Who cares more? Male and female family caregivers in Germany

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Ulrike Ehrlich (corresponding author)
German Centre of Gerontology (DZA)
Ulrike.ehrlich@dza.de

Nadiya Kelle
German Centre of Gerontology (DZA)
Nadiya.kelle@dza.de

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Introduction

People who provide care privately to family members and close acquaintances in need of care due to poor health, disability or age-related frailty (to whom we refer in this article as “family caregivers”) provide the backbone of the German care system. Of the 2.9 million people who required care in 2015 according the definitions provided in Book XI of German law on social affairs (*Sozialgesetzbuch – Elftes Buch – Soziale Pflegeversicherung – SGB XI*), 2.1 million were provided with that care in their own homes either by private individuals – by family members, friends, acquaintances – or by professional care services (Federal Office of Statistics 2017). The number of people not in receipt of long-term care insurance benefits but who nevertheless required support is estimated at 5.4 million more.[1] Such people live almost exclusively in their own homes and rely on the support and care given by family members, friends, acquaintances or neighbors (Geyer & Schulz 2014). It is therefore safe to conclude that the majority of people who provide such care is made up of private individuals doing all they can to maintain the health, welfare and quality of life of people in receipt of their care.

On the one hand, the important role played by family members in providing care is seen politically as something to be encouraged within the German care system (Leitner 2003, 2013; Rothgang 2010). German social legislation states the following about the benefits of the long-term care insurance system: “Care insurance should primarily concentrate on supporting home-based care and, in order to ensure that people in need of care are allowed to continue living in their own home environment for as long as possible, should encourage relatives and neighbours to provide such care. The day care and short-term care services should be given precedence over fully stationary in-patient care.” Since the shortage of staff in the professional care sector is unlikely to be resolved in the foreseeable future (Federal Ministry of Health 2018; Hämel & Schaeffer 2013), care within the family is expected take on increasing importance as a consequence of Germany’s ageing demographics (Federal Ministry of Health 2016).

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[1] This figure relates to 2011. The passage into force in 2017 of a second German law to strengthen the long-term care sector (the *Pflegestärkungsgesetz* or PSG II) extended the collective entitled to benefits from the German care insurance system. As a result, it may be expected that the number of people who do not receive benefits from the care insurance system but who are nevertheless in need of support is going to be under the 5.4 million mark.

On the other hand, however, the percentage of gainfully employed caregivers has considerably increased over time. This development may be connected to the ever more increasing female employment participation. Although women are to this day more likely to be deemed as primary family caregivers then men, the reality is that many women are ever less in a position to take on time-consuming caring responsibilities (Geyer & Schulz 2014). Therefore, the question that the scientific literature has been dealing with is as to whether and to what extent men can feel this gap in family care provision.

Yet, due to data limitations, a thorough and comprehensive description of female and male caregivers is still missing. First, we do not know under which circumstances men and women accept caring responsibilities and in which cases they do not. Do patterns of accepting or rejecting family caregiving differ between both genders? Second, for male and female caregivers we do not have a comprehensive picture on how they organize their caregiving, for whom they care, where the caregiving is located, how time-consuming the care is they provide or whether they receive support from other sources or not.

We employ data taken from the Innovation Sample of the Socio-Economic Panel (SOEP-IS) for our study. This dataset contains an innovative questionnaire module developed by the *authors* containing questions on such topics as the caregiving relationship, the extent of care provided and the location of care activity (care location). Firstly, this data make it possible for the first time to examine the patterns of accepting or rejecting caregiving by men and women who know at least one person in need of support and care. Using this data, we are able to discriminate between those who do not know anyone in need of support or care and are therefore (a) *not at risk* of providing family care versus those who know someone in need of support or care and are therefore *at risk* of providing family care (b) but *refuse* to take on family care or (c) *choose* to devote time to family care. Our aim is to compare Group (b) and Group (c) who we refer to as *potential caregivers* and investigate whether these groups differ in dependency of the gender. Secondly, we examine whether men and women provide care in differing contexts, at differing time intensities or for different groups of care-dependents.

Who cares and who does not? Male and female potential caregivers

Existing studies that deal with the issue of what sort of people actually take on care activities examine the extent to which caregivers differ from non-caregivers in terms of sociodemographic attributes (e.g. Geyer & Schulz 2014; Geyer 2016; Rothgang et al. 2015; Wetzstein et al. 2015; Klaus & Vogel 2019; Engstler & Tesch-Römer 2016). These studies agree that the caregiving group contains a significantly higher proportion of women than the non-caregiving group, even though the proportion of men on the caregiving population has increased over time (Schmidt & Schneekloth 2011). Some studies (e.g. Henz 2006; Kelle 2018) also show that married women tend to take on more caregiving activities than their unmarried peers. Furthermore, people who take on care activities tend to be older on average than people who do not do so. As for gender specific differences, caregiving men tend to be older than caregiving women. Thus, female family caregivers tend to be more often of working-age compared to male family caregivers.

While this research provides important insights into the social structure attributable to the group of caregivers, up until now studies have only been able to compare caregivers against non-caregivers (see, for example, Geyer & Schulz 2014; Geyer 2016; Keck 2016; Rothgang et al. 2015; Wetzstein, Rommel & Lange 2015). In our study, we aim at comparing the patterns of accepting or rejecting family caregiving between the genders. In order to be in a position to draw such comparison we need to focus on the group of *potential caregivers*. We define potential caregivers as group of people who know at least one person in need of assistance or care within their circle of relatives and close acquaintances. These men and women are then defined as *(family) caregivers* when they have actually taken on assistance or caregiving tasks for a person in need of care; they are defined as *non-caregivers* when they have not done so. Using this approach, we make sure that our comparison is made only within the set of people for whom the question of whether or not to engage in assistance or care activities actually arises in the first place. This approach not only enables us to compare these groups in terms of their own sociodemographic characteristics (such as age, marital status or education) but also in terms of the care-specific characteristics (such as care location or level of care dependency).

Comprehensive consideration of the care arrangements made by caregivers

If the focus of a study is to be on male and female caregivers, then among its important tasks will be that of researching and comparing in detail the care arrangements they make. For our purposes, the term *“care arrangement”* refers to the complexity of each individual care situation. To be more specific, the concept will include information on where the person to be cared for is living and being cared for, the relationship between the person doing the caregiving and the person in need of care and the extent of the care provided by the caregiver.

Existing studies tend to define the group of caregivers in different ways and therefore tend to show conflicting results concerning the gendered experience of family caregiving. For example, Maßgnug & Korotkaia 2017 conclude that women are more likely to provide care in their own household than men. However, Bestmann, Wüstholz & Verheyen 2014 find that the proportion of men living in the same household as the person to be cared for is higher. Furthermore, a number of studies show that women tend to accept more time-consuming caring responsibilities and tend to feel more burdened and experience more health impairments than male caregivers (Maßgnug & Korotkaia 2017; Kahn et al. 2016). Other studies find that men and women feel equally burdened by caring activities (Bestmann, Wüstholz & Verheyen 2014).

One of the main reasons for these conflicting results is that due to the lack of data, previous studies do not represent care arrangements for the whole group of caregivers, but concentrated on particular subgroups of caregivers. For example, many existing studies (e.g. Bestmann, Wüstholz & Verheyen 2014; Hiescheler et al. 2017; Runde et al. 2011; Schneekloth et al. 2016) have concentrated on the situation of primary caregivers, who take on the main responsibility for assisting care recipients, and/or on those who care for persons in receipt of long-term care insurance benefits in accordance with Book XI of the German corpus of social legislation (Sozialgesetzbuch Elftes Buch – SGB XI). Studies that look at the care situation independently of whether the caregiver provides primary care or of whether the care recipient receives any care insurance benefits focus on care in the caregiver’s own household (e.g. Meng 2013). Consequently, such studies exclude those who provide care outside their own household and the care given in institutional environments (e.g. Schneider et al. 2001). Also, some studies only describe family care arrangements of family caregivers aged 40 years and older (e.g., Klaus & Vogel, 2019; Klaus & Tesch-Römer, 2017). Although parent care and partner care responsibilities are most prevalent during mid age, family care responsibilities can occur randomly throughout the life course and may therefore go hand in hand with the need to care for a wide variety of people (Moen, Robison & Fields, 1994). Accordingly, it is important to include all age groups in the analysis of family caregivers’ care arrangements.

Furthermore, studies show that female and male family caregivers differ with respect to the question of who is cared for: While women more often provide care for their parents(-in-law), men more often take care of their (marital) partners (Bestmann, Wüstholz & Verheyen 2014). This pattern might partly reflect the fact, that women more often provide family care during working-age – when their parents(-in-law) are in need of care – while men more often provide family care in the post-employment phase when their partners start to become care-dependent (Geyer & Schulz, 2014; Rothgang et al. 2015). However, due to data limitations, it is not clear, whether women and men also differ with respect to care provision to more distant family members or friends and neighbors.

Moreover, again due to data limitations, no complete picture of *where* family care is provided exists. Previous research has shown that women more often provide their care for non-household members, while men more often care for household members (Bestmann, Wüstholz & Verheyen 2014). This confirms the results concerning the gendered experience of who is cared for. Most often parents(-in-law), who are predominantly taken care of by their daughters(-in-law), do not share the household with their children(-in-law). In contrast, men who predominantly provide care for their (marital) partners, cohabitate with their care recipients. However, up to now, it was not clear to what extent family caregivers provide care for someone living in an institutional setting and whether women and men do so differently. Care homes and similar institutions are at certain points in time the only alternative for families to cope with increasing care demands: if family care becomes either physically or mentally too demanding or too time-consuming, a full institutional care setting might be the more appropriate solution for both family caregivers and care-dependents.

There is consent in the literature, that women provide more often family care, they do so more intense and for longer periods of time (e.g. Glauber 2019; Klaus & Vogel 2019; Maßgnug & Korotkaia 2017; Stroka & Lindner 2016). However, due to data limitations a complete description of the family care arrangement is once again missing. Do women and men differ with respect to receiving help from other sources, e.g. from other family members or professional care services, and therefore in relaxing the family care burden? Moreover, do family caregivers only provide care for one person in need of care or do they provide care for several care-dependent persons simultaneously and do women and men differ in taking on additional care responsibilities?

Summing up, previous results are based on different care definitions and often apply only for some groups of caregivers. Thus, such past studies do not provide insights for the full gamut of all caregivers.

Through its use of the data from the new SOEP-IS “Informal care” module, this study contributes a comprehensive treatment of the care arrangements under which caregivers provide their care: The study looks at care activities of the whole group of male and female caregivers (1) involving varying degrees of intensity; (2) with and without the help of long-term care insurance benefits; and (3) either within one's own household or in another private or institutional setting. In sum, this study provides findings that are representative of the entire group of all caregivers and that comprehensively reflect the care arrangements under which caregivers operate.

Data and sample under study

Data

The data that provides the basis for our analyses is the SOEP Innovation Sample (SOEP-IS 2016), which is provided within the German Socio-Economic Panel. The SOEP-IS includes a number of innovative questions and question modules that do not (at least initially) form part of the SOEP Core.[2] At the same time, in a number of important standard question modules from SOEP Core, including sections relating to sociodemography, form part of the SOEP-IS in order to make it possible to undertake comprehensive analyses outside the limits of the innovation module. The most innovative proposals for new question modules for implementation in the SOEP-IS are selected via a competitive review process. The data yielded by any newly implemented SOEP-IS question module are made available for the exclusive use of the researchers who originally proposed it for a period of 12 months. At the end of this period, the data are made available to all SOEP users (Richter & Schupp 2015).

SOEP-IS data have been collected annually since 2011. As with the SOEP Core, the SOEP-IS is a representative sample of private households in Germany. The analyses employed in this study use SOEP-IS data collected in 2016. The sample is made up of 4,800 persons aged 17 and older from over 3,000 private households in Germany (Zweck & Glemser 2018). The data used for the analyses to follow come from the "Informal Care" innovation module, a module proposed for inclusion in the SOEP-IS by Ehrlich & Kelle (2015).

The module "Informal Care" has two decisive advantages over the pre-existing standard question modules on family care in the SOEP Core. The SOEP Core collects information on

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[2] The SOEP Core is the main study contained within the Socio-Economic Panel. The SOEP Core is a representative household panel study covering the adult population of Germany. It has been conducted in West Germany since 1984, with East Germany included since 1990. The data are based on information provided by individuals aged 17 and over. In 2014, approximately 30,000 adults from about 14,000 households took part in the various annual surveys included in the effort (Gerstorf & Schupp 2016).

how many hours a person spends supporting the recipients of their care, whether they do so within or outside their own household environment (a question on the personal questionnaire since 2001). It also collects detailed data on care requirements and care activities within participants' own households (through questions included on the household questionnaire since 1984). What is missing in SOEP Core, however, is information on the non-caregiving group (Group 1.2 in Figure 2): those people who know a person in need of assistance or care but who do not provide any such care for them. Furthermore, in contrast to the data available on family caregiving within one's own household, there is a lack of detailed information on care arrangements outside that household (e.g. on whether the person being cared for lives in another private household or in an institutional environment, whether they receive long-term care insurance benefits and on the social relationship between the interviewee and the person in need of assistance or care). The "Informal care" innovation module closes this gap in the data and enables, among other things, a comparison to be made between caregivers (Figure 2, Group 1.1) and non-caregivers (Figure 2, Group 1.2), as well as facilitating a more detailed description of care arrangements within and outside the households surveyed.

Sample

In the 2016 SOEP-IS, potential caregivers can be identified in a two-step process. In the first step, a representative random sample of 3,861 participants (47 percent of whom are men and 53 percent of whom are women) in the study are asked the following question: "Are there any relatives or close acquaintances who live in your household or outside your household who need care or assistance on a constant basis due to age, illness or disability?" The answer options given are "Yes", "No" or "Don't know." Those who replied "Yes" are then asked to provide information on the person in need of assistance or care: on whether that person receives long-term care insurance benefits[3] and, if so, at what care level that person has been assessed[4]; on the social relationship between the respondent and that person, and also where that person resides. In a second step, these respondents are then asked: "Does this person receive any

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[3] The question is worded as follows: "Erhält diese Person Leistungen aus der Pflegeversicherung?" ("Does this person receive long-term care insurance benefits?"). This wording makes no distinction between benefits from statutory and private long-term care insurance.

[4] The fieldwork phase of the survey took place in 2016. For this reason, respondents were asked about the care levels (*Pflegestufen*) that remained in force until 31 December 2016. It was therefore impossible to make any assertions on the degrees of care (*Pflegegraden*) used to classify the care requirements that have been in force since 1 January 2017.

assistance or care from you?” Those who say “Yes” are asked about the number of hours of care they provide and whether, and from whom, they receive support for their caregiving activities. Finally, all persons who have reported knowing a person in need of help or care are asked whether they also know any other person needing assistance or care. We have information available to us on a total of up to four persons in need of assistance or care per respondent.

Potential caregivers are defined as all individuals who answer “Yes” to the question “Are there any relatives or close acquaintances who live in your household or outside your household who need care or assistance on a constant basis due to age, illness or disability?” Caregivers are defined as all those individuals who have answered “Yes” to the question “Does this person receive assistance or care from you?” Those persons who answered “No” to this question are defined as non-caregivers. The classification into the groups “caregivers” and “non-caregivers” is therefore based on the self-assessment of the interviewee and not on any (outside) assessment made by the researchers or on any definition provided by German social law. This also has the consequence that the assistance or care provided by caregivers may cover a variety of different areas of activity. On the one hand, “assistance or care” may include the provision of support for activities of daily living (ADLs): for example, getting up or going to bed, dressing or undressing, locomotion, personal hygiene, going to the toilet and nutrition (Katz et al. 1963). On the other hand, the same expression, “assistance or care,” can also include the provision of support for instrumental activities of daily living (iADLs): for example, shopping, cooking or cleaning (Lawton & Brody 1969). But guidance, supervision and the provision of emotional and psychological support to persons in need of assistance or care may also be defined as "assistance or care" as well (Hiescheler et al. 2017; Folbre & Wright 2012; Knijn & Kremer 1997). Respondents may be active only in a single field of such activity or in several. The decisive factor is that the interviewees have a space open to them for interpretation as to whether the activities they carry out constitute “assistance or care.”

Empirical analyses and results

Who cares and who does not? Description of the group of potential caregivers

About one quarter of all men and women (24 percent of men and 25 percent of women) aged 17 and over know (and could potentially care for) at least one family member or person close to them in need of assistance or care as a result of severe illness, disability or age-related frailty. However, the simple fact of knowing a person in need of assistance or care does not entail that one will necessarily provide that assistance or care: Only 31 percent of men and 39 percent of women with such knowledge actually end up taking on the relevant assistance or care activities themselves. This means that while one in four men and women know at least one person in need of assistance or care, only 7 percent of men and 10 percent of women actually take on any such assistance or caregiving activities.

Table 1 shows differences between men and women who know and provide care for at least one person in need of assistance or care and those who do not. The first step is to compare family caregivers and non-caregivers in order to describe the two groups of people who decide to provide care or decide not to do so. In the second step we compare male and female caregivers.

By comparing male caregivers and male non-caregivers we observe that caregivers are on average older than non-caregivers and they are more likely to be married. There are no differences as for education level. Male caregivers are less likely to be employed and have lower earnings which may be attributable to the fact that many male caregivers are not at working age anymore.

Similar patterns can be observed for the comparison between female caregivers and female non-caregivers: for example, female caregivers are on average older and more often married than female non-caregivers. However, the differences between the groups of caregivers and non-caregivers are less pronounced for women than for men. The age difference is considerably smaller for women than for men, which also reflects in smaller differences between the percentages of being employed and the average amount of income. In short, the groups of female caregivers and female non-caregivers seem to be more comparable groups than male caregivers and male non-caregivers.

Comparing male and female caregivers, it becomes apparent that male caregivers are on average 61 when providing family care and are considerably older than women who are on average 55 when providing care. 77 percent of male caregivers and only 62 percent of female caregivers are married, which speaks to the finding in the scientific literature that men are more likely to provide care for their spouses than women. Although male caregivers are on average much older than female caregivers, they more often reconcile family care with full-time employment, while women more often work part-time hours over the course of family caregiving. This different involvement in paid work has consequences for the wages both groups of caregivers receive. Male family caregivers can rely on higher average monthly gross wages than female family caregivers. However, when taking into account the average monthly equivalized net household income, it becomes obvious that households can buffer the disadvantageous economic situation of particularly female family caregivers resulting from reduced wages.

Table 1: Demographic and socioeconomic characteristics of potential caregivers (caregivers vs. non-caregivers). Row percentages and means.

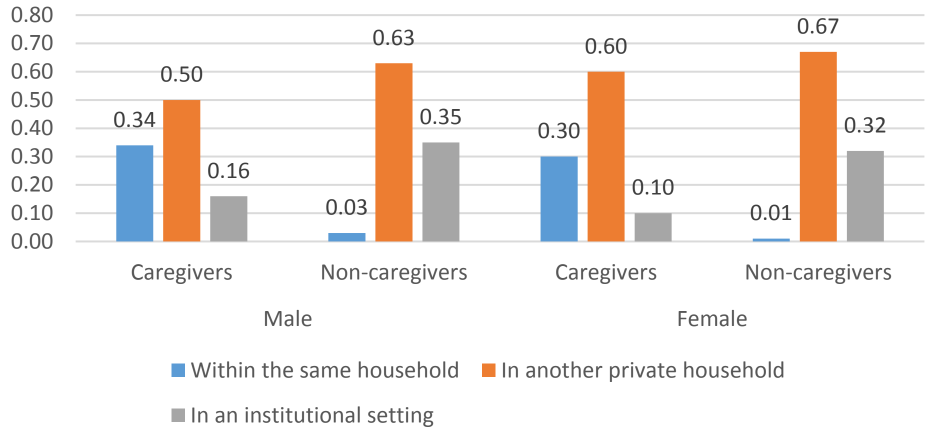
	Potential caregivers			
	Male caregivers	Male non-caregivers	Female caregivers	Female non-caregivers
Age	60.97	50.26	55.28	52.55
Living in East Germany	0.26	0.23	0.27	0.22
Family related characteristics				
Married	0.77	0.54	0.62	0.49
Not married	0.11	0.32	0.15	0.23
Separated/divorced	0.10	0.10	0.15	0.15
Widowed	0.02	0.04	0.09	0.12
Number of children ≤ 14 in household (mean)	0.20	0.31	0.24	0.30
Labor-marked related characteristics				
Education in years (mean)	12.77	12.75	11.99	12.42
Employed	0.47	0.55	0.50	0.48
Full-time employed	0.36	0.49	0.23	0.19
Part-time employed	0.01	0.03	0.22	0.19
Mini-Job	0.10	0.02	0.06	0.09
Not employed	0.53	0.45	0.50	0.52
Monthly net income in Euro (mean)	1420,71	2162,94	931,36	973,04
Monthly equalized household net income in Euro (mean)	1981,47	1886,58	1815,62	1913,23
Observations	*131*	*295*	*196*	*320*

Source: SOEP IS 2016, weighted results, own calculations.

Note: * p<0.05, ** p<0.01, *** p<0.00; t-tests and Chi²-tests were used for the group comparisons. 4 percent of caregivers (Group 1.1) answered the question about the care level with "do not know"; among the group of non-caregivers, 32 percent indicated to have no knowledge about the care level of the person in need of help and care; this information is not shown in the table. Some variables have missing values: Education (1 percent), monthly gross income (7 percent for the group of employed persons) and net equalized household income (5 percent). The percentages or means in the table are set in brackets when they are based on less than 20 persons.

Figure 3 informs about the care location of the person in need of support and care. We are able to differentiate between private care location where 1) respondents and care-dependents live in the same household and 2) respondents and care-dependents live in separate households and 3) where respondents provide help and support for a care-dependent person living in an institutional setting such as care homes. Out of male caregivers, 50 percent provide care in another private household, 34 percent in their own household and 16 percent in an institutional setting. As for female caregivers, 60 percent provide family care outside their own household, 30 percent within their own household and only 10 percent in an institutional setting. Taking a look at the non-caregivers, for men we observe that only 3 percent do not provide any care inside their own household, but 63 percent decline the caregiving role in another private household and 35 percent do not provide care for care-dependents in an institutional setting. The patterns for female non-caregivers are similar. These results show that both men and women with a care-dependent person in their own household are very unlikely to decline the family caregiver role, while there are more options to (not) take on the family caregiver role when the care-dependent person lives in another household (in another private household or in an institutional setting).

Figure 3: Location of the person in need of care, in percent

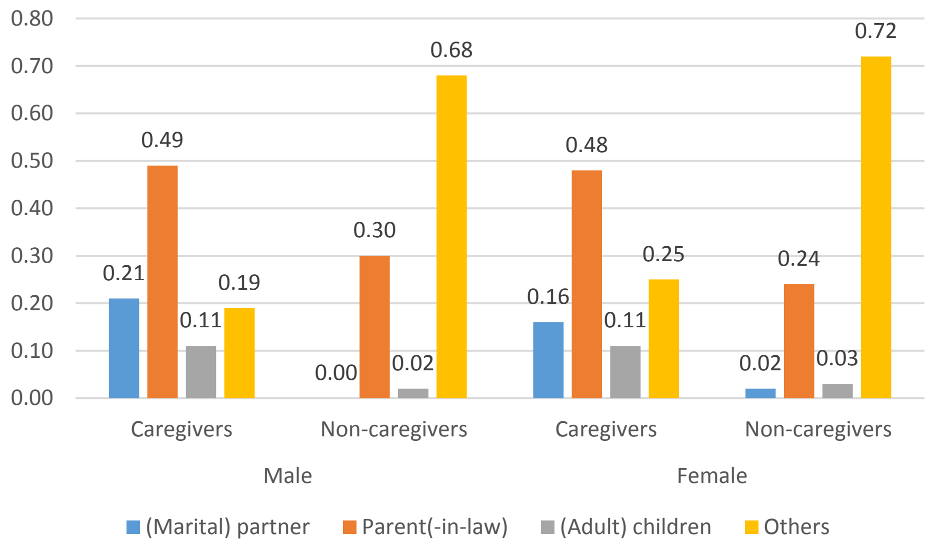


Source: SOEP IS 2016, weighted results, own calculations.

Figure 4 informs about the social relationship between persons in need of assistance and care and potential caregivers. Overall, women and men do not differ considerably to whom they provide/do not provide family care to. The most often reported group of care recipients are parents(-in-law) (male family caregivers: 49 percent; female family caregivers: 48 percent). Male family caregivers report more often to provide family care for a (marital) partner (21 percent) compared to female family caregivers (16 percent). Female caregivers, in contrast, report more often to provide family care for "others" (25 percent) compared to male family caregivers (19 percent). Both genders report equally often to provide family care to their (adult) children (11 percent).

As for non-caregivers, we find that both genders mostly choose not to provide care for "others" (male non-caregivers: 68 percent; female non caregivers: 72 percent). Furthermore, 30 percent of men but only 24 percent of women choose not to provide care for the parent(-in-law). Probably they choose not to provide care for their parents(-in-law) as there are other people who are closer to the care-dependent person or more responsible, and these people are expected to provide care first (e.g. other children or partners of the care-dependent person).

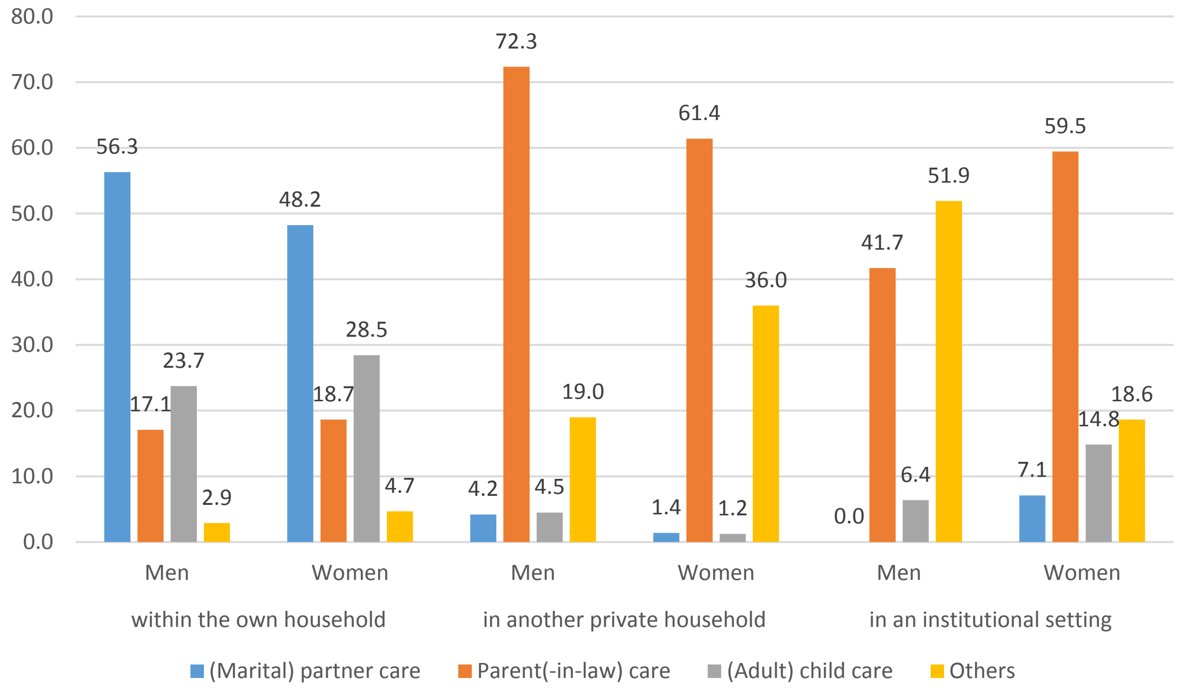
´Figure 4: Family care relationship, in percent



Source: SOEP IS 2016, weighted results, own calculations.

Figure 5 shows the care relationship in dependence of where the person in need of support and care lives. Depending on care location, we find considerable differences as to who is cared for. For both men and women we find that a partner is most often cared for in a shared household with the caregiver; parents(-in-law) are the biggest group of care-recipients living separately from their caregiver in a private household. As for differences between men and women, we find that men more often provide care for partners in their own household and for parents(-in-law) outside their own household. At the same time, women more often than men provide care for an (adult) child inside their household and more often provide care for other persons outside their own household. Within the framework of institutional setting, men most often provide care for others, while women most often provide care for parents(-in-law).

Figure 5: Family care relationship by care location, in percent



Source: SOEP IS 2016, weighted results, own calculations.

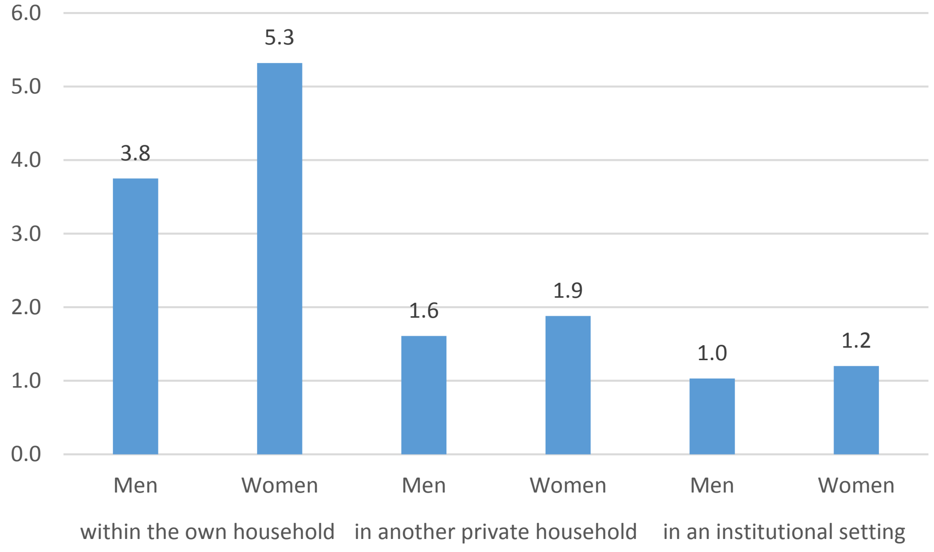
Caregivers’ care arrangements

In order to identify the ‘effort’ family caregivers provide, we inspect 1) how often per week caregivers provide family care and 2) how many hours of care they provide on average per day. To supplement this information, we also consider 3) whether family caregivers receive support by other relatives or unrelated acquaintances or get help from professional or semi-professional caregivers. Last but not least, we want to know 4) whether the family caregivers under study also perform additional caring activities for other people in need of care.

Referring to 1) we find no considerable gender differences (figure is not shown). Most male and female caregivers provide care the whole week from Monday through Sunday (male family caregivers: 77 percent; female family caregivers: 75 percent). Ten percent of the male and 12 percent of the female family caregivers provide care only on weekends, while 13 pecent of the male and female family caregivers take care of persons in need of care only between Mondays and Fridays.

Figure 6 reveals that the gender as well as the family care location has implications for family caregivers’ daily average care hours.

Figure 6: Average number of care hours by care location, in percent

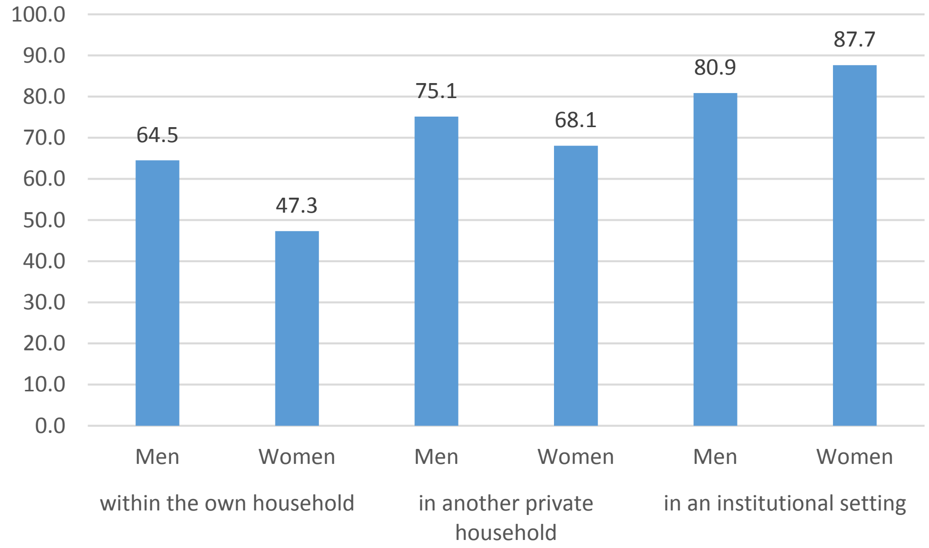


Source: SOEP IS 2016, weighted results, own calculations.

In every family care location, women devote far more time to family care, on average, than men. The biggest gender difference in average care hours can be found for in-household care: female family caregivers caring for a household member devote on average 5.3 hours a day to family care, while male family caregivers devote on average 3.8 hours of their time to family care. If the cared for person lives in another private household, women provide 1.9 hours to care, while men did so for 1.6 hours a day. For both genders, the care effort is smallest if the cared-for person lives within an institutional setting: women take care for 1.2 hours a day and men do so for 1.0 hour a day.

Another indicator of family caregivers' involvement in family care is the information on whether family caregivers receive help and support from other sources. According to Figure 7 women receive far more less support from others if they provide care within the same household compared to male family caregivers (female family caregivers: 47 percent; male family caregivers: 65 percent).

Figure 7: Support by others



Source: SOEP IS 2016, weighted results, own calculations.

When women and men provide family care in another private household they tend to receive more support from other sources compared to co-residing family caregivers. However, again, women rely on less additional support than men (female family caregivers: 68 percent; male family caregivers: 75 percent). Family caregivers caring for someone living in an institutional setting are most likely to receive additional help. In this care women report higher support rates than men (female family caregivers: 88 percent; male family caregivers: 81 percent).

The final indicator we consider for family caregivers' involvement in family care is the information on whether family caregivers provide family care for one single person or for several persons. According to our analyses it is rather unlikely that female and male family caregivers provide help and support to more than one single person. Five percent of the female family caregivers under study provide help and support to at least one more person. For male caregivers the rate is somewhat lower: only 3 percent of the male family caregivers under study provide help and support to one more person in need of care.

Summary and Discussion

In our paper, we focus on potential caregivers, i.e. individuals who know at least one person in need of care. We find that men are still less likely to opt for care than women: 31 percent of men and more than 39 percent of women take on caring responsibilities when care needs arise.

Comparing male and female caregivers and non-caregivers, we find that the groups of female caregivers and female non-caregivers seem to be more comparable groups than male caregivers and male non-caregivers, for example in terms of their age, .education, employment status and individual income. Focusing solely on the group of caregivers, our analyses show that although male caregivers are on average much older than female caregivers, they more often reconcile family care with full-time employment, while women more often work part-time hours over the course of family caregiving. This different involvement in paid work has consequences for the individual wages of both groups of caregivers. Furthermore, both men and women with a care-dependent person in their own household are very unlikely to decline the family caregiver role. While men are most likely to provide care for partners in their own household and for parents(-in-law) outside their own household, women more often than men provide care for an (adult) child inside their household and more often provide care for other persons outside their own household. Within the framework of institutional setting, men most often provide care for others, while women most often provide care for parents(-in-law).

In every family care location, women devote far more time to family care, on average, than men. The biggest gender difference in average care hours can be found for in-household care: female family caregivers caring for a household member devote on average 5.3 hours a day to family care, while male family caregivers devote on average 3.8 hours of their time to family care. Also, women receive less support from others when providing care.

Our study contributes to the literature by providing findings that are representative of the entire group of all caregivers and comprehensively reflecting the care arrangements under which caregivers operate. Furthermore, our study highlights the fact that the family care experience is gendered and points out the importance of analyzing family care arrangements separately for men and women.

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