that help is targeted more towards the most frail in these two countries. Israel stands out at the other extreme, showing only a small difference in help rates according to individual needs. It is primarily the high rates of help for those *not* at risk that sets Israel apart from the other four countries. The explanation is found in the high rates of paid helpers doing household work in Israel, where private domestic help is probably more common than in the other OASIS study countries. A more detailed analysis of the data (not shown here) indicates that personal care is more or less totally reserved for those at risk (as would be expected). The more instrumental types of help are less strongly associated with functional ability.

A final observation that needs to be noted is that the majority of 'at risk' respondents have at least some form of help. Help given to the at risk group is particularly high in Norway, where only 14% report that they are without help. Hence the great majority of Norwegian older people in need have at least some kind of help. But it is not possible to tell from the data whether they have the right type (or enough) help. In the other four countries, a large minority of the at risk group are without help (27-37%). This contrast may be taken as an indication that a partnership between a generous welfare state (in these domains) *and* the family is more able to cover the need for help among elders than a totally family dominated care system.

Help profiles

Although total help levels are fairly similar in each of the countries, help profiles – from whom the help comes – differ considerably (Table 2). *Service rates* are high in Norway (42%) and Israel (32%), considerably lower in England (25%), Germany (16%) and particularly low in Spain (7%). Spain and England on the other hand have high rates of *family help* (38-39%). Israel and Norway have lower (but not dramatically lower) rates (25-29%). Variation among countries in family help is thus considerably less than the variation in service rates. These results show that family help has clearly not been replaced by the welfare state. But it may be reducing or changing in character.

Table 2. Receipt of help[a] among 75 by country and health (%)

	Norway	England	Germany	Spain	Israel
Family help	**29**	**39**	**34**	**38**	**25**
– at risk	43	52	40	48	29
– not at risk	19	17	24	22	16
Services	**42**	**25**	**16**	**7**	**32**
– at risk	73	36	24	9	41
– not at risk	21	7	4	5	17
Help from 'others'[b]	**7**	**26**	**14**	**12**	**22**
– at risk	11	35	17	16	21
– not at risk	2	10	8	7	26
n	*411*	*385*	*483-493*	*384*	*368*

Notes: a) At least one kind of help. b) Help from 'others' includes neighbours, friends, volunteers and privately paid help.

It should be noted that family help has other features and functions than services alone. For one thing, families are more flexible and active when a broader range of domains than services are taken into consideration. Moreover, exchanging different forms of help is commonplace in most families and need not be restricted to circumstances where needs are compelling. This is illustrated in Table 2, where professional services are distributed more closely according to need (for respondents at risk) than is family help. This contrast probably also means that the help reported for the receipt of services is (on average) greater than help from families. If this is actually the case, then the help levels will probably be more slanted towards services than the reported percentages in Tables 2 and 3 (below) indicate.

A more vivid illustration of *help coverage* under the different welfare regimes is that 73% of the at risk group have help from services in Norway, which is the one country of the five where these kinds of services are the most easily accessible. The corresponding rates are half or less in the other four countries, and the lowest in Spain, where only 9% of respondents aged 75+ at risk receive help from services for household chores, transport/shopping, and/or personal care. The slightly higher rates of family help in Spain and England compared to Norway do not compensate for this difference. Germany and Israel have lower help rates for elders at risk than Norway from *both* services *and* families. Other sources of help might fill part of the gap, but only partly, and if so only in England and Israel which have fairly high rates of help from 'others'. These 'others' are mainly neighbours (England) and privately paid helpers (Israel).

Help profiles also vary by help domains. The family dominates in help with transport and shopping (over 50%), which is the only domain where the family is the dominant source of help in all five countries (Table 3).

Table 3.Family help as percentage of total help by domain and country.

	Norway	England	Germany	Spain	Israel
Household chores	27	39	49	59	19
Transport/shopping	52	56	62	74	49
Personal care	18	36	46	81	16
n	*412-413*	*389-392*	*494-498*	*384-385*	*368*

Notes: The reported help totals (from any source) from respondents in receipt of help vary from 146% in England to 102 % in Israel, implying that English respondents have often reported help from several sources, while Israeli have reported help from one source only in each domain. Help totals are therefore adjusted to 100 % in all countries in order to produce a fair comparison.

Table 3 shows that the family is the main source of help in all three domains in Spain, and the major source (but not equally dominant) in Germany. In contrast, Norway and Israel have services as the main providers of domestic help and personal care. The extreme cases are found in the domain of personal care, where there is a 81% dominance of *family* care in Spain, and a correspondingly large *non-family* (mainly services) dominance in Israel and Norway.

Preliminary conclusions

The 'care system' (Daatland 1983) has a simpler mix of services and family care in Norway and Spain compared to the other OASIS study countries. But the way that these two countries combine the two differs. Spain has a very family dominated care system, while a mix of public services *and* family helps to characterise the Norwegian case. Israel has a comparably high level of services than Norway. But it also has, like Germany and England, a broader mix of public and private services (although the latter are usually financed publicly). These three countries also have more input from other helpers, a category that includes friends, volunteers, neighbours and privately paid helpers. It is not possible to assess whether the more active role of 'other helpers' should be taken as a response to the failures of the welfare state or be seen as a strength of the total care system. Both may apply, pointing to the strengths and weaknesses of the different systems. The Norwegian model could benefit from a broader set of helpers, while countries like England, Germany and Spain could benefit from a larger input from services. Israel has the broader model, but would probably benefit from a more selective distribution of services to those at risk of dependency.

In conclusion, and judging in particular from the higher overall coverage of help for the at risk group in Norway, generous welfare state services seem to be more of a *complement* to family care than a *substitute.* They contribute to a larger overall

coverage of needs among elders, at least in the help domains that have been considered here.

Multivariate analysis

A more sophisticated test of if and how service provision affects family care requires a multivariate approach, which takes into account the effect of other factors. Table 4 summarises the results of a series of multiple regression analyses, where family help is treated as the dependent variable and formal services as an explanatory variable. Family help is here measured as 0-3 types of help received (household chores, transport/shopping, or personal care). Service provision help is introduced as a dummy variable, received help or not (0-1).

The control variables are:

- the need for help (risk of dependency), measured by scores on the SF36 physical functioning index. Respondents in the lower 6th decile on this scale are regarded as 'at risk' of dependency and in need of help
- the availability of family to provide help, measured by proximity of nearest child.
- being a widow(er) and living alone. These two variables are included as additional indicators of the a potential need for help
- preference for care – whether the respondent prefers help from family or services. Respondents are divided into two groups - those in favour of family care and those with a preference for help from services or others

The analysis is performed in two stages. The first stage is a simple bivariate regression of family help on formal services. The second stage includes the control variables. This procedure should make it possible to test whether any effects of *formal services* on *family help* are real or spurious, and hence in the latter case explained by other factors. The results are summarised in Table 4.

Table 4. OLS Regression of help received from family among 75+ on (a) help from services and (b) controlling for needs, availability of children and preference factors

	Norway		England		Germany		Spain		Israel	
	1	2	1	2	1	2	1	2	1	2
Help from services 1=received	.198[c]	.096	.174[c]	.144[b]	-.034	-.005	.029	.003	.036	026
Risk of dependency 1=at risk		.226[c]		.316[c]		.234[c]		.273[c]		.106[a]
Marital status 1=widow(er)		-.003		.160[b]		.095		.176[c]		.129
Household 1=live alone		.066		-.146[a]		-.134[a]		-.155[b]		-.254[c]
Child living close 1=within 10 min.		.100[a]		.129[b]		.256[c]		.104		.235[c]
Prefer family care (1=yes)		.072		.204[c]		.234[c]		.140[a]		.054
R^2	.039	.105	.030	.235	.001	.227	.001	.190	.001	.113
n	*411*	*397*	*385*	*376*	*485*	*479*	*384*	*370*	*368*	*348*

a)p<.05, b)p<.01, c)p<.001

Looking at the simple bivariate regression firstly (columns marked 1 in Table 4) the results show that service provision is significantly correlated with family help only in Norway and England. Moreover, this correlation is in the opposite direction of what should be expected according to the substitution hypothesis – respondents who receive services are *more* likely to have family help than those without services in these two countries.

When the influence of needs, family availability and preferences are controlled for (the column marked 2 in Table 4), the effect of services on family help gets weaker (England), and may even disappear (Norway). The reason is probably, and simply, that the need for help (risk of dependency) has explained (most of) the variation in both family help and service use. The small variation left points in the direction of a family support effect by service provision in England and Norway. The other three countries show that the presence of services has no effect on family help.

It is no surprise that needs (risk of dependency) have a significant effect on family help in all five countries. The availability of family to help (as indicated by having a child living near-by) also increases the probability of family help being given in all countries, although not significantly so in Spain. The impact of marital status is

less consistent, while household structure seems to be more of a family availability variable than an indicator of the need for help. Older people living alone may have a higher need for help, but they have less family resources, and hence a lower probability of receiving family help (except in Norway). Elders in shared households have *more* help from their family simply because they live with partners and/or children.

And finally, a preference for family care increases the probability of receiving family help, but only in England, Germany, and Spain. The coefficients for Norway and Israel point in the same direction, but do not reach acceptable levels of statistical significance, perhaps in part because very few respondents indicate a preference for family care in these two countries (see Chapter 5).

In conclusion, there is no support for the substitution hypothesis in these data. If older people receive formal services, then this does not seem to discourage the family *also* giving help and support. If anything, the evidence suggests that services are a stimulant for family help in England and Norway, although not significantly so for Norway. In the other three countries, service use does *not* seem to influence family help at all. Finally, on the basis of these data, it is not possible to assess whether receiving services may have changed the direction of family help, as suggested by the family specialisation hypothesis. This issue is discussed later in the chapter.

The analysis shown in Table 4 assesses the influence of service provision on family help. One could equally well argue for a possible effect in the other direction – that family help may influence whether older people receive services. Although not shown here, such an analysis (corresponding to the one shown in Table 4 but with service provision as the dependent variable), does show that there is no significant effect of family help on service provision when controlled for the same set of explanatory variables. Services tend to be targeted according to needs (those at risk) more closely than family help, in particular in Norway and Israel. Family helpe is obviously given for other reasons than need.

However, having a child living close-by *reduces* the probability for services in all countries, but with statistically significant results only in Norway and Israel. One of the Norwegian respondents from the qualitative phase of the OASIS project illustrates how informal norms about family help can reduce chances of receiving services. This respondent remarked: '*It's not easy to get enough help* (services) *if the family lives near-by'*. Family care tends to be taken for granted by administrators of service provision. They operate according to a logic of substitution, reducing services if families are able and willing to help out. One Norwegian daughter clearly illustrated this tendency when she stated that '*…we (two daughters) help out (the father), but the problem is if it's too clean at his flat,*

then the administration assumes he (father) doesn't need help, and they may reduce the services'.

The adult child perspective

The patterns analysed above relate to the perspective of the older person. The OASIS survey also covers the other perspective, that of adult children to parents aged 75 and over. Adult children were asked whether or not they have provided (and received) any of a number of types of help to (and from) parents during the last year.[4] This procedure produces considerably higher rates of help between children and parents because it includes more help domains (such as emotional and financial support). Also, the children and parent perspectives cannot be compared directly, because some parents may get (or give) help from (or to) several children. A more important limitation for the purposes of this analysis is that the data is restricted to parents and children. Childless respondents are excluded, and so also is help from sources other than the child. Hence it is not possible to examine the relationship between family help, service provision and others sources of help.

Notwithstanding these limitations, the reported help and support patterns from the perspective of adult children can be interpreted in the context of the substitution and complementarity hypotheses. Lower rates of help by these children in the countries with high levels of services (Norway, Israel) should point towards (possible) substitution effects, while higher help rates in these countries are more likely to indicate complementarity. Some indication, admittedly speculative, may also be extracted from the variation between help domains. If substitution is operating, high-service countries should have low levels of help given by children in those domains where services are de facto an alternative, as for example in help with household chores. But low levels of help by adult children is *not* expected, in those domains that are not covered by services, such as emotional support and help with house repairs and gardening.

As Table 5 shows, there is little or nothing in the adult children responses indicating substitution effects. Firstly, the adult child help rates are high in all five countries. Country differences are moderate and vary between 70 and 87% of children reporting that they have helped/supported parents in at least one of the listed domains during the past 12 months. The help rate is in fact highest in the high-service country of Norway (87%).

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[4] Adult child respondents were asked whether during the last 12 months they *provided* or *received* help, assistance or support to or from any of their parents. The list included help for house repairs and gardening, transport and shopping, household chores, personal care, financial assistance, emotional support, and (where relevant) help for child care.

Table 5. Help and support to and from older parents (75+) by domain and country from the adult child's perspective (%)

	Norway	England	Germany	Spain	Israel
Provided help to parents					
Emotional support	71	62	74	65	69
Transport/shopping	58	45	49	26	41
House repair/gardening	48	31	31	21	22
Household chores	27	29	34	22	18
Personal care	9	5	9	16	12
Financial support	4	14	7	18	23
At least one type of help	**87**	**76**	**83**	**70**	**74**
(n)	*(163-6)*	*(132-3)*	*(98-9)*	*(137-8)*	*(147)*
Received help from parents					
Emotional support	46	39	53	42	59
Transport/shopping	6	6	0	3	1
House repair/gardening	9	2	3	1	5
Household chores	7	4	4	6	5
Child care	18	n/a	4	6	10
Personal care	0	1	1	1	1
Financial support	26	8	11	7	47
At least one type of help	**59**	**44**	**54**	**45**	**67**
(n)	*(163-6)*	*(132-3)*	*(98-9)*	*(137-8)*	*(147)*

Notes: At least one type of help *from* parents does not include help to child care, as this item was not available for the English respondents.

Secondly, the availability of services has seemingly not reduced levels of help given by children in those areas that are generally covered by formal services, such as help with household chores and personal care. Few children in any of the five countries report that they have provided personal care to older parents, which is probably because few of them have parents with such large needs. The personal care rate is somewhat higher in Spain, probably at least in part because cohabitation rates are higher in this country. Other research has shown that older people in the Netherlands and the Nordic countries are quite reluctant to receive personal care from their children if they can avoid it (Daatland 1990, Wielink et al. 1997). As for help with household chores, Norwegian adult children are equally likely to provide such help as in the other countries, and hence not 'crowded-out' by services. This may in part be due to the character of such services, since they often provide only basic help on a weekly or fortnightly basis. Any needs beyond this, including acute problems, must be taken care of by the family.

These patterns can be illustrated with reference to the OASIS qualitative data. A Norwegian daughter voices her irritation about what she sees as an inadequate volume and quality of services: '*I don't expect them (public home help services) to take care of my mother 24 hours a day. But when they are here, I think they should do more than they do and not leave all the work to me as a daughter.'* Another Norwegian daughter complains about the poor co-ordination between the service providers and the family: '*They should communicate with the family, because we know the problems better than the home helpers who change all the time'*. A third Norwegian daughter adds to these complaints: '*I write messages (to the home help) all the time, but I never get any feedback. I'm really fed up!'*

Emotional support is clearly the dominant type of support between adult children and their older parents. More than two-thirds of adult children who have at least one parent aged 75 and above have provided emotional support to them. It should be noted that quite a few parents do likewise in return – nearly half of the adult children say they have received such support from their elderly parents.

As far as country differences are concerned, they seem to be particularly large in the domain of help with home repairs and gardening on the one hand, and with financial matters on the other. Financial support mostly flows *from* older to younger generations in Norway, Israel and Germany. In England and Spain, the pattern is in the opposite direction, possibly in response to lower pension levels and higher poverty rates among elders in these two countries. Israel stands out with considerable levels of financial support in both directions – a pattern which is probably explained by local and idiosyncratic factors. The comparably high flow of financial support from elderly parents to the adult child generation in Norway (and conversely the low rates of such help in the other direction) probably reflects a comparably generous pension system. This finding supports the crowding-in hypothesis suggested by Kohli (1999) and Künemund and Rein (1999). Generous pensions may enable the older generation to contribute and reciprocate in family exchanges, thereby encouraging, rather than discouraging, family ties and contacts.

Discussion

The OASIS survey data provide some evidence of substitution effects between services and families. Family help tends to be higher in countries with low service levels (Spain, Germany), and lower where service levels are high (Norway, Israel). Correlation coefficients between service provision and family help are, however, moderate. The *actual* patterns of the two different types of help and support show that there are substantial levels of family help in countries with high levels of services. At the same time, this appears to be in domains that are less well covered by services, as for example in help with transport and shopping (see Table 3). This

finding may be an example of the complementarity hypothesis at work, and more specifically of the family specialisation type. When some needs are met (and substituted) by service provision, families direct their efforts towards other needs and concerns that are less well covered by formal services.

The possibility of the family specialisation hypothesis in operation is indicated by a Norwegian adult son when he states that '… *society has the larger duty, but the family can top up with other things* (types of help).' A Norwegian daughter adds that '… *the family will be there and give support, but not as a job and a responsibility. The responsibility should rest with the public and professionals.'* An elderly Norwegian mother supports this view when she concludes: '*You should not expect care and nursing from your children; but you should expect some support from them, like visits from your daughter and so on… '*

Other indicators of intergenerational solidarity, like contact frequency (associational solidarity), emotional closeness (affectional solidarity), and filial obligations (normative solidarity) also tend to favour the family specialisation hypothesis. It is true that more Spanish elders live with a child (which partly explains Spain's high family help rate). But the striking thing, however, is how similar – and high – these forms of solidarity seem to be in *all* five countries. For example, nine out of ten elders report at least weekly contact with a child (Table 6). Affectional solidarity is as high in high-service countries like Israel and Norway, as in low-service countries like Germany and Spain. In fact, Germany seems to have the lowest levels of associational and affectional solidarity, even though service levels are low.

Table 6. Structural, associational, affectional and consensual solidarity, and conflict with adult children (respondents aged 75 and above).

	Norway	England	Germany	Spain	Israel
Structural					
Live together with a child	7	16	10	38	7
Nearest child within 1 hour	87	85	82	94	91
Associational					
Face-to-face contact weekly+	71	80	61	93	84
Telephone contact weekly+	90	90	72	89	96
Affectional					
Feel close (very or extremely)	69	80	51	70	85
Get along well (very or extremely)	79	86	50	66	85
Consensual					
Similar opinions (very or extremely)	29	43	30	17	39
Conflictual					
Conflict (a little or more)	23	17	39	27	39
n	*339*	*326*	*363*	*323*	*332*

Notes: Structural solidarity refers to the nearest child. Association refers to the child with most frequent contact. Note that parents living together with children are here considered to have daily face-to-face contact, but are left out in the frequency for contact by telephone etc. Affection, consensus, and conflict refer to a randomly selected child. For more details about the solidarity dimensions, see Chapter 6.

These findings suggest that overall there is no support for the idea that a substitution of family help by services in instrumental domains is a response to – or producing – a breakdown in other aspects of family solidarity such as affection and consensus. Neither is this the case for normative solidarity, as is indicated by general support for filial obligation norms (Chapter 5). The main impression from Chapter 5 was that these norms are supported by the majority of the urban population in both high and low-service countries, although they are slightly stronger in Spain. Hence lower family help rates in high-service countries is hardly

related to a lower willingness of families to support their elders. It is much more likely a response to the availability of alternative sources of help. The majority of the urban population in all countries except Spain have a preference for services over family care, and older people even more so than the younger (see Chapter 5).

Finally, it should be noted that the findings in Table 6 could be biased by an inclination among the older generation to gloss over conflicts and present a rosy image of the family. The younger generation does, however, present a rather similar pattern. To be sure, adult children respondents report less affectional closeness and more conflict with their parents aged 75 and above than older parents do (reporting about conflict with an adult child). This finding supports the *developmental stake hypothesis, where* the older generation invests more in family relationships than the younger (Bengtson and Kuypers 1971). But the variation between countries on these indicators of intergenerational solidarity, conflict, and ambivalence is moderate and/or inconsistent, except for the more frequent contact with elderly parents reported by Spanish adult children.

Conclusions and recommendations

The OASIS project does not have data to determine whether there have been changes in the balance between family help and service provision over time. There is only indirect information on substitution or complementarity processes. Such processes can only be deduced via the patterns observed, at the time of the survey as *more* or *less* likely. However, and considering that services have been available only during the last 30 or 40 years, it seems reasonable to assume that the family and service mix of high-service countries like Norway and Israel must have developed from more family dominated patterns like those of Germany and Spain. The major change must then have been in the service part of the mix, while families have more or less kept up their obligations. All the analyses undertaken in this chapter, although based on indirect evidence, add up to the complementarity hypothesis receiving greater support than the substitution hypothesis. This is not to say that some substitution effects are not observed. But the greater story is one of complementarity between services and families.

Within complementarity, the findings favour the family specialisation hypothesis, implying that more generous inputs from the welfare state enable, or trigger, families to direct their solidarity towards other roles and functions. The welfare state may in some areas even have stimulated family exchanges, as for example where generous pensions enable older parents to support younger family members. The introduction of services has, however, more likely contributed to a change in how families are supporting their elders.

The higher overall coverage of help to those at risk in high-service countries relative to low-service countries indicates that a partnership between services *and* family care is better able to meet the needs of elders than a family dominated care system. When services do not crowd-out help from families, this may in part be because families continue to be committed. As circumstances change, they seek new ways of expressing their commitment. Exchanging help and support is mostly a way of life in families, through routine activities such as visiting, making contact, providing comfort in difficult times and giving emotional support. Moreover, services are often so modest in volume, and so emotionally shallow, that they can hardly replace family and other informal helpers. Hence both are needed, even in high-service countries. Neither should it come as a surprise that the long time-span of ties between parents and children, be they positive, negative or both, are not easily wiped out. Emotional concerns and support for identity and self esteem must primarily find their response in close personal contacts, and family relationships are normally the most important here, in particular in old age.

In conclusion, services do not seem to discourage family help. They are more likely to balance family efforts towards other needs and concerns, and may even be a stimulant for intergenerational exchange. Besides, in care systems based on a partnership between families and the welfare state, the total coverage of needs are higher and more closely distributed according to needs. Hence one recommendation arising from these finding is that all welfare states should invest more in services to elders. This would not only be a support for older people themselves, but also for their families. As the care system is dependent upon both parties, partnership contracts that acknowledge and regulate the sharing of tasks should be encouraged. This partnership would also benefit from a broader base, where other parties are encouraged and supported to contribute. Contributions by others, be they neighbours or volunteers, are however more fragile and need institutional support in the form of services.

The larger context is that services and cash transfers in the modern welfare state represent a potential for adult generations to retain their independence - something which seems to be welcomed by both the younger and the older generation. The slightly lower family help rates in high-service countries is more likely a response to the availability of services than to a lower willingness of families to support their elders. Older people are themselves reluctant to be dependent on their adult children, be it for financial security, housing, or indeed most forms of help. Future generations of elders will probably be even more so. But family relationships and support, if and when one should come to need it, is warmly appreciated by older people, especially when it is seen as something that children want to do rather than doing so reluctantly. The modern family may have borrowed ideals from friendships. Whether this will be a threat to the family as a support to their elders, or is in fact a flexible adjustment to new social realities, remains to be seen. The

very potential for change has been one of the keys to the strength and persistence of family relationships, and may continue to be so.

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11

Social policy implications

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Introduction

The aim of this chapter is to outline the policy recommendations emanating from the OASIS project. The OASIS project was implemented with the RTD Work Programme, Key Action 6 of the European Commission's fifth Framework Programme: The Aging Population and Disabilities. The main objective of the OASIS project is to provide a cross-national knowledge base of the interplay between personal, familial and social service factors for autonomy in old age, so as to enhance the quality of life of elders and their family caregivers. Such a knowledge base is an important asset for creating viable and sustainable policies regarding ageing populations in the European Union. The recommendations that follow are derived from the findings of the previous ten chapters. The aim is to inform future European Union policy decisions concerning older populations in areas such as dependency, caregiving, the needs of carers and improvement in quality of life.

Heterogeneity is one of the key features of older populations and there is no single solution to the wide variety of needs associated with ageing and old age. The OASIS study therefore, aimed to provide a comparative perspective on the issues it identified as being relevant to the needs of older people. The study was a cross-national study, including the five following countries: Norway, England, Germany, Spain, and Israel. These countries have a diverse range of welfare regimes (institutional, conservative, residual) and familial cultures (family-oriented and individualistic). The five countries were selected under the following premises: First, they represent complex welfare state arrangements where the issue of family solidarity and its interaction with existing service networks is being debated in the context of developing social care services. Second, the four European countries in the study represent various types of welfare states as identified in theoretical literature on models of state provision. Israel presents particular challenges, as Israeli society has diverse family cultures and a wide range of social services for the elderly.

The chapter begins with a brief recapitulation of the project and an outline of its objectives and methodology. Policy relevant findings relating to the eight research questions of the study are then discussed. Finally, policy recommendations emanating from the overall findings are presented according to three levels of analyses: the macro-societal, the meso-familial and the micro-individual.

Ageing populations and changing family structures

There are important socio-demographic trends that are the driving forces behind the research questions in the OASIS project. These are first the enormous progress that has been made in increasing life expectancy and consequently the ageing of the European population, particularly those over the age of 85 (Eurostat, 1996; Kinsella, 2000). Fertility decline is also an important trend with major consequences for ageing populations (Eurostat, 1996). Alongside these demographic trends are changing profiles of the workforce, a diversity of family structures, transformed network compositions and new living arrangements of older people. An ageing society is the consequence of the improvement in working and living conditions during the last century. These developments have occurred together with the public internalisation of citizenship's rights, leading to greater demands on policy makers and politicians. The adequate provision of health and social services for the elderly is increasingly being perceived as a political right for every individual. European societies, and especially their welfare states, have responded to the changing needs and greater aspirations of older people and their families by developing a range of community and institutional care services. In addition to the arrival of ageing societies and family diversity, we are also witnessing the impact of broader societal and technological changes. These include internal and external patterns of migration, equal opportunities for women in education and employment, frequent shifts in social policies, and higher expectations concerning the preferences of families for social care provision. All these changes raise fundamental questions about the definition of old age, the micro experiences of elders and their families and the macro responses of societies to their needs.

The OASIS study is based on the concept of the 'ecology of human development', which distinguishes macro, meso and micro levels of analysis in order to promote a better understanding of the complex interplay between individuals, families and social structures. Three perspectives therefore run throughout the study. The first focuses on the quality of life and autonomy of elders and their caregivers (micro level). The second focuses on intergenerational relations (meso level). The third perspective is the welfare state and its interaction with the family (macro level). In addition to these three perspectives, the research also stresses the need to study ageing and intergenerational relations in a life course perspective. This framework offers a fruitful avenue for exploring the ways in which cultural, social and economic factors, as well as external structural-environmental conditions, shape care-giving behaviours and influence quality of life. In this way, the findings can provide a solid base for making policy recommendations.
We would also argue that at a macro level, social policy must address issues which go beyond health and social care. There should be an intersectional approach across a broad range of policy measures to adequately address issues of independence, care giving and quality of life. The consequences of ageing

populations must be incorporated in all areas of policy and at both national and EU levels.

Oasis project objectives and methodology

The OASIS project had three specific objectives:

- To analyse the interacting roles of family care and service systems on the quality of life in old age. In all five of the project countries, formal and informal elder care systems are in place. But the balance differs between countries according to family cultures and the availability and accessibility of formal services.
- To study variations in family norms and transfers (intergenerational solidarity) across age groups within the project countries.
- To learn how individuals and families cope when elderly members are at risk of dependency (intergenerational ambivalence).

The project combined quantitative and qualitative research methods, and both a cross- sectional, cross-generational approach was followed, allowing a triangulation of the findings. The main approaches adopted in the study were:

- baseline data collected through a standardized survey (cross-sectional) in all five countries. Representative samples were selected from urban areas of people over 25 years of age (25-74 years: *n*=4,042; 75+ years: *n*=2,064) totaling 6,106 across the five countries. Information was collected on basic socio-economic and demographic variables, health and functioning, family norms and transactions, intergenerational relations, access to and use of service systems, competence and coping and quality of life (autonomy, well being).
- Through the survey, ‘elders at risk’ were identified and a sample of 10 dyads of older people and their ‘primary adult child’ in each country were selected (totaling 100 persons in the five countries). In depth interviews were conducted with both members of the dyad. Thematic cross-national analysis was undertaken.

This range of research approaches strengthens a cross-national understanding of social policy at both the macro and micro level. The research team was able to accumulate large and varied data in order to understand how older people and their families interact in times of dependency.
Based on the theoretical frameworks of the OASIS project regarding the macro, meso and micro levels of analysis and the general objectives of the study, the following research questions were posed:

(1) What is the actual and preferred balance between families and formal service systems?
(2) Are families and services substituting or complementing in the care system?
(3) How do family norms and practices (family culture) influence the service system, and vice versa, how are they influenced by the welfare regimes?
(4) How do these behavioural and normative patterns vary between countries and generations?
(5) What are the normative ideals of intergenerational care and living arrangements in the different countries?
(6) To what extent are these norms shared across cohorts/generations, and what changes are to be expected for the future?
(7) How do families handle intergenerational ambivalence, and how is it related to quality of life?
(8) Can intergenerational solidarity and ambivalence exist together? Is there a balance between them, and how does this reflect on quality of life in care-giving situations?

The discussion of the policy recommendations that follows takes place in the context of the three OASIS objectives and the eight specific research questions.

The balance between services and family care

The first question addressed the actual and preferred balance of services between the family and the state in the care of elders in need. A relatively large proportion of older people (75+), ranging from 50% in Spain to 67% in Israel, receive help with at least one of the domains of: household chores, transport and shopping. Among older people at risk of dependency, most receive one or more items of help (in the above domains) or personal care, ranging from 63% in Germany and Spain to 86% in Norway. However, substantial minorities of those at risk do not receive any help, ranging from nearly 40% of older people in Germany and Spain to 24% in Norway.

The findings indicate that the balance between services and family care is different in the five countries. In Germany and Spain, and less so in England, when the 75+ elderly are 'at risk of dependency' and in need of support, they actually receive this support *more* from their informal network – mostly the family.

In Norway and Israel, where there is a wider range of services available (especially community services such as home help and home nursing care), the family provides less instrumental and personal care. But *total* help levels (family and services) are higher. Hence, family dominated models of services, such as Germany and Spain, are vulnerable, and in contrast to what both older and younger

generations themselves prefer. On the other hand, more specialised professional services such as doctors and hospitals are distributed differently, with in general low rates in Norway and high rates in Spain. Service development, however, should follow the path relevant to each country, because the family continues to play an important role - even in Norway with its wide network of services.

Complementarity versus substitution

The second question addressed the issue of complementarity versus substitution debate that concerns support given by the informal and formal sectors. The findings point out that welfare state services do not erode family solidarity. But they may change the way that solidarity is expressed within the family. Younger and older generations in all the five countries of the OASIS project emphasise the need for more services. Older generations (except in Spain) are pushing for an expansion of services to meet their needs. Some substitution between families and services is observed, but mostly the emphasis is on complementarity between the two types of social care provision. An important finding with policy implications is that alongside service provision, the family specialises in those forms of support that it is best able to give. This help is for the most emotional support, for which the family is much better equipped than formal services.

The data, particularly from the qualitative interviews, reflect considerable uncertainty about the provision of formal care. When provided, it is highly appreciated and valued. Formal care appears to make all the difference between managing independently or dependency. Uncertainty about the future availability and complementarity of care is strongly evidenced in the interviews from Norway, England and Germany. Older people at risk of dependency and their children express a high awareness of the existence of eligibility criteria in obtaining services, together with more restrictions on both the amount and type of community care currently being provided. Spanish respondents also express uncertainty over how care will be provided in the future given that family values are changing.

Family norms and practices

The third and fourth research questions deal with the issue of how family norms and practices (family culture) influence service systems, and how they are influenced in turn by service provision. These questions also address how patterns vary between countries and generations The data indicate that filial norms are still quite strong and prevalent, but support for filial responsibility is neither absolute nor unconditional.

Both the substance of filial norms and the level of support provided varies between the countries studied. It is more strongly expressed in countries with a stronger family culture like Spain and Israel, and lower in Norway, England and Germany. However, support for filial obligations does not necessarily imply that the family is seen as the natural care provider. Again, more support for more welfare state responsibility is observed. The older generations are those most eagerly pushing for governments to take more responsibility, except in Spain. But on the whole, no major age and gender differences in norms and ideals are found. Thus, the actual dominance of female and family care in the countries studied is imposed by a lack of alternative services. So in countries where female and family care is dominant, this dominance is imposed by a lack of alternative support services.

The perceived preferred balance between services and families in Norway and Israel is congruent with the actual balance in care provision in these countries. But preferences for services are higher than the level of services *actually* provided in the other three countries, implying an unmet wish for services. Respondents in all countries, though, prefer some form of partnership. But the Norwegians and Israelis, and to a lesser extent the Spanish, place the welfare state in the dominant role, supported by the family. Respondents in England and Germany tend to favour an equal split.

Older people in the majority of countries are hesitant to push responsibility onto adult children for care. Also, the majority prefer independence between generations and are reluctant, for example, to move to share households when needs arise. Residential care is preferred, with Spain again as an exception. Adult children are not downplaying their responsibilities but shifting the focus from providing practical instrumental care to other forms of care, like emotional support or managed care.

Intergenerational family solidarity

The fifth and sixth research questions investigated the normative ideals of intergenerational care and living arrangements in the different countries and to what extent these norms are shared across cohorts/generations Generally, the findings reveal that intergenerational family solidarity on its six dimensions of proximity, association, affection, consensus, functional assistance and normative solidarity, is strong in all the countries. Its strength, though, varies according to the dimensions. Regarding living arrangements, Spain stands out, with about a quarter of the elderly 75+ living with one of their children. This compares with only between 5% and 9% sharing their households with a child or their children in the other four countries. Most older parents, though, live close to at least one of their adult children.

Regarding functional help, relatively lower rates of assistance provided by children to elderly parents are found in Norway and Israel. This could be related to the levels of service development for older people in these countries. However, they both have levels of contact and affection as high as in those countries where family help is dominant. Generally, emotional support is the domain where most help is provided in all countries. The domains of personal care and financial assistance provide the least support. But when in need, elderly people prefer the help of a paid worker, as do their children. In times of crisis children are expected to provide support or act as care managers. Spain is again the exception, where normative expectations are very high, both for older and younger generations.

Data in the multivariate analyses point to the importance of country, level of education, marital status, gender, number of children, perceived financial situation and physical functioning as related to the solidarity dimensions. Widowed mothers with lower levels of education and a low perceived level of financial situation live closer to at least one of their children, have more contact with them, expect and receive more assistance. Parents who perceive their level of financial situation as high feel closer to their children and share similar views with them. Generally, those with a lower level of physical functioning receive more help from their family. But as older people are integral to family life, reciprocal transactions between the non-disabled elderly and their adult children also occur. Services, on the other hand, are more strictly distributed according to need than family help.

Intergenerational ambivalence and quality of life

The seventh and eighth research questions address how families handle intergenerational ambivalence, and how ambivalence is related to the quality of life of older people in care-giving situations. An important question here is whether

intergenerational solidarity and ambivalence can exist together The findings reveal that the key feature is the need to actively negotiate and renegotiate family relations and family responsibility in times of change and transitions when dependency needs arise. Older people who did not need assistance were uncertain about how their future care needs might be met. Four distinct patterns of parent-child relations emerged from the analyses: harmonious, steady, ambivalent and distant. The harmonious relationship, for example, portrays a picture of the dyad (older parents and one of their adult children) getting along well but with the acceptance that conflict and ambivalence can occur whilst not essentially altering positive relations. On the other hand, distant relations are characterised by emotional distancing and the experience of conflict and ambivalence in a way which could or does have deleterious effects on family relationships. Different family patterns are identified in each country, with Israeli respondents reporting higher 'harmonious' relationships; Spanish and English reporting high rates of 'steady' relations. 'Ambivalent' relationships are most evident in Germany and Norway and 'distant' relationships are found in England.

To summarize, several key issues emerge from the data. First, the issue of autonomy versus dependence, especially emphasised by older people age 75 and above. These individuals are eager not to be a burden on their adult children and they prefer more formal instrumental assistance. Stemming from this is the issue of the proper balance between preferred and actually provided support by informal carers and formal services to this group, who are at 'risk for dependency'. This balance relates to the issue of substitution versus complementarity between the two sectors – the informal and formal network – connected to the issue of under-utilisation of services and its impact on quality of life of elders and family caregivers. Overall, complementarity between the two sectors is preferred. In reality many of the services are either non-existent or not easily accessible. Basically, strong family solidarity, low conflict, and low ambivalence are observed. However, dependency raises the issue of ambivalence in family relations. Family relations and responsibilities need to be negotiated when care needs arise, and the process of negotiation entails ambivalence.

Quality of life

The overall quality of life of individuals is a multidimensional concept, including both objective living conditions such as income, education and wealth, as well as health status with subjective evaluations. Indeed, the findings indicate that subjective evaluations of the different domains of quality of life are influenced to a greater extent by the objective personal resources of individuals, such as financial, education and health. Family relations and family support play relatively minor roles.

Intergenerational relations are positively related to two dimensions of quality of life: 'physical health' and 'psychological well-being'. The solidarity dimensions, though, have a minor impact on quality of life, beyond the personal resources. The main dimensions relating to quality of life are close emotional bonds between older parents and their adult children and instrumental support provided by children to their parent. Country, age and gender differences are found regarding quality of life, but their impact is smaller in comparison with health status, income and education.

The recommendations, stemming from the findings, are grouped below into the three levels of analyses contained in the OASIS conceptual model: the macro, meso and micro levels.

Policy recommendations: macro level: older people, their families and the state

Part of the equation in retaining autonomy in old age is the relationship between the family network and service systems, particularly the extent to which the family can be alleviated from direct and instrumental care responsibilities and supported in redefining other care roles. Data show that the care of the elderly involves a public/private mix, with the exact amount of these respective support systems varying according to country. The specific mix is related to three factors: (1) cultural codes reflected in family norms and preferences for care; (2) family enactment of these cultural codes that guide the level of readiness to use public services; and (3) opportunities for using services- availability, accessibility, quality and cost.

Within the current context of population ageing and constant economic and cultural change which affect traditional values and norms associated with family intergenerational relationships, services are needed to fulfil new expectations relating to the care and support of frail elderly persons. This is because it is likely that families will not be able to care for their elderly relatives in the traditional manner in the future. New demands will be placed on external forms of support. On the other hand, because of financial pressures on the budgets of European governments leading to public expenditure containment, and the growing numbers of well-off elderly persons, individuals will be in a better position to obtain support from private services.

The division of labour in care tasks between family and services found in the research will probably increase. The family will remain mostly as an emotional support provider and will become a mediating structure between older persons and bureaucracies, even though it will probably continue, especially in transitional situations, to provide instrumental assistance and financial aid when needed. Even in traditional states such as Spain, there is a push towards more welfare state

responsibility. Public opinion however, favours some form of partnership between the family and welfare state. But the preferred mix takes on different forms. In Norway and Israel, the welfare state takes the dominant role. Other countries favour an equal split between the family and services.

An ageing population requires policies that address care needs independently of the family. This will place increasing pressure on policy makers at a national and EU level. On a national level there is already the existence of policies that target needs in countries with more developed welfare states, such as England and Norway. Anxiety about future care and lack of service provision is also clearly evident in our findings.

Health and social care

- There is consensus among the elderly respondents in the OASIS study that the welfare state should shoulder much more responsibility for future care needs. To support this, many people favour a redistribution of finances. Overall, the preferred model is towards some mix of informal family care and formal service provision, but with the welfare state in a more central role.
- Access to services increases their use, and is welcomed by all generations, with the elderly being even more reluctant to receive family help. Receiving help from the formal sector helps them maintain their independence and autonomy. Thus, services should be more accessible, especially to frail elders.
- A wider use of more creative services in community care, in adapted and assisted housing, transportation and education, is necessary if autonomy, independence and family solidarity are to be the foundation of a good quality of life for older people in the EU. Policies should exist that encourage access to affordable supportive and preventative resources for older people to maintain and improve their quality of life. This requires an integration of formal and informal support, health and social care, as well as private and public care systems. There also needs to be proper status afforded to the formal care workforce.
- More choice in care arrangements is preferred. Thus, the opportunity to empower older people and allow choice to exist between different care options is needed. This can only happen if there is determined policy action (e.g. apart from England no country has an explicit policy on carers). Policy action is important in periods of transition. For example, in Spain there needs to be services in place to accommodate changing family norms and values. Policies must support choice and promote other informal bases of support. In this context, the role of governments will be aimed at coordinating care provision (public or private) for elders in need, and supervising the quality of this provision through legal regulations that

control both material means and human resources. Therefore, better training programmes for care workers and an improvement in their working conditions is needed.

- The higher overall coverage of help to elders 'at risk of dependency' in high service countries (mostly Norway and Israel) indicates that a family dominant care system is more vulnerable and less able to cover needs. This points to the importance of increasing the availability and accessibility of the service networks in the other three countries (England, Germany and Spain). This development would be especially meaningful, as services represent a source of autonomy and independence for both older and younger generations.
- Countries that have legal obligations between generations, like Israel, need to reconsider such legislation in the light of demographic transition and the wish of older generations for more independence and autonomy.
- Involving service providers in the process of service development is also important to address the relevant needs of different elderly populations.

Meso-level - Older people in family context: intergenerational relations

The family orientation of social life and the value attached to sociability make the family a main reference point in the ageing process, with ageing needs best understood within the context of the family. Policy approaches need, thus, to recognise the role of the family in welfare provision and to respond by supporting redefinitions of family roles and strengthening those who are involved in care-giving. Reciprocity within the family is evident. Older people however, are reluctant to receive help from their family when alternatives are available. Younger generations, however, are more inclined to accept family help. For some adult children, though, their preference to provide care is hampered by the lack of appropriate and accessible health and social care provision and the competing demands of work and family life.

Policies to promote intergenerational relations can therefore take on a number of approaches. This means providing supportive and complimentary services in the workplace as well as in health and social care settings if families are to function properly. A family paradigm should be extended to the care workforce, given proper status, and disentangled from being seen as an extension of informal family care.

Reconciling work and family life

- Due to a lack of alternatives, women are still the main caregivers for family members when in need. Considering their increased participation in

the labour force, social policies that improve the life of women, in the context of the family and the workplace are a key element. Women's rights and equal opportunities in the workplace need addressing, not only to support women in their own older age but to allow carers to continue in their preferred roles.

- Policies should not be confined to women's issues alone. Attention needs to be given to the social protection of both men and women who devote themselves to care-giving across the life course. Policies should provide opportunities to juggle work and care for an older person, without discrimination, financially, socially and at the workplace. An equal sharing of care between men and women and a high quality of services for older people and their adult children needs to be in place.

- In order to strengthen families and family care-giving, and in order to help families redefine the roles of their members, special services should be developed, such as the training of care-givers, and the provision of respite services.

Micro Level: Older people: citizenship, social inclusion, participation and quality of life

Citizens in general, and older citizens in particular, will call for a broader and better service network and gain more political power due to their growing influence in an ageing society. As the preference of both younger and older generations is towards more involvement of the formal support network, it seems that more services are needed in order to alleviate family burdens and preserve the autonomy of elders. Older people especially do not want to be dependent on their families and want governments to take more responsibility.

- The opportunity to empower older people and allow choices to be made between different care arrangements can only happen if there is determined policy action. If more service options are provided, both by the public and private sectors, it will enhance the sense of autonomy of the elderly and their caregivers. In England, for example, the move to community based services, the onus on empowering older people to arrange their own care, and the emphasis on service user voices in welfare choices at an individual level, have all led to more empowering and individualistic responses to care choices.
- Policies need, however, to take into account the nature and timing of transitions within each individual country. For example, in the Spanish case, older people may not be totally ready to move to a partial substitution by services, which in turn may throw them back on their families.

- Additionally, long-term care solutions need to be attractive so that there are realistic choices available for alternatives to family care.
- In relation to quality of life, the findings indicate that policies must concentrate on building, protecting and maintaining individual resources to ensure the continued quality of life of older people. The accumulation of individual resources in terms of education, income and health earlier in the life-course are therefore important areas for policy consideration.
- In relation to autonomy, older people arranging their own care have an important source of independence and autonomy. Acknowledging the independence of older people can ensure full integration and participation in society. Social policy should move away from the notion of dependence and positive images of ageing should be strengthened.
- The need to identify groups 'at risk of dependency' is important in order to develop adequate service provisions.

Conclusion

This chapter has sought to highlight the main policy relevant findings and implications from a study of four European countries and Israel – the OASIS project on "Old Age and Autonomy: The Role of Service Systems and Intergenerational Solidarity". The study undertaken aimed to analyse the interacting roles of family care and service systems, variations in family norms and transfers and how they impact on quality of life in old age when elderly family members are at risk of dependency. The goal was to contribute to the debate on the overall sustainability of family care versus formal support systems of care. The OASIS study represents a significant step in this area, constituting an attempt to make comparable analyses of the impact of aging populations and changing family structures and norms across four European countries and Israel. Differences within countries and the complexity of social care cannot be simplified on the EU level. If policies can focus on all levels, then given the changes taking place in the demographic, economic and social aspects of families, intergenerational relations and care systems, the EU can draw closer to the goal of promoting the autonomy of older people. This could be achieved by developing more services in the community and through supporting families to develop a more balanced life between work and care and achieving a good quality of life for all EU citizens.

The main conclusions to be drawn from this study are twofold: first, as personal resources have a greater weight on the well-being of elders, policies must concentrate on building, protecting and maintaining individual resources. They must also provide more service options to meet a variety of service needs of the older population in order to enhance quality of life and sustain autonomy in old age. Second, complementarity between families and services is more prevalent than substitution, but still both the old and the young prefer more welfare state services. Thus, policies should not build on families as the primary foundation for elder care,

but should be aimed towards increasing autonomy and independence. There should be a redefinition of the roles of families in care provision. When families are involved they have to be supported. This can be done by developing policies and services in the workplace and services that free families to provide different forms of care based on the wishes of adult children and their older parents.

The analysis and results contained in this report can usefully feed into a variety of policy processes and initiatives on the future provision of care for frail elders. The findings are particularly relevant in the context of demographic aging and the future willingness and ability of the family to care when the EU is increasingly faced with the rising costs of long-term care. The findings of this report can be used as an input to enhancing autonomy, healthy aging, and improving the quality of life of elders and their family caregivers. The results cast light on the perceptions of older and younger family members regarding the expected balance between family and welfare state responsibility for elder care, as well as on the enactment of these norms and their impact on quality of life of the elderly. Thus, they will provide a useful input to the evolving policy debates in these areas.

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Appendices

Appendix 1 - Chapter 3

Contents

Table 1: OASIS basic variables – Marital status

Marital status	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
Married	38,7	48,3	44,1	75,4	56,3	65,8	59,3	17,9	34,6	53,8	47,1	50,1
Unmarried partn.	24,0	14,6	18,6	6,3	4,2	5,3	0,0	1,6	1,0	15,3	9,9	12,3
Unmarried	30,9	24,7	27,5	7,7	6,3	7,0	4,8	11,0	8,5	20,1	17,7	18,9
Widowed	0,0	0,3	0,2	2,8	16,2	9,5	29,3	65,4	50,8	3,9	12,7	8,7
Divorced	6,5	12,2	9,7	7,7	16,9	12,3	6,6	4,1	5,1	6,9	12,6	10,0
Partnershipratio[1)]	*1676*	*1691*	*1676*	*4489*	*1536*	*2469*	*1457*	*242*	*553*	*2236*	*1326*	*1660*
England												
Married	53,8	55,7	55,0	68,4	62,6	65,1	58,7	24,8	35,6	62,2	55,7	58,3
Unmarried partn.	16,9	11,9	13,8	3,7	0,8	2,0	1,6	0,7	1,0	8,5	5,3	6,6
Unmarried	22,3	17,8	19,5	8,4	4,7	6,3	5,6	6,3	6,1	13,4	10,3	11,5
Widowed	0,0	1,4	0,9	9,5	20,6	15,9	31,0	64,1	53,5	7,6	17,3	13,5
Divorced	6,9	13,2	10,9	10,0	11,3	10,7	3,2	4,1	3,8	8,3	11,4	10,2
Partnershipratio[1)]	*2421*	*2086*	*2198*	*2584*	*1732*	*2040*	*1515*	*342*	*577*	*2413*	*1564*	*1844*
Germany												
Married	55,4	61,6	58,3	78,2	58,4	67,4	68,2	21,8	35,9	66,2	54,6	59,9
Unmarried partn.	10,3	5,9	8,1	1,2	3,0	2,1	2,0	0,0	0,6	5,9	3,8	4,7
Unmarried	25,8	20,2	23,3	5,9	8,4	7,2	3,3	9,1	7,2	15,8	13,6	14,7
Widowed	1,9	1,0	1,4	4,1	24,8	15,6	23,8	65,2	52,9	4,3	20,4	13,1
Divorced	6,6	11,3	8,8	10,6	5,4	7,7	2,6	3,8	3,4	7,8	7,7	7,7
Partnershipratio[1)]	*1915*	*2077*	*1982*	*3854*	*1591*	*2279*	*2364*	*279*	*575*	*2584*	*1400*	*1820*
Spain												
Married	47,1	57,0	52,2	81,5	64,9	72,8	60,9	27,0	38,7	61,8	56,4	58,9
Unmarried partn.	6,7	8,0	7,4	1,8	0,0	0,8	2,3	0,0	0,8	4,4	3,9	4,2
Unmarried	42,6	30,0	36,1	6,0	4,8	5,3	4,5	4,8	4,7	25,2	17,1	20,9
Widowed	0,4	1,7	1,1	8,3	24,5	16,9	29,3	67,5	54,3	5,7	18,6	12,6
Divorced	3,1	3,4	3,3	2,4	5,9	4,2	3,0	0,8	1,6	2,8	4,0	3,5
Partnershipratio[1)]	*1167*	*1852*	*1472*	*4988*	*1844*	*2788*	*1717*	*369*	*652*	*1964*	*1519*	*1705*
Israel												
Married	62,4	66,3	64,8	81,6	59,0	69,1	58,3	15,3	35,2	69,7	60,1	64,0
Unmarried partn.	3,7	3,4	3,5	1,4	1,1	1,2	3,6	0,5	1,9	2,8	2,4	2,6
Unmarried	27,0	18,4	21,6	1,4	3,3	2,4	0,6	0,0	0,3	14,4	12,0	13,0
Widowed	0,5	1,6	1,2	7,5	21,9	15,5	33,9	82,7	60,2	6,4	14,3	11,1
Divorced	6,3	10,3	8,8	8,2	14,8	11,8	3,6	1,5	2,5	6,8	11,2	9,4
Partnershipratio[1)]	*1956*	*2300*	*2161*	*4854*	*1503*	*2367*	*1625*	*188*	*589*	*2627*	*1667*	*1988*

[1)] The 'partnershipratio' is defined as the number of persons living in a partnership (married or unmarried partnership) per 1000 persons without a partner (unmarried, widowed, divorced)

Source: OASIS 2000, n=6096.

Table 2: OASIS basic variables – Household situation

Household situation	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
lives alone	28,6	16,3	21,7	16,2	35,2	25,7	41,3	79,3	63,9	25,4	29,3	27,6
with others	71,4	83,7	78,3	83,8	64,8	74,3	58,7	20,7	36,1	74,6	70,7	72,4
England												
lives alone	11,5	3,2	6,3	20,4	24,8	22,9	33,3	59,6	51,3	18,1	19,4	18,9
with others	88,5	96,8	93,7	79,6	75,2	77,1	66,7	40,4	48,7	81,9	80,6	81,1
Germany												
lives alone	25,8	15,8	21,2	17,6	35,6	27,6	25,8	72,9	58,7	22,1	32,3	27,8
with others	74,2	84,2	78,8	82,4	64,4	72,4	74,2	27,1	41,3	77,9	67,7	72,2
Spain												
lives alone	12,1	8,4	10,2	8,9	15,4	12,4	21,1	37,7	31,9	11,5	14,7	13,2
with others	87,9	91,6	89,8	91,1	84,6	87,6	78,9	62,3	68,1	88,5	85,3	86,8
Israel												
lives alone	11,6	9,7	10,4	10,9	27,2	19,9	34,9	71,0	54,5	13,2	20,0	17,3
with others	88,4	90,3	89,6	89,1	72,8	80,1	65,1	29,0	45,5	86,8	80,0	82,7

Source: OASIS 2000, n=6106.

Table 3: OASIS basic variables – Generational household structure

Generational household structure	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
One generation	54,8	33,3	42,7	76,1	78,9	77,5	94,6	98,0	96,6	66,3	54,2	59,7
Two generations	45,2	66,0	56,9	23,2	21,1	22,2	4,8	2,0	3,1	33,4	45,4	40,0
Three generations	0,0	0,7	0,4	0,7	0,0	0,4	0,6	0,0	0,2	0,3	0,4	0,4
Four generations	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0
England												
One generation	24,0	15,2	18,5	65,6	71,1	68,8	87,9	85,9	86,5	51,7	49,8	50,5
Two generations	72,1	82,5	78,6	32,8	25,4	28,5	10,5	11,9	11,5	45,9	47,3	46,7
Three generations	3,9	2,3	2,9	1,6	3,5	2,7	1,6	2,2	2,0	2,5	2,9	2,7
Four generations	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0
Germany												
One generation	50,2	34,0	42,6	85,3	92,6	89,4	94,0	95,6	95,2	68,0	68,0	68,2
Two generations	48,8	65,0	56,4	14,7	6,9	10,3	5,3	3,5	4,0	31,5	31,3	31,1
Three generations	0,9	1,0	1,0	0,0	0,5	0,3	0,7	0,9	0,8	0,5	0,7	0,6
Four generations	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0
Spain												
One generation	36,3	25,7	30,9	42,3	41,0	41,6	71,4	64,3	66,8	41,3	36,4	38,7
Two generations	61,4	72,6	67,2	55,4	47,9	51,4	18,0	22,2	20,8	55,8	56,8	56,3
Three generations	2,2	1,3	1,7	2,4	10,6	6,7	10,5	13,5	12,5	2,9	6,4	4,8
Four generations	0,0	0,4	0,2	0,0	0,5	0,3	0,0	0,0	0,0	0,0	0,4	0,2
Israel												
One generation	34,4	24,4	28,1	66,7	56,5	61,0	98,2	88,4	92,9	53,1	40,0	45,3
Two generations	64,0	71,6	68,8	32,7	39,1	36,3	1,2	7,5	4,6	45,8	55,9	51,8
Three generations	1,6	4,1	3,1	0,7	3,8	2,4	0,6	4,0	2,4	1,1	4,0	2,8
Four generations	0,0	0,0	0,0	0,0	0,5	0,3	0,0	0,0	0,0	0,0	0,2	0,1

Source: OASIS 2000, n=.

Table 4: OASIS basic variables – Education

Education	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
low	1,9	1,1	1,4	5,7	11,8	8,7	22,2	35,6	30,2	5,3	8,3	6,9
intermediate	15,6	22,2	19,6	22,1	31,6	26,8	37,7	31,4	33,9	20,1	26,1	23,5
high	82,5	76,7	79,0	72,1	56,6	64,5	40,1	33,1	35,9	74,6	65,7	69,6
England												
low	0,8	2,8	2,0	11,7	9,6	10,5	19,7	27,7	25,2	8,3	8,8	8,6
intermediate	54,3	54,4	54,4	60,6	63,2	62,1	59,8	62,5	61,7	58,2	59,6	59,0
high	45,0	42,8	43,6	27,7	27,2	27,4	20,5	9,7	13,1	33,5	31,7	32,4
Germany												
low	2,4	6,0	4,1	3,6	10,1	7,3	2,7	17,4	12,8	2,8	9,4	6,4
intermediate	25,5	17,6	21,4	41,3	50,5	46,5	64,7	63,1	63,2	34,8	38,8	36,9
high	72,2	76,4	74,5	55,1	39,4	46,2	32,7	19,5	24,0	62,4	51,9	56,8
Spain												
low	9,4	11,8	10,7	41,1	65,2	53,8	67,4	88,1	81,0	26,3	41,9	34,6
intermediate	37,7	35,4	36,5	39,9	24,1	31,5	23,5	10,7	15,1	37,5	28,0	32,4
high	52,9	52,7	52,8	19,0	10,7	14,6	9,1	1,2	3,9	36,2	30,1	33,0
Israel												
low	2,3	3,0	2,7	21,8	19,4	20,5	32,5	42,8	38,0	13,0	11,3	12,0
intermediate	23,7	35,7	31,3	26,8	24,1	25,3	36,3	34,8	35,4	26,1	31,8	29,5
high	74,0	61,3	66,0	51,4	56,5	54,2	31,3	22,5	26,5	60,9	56,8	58,5

Education is defined by levels of schooling and vocational training/university education as follows:

low: primary level of schooling (or less) and no vocational training or university education,

intermediate: primary level of schooling and vocational training or secondary level of schooling without vocational training or university education

high: secondary or higher level of schooling with vocational training or university education.

Source: OASIS 2000, n=5957.

Table 5: OASIS basic variables – Present occupational status

Occupational status	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
Employed	81,6	78,1	79,6	53,5	52,1	52,8	1,8	0,4	1,0	63,7	61,3	62,4
Retired[1)]	4,1	3,8	4,0	45,1	43,7	44,4	98,2	99,6	99,0	28,0	26,8	27,3
Unemployed	3,2	1,0	2,0	0,7	0,7	0,7	0,0	0,0	0,0	2,0	0,8	1,4
Other[2)]	11,1	17,0	14,4	0,7	3,5	2,1	0,0	0,0	0,0	6,3	11,1	8,9
England												
Employed	71,5	57,1	62,5	25,7	21,8	23,4	0,8	0,0	0,3	40,8	33,8	36,5
Retired[1)]	,8	1,4	1,1	60,2	57,6	58,7	99,2	93,8	95,5	41,1	38,4	39,5
Unemployed	19,2	5,5	10,6	6,3	2,7	4,2	0,0	0,0	0,0	10,6	3,6	6,3
Other[2)]	8,5	36,1	25,8	7,9	17,9	13,6	0,0	6,3	4,3	7,5	24,3	17,6
Germany												
Employed	88,3	65,0	77,1	30,6	22,3	26,0	2,0	0,0	0,6	57,9	37,2	46,8
Retired[1)]	0,5	1,0	0,7	64,7	62,9	63,7	97,4	97,1	97,0	34,2	41,7	38,2
Unemployed	5,6	5,9	5,7	2,9	3,0	2,9	0,0	0,0	0,0	4,1	3,8	3,9
Other[2)]	5,6	28,1	16,4	1,8	11,9	7,4	0,7	2,9	2,4	3,8	17,4	11,1
Spain												
Employed	80,7	51,7	65,8	37,5	16,0	26,1	0,0	0,4	0,3	57,5	31,5	43,6
Retired[1)]	1,8	0,4	1,1	54,8	28,7	41,0	100,0	55,6	70,9	30,2	18,2	23,8
Unemployed	12,1	10,6	11,3	7,7	1,6	4,5	0,0	0,0	0,0	9,5	5,8	7,5
Other[2)]	5,4	37,3	21,8	0,0	53,7	28,4	0,0	44,0	28,8	2,8	44,5	25,1
Israel												
Employed	80,3	67,8	72,4	42,9	43,2	43,0	3,0	2,0	2,4	58,2	54,6	56,1
Retired[1)]	0,5	0,3	0,4	53,1	39,3	45,5	95,9	84,9	89,9	30,3	19,7	24,0
Unemployed	7,4	8,1	7,9	2,7	2,7	2,7	0,0	0,0	0,0	4,9	5,7	5,4
Other[2)]	11,7	23,8	19,3	1,4	14,8	8,8	1,2	13,1	7,6	6,6	19,9	14,5

[1)] Including pensioners and persons in early retirement schemes.

[2)] Including housewives and Students.

Source: OASIS 2000, n=6101.

Table 6: OASIS basic variables – Ever gainfully employed?

Ever employed?	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
Never	3,7	3,8	3,8	0,0	0,0	0,0	0,0	8,1	4,8	2,0	3,2	2,7
Not now but before	14,4	17,5	16,1	46,5	47,9	47,2	98,2	91,5	94,2	34,1	35,2	34,7
Currently employed	81,9	78,7	80,1	53,5	52,1	52,8	1,8	0,4	1,0	63,9	61,6	62,7
England												
Never	3,9	7,8	6,3	3,2	3,9	3,6	0,8	7,5	5,4	3,3	5,8	4,8
Not now but before	24,0	34,9	30,8	70,7	74,0	72,6	98,4	92,5	94,3	55,4	60,1	58,2
Currently employed	72,1	57,3	62,8	26,1	22,0	23,8	0,8	0,0	0,3	41,3	34,1	36,9
Germany												
Never	5,2	6,9	6,0	0,0	7,1	4,1	2,0	12,5	9,3	3,0	7,8	5,6
Not now but before	6,1	27,7	16,5	68,7	70,1	69,3	96,0	87,5	90,1	38,4	54,5	46,9
Currently employed	88,7	65,3	77,5	31,3	22,8	26,6	2,0	0,0	0,6	58,6	37,7	47,4
Spain												
Never	4,0	19,7	12,0	0,6	32,8	17,5	0,0	55,2	36,1	2,4	29,2	16,6
Not now but before	15,2	28,2	21,9	61,9	51,1	56,2	100,0	44,4	63,6	40,1	39,1	39,6
Currently employed	80,7	52,1	66,1	37,5	16,1	26,3	0,0	0,4	0,3	57,5	31,7	43,8
Israel												
Never	1,1	5,6	3,9	4,0	9,5	7,1	2,2	30,0	17,3	2,3	8,4	5,9
Not now but before	17,3	23,0	20,9	45,6	40,5	42,8	94,0	67,5	79,6	34,0	31,5	32,5
Currently employed	81,6	71,4	75,3	50,4	50,0	50,2	3,7	2,5	3,1	63,8	60,0	61,6

Source: OASIS 2000, n=5922.

Table 7: OASIS basic variables – Income situation

Income situation	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
1st quintile	19,0	28,0	24,1	16,1	11,9	14,0	24,7	15,9	19,5	18,5	22,1	20,4
2nd quintile	15,6	18,4	17,2	17,5	19,4	18,5	34,2	43,6	39,7	18,1	21,6	20,0
3rd quintile	18,5	20,2	19,4	16,8	23,1	19,9	20,9	20,3	20,5	18,1	21,1	19,7
4th quintile	24,2	20,9	22,5	21,2	24,6	22,9	13,3	17,6	15,8	22,1	21,6	21,9
5th quintile	22,7	12,4	16,8	28,5	20,9	24,7	7,0	2,6	4,4	23,3	13,6	17,9
England												
1st quintile	20,7	31,4	27,1	16,0	11,5	13,6	16,9	16,9	16,9	17,8	20,9	19,6
2nd quintile	14,1	15,3	14,8	24,4	24,5	24,4	26,2	26,5	26,4	20,2	20,8	20,5
3rd quintile	18,5	16,8	17,5	16,8	23,0	20,2	26,2	25,7	25,9	18,6	20,7	19,8
4th quintile	20,7	19,7	20,1	18,5	23,0	20,9	18,5	16,2	16,9	19,2	20,3	19,8
5th quintile	26,1	16,8	20,5	24,4	18,0	20,9	12,3	14,7	13,9	24,2	17,3	20,2
Germany												
1st quintile	25,3	27,4	26,1	15,0	15,1	14,8	16,4	12,9	14,0	20,3	20,0	20,0
2nd quintile	12,6	16,6	14,4	27,9	31,3	30,0	26,9	24,2	24,8	19,9	24,0	22,1
3rd quintile	22,5	23,4	23,1	7,5	13,3	10,4	9,7	31,5	24,8	15,2	20,6	18,0
4th quintile	17,0	17,1	16,9	26,5	16,3	21,1	31,3	7,0	14,4	22,6	15,0	18,5
5th quintile	22,5	15,4	19,4	23,1	24,1	23,7	15,7	24,5	22,1	22,0	20,4	21,4
Spain												
1st quintile	18,5	17,0	17,7	19,8	26,8	23,6	25,3	25,3	25,3	19,6	21,7	20,7
2nd quintile	12,6	18,8	15,8	21,7	24,4	23,2	25,3	19,1	21,2	17,1	21,0	19,2
3rd quintile	19,9	17,0	18,4	29,2	25,2	27,0	23,2	27,5	26,0	23,7	21,4	22,5
4th quintile	19,9	24,8	22,5	13,2	10,2	11,6	15,8	19,7	18,3	17,0	18,6	17,9
5th quintile	29,1	22,4	25,6	16,0	13,4	14,6	10,5	8,4	9,2	22,7	17,2	19,7
Israel												
1st quintile	14,4	22,0	19,2	17,7	19,7	18,8	31,9	22,1	26,4	17,3	21,2	19,6
2nd quintile	12,2	22,8	19,0	8,0	24,2	16,7	21,0	65,6	46,2	11,2	26,5	20,4
3rd quintile	26,6	22,0	23,6	23,9	12,9	18,0	12,6	1,3	6,2	24,3	17,5	20,2
4th quintile	22,3	21,1	21,6	18,6	18,9	18,8	22,7	4,5	12,5	20,8	19,2	19,8
5th quintile	24,5	12,2	16,6	31,9	24,2	27,8	11,8	6,5	8,8	26,4	15,6	20,0

Quintiles of equivalent income by country as the per household income deflated for household size and composition defined by the old OECD scale of equivalence weights to adjust for effects of the economies of scale (Faik, 1995; Figini, 1998; Merz et al., 1993)

Source: OASIS 2000, n=4684.

Table 8: OASIS basic variables – Current subjective financial situation

Financial situation	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
Very comfortable	7,4	5,9	6,5	11,4	4,9	8,2	15,7	5,7	9,7	9,6	5,6	7,4
Comfortable	46,1	42,7	44,1	57,9	50,7	54,3	53,6	44,5	48,2	51,0	45,2	47,7
I have to be careful but I get by	37,8	40,3	39,3	25,7	40,1	33,0	27,1	44,1	37,2	32,5	40,7	37,1
I have trouble making ends meet	6,5	8,7	7,7	3,6	2,8	3,2	3,6	4,5	4,1	5,2	6,5	5,9
Things are very difficult	2,3	2,4	2,4	1,4	1,4	1,4	0,0	1,2	0,7	1,8	2,0	1,9
Deprivation	*8,8*	*11,1*	*10,1*	*5,0*	*4,2*	*4,6*	*3,6*	*5,7*	*4,8*	*07*	*8,5*	*7,8*
England												
Very comfortable	7,7	5,9	6,6	7,9	5,5	6,5	10,5	5,2	6,9	7,8	5,6	6,5
Comfortable	33,8	39,3	37,2	42,1	41,4	41,7	40,3	45,1	43,6	38,8	41,3	40,3
I have to be careful but I get by	43,8	37,4	39,8	38,4	43,0	41,0	41,9	45,5	44,4	40,9	40,6	40,7
I have trouble making ends meet	5,4	8,2	7,2	6,8	6,6	6,7	4,8	3,7	4,1	6,2	7,0	6,7
Things are very difficult	9,2	9,1	9,2	4,7	3,5	4,0	2,4	0,4	1,0	6,2	5,5	5,8
Deprivation	*14,6*	*17,3*	*16,4*	*11,5*	*10,1*	*10,7*	*7,2*	*4,1*	*5,1*	*12,4*	*12,5*	*12,5*
Germany												
Very comfortable	5,6	6,9	6,4	10,1	10,6	10,5	6,1	6,3	6,1	7,4	8,3	8,0
Comfortable	58,7	49,5	54,2	52,7	49,0	50,5	68,2	58,0	61,3	57,3	50,5	53,6
I have to be careful but I get by	27,7	36,6	32,0	33,1	35,4	34,4	25,0	31,3	29,2	29,5	35,5	32,7
I have trouble making ends meet	7,5	5,9	6,7	4,1	4,5	4,3	0,7	3,9	3,0	5,6	5,0	5,2
Things are very difficult	0,5	1,0	0,7	0,0	0,5	0,3	0,0	0,6	0,4	0,2	0,7	0,5
Deprivation	*8*	*6,9*	*7,4*	*4,1*	*5*	*4,6*	*0,7*	*4,5*	*3,4*	*5,8*	*5,7*	*5,7*
Spain												
Very comfortable	1,8	2,1	2,0	1,8	1,6	1,7	3,1	,0	1,0	1,9	1,7	1,8
Comfortable	35,3	33,0	34,1	34,3	22,9	28,2	31,3	26,0	27,8	34,6	28,2	31,2
I have to be careful but I get by	52,3	51,1	51,7	44,0	52,7	48,6	54,2	50,4	51,7	49,1	51,6	50,5
I have trouble making ends meet	8,7	11,2	10,0	16,3	21,8	19,2	10,7	17,6	15,2	11,9	16,1	14,2
Things are very difficult	1,8	2,6	2,2	3,6	1,1	2,3	0,8	6,0	4,2	2,5	2,4	2,4
Deprivation	*10,5*	*13,8*	*12,2*	*19,9*	*22,9*	*21,5*	*11,5*	*23,6*	*19,4*	*14,4*	*18,5*	*16,6*
Israel												
Very comfortable	8,0	4,7	5,9	6,9	4,5	5,6	5,4	,5	2,8	7,3	4,4	5,6
Comfortable	46,3	33,8	38,4	52,8	46,9	49,5	56,5	38,6	47,1	49,8	38,5	43,1
I have to be careful but I get by	31,9	40,4	37,2	28,5	28,2	28,3	25,0	37,6	31,7	29,9	36,1	33,6
I have trouble making ends meet	11,2	9,8	10,3	8,3	13,0	10,9	10,7	18,0	14,6	10,0	11,4	10,9
Things are very difficult	2,7	11,4	8,1	3,5	7,3	5,6	2,4	5,3	3,9	3,0	9,6	6,9
Deprivation	*13,9*	*21,2*	*18,4*	*11,8*	*20,3*	*16,5*	*13,1*	*23,3*	*18,5*	*13*	*21*	*17,8*

Source: OASIS 2000, n=6040.

Table 9: OASIS basic variables – Physical health status

Physical health status	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
low	1,4	2,1	1,8	3,6	8,6	6,2	15,5	24,7	21,0	3,6	6,6	5,2
intermediate	4,2	7,7	6,2	13,9	22,3	18,1	29,8	38,5	35,0	10,1	15,5	13,1
high	94,4	90,2	92,0	82,5	69,1	75,7	54,7	36,8	44,0	86,4	77,9	81,7
England												
low	7,8	6,4	6,9	18,6	21,6	20,3	31,7	50,4	44,4	15,5	18,3	17,2
intermediate	6,2	8,7	7,8	22,3	24,3	23,5	35,7	33,1	33,9	17,5	18,9	18,3
high	86,0	84,9	85,3	59,0	54,1	56,2	32,5	16,5	21,7	66,9	62,8	64,4
Germany												
low	0,0	1,0	0,5	2,9	8,0	5,6	21,5	31,5	28,7	2,9	8,4	5,8
intermediate	3,3	7,9	5,5	18,2	29,0	23,7	45,0	48,1	47,1	13,0	23,1	18,2
high	96,7	91,1	94,0	78,8	63,0	70,7	33,6	20,5	24,2	84,2	68,5	75,9
Spain												
low	0,9	2,1	1,5	6,7	14,8	11,0	20,8	36,2	30,9	4,6	11,2	8,1
intermediate	4,1	8,2	6,2	27,4	38,3	33,1	43,1	47,6	46,0	16,1	24,6	20,6
high	95,0	89,7	92,3	65,9	47,0	55,9	36,2	16,3	23,1	79,2	64,2	71,2
Israel												
low	1,1	0,6	0,8	8,8	12,1	10,6	29,2	47,2	38,8	6,7	7,9	7,4
intermediate	3,7	8,0	6,4	21,1	20,9	21,0	54,2	41,5	47,4	15,2	14,8	15,0
high	95,2	91,3	92,8	70,1	67,0	68,4	16,7	11,4	13,9	78,0	77,2	77,6

The physical health status is measured by the SF-36 physical heath scale. The values are grouped as follows:
low: 0-40 points; intermediate: 45-80 points; hi: 85-100 points.

Source: OASIS 2000, n=6019.

Table 10: OASIS basic variables – Help to household chores

Household chores	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
Yes	17,1	20,1	18,8	11,3	26,8	19,0	39,5	53,7	47,9	17,2	26,1	22,1
No	82,9	79,9	81,2	88,7	73,2	81,0	60,5	46,3	52,1	82,8	73,9	77,9
England												
Yes	8,7	14,3	12,2	13,2	24,3	19,6	37,6	46,5	43,7	13,9	22,4	19,0
No	91,3	85,7	87,8	86,8	75,7	80,4	62,4	53,5	56,3	86,1	77,6	81,0
Germany												
Yes	9,9	15,3	12,6	15,9	19,8	17,8	38,4	45,4	43,3	14,5	21,7	18,3
No	90,1	84,7	87,4	84,1	80,2	82,2	61,6	54,6	56,7	85,5	78,3	81,7
Spain												
Yes	7,2	5,5	6,3	12,5	16,0	14,3	32,3	43,3	39,5	11,2	14,2	12,8
No	92,8	94,5	93,7	87,5	84,0	85,7	67,7	56,7	60,5	88,8	85,8	87,2
Israel												
Yes	20,6	30,3	26,7	40,1	44,0	42,3	60,4	66,3	63,6	32,0	37,6	35,4
No	79,4	69,7	73,3	59,9	56,0	57,7	39,6	33,7	36,4	68,0	62,4	64,6

Source: OASIS 2000, n=6092.

Table 11: OASIS basic variables – Help to transport or shopping

Transport/shopping	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
Yes	13,9	18,8	16,7	8,5	19,7	14,1	23,4	46,5	37,1	12,9	22,4	18,1
No	86,1	81,2	83,3	91,5	80,3	85,9	76,6	53,5	62,9	87,1	77,6	81,9
England												
Yes	4,8	11,1	8,8	11,1	24,9	19,0	31,2	54,0	46,9	10,6	22,2	17,6
No	95,2	88,9	91,2	88,9	75,1	81,0	68,8	46,0	53,1	89,4	77,8	82,4
Germany												
Yes	7,5	15,8	11,7	10,0	18,8	14,6	34,4	45,1	41,9	10,6	21,5	16,4
No	92,5	84,2	88,3	90,0	81,2	85,4	65,6	54,9	58,1	89,4	78,5	83,6
Spain												
Yes	1,3	2,1	1,7	8,3	11,2	9,8	23,3	37,3	32,5	5,8	9,9	8,0
No	98,7	97,9	98,3	91,7	88,8	90,2	76,7	62,7	67,5	94,2	90,1	92,0
Israel												
Yes	7,4	11,9	10,2	13,6	15,2	14,5	32,5	46,7	40,2	12,2	15,6	14,2
No	92,6	88,1	89,8	86,4	84,8	85,5	67,5	53,3	59,8	87,8	84,4	85,8

Source: OASIS 2000, n=6086.

Table 12: OASIS basic variables – Help to personal care

Personal care	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
Yes	0,9	1,4	1,2	2,1	1,4	1,8	9,6	13,4	11,9	2,2	2,8	2,5
No	99,1	98,6	98,8	97,9	98,6	98,2	90,4	86,6	88,1	97,8	97,2	97,5
England												
Yes	2,4	3,7	3,2	4,2	9,5	7,2	12,8	16,9	15,6	4,3	7,8	6,4
No	97,6	96,3	96,8	95,8	90,5	92,8	87,2	83,1	84,4	95,7	92,2	93,6
Germany												
Yes	0,5	1,5	1,0	1,8	2,5	2,1	11,9	20,4	18,0	1,8	4,8	3,4
No	99,5	98,5	99,0	98,2	97,5	97,9	88,1	79,6	82,0	98,2	95,2	96,6
Spain												
Yes	0,9	0,4	0,7	3,6	2,1	2,8	9,0	15,5	13,3	2,6	2,9	2,8
No	99,1	99,6	99,3	96,4	97,9	97,2	91,0	84,5	86,7	97,4	97,1	97,2
Israel												
Yes	1,1	1,6	1,4	4,8	3,3	3,9	17,2	22,1	19,8	4,0	3,7	3,8
No	98,9	98,4	98,6	95,2	96,7	96,1	82,8	77,9	80,2	96,0	96,3	96,2

Source: OASIS 2000, n=6087.

Table 13: OASIS basic variables – Use of other services (65+ only)

Use of other services	65-74			75+			Total		
	male	female	total	male	female	total	male	female	total
Norway									
None	85,4	69,0	77,8	60,9	37,8	47,2	75,0	51,8	62,7
1-2	12,5	26,2	18,9	27,8	30,6	29,5	19,0	28,6	24,1
3-4	0,0	2,4	1,1	7,9	24,3	17,7	3,4	14,5	9,3
5+	2,1	2,4	2,2	3,3	7,2	5,6	2,6	5,1	3,9
England									
None	93,8	75,0	82,4	61,5	54,1	56,4	84,0	69,0	74,6
1-2	3,1	21,0	13,9	34,6	33,3	33,7	12,7	25,5	20,7
3-4	3,1	4,0	3,6	2,9	11,3	8,6	3,1	5,1	4,3
5+	0,0	0,0	0,0	1,0	1,4	1,2	0,3	0,5	0,4
Germany									
None	98,4	91,1	94,1	86,5	78,4	80,7	94,0	86,0	88,9
1-2	1,6	4,4	3,3	6,8	13,2	11,2	3,9	8,2	6,6
3-4	0,0	3,3	2,0	5,4	6,9	6,3	1,6	4,6	3,4
5+	0,0	1,1	0,7	1,4	1,5	1,8	0,4	1,2	1,1
Spain									
None	81,7	85,7	83,9	79,7	76,4	77,5	81,0	81,7	81,4
1-2	16,7	14,3	15,3	19,5	21,6	20,9	17,7	17,5	17,5
3-4	1,7	0,0	0,7	0,8	1,2	1,0	1,4	0,5	0,9
5+	0,0	0,0	0,0	0,0	0,8	0,5	0,0	0,3	0,2
Israel									
None	57,3	58,5	57,9	28,4	25,1	26,6	48,3	46,2	47,3
1-2	26,7	24,6	25,7	40,2	38,2	39,1	30,9	29,5	30,2
3-4	9,3	10,8	10,0	16,0	23,6	20,1	11,4	15,5	13,4
5+	6,7	6,2	6,4	15,4	13,1	14,1	9,4	8,7	9,1

Services in the sense of this listing are: home help and home care, home nursing, alarm and emergency aid call system, day care centre, pensioners club, meals-on-wheels, transport service and others. In England it was not asked for meals-on-wheels so that the maximum number of services is seven in this country.

Source: OASIS 2000, n=2626.

Table 14: OASIS basic variables – Number of family generations

Number of family generations	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
One generation	2,3	0,3	1,2	7,7	8,5	8,1	10,2	21,1	16,7	5,0	5,2	5,1
Two generations	22,1	20,5	21,1	27,5	15,5	21,5	5,4	4,9	5,1	22,4	17,2	19,5
Three generations	62,7	59,7	61,1	57,0	60,6	58,8	84,4	74,0	78,2	62,8	61,6	62,2
Four generations	12,9	19,1	16,4	7,7	14,8	11,3	0,0	0,0	0,0	9,8	15,6	13,0
Five generations	0,0	0,3	0,2	0,0	0,7	0,4	0,0	0,0	0,0	0,0	0,4	0,2
England												
One generation	3,9	0,5	1,7	10,5	8,5	9,4	18,4	16,2	16,9	8,8	6,1	7,1
Two generations	28,7	16,4	20,9	24,7	17,4	20,5	16,0	8,9	11,1	25,6	16,2	19,9
Three generations	51,9	63,2	59,0	55,3	65,9	61,4	65,6	74,5	71,7	54,7	65,6	61,3
Four generations	14,0	18,6	16,9	8,9	8,1	8,5	0,0	,04	0,3	10,1	11,6	11,0
Five generations	1,6	1,4	1,4	0,5	0,0	0,2	0,0	0,0	0,0	0,9	0,6	0,7
Germany												
One generation	5,7	4,5	5,4	17,6	21,0	19,7	17,9	28,6	25,5	11,6	14,9	13,6
Two generations	36,8	23,7	30,4	24,1	23,0	23,5	15,2	14,7	14,6	29,8	21,8	25,5
Three generations	48,8	53,5	51,1	51,8	50,0	50,7	66,9	56,3	59,7	51,6	53,0	52,3
Four generations	8,6	18,2	13,1	6,5	6,0	6,1	0,0	0,3	0,2	7,0	10,3	8,6
Five generations	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0
Spain												
One generation	3,1	3,0	3,0	11,9	10,2	11,0	15,9	13,1	14,1	7,6	7,0	7,3
Two generations	41,7	28,7	35,0	26,8	24,1	25,4	9,8	5,2	6,8	33,4	24,0	28,4
Three generations	48,0	54,4	51,3	57,1	56,7	56,9	74,2	81,3	78,9	53,6	58,6	56,3
Four generations	7,2	13,5	10,4	4,2	9,1	6,8	0,0	0,4	0,3	5,4	10,2	8,0
Five generations	0,0	0,4	0,2	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,2	0,1
Israel												
One generation	0,6	0,0	0,2	2,5	4,1	3,4	4,8	8,6	6,8	1,7	2,0	1,9
Two generations	27,9	22,6	24,6	21,0	16,9	18,7	2,7	1,1	1,9	22,9	19,0	20,6
Three generations	65,5	64,8	65,0	69,7	60,1	64,4	92,5	90,3	91,3	69,6	65,2	67,1
Four generations	6,1	12,6	10,1	6,7	18,2	13,1	0,0	0,0	0,0	5,7	13,5	10,3
Five generations	0,0	0,0	0,0	0,0	0,7	0,4	0,0	0,0	0,0	0,0	0,2	0,1

The computation is based on the existence of members of the family lineage: grandparents, parents, children and grandchildren (in Norway: adult grandchildren only).

Source: OASIS 2000, n=5895.

Table 15: OASIS basic variables – Number of children

Number of children	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
None	45,6	29,9	36,8	14,1	11,3	12,7	10,8	22,0	17,4	31,0	23,4	26,9
1	19,4	19,1	19,2	11,3	11,3	11,3	22,2	18,3	19,9	16,7	16,7	16,7
2	23,0	33,0	28,7	40,8	39,4	40,1	35,3	30,9	32,7	30,6	34,7	32,8
3+	12,0	18,1	15,4	33,8	38,0	35,9	31,7	28,9	30,0	21,7	25,2	23,6
England												
None	29,2	13,2	19,1	12,0	10,9	11,4	19,2	16,6	17,4	19,1	12,5	15,1
1	16,2	22,3	20,0	12,6	19,4	16,5	26,4	25,5	25,8	14,7	21,3	18,7
2	26,9	27,3	27,1	36,1	32,2	33,9	22,4	31,0	28,3	31,5	30,5	30,9
3+	27,7	37,3	33,7	39,3	37,6	38,3	32,0	26,9	28,5	34,7	35,7	35,3
Germany												
None	43,2	30,0	37,1	23,5	25,9	25,0	18,5	30,4	26,9	33,1	28,0	30,7
1	22,1	25,1	23,6	24,7	29,4	26,9	35,8	30,7	31,9	25,0	28,0	26,4
2	26,8	34,5	30,2	31,8	25,9	28,7	28,5	23,3	25,3	28,5	29,1	28,8
3+	8,0	10,3	9,0	20,0	18,9	19,4	17,2	15,6	16,0	13,4	14,9	14,1
Spain												
None	57,4	39,7	48,3	14,3	11,2	12,6	16,7	14,0	14,9	37,2	25,5	30,9
1	22,4	21,5	22,0	17,3	14,9	16,0	16,7	17,6	17,3	19,9	18,5	19,2
2	15,7	27,8	22,0	29,8	28,7	29,2	34,8	25,2	28,5	22,7	27,9	25,5
3+	4,5	11,0	7,8	38,7	45,2	42,1	31,8	43,2	39,3	20,1	28,2	24,4
Israel												
None	42,2	27,8	33,1	3,4	4,3	3,9	4,7	8,1	6,5	23,1	18,3	20,3
1	13,5	13,2	13,3	9,5	11,4	10,6	15,4	15,2	15,3	12,1	12,8	12,5
2	23,8	25,6	24,9	30,6	28,3	29,3	36,7	33,3	34,9	27,7	27,0	27,3
3+	20,5	33,4	28,7	56,5	56,0	56,2	43,2	43,4	43,3	37,1	41,8	39,9

The number of children is defined as the number of currently living biological, step and adopted children as well as children that grew up with the respondent.

Source: OASIS 2000, n=6092.

Table 16: OASIS basic variables – Parents

Parents	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
No parents	7,4	8,0	7,7	71,1	70,4	70,8	100,0	100,0	100,0	39,2	37,1	38,0
Mother only	14,7	18,4	16,8	21,1	18,3	19,7	,0	,0	,0	15,6	16,2	15,9
Father only	6,0	5,2	5,5	2,1	2,8	2,5	,0	,0	,0	4,0	3,9	4,0
Both	71,9	68,4	70,0	5,6	8,5	7,0	,0	,0	,0	41,2	42,8	42,1
England												
No parents	19,4	11,4	14,3	78,9	82,2	80,8	100,0	100,0	100,0	58,5	55,0	56,4
Mother only	23,3	25,5	24,6	16,8	11,2	13,6	,0	,0	,0	17,9	15,9	16,7
Father only	4,7	5,5	5,2	2,1	2,7	2,5	,0	,0	,0	2,9	3,5	3,3
Both	52,7	57,7	55,9	2,1	3,9	3,1	,0	,0	,0	20,8	25,6	23,7
Germany												
No parents	21,1	14,3	17,9	75,9	82,7	79,8	100,0	99,7	99,8	49,7	56,1	53,3
Mother only	19,2	19,7	19,3	14,1	13,4	13,5	,0	,3	,2	15,6	14,1	14,6
Father only	4,2	3,0	3,6	3,5	1,0	2,1	,0	,0	,0	3,6	1,7	2,5
Both	55,4	63,1	59,3	6,5	3,0	4,5	,0	,0	,0	31,1	28,1	29,5
Spain												
No parents	13,5	10,5	12,0	78,6	81,9	80,3	100,0	99,6	99,7	45,8	49,2	47,6
Mother only	24,2	19,4	21,7	13,7	12,8	13,2	,0	,4	,3	18,2	14,5	16,2
Father only	4,9	3,4	4,1	2,4	3,2	2,8	,0	,0	,0	3,6	2,9	3,2
Both	57,4	66,7	62,2	5,4	2,1	3,7	,0	,0	,0	32,4	33,4	33,0
Israel												
No parents	5,9	6,3	6,1	80,3	68,3	73,6	99,4	99,5	99,5	44,1	34,2	38,2
Mother only	17,6	25,5	22,5	12,9	21,3	17,6	,6	,5	,5	14,1	22,2	18,9
Father only	4,3	4,7	4,5	,7	4,9	3,0	,0	,0	,0	2,4	4,4	3,6
Both	72,3	63,5	66,8	6,1	5,5	5,8	,0	,0	,0	39,3	39,2	39,2

Parents are those persons that were defined as their parents by the respondents.

Source: OASIS 2000, n=6100.

Table 17: OASIS basic variables – Siblings

Siblings	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
None	7,8	5,6	6,5	14,1	14,1	14,1	28,7	34,1	32,0	12,1	11,4	11,7
1	37,3	35,4	36,2	31,7	30,3	31,0	30,5	28,9	29,5	34,6	33,0	33,7
2	25,3	28,1	26,9	25,4	22,5	23,9	18,6	15,4	16,7	24,7	25,0	24,9
3+	29,5	30,9	30,4	28,9	33,1	31,0	22,2	21,5	21,8	28,6	30,5	29,7
England												
None	11,5	11,8	11,7	18,3	22,1	20,5	41,3	46,1	44,6	17,8	20,6	19,5
1	27,7	25,0	26,0	25,7	27,9	26,9	30,2	28,8	29,2	26,9	26,8	26,8
2	19,2	19,1	19,1	20,4	14,7	17,1	15,9	12,5	13,6	19,9	16,1	17,6
3+	41,5	44,1	43,1	35,6	35,3	35,4	12,7	12,5	12,6	35,4	36,4	36,0
Germany												
None	23,2	26,6	24,9	32,9	40,8	37,3	64,2	69,2	68,3	30,1	38,6	34,7
1	33,2	31,5	32,1	31,1	27,4	29,2	25,8	17,2	19,5	32,0	28,0	29,7
2	24,2	24,1	24,4	21,6	13,9	17,2	5,3	9,2	7,8	21,9	17,6	19,6
3+	19,4	17,7	18,7	14,4	17,9	16,4	4,6	4,4	4,4	16,1	15,7	15,9
Spain												
None	7,2	8,5	7,9	13,2	17,0	15,2	31,8	26,7	28,5	11,4	14,0	12,8
1	27,6	28,0	27,8	19,8	18,7	19,2	20,5	26,3	24,3	23,9	24,2	24,1
2	23,5	23,7	23,6	28,1	19,8	23,8	19,7	19,1	19,3	25,1	21,7	23,3
3+	41,6	39,8	40,7	38,9	44,5	41,8	28,0	27,9	27,9	39,5	40,1	39,9
Israel												
None	2,7	4,8	4,0	24,3	14,0	18,6	43,4	42,3	42,8	14,9	10,6	12,4
1	20,7	18,7	19,5	26,4	30,2	28,5	27,1	28,9	28,1	23,6	23,3	23,4
2	32,4	27,6	29,4	18,8	20,1	19,5	14,5	14,4	14,4	25,4	24,1	24,6
3+	44,1	48,9	47,1	30,6	35,8	33,4	15,1	14,4	14,7	36,1	41,9	39,6

Siblings include half- and step-brothers and -sisters.

Source: OASIS 2000, n=6064

Table 18: OASIS basic variables – Grandparents

Grandparents	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
None	63,4	67,7	65,7	99,3	99,3	99,3	100,0	100,0	100,0	79,9	80,8	80,3
1	19,9	19,1	19,6	0,0	0,7	0,4	0,0	0,0	0,0	10,8	11,3	11,2
2	11,1	7,6	9,1	0,0	0,0	0,0	0,0	0,0	0,0	6,0	4,5	5,2
3 and 4	5,6	5,6	5,5	0,7	0,0	0,4	0,0	0,0	0,0	3,3	3,3	3,3
England												
None	76,2	79,5	78,3	99,5	100,0	99,8	100,0	100,0	100,0	90,8	91,6	91,3
1	16,2	15,0	15,4	0,5	0,0	0,2	0,0	0,0	0,0	6,3	6,2	6,2
2	6,9	3,6	4,9	0,0	0,0	0,0	0,0	0,0	0,0	2,6	1,5	1,9
3 and 4	0,8	1,8	1,4	0,0	0,0	0,0	0,0	0,0	0,0	0,3	0,7	0,6
Germany												
None	77,5	71,9	74,8	99,4	99,5	99,5	100,0	100,0	100,0	88,3	87,8	88,1
1	11,7	16,7	14,0	0,0	0,0	0,0	0,0	0,0	0,0	6,0	7,1	6,5
2	7,5	5,9	6,7	0,0	0,0	0,0	0,0	0,0	0,0	3,8	2,5	3,1
3 and 4	3,3	5,4	4,5	0,6	0,5	0,5	0,0	0,0	0,0	1,9	2,5	2,3
Spain												
None	70,4	73,0	71,7	100,0	100,0	100,0	100,0	100,0	100,0	84,4	86,8	85,6
1	17,5	16,9	17,2	0,0	0,0	0,0	0,0	0,0	0,0	9,2	8,3	8,7
2	8,5	8,4	8,5	0,0	0,0	0,0	0,0	0,0	0,0	4,5	4,1	4,3
3 and 4	3,6	1,7	2,6	0,0	0,0	0,0	0,0	0,0	0,0	1,9	0,8	1,3
Israel												
None	66,9	70,9	69,3	99,2	98,6	98,9	100,0	100,0	100,0	81,7	81,7	81,7
1	22,1	19,2	20,3	0,8	1,4	1,1	0,0	0,0	0,0	12,3	12,2	12,2
2	6,6	8,6	7,8	0,0	0,0	0,0	0,0	0,0	0,0	3,6	5,3	4,6
3 and 4	4,4	1,4	2,5	0,0	0,0	0,0	0,0	0,0	0,0	2,4	0,8	1,5

Source: OASIS 2000, n=5065

Table 19: OASIS basic variables – Grandchildren

Grandchildren	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
None	–	–	–	–	–	–	–	–	–	–	–	–
1	–	–	–	–	–	–	–	–	–	–	–	–
2	–	–	–	–	–	–	–	–	–	–	–	–
3 and more	–	–	–	–	–	–	–	–	–	–	–	–
England												
None	94,6	91,8	92,9	45,5	33,3	38,5	34,1	24,8	27,8	63,1	56,6	59,1
1	3,1	2,7	2,9	12,6	10,1	11,1	4,0	5,2	4,8	8,4	6,6	7,3
2	0,8	2,3	1,7	9,4	14,3	12,2	20,6	16,7	17,9	6,7	9,5	8,4
3 and more	1,5	3,2	2,6	32,5	42,2	38,1	41,3	53,3	49,5	21,8	27,3	25,2
Germany												
None	97,6	98,0	97,8	54,4	51,0	52,7	32,5	41,7	38,8	74,7	68,9	71,6
1	1,9	1,0	1,5	13,0	10,5	11,5	15,2	13,0	14,1	7,8	7,2	7,4
2	0,0	0,5	0,2	13,6	13,5	13,6	17,9	16,9	16,9	7,2	8,6	8,0
3 and more	0,5	0,5	0,5	18,9	25,0	22,2	34,4	28,4	30,3	10,4	15,3	13,0
Spain												
None	99,6	97,0	98,3	53,6	43,0	48,0	25,0	17,7	20,3	75,8	66,5	70,8
1	0,0	1,7	0,9	12,5	11,3	11,9	6,8	7,7	7,4	5,5	6,1	5,8
2	0,0	0,8	0,4	12,5	12,4	12,4	9,8	12,1	11,3	5,7	6,7	6,2
3 and more	0,4	0,4	0,4	21,4	33,3	27,7	58,3	62,5	61,1	13,1	20,7	17,1
Israel												
None	99,4	96,3	97,5	32,1	29,1	30,5	7,4	9,6	8,6	63,0	64,8	64,1
1	0,6	3,0	2,1	10,7	11,4	11,1	1,8	1,5	1,7	4,9	5,9	5,5
2	0,0	0,4	0,2	5,7	13,1	9,8	11,0	6,1	8,3	3,4	5,5	4,6
3 and more	0,0	0,4	0,2	51,4	46,3	48,6	79,8	82,8	81,4	28,7	23,8	25,8

Source: OASIS 2000, n=4787.

Table 20: OASIS basic variables – Adult grandchildren

Adult grandchildren	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
None	100,0	100,0	100,0	90,8	82,4	86,6	39,2	31,0	34,3	90,8	86,7	88,6
1	0,0	0,0	0,0	2,8	5,6	4,2	14,5	8,6	10,9	2,4	2,7	2,5
2	0,0	0,0	0,0	2,1	3,5	2,8	18,1	17,1	17,5	2,5	3,0	2,8
3 and more	0,0	0,0	0,0	4,2	8,5	6,3	28,3	43,3	37,2	4,3	7,6	6,1
England												
None	100,0	100,0	100,0	83,7	70,4	76,0	44,3	31,9	35,9	86,8	78,5	81,8
1	0,0	0,0	0,0	4,9	9,2	7,4	9,8	8,1	8,6	3,5	5,4	4,6
2	0,0	0,0	0,0	5,4	8,0	6,9	20,5	21,5	21,2	4,2	6,6	5,7
3 and more	0,0	0,0	0,0	6,0	12,4	9,7	25,4	38,5	34,3	5,6	9,5	8,0
Germany												
None	100,0	100,0	100,0	84,0	74,5	78,9	41,1	46,6	44,9	88,8	80,6	84,4
1	0,0	0,0	0,0	7,7	8,0	7,8	17,2	13,3	14,6	4,9	5,9	5,4
2	0,0	0,0	0,0	4,1	8,5	6,4	17,2	17,7	17,4	2,9	6,0	4,5
3 and more	0,0	0,0	0,0	4,1	9,0	7,0	24,5	22,4	23,0	3,4	7,4	5,6
Spain												
None	100,0	99,6	99,8	90,5	78,5	84,2	40,9	28,5	32,8	92,0	83,0	87,2
1	0,0	0,4	0,2	3,6	7,0	5,4	7,1	10,0	9,0	1,9	4,1	3,1
2	0,0	0,0	0,0	2,4	7,0	4,8	15,7	15,9	15,8	2,1	4,6	3,4
3 and more	0,0	0,0	0,0	3,6	7,5	5,6	36,2	45,6	42,3	4,0	8,3	6,3
Israel												
None	100,0	100,0	100,0	74,1	74,8	74,5	24,4	16,4	19,8	84,4	85,8	85,2
1	0,0	0,0	0,0	9,8	8,9	9,3	8,9	7,3	8,0	4,3	3,3	3,7
2	0,0	0,0	0,0	7,1	7,4	7,3	14,6	13,3	13,9	3,8	3,3	3,5
3 and more	0,0	0,0	0,0	8,9	8,9	8,9	52,0	63,0	58,3	7,5	7,6	7,5

Source: OASIS 2000, n=5799

Table 21: OASIS basic variables – Close friends

Close friends	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
Yes	97,2	98,6	98,0	88,0	95,8	91,9	74,9	75,2	75,1	91,8	95,0	93,5
No	2,8	1,4	2,0	12,0	4,2	8,1	25,1	24,8	24,9	8,2	5,0	6,5
England												
Yes	85,3	81,8	83,1	73,7	81,3	78,1	60,3	70,4	67,2	76,3	80,3	78,8
No	14,7	18,2	16,9	26,3	18,7	21,9	39,7	29,6	32,8	23,7	19,7	21,2
Germany												
Yes	82,2	88,2	85,2	74,1	73,8	74,3	64,2	60,7	61,4	77,7	78,0	78,0
No	17,8	11,8	14,8	25,9	26,2	25,7	35,8	39,3	38,6	22,3	22,0	22,0
Spain												
Yes	90,1	92,8	91,5	85,7	80,9	83,1	75,9	69,9	72,0	87,3	85,4	86,3
No	9,9	7,2	8,5	14,3	19,1	16,9	24,1	30,1	28,0	12,7	14,6	13,7
Israel												
Yes	90,9	90,0	90,3	78,8	83,1	81,2	70,8	68,7	69,7	84,2	86,1	85,3
No	9,1	10,0	9,7	21,2	16,9	18,8	29,2	31,3	30,3	15,8	13,9	14,7

Source: OASIS 2000, n=6086

Table 22: OASIS basic variables – Overall quality of life

Overall quality of life	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
Very poor	0,5	0,0	0,2	0,7	0,7	0,7	0,6	1,2	1,0	0,6	0,4	0,4
Poor	2,8	2,4	2,6	2,9	2,1	2,5	6,6	4,5	5,4	3,2	2,6	2,9
Neither nor	12,0	11,2	11,5	9,4	9,9	9,6	20,4	18,5	19,3	11,9	11,7	11,8
Good	58,5	50,0	53,8	62,6	54,9	58,7	49,1	52,3	51,0	59,0	51,8	55,1
Very good	26,3	36,4	31,9	24,5	32,4	28,5	23,4	23,5	23,4	25,3	33,6	29,8
England												
Very poor	1,5	1,8	1,7	3,7	1,9	2,7	0,8	3,7	2,8	2,7	2,0	2,2
Poor	3,8	5,5	4,9	5,8	5,1	5,4	5,6	12,2	10,1	5,1	6,0	5,6
Neither nor	16,2	14,2	14,9	17,9	14,4	15,9	21,4	17,3	18,6	17,2	14,4	15,5
Good	52,3	53,4	53,0	47,9	52,9	50,8	49,2	49,4	49,4	49,6	52,8	51,6
Very good	26,2	25,1	25,5	24,7	25,7	25,3	23,0	17,3	19,1	25,5	24,9	25,1
Germany												
Very poor	0,9	0,5	0,7	1,2	1,0	1,1	3,3	1,8	2,2	1,2	0,9	1,0
Poor	1,9	3,0	2,4	2,9	5,5	4,3	6,0	7,1	6,8	2,6	4,7	3,7
Neither nor	11,3	16,3	13,6	21,8	20,4	21,0	29,8	43,0	39,0	17,1	21,7	19,5
Good	66,5	62,4	64,8	62,4	63,7	63,3	55,0	44,8	47,9	64,1	60,6	62,5
Very good	19,3	17,8	18,4	11,8	9,5	10,4	6,0	3,3	4,0	15,1	12,0	13,3
Spain												
Very poor	0,5	0,8	0,7	1,2	0,0	0,6	0,8	0,8	0,8	0,8	0,5	0,6
Poor	1,8	0,8	1,3	4,2	5,3	4,8	3,0	8,8	6,8	2,8	3,6	3,2
Neither nor	26,1	22,9	24,5	32,3	38,0	35,3	46,6	40,6	42,7	30,1	30,9	30,5
Good	58,6	62,3	60,5	59,3	52,9	55,9	46,6	47,4	47,1	58,0	56,8	57,4
Very good	13,1	13,1	13,1	3,0	3,7	3,4	3,0	2,4	2,6	8,3	8,2	8,2
Israel												
Very poor	0,0	0,6	0,4	0,7	1,1	0,9	1,2	2,7	2,0	0,4	1,0	0,7
Poor	1,6	4,8	3,7	2,8	2,3	2,5	6,6	7,0	6,8	2,6	4,1	3,5
Neither nor	18,0	21,3	20,1	19,0	23,6	21,5	25,9	39,5	33,0	19,2	23,4	21,6
Good	53,6	51,6	52,3	62,0	56,9	59,2	53,0	43,2	47,9	56,8	52,8	54,4
Very good	26,8	21,6	23,5	15,5	16,1	15,8	13,3	7,6	10,3	21,0	18,8	19,7

Source: OASIS 2000, n=6036.

Table 23: OASIS basic variables – General life satisfaction

Life satisfaction	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
Very dissatisfied	0,5	0,7	0,6	1,4	0,0	0,7	0,6	0,4	0,5	0,8	0,5	0,6
Dissatisfied	0,5	1,7	1,2	0,7	1,4	1,1	6,1	3,8	4,7	1,1	1,9	1,5
Neither nor	9,7	8,4	8,9	7,1	4,2	5,7	7,3	13,4	10,9	8,5	7,7	8,1
Satisfied	61,8	59,2	60,4	58,9	60,6	59,7	56,4	65,1	61,5	60,2	60,2	60,3
Very satisfied	27,6	30,0	28,9	31,9	33,8	32,9	29,7	17,2	22,3	29,4	29,7	29,5
England												
Very dissatisfied	0,0	2,3	1,4	2,1	1,9	2,0	1,6	2,2	2,0	1,3	1,7	1,5
Dissatisfied	3,8	2,7	3,2	3,7	2,7	3,1	3,2	6,7	5,6	3,7	3,2	3,4
Neither nor	12,3	11,4	11,7	10,1	8,6	9,2	16,7	13,4	14,4	11,5	10,3	10,7
Satisfied	56,9	55,3	55,9	52,4	56,0	54,5	55,6	57,6	57,0	54,8	56,3	55,7
Very satisfied	26,9	28,3	27,8	31,7	30,7	31,2	23,0	20,1	21,0	28,7	28,6	28,6
Germany												
Very dissatisfied	0,5	0,5	0,5	0,6	2,0	1,3	0,0	0,6	0,4	0,5	1,1	0,8
Dissatisfied	2,8	4,9	3,8	2,9	4,0	3,4	6,6	3,6	4,8	3,1	4,3	3,7
Neither nor	7,5	6,4	6,9	7,6	11,4	9,5	6,0	15,1	12,0	7,4	9,8	8,5
Satisfied	63,4	63,5	63,6	61,2	59,9	61,0	68,9	65,4	66,3	63,2	62,6	63,1
Very satisfied	25,8	24,6	25,2	27,6	22,8	24,7	18,5	15,4	16,5	25,9	22,2	23,8
Spain												
Very dissatisfied	0,0	1,3	0,7	0,6	0,5	0,6	0,0	1,6	1,0	0,2	1,0	0,7
Dissatisfied	1,8	2,1	2,0	3,6	5,9	4,8	4,5	9,2	7,6	2,7	4,5	3,6
Neither nor	6,3	9,4	7,9	15,5	21,6	18,7	17,3	26,3	23,2	10,8	16,2	13,7
Satisfied	69,8	67,2	68,5	67,9	61,6	64,6	69,9	55,0	60,2	69,0	63,6	66,1
Very satisfied	22,1	20,0	21,0	12,5	10,3	11,3	8,3	8,0	8,1	17,2	14,8	15,9
Israel												
Very dissatisfied	0,5	0,9	0,8	0,0	1,7	0,9	3,7	3,3	3,5	0,6	1,4	1,0
Dissatisfied	2,1	5,7	4,3	6,3	6,7	6,5	8,5	15,4	12,1	4,3	6,7	5,7
Neither nor	14,8	21,4	18,9	21,7	23,0	22,4	29,9	41,2	35,8	18,9	23,3	21,5
Satisfied	56,1	50,0	52,3	53,1	50,6	51,7	46,3	34,1	39,9	54,0	49,1	51,1
Very satisfied	26,5	22,0	23,7	18,9	18,0	18,4	11,6	6,0	8,7	22,1	19,6	20,6

Source: OASIS 2000, n=6045.

Table 24: OASIS basic variables – Frequency of loneliness

Loneliness	25-49			50-74			75+			Total		
	male	female	total	male	female	total	male	female	total	male	female	total
Norway												
Never	35,6	33,1	34,1	49,6	43,0	46,3	45,8	41,6	43,3	41,6	37,0	39,1
Seldom	55,6	58,2	56,9	42,6	42,3	42,4	34,9	35,4	35,2	48,9	50,8	49,9
Quite often	6,0	6,6	6,5	5,7	9,2	7,4	11,4	13,6	12,7	6,4	8,2	7,5
Very often	2,8	2,1	2,4	2,1	4,9	3,5	5,4	7,4	6,6	2,8	3,5	3,2
Always	0,0	0,0	0,0	0,0	0,7	0,4	2,4	2,1	2,2	0,2	0,4	0,4
England												
Never	65,4	53,4	57,9	63,2	52,9	57,3	60,3	41,5	47,5	64,3	52,2	57,0
Seldom	21,5	27,9	25,5	19,5	23,7	21,9	15,9	26,7	23,2	19,6	25,9	23,4
Quite often	8,5	11,4	10,3	12,6	14,4	13,6	13,5	15,6	14,9	11,0	13,3	12,4
Very often	3,1	4,1	3,7	3,7	6,6	5,4	7,9	11,9	10,6	3,8	5,7	5,0
Always	1,5	3,2	2,6	1,1	2,3	1,8	2,4	4,4	3,8	1,4	2,8	2,2
Germany												
Never	67,8	65,8	66,7	67,1	57,2	61,4	53,3	21,9	31,2	66,6	55,6	60,5
Seldom	24,6	23,3	24,2	22,4	24,9	23,9	28,0	38,9	35,9	24,0	26,4	25,5
Quite often	5,7	7,9	6,7	7,1	13,4	10,6	15,3	31,7	26,6	6,8	13,8	10,6
Very often	1,9	3,0	2,4	3,5	4,0	3,7	2,7	6,9	5,7	2,6	3,9	3,3
Always	0,0	0,0	0,0	0,0	0,5	0,3	0,7	0,6	0,6	0,0	0,3	0,2
Spain												
Never	50,0	46,0	47,9	49,7	34,8	41,8	32,1	22,8	26,0	48,6	38,8	43,3
Seldom	34,2	29,8	31,9	30,5	30,5	30,5	41,2	36,6	38,2	33,3	30,9	32,0
Quite often	11,3	19,1	15,3	13,2	21,9	17,8	20,6	24,0	22,8	12,7	20,8	17,0
Very often	4,1	4,3	4,2	5,4	10,2	7,9	6,1	13,4	10,9	4,7	7,7	6,3
Always	0,5	0,9	0,7	1,2	2,7	2,0	0,0	3,3	2,1	0,7	1,9	1,3
Israel												
Never	57,2	54,1	55,2	62,8	48,3	54,8	38,7	25,1	31,5	57,7	50,1	53,2
Seldom	23,5	20,4	21,6	16,6	25,6	21,5	26,8	25,1	25,9	21,1	22,5	21,9
Quite often	16,6	17,6	17,2	17,2	14,4	15,7	21,4	32,1	27,0	17,3	17,6	17,5
Very often	2,7	7,2	5,5	3,4	9,4	6,8	11,9	11,8	11,8	3,8	8,3	6,5
Always	0,0	0,6	0,4	0,0	2,2	1,2	1,2	5,9	3,7	0,1	1,5	1,0

Source: OASIS 2000, n=6048.

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Appendix 2 - Chapter 4

OASIS PROJECT

INTERVIEW – QUALITATIVE PHASE T1

1. SUPPORT NEEDS: CHANGE AND CONTINUITY

How do you manage right now in your daily life?

Probe/areas for exploration:

Map out how person manages and potential change since first interview contact (survey)

What happened that made you feel you needed help?(if relevant)

Probe/areas for exploration:

What made the person use current forms of help?

How well does help s/he receives meet preferences/choices?

How well does help received meet needs in his/her view?

What if any gaps are there?

To what extent does person feel their wishes and opinions were taken into account in provision of support?

What I'd like you to think about is an event linked to support in say, the last 6 months which was important to you in some way (THIS COULD BE A HAPPY/POSITIVE EVENT OR AN UNHAPPY/STRESSFUL EVENT SUCH AS ILLNESS OR A CHANGE IN CIRCUMSTANCES)

Probe areas for exploration:

What was the event and when did it take place?

What happened and how did it come about?

Who was involved?

Feelings about event?

Was this a change which has had long standing consequences?

Is this part of an ongoing exchange?

Mix of help – how arranged?

2. SUPPORT AND ASSISTANCE:

I wanted to ask you about people you rely on for support. This could be practical support, care, or emotional support – some other type of support – anything that is important to you right now.

(The people can be anyone at all that you rely on for support)

Probe/areas for exploration:

Relationship to person?

Type and duration of support received

Why is that support important

Evaluation of support offered?

Is this part of an exchange relationship?

Is interview child identified?

3. MIX OF HELP RECEIVED: (NOTE: this topic may have already been covered in the interview. DO NOT ASK AGAIN IF YOU FEEL THIS IS THE CASE)

How does the help received all together meet your needs as they are now?

Probe/areas for exploration:

Satisfaction with way help provided?

Would person prefer more or less help from various people who support them? Would person prefer others to help?

How does person feel about the way help is received/provided?

What formal support do they receive and how do they feel abot this? How and when did they seek support?

4. FAMILY CULTURE: Continuity and Change:

FAMILY CONFLICT (NOTE: this topic may have already been covered in the interview. DO NOT ASK AGAIN IF YOU FEEL THIS IS THE CASE)

Every family has times when there are issues that cause tensions or sometimes, conflict. How much would you say conflict was a part of your family life?

Probe/areas for exploration:

Type, seriousness, duration of conflict?

Attempts to manage conflict?

Impact on family relationships?

Is conflict temporary? Long standing? Unresolved?

How would you tend to celebrate an important family event in your family?

How would you tend to resolve a crisis in your family?

Probe/areas for exploration:

Who takes the lead or decides how events are celebrated/crises are resolved?

Do parents/children participate in this together?

How common is it to gather/join as a family

Are there any issues/problems in joining together (e.g. conflict)

Amount of family contact between parent/children?

Any particular close bonds? Obligations?

5. Dependence/Independence: (NOTE: this topic may have already been covered in the interview. DO NOT ASK AGAIN IF YOU FEEL THIS IS THE CASE)

How much do you feel you have been able to maintain parts of your life which are important to you?

Probe/areas for exploration:

How much does help or support provided enable person to maintain sense of independence?

Are important continuities maintained?

Evidence of ways change is managed?

Views about future?

Is there anything else that you would like to say about any of the topics we have talked about today – perhaps there is something you would like to say that you don't feel you have had the chance to say?

REMEMBER VIGNETTE

REMEMBER TO CHECK CONSENT TO CONTACT FOR FOLLOW UP INTERVIEW

REMEMBER TO COMPLETE INTERVIEW RECORD SHEET

OASIS PROJECT

INTERVIEW – QUALITATIVE PHASE T1 child

6. SUPPORT NEEDS: CHANGE AND CONTINUITY

How do you think your (parent) manages right now in his/her daily life?

Probe/areas for exploration:

Map out how person manages and potential change since first interview contact (survey)

What changes have happened that made you feel they needed help?(if relevant)

Probe/areas for exploration:

What made the person use current forms of help?

How well does help s/he receives meet preferences/choices?

How well does help received meet needs in his/her view?

What if any gaps are there?

To what extent does person feel their wishes and opinions were taken into account in provision of support?

What I'd like you to think about is an event linked to support in say, the last 6 months which was important to your (parent) in some way (THIS COULD BE A

HAPPY/POSITIVE EVENT OR AN UNHAPPY/STRESSFUL EVENT SUCH AS ILLNESS OR A CHANGE IN CIRCUMSTANCES)

Probe areas for exploration:

What was the event and when did it take place?

What happened and how did it come about?

Who was involved?

Feelings about event?

Was this a change which has had long standing consequences?

Is this part of an ongoing exchange?

Mix of help – how arranged?

7. SUPPORT AND ASSISTANCE:

I wanted to ask you about the people your mother/father relies on for support. This could be practical support, care, or emotional support – some other type of support – anything that is important to them right now.

(The people can be anyone at all that your mother/father relies on for support)

Probe/areas for exploration:

Relationship to person?

Type and duration of support received

Why is that support important

Evaluation of support offered?

Is this part of an exchange relationship?

Is interview child identified? Explore issues re: support provided and contact/time with child/parent

8. MIX OF HELP RECEIVED: (NOTE: this topic may have already been coverd in the interview. DO NOT ASK AGAIN IF YOU FEEL THIS IS THE CASE)

How does the help received all together meet your mother/father's needs as they are now?

Probe/areas for exploration:

Satisfaction with way help provided?

Would person prefer more or less help from various people who support them? Would person prefer others to help?

How does person feel about the way help is received/provided?

What formal support do they receive and how do they feel abot this? How and when did they seek support?

9. FAMILY CULTURE: Continuity and Change:

FAMILY CONFLICT (NOTE: this topic may have already been covered in the interview. DO NOT ASK AGAIN IF YOU FEEL THIS IS THE CASE)

Every family has times when there are issues that cause tensions or sometimes, conflict. How much would you say conflict was a part of your family life?

Probe/areas for exploration:

Type, seriousness, duration of conflict?

Attempts to manage conflict?

Impact on family relationships?

Is conflict temporary? Long standing? Unresolved?

How would you tend to celebrate an important family event in your family?

How would you tend to resolve a crisis in your family?

Probe/areas for exploration:

Who takes the lead or decides how events are celebrated/crises are resolved?

Do parents/children participate in this together?

How common is it to gather/join as a family

Are there any issues/problems in joining together (e.g. conflict)

Amount of family contact between parent/children?

Any particular close bonds? Obligations?

10. Dependence/Independence: (NOTE: this topic may have already been covered in the interview. DO NOT ASK AGAIN IF YOU FEEL THIS IS THE CASE)

How much do you feel your mother/father has been able to maintain parts of your life which are important to them?

Probe/areas for exploration:

How much does help or support provided enable person to maintain sense of independence?

Are important continuities maintained?

Evidence of ways change is managed?

Views about future?

Is there anything else that you would like to say about any of the topics we have talked about today – perhaps there is something you would like to say that you don't feel you have had the chance to say?

REMEMBER VIGNETTE

REMEMBER TO CHECK CONSENT TO CONTACT FOR FOLLOW UP INTERVIEW

REMEMBER TO COMPLETE INTERVIEW RECORD SHEET

Vignette

I would now like to ask you some questions about a short story I am going to read you. There are no right and wrong answers; I am just interested in your opinions and ideas:

Here is the story:

Susan Jones is a divorced woman and an only child in her early fifties. She has three children living at home. She has just started a new full time job as a physiotherapist. The work is demanding and busy. It is an important chance for her to have a career and be financially secure.

Her mother is widowed. They are on friendly terms but not over close. They generally see each other once a week when Susan goes to her mother for dinner. Mrs Hughes, her mother, had a stroke a few months ago. She has made a recovery and now wants to leave hospital and return home. She will need a lot of help with personal care and practical help such as cooking. There are some social services in her community.

a) Should Susan be expected to provide care and support to her mother?

Yes

No

Don't know

Probe for reasons for answer.

b) Should this be time she can spare or should she expect to have to give up some of her work to care for her mother?

Spare time

Give up work time

c) Why do you think she should give up the time she should spare (OR give up some of her job)>

Probe and record verbatim

d) She does not want to give any time but should she still offer it?

Yes

No

Don't know

e) Susan does offer help to her mother. But her mother knows that Susan will be loosing money. Should Susan's mother accept help or should she rely totally on formal services?

Accept

Refuse

Don't know

f) Why should Mrs Hughes accept the help from Susan?

Probe and record verbatim:

If refuse:

Why should the mother refuse help from Susan?

Any other comments?

OASIS PROJECT CODING FRAME

This is NOT intended to be an exhaustive coding frame. Instead, it is intended to be a beginning and, a basis for initial coding. Each of these codes can easily be developed and will evolve as you work on your interviews. At this stage they are rather concrete but we assume that they will develop conceptually as the work progresses.

It is anticipated that as you analyse your interview materials, your own codes, conceptual ideas and issues will emerge. These should be added to the coding frame as appropriate and will be fed back, discussed and developed during the team analysis feedback sessions. As you develop conceptual categories in your analysis, please be sure to write appropriate memo's providing information about the ways in which the work has evolved in order to communicate fully to other team members what you mean by the concept/code.

Family Culture/Norms:

- Duty and obligation
- Family events – time together
- Shared views / aspirations
- Conflict
- Family rules – codes of conduct
- Reciprocity / exchange
- Continuity and change

Care and support:

- Duty and obligation
- Family roles
- Formal roles

- Mix/balance of help received
- Preferences/balance of help received
- Evaluations of support
- Impact of support
- Continuity and change
- Reciprocity / exchange
- Conflict
- Ambivalence

Help seeking:

- Triggers to helpseeking
- Types of helpseeking
- Participation / involvement (of parent, child, family, others)
- Conflict
- Impacts
- Continuity and change

Autonomy:

- Mix of support
- Continuity Maintenance
- Management of change
- Mix of formal / informal help
- Reciprocity / exchange
- Involvement and participation

FRONT SHEET (to be completed prior to interview):

Interview Number:

Date of Interview:

Link with (adult child interview number):

Interviewed by:

Information from Questionnaire:

Age:

Gender:

Basic family information:

General assessment of health:

Overall assessment of support required/used; (identify mix of family/formal/other)

POST INTERVIEW COMMENT (to be completed immediately after the interview)

Overall Impression from interview:

Reflection on process:

Impressions re: health, housing, mood etc.

Any particular issues about the interview (e.g. difficulties conducting interview)

Any information relevant to the second interview contact)

Has participant agreed to second interview?

1.1.1.1.1 *Yes/No*

Appendix 3 - Chapter 5

Table 5A. Filial obligation index by country. Per cent in agreement and mean number of agreements by country, age and gender (n) [a]

1.2	***Norway***	***England***	***Germany***	***Spain***	***Israel***
0 agree	24,0	25,4	34,3	17,7	15,7
1-2 agrees	47,6	44,7	36,2	38,3	42,1
3-4 agrees	28,4	30,0	29,5	43,9	42,2
Mean					
Age 25-49	1,72	1,95	1,57	2,14	2,20
Age 50-74	1,55	1,49	1,52	2,14	1,95
Age 75+	1,69	1,44	1,96	2,50	1,84
Men	1,89	1,79	1,52	2,18	2,09
Women	1,48	1,59	1,67	2,17	2,08
Total	1,66	1,67	1,59	2,17	2,08
(n) (1156)	*(1110)*	*(1156)*	*(1131)*	*(1160)*	

[a] weighted samples

Table 5B. Family-welfare state responsibility index [a] by country. Per cent mainly in support for family, welfare state and equal responsibility, and mean scores by country, age and gender (n) [b]

1.3	***Norway***	***England*** [c]	***Germany***	***Spain***	***Israel***
Mainly family	6	39	36	30	18
Both equally	7	17	31	24	21
Mainly welfare state	86	44	33	47	60
1.3.1.1 Mean scores					
25-49	2,64	-0,59	-0,02	0,59	1,51
50-74	2,68	0,25	-0,14	0,87	1,56
75+	2,88	0,45	0,50	0,51	2,46
Men	2,49	0,03	0,01	0,88	1,67
Women	2,84	-0,13	-0,06	0,53	1,55
Total	2,68	-0,07	-0,01	0,69	1,60
(n)	*(1177)*	*(1152)*	*(1225)*	*(1154)*	*(1167)*

Appendix 4 - Chapter 6

Table 6A. Proximity to Study Child: Covariance analysis with country, demographic, familial, and health factors on proximity

Main Effect	SS	df	F	Sig.
Country	16.57	4	2.09	N.S.
Functional health (SF 36)	1.23	1	.62	N.S.
Number of children	6.37	2	1.61	N.S.
Gender	7.84	1	3.95	.04
Marital status (married vs. not married)	11.49	1	5.79	.01
Level of schooling (3 levels)	24.03	2	6.06	.002
Financial situation (comfortable vs. not comfortable)	.21	1	.10	N.S.
Two Way Interactions				
Country × Functional health	38.32	4	4.83	.0007
Country × Number of children	30.61	8	1.93	.05
Country × Marital status	32.70	4	4.12	.002
Country × Level of schooling	36.63	8	2.31	.02

Table 6B. Affectual Solidarity with Study Child: Covariance analysis with country, demographic, familial, and health factors on affectual solidarity

Main Effect	SS	df	F	Sig.
Country	36.05	4	12.69	.0001
Functional health (SF 36)	.27	1	.39	N.S.
Number of children	1.69	2	1.19	N.S.
Gender	.99	1	1.40	N.S.
Marital status (married vs. not married)	1.54	1	2.17	N.S.
Level of schooling (3 levels)	3.01	2	2.12	N.S.
Financial situation (comfortable vs. not comfortable)	8.81	1	12.40	.0004
Two Way Interactions				
Country × Financial situation	8.51	4	2.99	.02

Table 6C. Consensual Solidarity with Study Child: Covariance analysis with country, demographic, familial, and health factors on consensual solidarity

Main Effect	SS	df	F	Sig.
Country	18.27	4	3.61	.006
Functional health (SF 36)	2.58	1	2.04	N.S
Number of children	.16	2	.07	N.S
Gender	1.22	1	.96	N.S
Marital status (married vs. not married)	.18	1	.14	N.S
Level of schooling (3 levels)	7.69	2	3.04	.05
Financial situation (comfortable vs. not comfortable)	7.34	1	5.80	.02
Two Way Interactions				
There was no significant interaction.				

Table 6D. Associational Solidarity with Study Child: Covariance analysis with country, demographic, familial, and health factors on face to face contact

Main Effect	SS	df	F	Sig.
Country	37.31	4	3.29	.01
Functional health (SF 36)	5.22	1	1.85	N.S.
Number of children	7.72	2	1.36	N.S.
Gender	.08	1	.03	N.S.
Marital status (married vs. not married)	.18	1	.06	N.S.
Level of schooling (3 levels)	22.54	2	3.98	.02
Financial situation (comfortable vs. not comfortable)	4.97	1	1.76	N.S.
Two Way Interactions				
Country × Functional health	35.80	4	3.16	.01
Country × Number of children	45.70	8	2.02	.04
Country × Marital status	43.71	4	3.86	.004

Table 6E. Associational Solidarity with Study Child: Covariance analysis with country, demographic, familial, and health factors on phone or mail contact

Main Effect	SS	df	F	Sig.
Country	61.90	4	7.55	.0001
Functional health (SF 36)	2.73	1	1.3	N.S.
Number of children	25.91	2	6.32	.002
Gender	4.30	1	2.10	N.S.
Marital status (married vs. not married)	7.18	1	3.50	N.S.
Level of schooling (3 levels)	2.15	2	.52	N.S.
Financial situation (comfortable vs. not comfortable)	7.17	1	3.50	N.S.
Two Way Interactions				
Country × Marital status	24.05	4	2.93	.02

Table 6F. Functional Solidarity with Study Child: Covariance analysis with country, demographic, familial, and health factors on help received

Main Effect	SS	df	F	Sig.
Country	40.75	4	4.80	.0008
Functional health (SF 36)	183.54	1	86.45	.0001
Number of children	24.36	2	5.74	.003
Gender	.03	1	.01	N.S.
Marital status (married vs. not married)	99.46	1	46.85	.0001
Level of schooling (3 levels)	10.36	2	2.44	N.S.
Financial situation (comfortable vs. not comfortable)	.59	1	.28	N.S.
Two Way Interactions				
Country × Marital status	21.36	4	2.51	.04

Table 6G. Normative Solidarity with Study Child: Covariance analysis with country, demographic, familial, and health factors on normative solidarity

Main Effect	SS	df	F	Sig.
Country	28.65	4	11.89	.0001
Functional health (SF 36)	1.26	1	2.10	N.S.
Number of children	1.93	2	1.60	N.S.
Gender	7.65	1	12.70	.0004
Marital status (married vs. not married)	3.27	1	5.43	.02
Level of schooling (3 levels)	6.55	2	5.43	.004
Financial situation (comfortable vs. not comfortable)	.57	1	.95	N.S.
Two Way Interactions				
There was no significant interaction.				

Appendix 5 - Chapter 9

Table 9A. Means and standard deviations of the scale "subjective physical health"

Country		Age Group25-49			Age Group 50-74			Age Group 75+		Total		
		Male	Female	Tot.	Male	Female	Tot.	Male	Female	Male	Female	Total
Norway	Mean	17,0	16,5	16,7	16,2	15,3	15,8	14,6	13,8	14,1	16,5	15,8	16,1
	SD	2,2	2,6	2,5	2,9	3,1	3,0	3,1	3,4	3,3	2,7	3,0	2,9
England	Mean	16,3	16,1	16,2	14,6	14,5	14,6	13,5	12,8	13,0	15,2	15,0	15,1
	SD	3,2	3,1	3,1	3,8	3,7	3,7	3,5	3,8	3,7	3,7	3,6	3,6
Germany	Mean	17,9	17,3	17,6	16,6	16,1	16,3	14,6	14,1	14,2	17,1	16,3	16,7
	SD	2,2	2,3	2,3	2,5	2,7	2,6	2,9	2,9	2,9	2,5	2,8	2,7
Spain	Mean	17,4	17,0	17,2	15,4	14,2	14,8	13,6	12,2	12,7	16,3	15,4	15,8
	SD	1,9	2,1	2,0	2,8	3,3	3,1	2,7	3,1	3,0	2,7	3,3	3,0
Israel	Mean	16,8	16,0	16,3	15,2	14,9	15,0	13,4	11,8	12,5	15,9	15,3	15,6
	SD	2,1	2,5	2,4	2,9	2,9	2,9	2,7	3,0	3,0	2,7	2,8	2,8

Table 9B. Means and standard deviations of the scale "subjective physical health"

		Age Group25-49			Age Group 50-74			Age Group 75+			Total		
Country		Male	Female	Tot.	Male	Female	Tot.	Male	Female	Tot.	Male	Female	Total
Norway	Mean	15,9	15,6	15,7	15,7	15,5	15,6	14,9	14,7	14,8	15,7	15,5	15,6
	SD	1,9	2,1	2,0	2,0	2,0	2,0	2,4	2,5	2,5	2,0	2,1	2,1
England	Mean	15,6	14,9	15,1	15,2	15,1	15,1	14,9	14,2	14,4	15,3	14,9	15,1
	SD	2,4	2,7	2,6	2,9	2,7	2,7	2,7	2,9	2,8	2,7	2,7	2,7
Germany	Mean	16,8	16,3	16,5	16,3	16,0	16,1	15,7	15,1	15,3	16,5	16,0	16,2
	SD	2,2	2,6	2,4	2,6	2,5	2,5	2,3	2,5	2,5	2,4	2,6	2,5
Spain	Mean	15,3	14,9	15,1	14,1	13,5	13,8	13,5	12,5	12,8	14,7	14,1	14,4
	SD	2,3	2,4	2,4	2,2	2,2	2,2	2,1	2,4	2,4	2,4	2,5	2,4
Israel	Mean	15,8	15,0	15,3	14,9	14,3	14,6	13,8	12,9	13,3	15,3	14,6	14,9
	SD	2,2	2,3	2,3	2,2	2,6	2,4	2,5	2,6	2,6	2,3	2,5	2,4

Table 9C. Means and standard deviations of the scale "satisfaction with social relations"

		Age Group25-49			Age Group 50-74			Age Group 75+			Total		
Country		Male	Female	Tot.	Male	Female	Tot.	Male	Female	Tot.	Male	Female	Total
Norway	Mean	15,8	16,1	16,0	15,5	15,7	15,6	14,5	14,9	14,7	15,5	15,8	15,7
	SD	2,3	2,0	2,2	2,3	2,2	2,2	2,2	2,3	2,3	2,3	2,1	2,2
England	Mean	16,3	15,9	16,0	15,5	15,6	15,6	15,0	14,9	15,0	15,7	15,7	15,7
	SD	2,7	3,0	2,9	2,5	2,4	2,5	2,3	2,3	2,3	2,6	2,7	2,6
Germany	Mean	15,9	16,1	16,0	15,2	14,8	15,0	14,5	13,7	13,9	15,5	15,2	15,3
	SD	2,4	2,6	2,5	2,5	2,7	2,6	2,2	2,2	2,2	2,5	2,7	2,6
Spain	Mean	16,5	16,4	16,5	15,3	15,3	15,3	14,6	14,4	14,5	15,9	15,7	15,8
	SD	2,2	2,6	2,4	2,2	2,3	2,3	2,3	2,2	2,2	2,3	2,5	2,4
Israel	Mean	15,8	15,4	15,5	14,4	14,8	14,6	14,3	13,1	13,6	15,1	15,1	15,1
	SD	2,8	3,2	3,0	3,0	3,0	3,0	3,0	3,4	3,3	3,0	3,2	3,1

Table 9D Means and standard deviations of the scale "satisfaction with environment"

		Age Group25-49			Age Group 50-74			Age Group 75+			Total		
Country		Male	Female	Tot.	Male	Female	Tot.	Male	Female	Tot.	Male	Female	Total
Norway	Mean	15,5	15,6	15,6	16,2	15,9	16,1	15,8	15,0	15,3	15,8	15,6	15,7
	SD	2,0	2,0	2,0	1,9	2,0	2,0	2,0	2,2	2,2	2,0	2,0	2,0
England	Mean	14,6	14,1	14,3	14,7	14,7	14,7	14,4	14,1	14,2	14,6	14,4	14,5
	SD	2,4	2,6	2,5	2,5	2,5	2,5	2,2	2,5	2,5	2,4	2,6	2,5
Germany	Mean	15,8	15,7	15,7	16,0	15,6	15,8	15,7	15,3	15,4	15,9	15,6	15,7
	SD	2,0	2,3	2,1	1,9	2,2	2,1	1,9	2,1	2,0	2,0	2,2	2,1
Spain	Mean	14,6	14,3	14,5	13,8	13,5	13,6	13,5	12,8	13,0	14,2	13,8	14,0
	SD	2,1	2,1	2,1	2,0	2,0	2,0	1,9	2,0	2,0	2,1	2,1	2,1
Israel	Mean	15,1	14,3	14,6	14,6	14,4	14,5	14,1	13,5	13,8	14,8	14,3	14,5
	SD	1,9	2,2	2,1	2,0	2,2	2,1	2,3	2,4	2,3	2,0	2,2	2,1

Table9E: Means and standard deviations of the scale "positive affect"

		Age Group 25-49			Age Group 50-74			Age Group 75+			Total		
Country		Male	Female	Tot.	Male	Female	Tot.	Male	Female	Tot.	Male	Female	Total
Norway	Mean	16,0	15,5	15,8	14,1	13,2	13,6	10,9	11,3	11,1	14,9	14,4	14,6
	SD	3,8	4,2	4,0	4,4	4,6	4,5	4,1	4,6	4,4	4,3	4,6	4,5
England	Mean	14,7	13,9	14,2	13,1	13,7	13,4	11,5	11,4	11,5	13,6	13,5	13,5
	SD	5,3	5,1	5,2	4,7	4,7	4,7	4,2	4,2	4,2	5,0	4,8	4,9
Germany	Mean	17,2	16,8	17,0	16,2	15,5	15,8	14,6	13,9	14,1	16,6	15,8	16,2
	SD	3,2	3,3	3,3	3,6	3,3	3,4	3,1	3,4	3,3	3,4	3,5	3,5
Spain	Mean	12,1	12,4	12,3	10,4	11,3	10,9	10,0	10,1	10,1	11,3	11,7	11,5
	SD	4,5	4,6	4,5	4,2	4,3	4,3	3,9	4,0	4,0	4,4	4,5	4,5
Israel	Mean	12,5	12,3	12,4	10,1	11,2	10,7	10,4	10,7	10,5	11,4	11,8	11,6
	SD	4,3	4,0	4,1	3,8	4,4	4,2	4,1	4,3	4,2	4,3	4,2	4,2

Table 9F: Means and standard deviations of the scale "negative affect"

		Age Group 25-49			Age Group 50-74			Age Group 75+			Total		
Country		Male	Female	Tot.	Male	Female	Tot.	Male	Female	Tot.	Male	Female	Total
Norway	Mean	8,4	9,2	8,9	7,4	8,4	7,9	7,1	8,3	7,8	7,9	8,9	8,5
	SD	3,2	3,8	3,6	2,9	4,1	3,5	2,9	3,8	3,5	3,1	3,9	3,6
England	Mean	8,7	9,5	9,2	8,6	9,3	9,0	7,9	9,1	8,7	8,6	9,3	9,0
	SD	4,2	4,7	4,5	4,8	4,6	4,7	4,0	4,5	4,3	4,5	4,6	4,5
Germany	Mean	8,5	9,3	8,9	8,2	8,8	8,5	8,2	8,9	8,7	8,3	9,1	8,7
	SD	2,7	3,4	3,1	2,9	3,5	3,3	3,3	3,5	3,4	2,9	3,5	3,2
Spain	Mean	7,3	7,9	7,6	7,2	9,3	8,3	7,7	9,7	9,0	7,3	8,7	8,0
	SD	2,7	3,3	3,0	3,1	4,2	3,9	2,8	4,1	3,8	2,9	3,9	3,5
Israel	Mean	10,6	12,2	11,6	9,6	11,3	10,6	11,1	11,8	11,5	10,2	11,9	11,2
	SD	3,6	4,7	4,4	4,0	4,3	4,3	4,3	4,3	4,3	3,9	4,5	4,3