Family and Aging Policy

Francis G. Caro, PhD • Editor

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Family and Aging Policy

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ABOUT THE EDITOR

Francis G. Caro, PhD, is Professor of Gerontology at the University of Massachusetts Boston. He received a PhD in Sociology from the University of Minnesota. Dr. Caro's major current research interests are organization of home and community-based long-term care for elders, planning of residential adjustments associated with the aging process, and productive aging. He is the editor of the *Journal of Aging & Social Policy* and co-editor of a number of books including *Devolution and Aging* (2002), *Advancing Aging Policy as the 21st Century Begins* (2000), and *Achieving a Productive Aging Society* (1993). In addition, he is a co-author of *Personal Assistance: The Future of Home Care, Quality Impact of Home Care for the Elderly* (1988), and *Family Care of the Elderly* (1981). He edited *Readings in Evaluation Research* (1977). Dr. Caro teaches policy courses in the graduate programs in Gerontology at the University of Massachusetts Boston.

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INTRODUCTION

Family and Aging Policy

Francis G. Caro, PhD

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Historically, in "advanced" societies the emergence of public interventions to address special needs of elders can be traced to the limitations of families. In earlier eras in these societies, families were the primary source of assistance for dependent elders. In those times, the vast majority of those who survived to old age lived within multigenerational households. In part, public interventions to assist dependent elders in advanced societies are a reflection of the fact that both extended and nuclear families have weakened. Significant numbers of elders do not have relatives to call upon when they need assistance. Public interventions also have their origins in some substantial needs of elders that greatly exceed the capacity of families to provide help. (Other major factors also contributed to the emergence of significant public sector intervention including economic development, which has provided the financial underpinnings.)

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The family ties of elders in advanced societies are varied and highly complex. Elders who have no significant family involvement are the exception. For the majority of older people, many aspects of the aging experience tend to unfold in a family context. Examples of the family and aging connection are abundant. The timing of retirement is often the reflection of the agenda of married couples. For elders who are married, financial security is a reflection of joint income and assets. For married elders who co-reside with their spouses, housing choices are choices of couples (and sometimes other family members). For elders who co-reside with adult children, housing is a multigenerational family matter. For elders who need long-term care, unpaid relatives tend to be the first source of care and the most important source of long-term care. Family members are often involved with elders in negotiating the health care system. These examples illustrate the fact that, in the key areas of income security, housing, long-term care, and health care, the welfare of individual elders is often a reflection of their family circumstances.

The manner in which public programs affecting elders take families into account is varied. Some public programs are directly focused on families. In the United States, the Social Security Act, for example, was designed to protect both individual workers and their families. In addition to providing pensions for disabled and retired workers, the Social Security program provides pension benefits for survivors of deceased workers and spouses of retired workers. The Family Medical Leave Act is another example of a public intervention with an explicit family focus. The Act makes it possible for employees to take unpaid leave under certain circumstance in order to provide assistance to family members. Another example is the family caregiver provisions of the Older Americans Act that are designed to provide assistance to informal providers of long-term care.

Other public programs serving elders are focused on individuals but have important implications for families. Medicaid, for example, is fundamentally a source of health care financing for individuals. At the same time, Medicaid includes some explicit provisions concerning families. For elders who are seeking Medicaid-financed nursing home care, assets jointly owned by married couples pose a complication in determination of financial eligibility. Medicaid administrative policy addresses issues concerned with the complications associated with taking into account assets jointly owned by married couples in determining individual eligibility.

Historically, Medicaid has also addressed questions about the responsibility of adult children to pay for long-term care for their aging

parents. The filial responsibility issue has important financial implications for relatives. Public payment for nursing home care relieves family members of the obligation to pay for care.

Medicaid policy has also taken a position on the hiring of immediate family members as providers of financed care. On a long-standing basis, Medicaid programs have prohibited the hiring of immediate family members as personal assistance providers financed through Medicaid. Some contemporary consumer-directed care programs have challenged this long-standing policy.

The reasons for examining the implications of aging policy for families are multiple. One reason is to evaluate the direct effects of policies designed to affect families. When policies are designed to support families engaged in eldercare, for example, questions can be asked about their vertical and horizontal efficiency, that is, the extent to which they reach those in need of support and the extent of need among those who do receive assistance. Also of interest is the effectiveness of interventions in assisting those who use them. The indirect effects of family policies for individual elders also deserve attention. Of particular interest are instances in which the welfare of elders and families are in conflict.

Another reason to pursue this topic is to examine indirect implications for families of policies designed to affect individual elders. These effects may be unanticipated. Policies that limit the scope of public financing of services for elders, for example, often have financial implications for families when families become the payers of last resort because of inadequacy of public financing.

In the United States, possibilities for widespread indirect effects of policy on families are abundant because of the many aspects of policy that can affect elders, the narrow scope of many policies, and the absence of an explicit public policy agenda either for elders or their families. Individual elders and their families are expected to solve their own problems except in the exceptional situations in which the public sector has chosen to intervene. The situation is further complicated by the fact that the public sector can intervene at the federal, state, or local level.

Questions about the interplay between public interventions and families on aging issues arise in every country with some level of public attention to the needs of elders. Internationally, variation in the scope of public-sector intervention on needs of elders is enormous. In many developing countries, public intervention is nominal; extended families remain the mainstay in support of dependent elders. In more developed countries, the public interventions are often at least as well developed as they are in the United States. At the same time, the involvement of fami-

lies in elder support issues is extensive in all of these countries. Consequently, the potential for complex interaction between families and public interventions is great.

The papers in this volume are responses to a widely circulated call for papers. The intent was to include papers on many aspects of aging and policy that drew upon experiences in the United States and elsewhere. We succeeded in attracting a strong international response with four articles on experiences in countries other than the United States. Most of the papers are concerned with the role of family in providing long-term care. The heavy emphasis on this topic is not surprising in light of the major role that families play in providing care to elders living in the community and the fact that public programs tend to operate as supplements to informal care.

All but one of the papers are concerned with aspects of caregiving. Of the 12 articles concerned with caregiving, 11 are focused on elder care. The other paper deals with grandparents who care for their grandchildren. The volume begins with the articles on elder care. We have placed the papers on Sweden, Denmark, Singapore, and Canada first because they demonstrate effectively the universality of the tension between family and public responsibility for elder care. In each of these countries, families willingly play the major role in long-term care. The demands of caregiving often exceed the capacity of family members to provide all of the care that is needed. In every case, families look to the public sector for assistance. The manner in which the public sector complements family caregiving varies from one country to another. Lennarth Johannsson and Gerdt Sundström provide a historical perspective on shifts in the manner in which filial obligations have changed over time in Sweden. They argue that intergenerational solidarity in Sweden remains strong in spite of the country's extensive welfare programs. Similarly, Mary Stuart and Eigil Boll Hansen report that, in Denmark, even with the introduction of extensive publicly-funded home care programs for elders, involvement of family caregivers remains extensive. Examining family-oriented social policies of the Singapore government, Kalyani K. Mehta argues that the government should do more to help family caregivers look after elder relatives. Reporting on a study conducted in Quebec, Canada, Nancy Guberman and colleagues examine shared responsibilities of families and formal services for frail elders. They find high expectations for family caregiving at the same time that they find strong support for publicly-funded programs to support caregivers.

The papers about caregiving in the United States begin with an account by Lynn Friss Feinberg and Sandra L. Newman of the early experiences of the Administration on Aging's National Family Caregiver Support program. We follow with two papers concerned with employment and elder care. Donna L. Wagner provides a broad examination of employment and elder care. Steven Wisensale then argues for paid leave as a means of strengthening the Family Medical Leave Act. Carol J. Whitlatch and Lynn Friss Feinberg examine the experiences of California Caregiver Resource Centers that permit families to hire relatives and friends as in-home respite providers. Looking at the fact that eldercare responsibilities often continue for a number of years and change over time, Joseph E. Gaugler and Pamela Teaster examine the implications for policy and community-based care programs. Phoebe S. Liebig, Teresa Koenig, and Jon Pynoos call attention to the role of accessory dwelling units in facilitating family caregiving. They demonstrate the importance of local zoning ordinances in enabling this form of intergenerational co-residence. Carrie A. Levin and Rosalie A. Kane show that in assisted living, residents and family members have distinct perspectives on the features offered by facilities.

In her article about grandparents raising grandchildren, Casey E. Copen shows how welfare reform has affected intergenerational households headed by grandparents.

In the final article, Gretchen J. Hill examines the manner in which changes in state rules during the 1990s affected such areas as inheritance, estate taxes, homestead exemptions, Medicaid eligibility, and estate recovery. Hill's article is important in showing that public policy concerning families goes far beyond caregiving issues.

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Policies and Practices in Support of Family Caregivers– Filial Obligations Redefined in Sweden

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SUMMARY. This article provides an overview of how the expression of filial obligations has shifted over time in Sweden. Historically, and currently in many countries, the family, next of kin, and the social network are the only or major sources of help, as it was in Sweden till half a century ago. The article also explores how various aspects of solidarity–public and private–have developed and are changing in Sweden, known for its extensive welfare programs, with "from cradle to grave" security. It

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concludes that intergenerational solidarity has not vanished in Sweden; just the manifestations have changed. doi:10.1300/J031v18n03_02

KEYWORDS. Old age care, family, public services, Home Help

INTRODUCTION

The expression of filial obligations has shifted over time and varies internationally. Historically, and currently in many countries, the family, next of kin, and the social network at large have been and are the only or major sources of help, as it was in Sweden till half a century ago. One may say that dependent elderly persons rely on an implicit intergenerational contract, guaranteeing necessary support on a normative basis. In this sense, changes in care provided within the family and social network indicate a normative change in patterns of relations and exchanges between individuals, what we often term "solidarity."

Patterns of care for the elderly have received increasing attention over the last three decades, in Sweden and elsewhere. The reasons are well-known: More elders and more elders who live alone and need help. The explanations given for these changes vary, from purely demographic trends–the many elders who "overburden" shrinking families and the state–to the "disappearance" of the housewife, shifts in norms and values, social atomization, and waning filial piety. Others argue that intergenerational solidarity has not vanished, but that the manifestations have changed. Help to parents and other kin was never unconditional, not even when stipulated in law.

All the disintegrative forces are presumed to have culminated in Nordic welfare states, but they are well under way in many other societies. In Europe, several countries have legally binding filial obligations (Millar & Warman, 1996). The Nordic countries never had these obligations (Denmark) or recently abolished them. Other countries (e.g., Germany and France) seem to apply them only when institutional care is the option. In many welfare states, public spending may have reached a ceiling, as tax increases are politically impossible, and the issue then is how best to use available resources. Countries with fewer extensive

public services tend to focus more on economic support and pensions, though the picture is complex and does not always concur with the wishes of carers. For example, a recent (2004) nationwide Spanish survey of carers found that they above all want services, and more now than 10 years earlier. Financial support is less asked for, but still important because many carers suffer financially from their commitment (IMSERSO, 2004). The Nordic countries have invested more in services and residential care, though financial support has been used as well, but frequently as a secondary and marginal strategy.

With some guidance by a theory on intergenerational solidarity (Bengtson & Roberts, 1991), this article explores how various aspects of solidarity–public and private–have developed and are changing in Sweden, known for its extensive welfare programs, with "from cradle to grave" security. The sustainability and consequences of these policies might be of interest for American policymakers.

FILIAL AND PUBLIC OBLIGATIONS–A SYMBIOTIC STORY

Public responsibility for the frail, poor, and elderly has a very long tradition in the Nordic countries. There, the poor tithe was, by special permission, gathered and spent locally after collective decisions in the parishes in medieval times, rather then being forwarded to the ecclesiastical hierarchy as on the continent. The significance of this heritage is often overlooked, perhaps because these structures took form so early. Parish meetings on poor-relief and other communal affairs later developed into municipal councils (1862). These, together with village meetings, road maintenance associations, a court system with locally elected laymen, various self-help organizations, non-conformist religious groups, tea-totallers, labor unions and political organizations, library associations, and other more or less formalized citizen fora became so much part of Swedish life that they are now taken for granted. Yet, it remains that many modern welfare programs started out early, on a voluntary basis. The legal responsibility of the parish-municipality for their paupers, formalized in 1788, was of great importance because it trained (the more affluent) locals to take part in communal problem-solving and, early on, established habits of compromise and trust (in short, "social capital"). It also fostered the perception that care for the poor and elderly (often the same persons) was a concern both communally and lo-

cally. The Nordic welfare state has an old foundation and in a way, it's just the scope of action that is much larger today.

Inheritance rules and the corresponding expectation that heirs would provide care were stipulated in medieval laws in Sweden but applied only to the relatively well-to-do. In the early 1700s, a system (*undantag*) emerged where farmers (or other landowners) could transfer their property at a reduced price to offspring (or anyone else) and in return have a guarantee of food, shelter, and care, typically including a decent burial. The property served as security in contracts, which often specified the tribute in great detail. An 18th century law that required people without a livelihood to find an employer (vagrants were often arrested and sent to forced labor) made exceptions for women caring for frail parents. Still, in 1954, 6% of the Swedish elderly lived with *undantag-contract*–vanished today, but still surviving in Finland and Norway.

One should not romanticize the local provision of relief to the poor. Parishioners were generally poor, and human shortcomings sometimes interfered with provisions that, at best, were patriarchal and in the spirit of almsgiving. In spite of repeated central instructions over the centuries regarding what should be done, local differences in provision persisted and were still large in 1829, as disclosed in a government survey that year (Skoglund, 1992). Tensions between a powerful state and a semi-autonomous periphery have long roots in the Nordic countries.

After stipulating municipal obligations for the poor, filial duties were established. The poor-relief board in the parish, before giving any help, had to consider "the responsibility to see to the needs of the poor person that could be tied to kin or other persons" (Poor Relief Regulation, SFS 23, 1847 para. 4), though conditioned by their ability to provide. It is easy to find cases in the poor relief records where family members evaded the task with impunity or where they did provide, but received money from the poor relief board to alleviate their burden. There were obligations both on the public side and on kin's side.

In 1855 a government resolution restricted obligations to parent-child, a clause that remained in poor laws till 1956. Filial obligations were abolished in Swedish civil law in 1979 with explicit reference to pensions and old-age care now being so adequate that these regulations were obsolete. The lawmakers at the same time found it appropriate to point out that they in no way wanted to abolish the "moral obligation by offspring to help and support their parents in other ways."

By the early 1800s, Swedish poor relief clients could appeal local decisions in their cases to the county governor's office. The legal right to appeal decisions in old-age care free-of-charge up through the ladder of

administrative courts was established in the Social Service Act of 1982. Yet, complaints on old-age care are rare, and probably less common than they should be. The County Administrative Board acts on complaints, inspects, and strives to supervise residential care and home-based care for the elderly.

CHANGING OLD-AGE CARE IN SWEDEN

In modern times, Sweden and the other Nordic countries gradually replaced the intergenerational contract with a societal contract. Indeed, one of the explicit cornerstones in the post-war Swedish welfare system was to substitute public services for former family responsibilities. In pace with the economic growth, the state should gradually extend services and care for children, the disabled, and the elderly. In that vein, from the 1960s and up to the second half of the1980s, public old-age care expanded substantially in the Nordic countries.

Before 1950, public old-age care in Sweden equaled poor relief and often meant institutional care. About 20% of those aged 80 years and older were institutionalized in 1950. Major scandals in old-age homes and public pressure by media and demands from the fledgling pensioners' movements forced the government instead to promote public Home Help (help with chores but also personal care), that expanded dramatically in the next two decades. Yet, institutionalization also grew rapidly. In 1975, 30% of those 80 and older in Sweden were institutionalized, and 39% used public Home Help, that is, 7 out of 10 were covered (Sundström, Johansson, & Hassing, 2002). By that time, fees were low or waived altogether, and in all fairness it may be said that there was a degree of over-consumption of services.

In 2003, 19% of those 80 years and older were institutionalized and the same proportion used public Home Help; together these services covered 4 out of 10 of those 80 years and older. These are national averages: local variations in services for the elderly were and are big, in Sweden. Help to elders living in the community has suffered most during the 1990s. Institutional care is, by nature, more difficult to cut back or to run at half speed, but beginning around the year 2000, substantial cutbacks have also been made in institutional coverage. In general, cutbacks were accompanied by stricter and more professional needs-assessments, which tend to follow the letter of the law: services are provided "when a need cannot be seen to by other means."

In the 1970s-1980s, according to one study, about half of the elderly died without having ever used any public service. In recent studies, rates are much lower: Today, 90-95% of elders eventually seem to use public old-age care. Prevalence rates (in cross-sectional statistics) may decrease and incidence rates may rise simultaneously. One might interpret the above findings as improved targeting, but it comes at a cost: Elders now use help later and for a shorter period of time. Evidence of this is not collected routinely; therefore, cross-sectional data are used in Table 1 to describe changing support patterns. Public services may have decreased for a number of reasons. Municipalities are hard pressed financially, and there are budget restrictions, since Sweden already has the world's highest tax rates. Two thirds of all personal tax is paid to and spent by the municipalities, which are nearly self-financed and constitutionally independent. Government attempts to prescribe what municipalities should do–without providing sufficient means–are countered by municipal rationing and/or watering down of the quality of the services.

Some elderly tend to refrain from or postpone the use of these services when co-payments are raised, but fees also induce users to demand quality, which they increasingly do. Others, particularly those more well off, find it to their advantage instead to buy private services or to remunerate family for help given. Further, raised standards of living of successive cohorts of the elderly may also decrease dependence

TABLE 1. Family Care, Public Home Help, and Institutional Care for Elders, Sweden, 1954, 1975, 1994, and 2000

		Year			
		1954	1975	1994	2000
	Age	67+	65+	75+	75+
Received support from family*[1]		77%	39%	34%	37%
	65+[1]	1%	17%	9%	8%
Home help	75+[2]	..	..	18%	15%
	80+[1]	..	39%	22%	20%
Institutional care	80+	20%	30%	23%	21%

[1] percentage of total population.
[2] percentage of community-residing elders.
* All kinds of relatives, including small numbers of friends and neighbors, helping with household chores (1954). In 1975, 1994, and 2000, also personal care (see footnote of Table 2), but very few received help with this only.
Source: Johansson, Sundström, & Hassing, 2003.

on public support. As implied, rationing of services can be compatible with improved targeting in the longer run. This may be seen as a system response in a situation where it is impossible to expand service coverage.

Old-age care in the Nordic countries is in practice a municipal monopoly, with one point entry where all needs assessments and eligibility issues are handled by the same case manager. A good deal of the success of the system and its viability in the present situation of cutbacks is due to the simplicity of the system and its local anchorage, administratively and in day-to-day work.

To sum up, the Swedish welfare state has retreated and a similar process seems to be under way in the other Nordic countries. For mainly economic reasons, the expansion was halted in Sweden in the 1990s; after that, coverage ratios of various services have dropped substantially. This, then, points in the direction of a more selective mode of welfare provision. Previous fears that the state would eventually crowd out all family care were unfounded. In 1950, about 5% of the Swedish GDP was spent on the elderly (pensions, housing allowances, old-age homes, etc.); since the 1990s, the proportion is about 12%, and government budget forecasts show that it will not increase in the near future. When public services cannot keep up with demands for care, there remains the family or other private initiatives–or that (some) needy persons live in misery.

FAMILY CARE IN SWEDEN

In the 1990s, the family and family care was "re-discovered" in elder care in Sweden and even found its way into legislation. There are several explanations of this. First, one of the major experiences in promoting home-based community care was that home care is often dependent on extensive family caregiving. Second, along with the economic recession, there has been a growing interest in the informal care sector and its potential to substitute for costly formal services. Third, in recent years there is also increasing research evidence pointing to the crucial role of families, their care commitments, and their ensuing need for support. Fourthly, and most recently, carers and their organizations are now more openly lobbying for recognition and support. The resulting effect is a growing awareness that support for carers is a necessary precondition to mobilize carers in the future, which in turn is of crucial importance for the whole system of elderly welfare in an era of shrinking

public services. In a more critical vein, one might say that public recognition of family caregiving was very timely, as it coincided with the welfare program cutbacks.

As shown in Table 1, family care decreased steeply from the early 1950s, but then leveled off and seems to have increased somewhat in the 1990s (the 1994 and 2000 studies exactly comparable). Much help in the 1950s and 1960s concerned tasks like wood-chopping and water-carrying, no longer needed since 99% of the Swedish elderly now have modern housing, compared to about 20% in 1954 and 80% in 1975. Generally speaking, modern housing and adequate pensions facilitate independent living. Surveys also indicate that this increasingly is the preference.

Also, by other measures family care did increase in the 1990s: families are estimated to have provided 60% of all community care in 1994, but 70% in 2000, for elders 75 + (Sundström, Johansson, & Hassing, 2002). Since there are nearly three times more old people today than in 1950, this implies an absolute increase in family care. Likewise, a thorough Norwegian study found no evidence that the state had replaced family care (Lingsom, 1997). Spouses and adult children provide most of this family support, and there are more of both. More old people have children and more are married and also stay married longer, with a vast increase in Golden Weddings and other long-lived marriages, in spite of a simultaneous rise in elderly divorces.

Counter intuitively, men care for wives about as much as women care for husbands; many men need no help before they die, or only little help for a short time (Sundström et al., 2003). More elders are married: In the age-group 80+, 20% were married in 1950, as against 32% in year 2002. Of all the elderly 65+, 54% are married and another 4% co-habit with a partner. Further, maybe 7% of the elderly have partners with whom they do not live; that is, they are "living apart together" (Tornstam, 2005). The care provided by adult children is described in some detail in Table 2. Help from family, in particular children, increased in the 1990s.

The state can support caring families *directly*, but also *indirectly* through services: Offspring are relieved when aging parents use Home Help. Direct support to family carers is unusual in Sweden, with indirect support through the public Home Help decreasing. Yet, this service is the dominant source of help for Swedish elders with neither spouse nor children (it provides both household help and personal care, though it strives to restrict itself to the latter). Home Help clients pay a fee, according to income and number of hours used, up to a ceiling. The average client uses 32 hours/month, with large variations and no upper limit.

TABLE 2. Care for Elderly People 75+ Who Live Alone, Help from Children* and from Public Home Help. Sweden 1994 and 2000

	All		Has offspring, all elders		Offspring within 15 km		Childless	
Year	1994	2000	1994	2000	1994	2000	1994	2000
Help from								
Children	12%	22%	16%	28%	16%	36%	–	–
Home Help	25%	20%	24%	18%	23%	19%	27%	29%
N (weighted)	716	843	547	670	371	414	170	173

Note: Home Help is a needs-assessed public service that in Sweden provides help with *household tasks* (primarily shopping, cooking, cleaning, and laundry) and/or with *personal care* (getting into/out-of bed, bathing, toileting, eating, un/dressing, outdoor walks, etc.).
*Both for Home Help and children, help refers to aid with one or more of these aspects.
Sources: Johansson, Sundström, & Hassing, 2003.

Four percent of all Home Help recipients use more than 120 hours/month.

Currently, in Sweden, only *married* persons have legal obligations to support their partners, though this officially does not include "heavy" personal care. As indicated, the Social Service Act states that a municipality has an obligation to provide help if a need cannot be seen to otherwise. This has recently been interpreted, with dubious legality, to the effect that elders who have offspring or other family living nearby or who are well-to-do are denied public help. In a way, this reminds us of the situation half a century ago when public services equaled poor relief. As mentioned, filial obligations then applied, as they still do in many European countries. Some potential users are now instead helped by family, or they buy private services. In the 1970s and 1980s, there were no class differences in the use of public home help, but such differences seem to have reemerged.

Patterns of living and care are closely related. In contemporary Sweden the elderly and their adult children rarely live together; about 2% do so. This is also gradually decreasing in most other European countries, though Italy seems to be an exception. The Swedish elderly live alone (40% of those 65 years and older) or–importantly–with just their spouse/partner. Solitary living has culminated at least in the Nordic countries, in the Netherlands, and in Britain. It is less common, but increasing, in Southern Europe. Yet, family should not be confused with co-resident kin. Indeed, a number of studies show that there are family members available for most elders and maybe even increasingly so, in Sweden, Britain, Belgium, and possibly other countries (Socialstyrelsen, 2004a;

Pickard et al., 2000; Audenaert, 2003). Often this is due to more elderly living into high age with a partner, frequently the most important and often also the most neglected family member.

Families Recover Ground in Sweden

In an analysis of care patterns, the elderly increasingly are *givers* of financial help and often provide as much care as they receive, in Sweden 24% and 21%, respectively (Socialstyrelsen, 2005). Data for Sweden, Norway, and other countries indicate substantial transfers from the elderly to children and grandchildren. Young, mostly single adults both in Southern and Northern Europe increasingly remain in (or return to) their parents' households, because of adverse labor and housing markets.

Most European elderly have children who live nearby and who often call, visit, or provide support and care. Indeed, as we have seen, Swedish families now help their elderly more than before. It is especially daughters who obey the commandment to honor one's parents: In 1994, 29% of the elderly (75+) were helped by female family members; in 2000, 39%. For those years, daughters made up 22% and 33%, respectively, of these figures. Help from males was constant at 15%, mostly from a son. (Daughters-in-law are less frequent in the panorama of care.) Usually, it is one person in the family who supports a frail elderly person: a spouse, a daughter, or a son. When a son is the main carer, often no daughter is available (Johansson, Sundström, & Hassing, 2003).

A recent survey gives some evidence about sentiments of filial responsibility and whether those sentiments can be actualized to support parents or not. A single question was used to explore this among middle-aged persons, shown in Table 3. The vast majority say that they can help, and more than one in ten already do.

Many may say that this trend increases the burden on the family. Yet, loosely referring to (burdens on) the family may be unfounded. Most elderly persons in Sweden have never cared for a parent (or anyone else), but if family care becomes more common–as it seems to be doing in Sweden–this will not necessarily mean a greater burden on the family but that more *family members* are helping their elders. Usually one person in the family provides the bulk of care. The interpretation of this development is complex and should avoid doctrinaire analytic schemes. Assessments should include how much these individual family members are doing and whether they stand alone with their commitment in their family and/or without public support. Regrettably, these predica-