Cultural Change and Long-Term Care in China:

A Case Study of the Transition of the Role of Family for Care Provision in Guangzhou

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Abstract

The family is the primary care provider for older people in many countries, as it is in China, with its conventional family-centred care provision pattern and deeply rooted family values. Despite the newly implemented public long-term care insurance pilot funding the care provision, China's care system has been severely challenged by its substantial ageing population and worsening demographic structure.

In some pilot sites, family-provided care has been integrated into the insurance-funded care system. With multiple social transitions, such as changing cultural values, it remains unexplored whether the family's role in providing care has changed and how it has adapted to the development of the long-term care system. This study, which focuses on family, long-term care and cultural values, is therefore designed to address these research gaps.

This mixed-methods study examines the role of the family in providing long-term care in China, considering the impacts of cultural values. Based on secondary data analysis, the findings show that people have higher care expectations of the state in recent years, despite the majority agreeing with the family's principal caregiving role. According to the findings from a case study of one pilot site, Guangzhou, there is a more explicit division in terms of money and labour dimensions for the family in providing care from the defamilialisation perspective. Cultural values are significant not only for individual care decisions but also for the provision of long-term care within the care arrangement. In the light of care alternatives associated with a labour shortage and cultural values, the family continues to play an essential role for many for whom insurance-funded family care is available.

Given that China is 'getting old before getting rich', this thesis can contribute to better fulfilling the family's function in satisfying the care demands of its older members in future care provision in contemporary China.

Declaration

I, Jiayu Zhang, declare that this thesis is a presentation of original work, and I am the sole author. This work has not previously been presented for a degree or other qualification at this University or elsewhere. All sources are acknowledged as references.

Signature: Jiayu Zhang

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1 Introduction

This study investigates the changing role of the family in providing long-term care for older people and the impacts of changing cultural values on care arrangements following the implementation of the pilot long-term care insurance scheme in China.

This chapter introduces the research background by discussing the interaction between mixed care responsibility in long-term care provision patterns and cultural values, particularly those values in relation to the family, as this study is designed to explain the family's role in long-term care provision. The second section spotlights China, reviewing the family's role in care provision and cultural values regarding the role of the family change in policy and social practices. The following section summarises the ongoing long-term care insurance pilot scheme in China, laying the foundation for analysing the family's role in providing long-term care. The fourth section sets out the research questions of this study based on a brief summary of the preceding sections. The final section outlines the structure of the thesis.

1.1 Mixed care responsibility in long-term care provision and cultural values

In an ageing society, long-term care has been extensively developed to address rapidly booming care demands (Norton, 2000, Colombo et al., 2011, Spasova,Baeten and Vanhercke, 2018). Specifically, care provided by informal caregivers such as family members, friends and other volunteers remains the pillar of long-term care supply (Zigante, 2018, WHO, 2022) and the family is the principal direct care provider in many countries despite cross-national variations in the care system (Spasova,Baeten and Vanhercke, 2018, Le Bihan,Da Roit and Sopadzhiyan, 2019). Since formal and informal care patterns reflect the welfare mix of care responsibility between the state, the market, the family and the third sector (Theobald, 2012), the crowd-in and crowd-out effects between formal and informal care indicate the mixed responsibility of the state and the family (Motel-Klingebiel,Tesch-Roemer and Von Kondratowitz, 2005, Oudijk,Woittiez and de Boer, 2011). Specifically for long-term care, it remains debatable whether its development has a crowding-in or crowding-out effect on informal care (Miyawaki et al., 2020, Courbage,Montoliu-Montes and Wagner, 2020, Cao and Xue, 2023).

As a funding mechanism for long-term care provision, long-term care insurance has been employed in many countries (Colombo et al., 2011), possibly resulting in the reassignment of the care duties

of the family to society (Shin, 2013). As one of the most discussed long-term care insurance models, Germany's has been the focus of policy learning and transfer for several East Asian societies such as Japan and South Korea, and China is no exception (Campbell,Ikegami and Kwon, 2009, Campbell,Ikegami and Gibson, 2010, Nadash and Shih, 2013, Luo and Zhan, 2018). With the largest ageing population in the world, China introduced its long-term care insurance pilot programme in 2016, and 49 pilot cities have implemented their localised schemes so far. However, within the insurance-funded care system, diversified care provision mechanisms have been developed in China; for instance, informal care provided by caregivers beyond care homes is available in some cities but excluded in many. In some other pilot cities, only formal care is included in the insurance-funded care system. The implementation of public long-term care insurance has thus restructured the care provision from the public and private care providers, as well as the informal one. The ongoing long-term care provision patterns also reveal the mixed care responsibility mainly between the government, the market, and the family in the Chinese context. However, considering both the funding and provision mechanisms for long-term care, the market primarily delivers the care services paid by the public sector and individuals (families). Thus, in the Chinese context, the care responsibility for both funding and provision specifically falls between the state and the family.

Cultural values, it is argued, shape care provision in care policies and social practices, as well as the division of care responsibility (Pfau-Effinger, 2004a, Pfau-Effinger, 2005a). In the German case, strong family values[1] and traditions significantly impact the policy design for covering informal care and whether individuals are willing to accept these options (Pfau-Effinger, 2008). Particularly for care provided by the family, norms of perceived obligations towards family members and familism are important in informal care provision for care recipients and caregivers (Dykstra and Fokkema, 2012, Falzarano et al., 2022). Given that the incorporation of Asian cultural values (Korean, Japanese and Chinese) within socialisation has encouraged the growing filial responsibility of citizens during their lifetime (Zarzycki et al., 2023), these cultural values contribute to care behaviours and might be taken into account in social policy. Particularly, informal caregiving for older people is often seen as an inseparable component of old-age support in Confucian culture addressing family responsibilities across East Asia (Pascall and Sung, 2014) and filial piety is important and convincing in urging the family to support its older members (Canda, 2013, Yeh et al., 2013). Narrowing the

[1] 'Family values' in this instance refers to the "cultural values and notions regarding the structure of the family and the gender division of labour" (Pfau-Effinger, 2005a, p.24), which are different from 'cultural values' referring to "values relating to the institution(s) that should be responsible should care be provided outside the family, whether social rights relating to care should be family-based or individual, and the re-distributive role of the welfare state" (Pfau-Effinger, 2005a, p.25). Further discussions on the 'cultural values' and 'family values' in the context of this thesis are included in Chapter 3.

discussion to contemporary China, relevant cultural values in the country have changed over time (Zhang, 2017a, Yan, 2018, Fu,Xu and Chui, 2020) , and filial piety impacts old-age support in a more sophisticated manner than the past (Liu, 2023).

Whether cultural values also affect the informal or formal long-term care provision has rarely been discussed, and the late start-up of developing long-term care in China is one of the crucial explanations for this. Thus, regarding the various formal/informal care options in different pilot cities in China, whether the conventional family-dominated care provision patterns have been challenged and whether cultural values impact these changes, as with the development of informal long-term care, remain contested.

The long-term care provision patterns have reflected the mixed care responsibility of different actors, and cultural values are important for informal care provision in care policy, but how these issues are applicable in contemporary China has yet to be explored. The following section focuses on informal long-term care provision in China, where the family's role has been specifically emphasised.

1.2 Family's role emphasised in the care provision for older people in China

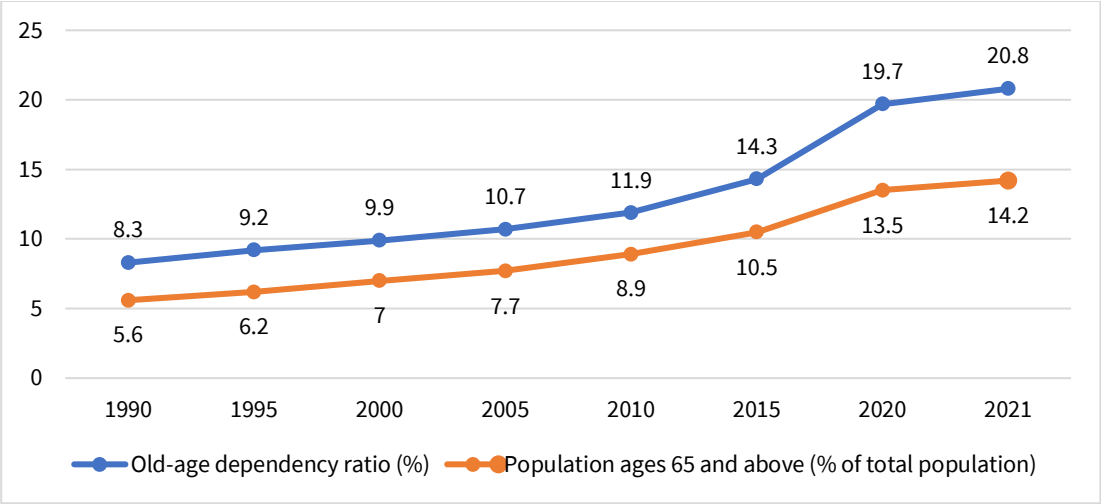
The family has long been the main care provider for older people in many countries (Le Bihan,Da Roit and Sopadzhiyan, 2019), and China is no exception (Feng et al., 2020). This is consistent with China's deeply rooted cultural values emphasising the family's role (Deutsch, 2006). Given that the current care system led by the government has been greatly challenged in China (Bai and Lei, 2019, Yang et al., 2021b), in response to transitions in demographic, socio-economic, and cultural aspects, the family's role in supporting older people has been further emphasised in age-related policies in recent years.

With these dramatic demographic shifts, China has an enormous number of older people – over 0.21 billion aged 65 and over by the end of 2022 (14.9% of the total population), shifting to an aged society from an ageing society (National Health Commission of the People's Republic of China, 2022a). It is also predicted that the peak for the ageing population and proportion will arrive in 2050 (ibid). The number of older adults with a high prevalence of chronic diseases and disabilities reached more than 42 million in 2020 in China (National Working Commission on Ageing, 2022, cited in Xinhua Daily), resulting in a soaring need specifically for long-term care. With all these transitions, 'getting old before getting rich' has been observed in China, calling for more policy responses to the old-age population (Lauren et al., 2016, Johnston, 2021).

Despite the increasing policy attention targeting the growing care demands, in terms of mixed care responsibility, support for older people from various care providers has changed to various extents, primarily those from the informal and public sectors.

On the one hand, the available support provided by the family has gradually decreased. The one-child policy implemented from the 1980s to the 2010s profoundly shaped demographic patterns such as population growth and the old-age dependency ratio in China for generations (Hesketh,Lu and Xing, 2005, Settles et al., 2013). Despite that policy's abolition in the 2010s, the fertility rate has continued to decline in China (1.3% in 2020) and the country saw an absolute decline in its population in 2022 (0.85 million),the first occurrence 'negative growth' (i.e., a dropping population) since the 1960s (National Development and Reform Commission, 2023) .The care provided has been under unprecedented pressure in China, as evidenced by the more severe old-age dependency ratio climbing to 20.8% by 2021 (Figure 1.1) (National Health Commission of the People's Republic of China, 2022b) and the shrinking family size from an average of 3.4 people in 2000 to 2.6 in 2020 (National Bureau of Statistics, 2022). In addition, with the relaxation of the household registration system (hukou) and the development of urbanisation, there has been a vast amount of internal migration in the past decades, particularly from the rural areas flooding to urban areas and from the inland to the coastal areas (He et al., 2016), as well as the separation of living arrangements between adult children and the older generation and the fluid and dynamic family structure in China (Xu and Xia, 2014, Zeng and Wang, 2018). Females who primarily act as the direct caregivers within the family, particularly in the Chinese context, have become further involved in the labour market (Ji et al., 2017). With the changing social attitudes towards the family's function in supporting its members, such as individualism and neo-familism, particularly among the younger generations (Yan, 2016, Yan, 2018), cultural values which used to connect the family ties for fulfilling the family obligation are often assumed to have weakened. All these changes in contemporary Chinese society have resulted in decreasing family support for its own members.

Figure 1.1 Old-age dependency ratio and the ageing population proportion in China (%)



On the other hand, a trend of retreat by the state from supporting older people in China has occurred. There is an increasing amount of policy regulation relating to old age, and the publicly funded care system typically serves as a safety net for those qualified for the means-test[1] (The State Council, 2016, The State Council, 2021). Although the government continues to dominate in leading the response to ageing issues in China, there is an expanding emphasis on other social actors besides the state to support older people in China (Cook and Dong, 2017). The increasing engagement of different actors to meet the care demand has been important, as many ageing policies in recent years have demonstrated (Jing, 2020). There is also a balance of responsibility for elderly care between the government, society, the market, the family and individuals in China (Guo, 2019).

Policies targeting older people have been introduced in China since the 1990s (*Law on Protection of the Rights and Interests of the Elderly*). Since the 2000s, 'community participation', 'market participation' and 'elderly services' have been the key topics for the ageing policies in China (Nan et al., 2020), and the elderly care system has been one of the priorities since 2010 (Jing, 2020). A more specific division of responsibility for funding and provision is proceeding: the government has gradually transformed its role from an omnipotent one covering regulating, funding and care provision to that of a regulator and supervisor for care delivery primarily financed by public insurance; the private sector has been facilitated in further investing in and providing care (Li,Wang and Wong, 2018), particularly for home- and community-based care, with keywords such as 'private

[1] In China, those who can get access to the publicly funded support are typically identified as 'the Especially Poor', which includes those used to be classified as 'Three Nos' (no income, no capacity to work, and no family support). Those above 60 or under 16 are identified as 'having no capacity to work' (The State Council, 2021).

capital', 'social forces' and 'care industry' consistently including in ageing policies (Luo and Zhan, 2018).

In recent years, the private sector has become more involved in care support for older people in China, particularly in urban areas (Feng et al., 2011, Maags, 2022). It is mainly in terms of the provision mechanisms, given that the public financing for elderly care has not been retrenched instead of offering subsidies and tax breaks, whereas many public elderly care services have been outsourced to non-profit care providers (Maags, 2022). For for-profit organisations, the main goal is to seek profits as well as deliver high-quality services, while providing cost-effective services with minimal expectations of profits drives the active engagement of non-profit organisations (Li,Wang and Wong, 2018). Most organisations are registered as non-profit for the subsidies and tax breaks from the government, whereas they work as for-profit services in reality (Feng et al., 2018).

There has been a rapid development of elderly care in China since the 2000s (Shum et al., 2015), as well as a great leap in nursing care facilities during the 12th Five-Year-Plan period (2011-2015) (Luo and Zhan, 2018). Specifically for long-term care facilities in the private sector, more related policies have been issued by the government since 2011 (Chen et al., 2018). Despite the emphasis on the role of the private sector in policy discourses, limited assistance has been provided from the government, such as resources like land, buildings, and equipment (Li,Wang and Wong, 2018), and relevant guidelines and regulations remain inadequate (Feng et al., 2012, Feng et al., 2020).

Alongside the shifting roles of the state in care support for older people, the private sector is of great significance in providing care in China. This is thereby shaping the mixed care responsibility among actors in the Chinese context and should also be considered in the analysis of the role of the family in this study.

Accordingly, the family's function in supporting the older generation has been valued in social policy, particularly since the 2000s. For instance, in the *11th Five-Year Plan of the Development of National Undertakings for the Aged and Elderly Care Services* issued in 2006, there are phrases such as '*developing the Chinese style of the elderly care system by insisting on the interaction of the state, society, family, and individual'*, in which the family's role in care support remained ambiguous in the policy regulations. In the policy announced in 2011, the narrative had changed to *'the interaction of support from the family and from society*'. Family-based care has been ranked first in developing the elderly care system since 2017, accompanied by narratives such as '*gradually establishing the supportive policy system for family care*', highlighting for the first time the duty of care as more than financial support and regular visits to older people in an official national document. The *14th Five-*

Year Plan launched in 2021 further highlighted '*supporting the family in undertaking its function of caring for older adults*'. These changing narratives in care policies show that the family has been gradually placed at the forefront of care policies in China. Thereby, it is the family and older people themselves taking care responsibilities instead of the governments (Krings et al., 2022), indicating the reducing role of the state to a certain extent. This is perhaps driven by the increasing workforce shortage in formal care provision (Zhang et al., 2018) and strong preference for home and community-based care (Feng et al., 2018). Specifically, those older people who cannot access public or private care services have to rely on their family members (Maags, 2022).

Given the significant impact of cultural values on care provision patterns and the growing policy emphasis on the family's caring function, the traditional family virtues of caring for older people have been cited as key, particularly since the 2010s (Krings et al., 2022). As stated in the *14th Five-Year Plan*, '*Consolidating and enhancing the family's function in supporting the older people ... conducting the national education on population ageing ... inheriting and promoting the traditional Chinese virtues for placing filial piety as the first of all virtues'*. Cultural values about supporting the ageing population have been strongly underlined by the state, but whether contemporary cultural values in Chinese society about the family's obligation to support older people reflect these traditional views remains unclear.

Because the development of long-term care in recent years might lead to a changing mix of care responsibilities, I shall next discuss how long-term care has been explored in China and how care responsibility has been reassigned between various actors, principally between the state and the family, as reflected by informal care provision patterns.

1.3 Implementation of long-term care insurance in China

Long-term care has received significant policy attention in China in recent years, particularly following the implementation of a long-term care insurance pilot programme in 2016 (Fang et al., 2020, Feng et al., 2020). A wide range of policies related to long-term care in China, including the elderly care system, healthcare system and welfare system, has also developed. With the long-term care landscape in China, a formal long-term care system, including institutional care, community care and home-based care, has been progressively developed to complement the family-based care system (Zhu and Osterle, 2019).

The development of long-term care in China has been driven by the implementation of public long-term care insurance schemes, which is the primary funding mechanism for care provision. Public

insurance in China began with local exploration in cities like Qingdao in 2012. With the substantial care demands of older people considering the vast internal heterogeneity in China, the Ministry of Human Resources and Social Security of China produced *Guidance for the Implementation of Conducting Long-Term Care Insurance Pilot* in 2016. Fifteen cities and two provinces were appointed as the pilot areas for setting up long-term care insurance schemes. Since then, these pilot cities have established localised insurance schemes. The national guidance was renewed in 2020, covering fourteen more cities for exploring their schemes. So far, diversified long-term care insurance schemes have been launched in 49 cities in China.

Under the national guidelines, the implementation of long-term care insurance is a bottom-up exploration, leading to a fragmented care system at the city level. There are multiple financing channels for the long-term care insurance schemes among the current pilot cities, including the insurance fund transaction from the public medical insurance surplus, contributions from individuals and employers, and fiscal support from the local government (Table 1.1).

Table 1.1 Funding sources of the long-term care insurance (by 2022)

Pilot cities	Funding sources					
	Surplus of public medical insurances[1]	Self-contribution	Employer's contribution	Local fiscal support	Lottery funds	Public donations
Changchun, Ningbo	X					
Anqing, Qiqihar, Chongqing, Xiangtan	X	x				
Qingdao, Shanghai, Suzhou, Hanzhong	X			X		
Jingmen, Chengdu, Shijingshan District	X	X		X		
Shangrao, Tianjin	X	X	X			
Guangzhou, Chengdu, Panjin	X	X	X	X		
Nantong, Shihezi	X	X		X	X	
Nanning	X	X		X	X	X
Tianjin	X	X	X		X	X
Jincheng	X	X	X	X	X	
Hohhot, Qiannanzhou	X	X	X	X		X
Fuzhou	X	X				X
Kaifeng	X	X		X		X
Kunming	X	X	X	x	x	X
Ürümqi	X	x		X		X
Source: based on the author's own summary of the policy documents issued by the local governments						

With the funding from public insurance schemes, the development of long-term care provision has been greatly accelerated ever since the implementation of long-term insurance schemes. Among the pilot cities of public long-term care insurance schemes in China, there are different care provision patterns, mainly varying from eligibility to benefits, benefits of care, and types of care services.

Regarding eligibility to benefits, disparities across the long-term care provision are typically several aspects, such as the funding sources, the assessment of long-term care needs, and the age of the care beneficiary.

[1] There are two primary public medical iinsurance schemes in China, including the Urban Employee Basic Medical Insurance and the Urban and Rural Resident Basic Medical Insurance. The total coverage rate of these two schemes is 98.44% by 2022 (National Bureau of Statistics, 2023). The former covers those working in government organisations and enterprises in urban areas (the premium is jointly contributed by employers and employees); the latter covers residents in both urban and rural areas (self-contribution for the premium). The insurance schemes are designed and implemented by the local government following the guidelines issued by the upper governments.

As shown in Table 1.1, the surplus and transfer from public medical insurance are the pillars of long-term care provision in all pilot cities. As with the complex public medical insurance system in China[1], primarily categorised as the Urban Employee Basic Medical Insurance (UEBMI) and the Urban and Rural Resident Basic Medical Insurance (URRBMI), one key criteria for eligibility to the newly launched long-term care insurance is participation in which kind of public medical insurance scheme. For instance, in many pilot cities, only the participants of the UEBMI can access long-term care funded by public insurance. However, with the proceeding long-term care insurance schemes, more pilot cities have expanded their coverage from the participants of the UEBMI to the participants of all the public medical insurances. Therefore, the funding channels in relation to the public medical insurance schemes are significant for the eligibility to benefits.

Another vital criterion for eligibility is the need for long-term care. Regardless of differences among pilot cities, the care need is mainly assessed by the Activity of Daily Living (ADL) and the Instrumental Activity of Daily Living (IADL)[2]. There are different levels of functional and cognitive disability for access to long-term care funded by public insurance. For example, there are 5 levels of severity of disability in Qingdao, 6 levels in Shanghai, and 3 levels in Guangzhou.

In a minor group of pilot cities, the age of the care beneficiary is considered. For instance, for the participants of URRBMI in Shanghai, only those above 60 are the targeted disabled population that could apply for the insurance-funded long-term care services.

There are various types of benefits provided, including benefits-in-kind, cash benefits, or a mix of them (Table 1.2). Benefits-in-kind are available for all pilot cities, whereas cash benefits are applicable for some of them. For the cash benefit, those ongoing schemes could be further categorised as two types: either the insurance reimbursement is paid to the care recipients (e.g., Nanton, Anqing) or paid to the caregivers (e.g., Chengdu, Guangzhou). According to current care patterns in pilot cities, there could be different reimbursement caps between benefits-in-kind and cash benefits for the same care recipients.

[1] Despite the variations across the schemes in different cities, such as the eligibility to benefits and reimbursement rates, the UEBMI generally has higher insurance reimbursement rates than those of the URRBMI, as well as with a larger amount of surplus. Thus, in all the pilot cities in China since 2016, the participants of the former medical insurance have been covered by the public long-term care insurance schemes, whereas the participants of the latter were included in some of them but have been gradually incorporated with the implementation of the public long-term care insurance.

[2] Although a pilot nationwide assessment guideline for long-term care insurance has been issued in December 2023 (National Healthcare Security Administration, 2023), there is limited detailed and practical assessment criteria for disability included. Therefore, the discussion in this thesis is based on the localised scheme for long-term care provision.

Table 1.2 Benefit types of the long-term care in pilot cities (by 2022)

	Benefit-in-kind	Mix of benefit-in-kind and in cash
1st wave (2016)	Chengde, Changchun, Qiqihar, Shanghai, Suzhou, Ningbo, Qingdao, Chongqing	Nantong, Anqing, Shangrao, Shihezi, Jingmen, Chengdu, Guangzhou
2nd wave (2020)	Panjin, Fuzhou, Xiangtan, Nanning, Urumqi	Hanzhong, Qianxinan Buyi and Miao Autonomous Prefecture, Jincheng, Shijingshan District, Tianjin, Kunming, Hohhot, Kaifeng
Source: based on the author's own summary of the policy documents issued by the local governments		

Note: In those underlined, family members providing home-based care are paid by the insurance fund.

Care services funded by public insurance generally include institutional care and home-based care, whereas equipment for assisting people with disabilities (e.g., wheelchairs) is also available in some cities (e.g., Guangzhou). Care could also be categorised as formal care and informal care, in which the former is mainly delivered by care homes (both public and private ones) and the latter is from informal workers (typically family caregivers and paid caregivers from the market). There is thus varying allocation of care responsibility as the direct care provider, primarily divided between multiple actors, that is, the state, the market, and individuals /the family.

With the policy objectives of the central government addressed since the 2010s (Office of the State Council, 2011), referring to '*home-based care as the foundation, community-based services as the backing, and institutional care as the support*' , home-based care has been weighted in many pilot cities. This includes both formal care and informal care. For the former, it is mainly provided by care homes from either the public or private sectors in China [1]. Whereas the private sector actors are paid by either the public sector or the individual/family to deliver care services. The state and the family are thereby the primary actors in funding and providing long-term care in China in such a pilot phase. Thus, in this study investigating the role of the family, the state-family is the principal focus, and the involvement of the market in long-term care provision is included in the analysis based on the state-family nexus.

Meanwhile, an increasing number of cities have explored insurance-funded, informal long-term care. Particularly, family members and friends, who used to be the unpaid caregivers, are the primary care providers in the current long-term care system for some pilot cities. Private caregivers recruited from

[1] Due to the data availability, in which only the total number of beds from all care homes is issued, no further details of the public and private care homes could be provided, particularly for the care delivered in the home settings of care recipients.

the care market are also a popular choice for many disabled older people. Similar to elderly care, workforce issues are challenging for long-term care. Despite the rapid growth of care workers from more than 30,000 to 330,000 by 2022 (CCTV.COM, 2023), given the mass number of people aged 65 and above (0.21 billion), there remains a huge gap between the number of caregivers and care recipients for long-term care.

Overall, with these diversified care provision patterns, a clearer and more specific care responsibility division of funding and provision between different actors, explicitly the state and the family in the long-term care systems, has emerged in China. However, with the early development of public insurance-funded long-term care in pilot cities in China, statistics for the overall picture of formal care remain unveiled. The underpinning explanations for these changes are under further discussion.

1.4 Research questions of this study

In contemporary ageing societies, long-term care has been developed worldwide, with the emerging diversified provision patterns reflecting mixed care responsibilities. Informal care provision, with the family as the central pillar, has been prioritised in many countries where cultural values emphasising the family's role in supporting its members might have an impact.

With its widely acknowledged cultural values and long-lasting, family-centred care pattern, China has faced unprecedented challenges in its care system targeting older people due to its dramatically booming ageing population. Despite the family's caring function having somewhat changed with multiple societal transitions in China, family care has been more frequently emphasised in policy discourses in recent years, as has the growing emphasis on cultural values. The implementation of long-term care insurance is one of the critical strategies in China as it is the primary funding mechanism for long-term care for disabled older adults. Informal care is covered in the insurance-funded long-term care system in some pilot cities in China, possibly affecting the family's role in providing care accordingly. However, whether and how the family alters its role in supporting older people has been largely unexplained.

Despite the long-debated significance of cultural values on care provision patterns, the cultural factors in the care policies in China have been mostly overlooked, even with the strong cultural values centred on family responsibilities and obligations in supporting its members. Whether and how these values are considered in designing care policies and how they affect care provision

patterns in China remains an unsolved puzzle, particularly with the development of long-term care in recent years.

Although many previous studies have shown the different divisions of care responsibility embedded in long-term care provision patterns and the important impact of cultural values, whether these findings are applicable in the Chinese context has yet to be explored. This study was therefore designed to extend the discussion in contemporary China based on the case study of Guangzhou, focusing on whether the conventional crucial family role in providing care has changed, and whether and how any changes in cultural value contribute to long-term care provision.

The research questions of this study are therefore:

RQ1: How have social attitudes towards the role of the family in providing care changed over time?

1.1 What are the social attitudes towards the family's role?

1.2 What are the intergenerational differences in care attitudes for the family providing care support?

RQ2: How has the role of the family in providing long-term care changed following the implementation of long-term care insurance schemes?

RQ3: Are there any intergenerational differences in the care attitudes and care decisions for the family providing long-term care support? Are there any impacts from cultural factors?

RQ4: Has the care arrangement been impacted by culture?

This study contributes to revealing the overall picture of cultural values concerning mixed care responsibility in China, the detailed mechanisms of how the family's role in providing care to its older members has changed and the underlying explanations for the development of long-term care, and how cultural values play their role in the family's changing caring role. The findings of this study can help optimise China's care policy, spotlighting family function fulfilment, to better satisfy the growing care demands of an ageing population, drawing conclusions from the care arrangements of multiple actors, mainly the individual, the family, and the state in China.

1.5 Structure of the thesis

This thesis is organised into five sections: this introduction, a literature review and methodology, findings, discussion, and conclusion.

The introduction section comprises Chapter 1, outlining the research background and the significance of this study, particularly that of the discussion in contemporary China.

The literature review section forms Chapters 2 and 3. Chapter 2 focuses on the family's role in care provision and explicitly looks at previous literature in the Chinese context. Chapter 3 reviews how cultural values play a role in social policy, particularly care policies in China.

The methodology section introduces the mixed methods approach adopted in the study. It outlines the rationale for the quantitative data analysis based on national databases (CGSS and CFPS) and the qualitative data analysis comprising a case study of Guangzhou City. It also includes a discussion of relevant ethical issues and some key limitations.

The findings are presented in Chapters 5 to 8.

Chapter 5 targets RQ1 about changing social attitudes in China, showing the changing social attitudes towards care responsibility between the state and the family in China, using descriptive data analysis of China General Social Survey (CGSS) from 2010 to 2017 and China Family Panel Studies (CFPS) of 2018, followed by an analysis of significant impact factors of these trends using the binary logistic regression models with data from CGSS.

Chapters 6 to 8 show how and why the family has provided long-term care since the implementation of long-term care insurance in the case study of Guangzhou. Chapter 6 summarises the sharing of care recipients, outlining their care attitudes, the reasons for choosing insurance-funded informal care, and insights into the family's role in long-term care provision before and after the implementation of the long-term care insurance scheme. Chapter 7 shifts the focus towards informal caregivers, showing their thoughts about the key elements covered in Chapter 6. Chapter 8 then presents the thoughts of other actors in long-term care provision, including care homes, insurance enterprises and local government, concluding in a discussion of the long-term care provided by the family within the care arrangement and the underlying considerations for developing informal care provision.

A discussion of the findings is set out in Chapters 9 and 10, which develop the analytical frameworks in the Chinese context for the research questions in this study. The former analyses the family's role in providing long-term care with public insurance from a defamilialisation perspective. It shows the changing family roles for RQ2 and the intergenerational differences for RQ3. The latter explores whether the framework established by Pfau-Effinger (2004a, 2005a) for cultural values and care policies in Western Europe is explicatory in Chinese society. This chapter develops another

framework for interpreting the ongoing stories in China, showing how cultural values affect the care arrangement for RQ4.

The final chapter is the conclusion, bringing back the main ideas from the preceding sections. It summarises the empirical and theoretical contributions of this study. This chapter ends with a discussion of the limitations of the study and some recommendations for future research directions for this crucial issue.

Part One: Literature Review and Methodology

2 Literature Review Part I: Family's Role in Care Provision

In East Asia, the family is the primary welfare provider for its members (Holliday, 2000, Gough et al., 2004, Aspalter, 2006, Abrahamson, 2016). It is also for care provision (Yamashita,Soma and Chan, 2013, Saraceno, 2016), given that care support is one of the fundamental functions of the family (Leitner, 2003, Saxonberg, 2013, Lohmann and Zagel, 2015, Yu,Chau and Lee, 2015). It is also the case in China (Duckett and Carrillo, 2011, Xu and Xia, 2014, Abrahamson, 2016). Nevertheless, with the recent development of long-term care, more discussion has yet to take place.

As shown in Chapter 1, whether the family's role in China has been challenged and how it has changed to respond to current societal transitions remains unclear. Given that RQ2 seeks to examine how the family's role in providing care has been challenged, and RQ3 regards intergenerational issues within the family, this chapter focuses on the family's role in providing care for its older members, specifically in the Chinese context in recent years.

There are five sections in this chapter. The first one examines the role of the family in providing welfare based on prior studies of the family's function in supporting its members, particularly in East Asia, as well as the long-argued welfare regimes sharing similar characteristics in these societies, including China. The subsequent section explains the family's role from the defamilialisation perspective, clarifies the family's support for its members in the care aspect, and focuses on An and Peng's (2016) defamilialisation analytical framework to identify the family's role in different dimensions. The third section describes the family's role in China, including the roles of the family in welfare provision and spotlighting care provision, with a particular emphasis on gender issues, as well as how the family's role has been considered in social policy and how the unique political system in China casts its influences. Given the family's caring role, the fourth section reviews the family's motivations for providing care to its older members. The chapter concludes by discussing the research gaps in the literature regarding the family's role in providing care in China. The review of previous findings and arguments in this chapter contributes to a more comprehensive and sophisticated picture of how the family supports its members in contemporary China, laying the foundation for the analysis for RQ2 and RQ3.

2.1 Family's role in welfare provision

This study examines the family's role in providing long-term care to older adults, with the 'family' being the central issue for the discussion. This section begins with the role of family and an overview

of its function for its members and society. The second part clarifies the family's role in welfare provision in East Asia, given the similar welfare regimes in these regions, with a particular emphasis on the family-state interaction as the basis for the defamilialisation discussion which follows in the next section of the chapter.

2.1.1 Functions of the family in society

The family is an institution with diversified forms in different periods in response to the changes of modern society (Wilson, 1985, p.6). Its functions are generally theorised to include reproduction, providing physical and economic support for the child(ren) and older people in need, socialisation and the stabilisation of adult personalities, teaching family members the roles they would play in society, and maintaining stability in society (Wilson, 1985, p10; Bales and Parsons, 2014). The family's function for its members is affected by its resources , such as time, income, human capital, psychological capital and social capital (Ma et al., 2009). Particularly for care support, the family is interpreted as "the classical locus of care" (Tronto, 2013, p.159).

Classic arguments define the family through different theoretical approaches, such as Wilson's work which summarises that, in the functionalist approach, the family is a core element of the social system, connecting the individual and the wider social group to explore whether the family is good for society; in the feminist approach, gender roles are analysed to determine whether the family is good for women; and in the Marxist approach, the family is a tool of capitalism concerning the historical development of a society and keeping control over the members of that society (Wilson, 1985, pp.20-28) .

The family is the counterpart of other social actors. With respect to the family-state relationship, Harding (1995, pp.177-203) summarised two extreme models (the authoritarian model and the *laissez-faire* model) and intermediate models within the authoritarian-libertarian continuum (enforcement of responsibilities in specific areas, manipulation of incentives, working within constraining assumptions, substituting for and supporting families, responding to needs and demands), and the control taken varied. Specifically, the state achieves social control and locates the family in the ideological state apparatus. The state does not need to use physical force to control people, as education, religion, the media and the family are all critical elements of the ideological state apparatus (Althusser, 2006), indicating that the family might be significant for policy compliance to follow the state's intention. As for the state, the welfare policy it develops is essential for helping the government to reduce risk and reallocate risk across society (Moss, 2004). The development of a welfare state can lead to a crowd-out or crowd-in effect on family support

embedded in social changes in different periods (Kasearu and Kutsar, 2013). The interactions between family and state can therefore be seen as control and support, as the state's response might come if the family's responsibilities are not adequately met, and *vice versa*. Any analysis of the family's role should therefore consider the state's fulfilment of its responsibilities.

Gender issues are significant in the state-family relationship in welfare state analysis (Lewis, 1992, Orloff, 1993, Ciccia and Lombardo, 2019). For instance, Pfau-Effinger (1998) clarified different family economy models in light of the gender roles of breadwinner and carer within a family. A gender-specific family policy typology is categorised by dual-earner support (whether they support a dual-earner family) and general family support (whether they support a traditional family in which the father is the primary earner and the mother undertakes care work) (Korpi, 2000). Thus, since female family members have long been perceived as the primary care providers within the family, the gender division of labour should also be included in this study of the family's role. The discussions on gender issues in care provision are expanded in section 2.2.1.

The previous literature shows that the understanding of the family's role varies with the theoretical approaches and the interactions with other social actors, particularly the state-family nexus. In this study, the analysis of the family's role in care provision will be embedded in the interactions between the family and other actors (mainly the state), as well as from a gender-specific perspective.

2.1.2 'Family' in the welfare provision in East Asia

The family's role in supporting its members is often embedded in a welfare regime analysis, since the welfare state is constructed upon the relationship between family, state and the labour market (Esping Andersen 1990). Given that various types of welfare regimes have been argued to exist in China (Carrillo,Hood and Kadetz, 2017, Ringen, 2017), in this section, I shall first review previous studies in the East Asian context, as well as the long-debated East Asian welfare regimes. It will be argued that despite the difficulties of idealising the 'East Asian' welfare regime, distinctive characteristics are shared in the social welfare systems in these societies.

Productivism is one of the most debated characteristics of East Asian welfare regimes. Compared with Western countries, social welfare spending in many East Asian countries is relatively low, despite higher state involvement in welfare provision, for instance, with various degrees of being a regulator in the welfare programmes without providing direct finance (Goodman,White and Kwon, 1998). Theorists such as Holliday (2000) and Gough et al. (2004) argue that in East Asia we can see a distinctive productivist welfare regime, where social policy is subordinated the economic policy to pursue a developmental agenda with remarkable economic success. The perspective suggests

social welfare programmes are piecemeal in response to immediate political and economic challenges instead of being based on a comprehensive plan, and where family and private transfers are consciously reemphasised by state propaganda (Goodman and Peng, 1996). In a similar vein, the debates about 'the developmental welfare state' refer to selective and inclusive welfare developmentalism; the former emphasises productivism, selective social investment and authoritarianism, whereas the latter is based on productivism, universal social investment and democratic governance (Kwon, 2005). The productivist orientation is significant in social policy development despite the transforming welfare regimes in East Asia. The governments recognise the duty of the state for welfare regulation and provision, and the market and family are facilitated to play a primary role in welfare provision (Aspalter, 2006). The state is therefore seen as playing a limited role in the welfare-mix in these societies.

However, most discussions on the productivist welfare regime focus on cases in the 1990s and early 2000s, but these societies have proceeded to establish their welfare states in the last two decades, perhaps moving out of productivism as a result. Lin and Wong (2013) argued that the productivist model in East Asia had evolved into a hybrid form of redistributive and inclusive social policy since the 1990s, considering the new policy trends and model shifts from an evolutionary view of system transition. Hudson,Kühner and Yang (2014) suggested that the simplistic classification identifying a welfare model as productive has been challenged due to the diversity of welfare provision in East Asia. Specifically in different societies, the regime in Japan continued to struggle to accommodate rapid socio-economic changes but in Korea showed more liberal characteristics (Choi, 2012), as well as the welfare hybrid in Taiwan and Korea based on the development of social policy in East Asian societies (Wilding, 2008). Abrahamson (2016) reported that only Macau, Hong Kong and Singapore retained their productivist and developmental characteristics based on their care policies, but that other societies such as Japan, South Korea and China had moved away from the previous welfare regimes. Nevertheless, despite the criticism, Choi (2013) stated that productivism continued to expand a more comprehensive set of social policies, with less state-driven developmentalism in response to socio-economic shifts.

Going beyond productivism, productive and protective dimensions of welfare systems in East Asia are further clarified in some recent studies, pointing to distinctive social policy development trajectories in specific policy areas in different regions (Yang, 2016a, Yang and Kühner, 2020). There has been a redesign of dominant social policy approaches into several further types, such as redistributive, inclusive and protective (Yang and Kühner, 2020). Considering the limits of productivism as a label, these studies showed that the role of the family varies in different parts of

East Asia due to the policy variations (Roumpakis and Sumarto, 2020). In this vein, the characteristic 'productivism' might be too ambiguous to describe the essence of the welfare provision in East Asia, not to mention the specific cases in different countries. Particularly, the family is assumed to be the supplementary actor to take on the unmet demands for its members in such productivism, but whether the family is willing or able to support its members is usually neglected.

'Familism' is another commonly identified characteristic of the welfare provision in East Asia (Saraceno, 2016). In familistic welfare regimes, despite the development of elderly care, care for older people has traditionally been a family affair (Abrahamson, 2016), and the state is not recognised as the primary resource for social welfare. The family obligation to care for children and older people beyond the state's responsibility is promoted by governments in such regimes (Pascall and Sung, 2014). With the strong continuity of support exchange over the generations in East Asia (Japan and China), the support from the family has changed from the direct provision of practical support to emotional, financial and organisational support in the new social contexts (Izuhara, 2010). Notably, although most welfare functions are assigned to household production, the family's ability to access social security and social services might have changed, thus increasing its dependency on formal systems (Croissant, 2004). Nevertheless, the family persists in its significance as the core of welfare capitalism in East Asia while undergoing transformation (Papadopoulos and Roumpakis, 2017). So given that welfare provision covers a wide range of support, whether familism persists in specific aspects in response to the societal transitions remains unclear.

According to these theoretical interpretations, in both productivist and familist welfare regimes in East Asia, despite being led by different rationales, the family acts as the principal welfare provider for its members. Whether it is the same for specific care provision and whether it retains the same role with the societal transitions requires further discussion. In addition, whether arguments about productivism and familism in East Asia welfare regime analysis are applicable to the contemporary Chinese context remains contested due to the vast heterogeneity of mainland China, as well as the huge social changes in recent years.

When highlighting the China case, Mok,Kühner and Huang (2017) argued that there is a productivist construction of selective welfare pragmatism with enormous regional disparities. With respect to the pragmatic and paternalistic welfare paradigm in China, social policies are implemented based on the rationale of economic development rather than citizens' social and welfare needs for the local government in the decision for economic growth and social protection (Qian and Mok, 2016, Mok

and Qian, 2019). Notably, these discussions have mainly focused on the government rather than the family.

In summary, therefore, regarding the welfare regime typology of East Asia, the family is commonly seen as essential in providing welfare for its members, coping with the low degree of support from the state, both for productivism and familism. In the Chinese context, whether a similar pattern exists with the family's significant role in welfare provision in contemporary society is worth further discussion.

2.2 Family's role from the (de)familialisation perspective

Whereas welfare regime analysis typically focuses on the interaction between the state, the market and the family, the state-family nexus will be investigated in this study considering the key role of the family in the Chinese context. Defamilialisation has been widely used as a specific analytical perspective for the family's role in welfare provision emphasising the interaction between the state and the family. Given that the family remains the care provider for older people in many countries within various long-term care systems (Spasova,Baeten and Vanhercke, 2018, Le Bihan,Da Roit and Sopadzhiyan, 2019), this current study adopts the defamilialisation perspective for capturing the family's role in care provision.

2.2.1 The dynamic of defining defamilialisation

In welfare regime analysis, 'decommodification' is one of the most widely acknowledged concepts, measuring the degree to which individuals maintain a socially acceptable living standard independent of market forces (Esping-Andersen, 1990, p66). With the extensive criticism of the vagueness of the gender issue in the decommodification discussion (Sainsbury, 1999, Saxonberg, 2013), 'defamilialisation' developed as a parallel concept, focusing more on the state-family interaction. Defamilialisation thus adds another layer to family independence by measuring the individual's ability to sustain a socially acceptable standard of living without relying on family relationships, i.e. through paid work and welfare benefits (Lister, 1994, Lister, 1995). Accordingly, defamilialisation policies reduce caregiving and financial responsibilities and dependency on the family (Lohmann and Zagel, 2015).

Defamilialisation has been women-focused or feminised (Lister, 1997), particularly in terms of the economic dependence on the family for females (Taylor-Gooby, 1996). It is about the woman's freedom from the family rather than the family's freedom (Bambra, 2004), explicitly evaluating how

the welfare state and welfare state regimes facilitate female autonomy and economic independence from the family. Policies related to women's labour market participation and pension schemes all contribute to defamilialisation (Korpi, 2000, Bambra, 2007, Leitner and Lessenich, 2007, Chau et al., 2017).

Regarding the gender-specific discussion from the defamilialisation perspective, degenderization has been developed as a new typology, which refers to eliminating the difference in gender roles by freeing women's burden and increasing men's contribution (Saxonberg, 2013). Degenderization highlights gender role norms in both the public and private spheres, and paid work and care are citizenship rights for both men and women (Finch, 2021). Related policies put more emphasis on increasing women's capacities than on changing how they live (Kurowska, 2018), regarding the reconciliation of work and family for women. Nevertheless, specifically for the care dependence on the family, the care provided within the family continues to be gendered, given that the considerable growth in women's labour market participation has not been accompanied by similar trends of men sharing caring responsibilities (Craig and Mullan, 2010, Papadopoulos and Roumpakis, 2017). Therefore, the gender issues in the defamilialisation analysis remain in doubt, particularly in the debates surrounding care provision from the family.

In the analysis of defamilialisation, the dichotomy of familialisation and defamilialisation is addressed. Although these two concepts are often used as analytical tools for comparing family policy across welfare states, they are not precisely reversed but can overlap in some cases, and a policy could show both defamilialisation and familialisation patterns (Lohmann and Zagel, 2015). Daly (2011) argued that, compared to familialisation who recognises the family as a collective in the policy, defamilialisation reifies the family and probably neglects the interests of individuals within the family. Whereas Kurowska (2018) suggested that, compared to the concepts of individualisation and familialisation, only the one of defamilialisation could offer a more accurate analysis comparing how the state supports welfare provision directly through state institutions or indirectly through families, referring to the welfare support provided by the state as opposed to solely leaving it to the family (familialisation). Despite the absence of uniformity in the contents of these concepts (Zagel and Lohmann, 2020), familialisation should be taken into account for capturing the essence of defamilialisation.

In summary, defamilialisation is a critical concept focusing on individuals' dependence on the family, in which the gender division of labour within the family is highlighted. Its notions have also developed over time, gradually serving as a multi-dimensional concept for independence in economic and social dimensions. In this study, I investigate the family's role in long-term care

provision; thus, defamilialisation is applicable for explicitly capturing the state-family interaction. The gender-specific discussion will also be included in the analysis.

2.2.2 Family's roles in the defamilialisation analysis

2.2.2.1 Family's role in the state-family nexus

The defamilialisation pattern reflects the economic and care responsibility shifting between the state and the family, as discussed above in section 2.2.1. The following analysis of the family's role is therefore placed in the state-family nexus.

Many previous studies have shown the family's role in social policy according to its interaction with the state in welfare provision. Esping-Andersen (1999) distinguished between familising and defamilising welfare regimes based on the public and market provision of services. Concerning women's role, he subsequently revised his earlier typology by taking familism into account, referring to the family's roles in income maintenance and care provision (Esping-Andersen, 2009). He also indicated that, "family reliance is the last resort when government provision is inadequate and when market alternatives are unaffordable"(Esping-Andersen, 2009, p.152). Saraceno and Keck (2010) suggested that defamilialisation describes the state's provision of individualised social rights that reduce family responsibility and dependence. The emergence of familialisation relates to the role of the state, as either the lack of state provision of services and financial support (familism by default) or active state support for an individual's family care (supported familism) can lead to the familialisation, the opposite concept to defamilialisation. In this way, the family is the institution supposed to cover the 'welfare gap' as it is supplementary to the state for welfare provision.

However, going beyond the discussion of the state-family nexus, the family is argued to be the key socio-economic actor in defamilialisation debates (Papadopoulos and Roumpakis, 2017). On the one hand, the family is the irreplaceable ground for the trusting, reciprocal and responsible social relations which are essential for individuals to live in society. On the other hand, the family is an economic actor, coordinating and deploying different economic practices to secure the well-being of its members (Papadopoulos and Roumpakis, 2019).

In the defamilialisation discussion, the family is therefore identified as a unit embedded in the interplay between different actors, particularly the state, whilst it is further suggested as is a socio-economic actor. Whether these arguments about the family's role can explain the Chinese case needs to be discussed. Specifically, how the family adjusts its role to respond to the newly

implemented care policies for supporting older people requires further discussion, and it is this issue which is addressed in this study.

2.2.2.2 Family's role in care provision from the defamilialisation perspective

In accordance with the family's role analysed in the previous section, extending to care provision, the state's available support (or intervention) is usually examined. Regarding the care provided within the family, the relationships between generations and between males and females have been the issues mostly discussed in previous studies.

Defamilialisation pertains to freedom from caring responsibilities (Yu,Chau and Lee, 2015). It refers to transferring care responsibilities to the state and the market, whereas familialisation refers to shifting care responsibilities away from the state and back to families (Saxonberg, 2013). Familialisation policies foster dependency among family members, whereas defamilialisation emphasises the terms and conditions under which people engage and do not engage in caring relationships (Kröger, 2011). Gender, generation and the reciprocity of care are the primary sub-dimensions for categorising diversified types of familialisating and defamilialisating policies, as welfare state provisions (social policies and regulations) decrease family members' care, financial responsibilities and dependency (Lohmann and Zagel, 2015). Combining the financial and care dependency, the interaction between caregiver and care receiver shows the emergence of defamilialisation and familialisation. The former refers to the state absorbing the financial costs, whilst the latter refers to the carer (mainly women) who would gain income by providing care within the family (Leitner and Lessenich, 2007). That is, if the state delivers limited social services, the family will take responsibility for care provision (Leitner, 2003). Notably, for care provision from the defamilialisation perspective, both those receiving and those providing care should be considered (McLaughlin and Glendinning, 1994).

Highlighting long-term care, the care policies for older people are closely associated with the defamilialisation debates (Le Bihan,Da Roit and Sopadzhiyan, 2019). The funding mechanism and provision mechanism for long-term care targeting economic and care dependencies should be clearly distinguished in the defamilialisation discussion. For the care provision in which the family used to be the direct care provider, some countries have developed outsourcing of some care work and have transformed informal care into formal, gainful employment (Gori and Gori, 2015). For the funding issues, public insurance reflects defamilialisation as the policy instrument reassigning elderly care as the family's duty to society (Shin, 2013). Shin (2013) showed that given that the long-term care provided in Korea was primarily formal care delivered beyond the family, long-term care

insurance supported the family to relieve it of the burden of direct care provision and financing. However, as the current study explores the long-term care provision in China, unlike the policy designs in long-term care insurance in Shin's study, the long-term care insurance covers both formal and informal care in many of China's pilot cities. Thus, how the family's role changes in the care provision mechanism alongside the public insurance scheme as the funding mechanism in China remains an open question.

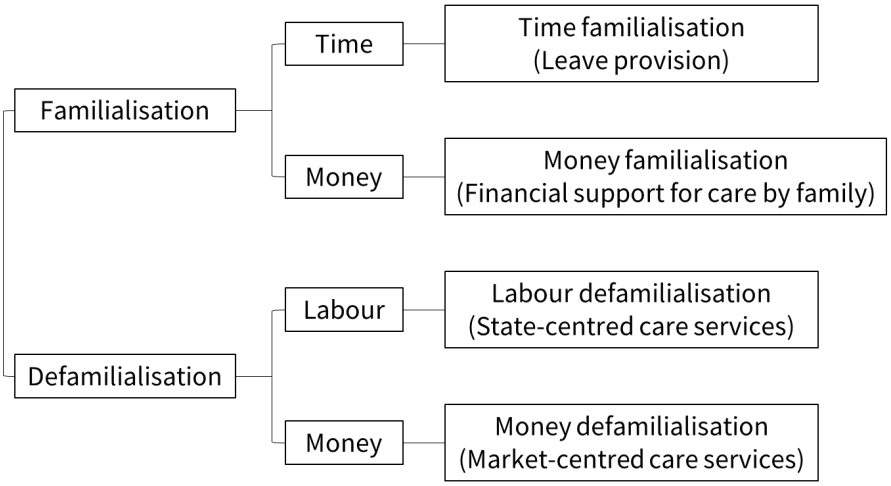
Concomitant with the consensus that the state and the family share the responsibility for care provision, policies reflecting defamilialisation and familialisation patterns with various family roles have been well debated. When it comes to the case of China, as with traditional family-dominant care provision (Shang and Wu, 2011), which has been dramatically challenged (Yang,Browning and Thomas, 2013), the discussion of the family's role in the Chinese context is essential, particularly with the development of long-term care provision primarily funded by public insurance. In addition, the literature about defamilialisation mainly sheds light on the policy analysis of individual independence shifting between different actors through the regulation set by the state. How the family, as the counterpart actor of the state, responds to changing care policies is still being determined, not to mention those policies specifically on care for older people and even in the China case.

2.2.2.3 Analytical framework for the family's role in care provision

Care provision has gained greater attention in the defamilialisation analysis (Leitner and Lessenich, 2007, Kröger, 2011, Yu,Chau and Lee, 2015, Kurowska, 2018). Many of the discussions so far have mainly identified the responsibility shifting between the state and the family, whereas the degree of defamilialisation is seldom explored, and how the defamilialisation policies relieve the care burden is ambiguous. Despite multiple approaches to relieving the family's care burden, the detailed mechanism of how the defamilialisation policies work has yet to be explored.

In order to address these research gaps, An and Peng (2016) constructed an analytical framework of familialisation and defamilialisation based on the childcare policies in East Asia (Japan, Korea and Taiwan). For the publicly financed and privately provided care services and those publicly financed and publicly provided, there are different roles of financier and care provider between the state and the family. The proportion of the state's provision to the total volume of care service use is adopted to measure the degrees of familialisation and defamilialisation. They clarified four typologies of (de)familialisation patterns into three dimensions (time, money, and labour), as Figure 2.1 shows.

Figure 2.1 (De) familialisation in four dimensions in childcare policies (An and Peng, 2016)



According to their framework, there are time-familialisation, money-familialisation, labour-defamilialisation and money-defamilialisation, capturing the state's intervention through specific policy design. Time-familialisation refers to "the extent to which policy reinforces the family's caring role through wage-compensated care leave", and the paid leave provision is a typical example. Money-familialisation is about "policy reinforces the family's caring role through financial support to value or sustain family care", thus the financial support from the state for childcare by the family. Regarding the defamilialisation pattern, labour-defamilialisation policy includes state-centred childcare services, in which the family's care burden has been relieved with the publicly provision of care services. Market-centred childcare services are examples of money-defamilialisation policies that ease the family's care burden with the financial support facilitating the use of care services. For instance, the financial support and the development of institutional childcare illustrate the defamilialisation in South Korea, helping with work-family reconciliation. These patterns can occur in a single case, combining various dimensions with a mix of care policies. As for the childcare patterns in South Korea and Japan, the largest provision in South Korea's for profit whereas the family remains the primary lotus of care provision in Japan (An, 2017). Thus the childcare policies in South Korea show a bolder defamilialisation trend than in Japan where a modest, means-tested child allowance is offered for the young child (Fleckenstein and Lee, 2017).

This framework therefore measures state intervention in specific childcare programmes to capture individual independence in family care support in various dimensions including money, labour and time. This multi-dimension framework lays the foundation for identifying the family's roles covering both familialisation and defamilialisation patterns, providing an in-depth insight into how these policies shift the care provision responsibility between the state and the family.

Nevertheless, given that childcare policies are well declared as social investment (Fleckenstein and Lee, 2017, Jun Choi and Fleckenstein, 2021), whether this framework based on childcare policies in East Asia can be transferred to elderly care policies has not been examined in subsequent studies. Compared with Western countries where childcare is given prior attention over elderly care, the unique cultural emphasis on filial piety in East Asia implies the significance of elderly care in East Asian societies, as well as the rapidly growing care burden due to the demographic transitions in these areas discussed above (Peng, 2018), whereas the care provision for older people from the defamilialisation has yet to be explored in the Chinese context. Moreover, since childcare is often carried out by females within the family, particularly mothers, in the defamilialisation analysis (Mathieu, 2016), the care provided for older adults might be different. Therefore, the defamilialisation framework elaborating on childcare policies might reflect different issues related to the gender division of labour with those targeting older people.

Further discussion of care support for older people is therefore essential in East Asian societies, and the current study will contribute to that. Given that long-term care insurance has reshaped the care responsibility division between the state and the family to a certain extent, this study will escalate the discussion on the changing family role in care provision in China based on An and Peng's framework from a defamilialisation perspective.

2.2.2.4 Research gaps in the (de)familialisation analysis for care provision

Although the defamilialisation perspective has been widely adopted in many studies to investigate the family's function in welfare regimes, prior findings may not be able to answer the research questions in this study about the family's role in long-term care provision in China. Research gaps are evident in the existing body of literature.

First, most studies have focused on care provision from the supply side, analysing the current policies about the responsibilities shouldered by the state and the family. However, whether these policies help to relieve the care burden on the family in social practice and what the responses are of individuals and families are usually overlooked.

Second, most defamilialisation analysis is about childcare, as it has a more significant influence on family care decisions and the labour market than care for older people. For this reason, the interplays between care policies and the care responsibility division for older people between the state and the family are worth further discussion, as the rising social risks in such an ageing society and the introduction of long-term care policies are generally reassigning the care responsibility among various social actors.

Third, the impact of culture on defamilialisation processes is seldom considered, despite the argued significance of unique, deeply rooted cultural values in some societies, like East Asia (*see* Chapter 3). As for this study, with the implementation of long-term care insurance in China, as well as the argued cultural values, how the family rearranges its care pattern in response to long-term care policies is still ambiguous.

So regarding the (de)familialisation perspective which outlines the family's role in care provision with the public intervention of care policies, in this study I discuss the care support for older people in contemporary China, contributing to filling these research gaps by exploring the family's role in various dimensions.

Considering these research gaps, this study investigates the role of the family from the defamilialisation dimension based on this analytical framework developed by An and Peng, specifically examining the state-family nexus in contemporary China following the development of long-term care. It elaborates on whether multiple dimensions, including money, labour, and time, have been adopted in China, as well as the detailed patterns of the family's role in providing long-term care. Particularly, based on the care patterns in different dimensions, this study captures the role of the family in the care provision mechanism with the newly implemented public long-term care insurance as the primary funding mechanism. Rather than An and Peng's framework measuring the extent of the state's intervention, this study shifts the focus to the family's role in response to policy interventions for long-term care. The newly developed framework is presented in section 2.5.

2.3 Family's role in care provision in China

Although this chapter focuses on the family's role in welfare provision in East Asian contexts (*see* section 2.1.2), the family's role discussed in this study remains unclear given the contested welfare regime in China. Although the family is the principal care provider for most older Chinese people (Lin, 2019, Feng et al., 2020), with the demographic, socio-economic and cultural transitions in contemporary society, particularly with more care policies for older people, for instance, long-term care, whether the family's role in providing care to older people has changed in China requires further elaboration.

In this section, I shall review the previous arguments on the family's role in providing care in China, and the discussion falls into three parts. The first part spotlights the family's role in welfare provision in China based on section 2.1.2 of the discussion of East Asia. The second goes through the existing care provision with the family's involvement in the Chinese context. The following one reviews

gender issues in relation to welfare and care provision in China over the past decades. The final part outlines the political considerations of analysing the family's role in care policies in China, particularly the political intentions of the central and local governments.

2.3.1 Changing family's role in welfare provision in China

The family's role in supporting its members, both for welfare provision and care provision in social policy, should be embedded in the state-family nexus as the defamilialisation discussion showed (*see* section 2.2). China's welfare system has undergone radical changes in the past few decades, specifically with its marketisation and urbanisation. The family's role in welfare provision in China has varied in different phases of this process (Chau and Yu, 2005, White, 2006, Duckett and Carrillo, 2011, Hu and Scott, 2016, Saich, 2017, Hong and Ngok, 2022b). Notably, the family is an adaptable institution which has undergone dramatic adjustments in response to broader social changes in China (Jankowiak and Moore, 2016).

From 1949 to 1980 (also argued as 1978), the basic welfare system was established as an 'iron rice bowl' welfare system in China's communist or state socialist society (White, 2006, Duckett and Carrillo, 2011). The welfare programmes based on the planned economy were designed to restore stability (Saich, 2017). The welfare provision in urban areas, and welfare benefits including healthcare, housing, education and childcare, were predominantly allocated through work units. Work units such as factories and offices were recognised as critical institutions for social control (Saich, 2017). They were the socio-economic institutions developed by the state for public welfare provision which was universal to all the members (Gu, 2001). In rural areas, there were collectives to fulfil the functions of work units. The policy favoured privileged groups and classes, including government and party workers, the industrial working class and soldiers. The rest, mainly the peasants, had to rely on the surplus of collective welfare provision, indicating highly unequal provision and vulnerability to a large extent (Saich, 2017). In such a socialist state, welfare policy was subordinated to economic development to support the productive workforce and reduce the burden of the vulnerable population on the state (White, 2006). The state did not play a direct role in welfare provision in Mao's period but relied mainly on work units to mobilise people to contribute to economic growth and allocate welfare services (Chau and Yu, 2005). The state mandated that families share the state's goal of socialist construction on the one hand, and it promised to provide welfare for the family on the other. The family was a key supplementary institution for those without work, mostly children, disabled people and older people without a formal work unit (Duckett and Carrillo, 2011). The government expected the family to care for those unable to work.

The turning point came with the introduction of Reform and Opening Up in 1978. Under the market-influenced economic reforms, markets for goods and services replaced the state allocation, leading to the collapse of collective welfare provision through the work units and communes (Gu, 2001, Saich, 2017). The state retreated from the fields including education, health and housing along with market transitions since the 1980s (Ngok, 2013). The government came to consider the state obligation for welfare, exploring a new social security system with the development of social insurance-based protection. Service provision shifted from the government, work units or collectives to other social actors, including the family and market-based institutions, thus the household again became the primary domain for welfare provision (Saich, 2017). Ever since the mid-1990s, there has been an increase in welfare support for urban China. With many laid-off workers losing their 'iron rice bowls' due to the economic reforms and the market economy orientation in the 1990s, greater responsibility for welfare provision was committed through individual contributions such as public pensions and healthcare insurances, largely relieving the welfare burden on the state-owned enterprises (SOEs) with the linkage between the contribution and the benefits which individuals make and receive (Leung, 2005, Hong and Ngok, 2022b). Many welfare programmes have become contributory with premiums from workers and employers, but not the state, through public insurance schemes (White, 2006, Chan, Ngok and Phillips, 2008).

As the state thus continued to withdraw its role from various areas of private life, the care provision for older people has been returned to the family (Shi, 2017a). The Chinese government continues its residual care by only financing and operating care homes for older and disabled people who meet the means tests (primarily because they have no children or family members to care for them) (Cook and Dong, 2017). That is, the state withdrew from social welfare provision to relieve the financial burden, develop a more individualised economy and promote political stability by using familial and collectivist thinking and social practice to encourage the family to act as the foremost provider of social welfare (Yan, 2018).

The era of social policy has come since the turn of the millennium in China (Hong and Ngok, 2022b), extending welfare support to rural areas and to migrants, as well as to different vulnerable groups. Advocating 'putting people first' and 'building a harmonious society', the policy incentives have shifted from providing short-term safety nets to developing a more integrated and comprehensive system, leading to a more inclusive system based on citizenship for entitlement with equal access to welfare services. The urban-rural harmonisation stressed in social welfare also contributes to blurring the binary division of social welfare provision based on local resident status (Shi, 2012b).

Since 2012, when President Xi Jinping first took power, a more people-centred orientation for building a moderately prosperous society has been introduced (Hong and Ngok, 2022a). However, despite the efforts of the president and prime minister to develop the new urbanisation furthering the programmes introduced by their predecessors, the urban bias of citizenship remains strong in welfare policy design. Increasing social inequalities prompted the government to develop a more universal and equitable social security system (Du, 2013). In recent years, public insurance schemes covering a wider range of people have been developed, but the public insurance run by local governments to replace the work unit welfare provision should not be simplified as the withdrawal of the state's role (Duckett and Carrillo, 2011).

With decades of exploration in welfare provision, China has developed a mixed type of welfare state, balancing state, market and family responsibility, with a conflict between central and local delivery and the risk of inequalities in access (Li and Greve, 2011). The changing welfare mix has led to growing family responsibilities (Duckett and Carrillo, 2011). Specifically for support for older people, 'caring for the older people' has been placed on the policy agenda since the 2000s. Support expanded from economic support to care provision, particularly in the relatively developed areas (Ji et al., 2017). Regarding care provision, the market, family, not-for-profit organisations and informal community groups have played more significant roles in China's transitional welfare economy (Wong and Jun, 2006). Therefore, with a more sophisticated responsibility-sharing mechanism between the public, private, third and informal sectors for welfare provision in China, the family's role has changed over time alongside the various policy focuses of the government. However, concerning whether similar patterns will emerge in long-term care provision with the newly implemented care policies, more evidence is essential in this study.

The evolution of family laws and regulations also reflects the changing role of the family in policy discourse. Since the 1980s, 'family relationship' has been redefined in the Marriage Law, referring to the responsibilities of rearing and supporting the parents and children, and in the Civil Code of the People's Republic of China since 2021. In 1982, 'family obligation' was included in the *Constitution of the People's Republic of China*. Later, in 1996, support for older people began to be seen as a responsibility undertaken by family members, as clarified in the *Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly*, implying the state's intention to promote filial piety in China (Zhang, 2017a). Terms such as 'family obligation' and 'family ties' were used to shift the government's responsibility for care support for older people. The Family Support Agreement (FSA) in China, which emerged as a voluntary contract between generations for providing care support to older family members since the 1980s, was legalised in the 2000s, alongside the

government's role in promoting and monitoring the support provided within the family without any costs. The FSA followed the state's intervention in family welfare provision for older people since ancient times, as well as the cultural norm, helping to redefine filial piety in a pragmatic way and using filial piety as the moral persuasion for enforcing the fulfilment of family support (Chou, 2011).

In the family policy system in China, the family obligation has therefore been legalised more for family function than ethical responsibility, reshaping domestic responsibilities as a matter of neutral, rational and individual preference. Whether and how these arguments explain the long-term care provision for older people in China has remained a contested issue and this study was designed to fill the research gaps.

2.3.2 Changing family's role in care provision in China

The division of care responsibility in China is embedded in the discussion of welfare provision, which is of great significance in examining the family's role in this study. It is commonly argued that the family remains the primary care provider for its members in East Asian societies (Yamashita,Soma and Chan, 2013, Saraceno, 2016), including in China (Feng et al., 2020). Alongside the family's role in welfare provision in China, there is a similar observable transition in care provision.

Reviewing the Five-Year Policy Plans in China since the 1990s, as with the market-oriented reforms in the welfare system, unlike many countries developing home-based care to relieve the family care burden, China addressed home care as the foundation of the elder care system and encouraged family involvement through the revival of the filial piety tradition. The first perennial policy for ageing was launched in 1994, with the introduction of the *Seven Year Plan (1994-2000)*, and the *Elderly Rights and Protection Law* was issued in 1996. The following Five-Year Plans reflected a greater policy focus on the ageing population. For instance, the Confucian teachings and moral values promulgated, the developments of mandatory social insurance, elderly care (home-based and community care) and long-term care, and the related policy emphasis on care support for older people. Ever since the economic reforms in China, the government has sought to reinstate the family as an important actor for moral order and social stability by legislating and reinforcing citizens' obligations to support their ageing parents (Ikels, 2006).

The willingness of the government to improve ageing conditions is apparent, although families and older people continue to be encouraged to shoulder the care burden (Krings et al., 2022). Particularly for long-term care, integrating publicly supported extra-familial and family care would be a practical approach to the new Chinese long-term care policy. The primary reason for this is that such a long-

term care policy design could help to diminish rising care gaps, compensate for deficiencies in extra-familial care supply and support families in realising their family-care preferences while being less cost-intensive than developing only an extra-familial care infrastructure (Eggers and Xu, 2023). The growing workforce shortage in formal care provision (Zhang et al., 2018) and a strong preference for home and community-based care (Feng et al., 2018) may be the crucial explanations for prioritising informal long-term care in China.

The Chinese government's policy for supporting older people relies on family-based care, mainly unpaid care provided by family members, especially women (Silverstein,Cong and Li, 2006). Despite increasing expectations for the government to develop formal support to complement informal care, particularly for the younger generations, the state seems to maintain the traditional filial piety emphasising the responsibility of the younger generation instead of that new form addressing mutual respect for the younger generation in the process of socio-economic development (Du, 2013). Regarding the changing care responsibility assignment among diverse social actors, the family has been stressed as having a duty to support older adults in China; for instance, in the increasing rhetorical support to boost filial and familial commitments and obligations for providing support (Croll, 2006), as well as the promotion of filial piety in traditional culture through education (Cheung and Kwan, 2009, Hu and Scott, 2016). The generational contract for mutual support, particularly from the younger members to the older ones, has also been reinforced in the latest law regulations (Chen, 2020).

The family's role in care provision in China has also been significantly shaped by the one-child policy since the 1980s. "One child is great, and the government will provide old age support" is one of the widely acknowledged slogans during the early years of its implementation, but this family planning policy was criticised as "a good sound bite", given that the support obligation ultimately falls on the older people themselves and their families (Cai and Feng, 2021).Although this family planning policy was abolished in the 2010s, its profound impacts are more than just on the demographic aspects but also on the family's role in care provision, including the care support for the older people within the family. The limited number of children which resulted implies the absence of support from siblings for individuals when caring for their parents, increasing their care burden in turn. The only child is more likely to reside in the same city as his or her parents to provide support, and also seems to embrace a weaker belief in patrilineal norms (Deutsch, 2006). Since the 2010s, in the face of challenges from the ageing society in China, abolishing the one-child policy and the expectation of individuals to have more babies to boost the national fertility rates has been encouraged in the discourses in the laws and regulations, as well as promoted in the

social media (Yan, 2018). So with the potential pressure on the family caring function led by the one-child policy, the family might be urged to play a more important role in care policies in China.

Therefore, the family's role in providing care in China has changed in policy and social practice. Due to large-scale social, political and economic changes, the support from the family has weakened incrementally (Yang,Browning and Thomas, 2013) but the family plays an irreplaceable role in providing care (Feng et al., 2020). Nevertheless, given the newly implemented public long-term care insurance schemes in pilot cities have led to various care provision patterns (formal/informal care), in terms of whether and how the family adjusts its care role in response to the recently developed long-term care system, further analysis is required in this study.

2.3.3 Gender issues in welfare provision and care provision in China

Given the great significance of gender division of labour in previous defamilialisation analysis (see section 2.2.1), this study also expands the discussions on gender issues in the analysis of the role of the family. This section reviews arguments specifically on welfare provision and care provision considering gender issues in the Chinese context, laying the foundation for the analysis of gender roles within the family in providing long-term care.

Following the overall patterns of welfare provision and care provision in China (see sections 2.3.1 and 2.3.2), there are evident trends of changing gender roles in recent decades. Since the founding of the People's Republic of China, a socialist policy emphasising productivity and encouraging women's labour mobilisation, was adopted. During the Mao era, urban women were mobilised into full-time employment under the state's belief that "women could hold up half the sky in China" (Zuo, 2016). They were encouraged to be 'iron women' who contributed equally with men to China's economic development (Tiefenbrun, 2017). The development of feminism in China is believed to be closely related to the dramatic shifts in the ideological and economic direction, and the status of women also grew due to their participation in and the state's intentions to encourage them in state-building (Manning, 2006). At that time, the gender role was constructed to legitimise the historical achievement of revolution and liberation in the socialist state of China (Leung, 2003). Despite the state's rhetoric on gender equality and the major efforts made to implement it, in reality, women workers were both horizontally and vertically segregated in the workplace and had limited access to resources and power in the work unit (Hiroko,Liu and Yamashita, 2011).

The subsequent reforms in China, such as the Opening Up policy and marketisation reforms in the 1990s, influenced the evolution of feminism. In recent years, the solid Confucian traditions regarding women have continued to change due to industrialisation, changes in family structure, women's

increasing participation in the labour market, and the recent development of gender equality policies (Ji et al., 2017). So as China has transitioned from a socialist, centralised economy to a productivity- and efficiency-oriented market economy, gender inequality in China has been reshaped (He and Wu, 2017).

Some scholars have argued that women remain disadvantaged in Chinese society. As marketisation had led to the neglect of women and increasing gender disparities (Berik,Dong and Summerfield, 2007), Ji et al. (2017) showed that with the withdrawal of socialist state welfare, there has been a greater separation between the private and public spheres for female roles. To alleviate the pressure of unemployment caused by global economic competition, the government urged women to 'return home' for childrearing (Song, 2011). There is a revitalisation of traditional gender values by reemphasising women's personal issues and domestic responsibilities in public gender discourse shaped by the mainstream media in urban China (Sun and Chen, 2015). For instance, President Xi emphasises the significance of women in the family and praises their contributions. This is seen as a form of neo-familism in Chinese society in which the 'unique role' of women in the family is about caring for older people and educating children (Hird, 2017). Women thus manage to reconcile their career achievements outside the family and negotiate with the patriarchal tradition about marriage and family (Ji, 2015). These arguments indicate that the policy addressing the gender division of labour within the family seems to serve the state's development better. Walker and Millar (2020) further concluded that the logic of the market in China worked against women, and a huge gender gap in labour force participation exists (Yu et al., 2021), which was largely related to social norms (Xiao and Asadullah, 2020).

In addition to the gender role in welfare provision and care provision following the societal shifts in China, support for women was also well-debated, particularly considering the vulnerability of females in their old ages. Given the different mandatory retirement ages across genders in China, which are 60 for males (65 for cadres) and 50 for females (55/60 for cadres), the gender pension gap is frequently addressed in previous studies[1]. They are mainly led by females' lower participation rates in occupational pension schemes, fewer years of employment contributing to the pension scheme, and lower salaries (Zhao and Zhao, 2018, Chen and Turner, 2015). Early retirement in China reduces the welfare of women (Lee,Zhao and Zou, 2022), and women are in a disadvantaged

[1] There are primarily two public pension schemes in China, including the Urban Employee Pension Scheme (UEPS) and the Urban and Rural Pension Scheme (URRPS). The former covers the employees working in government organisations and enterprises in urban areas (the premium is jointly contributed by employers and employees); the latter covers the residents in both urban and rural areas (self-contribution for the premium). Respondents over 60 years old are identified as the older generation because the retirement ages in China are 60 for males and 50 for females for the public pension scheme of urban and rural residents (65 for male employees and 55 for female ones).

position due to the labour market and the current pension policy in China (Zhu and Walker, 2018). Conceptualising the analysis in this study focusing on the gender division of labour for long-term care provision, those informal caregivers are usually women near their retirement ages (Wang and Zhang, 2018), Notably, the impact on employment of providing care to parents of females aged 50 to 59 is greater than that of females aged 45 to 49 (Ma, 2021). Therefore, in this study investigating the role of the family in long-term care provision in China, whether these arguments explain the gender division of labour remains unclear.

There are a rich body of debates on the positive relationship between informal care provision and retirement decisions in many countries (Van Houtven,Coe and Skira, 2013, Dentinger and Clarkberg, 2016, Carr et al., 2018), as well as discussions on the labour force participation reduction due to informal care provision (Schmitz and Westphal, 2017) and the maternalist logic (Orloff, 2017) for simultaneously reinforcing the female role in care provision. It was claimed that gender-neutral policies have enhanced the female gender role (Andersen, 2020). Whether similar scenarios are reflected in China with its relatively early retirement ages has yet to be explored, particularly in the context of long-term care provision with the newly implemented public insurance schemes,

In conclusion, despite the reforms in social welfare in China over the decades, women remain in a relatively weak position in social life, and they manage to reconcile their careers and families. Regarding females who are more likely to perform as caregivers, in this study, gender division of labour will also be included in the analysis, examining whether and how gender issues have been considered in the care provision for the individuals and their families, as well as in the care policy.

2.3.4 Family's role embedded in the political system in contemporary China

The state's intervention is important for the care provided by the family (Leitner, 2003, An and Peng, 2016). When it comes to the case in China, the debate over state intervention should specifically consider its unique system combining political centralisation and fiscal decentralisation with enormous internal heterogeneity (Cai and Treisman, 2006).

As stated in sections 2.3.1 and 2.3.2, the emphasis on the family's role as the state's counterpart has long been tightly associated with the political considerations and policy preferences of the central government. For instance, the work unit instead of the family was emphasised as the welfare unit to maximise economic development during the Mao era (White, 2006). In more recent decades, the family was assumed to be the safety net to complement the care provision gaps due to the residual care led by the subsequent reforms (Cook and Dong, 2017). To alleviate the financial burden, the family has been encouraged to perform as the primary welfare provider, along with highlighting

familial and collectivist thinking and social practice (Yan, 2018). Therefore, the family is highlighted as being mainly relevant to the government's intentions, and the family is considered resilient in complementing the gaps in care provision in China.

Given that the Chinese Communist Party (CCP) is the only political entity with dominant control over the policy-making process, the government might not face much pressure to expand social support (Saich, 2017). Unlike many countries with increasing individualism under ongoing multiple structural transitions, in China, the state manages the individualisation process as a strategy to realise rapid modernisation and maintain its monopoly over power (Yan, 2016). In reducing social welfare and the support provided by the state and disembedding the individual from the previous protective umbrella of the rural collectives and urban work units, the Chinese state has been resolute in preventing any mechanism that could strengthen society and weaken the state (Yan, 2010). In this scenario, the state has withdrawn its care role to a large extent and urged the household to take responsibility (Cook and Dong, 2017), given that the family has usually been the only source of protection, belongingness and meaning in life (Hansen and Pang, 2008). Therefore, the policy focus on the family's role reflects the state's political consideration, mainly for shifting its responsibility to the family.

Regarding the political considerations of the state, the central-local government interaction is significant in assigning responsibility for family care in policy discourse. The reforms in social welfare have been under substantial state control as reflected in the state's political and development agenda, although state control is relatively weaker than it used to be (Li and Greve, 2011). In China, fiscal decentralisation from the 1980s has encouraged local governments to promote economic growth and local agencies are authorised to fund social provision (Wong, 2007), resulting in diversified social provision patterns across different areas due to the divergent local economies. The decentralisation of resources has also provided space for policy innovation, through which local governments have found strategies for balancing public-private provision within the framework of national policies and regulations (Duckett and Carrillo, 2011).

Despite the decentralisation tendency for social welfare exploration in China, recentralisation since the Hu Jintao Administration (2002-2012) has been observed (Zhu, 2016). Specifically, for the exploration of long-term care, there is also a trend of recentralisation showing the potential social control taken back by the central government since the pilot period of the long-term care insurance (Chan and Shi, 2022); that is, there is a changing tendency towards centralisation reflecting the central government's intention to retake control of the local governments.

Nevertheless, there is a non-alignment of incentives between the central government and its local agencies leading to a variance between policy intention and local implementation (Saich, 2017). Based on the national policy framework, the local governments, with powerful voices for local development, might adjust the policy during implementation (Mok,Kühner and Huang, 2017). The welfare mix in China is shaped by the attitudes of local decision-making elites towards such issues as the place of markets and the private sector. For instance, policymakers show widely-held views among the urban elite that people experiencing poverty are more deserving of state assistance if they work (Hammond, 2011). Therefore, family policies, including those for care provision, are no exception. For the local governments, developing welfare provision, including care provision, by the family is the result of multiple considerations for the local governments and the bureaucracies themselves.

In short, the family's role in supporting its members is shaped by the political considerations of the various levels of government in the policy design. The interplay of central and local governments is significant, as the unique institutional settings of China. All these issues should also be included in this study exploring the family's role in care policies. How these political issues affect care provision and the family's involvement in the developing care system in China have been underexplored.

2.4 Rationales of the family providing care for older people

The family's role in care provision is more than just related to the family's function, which is emphasised in care policies, but also depends on the attitudes and behaviour of family members. For the research question examining the family's caring role (RQ2), the rationales of why the family provides care services are also essential.

Although the reasons for the family providing care are well-debated in the literature, such as care demands related to individual health status (Bonsang, 2009, Coe and Van Houtven, 2009), working caregivers' ability and their willingness to engage in informal care (Vos et al., 2022), the quality of the care relationship, normative beliefs and perceived barriers (Broese van Groenou and De Boer, 2016) and the conventional gendered role in providing care (Bianchi et al., 2006, Bakx et al., 2015), the outcome of caregiving is also denoted as the driving force for care provision. Particularly, care is more than a burden for the caregivers, it is a reward for them due to the care which they provide, which could be considered mutual support between the caregivers and the care recipients (Greenwood and Smith, 2016). Caregiving is not just a physical, emotional, social and financial hardship but also a positive sacrifice which involves love, initiative and goodwill (Mendez-

Luck,Kennedy and Wallace, 2008). The positive affective returns for caregiving satisfaction towards the caregivers are explicable in the care provided by the caregivers (Lawton et al., 1989, Lawton et al., 1991). Family values, referring to "traditional and collectivist value orientations with respect to the family with a normative character", are also of great significance for the younger generations, with a moderating role between the exchange of support and ambivalence (Albert and Ferring, 2018). However, these analyses mainly take other countries as the case rather than China, and the societal contexts in China might vary from the findings in previous studies.

In this section, I shall therefore focus on the case of China, summarising the significant rationales for informal care provision, primarily the intergenerational contract, available family care and care alternatives. Notably, these arguments also show that cultural factors such as those addressing obligations towards family and filial beliefs are significant for both intergenerational contracts and the available care support from the family.

2.4.1 Intergenerational contract to maintain the caring role

Regarding the support provided within the family, intergenerational contracts (exchanges) are highly valued. The intergenerational contract is guided by reciprocity in China (Cong and Silverstein, 2008, Cong and Silverstein, 2012a), generally containing the sentiment, time and financial assets transferred from parents to their children (Silverstein et al., 2002). The 'refeeding model' (emphasis on adult children's obligation to support their parents) instead of the 'relaying model' (emphasis on adult children's obligation for their next generation but not parents) in Western countries is found in the Chinese context (Fei, 1983), as the younger generation is responsible for supporting the older generation due to their blood relations with deeply embedded cultural values.

Reciprocity is a fundamental principle in maintaining this two-way exchange of support and care. With the reciprocal principle, older generations actively pursue identifiable strategies to ensure their own short- or long-term security and care (Yan, 2003). Hierarchy, discipline, duties and dominance are part of the traditional vertical relationship between generations in the family instead of emotions and affection (Santos and Harrell, 2017). Particularly in rural areas, older parents usually provide essential support (mainly non-financial support such as caring for grandchildren) to their adult children for a greater financial return (Takagi and Saito, 2013).

The intergenerational exchange is driven by more than cultural values, as the exchange model makes evident. The interactions between family members are impacted by individual objectives and resources, as they are the trades of different goods and services, which can be made not at the same time (Bianchi et al., 2006). The exchange motive for adult children to care for their parents is paying

back (Silverstein et al., 2002). The childcare or money transferred from parents was a time-for-money exchange aiming at the time transferred from children to parents (Cong and Silverstein, 2011b, Alessie,Angelini and Pasini, 2014), and the support from children is positively associated with the previous transfer (Silverstein, 2005).

The preferences and social norms shown in contract behaviours also concern the differences between sons and daughters. Gruijters (2017b) suggested the frequency of sons visiting their parents is higher than that of daughters, but daughters are more likely to keep in contact with their parents using mobile technology and are also more likely to provide emotional care than physical care. Moreover, financial support from parents is strongly gendered, as sons are usually more favoured (Jiang,Li and Feldman, 2015). Particularly in rural China, sons are expected to take on more care obligations because of their vested interests in maintaining the patrilineal system and their consequent stronger endorsement of traditional values (Cong and Silverstein, 2012b). Nevertheless, Tao,Wenting and Ting (2021) suggested that the number of children is not positively correlated to the guaranteed satisfying of support for older adults and that daughters play a more critical role in supporting older people in China.

However, instead of being a care burden, many older people provide support to their children and grandchildren as resources flow from the older to the younger generations (Liu, 2017). Although there might be conflicted motives in intergenerational transfers such as self-interest and altruistic preferences, these perspectives on filial support and the corporate group/mutual aid model of family functioning explain care support from the middle generation to their parents with affluent resources, whereas filial piety towards ageing parents tempers the competition with the care support of their younger children with limited budgets (Cong and Silverstein, 2019). Those in the sandwich generation (caring for both elderly parents and own children) spends more time and resources on raising their younger children, possibly leading to resource competition between the care demands of the younger and older generations (Falkingham et al., 2020), casting the burden onto the ageing population (Zeng and Hesketh, 2016). In this scenario, in addition to the contract between older parents and adult children, vertical intergenerational contracts exist between multiple generations. Particularly for adult children and their next generations, with the demonstration effect model (Cox and Stark, 2005), adult children care for their parents in the hope of guiding their own children to behave in the manner of their parents. This is about moral role modelling, somehow similar to an old saying in China: *The parents set the moral model for their children through their own words and behaviours*.

Nevertheless, long-term caring is led by social norms, moderate altruism and family norms (forced altruism), instead of the intergenerational contract, given that family norms are not intergenerational exchange, as the evidence based on the households in the Eastern and Southern European countries has shown (Klimaviciute et al., 2017). The investment and insurance models referring to unconditionally reciprocated parents regardless of their needs and the needs of parents for the intergenerational exchange are demonstrated. Parents prefer more active and frequent exchanges with their families, whom they feel are more trustworthy than those beyond the family, and adult children are more likely to understand the preferences and needs of their parents; thus, more efficient support could be provided than that by outsiders (Bianchi et al., 2006).

Overall, although the intergenerational contract is widely used in explaining the care provision between generations within the family, the social and cultural factors associated with reciprocity and values highlighting the family obligation shape individual behaviours, affecting the intergenerational contract within the family in providing care services. These findings all contribute to understanding why the family provides care for its members, as well as the family's role accordingly. However, as no single model could be applicable to all cases and there are various situations for the same individual in different life course phases, the analysis for each case should be based on the concrete social background. So for considering the case of China, this study expands the discussion on whether the intergenerational contract motivates the family to provide care for older people, and whether previous arguments explain the family's role in supporting its elder members. The discussion based on the intergenerational differences for RQ3 will also be laid out in this section.

2.4.2 Available support for providing family care

Available resources within the family are essential to the family's support of its members (Ma et al., 2009), and family support for older people is significant for the care choices between formal and informal care (Zang, 2022). In terms of care provision, since the care provided by family members is generally low paid as compensation for effort, or unpaid as voluntary work (Eichler and Pfau-Effinger, 2009), many families have no choice but to take on the care obligation (Schulz et al., 2012). The family usually fills the care provision gaps for its older members, and the family is the last resort for the individual to resist risks in Chinese society (Shi, 2017a). Care support is particularly a challenge for the sandwich generation in China, who shoulder the care provision for the older and the younger generations within the family, and those in rural areas have always been more urgent than their urban counterparts because of the massive numbers of older adults living in the rural areas and the

lack of alternatives there to family care (Zhang and Goza, 2006). In addition, the younger generation as a single child usually faces more severe pressure to support their parents with financial, caregiving, and emotional concerns (Zhan et al., 2011).

Older people are more likely to receive care support from their spouses than their adult children (Gruijters, 2017a). Family care provision is primarily about the support of the spouses (Bakx et al., 2015), particularly for men receiving care from their wives (Chen et al., 2018). The family's role in providing care is related to the individual retirement decisions of spouses of older people with care demands in many countries (Lumsdaine and Vermeer, 2015, Carr et al., 2018). However, the impacts on the labour market of care provision vary for the elderly care and childcare in China (Cook and Dong, 2011), particularly with the relatively early retirement ages of females (50 years old for the participants of the Basic Pension Insurance for Urban and Rural Residents).

The availability of family support is also associated with the geographical distance between adult children and their parents as it affects the likelihood of the children becoming caregivers. Co-residency is essential for informal care provision (Piggott, 2015). The impacts of mass rural to urban migration should particularly be considered, given that informal family-based support has been under pressure with a declining percentage of older people living with adult children primarily driven by the increasing migration in the past decades (Cong and Silverstein, 2012a, Giles et al., 2018), whereas long-term migrate children were less preferred as caregivers by parents in rural areas (Cong and Silverstein, 2012a). In China, although there is a reduction in traditional family care for older people due to the changing family structure and rehabilitation (Bao et al., 2022), Chen,Leeson and Liu (2017) pointed out that even when they live separately, adult children continue to provide financial, practical and emotional support to their parents.

In addition to the available support from the family for providing care, the available alternatives to family care are crucial for the family's caring function. Family care provision is in relation to the absence of formal support provision (Hu and Ma, 2018, Zhang et al., 2020, Yang and Tan, 2021) and formal care services are used by those who can afford them rather than those who actually need them (Hu, 2019). However, even with the usage of formal care, Lin (2019) demonstrated that formal care for older adults in China is a supplement to informal care, and (Liu, 2021) reported that formal care shows a dominant complementary effect on informal care but is a weak substitute.

Specifically, the available support from the long-term care system is significant for family care provision. The availability of long-term care is significant for the crowding-in effect on informal care (Miyawaki et al., 2020), given that the family care support policy of long-term care insurance may

encourage older people to take family care (Cao and Xue, 2023). Particularly, the public benefits of long-term care on informal care are associated with the typology of public coverage for long-term care, as the crowd-in effect is led by access to cash benefits, whereas the crowd-out effect is due to access to proportional benefits (Courbage,Montoliu-Montes and Wagner, 2020). However, the limited care services from the ongoing long-term care insurance with its current minimal coverage might increase people's reliance on their families.

These studies demonstrate that family care provision is associated with or limited by its availability and care alternatives. Whether these findings explain the family's role in long-term care provision, particularly in China, has rarely been discussed, despite the significant role of the family in providing care in Chinese society. This study provides an analysis of the family's role in providing care, considering the available support within and beyond the family.

2.5 Conclusion

With respect to care provision, it is commonly argued that the family remains the primary care provider for older people in China (Abrahamson, 2016, Feng et al., 2020). This is also the case in many other countries in terms of the development of long-term care (Spasova,Baeten and Vanhercke, 2018, Le Bihan,Da Roit and Sopadzhiyan, 2019). Even so, research gaps are evident.

First, many studies have focused on the family's role in welfare provision in the interplays between the family and other actors (Holliday, 2000, Gough et al., 2004, Aspalter, 2006, Abrahamson, 2011, Frericks,GurÍN and HÖPpner, 2023), as welfare provision has been thoroughly debated but not specifically for identifying the caring function. Only a small proportion of them have shed light on care provision (Saraceno and Keck, 2010, Saraceno, 2016), not to mention specifically in the Chinese context (Gao, 2014). Although informal care is the pillar of the care supply for older people in many countries (Spasova,Baeten and Vanhercke, 2018, Le Bihan,Da Roit and Sopadzhiyan, 2019), studies of the family as the centre of care provision have been notably rare, despite its great significance.

Second, although many studies from the defamilialisation perspective have paid greater attention to capturing the individual dependence on the family, the explicit discussion of care dependence has not been the central element, and they have mainly been concerned with childcare (Kröger, 2011, Chau and Yu, 2012, An and Peng, 2016). Only a very limited number of studies have focused on the care of older people (Michoń, 2008). Given the differences in family care for children and for older people (Peng, 2018), more discussion specifically on long-term care is required, particularly concerning the severe challenges in an ageing society. Furthermore, the defamilialisation analysis

shows the family's role by measuring the state's intervention in care policies (An and Peng, 2016), but whether and how the family responds to the policies remains unclear (*see* section 2.2.2.4). In addition, although the gender division of labour is very useful for understanding familialisation (Saxonberg, 2013, Kurowska, 2018), the gender issue in discussions of the family's role in China has been rarely considered.

Third, even for the analysis of care provision focusing on individuals and families, previous discussions have summarised many impact factors for family care provision, such as intergenerational contact and the available support reviewed in section 2.4 (Silverstein et al., 2002, Cong and Silverstein, 2011b, Schulz et al., 2012, Gruijters, 2017b, Hu, 2019). However, although cultural values such as those related to family filial piety are mentioned in some studies (Canda, 2013, Brasher, 2021, Falzarano et al., 2022), how these values affect care provision patterns lacks in-depth discussion, particularly concerning the significance of cultural values in policy and social practice about care support for older people (*see* Chapter 3).

Fourth, most of the arguments reviewed in this chapter were driven by cases in different countries; whether they can explain the underlying circumstances in the Chinese context remains an open question. This is also the case for the findings in China, concerning the dramatic transitions in contemporary society. So in addition to clarifying the distinctive characteristics of China, combining the current situations with the latest story will also be significant in contributing to a more comprehensive picture of related issues.

Considering these research gaps and the analytical framework developed by An and Peng (see section 2.2.2.4), this study seeks to remedy these research gaps about the care provision by clarifying provision mechanisms and more detailed dimensions from the defamilialisation perspective, investigating how the family delivers care for its older members and how its role changes in response to societal transitions, including policy changes, as well as the underpinning explanations in the Chinese context. Unlike An and Peng's work focusing on the state's intervention with diverse childcare policies, this study shifts the focus to the family's responses to long-term care policies, particularly the public insurance scheme as the primary funding mechanism to provide both formal and informal care. Therefore, this study explores how the family, in providing care for its older members, adjusts its role in different dimensions of (de) familialisation.

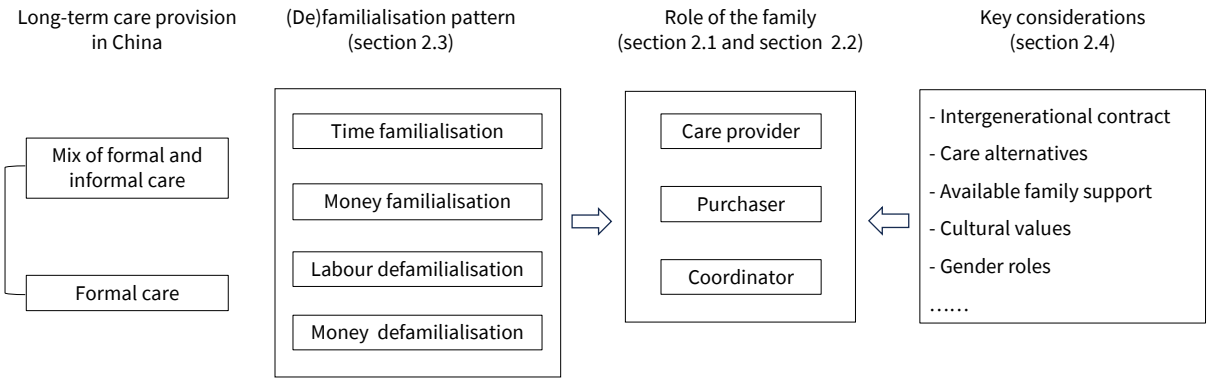
Specifically, based on the care provision funded by the public insurance schemes in China (*see* section 1.3), there are two types of care patterns: (1) a combination of formal and informal care and

(2) formal care. Diverse patterns of family involvement in the provision of long-term care may exist. They are both taken into account in this study.

Arguments regarding the family's role in welfare provision are summarised in section 2.1, and the explicit focus of section 2.3 is the family's role in care provision. The role of the family in providing long-term care in contemporary Chinese society to address RQ2 is examined. These are explored within the analytical framework of defamilialisation discussed in section 2.2, examining whether multiple dimensions, including money, labour, and time, have been adopted in China. Explanations of the family's care provision will also be explored, particularly considering whether those reviewed in section 2.4 are explicable in this study. Specifically, intergenerational contracts and gender roles in the context of long-term care provision in this study are examined to answer RQ3.

Therefore, drawing upon the existing literature on the analytical framework of defamilialisation in multiple dimensions and arguments related to this study's research questions, a new analytical framework, as shown in Figure 2.2, is established to investigate the roles of the family in providing long-term care in money, labour, and time dimensions, as well as the patterns in relation to intergenerational contracts and gender roles in the context of developing public insurance-funded long-term care provision in China. Thus, this study will address RQ2 and RQ3 with empirical evidence from contemporary China.

Figure 2.2 Family's roles in long-term care provision from the (de)familialisation perspective



3 Literature Review Part II: Cultural Values and Social Policies

Cultural values are significant in social policy analysis (Esping-Andersen, 1990, Stjernø, 2008, Opielka, 2008), as are care policies (Pfau-Effinger, 2005a, 2008). Cultural values addressing care obligations also explain the caregiving of individuals, as for the family providing informal care for its members (Pfau-Effinger, 2008, Zarzycki et al., 2023).

In this study, Chapter 1 has demonstrated the key role of cultural values in explaining differences in welfare and care policies in various countries and Chapter 2 was a review of the important role of the family in China. When carrying out an analysis in the Chinese context, whether any cultural values affect care provision in terms of family involvement has yet to be placed at the front and centre. RQ1 in this study investigates the cultural values involved in the role of the state as well as that of the family in care provision in contemporary China and RQ4 asks whether cultural values shape the care arrangement, so in this chapter, I shall focus on the cultural values affecting the family providing care and their impact on care arrangements in China.

This chapter is organised as follows. It begins with a discussion of cultural and social policy, outlining how social values affect social policy, particularly the values emphasising the family's function in welfare provision in East Asian societies. The second section focuses on the role of cultural values in care provision, primarily based on the approach to the care arrangement developed by Pfau-Effinger. This is followed by a summary of the cultural values related to the family providing care to its members and explains why and how cultural values are used in social policy in China. Given the unique government system in China, the fourth section focuses on the interaction between central and local governments in welfare provision in China, contributing to examining the state's consideration in developing care policies. The final section summarises the main ideas in the preceding sections, ending with the identification of the research gaps in the literature.

3.1 How cultural values affect social policies

Examining how culture plays a role in welfare provision in the previous literature is significant for exploring care arrangements in the Chinese context for this study (RQ4). In this section, the first part introduces the key issues of defining culture, followed by the most debated arguments about culture's impact on social policy. Based on the discussion of welfare provision in East Asia in section 2.1.2, this section then extends the analysis to cultural values, reviewing how cultural values are

taken into account in welfare provision in those societies, particularly concerning the family's role in social policy.

3.1.1 Culture in social policy analysis

Culture is a broad concept, encompassing a variety of elements, including values, beliefs, norms and attitudes shared by the majority of the population (Jones, 1990, Jones, 1993, Fitzpatrick, 2005, van Oorschot, 2007, Van Oorschot,Opielka and Pfau-Effinger, 2008, Van Kersbergen and Kremer, 2008). It is part of people's lives (Allen and Skelton, 2005), viewed as the basis of social and political identity affecting individual behaviours (Ross, 2000), given that values act as 'guiding principles' in an individual's life (Schwartz, 1992). Culture is also a system of collective constructions of meaning produced and reproduced by social actors' practices (Pfau-Effinger, 2012).

Culture changes over time as a result of ongoing human interaction (Allen and Skelton, 2005). This is an ongoing evolutionary process involving changes in the priorities of values at both individual and societal levels, like different personal values in various generations (Egri and Ralston, 2004). Despite the diversity of existing definitions, several important issues can be inferred from the various and nuanced cultural conceptions. In other words, culture is viewed as a collection of social values closely related to individual behaviours and social practice, varying depending on the societal context.

Culture, as a dimension of all social actions, including economic and political life, is considerably distinct from the political and economic sectors (Allen and Skelton, 2005). It is one of the explanatory factors for social welfare which is better understood when viewed as a context on a par with the economic and political contexts for policymaking (Pfau-Effinger, 2004a, Pfau-Effinger, 2005a, Jo, 2011). The values of the actors participating in social policy development and their interpretation of culture should therefore be considered (Freeman and Rustin, 1999).

There are two distinctive approaches to analysing the impact of ideas and ideology on policy issues: historical institutionalism and organisational institutionalism. Historical institutionalism focuses on how ideas and institutions limit the range of potential solutions that policymakers are likely to consider when resolving policy problems. Organisational institutionalism concentrates on cognitive structures instead of normative ones. It examines how actors initially define and articulate their policy problems and solutions by employing the institutionalised scripts, cues and routines which constitute their cognitive frameworks and empower them to act (Campbell, 1998). Path dependence is evident in the development and transformation of social policy as social actors are influenced by the essential elements of the institutional and cultural context (Pfau-Effinger, 2005a).

Consequently, cultural values are vital for comprehending care provision in people's life and social policy.

Cultural factors are of crucial significance in analysing welfare state systems. In Esping-Andersen's welfare regime debates (1990, 1999), various 'basic principles' are reflected in different welfare regimes, primarily liberalism, conservative corporatism and social democracy. Liberalism emphasises individual responsibility and freedom whilst state intervention is not advocated. Conservatism posits that society can be an organic whole of hierarchical inter- and intra-group relations, cherishing professional, communal and family bonds, and the family and the state should share responsibility for welfare provision. Social-democratic values place a strong emphasis on egalitarianism and solidarity, and the state is thought to play the leading role in the welfare system. These principles are fundamental values of welfare state action regarding solidarity, equality and the role of the welfare state versus the market (Pfau-Effinger, 2004a).

Correspondingly, the values shift, such as from an emphasis on collective to individual responsibility or shifts in family values and related ideas on gender differences in work-care responsibilities, and this has an ongoing impact on welfare states in many European countries (Lück and Hofäcker, 2008). Kalmijn and Saraceno (2008) revealed that, European countries with a familial culture tend to place a greater emphasis on strong family ties and the willingness and moral obligation to assist family members than in other countries; hence, the familial culture is also relevant to the design of care policies.

Nevertheless, despite their acknowledged significance (Pfau-Effinger, 2002, Pfau-Effinger, 2004a, Stjernø, 2008, Opielka, 2008), cultural factors are usually overlooked in favour of political and economic factors (Chamberlayne, 1999). Given that culture may be too abstract to be identified as one of the explanations for the construction and policy processes of the welfare state , cultural factors are usually interpreted as the given background, with culture deliberately unexplored or left unexamined because an assumption there is no direct causal relationship between culture and welfare state systems (Baldock, 1999). The difficulty of capturing the changing and complex contents of culture and ideas, as well as the ambiguous and amorphous current understanding of culture, contributes to the dearth of culture-focused discourse in social policy (Peng, 2008).

Regardless of diverse interpretations of this broad concept, culture ought to be essential in social policy analysis as it contributes to understanding the behaviours and actions of social actors and explains the variations in welfare provision. This current study is an investigation into the impact of

cultural values on the family's role and care arrangement. Further discussion should focus on the care policy in the context of contemporary China.

3.1.2 Cultural values in the family's role in welfare provision in East Asia

In East Asia, where the family is regarded as the premier welfare provider (Goodman and Peng, 1996, Holliday, 2000, Aspalter, 2006), cultural values emphasising the family's role in welfare provision have been widely discussed.

Confucianism is identified as a prominent cultural heritage in East Asian societies (Pascall and Sung, 2014), with a particular impact on pertinent social policy (Rieger and Leibfried, 2003). The common language of Confucianists in constructing their ethnic identity is shared, including essential notions such as respect for seniors, filial piety, parental benevolence, the group before the individual, conflict avoidance, loyalty and dutifulness. It has been extensively utilised in debates about constructing a social welfare system which is culturally appropriate for each society (Goodman and Peng, 1996).

Confucian values emphasising the importance of family and independence from the state have contributed to the absence of state welfare (Peng, 1998). The firm reliance on family for the provision of welfare and social security is one of the defining characteristics of East Asian welfare states and it even decreases the need for state welfare (Goodman and Peng, 1996). Jones (1993) argued welfare states running in the style of a would-be traditional Confucian extended family were developed in East Asia. Notably, Confucianism's political ideology is adaptable to local conditions in different regions. The rhetoric used by political leaders, the Confucian values of self-reliance and a vital family institution are widely observed in East Asian societies (Walker and Wong, 2005). In this way, Confucian familism legitimises the family policy (Lee, 2018). Thus, cultural explanations are critical in politics as ideological discourses which reflect and rationalise particular primary developmental motivations and political forces (Goodman and Peng, 1996). Rieger and Leibfried (2003) argued culture is a causal explanation for why the rapid industrialisation period in East Asia did not result in the development of more substantial welfare states, as was the case in European countries.

Confucian cultural values are argued to be used for specific political purposes in social policies in many East Asian societies. Chau and Yu (2005) argued that there is a 'traditional Confucian society' that reinforces the unequal distribution of resources rather than a 'Confucian ideal society' in which the government selectively uses Confucianism to meet the requirements of capitalism and please capitalists by promoting the supremacy of commodity relations and the private market as a mechanism for allocating and producing goods. Confucianism is therefore best understood as an

adjunct to political ideology as it provides robust backing to the conservatism of East Asian societies in the formative stages of social policy (Peng, 2018). These cultural values are interpreted as the state's instruments for development in East Asia. For example, Confucian values are a cover for welfare states pursuing economic growth at the expense of all else, especially the fundamental Confucian value of social solidarity (Ochiai and Johshita, 2014, Schmidt, 2018). In this vein, a Confucian belief such as the concept of harmony might be given as a pretext for minimising the risks from the society. In East Asia, governments tend to promote the family obligation for social welfare development as they draw on Confucian values to give families an extraordinary responsibility for social welfare over the state's responsibility (Pascall and Sung, 2014).

In addition, familial ethics inspired by Confucian teaching are used by these countries' governments as a compelling moral political justification for legitimising the deficiency of social protection (Jones, 1993). They are necessary for welfare provision because it is contingent on providing adequate welfare through a vast array of community or family resilience programmes (Kwon and Kim, 2015). Familial ethics have been considered the cultural underpinnings which contributed to East Asian development success and have shaped the historical path of contemporary welfare regimes (Roumpakis, 2020).

Some scholars, however, are cautious about interpreting the role of cultural values in welfare provision. Chau and Yu (2005) argued that Confucianism is a universal ideology and shares many ideas with the West's welfare values, such as the Commonwealth (*da tung* in Chinese), whose members treat one another with love, respect and dignity and which is similar to the Western welfare value system, which includes altruism and social integration. Similarities such as the lack of state provision for family and personal social services, and the policy emphasis on older people rather than children in line with some tenets of Confucian principles, are also witnessed in Southern European countries so are not unique to East Asia (Peng, 2008). More importantly, it has been argued that it is too simplistic to conclude that the 'Confucian welfare state' can represent all the East Asian countries (Jo, 2013) (also see the diversity of welfare regimes in East Asian societies discussed in section 2.1.2).

From this perspective, culture alone cannot adequately explain the development of welfare regimes in East Asian societies (Papadopoulos and Roumpakis, 2017). Peng (2018) argued that the influence of Confucian culture has been overestimated in the past and the present. In analysing various elderly care policies in East Asia, she asserted that despite a general marketisation trend, Japan and Korea had adopted a regulated institutional approach whereas a more liberal private market approach was developed in Hong Kong and Singapore. So, despite similar cultural contexts, mainly the Confucian

cultural heritage shared in these cases, the care policy variations indicate that cultural values can only partly explain the care policies implemented.

In conclusion, focusing on the family's role and cultural values, previous research has shown that related cultural values such as Confucian values are important for welfare provision, serving as the instrument of social policy for specific policy goals. The role of the family in providing welfare in relation to the state's role has been a key focus of previous studies, but few specific analyses have captured its patterns. Nevertheless, concerning the transitions in contemporary society and regional differences within East Asia, whether these findings drawn from previous East Asian studies explain the ongoing policy process in China has rarely been the focus of research, not to mention those specifically for long-term care given the conventional family-dominant care pattern which is greatly associated with cultural values.

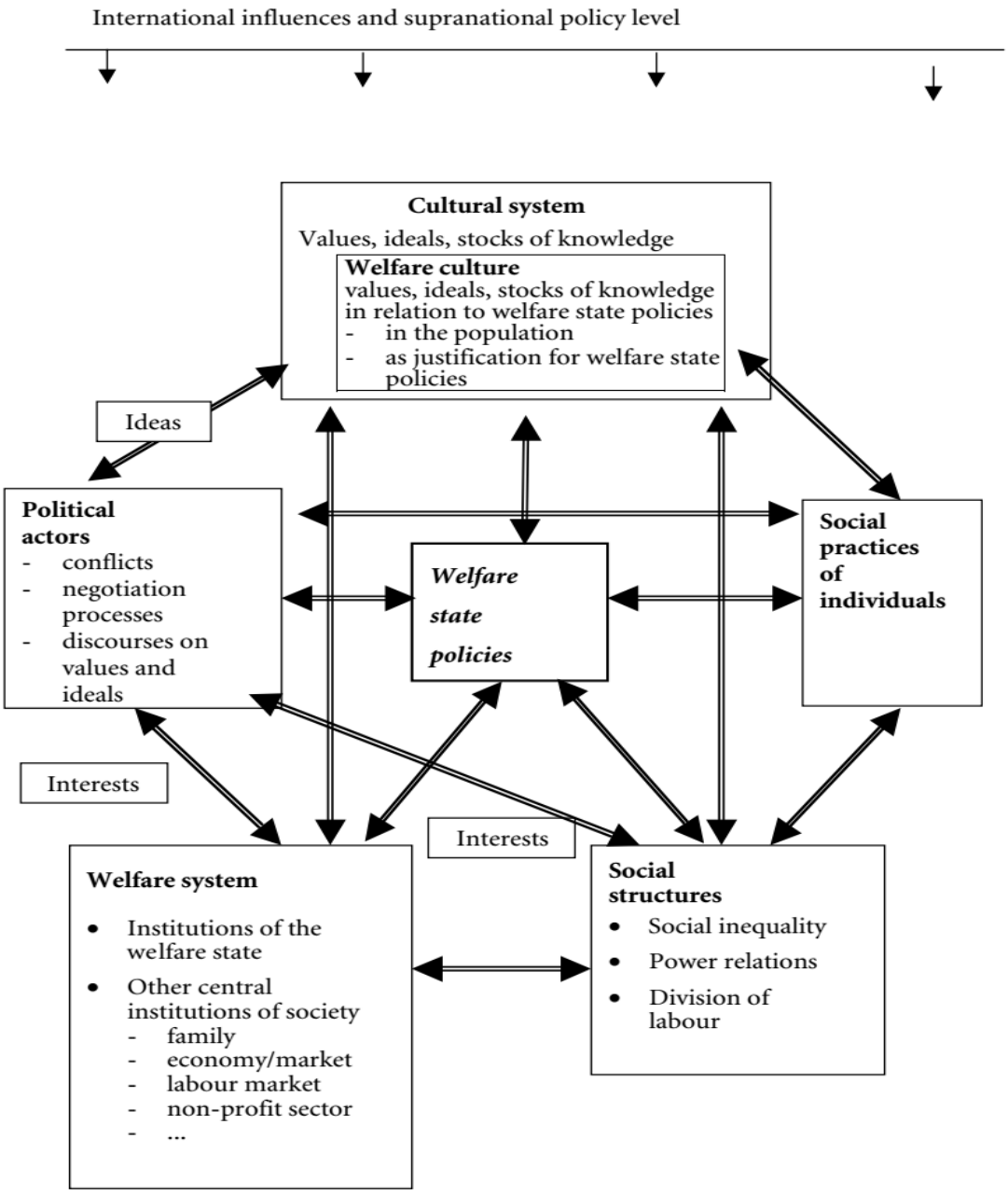
3.2 Culture and care provision within the care arrangement

Cultural values are significant in social policy analysis, as was shown in the previous section, and this is also true of care policies (Pfau-Effinger, 2005a, Pfau-Effinger, 2005b). Given that care policies represent the care task distribution between private and public actors (Daly and Lewis, 2018), the family's role in care provision is thus situated in its interactions with actors from other spheres. Emphasising cultural values and care policies, Pfau-Effinger (2005a) established a framework for analysing how cultural values play a role in the development of different paths of care arrangements, mainly in Western European countries, and these have been adopted by other scholars exploring care policies and culture (Naldini,Pavolini and Solera, 2016).

Since this current study also seeks to identify the impact of cultural values on long-term care provision, the analytical framework developed by Pfau-Effinger might also be applicable in the Chinese context. I shall therefore next consider previous studies which combined that approach to the care arrangement with cultural values.

The welfare arrangement in a society is embedded in cultural, institutional, social and socio-economic factors (Figure 3.1) (Pfau-Effinger, 2004a). Welfare state policies are embedded in a particular societal context comprising multiple elements, including the cultural system (mainly the welfare culture), political actors, the social practices of individuals, the welfare system, social structure and welfare state policies as the core of the welfare arrangement.

Figure 3.1 Interrelations within the welfare arrangement (Pfau-Effinger, 2004a)

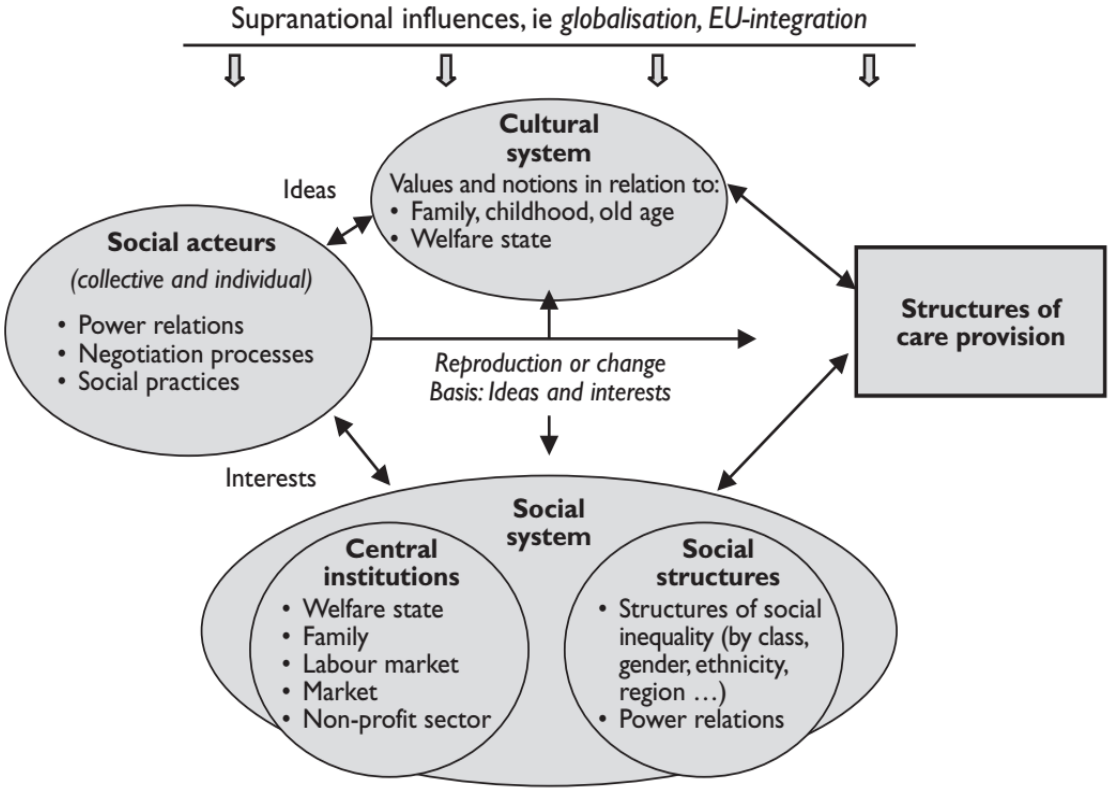


In Figure 3.1, the welfare state policies are embedded in a particular societal context comprised of multiple elements, including the cultural system (mainly the welfare culture), political actors, the social practice of individuals, the welfare system, social structure and the welfare state policies as the centre of the welfare arrangement, whether the policies are accepted by the population and whether the behaviour of individuals and social groups is associated with cultural values. The policies of the welfare state are the result of conflicts, negotiations, and compromises between social actors over ideas and interests. The cultural system and other elements are interrelated, and

culture and welfare state policies are connected through the practices of social actors. The discourses mediate between cultural attitudes in political decisions and the population (Pfau-Effinger, 2008).

Accordingly, the care arrangement specifies the analysis of the welfare arrangement (Figure 3.2) (Pfau-Effinger, 2005a). Elements are specialised in care provision based on Figure 3.1, such as the cultural system in Figure 3.2 mainly refers to cultural values concerning the family, childhood, old age and welfare state. This demonstrates the impact of cultural values on care provision. For example, the family-oriented culture profoundly impacts policy formulation in Germany. Family values changed because of demographic and socio-economic transitions, and those in the cultural dimension in relation to the dominant cultural values and notions in a population could be a critical explanatory factor for family policies (Pfau-Effinger, 2005b). However, similar to the welfare arrangement, whether cultural changes lead to policy changes depends on government roles and relationships with other social actors.

Figure 3.2 Care provision within the care arrangement (Pfau-Effinger, 2005a)



Within the welfare/care arrangement, culture is the subject of conflicts, negotiations and compromises between social actors, resulting in cultural change. The renegotiation processes include cultural ideas on the market/state relationship and those on the redistributive effects of welfare state policies (Pfau-Effinger, 2004a). Specifically, there exists a multi-level model for the relationship between welfare state policy and culture. The first level consists of the cultural values and models which serve as the basis. The second level consists of the cultural values and models of the population. The third level is the discourse typically employed by social actors in welfare state policy (Pfau-Effinger, 2005a). Public policy discourse is the interactive process of conveying ideas for coordination among policy actors and interaction between political actors and the public (Schmidt, 2008). The impact on political practice is led by the cultural bases determined by the power relations between social actors whilst the discourses controlled by political elites are used to shape public values for acceptance by society (Pfau-Effinger, 2004a, 2008). Similarly, Van Oorschot,Opielka and Pfau-Effinger (2008)showed that different cultural changes present chances or opportunities for welfare state development, but whether this could be put into practice depends on government roles and the relationship between government and other social actors (Pfau-Effinger, 2008).

Specifically for the care arrangement, cultural values are primarily welfare values and family values. Welfare values are cultural values and notions concerning welfare provision in society. They include values related to who should be responsible for providing care outside the family, whether social rights relating to care should be family-based or individual-based, and welfare state redistribution. Family values pertain to the family structure and the gender division of labour, which are associated with how the family should function with other societal institutions. That is, whether the family should be the primary care provider and which family member(s) within the family should carry the responsibility (Pfau-Effinger, 1998, 2004b, 2005a). Thus, welfare values can be viewed as the cultural values and notions about the central actors for providing welfare in society, whereas family values are those about the family structure and the gender division of labour.

Notably, as with family values within the care arrangement, gender issues are essential when analysing care policies (Pfau-Effinger, 1998, Pfau-Effinger, 2010, Naldini,Pavolini and Solera, 2016, Akkan, 2018). Kremer (2007) argued that the concept of ‘ideals of care’, meaning ‘what is considered to be good enough caring’, are the moral images shaped culturally which can explain the cross-national differences in policy choices within the development of social policy, particularly concerning the values related to the gender division of labour, such as professional care in Denmark and a massive alliance of mothers and surrogate mothers in the Netherlands.

Using the care arrangement to analyse care policies, the diverse paths of care arrangements in European countries reflect differences in traditions related to the cultural values of the family and the concepts of gender equality, as well as those in the values associated with welfare provided outside the family and the comprehensiveness and quality of social rights (Pfau-Effinger, 2005b). For example, in Germany, with the additional benefits to families and the support obligations assigned to families for public support entitlement, the family is exemplified as the redistributive principle of the welfare state (Frericks,GurÍN and HÖPpner, 2023).The family-oriented culture there profoundly impacts policy formulation in Germany. Its family values have changed because of demographic and socio-economic transitions, and different cultural changes in relation to the dominant cultural values and notions in a population could be a critical explanation for the family policies.

Therefore, reviewing Pfau-Effinger's studies, the impacts of cultural factors on welfare provision and care provision have been explicitly shown in the analyses focusing on the interplays between various societal institutions. Regarding the care arrangement, cultural values, including welfare values and family values, are explanatory in the cross-national differences in care policies. They are more than just shaping individual behaviours as the values are shared by the majority of the population, but also the discourses used by political actors in social policy. Whether they do have an impact on social policy is determined by the power relations between the different social actors. The approach to care arrangements provides an analytical framework for exploring how cultural values affect care provision, which perfectly fits the research questions of this current study.

However, these frameworks may not fit the case in China, particularly with multiple considerations for policymakers embedded in its specific central-local government interrelations. Other elements, such as the social and cultural systems, also differ in China, and long-term care policy should be subjected to a more specific analysis, as should the social practices of individuals primarily determined by the insurance scheme. To answer the research question regarding cultural factors and long-term care arrangements (RQ4), I shall develop a specific analytical framework for China based on the works of Pfau-Effinger (*see* section 3.5).

3.3 Cultural values and care provision in China

Regarding two research questions asked in this study (RQ1 and RQ4), it is essential to outline the cultural values in China, particularly with regard to the family's role in providing care. This section contains two subsections. The first provides an overview of the cultural values regarding family caregiving, laying the groundwork for the analysis of whether social values change (RQ1). The

second provides a more in-depth summary of how cultural values are incorporated into social policies in China based on previous research, which provides evidence that the explicit discussion regarding cultural values has evolved in recent years (RQ4).

3.3.1 Cultural values about care provided by the family in China

According to the care arrangement introduced in section 3.2, family values refers to whether the family should be the primary care provider and which family member(s) should assume care responsibility (Pfau-Effinger, 2005a). Specifically in China, a vast body of the relevant literature focuses on the cultural values concerning the family's role in care support, generally covering three key issues: (1) the family's responsibility, (2) the intergenerational contract and (3) gender roles within the family.

3.3.1.1 Family responsibility for care provision

The family values are traditional and collectivist value orientations for the family with a normative character (Kagitcibasi, 2017), so adherence to family values contributes to maintaining the family's role in supporting its older members. In Chinese society, family members are obligated to the family because the family is perceived as the "great self" (Yeh and Bedford, 2003) and caring for older people is a principal value of Chinese families (Wang, 2004).

Family responsibility is one of the most important issues in Chinese culture. In the traditional Confucian culture, there are several principles for a harmonious family: *Xiao*, filial piety, respect, support and obedience to parents and older people; *Cong*, a woman's obedience to her father, husband and son; and *Yang*, support for widowed older people, vulnerable people and orphaned children (Shang,Fisher and Guo, 2014). These deeply rooted Confucian values emphasise the responsibility of family members for one another.

Filial piety, as the most distinctive characteristic of Chinese culture, is a prominent ethic for supporting older parents (Brasher, 2021). It refers to the family lineage, guaranteeing the care for children and older people within the family, including both moral virtue and material aspects, as both a normative duty and a legal obligation (Chan and Tan, 2004, Whyte, 2004, Hashimoto and Ikels, 2005, Chow, 2006). In particular, filial responsibility has more to do with social and cultural norms than with individual beliefs, given that it is viewed as an obligation (Zhang,Clarke and Rhynas, 2019). It is generally based on affection or authority (Yeh and Bedford, 2003, Yeh et al., 2013), and affection is more influential in shaping the preferences of older people (Fu,Xu and Chui, 2020).

Specifically for care support, filial piety encourages people to take on family responsibility. The more adult children endorse filial norms, the more likely they are to support their parents, affirming the function of cultural values in shaping the family's role (Lin and Yi, 2013). The withdrawal of the state from supporting individuals makes the family the last bastion of individuals resisting societal risks, providing a solid ground for continuing reciprocal filial piety (Shi, 2017a). It is claimed, however, that filial piety only correlates with the provision of emotional support and has a relatively weaker impact on financial support and companionship, despite the vital role of filial piety in Chinese culture (Chappell and Funk, 2012). In that way, filial piety becomes more spiritual and less realistic. There are thus growing debates about the realistic and spiritual aspects of filial piety.

The interpretations of filial piety in China have been modified and modernised with the undergoing social transitions (Chan et al., 2012, Yeh et al., 2013, Lum et al., 2016, Shi and Wang, 2019, Zhang,Clarke and Rhynas, 2019, Bedford and Yeh, 2021), and 'caring and supportive but not obedient' is the new understanding of filial piety accepted by many. By relinquishing the hierarchical demands for the subordination of the young to the old (Yan, 2003), the new norm of filial piety emphasises mutual respect between generations as "mutual need, mutual gratitude, and mutual support for the two-way exchange of support and care" (Croll, 2006). Industrialisation and modernisation have undermined the foundation of traditional values and weakened the norm of filial piety, leading to a strengthened consciousness of independence and weakening expectations of reciprocity, given that the unique family structure of extended family for supporting filial piety is disappearing (Sheng and Settles, 2006). Nevertheless, despite the changing nature of filial piety with social transitions, cultural values remain important for family care decisions in China (Zhang,Clarke and Rhynas, 2019).

Another distinguishing characteristic of Chinese culture is familism. Familism emphasises the blood bond between generations within the family for the nurturing and exchanging of intergenerational relationships (Hashimoto and Ikels, 2005, Silverstein, 2005, Cong and Silverstein, 2011a). In essence, familism is the antithesis of individualism (Yan, 2018), prioritising the needs of the family over those of the individual (Albert and Ferring, 2018). Thus, the crucial role of the family in providing care is a natural reflection of culture (Duckett and Carrillo, 2011).

The erosion of Chinese family cohesion has caused massive concern in the literature, as individuals may be less willing to assume responsibility for the care of older family members. There is a decline in traditional values, including the eclipse of family values, decreasing parental responsibilities, the loss of traditional gender balance and the decreasing parental authority within the family (Sun and Chen, 2015), related to the increasing individualism and economic rationality in modern society (Yan,

2010, Zhang and Kulich, 2010, Yan, 2011, Hu and Scott, 2016), as well as the developing modernisation and marketisation (Cheung and Kwan, 2009). There is a “descending familism” referring to the new filial piety, changing intergenerational reciprocity and family life in contemporary Chinese society (Yan, 2016). Given the prevalence of individualism, especially among younger generations, there is less emphasis on the necessity for families to provide care for older people (Lei, 2013).

However, the individualisation arguments indicating that family ties and responsibilities are weakening have been refuted. With multiple challenges under social transitions in China, individuals can seek support from their families, thus reinforcing the utility of intergenerational relationships, as family collectivism and mutual dependence continue to rank higher than individualism (Xu and Xia, 2014). The reinterpretation and renegotiation of filial obligations alongside the ongoing societal changes for modifying filial behaviours in China should not be neglected, although filial relations are more associated with financial and emotional support for parents and less with authority (Qi, 2016). Despite generational differences in how to balance family and individual interests, the emerging neo-familism continues to prioritise the family's collective interests over the individual ones, even with societal shifts. The state thus withdraws from social welfare provision to relieve the financial burden, develop a more individualised economy and promote political stability through familial and collectivist thinking and social practice to encourage the family to act as the foremost provider of social welfare (Yan, 2018).

The changing social attitudes towards family responsibility impact the care provided by the family, as with differences between older and younger generations. With the decline of filial piety, family support has often been reduced to merely satisfying the most basic and essential needs of elderly members (Chow, 2006). The older generation shows a more adaptive expectation towards intergenerational relationships and social changes, a more substantial perception of filial piety to expect family care responsibility, and a strong belief in parental responsibility (Tang et al., 2009). Compared with young and middle-aged adults, older adults are more likely to endorse beliefs about individual independence instead of traditional filial obligations (Tang et al., 2009). With the broadening concept of filial piety, more older people are willing to receive care from beyond their families, such as from professional home-care workers and nursing homes (Zhan,Xiaotian and Baozhen, 2008). Accordingly, the younger generation is more likely to expect the development of formal support beyond the family to support them in fulfilling their filial obligation (Du, 2013).

In conclusion, cultural values such as filial piety and familism, which emphasise the importance of family in supporting individuals, remain entrenched in China. Nonetheless, as a result of multiple

societal transitions, conventional family care provision has been challenged alongside a decline in filial piety and a rise in individualism in opposition to familism, especially with intergenerational differences within families. Given that cultural values are not static and that existing arguments outline the current state of Chinese society, additional analysis is required for this study.

3.3.1.2 Cultural values and intergenerational contract

As demonstrated in section 2.4, the intergenerational contract is one of the primary motivations for individuals to provide care for their parents, and cultural values are significant in preserving the intergenerational contract. The intergenerational contract is a social exchange for intergenerational care and the reciprocal relationship between generations (Dowd, 1975). It is critical to analyse the family's role in providing care, given that adult children are the primary care providers in many Chinese families (Bedford and Yeh, 2019). Specifically, family values in China usually relate to filial piety, patrilineality, and gender roles (Hu and Scott, 2016).

Intergenerational contracts are closely associated with filial piety (Lin and Yi, 2011). Yeh and Bedford (2003) established the dual filial piety model (DFPM) to capture the intergenerational relationship within the family. It divides filial piety into reciprocal and authoritarian aspects. Reciprocal filial piety (RFP) is affection-based and corresponds to "the natural inner disposition of the filial ethic", referring to adult children being willing to provide care for their parents spontaneously. Authoritarian filial piety (AFP) is based on obedience to normative authority (the role of parents), as parents usually set models to shape their children's behaviours during growing up. In addition, AFP is associated with patriarchy in Chinese history as it was used to confirm political legitimacy. AFP is positively correlated with traditional and conservative attitudes compared with RFP (for instance, male superiority and submission to authority) and they influence the intergenerational contract in different ways (Yeh et al., 2013). These filial norms change over time despite the fact that no consensus has been achieved. In rural areas of China, for instance, filial norms have been adapting to urbanisation-driven shifts with unknown consequences (Cong and Silverstein, 2019). However, Wang,Wan and Gu (2023)argued that there has not been a significant decrease in RFP or AFP in China.

It should be noted that expectations for the family are complex because they are generational, and each age cohort has different conceptions and expectations regarding family interactions (Jankowiak and Moore, 2016). The filial piety shared by older people is more based on reciprocity than authority. Older people have lowered their expectations towards the obligations fulfilled by their children, and the parent-child relationship has become more egalitarian and reciprocal, particularly being impacted by the one-child policy (Fu,Xu and Chui, 2020). For both old parents and

their adult children alike, the ultimate goal of their hard work and their meaning in life are fixed on the happiness and success of the children of the third generation, thus leading to a downward flow of tensions, care, love and family resources in descending familism and paving the way to intergenerational intimacy (Yan, 2016). Moreover, the family focus has also shifted from older people to grandchildren, as both the younger and older generations work together to raise the third generation within the family, strengthening the bond between generations (Yan, 2016, Yan, 2018). Thus, social attitudes towards intergenerational contracts have become more pragmatic and realistic, particularly among the older generation. These changing social attitudes also shape family responsibility for individuals in everyday life, and the family is assumed to be the last resort for the individual to resist risks in Chinese society (Shi, 2017a).

Even in intergenerational contracts, there are different expectations of sons and daughters in terms of caring for their parents. In the family system of the traditional patriarchal society, only sons could continue the family lineage, and they were vital to their parents' economic support in rural areas (Ebenstein and Leung, 2010). Sons are expected to provide more care, influenced by this patriarchal culture (Lin and Wong, 2013) and they are permanently assigned the significant responsibilities of caring for their older parents (Lin and Yi, 2013). Correspondingly, daughters support their parents until their own marriage, when their primary responsibility shifts to their husbands' parents after marriage (Whyte, 2004). This conforms to the old Chinese proverb 'married daughters are like splashed water that cannot be retrieved' (Hu and Scott, 2016), shifting a woman's responsibility and contribution from her biological family to her husband's family. For this reason, intergenerational transfers between daughters and elderly parents resemble short-term, approximating reciprocal exchanges, whereas intergenerational transfers between sons and elderly parents are long-term contracts (Song,Li and Feldman, 2012). Despite this, in contemporary China, daughter-parent contact has increased in post-reform rural society due to the market reforms and the implementation of the one-child policy (Zhang, 2009). Cai and Feng (2021) also summarised that both parents and their children have modified their expectations in response to the new demographic reality mainly impacted by the one-child policy, including regarding care provided by daughters.

Regarding the care provision shaped by the intergenerational contract with gender differences, the care provided for parents varies for sons and daughters, including the care type and preferences for care delivered by sons or daughters. First, sons and daughters usually provide different types of care support. Lin,Fee and Wu (2012) noted that sons offer more financial and daily assistance and receive more help from their parents whereas daughters provide more emotional support, and Lei (2013)

contended that daughters are more likely to provide instrumental support than their male siblings in urban areas. Second, given that daughters are regarded as the "little quilted vests" who were more filial than sons (Shi, 2009), some older people prefer and receive care from daughters with greater filial piety due to the moderation effect, whereas the older mothers and fathers may have different considerations (Cong and Silverstein, 2012a, Yi et al., 2016), particularly in rural areas (Cong and Silverstein, 2012a). Despite parental preference for daughter-provided care, daughters typically receive a lower return than their brothers, even when providing care for their parents (Hu, 2017). In addition to the care from adult children, the informal care from daughters-in-law is controversial, whereas Wang et al. (2020) revealed that daughters-in-law with rural hukou fulfil more care duties than daughters in China due to the traditional gender norms and Confucian filial piety.

The urban-rural division also mattered in gendered care provision based on intergenerational contracts in China. There is an evident perception of reliance on sons due to traditional son preference in rural China (Zhang and Wang, 2010, Murphy,Tao and Lu, 2011). Sons usually provided more financial support than daughters to their parents in rural areas, whilst daughters provided more instrumental and emotional support than their male siblings in urban areas but no significant differences in rural ones (Lei, 2013). As has already been stated, particularly in rural areas, older parents usually provide essential support (mainly non-financial support, such as caring for grandchildren) to their adult children for a greater financial return (Takagi and Saito, 2013). Although there might be an attenuation of son preference under the socio-economic changes in Chinese society in rural areas (Murphy,Tao and Lu, 2011), different preferences towards the care provided by sons and daughters remain with the gendered filial norms deeply rooted in the stronger endorsement of traditional values (Cong and Silverstein, 2012a, Cong and Silverstein, 2012b).

Nevertheless, these gendered patterns may have changed. There is a weaker gendered division of parental care tasks as the patriarchal tradition for care provision declines and a stronger social pressure for shaping caregiving behaviours develops, and the caregiving performance of the family is related to structural factors such as family size, the absence of support for older people (public pension scheme), and the status and income of caregivers (Zhan and Rhonda, 2003). In addition, married daughters, especially those who live with their parents, usually provide more financial support to their parents than married sons, possibly resulting from the change in the family concept in urban areas and the increase in women's economic resources (Xie and Zhu, 2009).

In summary, although the traditional intergenerational contract related to reciprocity and filial piety emphasises support between generations, particularly for the younger generation to provide care for the older one, the differences between generations and between sons and daughters within the

younger generations should also be noted because they have affected care provision in some way. Since intergenerational contract is one of the motivations for family care provision (*see* section 2.4.1), the discussion about social attitudes towards intergenerational contract is essential for this study, particularly for RQ1 and RQ3.

3.3.1.3 Attitudes towards gender roles in care provision

In Confucian culture, highlighting filial piety, the family is the primary care provider, particularly the women within the family (Cook and Dong, 2011). The traditional gendered care provision is consistent with the Confucian values in Chinese society, in which women should follow 'the virtue of three obediences': "to the father, the husband and the son" (Gao, 2003), as women belong to their families-in-law and become strangers to their natal families after their marriage (Sung and Pascall, 2014). Thus, social attitudes towards gender roles in providing care are essential for the provision of family care.

Even though China is home to Confucian morality and has institutionalised a patriarchal ideology for thousands of years, changes in female status have emerged since the founding of the People's Republic of China in 1949. As stated in section 2.3.3, women were encouraged to play a crucial role in state building (Tiefenbrun, 2017), along with growing feminism (Manning, 2006). The reforms since the 1980s in China have accelerated the marketisation and urbanisation, enlarging gender disparities to a certain extent (Berik,Dong and Summerfield, 2007). There is a revitalisation of traditional gender values by reemphasising women's personal issues and domestic responsibilities in public gender discourse shaped by the mainstream media in urban China (Sun and Chen, 2015).

The impact on gender roles since the reforms was mixed, given that gender inequality had reduced and women's status had increased with the growth of the market economy but gender differences in wages and working status had not changed (Yang, 2016b). It was found that there was a decreasing trend of attitudes towards the traditional gender division of labour and patrilineal beliefs in China based on the survey data in 2006, in which higher education, women's employment and smaller family size mattered (Hu and Scott, 2016). Nonetheless, it was claimed that social attitudes towards gender equality had not changed in China. Based on data from 1995 to 2007, most Chinese people agreed that women should engage in the labour market to provide an economic contribution to the family while a large proportion of people believed that men should have more access to valuable resources than women. Notably, the college education of individuals showed a positive impact on the egalitarian attitude and it had increased over time (Shu and Zhu, 2012). It was also found that

women's income has a strong negative effect on attitudes towards traditional gender roles in China based on the 2013 data.

Therefore, alongside the social reforms of preceding decades, the issue of gender inequality has gained increased public attention (*see* section 2.3.3), many studies revealed changing social attitudes towards traditional gender roles, as well as possible explanations. However, social attitudes towards the gender role in providing care remain unclear, especially with the development of the care system in contemporary China.

To sum up, section 3.3 reviewed the primary cultural values associated with the family's role in providing care. Although cultural values have been long debated as significant in the family supporting its members, as filial piety, familism, the intergenerational contract and the gender role for care provision are all important for explaining why the family should and will provide care support, these values have been challenged under the various social transformations in China, but the precise picture lacks up-to-date analysis. RQ1 in this study therefore focuses on the current social attitudes in China, including social values towards the roles of the state and the family, as well as those related to intergenerational and gender issues. In addition, the persistence of these cultural values and their effects on family care provision, in terms of both individual care decisions and care policies, require further discussion, particularly when analysing the development of long-term care in China (RQ4).

3.3.2 Cultural values used in social policies in China

As discussed in section 3.1, the state employs cultural values as political instruments (Goodman and Peng, 1996, Walker and Wong, 2005). Particularly in East Asia, family policy is legitimised by Confucian familism (Lee, 2018), in which Confucianism values serve the welfare states over economic development (Ochiai and Johshita, 2014, Schmidt, 2018). Whether the case in China parallels these findings has not yet been investigated. Given that this study examines whether cultural values influence care arrangements in contemporary China, in this section I explain why and how cultural values are utilised in social policy in China by referencing previous research.

Many scholars share the view that Chinese cultural traditions, such as Buddhism, Confucianism and Taoism, conceive social orders and behavioural norms according to respect for authority, preference for harmony and group orientations (Rozman, 2002, Shin and Sin, 2012, Zhai, 2018), and paternalism, hierarchical obedience, harmony and group primacy are important (Chang,Chu and Tsai, 2005, Zhai, 2017).

Confucianism, as the most influential cultural tradition in China, profoundly constrains the state's political goals. Its emphasis on harmony promises to counterbalance the West's egocentric value system and provide an attractive alternative to the confrontational worldview that has come to characterise Western culture (Wang and Lu, 2008). In contrast to Western civilisation, Chinese traditional values are seen as favourable to authoritarian political regimes (Inglehart and Baker, 2000), and Confucian values have a negative effect on individual democratic values (Chang,Chu and Tsai, 2005). In addition, traditional Confucianism shares similar core values with socialism, consisting of the love of social order and stability, acceptance of hierarchy and devotion to the family and the state. Thus these values are qualified to legitimise authoritarian rule (Shi, 2001). Nevertheless, Confucianism has also been criticised; Zhai (2018) cited (De Bary, 1998) argument commenting that Confucianism is the ideological justification for one-party rule, for openly rejecting peaceful evolution to democracy, and for suppressing demonstrations .

Cultural values are also used to preserve social stability in China. Zhang (2010)stated that China has used indigenous philosophies and traditional culture to develop the collective socialist ideology which has emerged in China due to the transition to a market economy and Edney (2012) commented that it serves the CCP's domestic political goals. Given that self-discipline is the foundation of the ideal social control in China, in situations where one person's interests clash in important ways with those of another, the Chinese opt for non-confrontational approaches to resolving the conflict and are willing to sacrifice their own interests for society's harmony as a whole (Shi, 2001). Individuals are typically expected to submit to parental authority and place their own interests behind those of the family (Yan, 2018). In this way, as Chinese culture's significant idea is collective responsibility, the government emphasises it for specific political purposes.

Individual political loyalty can be influenced by the logic of filial piety in the context of family relationships. As Zhai (2018) reviewed prior literature, citing Kaji (1990) work that filial piety in the family shapes an individual's character and strengthens political loyalty, and filial piety at home is thought to serve as the foundation of political trust in the government. Hahm (2004) stated that family ethics positively correlate with the family-and-state system's political orientations. The more filial piety there is in the family, the higher the possibility that the family members are loyal to the state.

These arguments demonstrate that specific cultural values are emphasised in China to fulfil the state's goals, consistent with the discussion in the preceding sections regarding the East Asian context (*see* section 3.1.2). Despite the deeply rooted cultural values emphasising the importance of

the family (*see* section 3.3.1), there has been little focus on care policies in China. This study therefore investigates how cultural values related to family care provision influence care policies.

3.4 The state's role in care provision: Interaction between central and local governments

Cultural values, particularly those pertaining to family issues, are used alongside political considerations in China (*see* section 3.3.2), generally following previous arguments in East Asia. However, in the case of China, the unique government system which combines political centralisation and fiscal decentralisation has to be taken into account. Given that the long-term care development on which this study focuses is also a policy experiment at the local level under national guidelines, it is evidently of great importance. In this section, I shall therefore look at previous studies which examined the interactions between central and local governments, particularly those related to care provision and local government, in order to contribute to the analysis of care arrangements in RQ4.

Despite political centralisation, redistribution at the central government level is becoming an increasingly important issue in China (Hong and Ngok, 2022a). In the context of cost containment in a country with such significant regional differences, decentralised policymaking is vital for the bottom-up policy experiment in China (Heilmann, 2008a, Shi, 2012a, Li et al., 2019) and decentralised experimentation has decisively shaped policymaking in social welfare domains (Zhu and Zhao, 2021). Accordingly, the structure of central/local relations is conducive to the formulation and implementation of diverse welfare policies in China (Zhu, 2016, Guo and Zhao, 2022), and the power balance between central and local governments has been shaped decisively according to the centre's will (Kostka and Nahm, 2017).

The interaction between the central and local governments is the core issue of policy analysis in China. The authority of the central government over local policy exploration has been extensively discussed in the previous literature. Policy experimentation and diffusion among Chinese local governments in economic policies and public services results in economic growth and political adaptability to an environment which is constantly changing and complex (Heilmann, 2008b). To provide more financial support, the local governments can increase the central government's influence on the local government and the likelihood of policy adoption (Jiang and Zeng, 2020). Accordingly, vertical pressure from the central government rather than the local need (most recently the severity of the pandemic) was significant in the policy adoption by local governments during the

pandemic (Tai,Yao and Pizzi, 2022). Specifically, there has been strict control over the policy implementation process in the top-level design in the Xi Jinping era (Schubert and Alpermann, 2019). As for the research questions in this study, long-term care insurance was developed as a pilot programme at the city level, and the local governments have been granted significant autonomy for their exploration and innovation.

It should be noted that for the central-local government interaction in China, different vertical levels of government are identified as 'local', corresponding to the central government. For instance, the provincial governments play essential roles in the political system in China as intermediary agents, aligning local governments with central policy objectives (Guo, 2020). Particularly in the economic aspect, the provincial governments are essential for the local development trajectory under political centralisation and fiscal decentralisation in China, given that provinces create and shape 'development space' for different industries and localities (Jaros and Tan, 2020).

Many scholars take the central-local interaction into account in the analysis of welfare provision, showing that there might be an alienation of public service motivation between central and local governments. Even if policymakers at the national level are intent on providing universal social welfare coverage, local governments are more concerned about economic growth and fiscal resource allocation for productive purposes (Li and Zhou, 2005). In such decentralisation in the social welfare system in China, there is even a 'race to the bottom' among local governments in providing social welfare (Zhu, 2016), leading to welfare 'regions' rather than the welfare 'state' in China (Shi, 2012a). Local officials might prefer projects with more observable and easier-to-measure policy outcomes, contributing to short-term economic growth for their political advancement under China's current performance system (Gao, 2015, Qian and Mok, 2016, He,Zhou and Huang, 2016).

Thus, characteristics of the welfare provision in China are drawn. Qian and other scholars have reported pragmatic and paternalistic welfare paradigms in China, as social policies are implemented based on the rationale of economic development rather than citizens' social and welfare needs for the local government in the decision for economic growth and social protection (Qian and Mok, 2016, Qian et al., 2019). Mok,Kühner and Huang (2017) further summarised that with the widening regional disparities in China, there is a productivist construction of selective welfare pragmatism, in which local governments adopt their local exploration when maintaining productivism in welfare production. The local government ranks achieving the goals set by the upper government with the risk-aversion preference instead of better satisfying the care needs of the public. Particularly, Zhang (2020) asserted that the policy is a compromise of the interests of the actors involved, in which the government and its bureaucracies can be motivated by diverse forces as social policy objectives are

included as ‘hard target’ indicators which can secure the promotion of local cadres, so the logic of the ‘promotion tournament’ is shifting.

So because of the unique central-local government relationship ingrained in China’s political system, the interaction between central and local government, as well as the role of local government in policy experiment discussions, is crucial to social policy analysis in China. Since the long-term care insurance in China on which this study focuses is also a local exploration, these arguments should be included in this section for the care arrangement discussion, capturing how the cultural values are linked to care policy for RQ4.

3.5 Conclusion

Culture is significant for analysing welfare provision (Pfau-Effinger, 2002, Pfau-Effinger, 2004a, Stjernø, 2008, Opielka, 2008), as well as in the discussion of East Asian societies (Chau and Yu, 2005, Jo, 2013, Peng, 2018). Given that the family remains the primary welfare provider in East Asia, as shown in Chapter 2, relevant values are important for understanding the welfare provision systems there. Many prior studies have summarised the role of culture in care policies in Western countries (Pfau-Effinger, 2004a, 2005a, 2008), affirming the role of culture in shaping care policies.

Specifically in the Chinese context, cultural values emphasising the family’s role in supporting its members are widely accepted and deeply rooted, which is applicable to the patterns of care provision to a certain extent. Because its impact on care policies requires further discussion, the political consideration of the state, both the central and local governments, should be included, given the unique government system in China for shaping its social policy.

Revisiting the research questions of this study exploring the changing social values of the family providing care (RQ1) and the impact of cultural values on the care arrangement in China (RQ4), several research gaps requiring further discussion have been identified.

First, cultural factors have been overlooked in social policy analysis compared with political and economic factors, which are more apparent (Peng, 2008, Jo, 2011). Although the significant impact of cultural values has been widely suggested, they are not placed at the centre as one of the explanations for the overall pattern of welfare provision.

Second, most of the literature on cultural values and care provision has been established in a European context (Van Oorschot,Opielka and Pfau-Effinger, 2008, Pfau-Effinger, 2008). Although the family has always been the primary care provider for its members in China, and that the deeply rooted cultural values in East Asian societies emphasise the family’s core role in welfare provision as

well as care provision (Yamashita,Soma and Chan, 2013, Abrahamson, 2016), analysis of the Chinese case is relatively scant. Notably, although East Asian societies share cultural values with similar key elements (*see* section 3.1.2), specific contexts in China should not be neglected, given the unique circumstances in the country. Thus, the findings reported in other societal contexts are likely to fail to reveal the complexity of the reality in China.

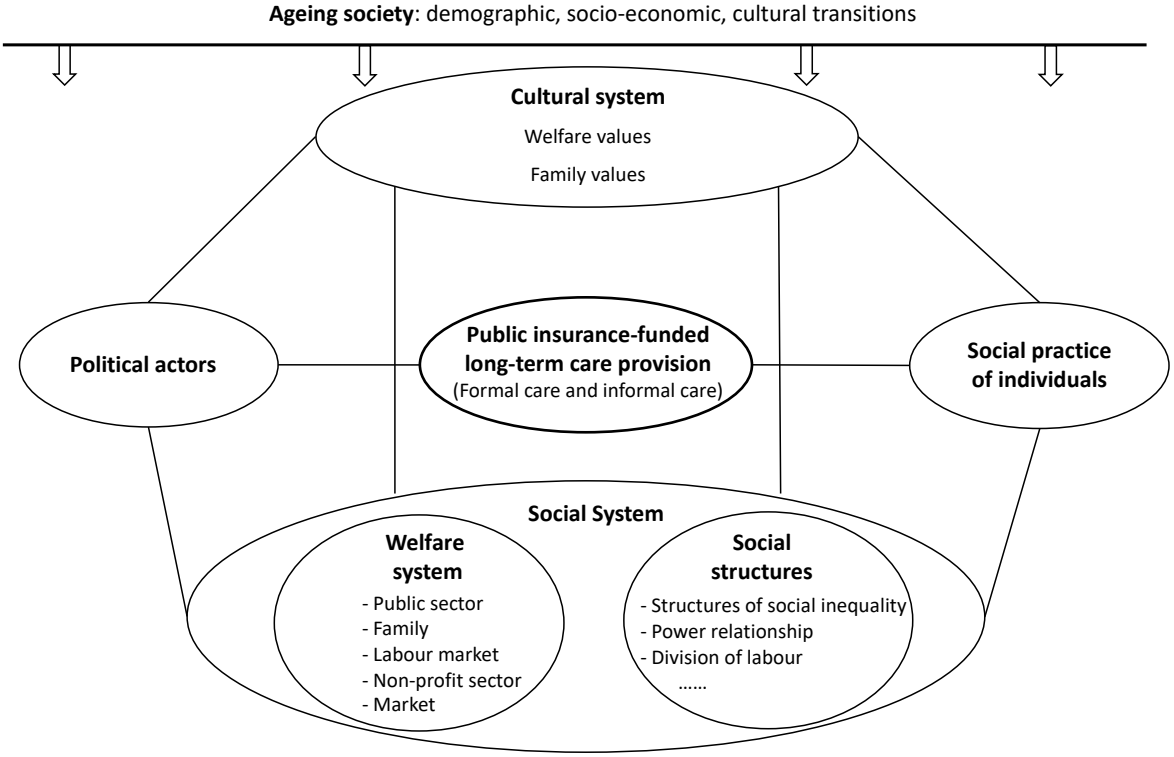
Third, although the cultural values related to the family's role in supporting its members in China have been extensively explored (Lin and Yi, 2011, Lin and Yi, 2013, Zhang,Clarke and Rhynas, 2019), how these values impact the care policies has been overlooked to a great extent, not to mention the concentration on newly developed long-term care. The interplays between cultural values and the ongoing policy experimentation with long-term care provision in China remain contested. Various impacts on actors engaged in care provision have yet to be considered. Despite the challenges faced by the care system in China, the care service provision mechanism is still under further discussion, explicitly in terms of taking cultural values into account.

Based on previous analyses of cultural values and care provision reviewed in this chapter and in Chapter 2, this study is designed to fill these research gaps by focusing on the case of China and exploring the impacts of cultural values on care provision in which the family plays a crucial role. This study captures social attitudes about the family providing care services to its members in contemporary Chinese society (RQ1), as well as extending the discussion on the cultural values within the care arrangement (RQ4), especially considering the long-term care system developed in recent years.

Regarding the interplays between cultural values and care policies (as RQ4), section 3.1 illustrates how cultural values might affect social policies, and section 3.2 explores explicitly how cultural values interact with other elements within welfare arrangement and care arrangement. This study attempts to investigate whether those debates summarised in other countries can explain the Chinese story. Based on the analytical frameworks of welfare arrangement (Figure 3.1) and care arrangement (Figure 3.2) built up by Pfau-Effinger (2004a, 2005a), another framework is developed to investigate how cultural factors impact long-term care provision within the care arrangement in China, as shown in Figure 3.3. The care arrangement in Figure 3.3 incorporates the key elements of Figure 3.1 and Figure 3.2, such as the cultural system, political actors, social system, and social practice. Transitions in an ageing society are also included. However, the complex interrelation between culture and other elements in the analytical frameworks remains unclear.

For this analytical framework in China, long-term care provision funded by public insurance schemes is the core element within the care arrangement in this study. The study redefines all these elements within the Chinese context. Cultural values in relation to care provision in China, outlined in section 3.3, and related political issues in China reviewed in section 3.4 are considered in this study. Whether and how all the elements in this framework, particularly culture and long-term care provision, are interrelated is also examined. This study thereby looks into the role of cultural values for long-term care provision within the care arrangement in China to address RQ4 (*see* Chapter 10).

Figure 3.3 Long-term care provision within the care arrangement



[Source: author adapted from Pfau Effinger (2004a, 2005a)]

4 Methodology

This study is an exploration of whether and how the family's role in providing long-term care to its members has changed over time, in both individual care decisions and care arrangements, particularly alongside changing social values in contemporary China. As shown in Section 1.4, the study addresses four research questions:

RQ1: How have social attitudes towards the role of the family in providing care changed over time?

1.1 What are the social attitudes towards the family's role?

1.2 What are the intergenerational differences in care attitudes for the family providing care support?

RQ2. How has the role of the family in providing long-term care changed following the implementation of long-term care insurance schemes?

RQ3. Are there any intergenerational differences in the care attitudes and care decisions for the family providing long-term care support? Are there any impacts from cultural factors?

RQ4. Has the care arrangement been impacted by culture?

To address these four research questions, this chapter is in five sections and introduces the project's methodology and research design. The first section identifies the philosophical assumptions of this study, clarifying the ontological and epistemological positions which were the rationales for using a mixed-method research design. The second presents the measurements and analyses of the acquired survey data using a quantitative approach. The following part explains the case study chosen, as well as the data collection and analysis procedures using a qualitative approach. The fourth section outlines the ethical issues considered during the research process and the fifth section contains a discussion of the limitations of the methodology devised for the study, primarily due to the outbreak of COVID-19 in 2020.

4.1 Research design

4.1.1 Philosophical assumptions in designing the research study

The philosophical position, primarily encompassing the ontology and epistemology behind a study is the basis for the methods of how social reality should be studied (Bryman, 2015, pp.16-17) and the methodology of how research should proceed (Blaikie, 2007, p.7). The discussion of philosophical assumptions is therefore essential to the design of this research project. Based on the

research questions set out above, the ontological position of constructivism and the epistemological position of critical realism were employed for this study, as well as pragmatism extending the discussion on ontology and epistemology. This mixed-method design was adopted because of its philosophical underpinnings.

Ontology refers to "the study of being", or "the nature of realities" (Crotty, 1998, p.10; Ritchie et al., 2014, pp.4-5). It is about 'what is' for how things really are and how they work (Scotland, 2012, Ritchie et al., 2014), as well as a social enquiry into the existence of social reality, the units making up the social reality, and how these units interact (Blaikie, 2007, pp.6-7). The ontological assumptions are generally about how the research questions are formulated and conducted (Bryman, 2015, pp.30-31).

Constructivism refers to the fact that "meaningful reality is contingent upon human practices, being constructed in and out of the interaction between human beings and the world, and developed and transmitted within an essentially social context" (Crotty, 1998, p.42) . From this worldview, knowledge is based on the understanding of phenomena and the interaction with social actors and can be seen as a social and historical construction (Creswell, 1998, pp.24-25; Creswell, 2014, p.8; Bryman, 2015, p.29). Because there are various realities, different interpretations might result from any research endeavour (Appleton and King, 2002). That is, regarding constructivism, social realities are constructed, and different elements integrated into the social system should be focused on.

As introduced in the preceding chapters, the core debate in this study is the role of family in long-term care provision embedded in contemporary Chinese society with changing social attitudes towards care responsibility, and the role of cultural values in the long-term care provision within the care arrangement in which multiple actors are involved. The discussion should be interpreted as a social construction concerning the interplays between different elements, such as cultural values about the family's role and the involvement of various actors (primarily the family and the state) in the care arrangement. Based on the research questions, the ontological position of constructivism, was considered to be the most appropriate paradigm for this study.

Epistemology is the nature and forms of knowledge, referring to the claims or assumptions made about how to gain knowledge of this reality, presenting a justification for what can be interpreted as knowledge (Crotty, 1998, p.8; Blaikie, 2007, p7). It is a way to understand and explain "how we know what we know" (Crotty, 1998, p.8) , providing a philosophical grounding for interpreting the essence of knowledge with adequacy and legitimacy (Maynard, 2013).

Although there has not yet been a consensus on how to best capture the nature of social entities, positivism and interpretivism are the most frequently debated approaches. Positivism advocates that the study of social reality and beyond should apply the methods of the natural sciences (Bryman, 2015, p.24), seeking to ensure that the research outcomes are not biased by the researcher's values (Doyle,Brady and Byrne, 2009). One common description of interpretivism is social constructivism (Denzin and Lincoln, 2011). The subjective meaning of social actions is significant because it is frequently interpreted as “an alternative to the positivist orthodoxy” (Bryman, 2015, p.26).

Critical realism is also widely discussed, specifically referring to “to recognise the reality of the natural order and the events and discourses of the social world” (Bryman, 2015, p.25). It is usually useful for evaluation-based studies because it strengthens the dialogue and compatibility between quantitative and qualitative approaches (Maxwell, 2010). By acknowledging various points of view, critical realism integrates quantitative and qualitative approaches (Shannon-Baker, 2016) and is therefore suitable for mixed-method research with the acceptance of the existence of different types of objects of knowledge with different ontological and epistemological characteristics and meanings (Venkatesh,Brown and Bala, 2013), as in this study.

Compared with these forms emphasising ontological and epistemological assumptions, pragmatism is a well-developed philosophical underpinning for integrating perspectives and approaches and also provides justification and logic for the use of mixed methods, in contrast to these forms which place emphasis on ontological and epistemological assumptions (Johnson,Onwuegbuzie and Turner, 2007). It is pluralistic and oriented towards what can work and be practised, focusing on the consequences of research, weighing the significance of the questions to be investigated higher than the methods adopted (Creswell, 2014, pp. 10-11).

With the claim of ‘double-faced knowledge’, for pragmatic researchers, any knowledge can be viewed as observable or unobservable depending on their ontological positions rather than the nature of knowledge *per se* (Maarouf, 2019). It recommends a balance between subjectivity and objectivity throughout the inquiry (Shannon-Baker, 2016), thus being considered as “a coherent, integrated paradigm with clear philosophical stances that lie in the middle of the quantitative, qualitative paradigm continuum” (Maarouf, 2019, p.10) . As an approach strongly appropriate for mixed-method research (Cameron, 2011), pragmatism emphasises using all approaches available in order to understand a problem (Rossman and Wilson, 1985). It is related to an action-oriented, problem-solving inquiry process (Greene and Hall, 2010). Notably, both quantitative and qualitative research approaches can be used in a single study as the research questions should be the primary

focus of the research rather than the methods, as a practical and applied research philosophy to guide the methodological choices (Tashakkori and Teddlie, 2003). According to pragmatism, researchers are free to select the strategies, tactics and processes that most suit their needs and purposes (Creswell, 2014, p.11). Thus, as stated in many previous studies, pragmatism is a set of ideas, referring to the use of diverse approaches which work for answering research questions.

Returning to the research questions, this study is an examination of social attitudes towards family care provision, the family's role in providing long-term care and the impact of cultural values on care arrangements in China. The interactions between different elements of the social system are the central topics which this study was designed to investigate. With ontological constructivism and epistemology from a critical realist perspective used in this study, the interpretations are driven by the evidence concerning the different actors involved in long-term care provision and related explanations for their care attitudes and behaviours. Instead of limiting itself to the distinction of specific ontological and epistemological positions to describe how this study understands and explains the world, pragmatism that goes beyond any specific philosophical position is also appropriate for the research questions addressed in this study. It enables the integration of various methods to capture both the overall social attitudes and the interplays of different social actors in care provision, guiding the methodology of this study.

4.1.2 Mixed method of quantitative and qualitative approaches

Quantitative and qualitative research differ with respect to the role of theory, epistemological issues and ontological concerns and represent different research strategies (Bryman, 2015, pp. 31-32). In accordance with the ontology and epistemology guiding this study, a mixed method which combines quantitative and qualitative approaches was used for the different research questions in this study.

Quantitative research strategies are deductive for testing theory as a top-down approach, whereas the qualitative strategies are inductive for the generation of theory as a bottom-up approach (Glogowska, 2011, Ritchie et al., 2014, Antwi and Hamza, 2015). Neither quantitative research nor qualitative research are entirely straightforward, so the pragmatic approach is an effective alternative by emphasising the abductive, intersubjective and transferable aspects of the subject being researched (Morgan, 2007). In a mixed-method study, both qualitative and quantitative approaches or methods are used for data collection and analysis, enabling integration and inference drawing, helping to legitimise the multiple approaches for answering the research questions (Johnson and Onwuegbuzie, 2004, Tashakkori and Creswell, 2007). Specifically, mixed-method

research is an approach to collecting both quantitative and qualitative data, integrating the two forms of data (Creswell, 2014, p.14). It recognises the value of quantitative and qualitative research and offers a third paradigm which is more powerful and able to result in the “most informative, complete, balanced and useful research results” (Johnson,Onwuegbuzie and Turner, 2007). In this way, different but complementary data are obtained on the same topic (Morse, 1991).

In the current study, the understandings of social realities based on quantitative and qualitative approaches jointly contribute to a comprehensive and thorough picture of the family’s role, with the examination of the impact of cultural factors. The quantitative approach for analysis based on secondary data from national surveys was applied to explore how social values about care attitudes have changed in the Chinese context (RQ1). Regarding the family’s role in long-term care provision and its changes with the development of long-term care in China (RQ2, RQ3, RQ4), the social behaviours of individuals are discussed based on in-depth interviews in a qualitative approach, revealing the realities and their underlying explanations from specific perspectives. The mixed-method technique thus enables the researcher to compile an overall picture of changing social attitudes towards care responsibilities divided between family and state and the details collected for the family’s role in care provision through the qualitative approach. A multi-dimensional exploration of the evolving role of the family in long-term care provision in China is therefore made possible by the mixed-method approach, which is ideal for addressing the research questions of this study.

4.2 Quantitative approach

Quantitative research is an approach for testing objective theories by examining the relationships among variables (Creswell, 2014, p.18). Regarding the mixed methods used in this study, a quantitative approach was used to investigate the social attitudes towards care responsibility and their changes over time in China (RQ1). The quantitative analysis outlines the overall picture of care attitudes in China, thereby laying the groundwork for the analysis of the other three research questions, mainly based on the case study. It is especially important for a more in-depth investigation of the influence of cultural values (RQ4).

The analysis was conducted on data from national databases, revealing the changing social values about the family’s role in caring for older people. Data covering the entire country were essential for examining the ongoing general changes in social attitudes because China has the largest population in the world and uneven development in different regions. Because it was difficult to conduct

nationwide research for this PhD research project, not to mention collecting data over several years to identify the changing patterns, secondary data were therefore used for the quantitative data analysis.

4.2.1 Secondary data analysis

Secondary data analysis refers to using existing data collected by other researchers (Bryman, 2007, p.208). This method has multiple advantages, particularly in saving time and cost, accessing high-quality data and providing opportunities for longitudinal analysis in this research (Dale, 1988). These advantages all help to generalise the findings based on mass-scale data. In this study, to estimate the effect of social values on the care responsibility division between the family and the state (RQ1), as well as the changing patterns of care provision for disabled older people in China, considering relevant variables measured in different national databases and data availability, individual-based data from the China General Social Survey (CGSS) and the China Family Panel Studies (CFPS) were used. These two databases were compiled by professional academic institutions in China and the data collection procedures were evaluated by research teams to ensure the reliability and validity of these surveys.

Chinese General Social Survey (CGSS）

To capture the patterns of social attitudes towards care responsibility (RQ1), the only publicly accessible national database with pertinent variables related to care attitudes was the Chinese General Social Survey (CGSS). Data from the CGSS were therefore acquired in order to examine the changing social attitudes and their underpinning explanations.

The CGSS is a nationally representative continuous survey project in mainland China; it is also a cross-sectional study. Its sampling design was made in 2010, using the 2009 national population data to assemble the frame. It is a multi-stage stratified design targeting civilian adults aged 18 and above. There are three sampling stages, covering county-level units, community-level units and households. Among 43 municipalities directly under the central government, provincial capital cities and vice-provincial cities in China, concerning GDP, Foreign direct investment and education level, the top five cities, Beijing, Shanghai, Tianjin, Guangzhou and Shenzhen, were selected as a representative stratum in the 2010 design. Probability-proportional-to-size (PPS) sampling was used based on the multi-levels of sample units[1]. The samples reflect the overall demographic pattern of China according to the representativeness of the CGSS.

[1] In addition to the five cities, the remaining PSUs are comprehensively ranked with GDP per capita, urbanisation rate and population

The questionnaire used since 2010 is an improved version of previous waves. The core module of the personal questionnaire is annually repeated, covering eleven dimensions such as social demographics, health, social attitude, cognitive ability, social welfare and family.

RQ1 investigates changing social values about the care responsibility division between the family and the state. Because elderly care has been given increasing attention in old-age policy in China since the 2010s (Jing, 2020, Krings et al., 2022), and the same questionnaire capturing social attitudes in the CGSS database has been used since 2010, 2010 was set as a time point to compare the social attitude changes in this study. Therefore, CGSS data from different waves collected from 2010 were used to investigate RQ1.

This study used samples from the CGSS taken in 2010, 2012, 2015 and 2017 to analyse how social values about the family providing care have changed over time. In particular, descriptive analysis of the care attitudes towards the care provided by the various actors (the family, the government) and regression analysis to investigate the associations between different factors for the changes in care attitudes were conducted using the data from the CGSS. Table 4.1 displays the total number of observations used in this study for various years.

Table 4.1 Samples of the CGSS used in this study

Year	Number	Percentage (%)
2010	11776	25.01
2012	11761	24.98
2015	10968	23.29
2017	12582	26.72
Total	47087	100

density, equally classified as stratum (N=50). The total sample size of 2010 design is 12,000 households and 2000 are in self-representative stratum (Chinese General Social Survey, available at: http://cgss.ruc.edu.cn/English/Documentation/Sampling_Design.htm).

China Family Panel Studies (CFPS)

In addition to the data of the CGSS to examine the changing social attitudes, individual care decisions reflecting the care patterns in daily life were essential for understanding the family's role in providing care, contributing to the overall picture of who primarily takes on the care responsibility for older people in China for the analysis of RQ2 and RQ3.

China Family Panel Studies (CFPS), as another nationally representative, annual longitudinal survey[1], is chosen for descriptive data analysis concerning data availability. In this study, data from the CFPS collected from older people in 2018 were used for descriptive analysis to examine the family's role in care provision in daily life, mainly about who provides care to older people when they are in demand in China. The descriptive analysis of the CFPS has drawn an overall picture of care providers for older people in daily life in China, as well as a comparison between social attitudes reflected by the CGSS dataset and the care provision pattern revealed by the CFPS dataset.

4.2.2 Measurement

In quantitative research, measurement provides the basis for more accurate estimates of the degree of relationship between concepts (Bryman, 2015, p.166). Indicators are necessary for the operational definition of a concept, with a question or series of questions in a questionnaire concerning the respondents' report of an attitude or behaviour and the results of official statistics (Bryman, 2015, p.152).

Data in China since the 2010s were analysed in addressing RQ1. On the one hand, descriptive data analysis was used to outline the individual social attitudes about the division of care responsibility (CGSS) and the care provision pattern (CFPS) in contemporary China. This outlined the changing social attitudes towards the roles of the state and the family, as well as those related to the intergenerational contract and gender roles based on data collected from national surveys, thus laying the groundwork for the following up analysis of factors associated with the changing social attitudes. The descriptive analyses are presented in section 5.1, followed by the analysis examining the relationship between multiple variables and care attitudes in section 5.2.

[1] China Family Panel Studies is a longitudinal survey of Chinese communities, families, and individuals by the Institute of Social Science Survey of Peking University, China (China Family Panel Studies, available at: https://opendata.pku.edu.cn/dataverse/CFPS?language=en)

On the other hand, explicitly on care attitudes, regression analysis based on the CGSS data was employed to examine the correlations between the care attitudes and other factors, revealing the underlying explanations for why social attitudes have changed over time. As stated in section 1.4, given that the state and the family play key roles in providing care for older people in China and this study specifically examines the role of the family, social attitudes towards the state and the family in supporting older people are analysed (RQ1). Therefore, the quantitative analysis in this study selects the outcome as a binary between the state and the family.

Given that only CGSS includes data capturing social attitudes, this study investigates whether time has had any effects on care attitudes in recent years in China. The dependent variable was social attitudes, and it was quoted from the CGSS database. With the rapid social-economic transitions in all fields in China, social values have changed over time (Hu and Scott, 2016, Yan, 2018). Considering the available data and the development of the elderly care system in China, this study used the data from 2010 to 2017 (2010, 2013, 2015, 2017) to identify changes in general social attitudes. Owing to the data availability[1], the 2010 data serve as the baseline to explore the changes for the data analysis. The analysis was thus placed to analyse the relationship between time and social attitudes towards the binary outcomes between the state and the family.

This study thus sets the answers to the question 'who should take the primary responsibility for supporting older people with children' as the dependent variable. There were four options in the questionnaire: 'the government', 'their children', 'the older people themselves' and 'the shared responsibility of these actors'. The data were re-categorised as a binary choice of 'the state' or 'the family' which should take on the care responsibility. However, as this study was mainly focused on the care responsibilities attributed between the state and the family as they are the primary actors in supporting people in Chinese society (*see* section 2.3.2) but the choice of 'shared responsibility' addresses the roles of both the state and the family. Thus, this variable was recoded into another two questions: 'Should the state take the primary care responsibility for older people' and 'Should the family take the primary care responsibility for older people'. These two dependent variables were recoded as a binary option between 'yes' and 'no'. The options for 'adult children' and 'older

[1] The questions examining social attitudes in China have only been included in the CGSS since 2010.

people' were combined into a new one, 'family'. Those who agreed with 'shared responsibility' were coded as 'yes' for both questions[1].

Specifically, regression methods are useful in analysing the relationship between a response variable and one or more explanatory variables. Different from a linear regression model, the outcome variable of a logistic regression model is binary or dichotomous (Hosmer, 2000). It is efficient in analysing the effect of independent variables on a binary outcome by estimating the probability of being one binary outcome instead of the other, thus qualifying the contributions of multiple independent variables (Stoltzfus, 2011, O'Connell, 2006). Thus, logistic regression can be efficient in examining the associations between time and social attitudes. However, although RQ1 is about changing social attitudes over time, it was difficult to construct time-series data, as with the cross-sectional data of the CGSS database. Time was accordingly chosen as one of the independent variables to determine whether any changes had occurred.

Further analyses investigating the effects on the care attitudes are established to understand what critical influential factors might be explaining social attitudes in relation to care provision, particularly whether the family remains concerned as the primary care provider for older people in China. The related impact indicators from various dimensions were compiled in this study as independent variables for quantitative analysis in accordance with prior research. Socio-demographic variables of age, gender, education level and rural-urban differences were always considered vital variables for interpreting their attitudes and choices, and the reasons for this are illustrated next.

4.2.3 Data analysis

For RQ1, this study examined social attitudes towards care provision. With the secondary data analysis based on the data from CGSS, following the descriptive analysis, regression models were established using SPSS. Validity, reliability and replication were also taken into account in this study.

[1] Since this study mainly focuses on the division of care responsibilities between the state and the family, the dependent variables were established by recoding the data from the CGSS. It is primarily for respondents who agreed that the primary care responsibilities for supporting older people should be 'shared responsibilities between the government, older people themselves, and adult children'. There might be a possible limitation of not being able to accurately distinguish the binary option between the state and the family due to the question designed in the CGSS.

Validity refers to the integrity of the conclusions drawn from a piece of research (Bryman, 2015, p.158), and particularly whether the researcher is able to derive meaningful and useful conclusions from scores on specific instruments in quantitative research (Creswell, 2014, p.160) . Since RQ1 investigated social attitudes towards the care provision for older adults in China over time, time was addressed as one of the independent factors. Based on existing studies, all the hypotheses were laid out for testing the relationships between the independent variables, which were time and family support, and the dependent variable identifying social attitudes about the division of care responsibility. The measurement of the variables was based on the previous literature and the relationships tested between the dependent and independent variables, indicating internal validity. The data analysis was placed in the Chinese context of providing care for older people so the findings can be expanded and generalised to China's general situation based on the proportionate sampling surveys.

Reliability is about whether the results of a study are repeatable. The term is commonly used in relation to whether the measures are devised for concepts. The idea of reliability is very close to another criterion of research – replication and, more significantly, replicability (Bryman, 2015, pp.40-42). RQ1 explored the changing social attitudes towards the care responsibilities divided between the family and the state using a quantitative approach based on secondary data available on the official websites, demonstrating the reliability and replication of the quantitative analysis in this study.

Specifically, in addressing RQ1, for the quantitative analysis in section 5.2 based on the CGSS, variables and hypotheses are defined as the following.

Variables

In this study, RQ1 investigates social attitudes towards the family's role in care provision for older people. The dependent variable was measured in the CGSS setting by two separate questions: 'Should the state take the primary care responsibility for older people' and 'Should the family take the primary care responsibility for older people' (*see* section 4.2.2). A binary option between 'yes' and 'no' was set in the quantitative analysis. Time was set as one of the independent variables to capture whether social attitudes towards care provision have changed over time, and data from

2010 was adopted as the baseline. In addition, to understand whether there are any differences between care attitudes between the younger and older generation (aged 60 and above),

Based on previous studies reviewed (*see* section 3.3.1), the socio-demographic characteristics of age, gender, household registration type (*hukou*), areas (the urban/rural difference), education and marital status are essential for discussing social attitudes towards the family's role in care support, as the following explains.

Age. With the socio-economic transitions in China, the public has experienced different historical events and social reforms in the past few decades, resulting in various identities between generations (Yu and Rosenberg, 2017). This variable was interpreted to determine whether people of different age groups hold distinct attitudes regarding the care responsibilities for older individuals.

Gender. Sons are always expected to contribute more to the provision of family support, especially after the daughters in the family have got married. There is a clear gender divide in the enduring traditional values in East Asia, with sons always expected to contribute more to the provision of family support (Whyte, 2004, Lin and Yi, 2013)(also see sections 3.3.1.2 and 3.3.1.3). This well-accepted norm might also shape female and male individual attitudes, as women usually have less patriarchal attitudes than men in China (Hu and Scott, 2016). However, some studies have shown that daughters take on more responsibility for care provision for older generations with the transition of family structures in contemporary China (Xie and Zhu, 2009, Tang et al., 2009). Although traditional solid family values underline female family members' contribution to providing care, these values have been significantly challenged by women's increasing labour market participation and the development of gender equality policies (Ji et al., 2017). There might therefore be differences between male and female perspectives on the division of care responsibilities.

***Hukou* and area (urban-rural difference).** The difference between urban and rural residents is believed to be significant for the changing social attitudes and individual choices for care provision in China. With the simultaneous development of urbanisation and marketisation in the past few decades, more people have migrated to urban areas from rural areas to make a living. Consequently, the traditional risk-sharing mechanism within the family has changed, which is more evident in urban areas. In addition, with the ongoing industrialisation and modernisation in China, the traditional values and norms about filial piety have been somewhat weakened (Hu and Scott, 2016).

The prevalence of Western attitudes regarding the care of the elderly has increased, and more residents have developed or strengthened their sense of independence (Sheng and Settles, 2006). The traditional cultural values emphasising the family's role as the only care provider have been dramatically challenged, and neo-familism is believed to be on the rise (Yan, 2018). This is primarily the case in urban areas, where residents have relatively easier access to 'modern' values influenced by the rapid development of contemporary China and the attitudes of other nations in an era of globalisation (Yan, 2011, Hu and Scott, 2016). Furthermore, as rural residents usually have a higher expectation of filial piety for children to provide care than those in urban areas (Luo and Zhan, 2012), this study also considers the differences between urban and rural areas, seeking to determine whether there are any variations in the individual's care attitudes., including (1) the areas of the respondents' living in and (2) the area of the respondents' household registration type.

Education. Given that Chinese virtue, like filial obligations, is constantly stressed in Chinese education and education level is associated with individual social attitudes (Liu, 2008), education level matters in individuals' values concerning traditional patrilineal beliefs (Hu and Scott, 2016). Individual educational attainment may be indicative of the public's acceptance of new social values. The education level was set as an ordinal variable, moving from primary school to junior high school, senior high school, and university.

Hypotheses

Based on the relevant literature (*see* section 2.4), several factors are significant for the individual's attitudes towards the family's role and the state's role in care provision for older people in China. In this study, they are summarised as hypotheses to evaluate their associations with the dependent variables, particularly with the latest data in contemporary Chinese society.

Hypothesis 1: Individual care attitudes are associated with the family's available support

Available care support is significant for families providing care (*see* section 2.4.2), but it remains to be determined whether it is also associated with individual care attitudes. In this study, the available family support mainly refers to the support from spouses and adult children following enduring cultural values, which is a substitute or complement for the care support provided from outside the

family. Hypothesis 1 is therefore about whether the family's available support is associated with individual care attitudes towards the family's care responsibility.

Two indicators are used to measure the available family support: (1) whether the individual lives with the spouse, related to the available support from the partner, and (2) the number of children, referring to the support from the younger generation regarding the intergenerational contract.

Hypothesis 2: Individual care attitudes are associated with the public sector's support

Corresponding to the available family support, Hypothesis 2 discusses the support from the public sector, given the long-argued crowd-in or crowd-out effects between public efforts and informal caregiving (*see* section 2.4.2). Among all the welfare programmes led by the state, the public pension scheme and medical insurance schemes are most closely connected to older people's everyday lives for their financial and medical care support. Although some cities have developed long-term care for disabled older people, this is still in the pilot phase with relatively limited coverage. No specific data clarifying whether the samples benefited from long-term care is available in the CGSS database, so it is not included in this analysis. In this study, two indicators are adopted as binary indicators: participation in public pension schemes and participation in public medical insurance schemes.

Hypothesis 3: Individual care attitudes are associated with the demand for care provision

Given that the care demand of older people is significant for family care provision (*see* section 2.4.2), Hypothesis 3 examines whether individuals' care demands shape their attitudes. Care demands are driven by health-related care needs but are determined by affordability. According to the available data from the CGSS, one indicator measures health status based on individual self-rated health conditions and another measures financial affordability through the self-rated household income levels in local areas.

Hypothesis 4: Individual care attitudes are associated with people's thoughts about the gender roles

Females are usually expected to be the family care provider, particularly in China, despite the growing feminism in recent years (*see* sections 2.4.1 and 3.3.1.3). Attitudes towards the gender division of labour might also affect the care provided by the family, calling for further discussion. Hypothesis 4 explores whether individual attitudes towards gender roles within the family relate to

those for family provision care. Although there is a series of questions capturing the social attitudes towards gender roles in the CGSS[1], two of them closely related to gender roles for shouldering family responsibility and obligation were included in the analysis of this study. Those two indicators referring to social attitudes towards gender division of labour within the family were included in the analysis. They refer to the degree to which the individuals agree with the opinions of 'Men should prioritise their careers but women the family' (Gender Role 1) and 'Couples should share the housework at home equally' (Gender Role 2) which are employed as ordinal variables.

Following section 4.2.2, binary logistic regression models are employed to examine whether social attitudes towards the roles of the state and the family have changed over time, with four hypotheses regarding the factors that might be significant for social attitudes based on previous studies (also see section 2.4). To assess the goodness-of-fit of logistic regression models, Hosmer–Lemeshow test is widely used for the values of the estimated probabilities (Paul,Pennell and Lemeshow, 2013). The results of the Hosmer-Lemeshow tests are thus employed in this study.

The validity of quantitative analysis is considered in this study. Given that the existence of collinearity leads to incorrect inferences about relationships between explanatory and other variables, the multicollinearity of the logistic regression models, which referring to whether two or more predictor variables are highly associated are also considered (Midi,Sarkar and Rana, 2010). Specifically, Variance Inflation Factor (VIF), referring to "how much the variance of the coefficient estimate is being inflated by multicollinearity" is one of the diagnostic measurements to detect multicollinearity (Senaviratna and A Cooray, 2019). In this study, the VIF is tested in establishing the binary logistic regression models investigating the changing social attitudes towards care provision in China based on the CGSS.

[1] The questions related to gender roles in the CGSS include: (1) Men should prioritise their careers but women the family. (2) Men's capacity is inherently better than women's. (3) It is much more important for a woman to marry a good person than to have a good job. (4) When it comes to the economic downturn, women should be fired first. (5) Couples should share the housework at home equally. Two of them regarding the gender role in supporting family members (2 and 5) were included in the quantitative analysis in this study.

4.3 Qualitative approach

Qualitative research can be used to follow-up quantitative research, particularly if the quantitative phase has presented findings which need further explanation or when more details or depth about a phenomenon are needed (Ritchie et al., 2014, p.4, pp. 30-31) . Compared to the quantitative method, the qualitative method provides a deeper understanding of social phenomena (Silverman, 2010).

In this study, in addition to the quantitative method for depicting the changing social values and the family's function in caring for the older generation at the national level in China, a qualitative approach was adopted to examine how the family role in providing care has changed and how cultural factors integrate with other elements within the care arrangements for long-term care provision in China (RQ2, RQ3 and RQ4). This contributes to the sophisticated mechanisms of long-term care provision. In particular, the national database used for quantitative analysis does not cover the care patterns affected by the long-term care insurance scheme introduced in 2016 and the diversified care provision patterns which have been implemented in the pilot cities in China. The qualitative research approach is better able to capture the current care practices of different social actors involved in the long-term care system.

4.3.1 Case study

Case study research considers the complexity and particular nature of the case in question (Stake, 1995). It is "an intensive study of a single unit to understand a larger class of units" (Gerring, 2004, p.342), entailing the thorough exploration of a specific case (Bryman, 2015, p.61). Case study is generally used for 'how ' and 'why' questions for a contemporary set of events, especially when the boundaries between phenomena and the real-world context may be too complex (Yin, 2014, p.2). This method is widely used in social science research (Baxter and Jack, 2008, Eunjung,Mishna and Brennenstuhl, 2010, Crowe et al., 2011, Priya, 2020).

Because of the specific research questions of this study, the case study method was deemed to enable an exploration of the detailed story in China, given the complexity of the discussion on China due to its vast internal heterogeneity and the combination of political centralisation and fiscal

decentralisation. Specifically for the long-term care on which the study is focused, different pilot cities have been developing localised care provision. Thus, the case study method, placing the analysis on one particular city, was adopted to examine the family's role in providing care in the case of public insurance-reimbursed care delivered by the family.

A good qualitative case study should present an in-depth understanding through various forms of qualitative data such as interviews, observation, documents and audio-visual materials (Creswell, 1998, pp.97-99). Criteria for the quality of the case study method including validity and reliability were considered. Since this study was not designed as a causal study, internal validity was not an explicit concern (Yin, 2014, p.47). External validity refers to generalisation, although there has been criticism that a case study can be so specific that its findings cannot be generalised (Bryman, 2015, p.62). Despite it being a single case study here, the case of one specific city can nevertheless comprehensively represent the roles of different actors involved in long-term care provision, particularly those recognising the family as the primary care provider. Given the key role of local government in policy experimentation (*see* section 3.4), the logic of the local government in the case study can be justified through the insightful examination of how a local government acts in response to the multiple transitions in China. Therefore, regarding RQ2, RQ3 and RQ4, the case study method contributes to showing the reflective case in the Chinese context of how different actors respond to the newly developed long-term care system in the country.

Reliability relates to the "operation of a study that can be repeated with the same results" (Yin, 2014, p.46), which is vital to minimising errors and biases in the study. Although the stories shared by various groups of interviewees will be different if another study is conducted following the same procedures as were used in this study, similar findings will be made due to the diversified characteristics of the sample included in this study, as demonstrated in the following data collection and analysis sections (*see* sections 4.3.3 and 4.3.4). Of the pilot cities implementing long-term care insurance in China, Guangzhou, where both formal and informal care are available for disabled older people, was chosen as the case study site.

Guangzhou is a valuable case

Guangzhou, located in southern China, is one of the most prosperous cities in China with more than 10 million household registered population (18 million resident population), of whom 13.75% are

over 65 by 2022 (1.42 million) (Guangzhou Municipal Health Commission, 2023) . With the Reform and Opening-up since 1978 in China, there has been a considerably remarkable economic development in Guangzhou; the city has consistently ranked among the top four cities in China in terms of GDP since the 1990s.

Regarding long-term care development, Guangzhou is one of the first-wave pilot cities in the long-term care insurance scheme in China since 2017 and is also one of the pioneers in developing insurance-funded informal care since 2019 (see Table 1.2). It is therefore most likely to explain how the family's role has changed in response to the local long-term care system (see Case Study Introduction in Part Two: Findings). The expansion from solely formal care to including the care services delivered by the family also reflect the significance of the family's role in care provision recognised in the care system, and similar patterns have subsequently been witnessed in many other cities.

Given that long-term care insurance implementation is a continuing policy experiment in China, the analysis of the Guangzhou case is embedded in the specific Chinese context, particularly for those at the city level. In such bottom-up policy experimentation for developing long-term care, Guangzhou's case shows the logic of the local government in policy design and implementation in relation to the socio-economic, demographic and cultural circumstances. In addition, it is an excellent example of how the local government's interests matter in the policy process.

Further reasons for adopting Guangzhou as the case study were that fiscal decentralisation in China, economic advancement and social development, the languages and the openness of Guangzhou demonstrate the values of the case study and these factors will be discussed in greater detail next.

Fiscal decentralisation. A case study of one city is determined by the fiscal decentralisation at the local level (provinces or even cities) in China. In the policy exploration in China (*see* section 3.4), the local government plays a prominent role in the policy process (Li and Zhou, 2005, Heilmann, 2008b), with strong incentives for local reforms (Cai and Treisman, 2006, Zhou, 2009). The long-term care pilot programme is a typical example of gathering local experience and fragmented long-term care schemes could be observed during the ongoing pilot period (Chan and Shi, 2022). The ongoing pilot scheme at the municipal level for long-term care is the critical reason for choosing one specific city as the case study.

Great economic advancement. With fiscal decentralisation, diversified long-term care provision patterns vary from city to city in China. For all the pilot cities, the funding for the long-term care exploration is mainly transferred from the surplus of public healthcare insurance and local public budgets (*see* Table 1.1). Given that the financial affordability of long-term care is the primary constraint to increasing local long-term care expenditure (Costa-Font,Courbage and Swartz, 2015), with fiscal decentralisation embedded in the political centralisation system in China, those cities with great economic advancement, such as Guangzhou as one of the wealthiest cities in China with an affluent fiscal capacity, are more likely to innovate in local policy exploration.

Individual affordability of care options. Since the affordability of out-of-pocket payments for care alternatives is significant for individual care decisions (Hu, 2019), local economic advancement could possibly lead to higher incomes for individuals and households. In addition, as income inequality among households, across regions and between rural and urban areas, is increasing (Knight, 2013), the household income inequality might link to household wealth gaps, leading to diverse care decisions for older people.

Language barriers between older people and caregivers outside the family. Previous studies have shown that language barriers impact care quality (Bourgeault et al., 2010). Speaking the same language usually means that people have similar beliefs and values and understand each other better (Barker, 1995), and a reasonable level of language proficiency can decrease the cultural and social distance between care workers and the clients' relatives and can alleviate the stereotypical images which relatives might initially have of the migrant workers (Da Roit and van Bochove, 2017). Whether these arguments are explanatory in contemporary China remains unclear. As most older people usually or even only speak dialect (Cantonese in Guangzhou) but many formal caregivers are internal migrants from other cities or provinces speaking the official language in Chinese (Mandarin), the language differences might also lead to the general preferences of the family caregivers. Since language is important for constructing individual and socio-cultural identities (Sharifian, 2014), the impact of language is considered in choosing Guangzhou as the case study. Regarding the long-term care provided in Guangzhou, for both the care recipients and the caregivers, the language issue might also be one of the primary considerations for individual care decisions.

Deeply rooted cultural values. Stronger cultural values emphasising the family's role are argued to persist in southern China, led by the better-continued lineages emphasising the family' role and the traditional values stressing kinship (Peng, 2009). Located in southern China, Guangzhou is a case study for analysing the changing role of the family in care provision, as people there might have a firmer belief in cultural values addressing family responsibility.

Overall, considering the local authority's role in policy development under the pilot programme, all the issues addressed above could affect long-term care provision and the unique characteristics of Guangzhou can contribute to a more insightful analysis of the sophisticated policy exploration compared with other pilot cities. Guangzhou is therefore an appropriately reflective case for addressing the research questions in this study.

4.3.2 Sampling strategies

In all the pilot cities in China, the care that the recipients receive is decided by the disability assessment set by the local government, mainly the Activity of Daily Living (ADL) and the Instrumental Activity of Daily Living (IADL). In Guangzhou, the assessment is undertaken by commercial insurance enterprises appointed by the local government. Only those older adults at the most severely physically disabled level (Level 3) can apply for home-based care delivered by family caregivers (part-time caregivers). Even with the development of public insurance-funded long-term care, informal long-term care remains the option for most care recipients, reimbursed by the insurance scheme in Guangzhou (*see* Case Study Introduction in Part Two: Findings). By August 2021, those receiving home-based care accounted for more than 84% of all care recipients compared with those receiving institutional care. Most of the caregivers are family members of disabled people.

In this study, the sampling strategy was purposive sampling intended to elicit answers from specific groups of actors involved in the long-term care system. Five groups of participants were adopted as a sample frame for interview: older people receiving insurance-funded long-term care (including from full-time caregivers and part-time caregivers), part-time caregivers, representatives of a care home and a commercial insurance enterprise, and one local government official. The information sheets for participants were listed in Appendix 2.

The purpose of the study was explained to each participant at the start of the interview and assurance was given that the data collected would be used for academic research purposes only. During the interviews, participants were asked semi-structured questions about the family's role in providing long-term care and their thoughts on the long-term care insurance scheme. The demographic characteristics of interviewees were presented in Appendix 3.

The approach to recruitment was snowballing. Only those care recipients who were eligible to apply for the informal care funded by the insurance were recruited for the interviews. All the recruited caregivers were registered with and managed by Care Home A, which was supervised by Insurance Enterprise P.

The manager of Care Home A was the first to agree to participate in the study and completed an interview. She then acted as a gatekeeper for the researcher. She helped by sharing the information about this research project with the care managers, who have rich experiences of working at the front line. Three care managers working in Care Home A were then recruited to share their views. The care managers then helped to promote this research project in their WeChat groups in which the caregivers whom they supervised were members. In total, 22 caregivers contacted the researcher for further information[1]. The care recipients receiving care services from them were also invited to be interviewed. Despite the invited care recipients being assessed as Level 3 in terms of disability, their family caregivers and care managers reported that they could express themselves clearly and communicate daily with others despite their physical disabilities. In addition, the care managers and the family caregivers recommended that disabled older people usually would not be able to participate in a one-to-one interview for more than half an hour. The question list for the care recipients was therefore simplified accordingly. For instance, the questions asking for basic personal information about age, household registration type (*hukou*), marital status and the number of adult children were deleted from the question list for care recipients. Instead, these data were collected from their caregivers, mainly their family members.

[1] Only the caregivers of older people with physical disabilities were included in the interviews. The cognitive impairment was only included in the assessment of disability in the case study since 2021 but with limited accessible data for the numbers of care beneficiaries identified as with cognitive impairment. Therefore, most care beneficiaries of the public insurance-funded long-term care are those with disabilities of daily living, thus as the target groups in this study. However, including the discussions on older people with cognitive impairment will be part of the further research if possible.

Three staff members from Insurance Enterprise P were also recruited. One of them was recommended to the researcher by another gatekeeper. After being interviewed, she recommended two of her colleagues who might participate in the research project. They engaged in different parts of the long-term care insurance implementation, including assessing applicants for insurance schemes, supervising caregivers, cooperating with each other and negotiating with the government. They illustrated how the commercial insurance scheme contributed to the long-term care provision funded by the public long-term care insurance in Guangzhou.

Because the researcher was only authorised to carry out online interviews for ethical reasons relating to COVID-19 travel and social distancing restrictions, contacting local officials for interviews was difficult. After a long process of contacting potential participants, one official of the Bureau of Healthcare and Security in Guangzhou, finally agreed to participate in an interview. This participant was involved in the policy design and policy implementation of long-term care insurance and was able to explain the considerations of the local government in the policy exploration.

4.3.3 Data collection

Interview, in semi-structured and online forms, was the technique adopted for collecting data in this study. The interview is an essential source of evidence for case studies, providing insightful information on human affairs or actions (Yin, 2014, p.113). In particular, an in-depth interview provides details about the experiences, motives and opinions of those who have knowledge of or experience with the problem of interest (Rubin and Rubin, 2004). The semi-structured interview designed for this study consisted of several key questions to collect interviewees' views in a detailed manner with high flexibility (Gill et al., 2008) and was also appropriate for dealing with sensitive topics (Elmir et al., 2011).

Interview questions

Concerning the research questions of this study, semi-structured interviews are used primarily for two reasons. On the one hand, to ensure that participants can give their own opinion without the potential influence of others, given that the content of some interviews might relate to the relationship between the participants and their family members, and on the other hand, to minimise

the difficulty of interviewing arising from gathering the participants in the same place, especially ensuring social distancing due to the pandemic.

Targeted at the research questions of this study (RQ2, RQ3, and RQ4), several sets of open-ended and understandable questions were designed to collect the points of view of various social actors engaged in long-term care provision in the case study, based on two analytical frameworks introduced in the literature review chapters (*see* sections 2.5 and 3.5).

For the analytical framework for the family's roles in care provision (Figure 2.2) mainly targeting RQ2 and RQ3, questions were designed to capture the role of the family in providing long-term care and specifically looking into intergenerational contract and gender division of labour within the family. Related questions capturing the role of the family and the government in providing long-term care were asked towards all participants, as in 'Public insurance-funded care received' in 1.1 and 1.2 of Appendix 1, as well as in 'Family's role in providing care' in 1.3 and 1.4. Information on how the care has been provided by the family in the public insurance-funded care system was collected to present an overall picture with affluent details of long-term care provision in China. For instance, for the care recipients and care providers, similar questions were asked with slight differences, including how care were services provided in daily life, reasons for choosing care provided by the family, changes in the care received or provided ever since the implementation of public long-term care insurance.

To examine the considerations in the family decision on caregiving, particularly the impact of cultural values addressing family responsibilities and obligations, another set of questions regarding care attitudes and preferences were asked to care recipients and caregivers. Those questions were significant to compare with the findings of quantitative analysis at the national level (*see* section 4.2.1).

For the analytical framework addressing RQ 4, this study will investigate the role of cultural factors in care arrangement based on Figure 3.3. Given that the elements of 'cultural system' have already been identified based on quantitative analysis targeting RQ1 and qualitative analysis for RQ2 and RQ3, as well as the 'social system' and 'social practice of individuals' based on RQ2 and RQ3. Further information would be necessary for the remaining element, such as the 'political actors' and the interaction between 'long-term care provision' and other elements within the care arrangement. Therefore, aiming at the insight of the policymaker for RQ4, development of long-term care

provision, particularly key considerations of developing long-term care with the involvement of the family, were asked of the interviewee from the local government. Since care homes and insurance enterprises are critical actors in long-term care provision in the case study, questions were designed to understand their interaction with the political actors, that is the local government in the case study.

Overall, all the questions for data collection were designed for the research questions of this study, specifically based on two analytical frameworks reviewed in the literature review chapters.

Participants recruitment

All the interviewees participated voluntarily and were fully informed of the content and intention of the research project; their informed consent to participate was obtained. All the interviews were held via online voice calls on WeChat from September 2021 to February 2022. The interviews were recorded with the participants' permission.

Various strategies were employed for the interviews, targeting the different groups of participants. The duration of the interviews ranged from 25 to 60 minutes, shorter for the disabled care recipients. They were all conducted in Cantonese. The list of interviewees was presented in Appendix 3.

After confirming the time and dates for family caregivers, all the interviews were organised online via WeChat. The family caregivers received voice calls from the researcher. They took part in the interviews, sharing their experiences as caregivers within the long-term care insurance scheme and their opinions on the family's role and values. After the interviews with the caregivers, the care recipients took part in voice calls to share their thoughts about the care support from their families and their attitudes to and expectations of long-term care development. However, three of these 22 cases were excluded because these disabled older people were aged 56 or 58, under the age requirement of 60 years old and above stipulated in the ethical approval. Of the remaining 19 cases, the researcher was informed that seven care recipients could not participate in the interviews due to their disabilities. Another two could not complete the interviews: one had hearing impairment and thus found it difficult to communicate with the researcher and the other one could not concentrate on the interview or understand the questions asked. Data from ten care recipients were

therefore finally acquired for this study, including two receiving care services from private caregivers. In addition, 19 caregivers were interviewed, of whom 17 were family caregivers and two were private caregivers recruited from the market. However, given that this study aims to investigate the role of the family in long-term care provision, only the data collected from 17 family caregivers were included in the analysis section.

For the representatives of the insurance enterprise and the care home, semi-structured questions were also asked regarding their roles in long-term care provision and their interrelationships with the family and the local government.

Elite interview is used to study those “at the top of any stratification system”, revealing the major and potential issues of social analysis (Jupp, 2006, p.135) . With careful preparation, a local official was also interviewed online. In order to understand the policy process of long-term care insurance in the case study, the elite interview was conducted explicitly with the local government official. Only online interviewing had been approved by the Ethics Committee, so it was much more difficult to conduct an online interview with the local official because the interviewee of the local government is more cautious for a non-face-to-face interview. The questions were mainly about the policy process of long-term care insurance in Guangzhou and the critical considerations in the local exploration.

4.3.4 Data analysis

For each interview, the key points of the transcript were summarised into a single Word document given a specific code number. Each transcript was input into NVivo as a case. The cases of the same target groups (care recipients, caregivers, care homes, insurance enterprises and government official) were classified into the same file and analysed together. All the documents were in Chinese to capture precise information and minimise misunderstandings due to translation. The coding was in English. Only the extracts quoted in the following chapters were translated into English by the researcher.

The analysis was conducted using a thematic analysis approach, which is the most commonly used approach for qualitative data analysis (Bryman, 2015, p.587). During the data analysis, all the

collected data were coded and analysed according to different codes and themes derived from the content of the data.

Based on the collected data, the analysis generally followed the six-phase approach to thematic analysis (Braun and Clarke, 2012). A three-step analysis was employed in this research. The first step was to generate initial codes, mainly describing the content of the data. The researcher set a draft coding frame covering those initial codes according to the relevant ethical considerations. The second step was to search for themes by reviewing the coded data to identify any overlap between codes for the research questions and review potential themes by reviewing the data with the summarised themes. The researcher then grouped similar initial codes to list the possible themes. The final step was to define the themes in the light of research questions RQ2, RQ3 and RQ4.

Inductive coding frames were adopted for the thematic analysis, as shown in Appendix 4. The transcripts of the different groups of interviewees were coded separately. Five coding frames were established, including multiple sub-themes and codes. The analysis was carried out after integrating all these results from the thematic analysis from the different target groups, drawing conclusions about the family's role in care provision and the underlying explanations of various social actors in the long-term care system in China.

4.4 Ethical issues

This study was given ethical approval by the Social Policy and Social Work Departmental Ethics Committee of the University of York. All steps of the research process followed the stipulations set out in the ethics application form. Due to the global pandemic, all the interviews were conducted online using the social media app WeChat with the different groups of participants to avoid in-person interactions. The researcher also spent a long time justifying with the Ethics Committee the necessity of conducting the interviews via WeChat, the most widely used social media app in China, instead of telephone calls. Because data protection issues were the concern of the Ethics Committee, the researcher further demonstrated the reasons in detail for using WeChat in a resubmitted application form, such as the wide usage of WeChat in China, the accessibility for participants (particularly during COVID-19), and the information safety. All the potential risks for the researcher

and participants in this research project were clarified. The main ethics application form was presented in Appendix 5.

The primary ethical issues arising in the data collection in this research project were working with gatekeepers when recruiting participants, avoiding potential harm to the participants and researcher, and the ethical issues in data collection related to the outbreak of COVID-19 were also fully considered.

Working through gatekeepers raises ethical issues particularly in ensuring that the gatekeeper is not excluding potential participants from the opportunity to participate (Ritchie et al., 2014). However, since the snowballing strategy was adopted in this study, the initial gatekeeper, the representative of care home A, merely helped to share information about the research project with care managers and caregivers of eligible disabled older people benefiting from long-term care insurance. No specific criteria were used during the information sharing. All the interviewees were informed of the objectives and procedures of the research before the interviews were held.

Ethical issues should be considered carefully by researchers to prevent harming the research participants (Israel and Hay, 2006), particularly when vulnerable groups are involved (Kavanaugh et al., 2006). Because the care recipients invited to be interviewed were physically disabled older people, more concern had to be given to risk management, particularly when asking questions related to sensitive topics which might cause potential harm to participants in the form of anger, sadness, embarrassment, fear and anxiety (Cowles, 1988), as well as to the researcher (Ritchie et al., 2014). During the interviews with care recipients and caregivers, adequate time was provided, particularly for those questions which might evoke memories of their hardships related to the care burden. The researcher paid close attention to the interviewees regarding their emotions to ensure that no possible emotional harm was caused. The confidentiality of personal information is essential for ethical issues (Richards and Schwartz, 2002). In this study, all the interviewees were anonymised with coding before conducting the thematic analysis in order to ensure privacy and confidentiality. The participants cannot be identified, avoiding any potential harm to them when using the quotes in any further publication.

Given the outbreak of COVID-19, only a virtual approach to data collection was permitted for specific ethical considerations, particularly for older people considered a vulnerable group during the

pandemic. There are different ethical considerations between online methods of data collection and in-person ones, such as privacy and confidentiality, accessibility, and resources (Newman,Guta and Black, 2021). All interviews conducted followed the main ethical application form, considering these issues. Particularly, data collection through virtual platforms can replicate in-person interactions or even more substantial engagement (Marhefka,Lockhart and Turner, 2020). A telephone interview is also considered appropriate for sensitive topics, access to hard-to-reach respondent groups, and safety issues (Sturges and Hanrahan, 2004). Therefore, the online interviews in this study enabled effective data collection in response to the research questions.

4.5 Limitations

The limitations of this study were mainly caused by the COVID-19 pandemic and the related lockdowns. The research design and methodology had to be changed because of the travel ban and ethical considerations due to the sudden outbreak of the global pandemic in 2020.

Because the study was designed to explore the changing family role in long-term care provision alongside the developing long-term care system in China, as well as to investigate whether cultural values contribute to any changing patterns, a comparative study establishing two or three pilot cities as case studies in China was the original design for the study.

However, the global pandemic considerably altered how the study was conducted, and this was one of its limitations. Due to the uncertainty of the global pandemic, the researcher had to delay making a research plan for the fieldwork for the research questions. Concerning the ethical issues regarding fieldwork in the qualitative research approach, during the time period in which no fieldwork could be conducted, the researcher adjusted the research plan. The researcher expanded the analysis to include the trend in general social attitudes in China at the national scale based on secondary data analysis, as RQ1, rather than using multiple case studies to paint a more comprehensive picture of long-term care provision in China.

In addition to the research design, the methodology of the study was also greatly affected by COVID-19. On the one hand, only one case study was undertaken because the comparison between different pilot cities in China was unavailable for the researcher. Because all of the interviews had to

be carried out online, it was difficult to take on more than one case study, particularly for the vulnerable older people involved. The research plan had to be revised to concentrate on just one case, Guangzhou City, because the Guangzhou case was both reflective and feasible for the fieldwork. Despite the representativeness of the Guangzhou case in explaining the changing family role in providing long-term care for older people in China, discussions in more than one city could have contributed to a more comprehensive understanding of the family's role in care provision with more details.

On the other hand, the interviews were conducted online, probably limiting the information collection. The interviews were supposed to be in person, but they had to be adjusted. Since the global pandemic impacted the fieldwork, the researcher could not visit China for face-to-face interviews for the ethical reason given above. At the suggestion of the Ethics Committee, all of the interviews had to be shifted online. Since some older people might not be used to talking to others on social media apps such as WeChat, some cases had to be dropped from the study. The viewpoints of older people with severe disabilities were also excluded. The recruitment of participants was limited because of the imposed online method, particularly in the case of the local official. In addition, because the interviews were voice calls, the participants' facial expressions and body language were not accessible, which might have led to the researcher missing some helpful information to a certain extent, particularly in the interviews with care recipients and caregivers.

Part Two: Findings

In this part, the findings from both the quantitative and the qualitative approaches are set out.

Using the data from CGSS and CFPS, in Chapter 5 I investigated the changing social attitudes towards care provision, including the division of care responsibility between the state and the family, and the support between generations and between males and females within the family based on the descriptive data analysis. A follow-up analysis based on regression analysis showed the significant impact factors of social care attitudes. The findings presented in this chapter explain how social attitudes towards the role of the state and the family affect the provision of care support for older people in China (RQ1) and serve as the background for the care attitudes discussed in the insightful case study which captured the impact of cultural values as one of the motivations for family members providing care (RQ2 and RQ3), as well as the care arrangement (RQ4).

Based on the data collected in the case study of Guangzhou, Chapters 6, 7 and 8 show the family's role in providing care, as well as the changes and their underlying causes. Chapter 6 is based on data gathered from the interviews with care recipients, then with family caregivers in Chapter 7 and finally with other social actors involved in the long-term care system, including staff from the care home, the insurance enterprise and local government, in Chapter 8. Several critical issues surrounding the changing family role in providing long-term care, such as care attitudes, reasons for family members providing care and policy expectations are summarised.

The findings in these three chapters provide answers to the research questions about the family's role in long-term care provision, intergenerational differences and interactions between cultural values and care arrangements, as well as evidence for the discussion section that follows.

5 Changing Social Attitudes towards Family's Role in Care Provision

The family has long been the primary care provider for its members in China (Wong and Leung, 2012, Feng et al., 2020) and cultural values, such as those that pertain to filial piety and intergenerational contract, are significant for the family providing care for its older members (Chappell and Funk, 2012, Lin and Yi, 2013, Bedford and Yeh, 2019, Brasher, 2021). However, with demographic and socio-economic transitions in contemporary Chinese society, whether social attitudes highlighting the family's caring role persist remains an open question. In this chapter, I shall investigate the first research question:

RQ1: How have social attitudes towards the role of the family in providing care changed over time?

1.1 What are the social attitudes towards the family's role?

1.2 What are the intergenerational differences in care attitudes for the family providing care support?

This chapter provides a comprehensive portrait of Chinese social attitudes regarding the family's role in caregiving. It is constructed in three sections. The first section presents the overall patterns of social attitudes towards care responsibility for older people and the care provision patterns for older people in everyday life based on the data of the CGSS and CFPS with descriptive analysis, outlining the trends of care attitudes at a national scale over time, particularly spotlighting the division of care responsibility between the family and the government. The second investigates the causes of the observed changes by applying a binary logistic regression analysis to the CGSS database, drawing conclusions concerning the available support, individual care demand and gender role attitudes. The final section is the conclusion.

In addition to addressing RQ1 by revealing the changing social attitudes over time in China, these findings provide the foundations for a thorough analysis of the family's role in providing care for its older members, as emphasised in the other research questions. They contribute to understanding cultural values identified from data at the national level, thus providing a more comprehensive

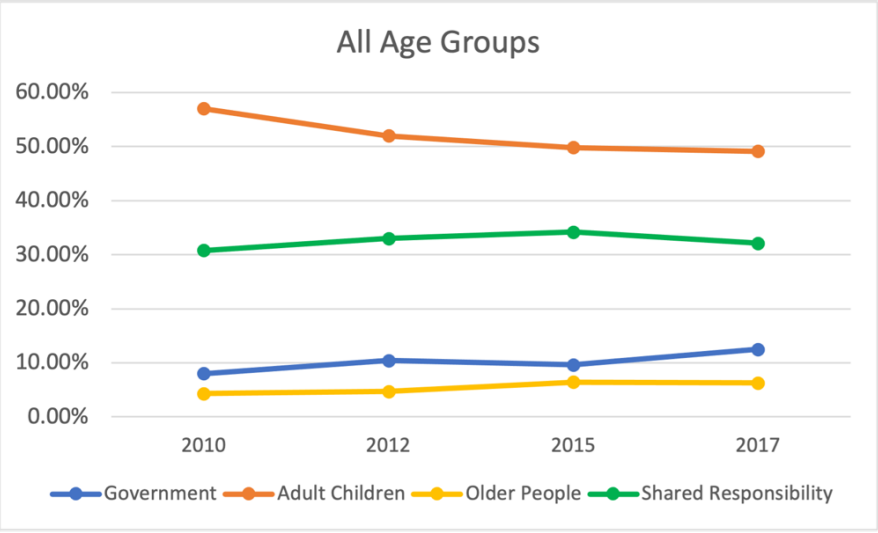
picture of cultural values based on data than derived from the case study in the qualitative analysis, particularly for comparing the findings from the quantitative and qualitative analyses in this study.

5.1 Changing social attitudes in contemporary China

This section presents the social values related to care provision for older people in China with descriptive analysis, including familism, intergenerational contract and gender roles. All the data presented capture subjective social attitudes based on national surveys, outlining the general patterns of changing social attitudes in China.

Familism is one of the core values of Chinese culture, as reflected in the public attitude towards care provided by the family (*see* section 3.3.1.1). In this study, it is measured by the division of care responsibility, mainly between the government, adult children and older people. Based on the data from 2010 to 2017 from the CGSS database, Figure 5.1 shows similar trends in people's care expectations for different actors. The figure shows that most respondents agreed that adult children should be the primary care provider for older people, but that there was a slight descending trend from 2010 to 2017 (from 57% to 49.1%). The expectations towards the government in supporting older people rose from 8% in 2010 to 12.5% in 2017 accordingly. Therefore, the family continues to be viewed as the principal care provider, despite the societal transitions in contemporary China and particularly the ongoing development of the elderly care system since 2010.

Figure 5.1 Who do you think should take care of older people? (CGSS)

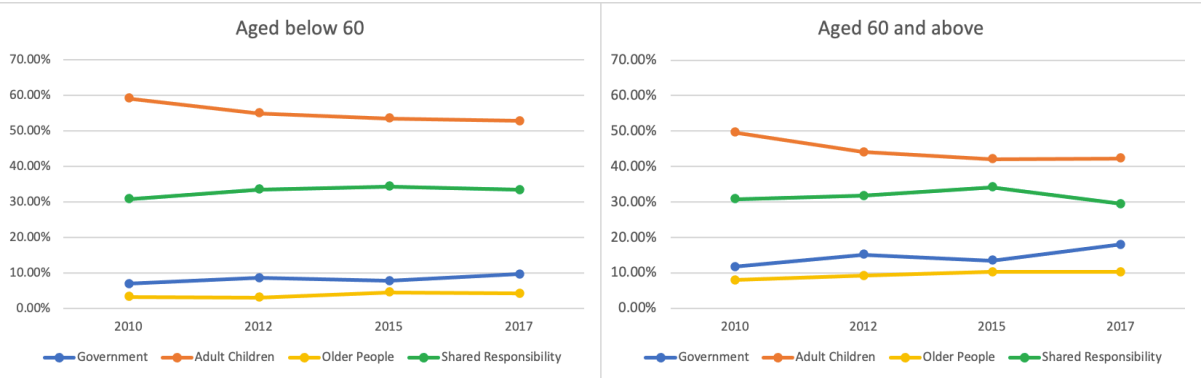


The division in the trends of care responsibility between the government and the family therefore followed the general patterns found in previous arguments, as did the decreasing expectations towards the family for shouldering care obligations (Lei, 2013, Du, 2013). Nevertheless, the increasing expectations towards the government appear to be minor, as those towards the family (including adult children and older people themselves) remain dominant. These findings correspond to the arguments addressing the family values and role of the family despite social transitions in recent years in China (Yan, 2016, Xu and Xia, 2014).

Specifically, when comparing the care attitudes between age groups (younger and older generations), that is, those samples aged below 60 years old and those aged 60 and above, evident intergenerational differences in care attitudes were shown in Figure 5.2.

For those aged below 60 (younger generation), more than half agreed that adult children should be the primary care providers despite a decrease from 2010 (59.2% in 2010, 52.8% in 2017). It was slightly higher than the attitudes of those aged 60 and above (the older generation) (49.6% in 2010, 42.3% in 2017). Correspondingly, the expectations from the government showed fluctuating trends in two groups, reaching peaks in 2017, in which the older people expressed a slightly higher expectation from the government (9.6% for those below 60, 18% for those 60 and above in 2017). Similarly, in relation to the proportion of those who agreed that it should be the older people who look after themselves, the older generation shared a higher trend (4.2% for those below 60, 10.2% for those 60 and above in 2017).

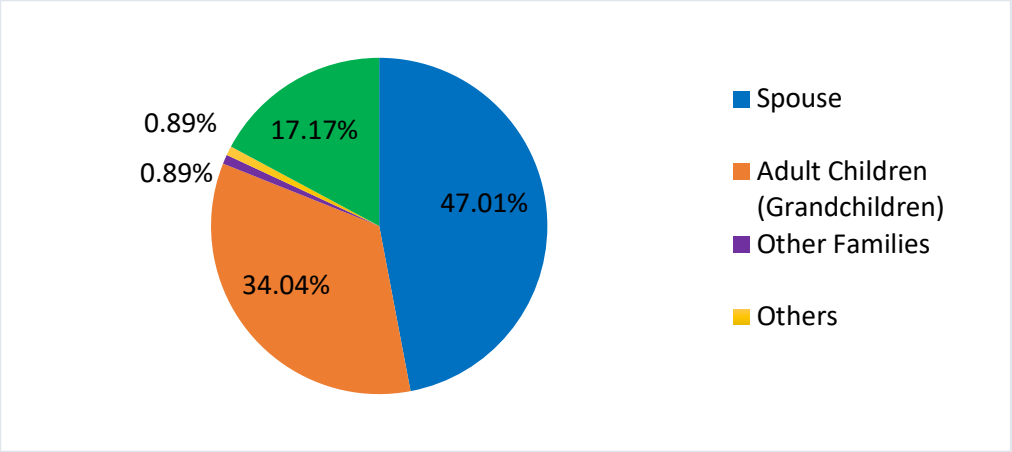
Figure 5.2 Who do you think should take care of older people? (CGSS) (below 60 and above 60)



These differences in care attitudes between older and younger generations affirm the arguments addressing the individual independence of older people than young and middle-aged adults (Tang et al., 2009), and they are more likely to accept care support beyond their families (Zhan, 2008). Furthermore, it should be noted that the relatively low but decreasing care expectations towards the government for the younger generation demonstrate the growing expectations for more support to relieve the burden of adult children.

Despite high expectations for adult children to provide care, the spouse of older people was the main caregiver in everyday life. Figure 5.3 shows the care providers for older people in 2018, and the proportion of spouses was 47.0%, and that for adult children (grandchildren) was 34.0%[1].

Figure 5.3 Who took care of you when you have not felt well in the last 12 months (over 60) (CFPS, 2018)



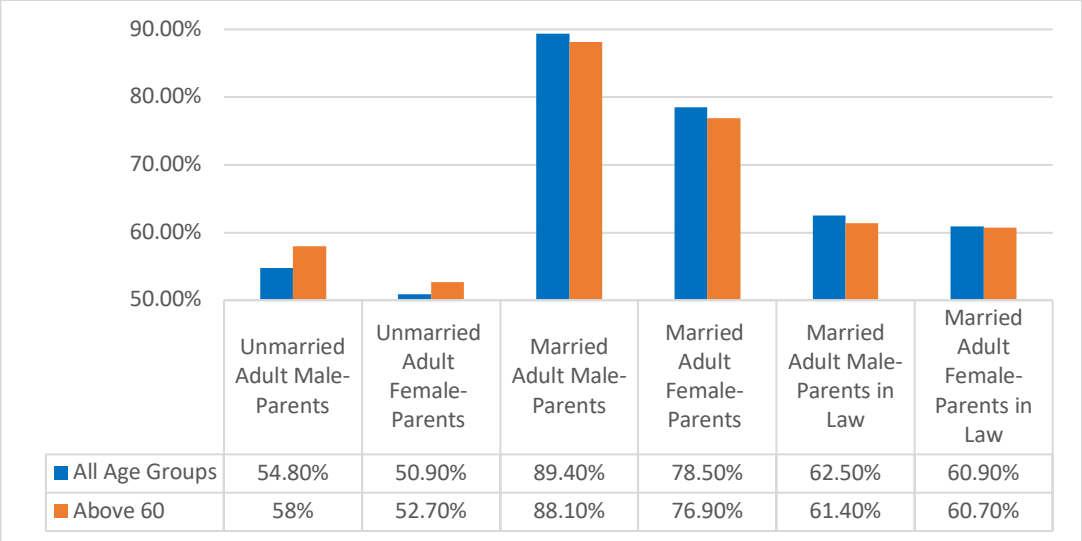
Comparing the care expectations in Figure 5.1 and the care provided in everyday life in Figure 5.3, the gaps between the care attitudes and care decisions show that the family retained its dominant caring role for older members despite slightly growing social attitudes towards the state's primary role in providing care. However, given that the question asked in the CFPS was 'Who took care of you when you have not felt well in the last 12 months', the current care provider for disabled older people in daily life has not been explicitly investigated to capture the precise care provision pattern.

The intergenerational contract refers to mutual help between older and younger generations within the family and specifically it has been long believed that adult children are obligated to support their parents through financial transfers and caregiving (*see* section 3.3.1.2). In Figure 5.4, it is apparent

[1] However, the question in CFPS did not specify the gender of care providers thus no accessible data to elaborate on the gender role in providing care in daily life.

that social attitudes towards care responsibility within the family varied by gender and marital status. The married sons were most likely to be assumed to shoulder the care obligation, reaching nearly 90% for all respondents and those aged 60 and above. Compared with single adult children, married ones were more expected to fulfil the care duty. Furthermore, gender differences are evident, given that males are generally expected to care for their parents more than their female siblings. A higher proportion of respondents agreed that more adult children should support their parents but not their parents-in-law, both for males and females. The one-child policy from the 1980s to the 2010s, which resulted in the '4-2-1' structure for many Chinese families, may be one possible explanation for this.

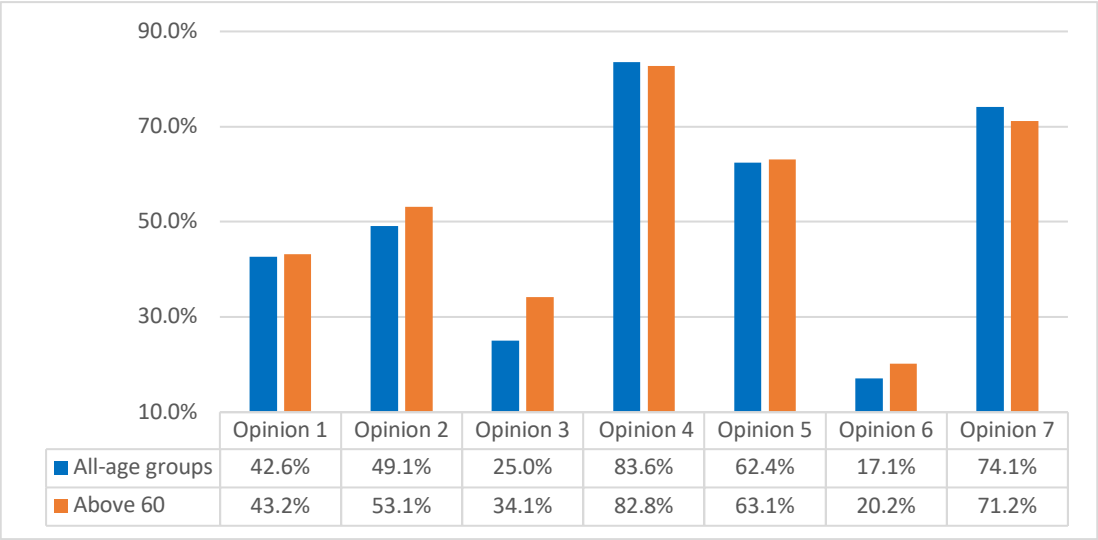
Figure 5.4 Should these family members provide support for their parents (-in-law)? (CGSS, 2017)



	Unmarried Adult Male-Parents	Unmarried Adult Female-Parents	Married Adult Male-Parents	Married Adult Female-Parents	Married Adult Male-Parents in Law	Married Adult Female-Parents in Law
All Age Groups	54.80%	50.90%	89.40%	78.50%	62.50%	60.90%
Above 60	58%	52.70%	88.10%	76.90%	61.40%	60.70%

Public attitudes regarding filial piety were also captured by CGSS data (Figure 5.5). There were shared opinions about how the younger generation should get along with the older generation, including (1) in all circumstances, the father's authority must be respected in the family; (2) the children should make their parents proud of them; (3) a son is necessary for the continuation of the family name; (4) younger generations should be grateful to their parents for their support; (5) regardless of how unkind your parents are to you, you must still take care of them; (6) personal ambition should yield to parental expectations; and (7) children must provide a higher living standard for their parents.

Figure 5.5 Do you agree with these opinions about filial piety? (CGSS, 2017)



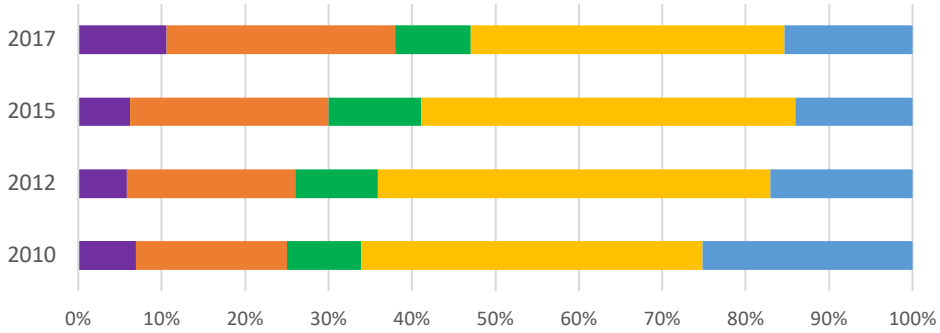
	Opinion 1	Opinion 2	Opinion 3	Opinion 4	Opinion 5	Opinion 6	Opinion 7
All-age groups	42.6%	49.1%	25.0%	83.6%	62.4%	17.1%	74.1%
Above 60	43.2%	53.1%	34.1%	82.8%	63.1%	20.2%	71.2%

The fourth view, regarding gratitude, was agreed upon by the majority of respondents, over 80% for all samples, and material support from adult children to their parents was also deemed essential by more than 70%. The second most approved factor was children's duty to provide their parents with a better life. These two preferences are both associated with intergenerational support, confirming the general social attitude about the obligation of the younger generation towards their older relatives (Lin and Yi, 2011, Zhang,Clarke and Rhynas, 2019).

Females are generally more likely to provide care to older family members and China is no exception (*see* section 3.3.1.3). Social attitudes towards the gender division of labour within the family are significant when analysing the family's role (Pascall and Sung, 2014, Hu and Scott, 2016). According to the CGSS data (Figure 5.6), it continues to be the prevailing opinion that males should rank their careers first, but the family first for females, despite an observable declining trend from 2010 to 2017

(66.1% in 2010, 53% in 2017). Females are more likely to be expected to contribute more to the family compared with their male counterparts, including providing care support for family members, and this attitude might also relate to the constant decrease in female labour participation in China over the past decades, as well as the policy discourses urging women to 'return home' (Song, 2011).

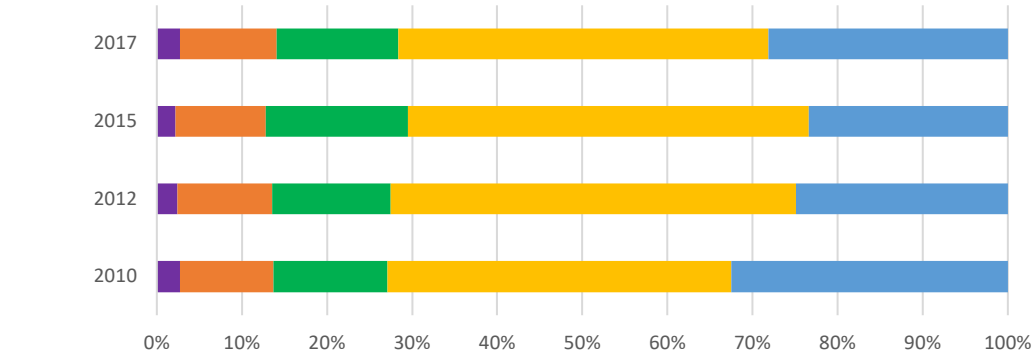
Figure 5.6 Men should prioritise their careers but women the family (CGSS, 2010-2017)



	2010	2012	2015	2017
Totally Disgreed	6.90%	5.80%	6.20%	10.60%
Disagreed	18.10%	20.20%	23.80%	27.40%
Average	8.90%	9.90%	11.10%	9.10%
Agreed	40.90%	47.10%	44.80%	37.60%
Totally Agreed	25.20%	17.00%	14.00%	15.40%

Specifically for housework sharing within the family, a slightly higher percentage of respondents agreed that husbands and wives should share equally all the housework at home (from 73% to 71.6% from 2010 to 2017) (Figure 5.7). It indicates that it is widely agreed that men are expected to carry out the workload that used to belong to their wives, which may include providing care to older family members. Nonetheless, the slightly fluctuating but decreasing trend over the years should be noted.

Figure 5.7 Couples should share the housework at home equally (CGSS, 2010-2017)



	2010	2012	2015	2017
Totally Disgreed	2.70%	2.40%	2.20%	2.70%
Disagreed	11.00%	11.20%	10.60%	11.40%
Average	13.40%	13.90%	16.70%	14.30%
Agreed	40.50%	47.70%	47.10%	43.50%
Totally Agreed	32.50%	24.90%	23.40%	28.10%

Therefore, social attitudes regarding the family providing support for the older members are revealed concerning the division of care responsibility, intergenerational contract and gender roles. Based on the data from the CGSS and CFPS databases, an increasing number of people recognise the responsibility that the state should shoulder instead of solely relying on the family (Lei, 2013), as well as the changing social values concerning the family's role (Yan, 2016, Yan, 2018). Accordingly, the family is consistently ranked as the primary care provider for older people, which is in accordance with the care provision patterns in everyday life (Cook and Dong, 2017). Moreover, there has been a shift in attitudes regarding gender roles (Ji et al., 2017), with males being more expected to share household duties with their female relatives. The cultural values concerning intergenerational contracts persist strongly (Wang,Wan and Gu, 2023), which might further shape the family's role in providing care support. The up-to-date evidence reveals the changing social values about family care provision in contemporary Chinese society, but descriptive analyses have yet to explore why social attitudes about the family's role in care provision are changing.

5.2 Explanations for the changing social attitudes towards care responsibility

In the light of the changing social attitudes towards care responsibilities divided between the state and the family in China discussed in the previous section, in this section I shall further examine the associations between these attitudes and the potential influential factors suggested by the previous literature. To capture precisely the care expectations from the state and the family, the dependent variable taken from the CGSS questionnaire was recoded as binary. This study uses binary logistic regression to estimate the association. Given that the data from the CGSS is cross-sectional, time was also identified as one of the independent variables in the analysis.

With the variables and hypotheses introduced in section 4.2.3, the operationalisation of the variables for these four hypotheses is shown in Table 5.1 and the descriptive statistics of the analytical sample are outlined in Table 5.2. There was no multicollinearity among the independent variables concerning the values of VIF.

Four logistic regression models were established. To address the intergenerational differences in care attitudes, Models 1 and 2 involved the analysis of all samples and Models 3 and 4 only covered the samples over 60 to determine if there were distinct associations for the older generations. In Models 1 and 3, the dependent variable is ‘the state should take the primary care responsibility for older people’; in Models 2 and 4, the dependent variable is ‘the family should take the primary care responsibility for older people’.

Table 5.1 Definitions of variables

Variable		*Measurement*
Care responsibility for older people in China		Model 1 and Model 3: 0 = State, 1 = Family Model 2 and Model 4: 0 = Family, 1 = State
Socio-demographic	Age	
	Gender	0 = Male, 1 = Female
	Hukou	0 = Urban, 1 = Non-urban
	Area	0=Living in rural area, 1=Living in urban area
	Education	1 = Primary school and below 2 = Junior high 3 = Senior high 4 = University and above
	Marital status	1=Unmarried, 2=Married 3=Divorced, 4=Widowed
	Year	1 = 2010, 2 = 2012, 3 = 2015, 4 = 2017
H1	Living with the spouse	0 = No, 1 = Yes
	Children	Number of children
H2	Participation in public pension scheme	0 = No, 1 = Yes
	Participation in public medical insurance	0 = No, 1 = Yes
H3	Health status	1 to 3: Unhealthy to healthy
	Household income level in local areas	1 to 3: Below to above the average
H4	GR1. Men should prioritise their careers but women the family GR2. Couples should share the housework at home equally	1 to 3: Disagree to agree

Table 5.2 Descriptive statistics

Variable	*Measurement*	*Frequency (%)*	*Mean (Std Dev)*
Year	1 = 2010	11776 (25.01)	
	2 = 2012	11761 (24.98)	
	3 = 2015	10968 (23.29)	
	4 = 2017	12582 (26.72)	
Age			49.40 (16.49)
Gender	0 = Male	22759 (48.33)	
	1 = Female	24328 (51.67)	
Hukou	0 = Urban	21708 (46.22)	
	1 = Non-urban	25257 (53.78)	
Area	0=Living in rural area	18223 (38.70)	
	1=Living in urban area	28864 (61.30)	
Education	1 = Primary school and below	17038 (36.24)	
	2 = Junior high	13357 (28.41)	
	3 = Senior high	8688 (18.48)	
	4 = University and above	7934 (16.87)	
Marital status	1=Unmarried	5038 (10.70)	
	2=Married	36779 (78.12)	
	3=Divorced	1022 (2.17)	
	4=Widowed	4240 (9.01)	
Living with the spouse	0 = No	10048 (21.34)	
	1 = Yes	37031 (78.66)	
Children	Number of children		1.74 (1.32)
Participation in public pension scheme	0 = No	17040 (36.99)	
	1 = Yes	29028 (63.01)	
Participation in public medical insurance	0 = No	4666 (9.97)	
	1 = Yes	42151 (90.03)	
Health status	1 = Unhealthy	8950 (19.02)	

	2 = Average	11253 (23.91)
	3 = Healthy	26853 (57.07)
	1 = Below the average	19006 (40.57)
Household income level	2 = Average	24088 (51.42)
	3 = Above the average	3756 (8.02)
	1 = Disagree	14027 (29.88)
GR1	2 = Neutral	4550 (9.69)
	3 = Agree	28362 (60.42)
	1 = Disagree	6353 (13.55)
GR2	2 = Neutral	6811 (14.52)
	3 = Agree	33728 (71.93)

5.2.1 Results

The descriptive analysis presented in section 5.1 reveals the increasing care expectations towards the state and the decreasing ones towards the family in supporting older people in China. The analysis in this section further investigates whether those attitudes have significantly changed over time and possible factors associated with those care attitudes. To test the hypotheses regarding the associations between individual attitudes towards care responsibility and the factors listed above, four binary logistic regression models were established using CGSS data from 2010 to 2017.

Table 5.3 Coefficients of logistic regression for individual social attitudes towards care responsibility (CGSS)

		Model 1 Family (N=47087)		Model 2 State (N=47087)		Model 3 Family (over 60) (N=13302)		Model 4 State (over 60) (N=13302)	
		Coeff	Exp(B)	Coeff	Exp(B)	Coeff	Exp(B)	Coeff	Exp(B)
	Intercept	2.933***	18.789	.1.263***	0.283	2.489***	12.045	.384	1.468
	Age	-.032***	.969	.016***	1.016	-.009*	.991	-.002	.998
	Gender (Female=1)	106**	1.112	.075***	1.078	.120*	1.127	-.038	.963
	***Hukou* (Non-urban=1)**	-.550***	.577	.404***	1.498	-.523***	.593	.407***	1.502
	Area (Urban=1)	.233***	1.262	-.234***	.791	.363***	1.437	-.274***	.760
	Year								
	2010 (Ref)	***		***		***		**	
Controls	2012	-.252***	.777	.164***	1.178	-.303***	.739	.171**	1.186
	2015	-.150**	.861	.171***	1.186	-.181*	.834	.216***	1.241
	2017	-.364***	.695	.117***	1.125	-.433***	.648	.102	1.107
	Education								
	Primary school (Ref)	-		***		-		***	
	Junior high	.024	1.024	.201***	1.223	-.037	.963	.230***	1.258
	Senior high	.012	1.013	.361***	1.434	.024	1.025	.237***	1.267
	University	.079	1.082	.581***	1.788	.001	1.001	.340***	1.405
	Marital status								
	Unmarried (Ref)	***				*		*	
	Married	-.243**	.784	.092	1.096	-.593**	.553	.144	1.155
	Divorced	-.066	.936	.051	1.053	-.351	.704	-.244	.784
	Widowed	-.421***	.657	.098	1.103	-.247	.781	.294	1.342
H1 Family support	**Living with spouse (Yes=1)**	.140	1.150	-.049	.952	-.236	.790	-.293	.746
	Number of children	.121***	1.129	-.110***	.952	.055**	1.057	-.065***	.937

H2 Public support	**Participation in medical insurance (Yes=1)**	-.145**	.865	.022	1.022	-.107	..899	-.090	.914
	Participation in pension scheme (Yes=1)	.015	1.015	-.124***	.884	.084	.087	-.141**	.868
H3 Care demand	**Self-rated health status**								
	Below the average (Ref)	***		***		-		***	
	Average	.066	1.069	-.019	.982	.073	1.076	.037	1.038
	Above the average	.171***	1.187	-.157***	.855	.137*	1.147	-.196***	.822
	Household income level								
	Below the average (Ref)	***		***		***		***	
	Average	.408***	1.503	-.232***	.793	.365***	1.440	-.297***	.743
	Above the average	.420***	1.521	-.212***	.809	.415***	1.515	-.269***	.764
H4 Gender role	**GR1 Male should prioritise career but females the family**								
	Disagree (Ref)	**		***		***		***	
	Not sure	.056	1.058	.007	1.007	.142	1.119	-.103	.902
	Agree	.121**	1.128	-.196***	.822	.239***	1.270	-.270***	.763
	GR2 Couples should share housework equally								
	Disagree (Ref)	*		***		-		**	
	Not sure	-.020	.735	.309***	1.362	.022	1.023	.167*	1.182
	Agree	.077	1.081	.254***	1.289	.009	1.009	.193***	1.213

Notes: Ref.: reference category. * P<0.05, ** P<0.01, ***P<0.001. Homser and Lemeshow test >0.05.

In this section, I examine whether these hypotheses correlate with individual attitudes towards care responsibility for the state and the family based on the binary logistic regression models (Table 5.3). The results of Hosmer and Lemeshow tests for four models indicate the good fitness of the models.

Socio-demographic variables

According to the models, variations between the analysis of older people (over 60) and all respondents were found. Regarding the control variables, different impacts were found on individual attitudes.

Age. Age is significant for individual attitudes towards care responsibility, as the results suggested that the respondents of higher age might believe that it is the state rather than the family that should shoulder the obligation to take care of older adults (Model 1, OR = 0.969; Model 2, OR = 1.016). Similar patterns are shown in Model 3 for those over 60 towards the family's care responsibility (Model 3, OR = 0.991) but not for Model 4. Therefore, older respondents are more likely to expect less care from their families but more support from the government.

Gender. The results revealed that female respondents were more likely to agree that the state and the family should have the primary care responsibility for older people (Model 1, OR = 1.112; Model 2, OR = 1.078), as were the cases over 60 (Model 3, OR = 1.127). Some findings of this study were in accordance with the argument that women have significantly less traditional attitudes towards patrilineality than men (Hu and Scott, 2016). Although it is claimed that there is a gender division of family care patterns in China (Chen et al., 2018), no specific gender variations regarding care expectations towards the family were found for the respondents.

***Hukou*.** The *hukou* reflects the urban-rural differences, which are also associated with the development of these areas since urban areas are typically much more developed than the nearby rural areas, especially in the non-coastal regions of China, after the Reform and Opening in the late 1970s. Comparison of the responsibility of the government and the family in this study showed that non-urban residents were less likely to believe that the

family should assume the responsibility (Model 1, OR = .577). Correspondingly, these respondents were 1.498 times more likely to agree that the state should provide care for older people in comparison with urban *hukou* types (Model 2, OR = 1.498). Comparable patterns were found for respondents in Model 3 (OR =.593) and Model 4 (OR = 1.502). In other words, respondents with an urban household registration type were less likely to expect the state to assume responsibility for caregiving, whereas they were more likely to expect the family to do so.

Place of residence. Similar patterns were illustrated in another indicator measuring whether the individual lives in an urban or a rural area. Those respondents living in urban areas were more likely to believe that it should be the family to shoulder the care responsibility compared with those living in rural areas (Model 1, OR=1.262). There was a lower probability that they would agree it should be the state's duty (Model 2, OR=.791). These conclusions were also evident for the older generation, as shown in Model 3 and Model 4.

So both *hukou* and location were used to capture urban/rural differences in care attitudes and reflected similar patterns. Although it has long been argued that rural residents usually have high filial expectations of their families (Liu and Cook, 2018), these results in this study do not support this argument regardless of people's *hukou* status or where they lived. However, the greater unmet care needs for people with rural *hukou* status than their urban counterparts (Zhu and Österle, 2017), the disparities of the care facility setting between rural and urban areas (Hung et al., 2013) and the absence of the state in welfare provision in rural areas in China (Fisher,Shang and Li, 2011) might be the explanations for the respondents with non-urban *hukou* status having higher expectations from the state than those with urban ones. Correspondingly, since urban residents are more likely to benefit from public insurance schemes which provide better coverage, they might be more likely to express gratitude to the state than have higher expectations. Nevertheless, with the profound socio-economic transitions in contemporary China, the detailed patterns of residents' choices need further discussion, given the enormous interprovincial disparities and the rising number of rural-to-urban migrants within China.

Education. There was a significant difference in education qualification for individuals' expectations of the state rather than the family for care provision for older people (Models 2 and 4). Compared with those respondents whose highest education level was primary school, those with higher education levels were more likely to believe that it is the state's duty to provide care for older people (Model 2, junior high, OR = 1.223; senior high, OR = 1.434; university, OR = 1.788; Model 4, junior high, OR = 1.258; senior high, OR = 1.267; university, OR = 1.405). These results are consistent with those reported previously (Hu and Scott, 2016), as the higher the educational level someone attains, the more open-minded s/he will be to welfare programmes provided from beyond the family. Those with higher education degrees usually have a higher expectation of care support from the state, which is more prevalent in contemporary China with the rising average education level. In addition, the education indicator is usually related to variables such as urban and urban areas, individual occupations and income. The analysis should therefore consider all these factors simultaneously.

Marital status. The results show that marital status was only associated with care expectations from the family. Married respondents were less likely than unmarried respondents to agree with the family having primary care responsibility (Model 1, OR =.784; Model 3, OR =.588). There were no significant differences in care expectations towards the state for samples of different marital statuses.

Time. Individual attitudes have also changed from 2010 to 2017. Respondents who, based on the data collected in 2017, were more likely to believe that the family should not shoulder primary care responsibility for older people than the respondents from 2010 (Model 1, 2017, OR =.695) Compared with 2010, there was a slightly higher probability that respondents would agree that the state should take a significant role in caring for older people in 2017 (Model 2, 2017, OR =1.125). In terms of older people, similar changes emerged when comparing the cases in 2010 and 2017 (Model 3, OR = 0.648; Model 4, OR = 1.107). This indicates the public's growing dependence on the government for care provision to a certain extent, in accordance with the findings of the descriptive data analysis in section 5.1. Relatively, the family always plays a vital role in supporting older people and is supposed to

lessen the burden of providing support for their older generations. Furthermore, since the growing policy attention in the elderly care system (Jing, 2020) and in the traditional virtue of filial piety in China (Krings et al., 2022), particularly since the 2010s, this development might also explain the changing public attitudes towards the public care schemes for older people, as they can access care provision more easily. The definite correlation between how development has shaped these related social attitudes is still indistinct, and it will be one of the primary issues in the following discussion based on the case study of this study.

Available support from the family

Available support from adult children is significantly associated with individual preference. The results demonstrated that those respondents with more children endorsed the view that the family should play the most crucial role in taking good care of older people (Model 1, OR = 1.129), but with a slightly lower probability for those over 60 (Model 3, OR = 1.057). Those with fewer children (or no children) believed that the state should take primary responsibility (Model 2, OR = 0.952). The models constructed for those over 60 also share similar patterns (Model 4, OR = 0.937). Since those with a single child are more likely to worry about their life in old age (Gustafson and Baofeng, 2014), the results in this section showed that those with fewer children or no children usually support the state as the primary care provider, as all four models support this view.

Since the long-established socialist system in China was implemented in the 1980s, older people accepted that it would not be easy for their single child to take care of them (Zhang and Goza, 2006, Cai and Feng, 2021). The results presented in this section show that it was believed that the state will take good care of you when you get older, particularly in urban areas, although the support for older people based on the commitment of the one-child policy has been criticised as merely “a good bite” (Cai and Feng, 2021). Despite a rich body of literature arguing the changing filial piety in China with the undergoing social transitions (Yan, 2016, Fu,Xu and Chui, 2020), the models show the positive associations between the care expectations from the family and the number of children, demonstrating the significance of available care support from adult children (Lin and Yi, 2011). However, the data about how the number of children have the detailed impact on the care provision are

not covered by the CGSS database and will be discussed in the later analysis based on the case study.

Whether individuals lived with their spouses was not statistically significant to the care expectations from the state or the family. Although it is claimed that spousal support contributes to delaying or avoiding the period of complete dependency on children (Xu, 2001), particularly for the large-scale out-migration of children and a corresponding decline in co-residence rates which are believed to have increased the importance of spouses as caregivers (Gruijters, 2017a, Gruijters, 2017b), the current results contradict these arguments as the presence of a spouse did not show a distinctive difference in the individual's thoughts about the family role in care provision. Notably, given that marital status is significant for individual care expectations from the family, married respondents were more likely to have lower family care expectations than unmarried ones.

Hypothesis 1 indicating the available family support is associated with individual care attitudes is therefore partially supported. The children of individual respondents rather than the spouse are associated with individual attitudes towards the family role in care provision for older people. This is consistent with the enduring, profound filial norms on the intergenerational support (Lin and Yi, 2011, Silverstein,Conroy and Gans, 2012, Du, 2013), as children are always seen as the primary pillar of necessary support. Nevertheless, the current findings affirm the significance of available family care support for the public expectations from the state and the family (Sheng and Settles, 2006, Cai and Feng, 2021). In line with the result for Hypothesis 1, when considering the policy design of the care provided for older people, given the shrinking family size in recent decades in China, developing care delivered by younger generations within the family may be favoured in terms of the preferential family obligation agreed upon by the public, demonstrating the necessity of promoting informal care for older people.

Support from the public sector

Participation in the public healthcare insurance scheme was only statistically significant for the individual attitude towards the family for all age groups (Model 1), but not for either

model of respondents over 60. Compared with those respondents who did not benefit from public healthcare insurance schemes, those who did participate were more likely to agree that the family should take responsibility for the care (OR =.865).

Those respondents who were participants in the public pension scheme were less likely to agree that the state should bear the paramount duty of caring for older people (Model 2, OR =.884; Model 4, OR =.868), despite a slightly tiny degree of difference. One of the possible explanations for this is that those who have not benefited from the public pension insurance for financial support might expect the government to play a significant caring role. However, given that the public social schemes for older people are mandatory for urban employees, who form 95% of residents in China, the broad coverage of public healthcare insurance might lead to a low variance in care attitudes, particularly for the younger generation.

Given the arguments regarding the crowd-out effects of welfare generosity and public efforts (van Oorschot and Arts, 2016), and of family support and the development of the welfare state (Kasearu and Kutsar, 2013), the support from the public sector might also affect the family care support, as does the individual expectation towards the care provision. As with the results discussed in this section, the public sector's support is partly associated with public attitudes towards care obligations. The pension scheme possibly links to financial support or a guarantee for their future old age, whilst the healthcare insurance is related to the more professional care support available outside the family, thereby shaping the different care expectations from the state and the family. With the expansion of healthcare coverage in China, especially among the younger generations, the state is expected to play a more important role in supporting the public in the foreseeable future.

Individual care demand

Individual health status was significantly associated with the care attitude towards the state and the family in all four models. Specifically, it was positively correlated with the care expectations from the family. Compared with those respondents who rated themselves as unhealthy, those who claimed to be healthy were more likely to believe that the family should take care of older people (Model 1, OR = 1.187; Model 3, OR = 1.147). Accordingly, they

were less likely to expect the state to provide care (Model 2, OR = 0.855; Model 4, OR = 0.822). Therefore, those with better health were more likely to have a strong sense of self-reliance, with lower probabilities of expecting the state to provide care support. These results about care attitudes are in accordance with the argument about care decisions claiming that the substitution effect of informal care for formal care disappeared with the increasing degrees of disabilities of care recipients (Bonsang, 2009). One explanation for this might be that those in better health might not have an urgent demand for the provision of care because the family, as the conventional care provider, can satisfy their current care demands.

In addition, as the development of the care system for older people is still in its early stages in China, not to mention the long-term care system, most people have not had access to these services and therefore perhaps do not view the state as a dependable provider of the necessary care. The public's understanding of responsibility-sharing beyond the family might change as a result of the continued development of policy programmes aimed at older individuals. Further discussion is placed based on the case study in the following chapters.

The self-rated household income level in the local area was also significantly associated with expectations of care from the family and the state. Those respondents who considered their household income to be above average were more likely to agree that the family should carry the care burden (Model 1, OR=1.521; Model 3, OR=1.515) and had fewer expectations of the state. These results about care attitudes share similar patterns in the conclusion of care decisions, as affordability for formal care was largely associated with the informal care provision from the family (Schulz et al., 2012, Hu, 2019).

The models support Hypothesis 3, which assumes that individual demand for care provision is associated with care attitudes. Demand for care was significant for the individual's perception of the state's and family's responsibility for care provision. These associations captured in all age groups were also observed in the models of older individuals, contributing to the policy implications of future policy design or revision.

Gender role attitudes

Females are usually expected to provide direct care for older people, particularly in China, which has a long-standing patriarchal system (Cook and Dong, 2011, Cong and Silverstein, 2012b). Although it was argued that there is a decreasing trend of traditional gender attitudes in China (Hu and Scott, 2016), the findings of this study reveal that the attitudes towards conventional gender division of labour remain robust, while they are consistent with Shu and Zhu's (2012) work. Those respondents who agreed that men should prioritise their careers and that women should concentrate on the family were more likely to view the family as the provider of care support (Model 1, OR = 1.128; Model 3, OR = 1.270).

The opinion that couples should share housework equally reflects individual attitudes towards the family's labour division. Only Model 2 and Model 4 of the care expectations from the state showed significant effects, with similar patterns. Model 2 showed that the respondents agreed that housework sharing between husbands and wives makes them more likely to consider that the state should support older people (OR = 1.289), as it did for the respondents over 60 (OR = 1.213). However, it should be noted that there may be different perceptions of gender roles for males and females. That is, the understanding of 'equally share' may vary.

Given that social attitudes have reflected growing gender equality in recent years (see Figure 5.6 and Figure 5.7), as with the significant associations between gender role attitudes and care attitudes towards the state providing support for older people, there might be higher expectations towards the state in the future.

5.2.2 Summary

In this section, these four models were used to examine the associations between individual attitudes regarding the division of care responsibilities between the state and the family and various factors discussed in previous research. Age, gender, rural-urban differences, education, available family support, support from the public sector, the demand for care and attitudes towards gender roles were all found to be moderately significant factors of an individual's care expectations from family and the state. To satisfy the demand of older

people as much as possible, the government, primarily local governments, should design and promote a care scheme that corresponds to the characteristics of the target groups, as many related care schemes for older people are undergoing rapid development.

Notably, the data in the CGSS database show that public attitudes may have changed from 2010 to 2017; the public are now more likely to receive care from the state rather than relying on the family, which is to some extent contrary to the extensive and enduring cultural values that emphasise the importance of the family in caring for older generations but consistent with the more pragmatic care attitudes (Shi, 2017a), but the precise patterns are still being debated. The evolution of elderly care and the long-term care system in recent years could also have contributed to these shifts, although their interrelationship remains unclear. Corresponding to the changes in public attitudes, it is still unclear whether and how the family's role in assisting older people has changed in everyday life, which is essential for policy designs addressing informal care in the current long-term care system.

5.3 Conclusion

In this chapter, the social attitudes regarding the role of the state and the family in providing care for older people in China have been examined using a quantitative approach (RQ1).

In the first section, the descriptive analysis outlined the changing public attitudes towards the care responsibility of the state and the family in supporting older people in China. According to data from the CGSS database, there are visible changes from 2010 to 2017, as an increasing number of respondents agreed that the state should take the primary or share the care responsibility for older people, although most people consented that the family, including the older people themselves and adult children, should be the principal ones. Despite cultural values highlighting the family as the principal care provider for its older members (Chappell and Funk, 2012, Lin and Yi, 2013), these values have been weakened to a certain extent, particularly based on the data from 2010 to 2017. Concerning the slow changes in social attitudes, a subsequent examination with data from additional waves will result in a more complete understanding of RQ1 in further research.

Nonetheless, as evidenced by the CFPS database, the pattern of family care for older people in everyday life has not yet shifted accordingly, and informal care remains the predominant care option for older people in China (Lin, 2019). There is a gap between care expectations and actual care provision for older people in China, in spite of the development of the elderly care system in recent years, for example, the implementation of long-term care insurance as the financial mechanism for care services with urgent care demands due to disabilities. At the time the data were collected, most respondents may not have had access to the long-term care pilot programme launched in 2016 with limited coverage. These results contribute to RQ1 by demonstrating more complex care attitudes regarding the state's and the family's responsibility, as well as those related to intergenerational contract and gender roles within the family.

Based on the overall patterns of care attitudes, the second section examined the possible associated factors using CGSS data from 2010 to 2017. In addition to the data presented in section 5.1 regarding the changing individual care attitudes, time as an independent variable was statistically significant, confirming the shifts in social attitudes regarding the role of the state and the family in providing care (RQ1). These findings are consistent with the arguments about the decreasing emphasis on the family for providing care in prior research (Lei, 2013), as well as the changing social attitudes towards the family's function in supporting its members (Yan, 2016) .

Concerning the hypotheses derived from previous studies, they are largely consistent with the binary logistic regression models, both for those covering all age groups and for respondents over 60.

Although the associated factors for all age groups of respondents and those over 60 were similar, age was found to be a significant factor for care attitudes, indicating that the younger generation is more likely to expect the state to play a larger role in care support for older people, as Du (2013) argued that the younger generation is more likely to anticipate the development of formal support. These findings also make a valuable contribution to the

discussion of RQ3, specifically in relation to the comprehensive examination of social attitudes on a national level within the context of the case study.

Regarding all regression models and the significant associated factors, the policy design for care policies aimed at older people should take into account the availability of family support and public insurance programmes (Shi, 2017a, Hu and Ma, 2018, Zhang et al., 2020), as well as care demands related to household income (Hu, 2019), and individual health status (Bonsang, 2009, Coe and Van Houtven, 2009).

In the light of the ongoing decline in family size and fertility rate, the predictable lack of available family support might result in higher care expectations from the state and lower expectations from the family. As a newly implemented public insurance scheme, long-term care insurance might result in similar but more complex patterns of care attitudes than public healthcare insurance and pension schemes. The household income, which largely relates to the affordability of care support, is crucial for understanding individuals' reliance on the government. Moreover, given that the existing long-term care schemes primarily determine the care provided based on an individual's health status as determined by instrumental and cognitive disabilities, other factors must still be considered in the design of the policy, particularly the gradually changing individual attitudes towards care provision from the family and the state, which could influence the care provision pattern adopted by the individual. The gender role attitudes were associated with the care attitudes towards the state, but how these associations could change requires additional analysis given the complexity of the gender role attitudes in contemporary Chinese society.

According to the findings presented in this chapter, changes have been observed in the social attitudes towards the state and the family in providing care for older people in China, particularly in the care expectations from the state. Therefore, the analysis addressing RQ1 outlined social attitudes towards the division of care responsibility between the state and the family, the intergenerational contract, and gender roles in care provision. It provides evidence of cultural values in relation to the role of the family in providing care for older people. Specifically, the findings of this chapter reveal what cultural values in China might

impact the care decisions of individuals and families in RQ2 and RQ3, as well as the care policies in RQ4.

Case Study Introduction: Long-Term Care Insurance in Guangzhou

Guangzhou was one of the first pilot cities to implement long-term care insurance in China. It began its exploration under the national guideline in 2017 and care from non-formal caregivers was included in the insurance-funded care system in 2019.

Institutional care and home-based care are available for older people according to the ADL assessment conducted by the insurance enterprises authorised by the local government, identified as Levels 1, 2 and 3 (3 is the most severe disability). The reimbursement rates and caps for different types of long-term care vary across the public healthcare insurance types in which individuals have participated (Table 6.1).

Table 6.1 Reimbursement of the long-term care insurance scheme in Guangzhou

	Participants of the Urban Employee Basic Medical Insurance (UEBMI)			Participants of the Urban and Rural Resident Basic Medical Insurance (URRBMI)		
	Cost	Reimbursement Rate	Reimburse-ment Cap (Yuan/day)	Cost	Reimburse-ment Rate	Reimbursement Cap (Yuan/day)
Institutional care	120	75%	90 (£10.1)	60	70%	42 (£4.7)
Home-based care	105	90%	94.5 (£10.6)	50	85%	42.5 (£4.8)

Specifically for home-based care, there are services provided by full-time caregivers and part-time caregivers. The former have formal employment relationships with the care homes authorised by the local government; the latter are those caregivers who are given qualification certificates after undertaking mandatory training courses and examinations, mainly family caregivers and private caregivers hired from the care market. After registering in the long-term caregiving online system led by the local government, all the part-time caregivers are trained and supervised by the care managers from the care homes. In this way, the family members providing long-term care are not identified as informal caregivers but as part-time caregivers. The provision of long-term care in Guangzhou differs slightly from other pilot cities with insurance-funded informal care *(see* Table 1.2), with the family's role in the long-term care system being somewhat ambiguous.

Only people identified as Level 3 can choose the care provided by full-time caregivers and part-time givers. For example, the same reimbursement cap of 94.5 yuan per day (about £10.6) applies to participants in public healthcare as employees in urban areas, regardless of whether the care is provided by full-time or part-time caregivers, covering approximately three hours of daily care. Care recipients can select one of the following options:

1. Care provided by full-time caregivers: if care recipients require care services that exceed the reimbursement cap (about three hours per day), they can purchase additional services from the full-time caregivers (care homes) at their own expense.
2. Care provided by part-time caregivers: the caregivers receive monthly wages transferred from the care home, which account for approximately 85% or more of the reimbursement (depending on the contracts between care homes and caregivers). In many cases, the part-time caregivers continue to provide care beyond the insurance reimbursement cap.

The next three chapters present various perspectives of the family's role in long-term care provision in the case study from the perspectives of care recipients (Chapter 6), part-time caregivers (Chapter 7), and other actors involved in the long-term care system (Chapter 8). These chapters provide empirical evidence for two analytical frameworks of defamilialisation and cultural values within the care arrangement, thus addressing RQ2, RQ3, and RQ4 based on the case study.

6 Care Recipients

Of the diversified long-term care provision patterns in the pilot cities in China, Guangzhou's pattern valued the family's contribution by offering insurance reimbursement for care provided by the family. Nonetheless, based on the data collected in the case study, different perspectives towards the family's role in providing long-term care and pertinent issues were shared by care recipients and caregivers, some of which appear contradictory, leading to a more comprehensive understanding of the care provision in the local policy exploration in Chinese society.

This chapter presents the responses of ten care recipients. For the older people receiving the public insurance-reimbursed care services provided by part-time caregivers, eight received care from their family members and two from private caregivers recruited from the market. The findings are presented under four themes: (1) the care expectations from the state and the family; (2) the reasons for choosing family care; (3) the changing family care patterns before and after the implementation of long-term care insurance; and (4) the policy expectations for long-term care. Their answers are set out based on the themes identified in the analysis, with quotations from the interviewees (*see* Appendix 3 List of Interviewees and Appendix 4 Coding Frameworks). These results reflect the care recipients' attitudes and care decisions of the family providing care, shedding light on how the family adjusts its role in response to its members' care demands, the development of long-term care and relevant explanations.

6.1 Care expectations from the state and the family

Chapter 5 presented the social attitudes regarding care responsibilities based on the data from two national databases; this chapter focuses on the discussion in the case study, targeting those who have already received long-term care. This section summarises the different care expectations from the state and the family.

6.1.1 Satisfaction with the state's support for ongoing social programmes

Regarding the question 'Who do you think should take responsibility for taking care of older people' (the dependent variable of the analysis presented in section 5.2), most interviewees agreed that there was a natural family obligation: the family should inevitably be the caregiver rather than anyone else, even the government.

Interviewee RF3 considered that it was the inherent responsibility of the family to care for its members, and that the state had already done its best by running healthcare insurance for medical care services and pension schemes for income maintenance:

> *To take care of its members is the undoubted duty of the family. The government has spared no effort to support us, just like the old age scheme and health care insurance. I could not expect more because I knew it would be beyond its capacity.*

Her view was not a single case, as interviewee RO2 also felt grateful for the support received. She was satisfied with the financial support from the public pension scheme and the instrumental care support paid by long-term care insurance. Although her family did not act as the direct caregiver, it provided financial assistance to increase the household's purchasing power for care alternatives:

> *The government has done all it could to support us, such as long-term care insurance and a pension. I have never thought of relying on the government for care support.*

They thought highly of the support from the government due to other ongoing social programmes which are much more direct and visible as a cash benefit. The newly implemented long-term care insurance was more recognised as an additional financial support for older people because they had never had expectations from the care provision beyond the family, given that care for older people is traditionally a family affair in China (Abrahamson, 2016). These comments also reflected their great understanding of the care burden of the government; hence they had never raised any wishful thinking or even extravagant hope for the state to cover more than the insurance-based pension and healthcare services. Unlike the old-age pension and healthcare insurance which have been

widely known since their implementation in the 2000s, many older people lack a clear understanding of the newly launched long-term care insurance.

Although interviewee RF5 highly praised the support from the government, he confessed that he could not afford any care services except those provided by the family, even with the implementation of long-term care insurance:

> *It is the family obligation to take care of older people if the children are filial …. My monthly pension is about 3000 yuan, and it is not enough to pay for the cost of living in the care home. It is easy to understand that I am hoping to receive more support from the government, but the government has helped me a lot with economic support.*

Thus despite the monthly income from the public pension insurance, for many disabled older people, the care services were much more essential for meeting their care demand than any financial support, particularly considering the high costs of any other care options outside the family.

The widely shared self-reliance without relying on the government has been shaped by the historical events which individuals have experienced (Yu and Rosenberg, 2017), affecting individual attitudes towards the state's care responsibility accordingly. Interviewee RO1 described her experience in the work unit. She insisted that she kept herself self-reliant as long as possible so as not to cause an additional burden on the state with her self-discipline in living independently to support the government. Her words show that people are educated to be independent rather than to seek or expect government support, thereby shaping their expectations of the state:

> *The family should provide the care. The government has done an excellent job, and I would not wish too much …. It is my fault that I did not know how to take care of myself when I was young …. In the past, when I worked in the work unit, all the contributions did not get money as a reward; instead, just a piece of paper to praise the 'outstanding individual'. I had worked extremely hard to get that, and as the work model.*

This part shows respectively high satisfaction with and low expectations from the support provided by the state. Correspondingly, some older people continued to take it for granted

that the family should carry out its caring responsibilities, possibly due to a lack of understanding of long-term care insurance and the affordability of alternative family care options.

6.1.2 Eager for more state support as the payback for the one-child policy

Concerning the care responsibility division between the family and the state, the one-child policy was a critical issue mentioned by some interviewees. They believed that the state should ensure good lives for the older generation as a reward for upholding the family policy in China for decades. Given the limited care provision available from the family, those older people with a single child expressed more substantial expectations from the state's support for the care provided. Interviewee RF7 asserted that the state should support those who adhered to the policy and had a single child:

> *It should be the state's obligation to take care of the older people because we have just one child. In the late 1970s, the state urged us to just have one child, and we had no choice but to obey the laws …. It would be unreasonable if the state ignores our current demand.*

As the one-child policy in China limited the number of children the public gave birth to, some older adults with a single child expressed the view that it was unfair for them not to receive sufficient policy attention in their old age. In their opinion, they had less access to care and support from the family than the previous generation. Unlike the economic support from the pension scheme, the labour for care provision should be the most pressing concern, demanding care delivered by the public sector as a reward or even as compensation for the generation with a single child. Interviewee RF6 suggested that the support from the state should prioritise the care services over the cash benefit, given that their contribution and sacrifice to the state should be repaid through the care support provided by the public sector:

> *Our generation has contributed a lot to the state's development, thus hoping the government would provide more support for us in return. Otherwise, we have to live difficult lives. It is not about the money provided by the state, but it is about who could provide care services to us. It is nonsense for someone like me even if you give me one million yuan. What I need are care services.*

Comparatively, for those interviewees with more than one child, the wish for compensation from the state was barely mentioned. Instead, they took it for granted that their adult children should share the care obligation. The data drawn from the case study show that some people with more than one child were more likely than those who were childless or with a single child to endorse or maintain the traditional family role in fulfilling its care responsibilities. The one-child policy was interpreted as the commitment between the state and the public to guarantee their old age; thus those who had been committed to the family planning policy imposed when they were young tended to believe that the state should fulfil its promise, which is more than just financial support but also care provision. Hence, even those with a single child had no alternative but to ask their child to provide care services; thus, more available and affordable care options tailored to their specific demands merit further policy attention.

6.1.3 Taking care of older people is the family tradition in Chinese society

The family has always been considered the basic unit in Chinese society (Faure and Fang, 2008), and it is an intrinsic custom in Chinese society for older parents to ask for support from their adult children (Yan, 2018). Most of the interviewees had not changed their perceptions of family care provision since the introduction of long-term care insurance as their caregivers had been their family members before that and continued to be so after it. Although the cultural values addressing family obligations might have been too abstract for them to comprehend, several key terms were frequently stressed, such as 'filial piety' and 'affection'. Interviewee RF7 admitted that the care support from the family was not just a legal obligation but also a longstanding tradition in Chinese society. Older Chinese family members are bestowed the highest respect by family members and society:

> *It is in the DNA of every Chinese person, and I am pretty sure that your parents teach you to respect and care for older people. In China, it is the written law stating that it is everyone's duty to take care of their parents.*

In addition to familism, it is argued that receiving care support from the younger generation is the payback for the older generation's previous contribution, generally based on the intergenerational contract or the principle of reciprocity (Cong and Silverstein, 2011b,

Gruijters, 2017b). The exchange between care support from the younger generation and previous support from the older generation was frequently highlighted in the interviews. It mainly refers to older people rearing their adult children and grandchildren, caring for them and contributing to the housework when the older people are healthy. Consequently, older people take it for granted that they will receive care from their adult children. Interviewee RF8 noted that she assisted her son in raising her grandchildren. They should therefore have taken care of her when she demanded care as the compensation:

> *If you are childless, you have no other options but to live alone, and it will be tough when you can no longer take care of yourself …. I look after my grandson and granddaughter, and my son has not hired others to do all the housework, including shopping, cooking and taking care of the children …. So I have never worried about becoming a burden to them.*

It should be noted that, considering that the period of an individual requiring care support due to disabilities or chronic diseases is respectively short in the life course, the parents usually sacrifice unequivocally much more than their children in the resource exchange between the generations.

The older people held different opinions regarding an ancient Chinese proverb, 'raise children in order to have a secure life in old age'. Although most of the interviewees agreed with the cultural values regarding filial piety, respect and care for older people as notable individual merits, their thoughts were more practical, with more understanding and consideration for their adult children. Interviewee RF1 said that she entirely approved of the well-known obligation of adult children to support their parents, and it had been fulfilled by most of the public:

> *I agree with that saying, and it is just a rare case that there are unfilial children. My children are all very caring for me and often ask me what I want.*

However, with the rise of individualism, the impact of values driving care support from the younger generation appears to have diminished (Bedford and Yeh, 2019, Hamamura et al., 2021). Interviewee RF6 argued that this proverb emphasising the support driven by intergenerational contract should be clarified with different considerations in contemporary

China and emphasised the necessity of educating the younger generation to show filial piety to the older, as individual interest had notably harmed the traditional virtues:

> *The government in various periods has had different thoughts about supporting older people. This does not mean that this saying is meaningless now, but we need to strengthen young children's education. For instance, to pay more attention to teaching children to respect and be filial to their parents. Thus, my daughter takes care of me, and she knows that her child would see her as an example …. However, it is very different now, as the interest is most significantly impacting the filial piety of the parents.*

Specifically, the family's support involves financial and physical support, the latter of which is urgently required by many disabled older people. Interviewee RF3 said that she needed care services rather than any financial assistance from her family:

> *Although there is a saying that children would no longer be filial if they had taken care of their parents at their bedside for a long time, I believe that only just a minority of people are like that. Undoubtedly, individuals would depend on their families when they are old. I do not need my children to provide economic support to me, what I need is the care services they provide.*

So although cultural values based on filial piety and intergenerational contact continue to be widely accepted and supported by older people, many interviewees acknowledged that these values had become more adaptable in emphasising family care responsibility. These findings are, to a certain extent, consistent with those set out in Chapter 5 regarding less-familial social attitudes towards care responsibility.

6.1.4 Different roles of sons and daughters in family care provision

Responding to the question concerning the family's principal responsibility for taking care of older people, different roles were claimed to be expected from sons and daughters. Given the traditional belief in son preferences rooted in the country's patriarchal society (Santos and Harrell, 2017), sons are granted greater care expectations than their sisters (Cong and Silverstein, 2012b). Interviewee RF8 said that a son should inherently shoulder more care duty for his parents because a daughter's responsibility shifted once she got married:

> *The son should take on more obligation because it is the son who carries on the family name whilst the daughter marries others. It has nothing to do with the support I gave them.*

However, more interviewees claimed that there are no distinctive differences between sons and daughters in terms of care obligations considering the available care support from their adult children and their own busy lives. This was mainly the case for those with a single child, whether a son or a daughter, due to the one-child policy. These traditional cultural values in urban areas such as Guangzhou have become more pragmatic for sons and daughters, as interviewee RF3 stated that her son and daughter shared the care work equally because neither could act as her full-time caregiver:

> *My son and daughter take care of me in turn, and I am satisfied with that. My son has three children, and my daughter also has a job. By the way, I do not care about who my caregiver is because both are my children.*

Interviewee RO2 underlined that social attitudes towards the gender roles of sons and daughters were less traditional and rigid in urban areas, indicating the significance of urbanisation:

> *I do not think there would be any differences for sons and daughters, particularly in Guangzhou. Those who live in the rural areas might have these thoughts such as they are keen on having sons whilst the daughters are not members of their birth family anymore once they have married.*

In summary, with respect to the care responsibility from the state and the family, for the older people receiving public insurance-funded care from family members, the case study showed that the family remains the predominant provider and is expected to shoulder more care work rather than relying on the state. There were accordingly few care expectations from the state, despite the implementation of long-term care insurance as the funding mechanism.

6.2 Considerations in care decision-making

In response to the question 'Why do you choose the care services provided by the family', the interviewees gave various determinants and the reasons mentioned could be broadly

classified as economic and value-related factors. Notably, the care decision was derived primarily from collective family discussion.

6.2.1 Capacity for care alternatives

For many interviewees, the economic constraint was the most decisive factor in their care decision, referring to the capacity to pay for care alternatives beyond the family. They emphasised that the pricey direct out-of-pocket payments for the care provided by the care homes and the full-time caregivers restricted their options, leaving only those from the informal sector that were affordable.

Interviewee RF6 said that the high cost of hiring a caregiver from the private market exceeded his purchasing power, even with the pension and long-term care insurance scheme reimbursement:

> *We had considered hiring a full-time caregiver before, but it takes at least 7000 yuan per month (about £750), far beyond my monthly pension. He or she might even ask us to cover all her daily costs and even reference the rights of the worker to defend her rights.*

Because he knew his family had endured a great deal of suffering, interviewee RF7 wanted to hire a carer at a cost-effective rate to share the caregiving responsibilities, but he could not manage to do this because of the cost:

> *I could not afford to hire a full-time caregiver, nor the fees for living in a care home. Without the economic constraints, I would do so because both my wife and my younger cousin [his current family caregiver] have to work hard to look after me.*

The economic strains for the interviewees were not individual-based but rather household-based, as the adult children managed all the financial issues of the older people, including their savings, pensions and all other benefits from welfare schemes. They were unclear about their daily spending, not to mention the expensive care services. Interviewee RO2 said that she had no idea of all her income, so she had never worried about the costs of the care services:

> *It is my daughter who manages all my income, and I do not know how she uses it, nor the cost of hiring a caregiver.*

In this way, although long-term care insurance may have increased the affordability of care services, the family remains the most feasible care provider due to the reimbursement caps which are largely determined by the family's ability to afford to pay for care alternatives other than the care provided by the family.

6.2.2 Available family care provision concerning the labour and money dimensions

The availability of care services provided by the family was another crucial consideration why the older people preferred the family as caregivers. According to the interview responses, this was mainly related to whether or not family members were willing and/or able to act as caregivers. Interviewee RF1 believed that support from her children was the best option, and they were filial and willing to provide care services:

> *I would hire someone to take care of me if I could afford it. However, I cannot. I have sons and daughters who can and are willing to care for me. This is enough for me; otherwise, it would cost too much.*

Compared with getting care from family members, interviewee RO2 received care services from a hired caregiver because her family could afford the care services from the private market. She highlighted that she did not want to alter her family members' lifestyles, which also related to their willingness:

> *I have lived with my daughter since she came back from abroad during the pandemic. My son and his family live in America. I keep a close relationship with them as he has set up a CCTV at home to see what I am doing and check if everything is all right …. My daughter is not at home today because she has gone to Jilin Province for traveling …. Although I live with my husband and my daughter, I do not want to bother them, and they are not good at taking care of others. Both have busy lives as my daughter travels to different places, and my husband spends lots of time on exercises.*

Personal preferences for support from spouses instead of the next generation were also mentioned. In some cases, especially for the male interviewees, they did not want to cause trouble or increase the difficulties of their adult children. However, it might be a different dilemma for the female older people because of care becoming inaccessible from their

spouses, as their husbands might die before they become disabled. Interviewee RF2 said that he was receiving care from his wife to relieve the care burden on his children:

> *My wife is the first choice for providing care for me. I have never considered asking my children to take care of me because they have their own families.*

6.2.3 Ageing-in-place preference rather than leaving their homes

When asked about their priority among the care options without considering the material constraints, some of the older people insisted on home-based care from their family and hiring full-time caregivers as their favourite choices. Some claimed that they were reluctant to go into a care home because of the negative thoughts about them coming into their minds, as interviewee RF3 said:

> *I would never go to a care home because it is much freer and more comfortable for me to live in my own home.*

Interviewee RF4 mentioned that hiring another person to take care of her at home was her best choice. Therefore, even if she wished to relieve the family's care burden, leaving the home setting was the least favourable option:

> *Even without the economic considerations, I prefer to hire a full-time caregiver to take care of me at home rather than go into a care home.*

Their responses showed a general preference for 'ageing in place' because older people preferred to stay in places which are familiar and give them a sense of belonging.

6.2.4 Family members are more trustworthy for care provision

For many interviewees, the family was a more dependable source of care, described as 'a safer choice'. This is primarily attributable to the familial relationship between carers and care recipients.

Interviewee RF6 shared his primary concern about receiving care from others outside his family, as others might not tolerate his bad temper, causing tension between the care recipient and caregiver. This might in turn harm his mental or even physical health. He believed that family caregivers are more tolerant and patient due to love within the family:

> *Even if there are any affordable care services, I do not want to get care services from others except my wife and my daughter. Because I have a bad temper with my disease, which might easily cause quarrels with others … if I hired someone to take care of me living in my house, it would be very normal to have conflicts between us because older people with severe illnesses usually have bad emotions. However, someone who serves you also needs to vent their negative feelings, which would twist together.*

Compared with the inherent trust within the family, anyone else is generally considered a 'stranger' for disabled older people. Interviewee RO1, who was receiving care from a hired caregiver, said she was cautious when getting along with her caregiver, relating to two concerns: (1) recruiting a caregiver at a reasonable price in Guangzhou is not easy, considering the high salary and work package as a relatively heavy financial burden for the employees; (2) the caregiver is someone beyond her acquaintance, even if they live together. She therefore carefully maintained a harmonious relationship with the hired caregiver, and had never shared her secrets with her, specifically those related to economic issues:

> *It would be nothing even if I shouted at my daughter, but I am always very nice to my caregiver, and I would not share any secrets with her. I worry that she might quit the job if there are any strong words between us. I have hired this caregiver for four years, and we have a very close relationship without any quarrels.*

Some interviewees also said that they were more willing to hire caregivers who spoke Cantonese due to the trust needed in the care relationship between care recipients and caregivers. Even those speaking Cantonese with an accent from other cities in the same province were also less favoured. The older people claimed they were reluctant to be cared for by someone unfamiliar, particularly those migrant carers speaking different languages and having different daily habits.

So in addition to the fact that the ageing-in-place option reflected a preference for home-based care, the trust for family caregivers further showed a preference for care services delivered by family members.

6.2.5 More pragmatic family values towards family care provision

Concerning the changing roles of the family in care provision, all the socio-economic and demographic transitions might not have shaken deeply ingrained family values, but they may have transformed them into a more pragmatic approach to adapting to these circumstances. Interviewee RF6 expressed considerate tolerance for the younger generation, given that they were born and grew up in different historical periods:

> *My daughter is very filial. Despite not being one hundred percent satisfied with that, we have to be more tolerant as we were born and grew up in different stages. When you read the news, you can easily find that some items are about the conflicts between children and their parents. It is some kind of historical problem relating to education. Now, I have come to realise that I should forgive my own parents for the way they raised me.*

Consequently, the expectations from family members, especially the adult children, to act as significant caregivers have gradually become more realistic due to their capacity to provide care. This aligns with China's family policies, particularly the one-child policy. There is a double burden of care for the middle-aged citizens of the sandwich generation, involving caring for the older and the younger generations. This would also be the case with the anticipated demographic transitions in the forthcoming decades.

In conclusion, the care recipients shared a range of reasons for choosing care provided by the family, even with the implementation of a public insurance scheme funding long-term care services. They were notably identified as the incentives for preferring family care (for example, cultural values highlighting family obligations and responsibilities, ageing-in-place preferences) and enforcement due to the lack of substitutes (for example, capacity to pay and available family support). With comprehensive consideration of not just the individuals but also the families, the family was identified as the most suitable option for many, although general family attitudes were observed as more adaptive and pragmatic in contemporary society.

6.3 Changing family roles in long-term care provision

Although the family has been the primary caregiver for its members in China, with the implementation of long-term care insurance as a form of state intervention, individuals have the option of receiving care from within or outside the family, funded by the insurance reimbursement. In this section, I shall discuss how the family's role as the direct care provider has changed because of this.

6.3.1 Lack of understanding of long-term care insurance

In addition to the first two questions about the care responsibility division and the reasons for choosing family care, a further question about the changing role of the family in supporting disabled older people was asked. Although the long-term care insurance scheme has been implemented in Guangzhou since 2017, some of the care recipients interviewed knew nothing about long-term care insurance.

Interviewee RF3 said she had not heard anything about public long-term care insurance, although she had already been receiving it for two months. Nevertheless, she clearly understood the public old-age scheme for financial support rather than the care services funded by the long-term care insurance because her daughter had been her caregiver for a long time, before and after the implementation of the insurance:

> *What do you mean by long-term care insurance? I have never heard about it! I have not received any money for that. My daily life has not changed because I have always depended on my pension for my daily life.*

Interviewee RO2 stated that her daughter had managed her entire income and she did not recall how much she spent or received each month. All she knew was that a caregiver had been recruited by her daughter to take care of her:

> *It is my daughter who manages all my income, and I do not know how she uses it, nor the cost of hiring a caregiver.*

In many cases, given that those providing care for older people had not changed before and after implementing the public insurance, their family members still acted as direct caregivers even though the insurance reimbursement had paid them. For the older

generation, the role of the family in taking care of them has remained the same, and the lack of awareness of the newly launched insurance may be one of the significant reasons for this.

6.3.2 Financial support paying for the family care

When talking about the support for the family from the long-term care insurance, rather than considering the care services as a benefit-in-kind, many interviewees believed that the support from this insurance was a kind of financial support. Nearly all of the interviewees interpreted the insurance reimbursement as a subsidy for older people due to their disabilities. Interviewee RF1 said that the financial support from the insurance typically paid for daily necessities:

> *I think long-term care insurance helps a lot. (With the reimbursement) I can buy the diapers and wheelchair I need … the subsidy I receive from the insurance is sufficient for the medicines.*

Interviewee RF8 commented that all the support from the insurance was a cash benefit so that their family could live a better life:

> *I know about long-term care insurance as my son has told me about it. I have received more than 1000 yuan (about £109) from the insurance scheme each month. It is helpful. I lived with a relatively tight budget before, but it is much better with the subsidy.*

With the different reimbursement caps for the participants for the public healthcare insurance of residents and employees, interviewee RF4 claimed that the support was inadequate for their daily lives. In her opinion, the insurance reimbursement was a living allowance rather than for the care services purchased from the family caregivers:

> *Food is much more expensive nowadays, so 750 yuan (nearly £82) a month is not enough.*

According to the official documents, however, the long-term care provision in Guangzhou is a benefit-in-kind for paying for the care services provided by either the full-time caregivers or the part-time ones, specifically the family members, rather than a direct cash benefit for eligible care recipients. Nearly all the interviewees considered it the latter, indicating a misunderstanding of long-term care provision. Even for those older people who knew about

long-term care insurance, the family continued to provide care prior to and after its implementation, but the helpful financial support from the insurance scheme has been acknowledged by the older people.

6.4 Policy expectations from the long-term care insurance

Among the expectations from long-term care insurance and related care policies, the one most mentioned was the higher reimbursement caps. Interviewee RF2 stated a wish for more financial support from public insurance:

> *I hope to have more economic support as my wife does not have a job so there is no other income for our daily life.*

More accessible care services and facilities were also keenly expressed. Interviewee RF6 looked forward to more types of care being delivered in addition to the existing physical or medical ones:

> *It is always my wish to have more options for canteens and medical care centres for older people. A place for them to receive care services and gather together would be necessary. I would be willing to go there if there is one. Because we older people are different from the younger ones, we prefer somewhere where we could spend time with people of our generation.*

Given that the ongoing long-term care insurance has been partly financially dependent on healthcare insurance in all the pilot cities (*see* Table 1.1), including Guangzhou, this has led to path dependence on the policy design to some extent. Similar to healthcare insurance which divides the insurance participants into urban employees and residents, reflecting the urban and rural differences, these two types of insurance participants have different reimbursement caps (*see* Table 6.1). Interviewee RF4 complained about the low payment for residents:

> *I am satisfied with the long-term care insurance because of regular monthly visits. I am happy to talk to the staff who come to see me. However, with the recent inflation, 750 yuan (nearly £82) per month could not buy many essential goods.*

In addition, since the development of elderly care in China did not start until the turn of the millennium, many older people did not hear of or expect any care services from the public

sector when they were young. Some interviewees said that they had never taken thinking of their care patterns seriously before they were vulnerable. Interviewees RF2 and RF4 expressed similar opinions:

> *I had never thought about my care plan when I was young. Nevertheless, the one [we have now] is similar to what I expected at that time.*
>
> *It was always my wish to depend on my family in my old age.*

As the long-term care insurance scheme is in its pilot phase, most care recipients are pleased with the insurance-funded care because they gain free services without ever contributing even a penny. Nevertheless, given that it is a pay-as-you-go social insurance scheme for the current working-age group, all the long-term care services from which they benefit would be self-purchased based on a monthly or annual contribution, which might lead the younger generation to have higher expectations of the care provision, in terms of both quality and quantity.

6.5 Conclusion

Based on the interviews with care recipients receiving care from part-time caregivers in the case study, this chapter has summarised the care attitudes towards family responsibility, reasons for choosing family care, the changing family role in long-term care provision, and policy expectations.

Most interviewees insisted that the family should be the prominent caregiver rather than the state and interpreted the implemented public long-term care insurance as a supplement to the family's financial resources. The economic constraint was the primary determinant for family care decisions, and the values implicit in the tradition of family care obligations were significant. Intergenerational contracts on resource exchanges and trust and reliance on family members were expressed as primary considerations. Family care was frequently the preferred option in many cases, even with the affordable and reasonable prices of other care options. Family values are explicative of the family care option, even with state intervention through the public long-term care insurance.

Despite the implementation of long-term care insurance in the case study for several years, many interviewees had yet to have a clear understanding of this public insurance, although some did express gratitude for its financial support. No significant changes in the care services provided by the family had been noticed by the care recipients receiving care from part-time caregivers, indicating the complexity of exploring the changing roles of the family in care provision.

Returning to the research questions, for RQ2, it is apparent that the family's role as the direct care provider had not changed for these interviewees and that the insurance-reimbursed care services provided by the part-time caregivers, mainly family members, were viewed as a cash benefit for those with disabilities instead of compensation for those providing care services. The support from the insurance scheme is thus concerned with the financial dimension and not the care one. A discussion of the findings in regard to RQ3 will be given in the next chapter from the perspective of caregivers, drawing on the differences between generations.

7 Family Caregivers

In the case study, after the views of care recipients presented in Chapter 6, this chapter presents the thoughts of their caregivers on the crucial topics related to the family's role in long-term care provision since the implementation of long-term care insurance. In this chapter, I shall report the responses of seventeen part-time caregivers. They were the spouses, sons or daughters of the care recipients, and one interviewee was the neighbour of a disabled care recipient whose only son was abroad.

In this chapter, the findings are presented under six themes: (1) the care responsibility division between the state and the family; (2) the reasons for choosing family care; (3) the motivation for acting as a caregiver; (4) the changing family care patterns before and after the implementation of long-term care insurance; (5) the care preferences for future plans; and (6) the policy expectations from long-term care. The findings are presented through quotations from the interviewees. The chapter concludes with a section summarising the central ideas of the six themes.

These findings illustrate the responses to the family's role in providing long-term care and the underlying explanations from the perspective of the caregivers. In addition to addressing RQ2 for capturing the family's role, they help to establish the comparison between generations for RQ3. The discussion based on these findings is presented in Chapter 9.

7.1 Care responsibility division between the state and the family

7.1.1 Satisfaction with the state's support

Regarding care responsibility, most interviewees stated it was a family affair, with gratitude for the state's support, such as the current social insurance schemes (pension schemes and healthcare insurance schemes). The caregivers, especially the spouses of the care recipients, also the older generation, conveyed their appreciation of the state. Interviewees FC4 and FC5 stated:

> *Taking care of older people should be the responsibility of the family …. The government has done a nice job with cash benefits as financial support.*

> *I am very grateful for how the government supports us …. I get more than 1000 yuan (£109) a month, and the staff from the neighbourhood committee call me from time to time to ask about our further needs.*

Some interviewees also reported that expectations from the state should be associated with its capacity to provide and that individuals should be as self-reliant as possible. For example, interviewee FC6 believed that individuals should strive to live independently rather than relying excessively on the state:

> *If the government provides care services for all older people, how could it help so many cases in China? China has a huge population of more than 1.4 billion, the welfare system in our country should not be expected as in other countries by shifting the obligation to the state …. The government has loads of consideration with its limited resources rather than explicitly focusing on one family …. There are many families in China …. Humanism concentrates more on those with tougher lives and heavier burdens. So we try our best to take care of our family by ourselves.*

Interviewee FC8 commented on the advancements made in the welfare system. He said that any other expectations of more state support might not be met, given that the state's policymaking was based on its capacity rather than on public demands. This somewhat indicated the general public attitude towards public affairs in China:

> *There is great progress towards the welfare state. I would not put forward any advice as the government should make its plan based on the situation in current society.*

Rather than the state, interviewee FC9 valued the support from the care home, as it was the care home that provided direct professional support to both the care recipients and caregivers:

> *It must be the family to take care of older adults …. The government could not do more than provide subsidies …. The care home has helped us a lot. When my mother had sores, some professionals came here to help.*

As opposed to emphasising the sole responsibility of the state or the family, some interviewees stated that the state and the family should mutually contribute to caring for disabled older people, and in particular, the state should take action to reward those who have worked tirelessly for decades to develop the nation. Interviewee FC13 wished that the state could play a more significant role, and self-reliance was also highlighted in order to alleviate the care burdens of the next generation:

> *Both the government and the family should take care of the elderly together …. When we were young, we dedicated ourselves to the nation so it is natural to hope for more support and care in old age from the state. Our children are busy and struggle with their own lives, and taking care of us would impact their lives. I wish I could take care of myself for as long as possible.*

These interviewees therefore viewed the reimbursement of long-term care insurance as a cash benefit for disabled older people rather than a wage for their caregiving work. With the insurance reimbursement seen as financial support, disabled older people and their families lived better lives, resulting in their understanding and even appreciation for the current care policies led by the state.

7.1.2 Higher expectations from the state

More than mere appreciation for the state was found in the case study. Some interviewees argued that it should be the state's responsibility and that more must be done to care for older people.

Compensation for the one-child policy was one of the main considerations. Some interviewees stated that the state was assumed to have greater care responsibilities for single-child families. Interviewee FC5 criticised the implemented family planning policy, which had significantly impacted the available family care support, causing her future concerns and anxieties. She was the caregiver for her husband, despite being over 70. She believed those with a single child would be forced to shoulder a heavy care burden because the costs of other care services exceeded their financial capacity. She also expressed concern about the lone child being unwilling or unable to take care of them:

> *The government should share the responsibility with the family because of the one-child policy. There should be at least two children so that they could take care of us in turn …. Take my sister-in-law as an example. Her single child lives in Canada and he could not come back home to care for his father.*

Interviewee FC5 believed that she deserved more care services provided by the state because she had just her son as the only source of family support:

> *For older people with just a single child, the government should send someone free to take care of them … I am furious about having one child …. I have been a party member for decades, and I have long followed the advocacy of the Party and the government. That is why we end up like this tough life now. The single child has to suffer a lot because he does not have a sibling to share the obligation. I do not have any other child to depend on when*

> *my only son is busy with his work … although he does not live with us he is our only available family supporter after all.*

Interviewee FC8 stated that more than one child could ensure that older people could access the required care services, which was in accordance with the preferences of the Chinese for having more children:

> *If parents have many children, then at least one is filial and willing to take care of them. That is the reason for giving birth to more than one child. As for my unfilial brother, he does nothing with just the red pocket [a cash gift] on my mother's birthday once a year. However, older people may not need financial support, but that filial piety is shown to them.*

Nevertheless, the available care services may not be directly related to the number of children. Interviewee FC15 had taken care of her mother for years, and she thought that even with just one child, she could access sufficient care support from her filial son. However, she also said that having a daughter may be more advantageous for the provision of care services than having a son and criticised the enduring patriarchal belief that a son is more valuable than a daughter:

> *It has nothing to do with how many children you have raised. If your child is filial and caring for you, even one child is enough to support your daily life. Like my only son, he cares very much about us, but sometimes he shows his bad and weird temper …. Although a son might be more valued in rural areas, I prefer a daughter. It is a wrong and patriarchal thought to keep giving birth to babies until a son is born.*

Consequently, these results indicate that interviewees with a single child may have a strong desire to receive more care assistance from the state in exchange for their contribution to the family planning policy, similar to the perspectives of care recipients (*see* section 6.1.2).

In this section, despite a wide range of opinions on the care responsibility division between the state and the family, most interviewees who were family caregivers agreed with the principal role of the family in providing care support to older people. Their considerations mainly included appreciation for the state's support and the available family support affected by the one-child policy. However, it should also be noted that given that all the interviewees were family caregivers for their disabled family members fulfilling the care obligation, their attitudes towards the expectations of various social actors might be affected by their positions as the direct caregivers.

7.2 Diversified reasons for choosing long-term care provided by the family

Different responses were given to the question 'Why do older people choose to receive care from family caregivers instead of formal carers?' They were partly similar to the thoughts of the care recipients (*see* section 6.2), but the differences deserve further discussion.

7.2.1 Capacity for care alternatives

Slightly inconsistent with the thoughts of the care recipients, almost all the caregivers agreed that the long-term care which disabled older people receive is associated with or somehow decided by the individual's or their family's financial resources.

Interviewee FC5 said she had hired a second caregiver to share the workload of providing care to her husband. However, despite her deteriorating health, she had to continue to be one of the caregivers because her family could not afford a full-time one:

> *I am my husband's primary caregiver, and another hired caregiver comes to help from 8 am to noon. I am too old to give my husband a bath. So we hired a part-timer but could not afford a full-time one …. In addition, we do not have a spare room for the caregiver to live with us. It is a long-held wish for us to hire someone if we can pay for it.*

Concerning the expensive care services provided by private caregivers and in the care facilities, interviewee FC4 said her mother's care decision was determined by the high cost of alternative options:

> *We could not afford to hire a full-time caregiver. The sponsorship fees are relatively high for moving into the care home, not to mention the monthly cost. My mother's pension is just slightly above 1000 yuan (£109) per month. However, it takes at least 6000 yuan to hire someone. We do not have any other choice but to take care of her on our own …. Although all our siblings are filial, we are not so rich to financially support them. The pensions of my parents plus the long-term care reimbursement would merely cover the cost of their everyday lives, but obviously, it is not adequate for purchasing care.*

Compared with the care recipients highlighting their economic conditions such as their pension, the family caregivers, particularly the adult children, spoke more about their parents' and siblings' joint purchasing power. The family was depicted as a collective actor, reallocating income, including the monthly pension of older people, particularly the disabled ones. The household income was usually

managed by their adult children if their partners have passed away. Therefore, FC4's case exemplified the trust and reliance on the younger generations when individuals get old, following the cultural values in China to some extent.

In some instances, the care provision for disabled family members remained voluntary. Interviewee FC15 clarified that she had never considered receiving compensation for caring for her father. The insurance reimbursement was used to pay her father's everyday expenses rather than her wage:

> *We have never talked about that formally, but it has defaulted that it is me to be the caregiver. I am very selfless because I have never taken a penny from the insurance scheme and all the money was spent on him … my father loves me most among all my siblings, and I am the only daughter and the most considerate (compared to my brothers and their wives).*

Many interviewees acknowledged that economic factors played a more significant role in care patterns. In Guangzhou, although long-term care is benefit-in-kind as the insurance fund purchases the care services from the registered care homes from the part-time (family) caregivers, both the care recipients and the caregivers regarded the insurance reimbursement as a cash benefit comparable to the disability allowance rather than for the purchase of the care. With the caps (see Table 6.1), the reimbursement could not fully cover the total cost of the hired caregivers rather than family caregivers, so the family members preferred to provide care themselves rather than incurring the additional expense of employing someone else. In this situation, the family has to shoulder the care obligations because of the unaffordable alternatives. So although the family should always support older people, the insurance has led to the formalisation of care or the commodification of formerly unpaid care services (Le Bihan,Da Roit and Sopadzhiyan, 2019).

7.2.2 More considerate care services provided by the family

Many interviewees believed that the care provided by the family would be of higher quality and that family caregivers were more considerate and reliable, related to the inherent trust based on the blood ties. For example, interviewee FC9 was adamant that no-one besides the family would make an effort to care for older people:

> *Even if you hire someone thought to be highly rated, she will not take care of my mother as considerately as me. It is similar to working in a company; if you are the boss, you must*

try your best to work hard, but you would work less carefully if you were just an employee. It is the same in the care provision issue.

Compared with the economic factor, care quality was valued higher. Interviewee FC10 admitted that caring for his mother was more important to him than earning a higher wage on the formal labour market:

If I go to take a job rather than taking care of my mother, I could earn more than I get from the insurance scheme as a family caregiver.

Interviewee FC15 described her experiences caring for her father, adding that no-one could replicate long-term care provision practices. However, she mentioned that she might send her father into a care home if she could no longer be the caregiver because all her male siblings were not so caring and conscientious in their care provision:

My father prefers me to be his caregiver … I think it is my father's good fortune that I am his caregiver. If I were not here, no-one else would be willing to help my father to go to the toilet, which I have got used to. I put on gloves and a mask and help him to wipe his body with hot water and wet tissues. I do not think others would be as considerate as me.

Interviewee FC1 said that it was the older people's preference to receive care from the family, particularly from daughters:

We have not discussed this issue before. My mother likes her daughter and prefers me to look after her. My sister-in-law has not retired [is still working].

Similarly, interviewee FC17 said she had become her father's caregiver following her father's preference. Although their family had discussed him going into a care home, her father had turned down this suggestion:

We have not considered sending my father into a care home before, but we have thought about this option recently. However, he is unwilling, so we would not force him to do so. He prefers to stay with his family.

In her case, even though the insurance reimbursement had increased the household capacity for other care services as identified as financial support, the family was still the preferable option for older people.

Furthermore, the care relationship was the critical consideration, given that only family members could remain patient when caring for older adults and tolerating their anger, as indicated by interviewee FC5:

My husband easily gets angry. Before his retirement, he was very active in our work unit, organising the dancing and singing. His temper has changed after he became ill. He is like a child and needs others to coax him to go to sleep and comfort him. It is very troublesome for others to provide care services to him, and only me as his wife could put up with him.

7.2.3 Worries of living in a care home

The negative impression of living in care homes was another key reason for family members to provide care. The stigmatisation may have led to the general perpetuation of the conventional family-centred care pattern.

Interviewee FC5 said there was also a widespread thought about older people waiting to die in a care home. She preferred to care for her husband for as long as possible until her son sent them into a nursing home:

My son had suggested that we should move into a care home, but I rejected it, and my husband also disagreed … if someone goes into a care home, it seems that he is waiting to die, and I can still take care of myself and even my husband now.

Interviewee FC6's mother lived in a care home, but she had been taken back home since her family found that she had not received the care services which she needed. He criticised the quantity and quality of the care services provided in the care homes, believing that the family care was much more considerate:

I do not want my mother to live in a care home …. My mother used to live in a care home with the subsidy of long-term care insurance. I found that the nurses were very busy dealing with many older people at the same time. Even when my mother wanted a drink of water, they ignored her request. They did not respond or deal with the care demand on time.

Interviewee FC1 stated that living in care homes might harm people's mental and physical health, according to their visits and observations of nearby care homes:

I have visited some care homes before and I think the residents there are in poor mental health and physical health situations. I am psychologically resistant to that. My mother loves to keep clean and might not get used to living there.

Interviewee FC8 mentioned the mental health considerations of his mother as he feared that residents would quickly feel lonely when living in a care home, leaving their homes and loved ones

behind. The psychological support and emotional demands of disabled older people were prioritised by the family, which might not be met in care homes because of the underdeveloped care system in China, even in prosperous cities such as Guangzhou:

> *We do not want to put my mother into a care home even if we could afford it. She might easily feel lonely there. If her health worsens one day, I shall send her to the hospital instead of a care home.*

Addressing concerns regarding the quality and quantity of care provided by other options, in the next section, I present family caregiving as a last resort in many cases: meeting the care needs of disabled family members was the top priority for the family caregivers.

7.2.4 Untrustworthiness of hired caregivers providing care services at home

In addition to residential care, the untrustworthiness of other caregivers from outside the family was frequently mentioned. Interviewee FC5 doubted the honesty of low-quality caregivers in the care market:

> *We want to hire someone, but no high-quality caregivers are available in Guangzhou. Before, I had talked to my younger brother about hiring a caregiver, but he worried that the caregiver might steal something at home. I have heard from my relatives that the caregiver at their home had stolen valuable things.*

Accordingly, interviewee FC7 worried that family members could not get the care they needed because of information asymmetry. She said she feared that her husband might be unwell, as she had read some news stories about these situations:

> *I do not trust anyone else. If a caregiver works at home, I have to keep an eye on how she works the whole day. If any relatives are willing to provide care services, that is the first choice.*

Thus caregivers, except for family members, were always considered 'external carers' or 'outsiders' even though they might live with the care recipients to provide 24/7 care services. This could stem from the profound reliance and trust fostered by family ties.

Stable long-term care provision is a consideration for the family when deciding on care patterns. Given that disabled older people are generally in urgent need of 24-hour care services, a private carer might sometimes ask for regular leave, especially if they reside in a different city or province, usually

leaving for days to return to their hometown. It is clearly more convenient for the care to be provided by family caregivers if they are willing and able to stay at home with the disabled older people all the time, even exceeding the insurance-reimbursed work hours of three hours a day.

Interviewee FC14 said that some caregivers might ask for a salary increase, causing pressure on the family's finances. She added that the care home had advised her, as the daughter, to be a registered family caregiver in the long-term care insurance system. She recruited a caregiver from the care market to avoid the cumbersome procedures for changing caregivers:

> *Some caregivers might quit after just a few days. We have changed six caregivers for my mother in the past few months. Some said they hoped to ask for leave for a long time to return home, and some asked for higher salaries. We are pretty worried about that … what we want is stable care to be provided for my mother.*

7.2.5 Gender differences in family care provision

Asked whether gender differences mattered in providing care, the interviewees offered different responses. Some mentioned that females were usually more considerate when caring for older people, whereas males were stronger for helping older people to move about or take a shower in relation to the physiological differences. Interviewees FC15 and FC7 held comparable views:

> *There are more female caregivers because they are usually more careful when taking care of older people. Males would not work as caregivers unless they could not find other job positions … just take my younger brother as an example. He also wants to offer a hand to take care of our father, but he is not good at it.*
>
> *Female caregivers are more careful and thoughtful than their male counterparts. Although it might be inconvenient or embarrassing to provide care services to older men or they do not have enough strength to do so, it is still more appropriate for women to do so after all.*

However, interviewee FC9 thought that there were no significant differences in the care services provided by males and females. He said that the caregiver could overcome the difficulties caused by gender differences as long as s/he worked diligently:

> *I do not think there would be any differences in the care provided by males or females. It is not about gender but about whether they spare no effort.*

Despite the possible embarrassment or inconvenience due to the different genders of caregivers and care recipients, interviewee FC12 explained that he had had to overcome that due to the limited available labour force among the family members. However, he also mentioned that he took his mother's dignity seriously despite the gender difference:

> *Although all my siblings are male, I always tell my younger brothers that we should take the gender difference seriously when taking care of our mother …. We need to remember to close the door when we leave her bedroom and knock on the door first before entering her room. When changing her clothes, we should also keep the door closed. It is about dignity.*

In conclusion, family members decided to shoulder the care burden by employing family carers for many different reasons, as this section has shown. This decision is generally made by comparing different care options (residential care or home-based care provided by private caregivers). The care provided by the family was considered more affordable, cost-effective, favoured, considerate and reliable in the findings of the case study. For this reason, family-provided care services continued to be the most popular option, even after the introduction of long-term care insurance.

7.3 Motivations for acting as a family caregiver

In the light of the reasons for choosing family care presented in the previous section, the interviewees were asked why they were family caregivers instead of other family members in order to explore the motivations for preferring to be a family caregiver.

7.3.1 Family values

Family virtue in supporting the older generation was the primary reason widely admitted by the interviewees. For the family caregivers, particularly those of the younger generation, filial piety and respect for their older parents had driven them to fulfil their obligations as care providers. Compared with their parents, who took for granted that it was the family rather than any other actors to be depended on (*see* section 6.1.3), the caregivers usually had a more precise notion of values regarding the family obligations and responsibilities, particularly filial piety, as one of the vital explanations for their willingness to deliver voluntary care or as family caregivers paid by the insurance reimbursement.

Interviewee FC1 said that caring for her mother was an inborn habit because she was willing to fulfil filial piety because she deemed not supporting her parents to be immoral:

> *It is a habit to take care of my mother. In China, there is no exception to relying on others rather than the family to care for older people. However, I have also heard that people are leaving their parents alone, which is very unfilial.*

Interviewee FC8 emphasised filial piety as one of the vital virtues, as it is undeniably crucial for adult children to look after their parents:

> *There is a saying that piety is the foundation of all virtues. The government could perform no more than a supplementary role as we could not expect the state to provide all care services to us. Only the family could be so caring and considerate to the aged.*

7.3.2 Intergenerational exchange

Paying back for the precious support from older family members in the past, which pertains to intergenerational exchange, was often mentioned. As the family has long been the economic unit for resource allocation and redistribution, the parent/offspring obligations implied in these parental sacrifices were no longer the primary bases of emotional bonds. It was more about the payback for the interest than the cultural or value factors.

Interviewee FC12 stated that his youngest brother had received substantial economic support from his mother for years, so he spent more time caring for his mother than his two older brothers:

> *We have thought of other care options but ultimately decided on the family care provision concerning my youngest brother's situation. He has been laid off for over ten years and lived with our mother. Thus we take care of our mother in turn, averaging our mother's pension and long-term care insurance reimbursement. But he has to spend more time staying overnight here to look after our mother.*

However, as the spouse of a care recipient, interviewee FC5 said it was understandable for them not to rely too much on their adult children, reflecting the more pragmatic attitudes towards the family's role in caring for older people:

> *It is as if my son lives off us rather than supporting us. I have always told my son that it is not easy for him to have a job as a civil servant, so he needs to work hard. Compared to so many people losing their jobs during the pandemic, he should work hard (to keep his job).*

Interviewee FC13 was the neighbour of care recipients because the old couple had lost one of their sons in the previous year and another son living abroad could not provide any help or assistance except financial support. Even with the widely accepted intergenerational contract, the capacity of the next generation to support their parents was worth noting:

> *I agree with the old saying emphasising filial piety, but whether it is about the actual care provision is another issue. One of his [the care recipient's] sons passed away last year. It was a big blow for him…. Even though you have a son, you do not know whether it will be security for yourself.*

7.3.3 Gender roles between sons and daughters

Given that sons and daughters might take on various care responsibilities and roles for providing care to older people, interviewee FC16 agreed that a son should shoulder more care duty because the daughter's responsibility to her birth family shifted upon her marriage:

> *I only partly agree with the saying of raising a child to secure life in old age because it might not be true for a daughter. It might be inconvenient as she has been married. It is troublesome then for her to take care of her parents. So, a son must take more responsibility to support the parents.*

Correspondingly, interviewee FC1 expressed the opinion that there should be equal obligations between sons and daughters:

> *I have seen some unfilial cases. So I am afraid I have to disagree with raising children to secure old age. However, the situations might differ in various families …. Sons should share equal responsibility with daughters as there are no gender preferences in urban areas.*

7.3.4 Role model setting

Another reason given for becoming a caregiver was to set a moral example for subsequent generations. It was seen as education by parents aiming to instil moral virtue in their children to secure their life in old age. Interviewees FC12 and FC3 said that taking care of older family members was to give an example for their own future care services provided by other family members. It could even be seen as a guarantee:

To set up a model for the children is one of the reasons. It is a causal issue. It will have a passive impact on the next generation if you do not behave well. My daughter brings her child to visit me once a month to teach him to respect and love the aged.

I take care of my mother together with my younger brother. Undoubtedly, I want to show my piety and act as a good example to my child. It should be taught from one generation to the next.

In particular, considering the predictable demographic changes and the tendency to emphasise the role of the family in public policy for elderly care provision in China, setting a moral role model has been increasingly recognised and valued mainly for the generation with a single child.

7.3.5 Authority maintenance within the family

Maintaining or even enhancing the family's authority was another incentive. Since the care decision is a collective one based on family discussion, those taking charge of the family authority might prefer to shoulder the obligation by themselves to show their individual contribution to the extended family and earn respect from other family members. Interviewee FC15 said that she had made sacrifices for the family without expecting any return:

I am the eldest child of my father and I make all decisions for my father's care arrangement. I am selfless and I have sacrificed for my family, and others do not have any voice in the family.

7.3.6 Lack of other family caregivers

The insufficient support available from other family members was also stated. Interviewees FC16 and FC10 made similar responses, saying that no other family members could provide support because their siblings lived far away, were busy with their own families, or could not provide considerate care services. Thus, they were the only choice for their parents because the family could not afford other care options. Although they had siblings with whom to discuss the care issues of their parents, they were geographically, emotionally or otherwise unavailable or distant. To serve as family caregivers was therefore their very last option:

I do not have any other work, so I come here to take care of my mother. My wife is not good at taking care of others. I live close to my parents, and it takes about half an hour by subway. My brother lives relatively far away, in another district in Guangzhou.

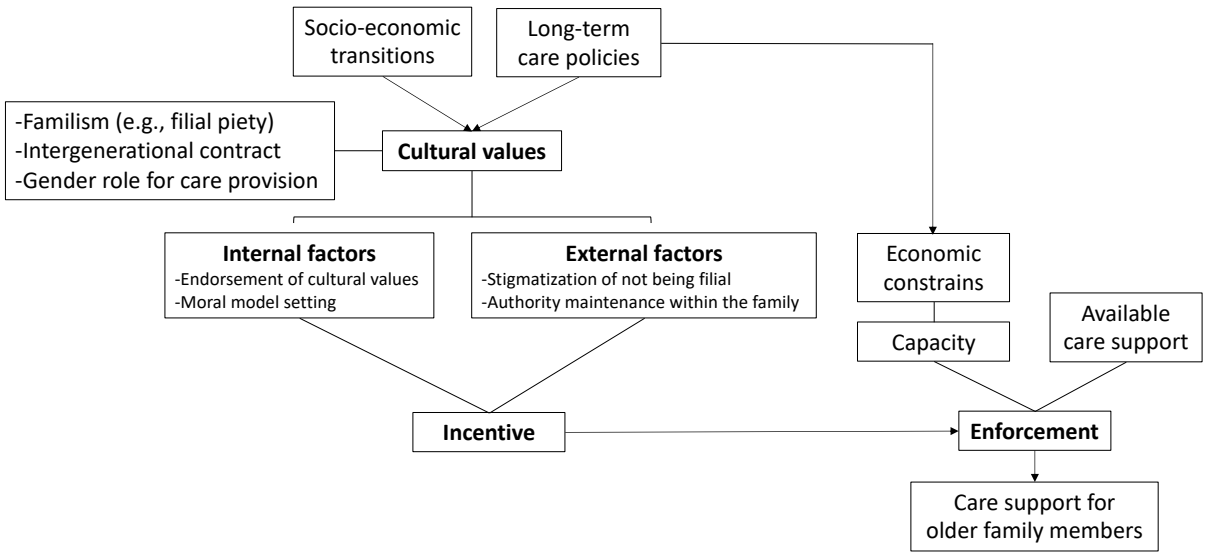
We have not specifically discussed the care provision among our siblings. I want to be filial towards my parents. My older brother and sister are busy taking care of their grandchildren, and my mother has always lived with us. So I have been the caregiver for my mother.

Ever since the implementation of long-term care insurance funding for the care provided by the family, the insurance reimbursement has provided financial support for individuals and their families, serving as a strong incentive for family care provision. Interviewee FC10 said that he had substantial economic incentives to care for his mother with the insurance reimbursement. He was the family caregiver before the scheme was introduced, but he expressed gratitude for the scheme as a social welfare programme supporting the residents and was determined to work harder:

I was my mother's caregiver even before the implementation of long-term care insurance. The insurance has relieved our financial burden; in this way we have been motivated to work harder to take care of my mother. It is some kind of welfare.

Given that incentive and enforcement are significant in explaining the family providing support to older people (Aboderin, 2004), the findings of the case study (sections 7.2 and 7.3) demonstrate that cultural values are important as an incentive for family care provision, but the enforcement of care provision usually also considers the capacity for alternatives and available care support in addition to the incentive (Figure 7.1).

Figure 7.1 Incentives and motivations for family members to provide long-term care



7.4 Changing family roles in long-term care provision

The changing roles of the family in care provision have also been explored. As demonstrated previously, the care services delivered by the family had been encouraged by the insurance regarding the gap between the insurance reimbursement caps and the costs of alternatives to family care. Thus, the role of the family as the direct care provider has been strengthened in terms of its limited capacity to access other care services.

7.4.1 Direct caregivers with financial support from insurance reimbursement

The family caregivers are paid for the care services; thus, the implementation of long-term care insurance has alleviated the family's financial burden. For this reason, disabled older people have come to be less financially dependent.

Some interviewees said that they had larger budgets for everyday expenses and the medical fees of older people from the insurance reimbursement. Although the reimbursement was interpreted as the purchase of the care services from informal caregivers, it was usually used for disabled older adults themselves and not retained by the caregivers, given that the family generally worked as an economic unit with the different generations sharing their resources. As some older people were economically dependent on their adult children, particularly those with severe disabilities, the insurance reimbursement was thought of as a cash benefit for older people rather than a salary for the caregivers. Interviewees FC10 and FC9 expressed the same opinion:

> *We have received financial support. However, I would also take care of my mother even without the insurance scheme. It is an extra reward for me as it is not an urgent demand because my mother does not need to take expensive medicines daily. But for others, especially the older people with different types of disease, it might be very helpful.*
>
> *Although about 1000 yuan is not so much, I have a loose budget in my daily life …. My siblings do not provide economic support for my mother because they are not so rich …. Although we could not buy all we want even with the insurance reimbursement, we could live a relatively better life, for instance, by having lights with a higher-power incandescence, which are brighter.*

7.4.2 More care support provided by family caregivers

Interviewee FC8 said that he had spent more time taking care of his mother with the insurance, despite being the family caregiver for his mother for years. He was an Uber driver with flexible work hours, so his daily schedule had enabled him to have more time for providing care services to his mother ever since the introduction of the long-term care insurance scheme. More care services and longer care times were provided in his case:

> *I have spent more time caring for my mother since the introduction of long-term care insurance, although I had been my mother's caregiver before that. I come here several hours each day, and then go out to work. I come back if there is any emergency. My mother can be self-reliant to some extent, but she does need others to feed her. However, if her health gets worse, we might hire someone to provide 24-hour care services for her.*

Interviewee FC7 reported that the insurance scheme had relieved the previous caregiver's original care burden, as other family members could provide more support with the reimbursement as financial support for the family. In other words, disabled older people received more care services even if their care patterns have not changed:

> *I am the one who took care of my husband before, even when he stayed in the hospital for a month. My son and daughter-in-law only came to see him from time to time because they were busy with their work. However, ever since he has had access to the long-term care insurance scheme, his younger cousin comes here from two to six in the afternoon every day.*

7.4.3 Enhancing the role of a direct care provider

There are differences in cultural values in relation to family responsibilities and obligations and the family's role in care provision with long-term care insurance. The insurance scheme has strengthened those related values and the role of the family in care provision in turn. Given that there are options for informal care, the family is employed as the caregiver, supervised and managed by the care homes, thus also with higher care quality.

For interviewee FC10, despite the long impact of cultural values on family care provision, the long-term care insurance had reinforced its role in actual care provision:

> *My mother has been seriously ill for more than ten years, but she has not received such care services until she qualified for the long-term care insurance scheme …. Although we*

provided care to my mother before receiving payment from the scheme from time to time, we have worked harder as it is some benefit for us to relieve the economic burden.

Consequently, the family caregiver has been financially motivated to deliver long-term care due to the reimbursement from public insurance, which recognises the value of the previously voluntary care work. Particularly since the introduction of long-term care insurance, the family's care services have been formalised with a specifically appointed family caregiver. Even though more than one family member might provide care services for older people, only one family caregiver is registered and supervised by the care homes and insurance enterprises to adhere to all procedures, performing a more formal role than ever. The caring responsibility distributed among family members was more explicit than before with the implementation of the long-term care insurance scheme.

In addition to conventional family care provision, the role of the family has been expanded with professional care support from the care homes. According to the scheme in Guangzhou, similar to some cases in other pilot cities, all caregivers have to participate in a series of training courses held by care homes and take an examination in order to receive a qualification certificate. As supervised by the care managers, the caregivers gain additional advice for taking care of older people. The quality of long-term care provision has therefore been significantly improved with the established formalised care system. The care services have been developed to better target the care requirements of disabled people. Interviewee FC1 said she had provided her mother with more professional and high-quality care services by making use of the long-term care insurance:

I have taken training courses about care skills for disabled older people, and the examination. Nurses are coming to my mother's home to see her regularly, and they provide different types of teaching from time to time.

Interviewee FC13 also said she had learned more care knowledge from the courses:

I went to take the examination about how to help older people to get into bed, what to do if he falls down and what kinds of food we should cook for him.

7.4.4 Increasing family capacity to pay for care alternatives

Since the long-term care insurance has alleviated the family's economic burden, some families could afford to purchase care services from the market, leading to a shift in care provision from the family to the market and the third sector to a certain extent. However, the family remained part of the

financial responsibility due to the reimbursement cap to cover the high expenses of the care services beyond the family.

Interview FC14 said that her family could afford to buy care services from the private market with the insurance reimbursement, relieving the previous heavy care burden on the entire family. In this situation, the family is no longer the direct caregiver but rather the financial supporter for the care services and daily life of the disabled older people:

> *I took care of my mother before the implementation of the long-term care insurance scheme and my sisters also helped me from time to time. Nevertheless, I am too old to provide full-time care services to her, as I also suffer from chronic diseases. So we have hired someone with the insurance reimbursement.*

Nevertheless, even with the financial support from the insurance, older people's preferences continued to have an impact on care patterns. The family preserves its role in care provision and partially funds it by considering older members' expectations towards the family for its caring responsibilities. Interviewee FC17 commented that her father was reluctant to use other care patterns due to his emotional reliance on his family:

> *We have never thought of other care choices except for family care before, but we have come to consider this option recently. However, my father refuses to leave us but spends more time staying with us. So we shall continue the current care pattern because we do not want to go against his will.*

Receiving the care that the family provides is considered a rational choice concerning the cost of care alternatives, as most of the qualified older people in Guangzhou have done. The family has to continue the care provision that exceeds the insurance reimbursement caps for older people's care needs. Interviewee FC5 said that although her younger brother, as the family caregiver, did share some of the care provision workload with the insurance reimbursement, she had also suffered greatly from her own worsening health situation when caring for her husband as her brother only returned home during the night:

> *It is hard for me to take care of my husband. I have diabetes and lung cancer. My son lives in another district in Guangzhou …. My younger brother helps a lot as he looks after my husband when I go shopping. But I could not dare ask him to stay here all day long as he has his own family … I am the one helping my husband to take a shower. It is not easy …*

My husband has to pee at midnight every day and then I cannot go back to sleep again after assisting him to go to the toilet.

7.5 Different care preferences for future care plans

Although the interviewees were care providers for their family members, when asked what their future care plans were, they gave different thoughts. Most believed that going into a care home might be a more feasible and possible choice. Even though they considered that the next generation should be filial, it was nevertheless not equivalent to the adult children being the direct care providers, given that they understood they might not be capable of doing so. So when home-based care is no longer possible, older people were resigned to the possibility of having to turn to residential care.

Interviewee FC11 said she would be willing to go into a care home with her husband if she could no longer independently care for him, even if her son opposed it. She added that her son had strongly negative thoughts about care homes because his grandmother had died there shortly after moving in:

The first choice must be taken care of by my son, but he is very busy as a teacher in another city …. Concerning our pensions, it would be fine to hire one caregiver to take care of one of us, but they are not enough if both of us need to be taken care of … we do not want to increase our son's financial burden … if the situation worsens, we might go into a care home, but our son resists that because his grandmother died in one a month after being sent to a care home. However, if our son cannot provide care services to us, we shall have to do so one day.

Interviewee FC7 praised her filial son, but she urged him to spend more time on his career for promotion rather than staying with them for care provision. She had prioritised her son's interest over her husband's and her own as a selfless mother:

My son is filial. Sometimes he comes here to see us, but he has to leave after a day to go to work. I always remind my son to work harder and spend more time on his work. I do not want him to be troubled because of taking care of us.

As for the middle-aged generation with a single child, interviewee FC3 said that going into a care home would be the last option due to the limited available care provision from the family both financially and physically, despite her also preferring to receive care services at home:

It would be best to hire a caregiver if I could afford it …. Our generation has just one child, and he might be too busy to care for us. However, it is acceptable for me to go into a care home, although I am afraid that I might not be taken care of well. However, I have no other choices because my child also has his own family.

Interviewee FC9 commented that he did not mind if his only daughter could offer any care services to him. It would have been most meaningful for him if she had shown him any filial piety even if she did not take care of his wife and him by herself:

Do your parents still count on you? What your generation thinks is different from us …. To be honest, if your son is filial, you will think everything is fine.

In addition, interviewee FC1 said that she might ask for help from other social actors, for instance the neighbourhood committee, because she did not want to burden her single child and could not afford any other alternatives from the care market. So apart from the long-term care provided by the family, it would also be essential to develop other supportive care schemes for disabled older people:

I would try to be self-reliant for as long as possible. I might ask for help from the neighbourhood committee at that time as it would cost too much to go into a nursing home, as well as the expensive sponsorship fee.

Interviewee FC10 pointed out that the family income might severely decrease if his daughter acted as their caregiver rather than going out to work. Therefore, he preferred other care options to maintain the financial contribution from his daughter to the family. In this case, his care plan was decided by economic constraints similar to the financial capacity factor illustrated before:

Of course, we prefer care provided by the family, but our generation has been more open-minded, like choosing to go into a care home. Because when our child takes care of us, he has to stay at home and cannot go out to work to make a living. It is a different time compared to before. I do not want to ask my daughter to spend all her time taking care of me at home …. Even when older people have suffered from diseases, we cannot depend on the younger generation; otherwise, they do not have any income to support their own lives.

Based on the multiple care options shared by family caregivers, many of them who are working as direct care providers for their family members were open-minded about accepting care delivered from beyond the family. Although family support remained presumed to be significant, more pragmatic considerations were observed, mainly the available care resources from the family.

7.6 Policy expectations from the long-term care insurance

Regarding the interpretation of care responsibility revealed in section 7.1, some interviewees said that they did not have any specific expectations because they did not wish to increase the burden on the government since the insurance reimbursement had already provided financial support. In spite of this, several concerns were expressed by the interviewees, who expected the improvement of the current long-term care insurance scheme in the case study. These results can contribute to the policy design for insurance schemes in other pilot cities during the pilot period, as well as the nationwide exploration after the pilot phase.

Many interviewees hoped to receive more financial support from their insurance with higher insurance reimbursement caps. Interviewee FC1 said that the reimbursement of the insurance could not cover the everyday costs of older people and interviewee FC3 suggested that more should be provided by the state, either affordable care services or higher reimbursement:

> *I wish to have more subsidies for that, as the current amount is not enough. [It has increased this year], but considering inflation, it is more and more unreasonable.*
>
> *I hope that long-term care insurance would improve the reimbursement ceiling, or that it would provide more affordable care options. For example, if older people are seriously ill so the family could not provide the care they need, I hope some professional care could be delivered to disabled older people.*

Rather than a higher reimbursement cap for care provided by family members as financial support, some interviewees preferred more affordable care alternatives to family care. Interviewee FC6 complained about the unaffordable care services of the private care market, indicating a preference for benefits-in-kind and not a cash benefit:

> *The critical issue is the labour force, and it is about who could provide the care services. It is pointless even if you give me 10,000 yuan a month if no-one is willing to provide care services. It is not for us to choose the caregivers, but they have high standards when picking the employers. They claim they need separate rooms, four days of paid leave a month and an annual holiday to return to their hometowns. It is not easy to find a caregiver at a reasonable price.*

More regular care training from the care homes was also what the family caregivers hoped for, as interviewee FC1 said:

I hope there will be more practical advice about taking care of older people for us from the care homes.

Despite the age 65 restriction for all caregivers, some caregivers who were older than that were still providing care services, but their younger family members were the ones registered in the care homes. In these cases, spouses over 65 worked as caregivers, particularly wives, to care for their husbands. Interviewee FC2 said that the age limit of 65 was too strict considering the increase in life expectancy, and she was able to provide all types of care services which met the assessment standards of the care home to target all the care demands of disabled older adults:

I am 67 years old … but I could not register as the caregiver for my husband because the age restriction for that is 65 … my daughter usually comes here at around 3 pm every day to log in to the system, but she does not live with us, and she is also busy with her own work so sometimes she might miss [a visit], causing the subsidy we receive to be less … . It is troublesome for her to come here every day, just like if it is a rainy day and she has not come.

The development of other social programmes was also expected, for example, the healthcare insurance scheme. The point of view of interviewee FC12 proved this, as the long-term care provision was more than the long-term care insurance scheme:

Even though I am over 60, I still feel young. In the past, whenever older people fell ill, they might die within a few months. With technology developments, even people of old ages could recover with surgery …. We could not expect too much of the government … the healthcare insurance scheme has also greatly helped.

7.7 Conclusion

In the case study, it was found that compared with the care recipients, the caregivers shared more thoughts about the long-term care insurance scheme and family care provision, as this chapter has shown.

Although the family is assumed to be the vital caregiver for the older generation, the state was expected to assume a greater share of caregiving responsibilities, with higher policy expectations, including a levelling-up reimbursement cap, more professional care support and specific adjustments to the age registration requirements.

Based on the findings presented in this chapter, the reasons for choosing family care (section 7.2) and the justifications for acting as a family caregiver (section 7.3) were specifically clarified. The former part raised several key points from the opinions from care recipients (*see* section 6.2), such as the capacity to access care alternatives, and reliance and trust on the family. The latter outlined the incentives and enforcement of individuals in providing care (*see* Figure 7.1), including cultural values relating to family caring responsibilities and obligations and the intergenerational contract, the absence of other care providers, the intention to set a role model and the maintenance of family authority.

Combining the findings presented in these two sections, economic constraints and cultural values were most stressed in relation to family care provision, with the former being decisive in many cases. However, the cultural values did have a significant impact on the family's motivation to fulfil its care responsibility. They could thus be interpreted as one of the critical determinants for reinforcing the family's roles in care provision, even with the implementation of long-term care insurance. This has shown more sophisticated mechanisms for cultural values affecting care decisions than those analysed in the quantitative discussion. It is worth noting that the interviewees were those chosen to act as family caregivers.

The family role in providing long-term care has been summarised, especially in the light of the introduction of long-term care insurance. The insurance reimbursement for part-time caregivers was also found to be viewed as a cash benefit for disabled older people and not a benefit-in-kind paid by the insurance fund but delivered by the family caregivers, consistent with the views of the care recipients, and the insurance reimbursement was used for the care recipients' daily lives in many cases. In some cases, the family had been motivated to provide care as before or even more; in others, the family has shifted the direct care burden to others, increasing the family's capacity for alternatives.

Regarding the research questions about the family's role in long-term care provision and the intergenerational differences between care attitudes and decisions, the younger generation, the adult children of disabled older people, was also explored. Further discussion for RQ2 and RQ3 will be presented in Chapter 9, along with supporting evidence from this chapter.

8 Other Social Actors in the Long-Term Care System

Regarding the public-insurance-funded long-term care provision explored in the case study, in addition to the caregivers, other actors, primarily the care homes, the insurance enterprises and the government, all play their parts. The interplay between these actors shows how different actors integrate into the long-term care provision mechanism, sharing similarities but also differences in the care provision patterns with those in other pilot cities in China. Notably, in the provision pattern in Guangzhou, the blurred division between formal and informal care is distinct from other ongoing pilot cities.

Multiple actors collaborate to provide long-term care: local government dominates the care provision system, purchasing the care provided by the care homes and outsourcing the insurance fund management to the commercial insurance enterprises; the insurance enterprises act as public insurance fund managers as well as the organisers of disability assessments for older people; and the care homes operate as the employer, manager and supervisor of caregivers.

This chapter is divided into four sections. The first three sections present the evidence for the long-term care provision in the case study, with separate presentations of responses from these three social actors, specifically their thoughts about the care delivered by informal caregivers. The final section is the conclusion. The first and second sections provide separate responses from staff from a care home and an insurance enterprise, including the necessity of family members providing long-term care from their perspectives, and their contributions to the long-term care provision system. The third section offers evidence of care policies, showing the reasons for including family caregivers in the insurance-funded care system and the critical considerations in developing long-term care with the family involved. These findings provide a variety of perspectives from the actors involved in the provision of long-term care, with particular emphasis on addressing RQ2 and RQ4.

8.1 Care homes

In this section, four interviewees working in care home A shared their perspectives of the long-term care provision in the case study, particularly that of the care delivered by the family. Care Home A provided care services to over 600 care recipients who had registered in the home[1], 60% of whom were Level 3 recipients receiving care from part-time caregivers, mainly their family members. Around 40 care managers, who were nurses with professional qualifications, supervised the caregivers. Each care manager had set up a WeChat group with the caregivers. Care managers shared information about care provision in the WeChat group and caregivers were free to ask the care manager any questions. Interviewee E1 was the director of care home, responsible for the long-term care provision. Interviewees N1, N2 and N3 were care managers working on the front line, providing support and conducting monthly home visits to care recipients.

In this section, details are given about how the care home became involved in long-term care provision in the first part, followed by a second part which outlines the reasons for developing long-term care delivered by informal caregivers from the perspective of the care home.

8.1.1 Involvement in long-term care provision

Considering the interplay with the local government, the care homes primarily follow the regulations rather than engaging in the policy process. Disabled older people make applications to the care homes for long-term care insurance, and the care homes report the cases to the insurance executives, who organise a disability assessment to decide the qualifications of applicants. The care homes design the care plan for care recipients, offering care provided by full-time caregivers and part-time carers for those with Level 3 disability. As has already been explained, the former are formal employees of the care homes, and the latter are informal caregivers of care recipients registered in the care home through the long-term care system in Guangzhou. Every month, the care homes report the care provision and insurance reimbursement of each case to the insurance enterprises, which then transfer the appropriate insurance funding to the care home, and then the care home uses it to pay the wages of caregivers. Particularly for part-time caregivers, the wages vary in different care homes depending on the contract between caregivers and care homes. As the insurance reimbursements generally cover three-hour care services each day, the care homes also provide additional care, exceeding the reimbursement caps and paid by care recipients. However, a new official document issued in 2021 sets the wages paid for the

[1] Care recipients do not live in the care home but register to receive the care provided by the caregivers, either the full-time or part-time ones that are supervised by the care home (see section Case Study Introduction).

part-time caregivers at least 85% of the insurance reimbursement the care homes received from the insurance enterprises from 2022. In the long-term care provision system in Guangzhou, the interviewees from the care home reported that the government and the insurance enterprises had the largest say and not the care home. Interviewee CH1 said this regulation was to set a threshold for part-time caregivers' wages, which might possibly narrow the profit margin of care homes:

> *In Guangzhou, if you want to hire a caregiver from the private market, it would cost at least 5500 yuan (£617). However, the average pension of many older people is about 4000 yuan (£449). Even if the insurance could pay about 2000 yuan (£225) per person, it is not easy to cover the rest. Nevertheless, the (formal) care system in Shanghai is relatively developed … . The consumption habits are very different between Shanghai and Guangzhou. Most older people in Guangzhou believe that it is natural for adult children to take care of them rather than anyone else.*

Interviewee CH1 also stated that the local government did not provide any support for the care home. She added that the current social welfare provision was far from enough to provide care support for older people, so support from the public sector was critical for developing the long-term care system:

> *The government provides no financial support for individuals or care homes. The local government has never intended to fund older people but asks the care homes to provide care support for them. They just fund individuals who have passed the means tests or the childless older adults … . They hope that the public would praise them but do not wish to contribute even a penny, and then the enterprises from the care market pay for that. How can that work?*

Talking about the care homes and the insurance enterprises, interviewee N3 doubted the assessment of long-term care provision. He thought the ongoing care assessment failed to precisely capture the care demands due to the use of unqualified assessment experts:

> *When operating with the insurance enterprises, the professionals measuring the care levels of disabled older people are not always qualified. All the care assessments are not practical, and they do not specifically vary the differences in disability in various cases.*

8.1.2 Need for developing care provided by the family

Regarding the reasons for developing care provided by part-time caregivers, interviewee N1 explained that many older people preferred care provided by the family primarily due to their limited financial capacity and their trust in their family members, as well as the language barrier for caregivers outside the family:

> *Some older people do not like strangers taking care of them … the family is more thoughtful when providing care services. Language issues also matter. Some caregivers are not from Guangdong Province, so they do not know how to speak Cantonese or speak with a strong accent. Many older people do not understand how to communicate with them …. To hire a*

caregiver is very expensive, as the salary for a full-time caregiver might even be higher than that of one of their adult children.

In particular, interviewee N1 highlighted the importance of cultivating the public's consumption habits to purchase care services from the private market rather than relying solely on subsidies from the state:

We cannot always expect the state to pay for everything for us. With more disabled people, if the extra self-paid care services are no longer available, more people would think they could depend on the state instead of paying out of their pockets. We have to guide the residents to form their own consumption values by paying for all the care services on their own. After all, the care provided by the family members is much cheaper than purchasing the care services in the care homes.

These comments show that the limited capacity for affording care alternatives was significant, even with the long-term care insurance. However, she expressed concerns about the family's caregiving workforce because most family caregivers are retired:

When we visit some older people, we find that some family caregivers are over 60 years old and their parents, the disabled care recipients, are above 80 or even 90.

When talking about the benefits of care provided by family caregivers, interviewee CH1 stated that the thoughtfulness of family caregivers was a key concern and that the skills and knowledge shared with them were also helpful for the caregivers themselves. Given that family caregivers help to spread practical advice to other family members, they contribute to preventive care support for the public to a great extent. This helps to lead family caregivers and their families to develop a more precise understanding of long-term care insurance and an open-minded attitude towards it when they require care in the future. It could also be considered a form of public advertising:

First, the family caregivers are much more considerate than others. When they come here to take the courses and training, they are more careful because they are eager to grasp more skills for higher-quality care services for their parents. As for other caregivers, they usually learn more carelessly because what they consider most is that they do not want to work so hard. Second, if a family caregiver comes to take the training, although they provide care services to just one disabled older person, they usually share helpful information and instructions with others. Thus, more older people could get to know what they should pay more attention to in their daily lives. It is just like a warning alarm to notice the signals of their health situations.

So although the full-time caregivers recruited by the care homes were commonly assumed to be more professional in their care provision, interviewee CH1 admitted that it might not be the case because there were no significant differences between the care quality provided by full-time and part-time caregivers:

> *As for the caregivers recruited from the private market, there are only tiny differences with the family caregivers, as well as the care services provided …. Of course, there are also caregivers of high quality, but their salaries are very high accordingly.*

In Guangzhou, the family caregivers are regarded as the crucial labour force in the provision mechanism, but there is no clear dividing line between the formal and informal caregivers in care policies. Interviewee CH1 emphasised that the family caregivers were supposed to be viewed as general hired caregivers rather than family members, as the family had been recognised as an essential part of the insurance-funded long-term care system:

> *Even though the family members register as part-time caregivers, the local government has stressed that they are not relatives applying for the subsidies but employed caregivers with salaries. Thus, this is obviously a different story in Guangzhou.*

In accordance with public preferences towards family caregivers, the care home also had a strong incentive to encourage disabled older people to choose part-time caregivers, mainly associated with the cost-effectiveness of operating the care home. Interviewee CH1 said that because the care home had to pay a contribution to the mandatary welfare package for formal employees (old-age pension, healthcare insurance, unemployment insurance, employment injury insurance, maternity insurance and housing provident fund) for full-time caregivers, the care home preferred to employ part-time caregivers because of the lower administrative costs:

> *The long-term care provided by the family members is helpful for many older people and their families … as it helps to relieve the financial burdens, to strengthen the family connection and to reinforce the incentives in family care provision. If we employ a full-time caregiver, we need to pay for her public insurance schemes as the employer under the regulation, but not for the part-time caregivers, so it is about our running costs.*

These findings indicate that the care provided by part-time caregivers was a preferred option not just for care recipients for a range of considerations, mainly their economic capacity, but also for the care home, which was primarily profit driven. Developing the care provided by the family in the case study had thus proved to be appropriate.

In conclusion, the care provided by family caregivers is not only favoured by the care recipients and their families but also by the care homes, despite various issues. The care home has also played a significant role in developing the care provided by the family, particularly in terms of care quality, contributing to reinforcing the family's role as the direct care provider. Accordingly, the role of the care home has somewhat shifted away from the direct caregiver and towards the care manager to ensure adequate and professional care service delivery for more disabled older people, aligning with the changing family role in long-term care provision. However, although care homes are essential in the long-term care

system, they mainly engage in the care provision following the current insurance scheme without having any say during the policy process.

8.2 Insurance enterprises

The primary function of the commercial insurance enterprises for long-term care provision is to undertake the outsourcing of the insurance fund management from the local government, monitor the income and pay from the insurance funds through supervising care home caregivers. Their role partially overlaps with that of the government in funding management. Four insurance enterprises in Guangzhou are running the insurance funds, one of which is insurance enterprise P. The findings from the interviews with three participants from insurance enterprise P are set out in this section, showing their thoughts about implementing long-term care insurance in Guangzhou, particularly the care provided by family caregivers.

8.2.1 Involvement in long-term care provision

Regarding the agent/principal cooperation between the local government and the insurance enterprises, interviewee IE1 stated that it was outsourcing for the insurance fund management instead of sharing any risks or benefits with the government. The insurance enterprises are the executors responsible for ensuring the operation of the care insurance whilst the government is the policymaker inspecting everything. Compared with pursuing commercial profit by participating in implementing long-term care insurance with other types of interaction, following the procedures stipulated by the government is a more cost-effective approach for the insurance enterprises:

> *All we do is to help the local government manage the insurance fund, but we do not take any additional profit beyond that written in the contract, given that the insurance fund is part of the healthcare insurance fund. To establish a new system for managing the fund by ourselves would cost a lot. However, we follow the Department of Healthcare Insurance procedure, which is relatively mature and orderly.*

In addition to the care managers from care homes, the insurance enterprises regularly visit the care recipients. If anything during care provision is discovered to have violated the regulations, they will report the cases to the government and send feedback to the care homes as reminders. By ensuring the efficient use of the insurance funds, the insurance enterprises help to guarantee regular, high-quality care provision, especially the care provided by part-time caregivers. Interviewee IE3 explained that:

> *In some cases, we find that the home in which the care recipients are living is messy which makes it no longer suitable for them to receive care services. We will ask the care home to provide some instructions for them because they are care home employees while they are*

supporting the caregivers … but we do not contact any caregivers directly because we only get in touch with the government and the care homes.

However, interviewee IE2 expressed a contradictory opinion. Although the insurance enterprises and the care homes visited the care recipients' homes regularly, whether the family caregivers would accept the advice or suggestions given remained doubtful:

When we advised the family caregivers to have higher care quality or a cleaner living environment, they insisted that they would treat the care recipients well because they were their parents …. The care advice offered by the care homes is also useless because family members are reluctant to accept it. As for the private caregivers, although the long-term care insurance pays part of their salaries, the family covers the majority of it. Thus, the family is their employer and has the strongest say in deciding the care provision for older people.

Consequently, despite the supervision from the care homes and the inspections from the insurance enterprises for caregivers, these findings reveal the tenuous relationship between part-time carers and other actors in the care provision system, which raises additional concerns regarding the quality of care.

The government plays a significant role in policy advocacy to gain broader public awareness of long-term care insurance. Interviewee IE2 described how the government promoted the insurance scheme to the general public:

There has been more promotion this year than before. Some public service advertisements introduce long-term care insurance on the bulletin boards in the subway stations because the government has access to resources [to do so]. Some advertisements are put up at some community building entrances or in the elevators. The government also posts information about the insurance scheme on the WeChat official accounts. Even so, this might be ineffective because not all disabled older people and their families notice.

In this section, I describe the roles of insurance enterprises and the government in long-term care provision, particularly in regard to the part-time caregivers in the case study. The insurance enterprise also adhered to the routine established by the local government to manage the insurance fund through inspection of the care provision whereas the local government plays the decisive role in both care provision and the funding mechanisms of long-term care insurance.

8.2.2 Vague notions for the family caregivers

Due to the relatively higher operating costs for care provided by full-time caregivers but not part-time ones for the care homes, interviewee IE2 explained that the care homes preferred the latter. However, there was a requirement for 50% of caregivers to be full-time regulated in the long-term care policies in Guangzhou, so some care homes might even advise the family caregivers to pretend to be the full-time caregivers in order to reduce their operating costs while still meeting the percentage requirement:

> *Many care homes found that the policy scheme did not clarify whether the care provided by the family members based on affection, they advised the family to act as the caregivers. There are very few full-time professional caregivers, just 10 out of 1000 caregivers … if they do not confess the family relationship to the care home, no-one will know whether the caregivers are their family members or just those recruited from the care market. The care homes usually ask the family caregivers who have registered as full-time ones to sign a contract agreeing that they are willing to give up their participation in basic public insurance schemes (so the care homes do not need to cover the contribution as employers) and then repay some insurance costs to the caregivers.*

Despite the possible differences in quality of care between family caregivers and full-time ones, there had yet to be any classification of the definitions of family caregivers and others in the long-term care policies in the case study. Thus, there were few incentives for professional caregivers to work as full-time caregivers, which might harm the possibility of improving professional care in the long run by increasing the shortage of formal caregivers. Interviewee IE3 added that it was unfair for the professional caregivers given that they got the same pay for providing higher-quality care to disabled older people. In terms of the caregivers' qualifications, in particular the family caregivers, there were no specific standards, which was one of the main obstacles to the care provided by the family:

> *The most effective way to develop long-term care provision may be to separate the family caregivers from the others. Only by doing this can professional caregivers earn a higher wage for long-term care provision than family caregivers. This is not the case for the current policy scheme and practice. Although we all know that family members act as caregivers, they are identified as part-time caregivers but never as informal ones.*

Therefore, the role of the family caregivers identified in the long-term care provision mechanism merits further discussion. In the case study, the sole criterion for classifying different types of caregivers was whether the caregivers had a formal employment relationship with a care home. There was no specific distinction concerning the relationship between the caregivers and the care recipients, as well as the quality of the caregiving. The family has also not been confirmed by the official documents, despite being the pillar or even the heart of the workforce for long-term care provision.

In conclusion, the interviewees from the insurance enterprise provided additional information about the long-term care provision in the case study, particularly some which had been ignored or omitted by the care home. The insurance enterprise primarily served as the insurance fund manager and thus had a more neutral stance regarding the provision of care. Their responses confirmed that the individuals and the care homes had different but strong motivations to develop the insurance-funded long-term care provided by family caregivers. This reflects the government's intention for the provision of family care, considering the vague notions of 'part-time' instead of 'informal'.

8.3 Local government

The care arrangement is based on the ground of negotiation between different actors (Pfau-Effinger, 2004a). Regarding the care arrangement for long-term care in China, the policy process, mainly including implementation, development and exploration, is dominated by the local government during the ongoing pilot phase. Similar to many pilot cities, the Bureau of Healthcare and Security[1] is in charge of long-term care provision in the case study, given its financial reliance on public healthcare insurance. In this section, I introduce the government's considerations of developing long-term care provision according to the interview with interviewee GO1, an official from the Bureau of Healthcare and Security in Guangzhou involved in the policy design and implementation of long-term care insurance. The reasons for prioritising the care provided by part-time caregivers, the critical issues and the challenges for developing the insurance scheme at the local level are outlined as different themes in this section.

8.3.1 Reasons for developing long-term care provided by the family

In the interview, interviewee GO1 gave several reasons why the long-term care insurance scheme had expanded from solely formal care to a combination of formal and informal care, covering the care provided by the family.

Shortage of available residential care provision

Residential care is one of the principal alternatives to home-based care provided by the family. For public care institutions, due to the relatively low living costs compared with private ones, beds are typically in short supply except for those reserved for those qualified by the means-test. Public care homes are the foundation for residual welfare support fulfilment in China. For instance, with high occupancy rates generally above 90% in many care homes in Guangzhou, older people have to wait a long time for a bed. Correspondingly, most private institutions are middle- and high-end, and many older people cannot afford the care they provide even with long-term care insurance reimbursement. Interviewee GO1 described the development of residential care:

> *It is impossible to find empty beds in public care homes in Guangzhou except for the one in the most distant administrative area. Although the data show that the overall occupancy rate of beds in care institutions is over 50%, many empty beds are available in private care homes with comparatively high prices.*

Consequently, there are few incentives for public care homes to attract more residents and the private care homes are unwilling to reduce their fees to compete for more customers in the care market,

[1] The Bureau of Healthcare and Security is the department that manages the insurance fund for public healthcare insurance.

considering the high costs of hiring caregivers. Long-term care provided by private sector actors is not primarily motivated by unmet care needs but rather by the profit motive. There is therefore limited basic room for different care homes to expand long-term care coverage. Accordingly, developing home-based care to supplement residential care appears to be a viable option, particularly in the light of the enduring family-centric care provision pattern.

Little room for raising the reimbursement cap

With the lack of an independent finance source for long-term care in China (*see* Table 1.1), long-term care insurance has heavily relied on the healthcare insurance fund and financial support from the local government. However, as the economy has been severely hit during the pandemic and public finances have suffered a massive burden due to substantial public expenditure on hospital operations and the treatment of COVID-19 patients, the fiscal capacity of the local government has been challenged. Interviewee GO1 insisted that there was little room to increase the reimbursement level for raising care recipients' purchasing power for care alternatives to family care considering the insurance fund's sustainability and financial affordability:

> *The reimbursement ceiling in Guangzhou is relatively high in China. We could not increase it any more …. The ongoing economic downturn and the outbreak of COVID-19 in the past few years also matter [for the fiscal capacity].*

So with high-cost care on the private market and that inaccessible from public care institutions, seeking an alternative option for the public is crucial for long-term care development. As with the general preference for home-based care, the family appears to be the best available caregiver, continuing its conventional care role for vulnerable members.

Need to promote the care provided by the family

Addressing the rapidly expanding care demand of disabled older people in such an ageing society has been set as the national strategy on the policy agenda in China. Ever since the central government launched the pilot insurance guidance in 2016, the primary concern of the policy design in Guangzhou has been meeting the care demand with the affordable fiscal capacity of the local government. In Guangzhou, part-time caregivers, primarily family members, have filled the massive shortfall of full-time caregivers and the high staff turnover. As the workforce is one of the most concerning issues in developing long-term care system, interviewee GO1 said that it was unnecessary to differentiate between formal and informal caregivers:

> *There are just slightly more than 20,000 caregivers qualified as full-time, but about 70,000 people are receiving care services from the insurance scheme. The informal caregivers have*

> *filled the care provision gap … if we could train the caregivers to achieve specific professional standards, it does not matter whether they are formal or informal … they are all accessible labour forces in the care market. If their care recipients pass away one day, they could provide care services to others with their transferable experiences and skills.*

Furthermore, interviewee GO1 insisted that the workforce issue was of great importance in comprehending the specific logic of the public sector in developing long-term care but had rarely been clarified previously:

> *Many draw conclusions based on the academic discussion…. One solution most mentioned is to urge the government to invest more in optimising the supervision of care delivery and fund management… But how could we find so many people for the supervision?*

For the local government, the core concern is whether there are sufficient caregivers to meet the public care demands. The family is helpful, providing a considerable labour force. During the pilot period of long-term care insurance, the local government demonstrated the need for informal care in an effort to attract more attention from the central government. Interviewee GO1 explained that it was a critical time to earn more attention for the Guangzhou Model, revealing the political considerations in developing long-term care:

> *We hope the central government can notice the model prioritising informal care with so many positive outcomes … Otherwise, if the central government directly proposes the strict guideline that all cities should develop formal care but not the care services provided by the family, it would be a fatal blow for us. Many care homes would not be able to survive.*

Multiple reasons given by the interviewees explain the development of care provided by part-time carers, primarily family members, in the case study. In the light of the labour shortage in the caregiving options beyond the family and the limited room for increasing the insurance reimbursement cap, it is crucial to develop family-based long-term care, which also seeks greater policy attention from the central government.

Blurry notion of the 'family caregiver'

Although family members remain the primary caregivers, there is no specific distinction between the family caregivers and others in the insurance-funded long-term care system in the case study. Instead, there are two types of caregivers for home-based care, depending on whether they are formal employees of the care homes. The family caregivers are classified as part-time (*see* Case Study Introduction in Part Two: Findings).

In the long-term care insurance regulations in Guangzhou, the maximum percentage of disabled older people accessing long-term care services from part-time caregivers has been set at 50% since October

2020 (40% before). The policy adjustment of the increased percentage has led to the increasing importance of the family caregiver, as well as the expansion of informal care provision. Interviewee GO1 said that the long-term care insurance in Guangzhou differed from many cities which require formal care:

> *In Guangzhou, family members are paid as part-time caregivers...Some other cities may be against this pattern, as they believe that all family members are presumed to shoulder the care obligation of their older parents. (They believe that) all the public support for the family caregivers is respite services but not the care services delivered by the family.*

Compared with clarifying who is the direct caregiver, the higher priority of the government appears to be whether the sustainable urgent care demands of disabled older people have been met. Professionalisation has therefore been highlighted as a way to promote long-term care delivered by different caregivers. The vague boundary between family caregivers and others is considered a pragmatic strategy for the local government to adopt. Interviewee GO1 added:

> *With high-quality training, all the caregivers could access the professional training courses. It is meaningless to clarify who the caregivers are. They are the qualified workforce for the care market. The increasing number of family caregivers might be led by the real pressure.*

Interviewee GO1 stated that the Guangzhou case was likely to be widely applied considering the predictable lack of caregivers shortly in China:

> *The development of informal care could be mainstream in China, just as we prioritise it in Guangzhou. The main reason is that we do not have enough workers in the care market for sufficient care provision.*

So regarding the current fragmented care systems in different pilot cities in China, in order to promote the quality of care, the training courses set up for all caregivers should be given more attention, according to interviewee GO1:

> *The training is organised [differently] by local governments…. So unified standards of training and examination on the national level are constructive, including the requirements for the tutors and agencies holding the training courses, the handbooks, and those eligible for these courses.*

8.3.2 Critical consideration of developing long-term care provision

Limited available labour force for long-term care provision

Home-based care is the popular choice for care recipients in the case study, but that provided by non-family members is typically costly due to the observable shortage of full-time caregivers in the private market. Interviewee GO1 stated that the government did not intend to make clear distinctions between family caregivers and others as long as the care provision was high-quality and professional:

> *We do not care how many care homes are in the market. Instead, we focus on how many people are able to provide care services after the training …. The primary concern is the number of caregivers in the care market and their profession. First of all, there should be sufficient caregivers to deliver care services. The next step is that they are professionals, as the requirements for long-term care services are different from those for the housework provided by housemaids.*

However, with the rapidly changing demographic transition in contemporary Chinese society, such as the shrinking family size and booming ageing population (*see* Section 1.2), a more sustainable and stable labour force than family caregivers may be required. Whether this pattern of family as part-time caregiver can continue to meet the rapidly expanding care demand is uncertain.

Various narratives for emphasising the family's function in long-term care provision

The emphasis on cultural values addressing family's role in supporting its members is considered convincing for both the central government and the public to understand why informal care provision has been prioritised in Guangzhou. Interviewee GO1 explained how family affection had been highlighted to urge more family members to shoulder the care responsibilities as direct caregivers, with the consensus that filial piety is one of the principal merits in East Asia:

> *When developing the local insurance scheme, we emphasise the family affection for taking care of older people. It follows traditional family values such as filial piety in East Asian societies, and it is quite persuasive to explain why we prefer the care provided by the family.*

Even so, interviewee GO1 admitted that the family bonds might be less compelling for the family to maintain or even retain its role as the direct caregiver. Accordingly, the policy regulation for supporting family caregivers in providing care is essential:

> *There is also a saying that the children would no longer be filial after looking after their elderly parents lying in bed for a very long time. So here comes another problem: specific regulation of informal care is necessary for the family affection.*

The long-enduring cultural values and the conventional family function for care provision were underlined in the case study, catering to the general preferences of both the general public and the central government. The local government in the case study is pleased with the policy outcomes for the implementation of long-term care insurance, with the wide insurance-reimbursed long-term care coverage addressing the rising demands. The informal care prioritised care pattern is also viewed as the most feasible and practicable option with the socio-economic and cultural conditions in Guangzhou, or probably even in China.

8.3.3 Summary

In this case study, the development of long-term care was predicated on meeting the care needs of disabled older people. According to the findings presented in this chapter, the coverage of insurance-funded care appears to be valued more than the quality of the care in such a pilot phase of local long-term care insurance exploration.

Compared with the care alternatives, home-based care delivered by the family was included in the long-term care system in the case study. The family is assumed to be a readily available workforce as direct caregivers, primarily bearing in mind the shortage of formal caregivers and the cost of private caregivers recruited from the care market. Despite the development of long-term care insurance, the reimbursement caps have limited the care options for many older people and their families due to the affordability of care alternatives to family care. The family is expected to fill the care provision gap by continuing to provide care in excess of the reimbursement ceiling, as many families have been doing, as well as being made aware of it by the local government.

Family caregivers, as part-time caregivers, had therefore been included in the current long-term care exploration in the case study. The blurry distinction between family caregivers and others is one of the pragmatic solutions for addressing the care demands when expanding care coverage, with specific narratives emphasising family function and values in the light of the limited available labour force in the current care provision mechanism. Notably, despite the diversified care provision patterns adopted in the pilot cities (*see* Table 1.2), the case in Guangzhou has shown how the local government there developed a local pattern by taking multiple factors into account.

8.4 Conclusion

In the case study, care homes, insurance enterprises and the local government played distinct roles in developing long-term care. In this chapter I have explored the perspectives of actors other than care recipients and carers.

Despite the various explanations offered, all of these actors have come to the same conclusion: the family's role as a part-time caregiver is significant and practical for meeting the care demands in the local exploration. The shortage of a workforce of care alternatives to family care, and the general preference for family care, are highly concerning. The local policy design has been primarily impacted or even determined by the increasing gap in care provision. The blurry distinction between family caregivers and others in the current policy scheme illustrates the local government's intention to satisfy the immediate care demand without clarifying the care providers. It is acknowledged that cultural

values are persuasive for the family to continue its conventional role as the caregivers of disabled older relatives in the light of specific narratives in care policies emphasising the family's role. In this way, the family, as the most feasible workforce, is able to continue to provide care even beyond the insurance-funded hour limits without additional compensation. The family has shown resilience and adaptability in adjusting its role in providing long-term care with the implementation of long-term care insurance. These results contribute to the analysis of RQ2 regarding the family's changing role and RQ4 regarding the cultural values utilised in the care arrangement.

Notably, in terms of the interplay of multiple actors, the government dominates the long-term care provision system. Care homes and insurance enterprises provide professional care support and fund management under the strict inspection of the government. Both local and central government affect long-term care provision to varying degrees, and the interaction between central and local government is also important. An analysis of care arrangements should therefore consider all of these factors, and this will be presented in Chapter 10.

Part Three: Discussion

9 Changing Family Role in Long-Term Care Provision from the Defamilialisation Perspective

The family's role in providing care in China has been extensively discussed in previous studies (*see* section 2.3), but the findings from the case study (Chapters 6, 7 and 8) have shown its changes as the direct care provider. Given that the family's role in supporting its members can be captured from a defamilialisation perspective (*see* section 2.2) and that long-term care policies targeting older people are closely related to the defamilialisation debates (Le Bihan, Da Roit and Sopadzhiyan, 2019), this chapter will present a discussion from a defamilialisation perspective for the following two research questions:

RQ2. How has the role of the family in providing long-term care changed following the implementation of long-term care insurance schemes?

RQ3. Are there any intergenerational differences in the care attitudes and care decisions for the family providing long-term care support? Are there any impacts from cultural factors?

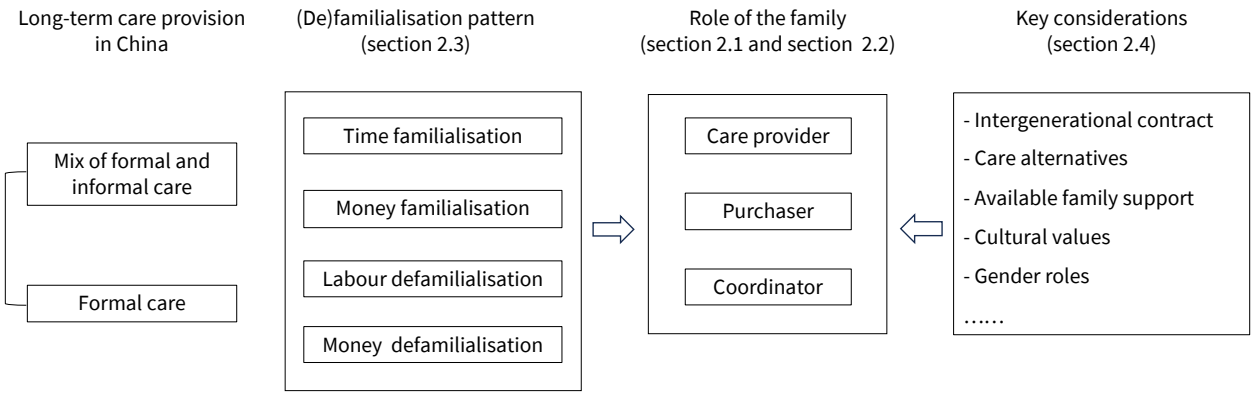
This chapter is structured in five sections. The first section summarises how the family's role as the direct care provider for its members has changed in the money and labour dimensions with evidence from the case study, establishing an analytical framework for long-term care provision covering informal care in the Chinese context. The second provides explicit insight into the gender role division for care provision, discussing the care burden shared between females and males within the family. The section that follows focuses on the intergenerational differences in care attitudes and care decisions within the family. The fourth section compares the findings derived from the quantitative and qualitative analyses, outlining the variations in the family's role in care expectations and care provision mechanisms in contemporary China. The fifth section ends the chapter with a summary of the main ideas in this chapter, showing how the findings address the two research questions (RQ2 and RQ3). This chapter presents a comprehensive picture of the family's involvement in long-term care provision with its changing caring role, with particular attention to cultural values addressing the family responsibilities and obligations, thus contributing to Chapter 10 for the discussion of cultural values and the family's role in response to RQ4.

9.1 Family's role in long-term care provision from the defamilialisation perspective

The ongoing long-term care insurance in pilot cities in China, as the funding mechanism for long-term care provision, has relocated the care responsibility between the state and individuals (families) (*see* section 1.3). The results of the case study demonstrate how the family provides care for its older members (*see* Chapters 6, 7 and 8), and in this section I examine how the family's role has changed from the defamilialisation perspective.

Based on Figure 9.1 (also as Figure 2.2 in section 2.5), the findings of this study provide empirical evidence for the roles of the family in providing long-term care when clarifying the care provision pattern from the defamilialisation perspective. Key considerations of the changing roles of the family are revealed.

Figure 9.1 Family's roles in long-term care provision from the (de)familialisation perspective



Care patterns in the money and labour dimensions have been witnessed in the Chinese context, as evidenced by the case study in which older people could choose the insurance-reimbursed care services provided by family and others.

Consisting of observed patterns of money-defamilialisation and labour-defamilialisation, this section develops a framework for capturing the family's role in long-term care provision in China. With the findings from the case study, this section discusses the changing family role in long-term care provision in three parts: (1) money-familialisation; (2) labour-defamilialisation; (3) a combination of these two.

Although the time dimension is included in An and Peng's framework analysing the (de)familialisation of childcare policies in East Asia (*see* section 2.2.2.3), it has not been reflected in long-term care provision based on the empirical evidence from the case study. As for the early development of long-term care funded by the public insurance in China in such a pilot phase, benefit-in-kind and cash benefit

for long-term care are available for older people with disabilities (*see* section 1.3). Time-familialisation such as paid leave for childcare is not found in care support for older people in this study. Thus, familialisation in the time dimension is excluded from the analysis of this study. However, it might be included in the long-term care provision in China with its development in the near future.

9.1.1 Money-familialisation

Money familialisation refers to the degree to which policy reshapes the family's caregiving role by providing financial assistance to value family care (An and Peng, 2016). Compared with the money-familialisation in An and Peng's discussion highlighting the policy input of childcare (such as the total social expenditure and the total expenditure on family) to measure the state's intervention, this study focuses on the outcomes in relation to the family's role in supporting its older people in response to the long-term care policies.

Family's role in the money-familialisation pattern of long-term care

In the case study, although care provided by full-time and part-time caregivers was set to be a benefit-in-kind for care recipients according to care policies, it has typically been viewed as a cash benefit for older people with disabilities, given that the wages of part-time caregivers, who are primarily family members, have been used to cover the care recipients' everyday costs (*see* sections 6.3 and 7.4). The public insurance reimbursement has been interpreted as a form of financial support rather than valuing informal care provided by family members employed in the workforce. In this way, three major care provision patterns for money-familialisation emerged among care recipients who opted for long-term care provided by their families.

In many instances, the family's caregiving role has not changed, as family members had been caregivers without pay even prior to the implementation of long-term care insurance funding long-term care provision. They are typically spouses and adult children with flexible working hours, such as full-time housewives and those informally employed, or those who do not have a job because they have been laid off or have retired. With ample free time, they choose to fulfil caregiving responsibilities, which might be based on family discussions or the preferences of disabled care recipients. The reliance and trust in family members closely associated with cultural values were most frequently mentioned (*see* sections 7.2.2, 7.2.4 and 7.3.1). So even without accounting for the costs of alternatives to family-based care, the implementation of long-term care insurance funding long-term care services has not significantly diminished the family's role in providing care in these instances.

In other instances, however, family members did not provide care until they were compensated by insurance programmes. The insurance reimbursement served as their compensation for providing care and the incentives include spending more time with elderly relatives and being more considerate (*see* section 7.4). These cases exhibit patterns similar to the cash-for-care programmes adopted in many other countries (Da Roit and Le Bihan, 2019, Ranci et al., 2019). However, the cases in this study showed that individuals rarely leave the formal labour market to return home to fulfil their care obligation as most family caregivers were in their 50s and 60s. Although some family caregivers might stay at home rather than look for another formal job, prioritising the care obligation over their careers, the consideration and patience of the family members are crucial for the care decisions. Care decisions place a premium on quality of care in many cases.

For these two stances, even with the optional formal care funded by the long-term care insurance, the family continues to provide care, not only as work reimbursed by the insurance but also as care provided voluntarily that exceeds insurance reimbursement caps. The family is therefore the direct care provider, bridging the gap between the insurance reimbursement cap and the actual care demands of disabled family members. Notably, despite having the same role as a direct care provider, the family has alleviated the financial strain caused by disabled older members, even though they complain about the low reimbursement in the light of rapidly rising inflation (*see* sections 6.3.2 and 7.4.1).

The formalisation of informal care reflected in the family care provision patterns should also be noted. The shortage of workers beyond the family for providing care has led to difficulties in recruiting a full-time caregiver from the private market at an affordable price. Instead of the cash benefit, the formalisation of informal care had also been employed in the case study, despite the lack of an explicit or precise definition of the family's role in care provision. It can be interpreted as informal care, or as a semi-one, similar to the cash-for-care scheme adopted in many European countries (Ungerson, 1997, Da Roit and Le Bihan, 2010, Da Roit and Gori, 2019), which compensates informal carers with cash benefits for the care which they provide (Pfau-Effinger,Jensen and Flaquer, 2010).

However, the situation is different in China. In the case study, the ambiguous role of the family in both national and local policy discourses regarding the provision of long-term care services suggests that the policy appears to intend to encourage the family to join the formal labour force following training and qualification in the care market, thereby supplementing the long-term care system (*see* sections 8.3.2 and 8.2.2). All carers are supervised by care homes and insurance companies (*see* sections 8.1.1 and 8.2.1) to ensure that care services are delivered appropriately. In addition to leading to the family transferring to being qualified carers in the insurance-paid long-term care provision system as the

workforce, the formalisation of informal care has also resulted in an improvement in the quality of long-term care, in accordance with the intention of the local government (*see* section 8.3.1).

Inasmuch as the family continues to provide direct care for disabled older members in these cases, even though a proportion of their care costs are now covered by the newly developed public insurance scheme, the family's role in the provision of care has not fundamentally shifted. The care provided by the family is preferred, and the money-familialisation pattern in the case of Guangzhou is comparable to that of the pilot cities in covering informal care (*see* Table 1.2), despite the fact that 'informal care' had not been specifically identified in the policy documents in the case study.

Money-familialisation is a rational and reasonable care decision

For many families providing care for their older family members, the public long-term care insurance was viewed as a 'universal'[1] welfare programme for eligible individual health conditions (such as ADL assessment for the physical disability in the case study) rather than a public insurance (*see* section 7.4.1). One of the possible explanations for this is that the current care recipients have not contributed to the public insurance scheme during a pilot period in which the majority of the start-up fund comes from fiscal transfers and the public healthcare insurance surplus at the local level. Due to a lack of understanding of the insurance scheme (*see* sections 6.3.1 and 7.4.1), the family's role as the direct caregiver has not altered significantly prior to and after the implementation of the public insurance funding long-term care services.

Regarding multiple justifications for the care decision based on family members providing care as opposed to other alternatives (*see* sections 6.2 and 7.3), the ability to pay for alternative care options was most emphasised, particularly for caregivers. Having the family continue to provide direct care is a sensible option for the family, not only for the care recipients but also for their family as a whole. The capacity to pay for other care alternatives was the decisive factor in affordability, thoroughly considering the resource allocation and redistribution within the family. The family acting as the direct caregivers was the last resort due to the pressing care demand but the insufficient purchasing power for any other care substitutes from the private market and the unavailable public services confirm the arguments emphasising the limited alternatives (Schulz et al., 2012, Piggott, 2015, Hu, 2019).

For both care recipients and caregivers, deeply ingrained social values and norms regarding filial piety and intergenerational contract are essential to the family's willingness to fulfil its caring responsibilities

[1] With relatively limited understanding for many participants, the ongoing public long-term care insurance in the case study has been viewed as financial support for older people due to their disabilities (see section 6.3 and section 7.6). It might be mainly due to the early development of public long-term care insurance as the funding mechanism during the pilot phase. The start-up funding for public insurance were mainly from the transfers of the surplus of the public healthcare insurance fund and financial support from the local government (see section 1.3).

for its older members. Many therefore take it for granted that the family should shoulder the caregiving responsibilities of its elderly members and be willing to offer voluntary caregiving support which has usually been undervalued (Silverstein et al., 2002, Whyte, 2004, Chappell and Funk, 2012, Bedford and Yeh, 2019, Zhang,Clarke and Rhynas, 2019), as well as other possible incentives and enforcements such as setting a moral model (Cox and Stark, 2005). In this way, since the care provided by the family has been included in the publicly funded long-term care system in some pilot cities, such as the case study of this study, the care work used to be unpaid and voluntary has been valued. Since care work beyond the public insurance reimbursement cap remains unpaid, the value of family care work receives partial compensation.

In addition to the cultural values shared by many that are important in motivating the family to continue its caring role, the practical considerations, mainly the lack of alternatives, also explain. The newly developed public insurance paying for informal care is significant in shaping individuals and family decisions as the direct care provider (*see* section 7.3). In other words, cultural values addressing family responsibilities and obligations persuasively explain why the family provides care despite the availability of alternative care options. Similarly, the insurance reimbursement is believed to be a monetary reward for filial children, resulting in stronger family values (*see* section 7.4.3).

A care decision is therefore determined by comparing the costs of all possible care options as a family unit (*see* sections 6.2 and 7.2), taking into account the perspectives of all family members. Using empirical evidence from the case study, the findings of this study provide a more detailed account of the situation in China. In the pilot cities where informal care is covered by the insurance-reimbursed care system, family-provided care is favoured in the light of all considerations for care recipients and their families. This demonstrates the family's determination and resilience to meet the needs of its members (Shi, 2017a), despite the fact that the ongoing care policies have not mitigated the new social risks. Specifically for long-term care, the family has largely bridged the gap between the care reimbursed by insurance and the care needs of older people. Thus, the family continues to provide direct care partially supported by public insurance.

In addition to individual and family factors, the characteristics of long-term care insurance, such as eligibility rules and coverage generosity, influence the choice between informal and formal care (Bakx et al., 2015). In the case study, the reimbursement cap for informal care was greater than that for formal care, resulting in a gap between reimbursement and care demand. This is true not only in Guangzhou, but also in many other Chinese pilot cities.

Regarding the caregivers paid by the public long-term care insurance, many of them are middle-aged or older. Given that the occupation-related retirement ages in China are younger than in many other nations, as males usually retire at 60 (cadres in the public sector at 65) and females at 50 (cadres in the public sector at 55 or 60), quitting the labour market to work as a part-time caregiver for their family members is not even a choice for many of them given that they have already retired. With the gaps in retirement ages between men and women, informal caregivers are usually women nearing their retirement ages (Wang and Zhang, 2018), therefore reflecting the impacts of the gender division of labour on long-term care provision to a certain extent.

In conclusion, given that long-term care insurance covers both formal and informal care, insurance reimbursement for the formalisation of informal care is offered as a benefit-in-kind to older people with disabilities and their families. In many cases, the family continues to finance the everyday lives of its older people, including the redistribution of insurance reimbursement funds within the family and the provision of voluntary care work in excess of the reimbursement ceiling. Although money-familialisation and labour-defamilialisation are comparable in that the direct care burden is transferred from the family to paid care providers outside the family (An and Peng, 2016), in the case study, long-term care was provided as (and viewed as) cash benefits for money-familialisation due to the redistribution (for economic and care resources) within the family. With the money-familialisation, the family's role as the direct care provider has been maintained or even strengthened.

9.1.2 Labour-defamilialisation

According to An and Peng's work in labour-defamilialisation, with the defamilialisation policies, individuals are offered a benefit-in-kind for care services provided by the public or the private sector (*see* section 2.2.2.3). In pilot cities where only formal care is available, defamilialisation of labour is the only option. In other pilot schemes, the care beneficiaries are offered options for care provided by caregivers from outside the family, mainly the formal caregivers from the care homes (*see* Table 1.2), which can be viewed as a form of labour-defamilialisation. The family's care obligation as the direct care provider has thus been partly shifted. Evidence from the case study also demonstrated this changing role.

In the case study, some families had sought more professional and higher-quality care services purchased by the insurance fund to alleviate their caregiving responsibilities. The reasons for the family stepping back as the direct caregiver were varied, mainly including reimbursement caps for the care alternatives to family care, the family's desire to decrease the heavy workload, and the inaccessibility of family care support due to the lack of a family-based labour force, specifically for those older adults with

a single child (*see* sections 6.2 and 7.2). Nevertheless, the family has to pay for the cost beyond the reimbursement caps. The family is no longer the direct care provider but is changing to become the coordinator of support (Izuhara, 2010). The findings of this study also show that despite the care provided by others outside the family, the family continues to play an important role in providing everyday support for its disabled older people, particularly emotional support.

Various explanations shaping the possible labour-defamilialisation pattern were identified in the case study. With the implementation of long-term care insurance, although eligible older people are offered alternatives to family care, and the insurance reimbursement has increased the family's purchasing power for care services from the private market, some older people nevertheless insist that they would rather spend more time with their loved ones (*see* section 6.2.3). Correspondingly, those outside the family who provide care for older people are usually recognised as external carers or outsiders due to the stereotype of caregivers in the developing care market in China and the irreplaceable emotional support from the family (*see* section 7.2.4). Family values based on the inherent reliance and trust due to intrinsic blood ties and cultural considerations might reduce the likelihood of employing the labour-defamilialisation pattern, reflecting the strong cultural impact on individual care decisions (*see* sections 6.2.3 and 6.2.4). Therefore, the defamilialisation dimension for relieving the family's care burden could not comprehensively cover the specific family function.

Considering the additional expense to individuals to cover the gap between the insurance reimbursement cap and the cost of care from outside the family, the defamilialisation pattern has been challenged to some extent, particularly in those pilot cities covering informal care in the public insurance scheme, as illustrated by the case study in this study. So although long-term care insurance is argued to be a defamilialisation policy instrument (Shin, 2013), it is primarily significant as a funding mechanism but it also alters the provision mechanism. This is mainly the case for the schemes covering informal care services in China.

9.1.3 A combination of money-familialisation and labour-defamilialisation

Regarding the long-term care provision from the defamilialisation perspective, the money and labour dimensions reflect the fact that the individual receiving long-term care relies on care provided independently from the family. As a state intervention, long-term care insurance shifts some care responsibilities away from the family due to the insurance reimbursement. According to the findings from the case study, in the pilot cities covering the care services provided by both family members and other actors in the public insurance-reimbursed care provision mechanism, money-familialisation and

labour-defamilialisation patterns were mainly proceeding, whereas money-defamilialisation might also be witnessed in some pilot cities but was not found in the case study.

Regarding the money dimension, although direct care is claimed to be provided as a benefit-in-kind, the family has in effect been compensated monetarily for providing direct care. The family's role in long-term care provision has been reinforced, with the family being identified as the significant direct care provider. The policies supporting public insurance-funded long-term care may motivate older people to choose family care (Cao and Xue, 2023), as found in the case study regarding the choice between money-familialisation and labour-defamilialisation.

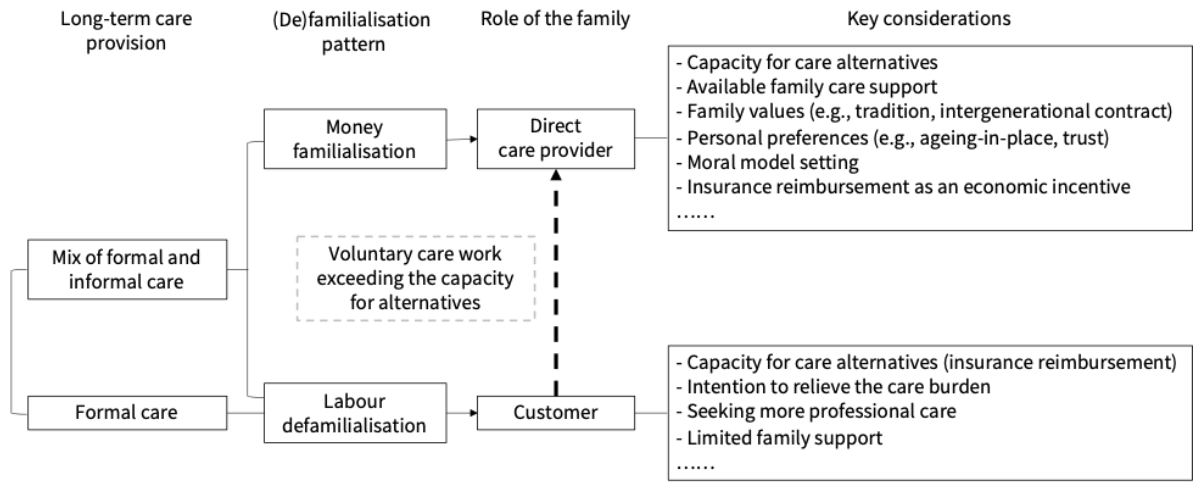
In addition, as the insurance reimbursement is commonly viewed as a cash benefit, valuing the informal care, and the family is the economic unit, disabled older people have become less economically dependent on their family, reflecting the fact that the care responsibility has relieved the family of its burden. The critical determinants of the choice between money-familialisation and labour-defamilialisation are the capacity to pay for the care alternatives and the general preferences for family care shaped by cultural values. The economic factor is the decisive one whereas the latter has turned out to be more pragmatic in the light of the demographic and socio-economic circumstances in contemporary society (as also demonstrated in Chapter 5). With the implemented insurance segregating financial support and care support, the family's role in supporting its older members has been more clearly delineated in terms of the money and labour dimensions. So even with long-term care insurance, the family-dominated care provision pattern has not yet been transferred. This is especially true for relatively low-income families, as with disparities in care provision between households.

Specifically in the case study, there was a semi-money-familialisation pattern associated with the public misunderstanding of the benefit type. The dividing line between the money and labour dimensions is vague and the family's role has never been explicitly mentioned in the policy discourse (*see* section 8.2.2). Instead of clarifying formal and informal care, the formalisation of informal care in the long-term care system had happened in the case study (*see* section 8.3.1). The determining reason for the insurance reimbursement as a cash benefit is the family as the socio-economic actor for its members (Papadopoulos and Roumpakis, 2017). More importantly, this pattern is not exclusive to the case study among the pilot cities in China. As the pioneer of developing informal care in the long-term care system, Chengdu also adjusted its insurance scheme in 2021 after the first round of exploration, shifting from clearly defining the care provided by the family to identifying the family carers as part of the non-formal carers, mirroring Guangzhou's policy setting.

Furthermore, as with the combination of money-familialisation and labour-defamilialisation, it should also be noted that the care needs of those with greater household purchasing power are more likely to be met and have a lower care burden on the family. Thus, care inequality has emerged due to the fact that material constraints determine care decisions. Specifically, compared with the care inequality alongside the choices between public and private care services in previous studies (Mathew Puthenparambil and Kröger, 2016, Mathew Puthenparambil,Kröger and Van Aerschot, 2017), the case in China is more about the care choice between family care and care provided from beyond the family, as with the underdeveloped care provision beyond the family in China, further illustrating how the care responsibility has shifted between the family and the state.

Based on the findings of the case study, in this section I examine how and why the family adjusts its role in response to long-term care insurance as a policy intervention in China. The family is depicted as a unit as the state's counterpart for care providing and purchasing with a variety of incentives and enforcement (*see* Figure 7.1). In the long-term care system in which the family is one of the insurance-funded care providers, based on the analytical framework developed based on previous studies in the context of long-term care provision (Figure 9.1), this study demonstrates the combination of money-familialisation and labour-defamilialisation (Figure 9.2).

Figure 9.2 Changing family role from the defamilialisation perspective



As Figure 9.2 shows, as in the cities with a mix of formal and informal care in China, in the case study of this research, with the combination of money-familialisation and labour-defamilialisation patterns, the family performs as the direct care provider or customer of care delivered by other actors. Care decisions are primarily determined by a family's capacity to pay for care provided within or outside the family. Despite the available labour-defamilialisation option under the current long-term care insurance and the preferences for relieving the family's care burden, familialisation is the practical and rational choice

for many, primarily due to the insurance reimbursement caps. Family values are persuasive for causing the family to transition from defamilialisation to familialisation or to continue providing voluntary care work in excess of the caps. Consequently, family values have rationalised the care burden and maintained a degree of family responsibility, and this is discussed further in Chapter 10. In addition, the disabled older people who pass the means test can access the long-term care provided by the care home, as depicted by the labour-defamilialisation pattern in Figure 9.2, despite the possible absence of their family support.

Overall, the family and policymakers recognise it for emphasising the family function in public discourse and addressing the family's contribution through cultural values. The affordability of care alternatives of family care is significant for individual care decision (Hu, 2019). If the state provides limited care services, the family is responsible for care provision (Leitner, 2003). In China, the family is a particularly adaptable institution with strong resilience in response to social change (Jankowiak and Moore, 2016), as well as the last resort for the individual to resist risks (Shi, 2017a). The family demonstrated as a socio-economic actor (Papadopoulos and Roumpakis, 2017), with its social reproduction for supporting its members. Thus, the state's resources have been directly or indirectly redistributed to various households, based in part on the capacity of the household (Liu, 2017). With the implementation of long-term care insurance covering family-provided care in China, the gaps in care provision are expected to be filled by the paid and unpaid work of the family. The family's role as the primary provider of voluntary care has therefore changed to some extent.

9.2 Gender role division within the family in long-term care provision

Gender issues are significant in the discussion on defamilialisation (*see* section 2.2.1). After interpreting the family as a unit in the previous section, this section investigates the specific gender role division within the family in the provision of long-term care.

Regarding the case study, the gender division pattern appears to vary from the presumed one highlighting females, including daughters and daughters-in-law, due to traditional gender norms and Confucian filial piety in the previous literature (Yi et al., 2016, Liu, 2017, Wang et al., 2020). Although it is taken for granted that females' primary responsibility shifts to their husband's parents after marriage under the deeply entrenched patriarchal ideology in China (Whyte, 2004), this is not the case for the long-term care provided examined in this study (*see* sections 6.1.4, 7.2.5 and 7.3.3). Instead, the caregivers are usually the spouses, sons or daughters without specific gender division, somewhat going against the gendered filial expectation. The findings have shown that adult children without distinctive gender preferences between sons and daughters carry a heavier care workload than children-in-law.

The blood ties may be more explanatory than the conventional gender role within the family due to the preferences of care recipients and the family values for fulfilling filial responsibility and the intergenerational contract (*see* sections 6.2.4, 7.3.1 and 7.3.2).

These findings do not align with the arguments on the distinctive filial expectations that sons are permanently expected to provide more support than daughters (Song,Li and Feldman, 2012, Lin and Yi, 2013), as well as those claiming that the parents' favour for sons or daughters as the care providers (Zhang and Wang, 2010, Cong and Silverstein, 2012b, Yi et al., 2016). Therefore, the gendered caring role between sons and daughters was not significantly illustrated for the family care decision based on the findings of the case study (*see* section 6.1.4). One critical explanation is the available family support, particularly for those one-child families who do not even have a second choice but accept the care provided by their child regardless of gender. Thus, the case study of this research reveals that the availability of care services is determining in family providing long-term care regardless of the gender of family members. It should also be noted that the interviewees in this study were carers for their parents, so their positions might somehow influence their attitudes towards the gendered role of care provision.

In addition to adult children concerning the intergenerational contract, spouses were the significant caregivers, particularly wives, comprising the available family workforce for caregiving. This specific gender pattern was led by the availability of a spouse as a caregiver, which is associated with the marriage pattern and demographic changes in China. As husbands are typically several years older than their wives in China, wives usually provide care to their husbands until they pass away but lack care support from their partners. For example, according to the 2020 national census in China, the average age of marriage for males was 29.38 years and 27.95 for females (China News Service, 2022) , demonstrating the age difference between husband and wife, whereas the life expectancy of females was 81(World Bank, 2023a) and 75 for males (World Bank, 2023b)in China in 2021. Men are more likely to receive care from their wives, but (widowed) women's caregivers are usually their adult children (Chen and Ge, 2018, Chen et al., 2018), according to the findings of this study.

Despite no specific significant preferences for female or male caregivers, the early retirement ages in China might result in an increase in female family caregiving. The arguments regarding labour force participation and informal caregiving (Van Houtven,Coe and Skira, 2013, Dentinger and Clarkberg, 2016, Carr et al., 2018) are not the same in China with its relatively early retirement ages, particularly for females (50 for employees and 55/60 for cadres). Considering that most family caregivers are nearing retirement age, the debates about gender issues such as reconciling work and life (Cook and Dong, 2011), women's double burden (Ji et al., 2017) and the gendered division of labour related to family economy models (Pfau-Effinger, 2005b) are therefore less crucial considerations for long-term care in China.

Consequently, the explicit gender role division between males and females appears to carry less weight in the family care decision, especially when compared with the available family care support. Although the initial policy intention might not be gender-specific, the question of 'who provides care' is less significant than the more realistic one about ‘whether there is someone who could provide care’ (*see* section 9.1). Unlike the argument that gender-neutral policies have strengthened the female gender role in caregiving (Andersen, 2020), the long-contested strong cultural values regarding intergenerational contract relying on adult children with blood ties have impacted the gender role division. However, the gender-specific considerations for long-term care provision in China remain complex, given the early retirement ages linked to the available family support, as well as the long-term effect of the one-child policy in China (*see* sections 6.1.2, 7.1.2 and 7.5).

9.3 Comparisons between generations for the family role in providing long-term care

From a defamilialisation perspective, although the family is a unit serving as the state’s counterpart in providing support for its members, different generations within the family have varying attitudes towards the family’s role in providing long-term care.

The results from the case study indicate that older people usually have lower expectations of the government (*see* sections 6.1 and 7.1). They are generally consistent with the data outlined in Chapter 5 (*see* Figure 5.1). For the older adults, as with the conventional and accessible care services they have heard of, the state or government has never assumed the direct care provision responsibility for the public, even during the public ownership period in the last century when the current older generation was young. The limited information accessed could explain their care decisions with bounded rationality. Considering the underdeveloped public care service system and private care market, many have never thought of receiving care support from anyone other than their family members (*see* section 6.3.1).

The support which they receive from the ongoing social programmes also affects their perceptions and expectations of the public sector (*see* sections 6.1.1 and 7.1.1). With the broadly implemented pension scheme for direct cash benefit, strong desires were expressed for financial support from the state, no matter whether from the pension scheme, the long-term care insurance scheme, or any other social programmes, regardless of the policy initiative of the long-term care insurance to target the care demand rather than the economic one.

So in terms of the state's support, there was a solid preferential expectation for financial support rather than care delivery. Accordingly, most people have yet to be aware of receiving care support from the public sector (*see* section 6.1.1). This also reflects that seeking professional help is usually the last resort as self-reliance has historically been a highly regarded value in Chinese families (Cheung and Law, 2003, Yu and Rosenberg, 2017). The state is more presumed to support older people in the funding mechanism than the provision one. The inherent trust and reliance embedded within family bonds remain influential in older people's preferences for the care which their families provide, as section 9.1 shows. The findings thus demonstrate the combination of the retained family care provision preference and the greater expectation from the state for economic support, particularly for the older generation.

Public and policy discourses born of political ideology might also shape care expectations from the state, specifically for the older generation. Many older people are proud of their independence rather than relying on the state as some kind of 'burden', possibly related to the fact that the generational consciousness is closely associated with pre-reform collectivism and the socialist ideologies of the past (Yu and Rosenberg, 2017). Due to their self-respect and sense of personal honour, older people are reluctant to abandon their unwavering self-confidence despite the need to be provided with care. Correspondingly, given the new interpretations of filial piety with the "descending familism" (Yan, 2016) and the growing attention towards the tension between individual interests and family ones (Yan, 2018), particularly for the younger generation, the impacts of such discourses might be less convincing.

Correspondingly, family members providing long-term care is the only option for the younger generations working as direct caregivers in some cases (*see* sections 7.2.1 and 7.3.6). Although the significance of cultural values regarding filial piety and intergenerational contracts is widely acknowledged (*see* sections 7.3.1 and 7.3.2), the family is irreplaceable as the primary or even direct care provider. Family values are essential in adult children for continuing care provision, thus family values have a moderating role in the relationship between support exchange and ambivalence (Albert and Ferring, 2018), given that adult children are willing to provide care because they have internalised family values and associated norms.

With the rigorous implementation of the one-child policy in China from the 1980s to 2010s, particularly in urban areas, those with a single child demanded that the state play a larger role in supporting those adhering to the family policies as an entitlement, reward or even compensation (*see* section 6.1.2). Given that they have just one child as their underlying family caregiver, the limited available family care support means they have to seek alternative care options for their care needs. Even though acting as family carers, the care expectations towards the provision of family care appear to be more pragmatic, as evidenced by a greater willingness to receive care from others rather than directly from their adult

children (*see* section 7.5). These findings confirm that sandwich generations are more considerate of their single child as a direct care provider, particularly in urban areas (Zhang and Goza, 2006). Those with a single child are more worried about being abandoned in old age than those with more than one child (Gustafson and Baofeng, 2014) and the older generation has lowered the expectations towards the obligations fulfilled by their children, and the intergenerational relationship has been more egalitarian and reciprocal (Fu, Xu and Chui, 2020). Thus, single-child parents usually expect more care support from the government.

In summary, the findings of the case study demonstrate that, the older generation is more likely to prefer the familialisation pattern in which the family continues as the direct care provider, as the long-term care insurance schemes covering informal care, like the one in the case study, precisely target their demands and preferences (*see* section 6.2). Some younger generations prefer the defamilialisation policies freeing the family's direct care burden, particularly for their own future care plans (*see* section 7.5). In this way, the current long-term care pattern with the family members involved is somewhat inconsistent with the general preferences of the younger generation, reflecting a discrepancy with parents' preferences and expectations for family care provision. It is thus compatible with previous arguments about different age cohorts' expectations of family interactions (Jankowiak and Moore, 2016).

Despite the implementation of public insurance, the reimbursement caps for insurance have largely determined the family's role in providing care. Intergenerational differences in care attitudes regarding the family's role have not been reflected in different care decisions, given that the family remains a collective actor for resource redistribution among its members and that family care is the only affordable option for the family. That is, the family's role as the direct care provider has not significantly changed (*see* section 9.1). It should be further noted that, although the one-child policy limiting available care labour for parents as they grew older was abolished in 2016, its long-lasting impact on the Chinese family is evident (Settles et al., 2013, Zhang, 2017b, Cai and Feng, 2021). The adult children of the older generation may not be able to access sufficient family labour forces for their care demands in the coming years, particularly considering the predicted demographic transitions in China.

9.4 Comparison between quantitative and qualitative analysis findings

As demonstrated in the preceding sections of this chapter, family value is one of the primary reasons why the family in the case study was selected to provide care for disabled older members. These qualitative findings are generally consistent with the quantitative findings presented in Chapter 5.

However, a more complex relationship between cultural values and the family's role in providing long-term care is seen by comparing the quantitative and qualitative analysis findings.

The family as a unit

The quantitative analysis showed higher expectations from the state in care support over the past few years, in which intergenerational differences were also summarised. As the younger generation, some adult children acknowledged that family care provision was more likely to be the result of a lack of alternative care options (*see* sections 7.2.1 and 7.3.6). The state is anticipated to play an increasingly vital role in supporting older people. Although cultural values regarding family responsibilities and obligations have been emphasised in shaping individual care decisions in China, they are frequently less decisive. This finding explains the discrepancy between a declining preference for family dependence and the maintenance of a caring family role in everyday life. The individual care decision is the rational choice for disabled older people and their families, as illustrated in the quantitative and qualitative analyses, with more details reflected in the latter. The case study further showed that for long-term care insurance schemes covering informal care, the family's role in care provision has been reinforced based on the analysis from the defamilialisation perspective, thereby shedding light on the individuals' incentives and enforcements for long-term care provision (*see* Figure 7.1).

Comparative to the findings derived from the quantitative analysis, the case study further demonstrated that even with long-term care insurance which values informal care, when individuals and their families make care decisions, cultural factors are less important than the available care support, which is largely determined by the capacity to access and/or afford the care alternative. Consequently, the qualitative analysis provided more in-depth accounts of how the family's role in caring for older individuals adapts to policy shifts, particularly the newly developed long-term care insurance. The negotiations within the family concerning the different incentives were specifically outlined.

Gender role division

The findings of the quantitative analysis showed that an increasing number of people agreed that women who formerly played the crucial role of care provider within the family should be relieved of the full responsibilities, reflecting the growing awareness of gender equality in the past few years in China (He and Wu, 2017, Ji et al., 2017).

These conclusions were partially supported by the case study. The blood ties within the family were highlighted accordingly. However, as the gender role division is not specified in the long-term care policies, even those covering informal care, particularly for the care work shared by sons and daughters, it is slightly different from the findings presented in Chapter 5. The findings of the case study

demonstrated that available family support is more important than gender preferences in providing long-term care. Adult children's care obligation has been clarified in terms of supporting their vulnerable parents, emphasising the trust and reliance primarily rooted in blood ties and family bonds, indicating a weakening trend of gendered care provision within the family, especially in the aftermath of the profound impact of China's one-child policy.

Differences between generations

Chapter 5 showed that the availability of family and public sector support has an impact on public attitudes. This follows the case study findings in this study. The intergenerational contract, which is the most influential factor in sustaining the family's role as direct carers, is primarily driven by economic constraints. Even though the quantitative analysis did not capture the policy outcome of the long-term care insurance scheme, similar conclusions have been drawn for addressing the family as a substitute for state intervention in caring for older people.

In addition, the analysis of the CGSS data showed that age is a significant factor in attitudes regarding the allocation of care responsibilities between the family and the state. This was partially confirmed in the subsequent chapters. Those who are older might be more likely to agree that providing care services to vulnerable family members is a family responsibility, indicating that older adults in China are more likely than younger adults to have a more substantial perception of expecting the family to assume responsibility.

In summary, regarding the changing family role in providing care to older people, the conclusions from the case study are broadly consistent with those drawn from the quantitative analysis. Chapter 5 showed the changing social values for the family's role in care support for its older people and the conclusions drawn from the case study further demonstrated how the changing cultural values affect the care provision patterns, taking into account the perspectives of various groups of actors. The case study revealed that the affordability of care alternatives, the availability of family care and cultural values were found to be the key considerations for individual care decisions.

Furthermore, the quantitative analysis might not capture the up-to-date changes in the general preferences and care decisions on the family care provision simply because of the lack of availability of the data. Although the pilot development of long-term care insurance in China began in 2016, it was largely overlooked in the previous national surveys. The findings of this study provide additional information for comprehending the development of long-term care and the future national implementation of insurance in China.

9.5 Conclusion

This chapter has addressed the two research questions by elaborating on why and how the family adjusts its role for organising and reorganising care work from the defamilialisation perspective in the field of long-term care for older people in China. In the analysis for RQ2, the family was interpreted as a unit acting as a counterpart of the state, whereas in the analysis for RQ3, the interaction within the family was examined to determine the differences between older and younger generations.

Based on the analytical framework of (de)familialisation, this chapter has developed an analytical framework combining money-familialisation and labour-defamilialisation in long-term care provision in the Chinese context based on the findings from the case study, as depicted in Figure 9.2. Regarding the family's role in providing care for its older members, this chapter had also analysed the gender role division and intergenerational differences within the family, particularly considering the impacts of cultural values.

The findings have shown that despite disabled older adults being offered the care options of money-familialisation and labour-defamilialisation, the family remains the primary direct care provider (*see* section 9.1). Money-familialisation is the common and practical decision due to the care substitutes being rendered inaccessible on financial grounds, reinforcing the family's conventional caring role. With various societal transitions in contemporary China, for both the care recipients and their families, developing informal care in the long-term care system is more likely to be a feasible strategy for addressing the enlarging care provision gap concerning the pressing care demands, especially with the formalisation of informal care to improve the quality of care. However, given that affordability and cultural values highlighting family responsibilities and obligations have been shown to be the primary determining factors for care decisions, care inequality across the family varying the purchasing power of care alternatives is significant, whereas the money-familialisation pattern may even result in widening the gaps of this inequality. Nevertheless, unlike An and Peng's work focusing on the state's intervention in childcare, this chapter has analysed how the family adjusts its caring role, reflecting the outcomes of the implementation of long-term care insurance. Based on this study's case study, Figure 9.2 illustrates in detail the family's role in providing care and related important considerations.

Despite the long-argued gender division of care burden within the family (Song,Li and Feldman, 2012, Lin and Yi, 2013, Liu, 2017), the findings indicate a different pattern in which the available care support from the family is valued highest in decision-making. The family works as a unit to redistribute the available resources for its members, and family members having spare time and living closer are seen as the appropriate caregivers for its older members, in which the family values are viewed as the social

norms for illustrating the necessity. In this manner, the conventional gender division of labour appears less practical than considering the availability of care provision. Nevertheless, given the relatively early retirement ages for females in China, it is difficult to clarify how gender issues are concerned in family care decisions.

Regarding RQ3, intergenerational differences are also evident. Although older adults somehow lower their care expectations towards their children (Fu,Xu and Chui, 2020), the older generations usually hold more solid family values and preferences for the family delivering care than the younger ones (Jankowiak and Moore, 2016). Many pilot cities in China prioritise formal care through the benefit-in-kind, but some cities deliver long-term care as a (semi-)cash benefit, given that the family is recognised as continuing to be the resource allocation and redistribution unit. The findings of the case study demonstrate the various reasons why the older and younger generations of the family continue to provide care (some may be conflicting), but all of these are negotiated within the family as a unit.

When gender roles and intergenerational preferences for care provision are combined, they appear to carry less weight than the material burdens and affordability of family care alternatives. Public insurance reimbursement has partially alleviated the financial burden of supporting older people, thereby shifting the primary role of the family in terms of financial support. Consequently, policies which support informal care beyond professional care are necessary. More policies that facilitate a balance between personal and family care responsibilities should be implemented.

Therefore, for RQ2, the findings revealed that even with the implementation of long-term care insurance as the public funding mechanism, in the cases where both formal and informal care are available to disabled care recipients, as with the combination of money-familialisation and labour-defamilialisation, the family's role as the direct care provider in the care provision mechanism has not fundamentally changed. Various considerations are significant in affecting a family's caregiving role, as shown in Figure 9.2. Although family values play a significant role in individual care decisions for both care recipients and carers, the family should not be the sole pillar but rather a part of the care provision, and formalisation of informal care potentially playing a significant role.

The findings have shown that the family is a socio-economic actor for its members through social reproduction (Papadopoulos and Roumpakis, 2017, Papadopoulos and Roumpakis, 2019). Individual care decisions are made based on the negotiation between all family members, considering different determinants relating to the family as a whole rather than to individuals. However, affordability (capacity to pay) is the decisive factor limiting care options and shaping the public's adaptive preferences, making it difficult to compare the effects of various determinants. Due to the shortage of

workers who provide care (Zhang et al., 2018), even with the development of the care system, the family is still viewed as the appropriate care provider for disabled older people, although not as the sole provider, ensuring that they have access to the care they require. The Chinese family is thus adaptable in response to social change (Jankowiak and Moore, 2016). Family values were found to be persuasive or even convincing for individuals to maintain the family's function. The family has been encouraged to shoulder the care obligation, partly internalising the new social risk within the family instead of relying on the state (Shi, 2017a), reflecting the family's resilience in supporting its members.

However, the sustainability of these care provision patterns should be noted. With the predicted worsening demographic structure in China, particularly affected by the one-child policy (Settles et al., 2013, Zhang, 2017b), as well as the intergenerational differences in care expectations, the compliance and feasibility of whether the family is willing and able to carry the care obligation are critical in future policy schemes targeting the rapidly booming care demand but remain doubtful. Whereas the local government intends to urge the family to shoulder more care obligations even with the implementation of long-term care insurance, at least in the short run, given the significance of family values recognised and the workforce shortage for providing long-term care (*see* section 8.3). Based on the discussion of family values in care decisions involving family care, the following chapter will examine how the local government considers these issues in terms of the interactions between cultural values and care arrangements in policy design in the Chinese context.

10 Has the Care Arrangement been Impacted by Culture?

In China, diversified patterns of long-term care provision have been established in pilot cities and the family has been integrated into the public insurance-reimbursed care system in some cities (*see* section 1.3). However, the combination of money-familialisation and labour-defamilialisation for long-term care has not significantly altered the family's role as a direct care provider, whereas the formalisation of informal care has been observed (*see* Chapter 9). Family-provided care is a rational option for many disabled individuals and their families, primarily due to the unaffordability of care alternatives and family values.

From the defamilialisation perspective, which captures the shifting responsibility between the family and the state corresponding to the rationales for individual care decisions, it has yet to be determined if these factors have been considered by policymakers in the policy process. Given the well-debated interplays between deeply rooted cultural values and the family's role in providing care, as well as social policies (*see* Chapter 3), whether cultural values are also significant in long-term care policies in China has rarely been addressed in previous research, despite the changing social care attitudes (*see* Chapter 5). In the light of cultural values and long-term care policies, in this chapter I investigate the fourth research question:

RQ4. Has the care arrangement been impacted by culture?

This chapter is organised in three sections. The first provides insights into the critical considerations of the policy process for public long-term care insurance schemes, focusing on how and why long-term care policies covering family care have been developed and situating the discussion within China's unique central-local government interaction. Using evidence from the case study, this section explicates the policy intent underlying the development of long-term care by focusing explicitly on policy implementation gaps between care policies and outcomes. The second section investigates whether and how contemporary Chinese care arrangements are influenced by cultural values. Based on the theoretical framework established by Pfau-Effinger for western European cultural values and welfare/care arrangements (Pfau-Effinger, 2004a, 2005a, 2008), this section examines the interaction between cultural values and patterns of care provision in long-term care policies. It develops a new framework that takes into account the unique characteristics of central/local government issues within the care arrangement in China based on Figure 3.3. The conclusion forms the final section.

This chapter spotlights the cultural values, the family's role in supporting its members, and long-term care provision in China based on the research gaps identified in previous studies and the findings of the

preceding chapters of this study. This chapter provides a response to RQ4 by highlighting the significant role of cultural values in Chinese care policies.

10.1 Central-local government interplays in developing long-term care insurance in China

Given China's political centralisation and fiscal decentralisation, it is essential for policy analysis to consider the complex, dynamic interrelationships between different levels of government (He,Zhou and Huang, 2016, Zhu, 2016, Guo and Zhao, 2022). As a policy experiment to effectively activate local innovation for a broader selection of demonstration sites for universal replication (Heilmann, 2008a, Zhu and Zhao, 2021), the pilot long-term care insurance scheme has been implemented as a policy experiment, serving as the principal funding mechanism for providing long-term care (Zhu and Osterle, 2019, Chan and Shi, 2022). In China, economic pressures on the central bureaucracy have made devolution a functional necessity (Béland et al., 2017) and the local governments play a decisive role in top-down policy enforcement (Zhu, 2016). The tension between the upper level of government and the control of lower-level discretion and autonomy has been crucial for the policy process in China, particularly since Xi's premiership began in 2012 (Schubert and Alpermann, 2019).

So to fully comprehend how the changing family roles and associated social values are reflected in China's care policies (RQ4), this section first provides a valuable understanding of the roles of central and local governments in long-term care insurance as well as their interrelation, particularly in local practice, due to the significance of local government in developing long-term care provision during the pilot phase. This section focuses on the central and local governments' considerations in developing long-term care insurance as a pilot programme, and policy implementation gaps based on the case study evidence.

10.1.1 Central government: responses to structural changes in the ageing society

Although the political system is led by a single party as an authoritarian regime in China and the voters' support is not vital for the central government's political legitimacy, maintaining social stability and harmony to assert its political legitimacy is an important driving force for the Chinese central government (Mok and Qian, 2019). Particularly since the turn of the millennium, China has been in an era of social policy (Hong and Ngok, 2022a). Therefore, developing new policies to meet the rising demand for care is given a higher priority on the policy agendas of the central government, as well as the local governments which adhere to national guidelines. Regarding long-term care provision, its

primary funding mechanism, public insurance, was first introduced in two rounds of pilot cities in China in 2016, with the national guidelines targeting 49 pilot cities issued in 2016 and 2020.

The balance between centralisation and local autonomy is one of the core issues in China's politics, but it has been shaped decisively by the centre's will (Kostka and Nahm, 2017). The long-term care insurance scheme was developed as a pilot programme without causing a burden on the central government (Huang and Kim, 2020). Thus, social decentralisation emerged as the central government's principal goal is to develop a future national programme based on various local explorations of long-term care insurance (Chan and Shi, 2022). As with many previous policy explorations in China, long-term care insurance is a trial-and-error approach for the policy experiment, developing local policies before the central government adopts and promotes successful versions (Husain, 2017, Li et al., 2019). The reasons why long-term care insurance was developed as a pilot programme in China are therefore closely associated with the central government's considerations.

The policy experiment represents a comparatively safer and more conservative option for the central government. As a pilot programme, the brand-new long-term care insurance scheme was designed to increase the ability of vulnerable individuals to pay for the long-term care which they require (Chan and Shi, 2022). Risk and implementation expenses were the determining factors. The central government tends to explore the appropriate policy frameworks for long-term care insurance in China based on this kind of local exploration. As with the traditional and conventional family-dominant care provision pattern in China (Feng et al., 2020) and deeply-rooted family values (Bedford and Yeh, 2019, Brasher, 2021), because the family is the critical unit for political stability (Yan, 2010, Zhu, 2016), highlighting the family's crucial role and related family values in providing care to older people appears to be a conservative option for the central government. One study placed in another country demonstrates that encouraging kinship networks to internalise uncovered social risks for social stability was another key consideration of the central government (Yuda, 2021), and it possibly explains the emphasis on family in care policies in China.

In recent years, the importance of the family has increased in official discourse and policy principles (*see* section 1.2). In the official national documents pertaining to the central government's long-term care policies, despite the fact that the non-profit and private sectors as well as the family are urged to play more central roles in providing care services, no specific instructions have been provided. The fiscal decentralisation and risk-averse considerations within China's internal heterogeneity also explain the trend of encouraging the family to take on more care responsibilities with less state involvement. In a growing number of pilot cities, therefore, informal care has been integrated into the insurance-funded care system (*see* Table 1.2).

Notably, despite the significance of provincial governments in social policy in China (Guo and Zhao, 2022), long-term care insurance exploration is somewhat different from many policy experiments on the provincial level. It is a policy experiment at the municipal level, whereas the provincial government's role in proceeding with this public insurance is generally less considered. Instead, it has overseen the practice of pilot cities and considered the possibility of policy diffusion to other cities within the province.

Long-term care insurance is therefore being developed in China as one of the constructive solutions to the rapidly increasing demand for care in an ageing society. Any analysis should therefore take place at the local level as the central government has left the options open to the pilot cities. Nevertheless, the central government's role in the development of long-term care insurance following the ongoing pilot phase in China requires further discussion.

10.1.2 Local government: pragmatism in policy design and implementation

For top-down policy enforcement, local governments are granted substantial autonomy for best-fit care schemes with resilience (Teets, 2016) and long-term care insurance in China is no exception. It is implemented in pilot cities, considering the local context of central government interaction.

10.1.2.1 Long-term care insurance is designed according to local circumstances

The local government is the principal decision-maker in developing long-term care, and diverse care provision patterns are implemented based on local conditions (Zhu and Osterle, 2019, Yang et al., 2021a). Long-term care insurance is principally designed taking into account the feasibility of the local government's available resources, primarily the local government's capacity to manage the care demand (Chindarkar,Howlett and Ramesh, 2017), demonstrating the resources and competencies of the government to perform its function (Wu,Ramesh and Howlett, 2015). For the local government, the care provided should be financially viable, meaning that the care providers are able to provide core services in a sustainable manner and that the citizens are willing to pay for the services.

As the case study has shown, it is difficult to finance a sufficient workforce. As a result, continuous long-term care insurance covers the care provided by qualified family members rather than establishing a formal care provision team from scratch. Formalising informal care is its critical strategy for addressing the provision gap for long-term care. It reflects pragmatism by emphasising outcomes which adapt to changing circumstances (Keijzer and Bossuyt, 2020), given that the local government's priority ranking for developing long-term care is cost-effectiveness.

On the one hand, the insurance covering care provided by family caregivers urges the family to continue its care without explicitly increasing the government's burden with limited fiscal transfers for the social insurance programme. The family is willing to continue its unpaid care provision exceeding the insurance reimbursement caps but as needed by the disabled older relatives (*see* money-familialisation in section 9.1.1). On the other hand, formalising informal care can assist local governments in developing the local care industry by incentivizing market forces (care homes) to serve more disabled older adults as customers (*see* section 8.3.1). This is similar to the reasoning behind the preference for formal care in many pilot cities in order to stimulate the local economy, and the expansion of informal care with the critical role of care facilities exemplifies the adaptive strategy in some pilot cities.

Concerning the public insurance programme, sustainable finance is of the utmost importance (Yang et al., 2016, Wiener et al., 2018). Nevertheless, this was not found in the case study because the cost of long-term care insurance might be a minor consideration, particularly for the financially strong cities (Chan and Shi, 2022). Despite the fact that this study outlines the general logic of the local government in long-term care exploration (*see* section 8.3), the strong financial capacity of the Guangzhou local government, as a distinguishing feature, might make it difficult to transfer its pattern to other cities. In this context, formalising informal care is highly valued as a pragmatic solution to the lack of a labour force in an underdeveloped care market (Zhang et al., 2018). Accordingly, the family providing care is preferred not only by individuals and their families due to the unaffordability of care alternatives (*see* section 9.1), but also by local governments.

To a certain degree, the priority of the local government is coverage expansion rather than the quality of care, following the official narrative highlighting 'moderate universalism' put out by the central government in China (Pan, 2019, Dalen, 2020), emphasising the broader coverage of universal care support due to its current social welfare system and public fiscal capacity (Lu,Liu and Yang, 2017, Li and Otani, 2018). Moreover, since coverage expansion is more observable during the pilot period (Qian and Mok, 2016), the local government is more likely to prioritise quantity over quality in the early stages, as demonstrated by the case study. This is comparable to the public elderly care provision in China, which could be viewed as residual or at least rendered less generous than in many other countries (Gao, 2014) because only a small proportion of older people have access to the publicly funded services determined by means-testing. This reflects a realistic, possible and feasible welfare society combined with Chinese characteristics associated mainly with the local government's capacity.

With all these considerations, local governments are actively adopting policies and measures in social welfare provision to meet their particular social and economic needs (Mok,Kühner and Huang, 2017). In an effort to strengthen the family's fundamental caring role, policy measures have been implemented

to assist family carers in a variety of ways, with the common goal of providing them with the flexibility they require for varying care patterns (Feng et al., 2020, Zeng et al., 2020). This is particularly the case for the care policies in China, including informal care, on which this study focuses.

10.1.2.2 Long-term care insurance reflects the social welfare pattern

The local exploration of long-term care provision reveals the essence of the welfare system to a certain degree. The priority of formal care provision in many pilot cities reflects the intention to stimulate the care industry in the private market for economic growth, whereas the formalisation of informal care observed in the case study demonstrates pragmatism by enhancing the family's caring function to fill the care provision gap (*see* section 8.3.1).

Referring back to the debates on social welfare, specifically for the provision of long-term care, neither productivism nor familism analysed in previous literature are suitable for describing social welfare in China, at least in the field of long-term care policy.

On the one hand, the previously contested familism has been challenged as responsibility has shifted away from the family and towards other spheres. The long-term care provision is run through the public insurance programme to socialise the burden of caring for older people, primarily to lessen the financial burden on the individuals and their families (*see* section 9.1.2). Regarding care provision, the family continues its central role as the direct care provider to partially internalise the social risk (*see* section 9.1.1). A separation between finance and the provision of long-term care emerges as the family is included in the care system. Specifically, non-profit and private care homes play crucial roles in long-term care delivery and the family is paid as the direct care provider (*see* sections 8.1.1 and 8.2.1). The family's conventional responsibility for its members has been moderately changed (*see* section 9.1).

On the other hand, developing long-term care involves more than seeking an economic boost for productivism. Improving the rights and interests of older people, such as the 'desire for a happy life', 'people-oriented governance' and a 'harmonious society', which contribute to the local social stability and prosperity, has been accorded greater weight in recent years in China, alongside the rising emphasis on the happiness of people's everyday lives in national policy discourses. In addition to manifesting the growing awareness of the state about social protection, this is consistent with the social management extension to adhere to social justice and public security in its economic reforms (Shi, 2017b). In this situation, the productivist welfare regime that promotes social policy for economic development may not be the defining feature of long-term care delivery. Even though developing social welfare provision consumes local fiscal resources, the local government implements innovation without external pressure from the central government. Pilot cities strive hard to satisfy the local care demand with their

capacities for other considerations, such as the political ones. Also, these goals for the betterment of people's lives are the central government's guiding principle, compelling local governments to explore them locally (*see* section 8.3.1).

Furthermore, the private and informal sectors included in the long-term care system have minimal influence on policy design and implementation in China's local exploration. Even for informal care, care homes and commercial insurance companies were involved in the provision of long-term care in the case study, creating competition to innovate and enhance the performance of market actors. Other actors have been admitted to subordinate roles (*see* section 8.3.2), revealing a pattern of semi-marketisation. Alternatively, the family is appointed and is responsible for a significant proportion of the care workload in response to the state's reduction in provision dimensions, particularly in cases where informal care is formalised under the state's long-term care insurance.

Consequently, the development of the long-term care system with family participation follows the social welfare provision patterns observed in China, in which the state remains a key player in the welfare mix but seeks to strengthen the family's role in the provision aspect for various reasons (*see* section 10.1.2.1).

10.1.2.3 Local long-term care insurance is developed in regard to central-local government relations

The findings have shown that developing a localised long-term care provision pattern is vital for the local government, taking into account political considerations mainly about central-local relations in the Chinese context.

First, it is about local protectionism. Always one of the top priorities of a local government is to meet the care needs of the local populace. The local government attempts to use the insurance funds of the public healthcare insurance scheme locally rather than having them redistributed by the central government (Chan and Shi, 2022). Similarly, since regional social programmes are primarily financed by local budgets, local social programmes tend to become exclusive in order to prevent outsiders from sharing the resources (Qian and Mok, 2016). In this way, despite the comparatively high cost of expanding long-term care, preserving the local resources for its citizens is one of the critical considerations, despite re-centralisation attempts for allocating and inter-regionally redistributing the resources among the financially strong and weak regions by the central government. It also reflects the developmentalism inherent in China's local governance with the competitive solidarity between regions (Shi, 2017c).

Second, it is associated with policy diffusion in China's authoritarian system. During the pilot period of long-term care insurance, the national guidelines outlined the main principles and the policy framework without establishing clear policy contents for local exploration, and the competition between local governments for innovation led to a range of different policy instruments (Liu and Li, 2016). This could also be seen as the championship policy diffusion between peer local governments in China (Zhu, 2013). Establishing a local model and promoting it as the pioneer in the policy experiment is a significant driver for a local government (*see* section 8.3), so it usually actively develops new policy instruments in order to be the pioneer of a new policy instead of copying the existing policy instruments and being regarded as a follower (Zhu, 2017).

In addition to the competition among local governments in the fragmented care system, the case study rarely mentioned the local officials' political incentives, such as career advancement and bureaucratic interest in policy implementation (Ran, 2013). There is little conclusive evidence regarding local government officials' motivation for the promotion tournament. It could be a result of the limited data available in this study for painting a complete picture of the situation in China.

Overall, in China, long-term care insurance is designed and implemented according to local conditions, particularly the capacity of the local government. The family as the primary care provider is not only the most feasible option for individuals and their families (*see* section 9.1), but also for the local government, which must reconcile the substantial unmet care demand with the underdeveloped long-term care system. In this section, I shall discuss the interaction between the central and local governments as representing the general situation of China's social policies, which differ from those of many other nations due to the unique political context. Regarding RQ4 capturing the cultural values addressed by care policies, the role of local government and the relationship between central and local government should be examined in detail.

10.1.3 Policy implementation gaps for long-term care provision

In the development of long-term care provision, policy implementation gaps emerge, as the case study showed. However, the local government did not appear to intend to fill the gaps, indicating a pragmatic approach to implementing social policy. Specifically, there were the gaps between policy and practice regarding the benefit type and patterns of defamilialisation and familialisation. These findings contribute to a more comprehensive understanding of how the local government develops long-term care provision in conjunction with family care, thus explicitly clarifying the role of cultural values, which I shall discuss in the next section.

Gap 1: Benefit types: benefit-in-kind or cash benefit?

Regardless of the advocacy of long-term care provided as a benefit-in-kind, it is mainly viewed as a cash benefit for the public (*see* section 9.3.1). A possible explanation for this is the misunderstanding of the insurance reimbursement for the family care providers. The family continues working as a unit fulfilling the social reproduction function as a socio-economic actor (Papadopoulos and Roumpakis, 2017), which is demonstrated to be the case in China. The informal care covered by the public long-term care insurance schemes formalising care provided by private individuals is similar to that widely applied in many European countries (such as Germany, Austria and Italy) (Saraceno, 2008). Individuals are offered financial incentives to employ family carers rather than social services. This leads the kin network to continue as the pillar for care provision despite the development of social services. However, the management and supervision provided by the care homes and the blurry dividing line between formal and informal care in policy narratives are unique in China.

In the case study, there was a hybrid of two major benefit types for home-based care: the benefit-in-kind for the care provided by those except the family members and the cash benefit for the rest. The policy implementation gap is the benefit type for the long-term care provided by the family caregivers, referring to the benefit-in-kind clarified in the policy, which the public considered a cash benefit.

Similar to the cash-for-care schemes that enable individuals and their families to be offered available care options as the defamilialisation pattern in many European countries (Da Roit and Le Bihan, 2010, Da Roit and Le Bihan, 2019), the insurance-reimbursed family care option is a practical option for both individuals in need of care and their families (*see* section 9.1.1), as well as the local policy-makers (*see* section 10.1.2.1). Since family care provision contributes to supplementing the socialised care system and reducing social expenditure through more informal care provision (Zigante, 2018), the current cash benefit provided in the case study was a flexible policy option. Concerning the pressing care demand as the primary trigger or driving force for long-term care insurance development and comparing the cost-effectiveness of different types of care, the case study introduced the 'semi-cash-for-care scheme' with the formalisation of informal care in providing long-term care by the family. Despite this policy implementation gap, the local government did not appear to be attempting to alter the public's misperception of the benefit type (*see* section 8.3.1).

Gap 2: Policy and practice: defamilialisation or familialisation patterns?

Although long-term care insurance is supposed to be the defamilialisation pattern that shifts the care burden of older adults away from the family (Shin, 2013), defamilialisation is observed in the provision mechanism in China. As demonstrated in this study, for the pilot schemes covering the care provided by

the family, with a combination of money familialisation and labour defamilialisation in long-term care provision, the former is more commonly seen, especially for the older generation who prefer to be cared for by family members. In comparison, the defamilialisation option seems to appeal more to the younger generation, relieving them of the burden of family care. Notwithstanding this, the future old generation has to continue the family's caring obligation owing to the household's economic constraints (*see* section 9.3). Thus another policy implementation gap is a mismatch between the general preference and the actual care decision.

With the reimbursement of informal care by long-term care insurance, the caring function of the family has remained the same or has even been strengthened, and the economic support function has been partially released (*see* section 9.1) in order to better meet the public's care demand within the context of the particular policy setting.

The essence of 'care' should also be considered when choosing between familialism and defamilialism patterns. Care provision is probably merely the job of the caregivers outside the family to provide physical care services, whereas it is different for the family members, who see care provision as a positive and willing sacrifice involving love, initiative and goodwill (Mendez-Luck,Kennedy and Wallace, 2008). Instead of an economic incentive, the family provides care services with love according to the altruism motive (Klimaviciute et al., 2017) and notably, the family values highlight filial piety and the intergenerational contract in China (Gruijters, 2017a, Liu, 2023). Although social attitudes towards 'care' have also changed over time, the family continues to bear the principal care responsibility (*see* section 5.1) and the emotional support provided by the family is irreplaceable. This also helps to shape individual preferences of the familialisation pattern.

As demonstrated by the case study, instead of dismantling family ties by the implementation of long-term care insurance, policymakers have shifted the voluntary mutual obligation within the family to a more formal involvement in the provision aspect in response to the labour shortage for care provision.

The local government had therefore developed a care provision mechanism which involved the family, with a hazy distinction between familialisation and defamilialisation in the funding and provision mechanisms. Instead of creating a policy implementation gap, this exemplifies the pragmatism of local government in developing care provision as opposed to explicitly clarifying (de)familialisation patterns.

In brief, the policy implementation gaps result from the flexible strategy under the relatively vague national guidelines for developing the long-term care system in China. In conjunction with local exploration as in the case study, many innovative patterns have been set up in other pilot cities, affirming the paternalistic welfare pragmatism in China contingent on local economic and social

conditions (Mok and Qian, 2019). The local government is pragmatic in examining its patterns of long-term care provision, and family care is one of the most important solutions. This finding is essential for interpreting the state's considerations regarding the complex central/local government interaction in China.

Specifically for the cultural values concerned in care policies, despite the long-argued significance of cultural factors (Pfau-Effinger, 2005a, 2008), the related discussions in China remain in the early stage, not to mention those for the newly implemented long-term care insurance scheme. Moreover, given that Pfau-Effinger's framework is primarily grounded in western European countries, whether it adequately explains contemporary China has yet to be examined. Consequently, in this chapter I investigate the interplays between cultural values and the long-term care provision pattern in which the family is involved in contemporary Chinese society (RQ4).

10.2 Cultural values in the explanations of care arrangements

As demonstrated in Chapter 3, cultural values are significant in social policy analysis. Specifically in section 3.2, various cultural values, primarily welfare values and family values, influence the behaviour of social actors in the population and political actors, and the role of culture is elaborated in the policy analysis (Pfau-Effinger, 1998, 2004a, 2005a, 2008). Since most previous studies have been rooted in European contexts, cultural factors are rarely emphasised in China-focused research. Based on the discussion on the central-local government interaction in the policy process in China in section 10.1, this section explicitly focuses on cultural values in the development of long-term care provision, capturing the impact of cultural values on the care arrangements for long-term care in China.

This section clarifies the welfare values and family values regarding long-term care in China, followed by a discussion of the interactions between cultural values and long-term care policies within the care arrangement in the Chinese context, establishing an analytical framework with evidence from China based on the work of Pfau-Effinger (*see* Figure 3.3).

10.2.1 Welfare values about the care responsibility outside the family

For care provision, welfare values are cultural values connected to the institutions which should fulfil the responsibility for providing care outside the family, whether social rights relating to care should be family-based or individual, and the re-distributive role of the welfare state (Pfau-Effinger, 2005a). There are several levels of welfare cultures: the first level is the basis for policies, the second refers to those predominating in the population and the third level is the political and public discourses on cultural values and ideals which are used by social actors, especially political actors who mediate the first two

levels. The power relations between social actors are determined by the cultural bases predominating in political practice (Pfau-Effinger, 2005b). However, the care arrangement in China is rarely discussed, not to mention taking the welfare values into account.

Regarding the welfare values concerning care responsibility outside the family, there are various care responsibility divisions between social actors reflected by welfare values. For instance, liberalism, conservatism and social democracy reflect distinctive welfare cultures in which the market, a non-profit organisation or the state play a prominent role in care provision (Pfau-Effinger, 2005b). As reviewed in sections 2.1.2 and 3.1.2, whether productivism, familism or even Confucianism can best interpret the welfare state regime in China remains controversial, particularly in the light of recent social transitions, as do its welfare values.

The welfare state debates may simplify the government's logic in developing social welfare, given the differences in various policy fields and societies or even regions due to the vast internal variations within China. Regardless of the productivist, familialist or even Confucian welfare regimes which are the most contested characteristics in the case in China, the family is assumed to have a vital obligation (Duckett and Carrillo, 2011, Choi, 2012, Abrahamson, 2016). The family continues to act as the principal caregiver for older adults despite changing social attitudes (*see* Chapter 5). Individuals are constantly urged to be independent or to rely on the family instead of other social actors (Krings et al., 2022), particularly the state, for care in China, indicating a retreat by the state to a certain extent, primarily the central government, towards shifting the responsibility for public provision to the local government through policy experimentation (Duckett, 2010). With the respectively low degree of involvement of other social actors except for the government in the development of care insurance (*see* sections 8.1.1 and 8.2.1), the welfare values outlining the family's contribution mainly reflect the policy intention to encourage the family to continue its vested caring function.

Although the welfare values are about the care responsibility outside the family, the family remains significant in the long-term care system in China (Feng et al., 2020), given the long-lasting family-centred care provision pattern and the late start of the care system supporting older adults. Care from non-profit or private care homes is typically unavailable for many due to the family's inability to afford care alternatives (*see* section 9.1). Correspondingly, the state continues its limited care support in the long-term care system as in other social welfare programmes, both in terms of the funding and the provision. The pillar funding mechanism is public long-term care insurance, mainly depending on contributions from individuals and employers, and on fiscal transfer from the local government. The narrow access to public care homes with lengthy waiting lists is a significant barrier for older people, decreasing their reliance on the state, not to mention the high costs for the private or non-profit care homes, which are

usually mid- and high-end. The limited care alternatives to family care have shaped the public expectations of state support or care services outside the family (*see* sections 6.2 and 7.2). In this situation, the welfare values are less influential for the care arrangement than the realistic factors. Conversely, the individual's affordable and accessible care options limit the welfare values used to justify attributing care responsibility to the family rather than to others outside the family. At the very least, this was observed in providing long-term care, as the case study showed.

Despite increasingly lower care expectations towards the family but higher towards the state (*see* Chapter 5), narratives addressing the family's function in terms of filial piety or family merit are frequently mentioned in social policies in China (*see* section 1.2), and the care provided by the family has been reimbursed from the public long-term care insurance in more pilot cities (*see* section 1.3). The family is the most feasible care option for many older adults and their families in terms of individual and family material constraints (*see* Chapter 9.1), as demonstrated by previous studies (Lu, 2015, Hu, 2019), and the local government recognises the family as the feasible workforce to fill the shortage of long-term care providers, alongside the formalisation of informal care (*see* section 8.3.2). Therefore, the long-term care policies emphasising the family's function as a state intervention help to strengthen or even re-establish the cultural values highlighting the family's caregiving role in turn.

In summary, in relation to welfare values in the Chinese context, the family is expected to continue as the primarily responsible institution in long-term care provision, corresponding to the low level of responsibility assigned to the state and the market. That is, the societal actors outside the family are supposed to play supplementary roles in supporting the family to carry on its conventional and irreplaceable (in many respects) caring function, as the family is the default basic institution in Chinese society. Notably, this is the case in the pilot cities where the care provided by the family is paid for from public insurance, including the formalising of informal care identified in this study's case study. The affordability of care from outside the family and the welfare values involved in care responsibility outside the family affect each other accordingly, particularly with the ongoing development of long-term care in China.

10.2.2 Family values about care responsibility within the family

Family values are associated with cultural models for family and gender relations (Pfau-Effinger, 2004a, 2004b) and the gendered division of labour is of great significance in the discussion of long-term care for older people (Eggers et al., 2020). In China, most agree that the family plays the central role in caring for older adults (*see* Chapter 5), even with the development of long-term care provision (*see* sections 6.1 and 7.1). According to the case study, although there did not appear to be a significant direct gender

division of labour within the family for long-term care provision, the preferences for sons and daughters influenced older people's care attitudes and care decisions to some extent. However, gender role expectations were given less weight than the availability of alternative care options (*see* section 9.2).

Instead of the traditional family structure addressing the older people being granted authority and respect within the family under the patriarchal and patrilineal system (Chen and Ge, 2018), the situations vary in contemporary Chinese society, with the declining traditional values and the gender role division being market-oriented, premised on market efficiency and individualism caused by industrialisation and modernisation (Sheng and Settles, 2006, Sun and Chen, 2015, Yan, 2016). The findings of this study have shown that family values, notably family solidarity and the intergenerational contract, enhance the care support from adult children but are less gendered (*see* sections 6.1.4 and 7.5). Although females have long been supposed to be the primary caregivers, sons are expected to take more care duty for their parents in Chinese culture (Whyte, 2004, Hu and Scott, 2016). The older people may be more satisfied with the care from their daughters (Yi et al., 2016). However, the caregivers appointed within the family may be less influenced by the conventional gendered division of labour than the available family care support (*see* sections 9.1 and 9.2), implying the significance of available family support and family values, which are usually linked to moral, gender-defined obligations based on kinship and intergenerational exchange, in accordance with the previous argumentations (Cong and Silverstein, 2012a, Silverstein,Conroy and Gans, 2012, Brasher, 2021). The significance of the availability of care of the one-child policy in China should be specifically noted.

Given that the retirement age for the majority is 50 for females and 60 for males under the occupation-based retirement system in China (*see* section 2.3.3), daughters and daughters-in-law are probably more likely to become caregivers after retirement. However, the higher expectations for sons primarily impacted by cultural values in China also matter (Murphy,Tao and Lu, 2011, Santos and Harrell, 2017) . Despite the relatively early retirement age, female retirees can spend their time working part-time, engaging in social activities with friends, caring for their grandchildren and providing care for their spouses or elderly parents. Their decisions reflect their priorities, and it appears that returning to the family as a carer is not the only option. Even so, the findings have shown that, given that the family is recognised as a unit for resource allocation and redistribution, wives were always their spouses' caregivers instead of asking their adult children to provide care, as the findings of the case study demonstrate (*see* section 7.3). Female retirees can be seen as the labour resources within the family, competing with the care demand from grandchildren and parents (Cong and Silverstein, 2019).

Regarding the care responsibility divided between males and females, as well as between generations, section 9.2 showed that, different from the conventional gender division of labour in care provision

within the family to a certain extent, older adults prefer care from children rather than from children-in-law. Family ties based on blood relationships are weighed more heavily for older and younger generations, as evidenced by the case study. Care task distributions between the older generations (spousal caregivers) and those between the younger generations are valued higher than the conventional gender division of labour within the family. The care decision is a willing but complex family choice, and although the females may have more time for care provision, the sons' obligations are assumed in Chinese society. Nevertheless, the son-preference will probably become less considered because of the predictable lack of care support from the younger generation impacted by the one-child policy (Zhang and Goza, 2006, Gustafson and Baofeng, 2014, Cai and Feng, 2021).

Regarding the formalisation of informal care, family members are paid with re-routed wages with the commodification of care (Ungerson, 2004) whereas the paid care provision is 'compensation for effort' (Eichler and Pfau-Effinger, 2009). This pattern is reflected in some pilot cities in which insurance-funded informal care is available for disabled older people in China. Although the underlying family values are hard to measure for the causal discussion on the formalisation of care, long-term care insurance does show the informal care preferences shaping the family values in turn. It is associated with China's specific policy design process compared with other countries, as it is more pragmatic in tackling structural problems rather than driving social policy development in the political approach, following pragmatic productivism to a certain degree (Mok,Kühner and Huang, 2017, Mok and Qian, 2019). The care policies are not intended to expand the role of the welfare state in long-term care but to satisfy the substantial unmet long-term care demand as soon as possible, in conjunction with the available care service supply (*see* section 8.3.1). The findings of the case study demonstrate that, resembling the welfare values, the family values highlight family functions and are used for public compliance within the current care arrangement.

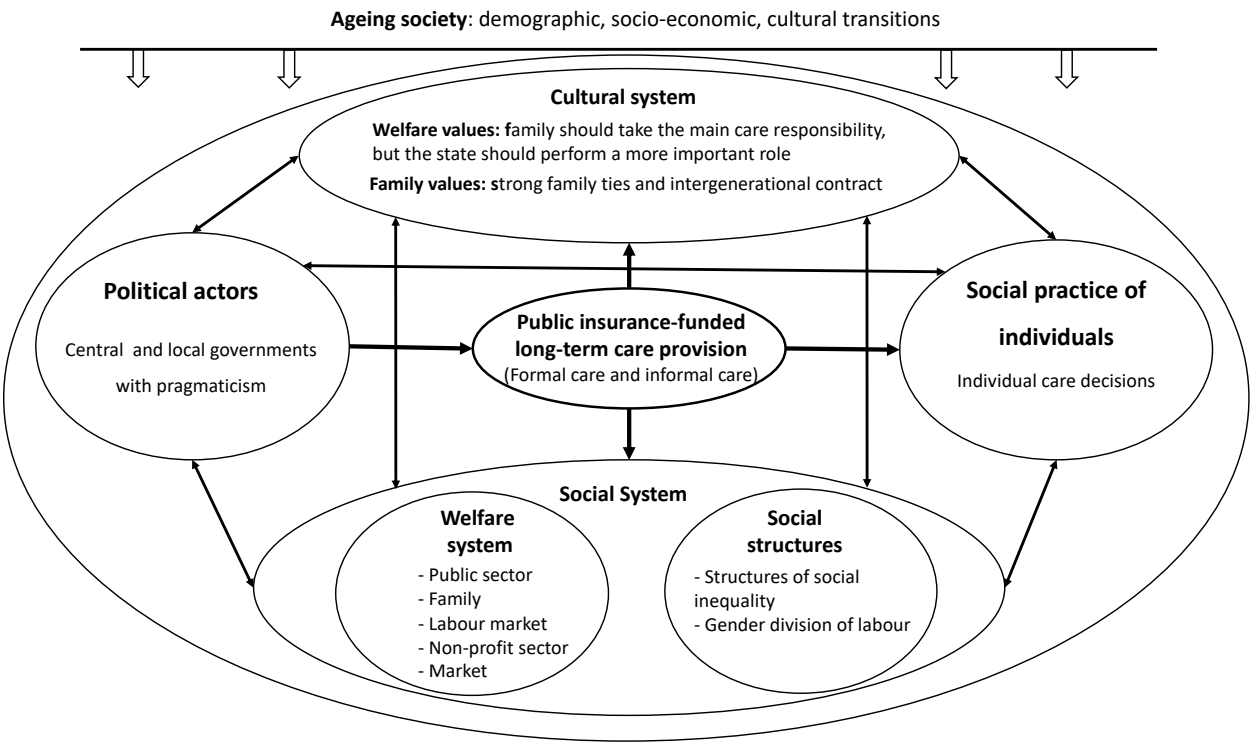
In short, the family values associated with long-term care provision are more about the care responsibility shared between generations within the family than between females and males. One of the possible explanations for this is that family caregivers for long-term care are usually retirees over 50 or even 60 years old, and those quitting the labour market for care provision such as childcare are rarely the cases for long-term care in China. Given the limited available care options for individuals and their families, the care responsibility is relocated within the family overlooking the gender role division for its members (*see* sections 9.1 and 9.2). The family is proven to be the basic institution for mitigating social risks with its resilience in the light of long-term care provision in China (see Chapter 9), even after the implementation of the public insurance scheme.

10.2.3 Care arrangement of long-term care provision in China

With the cultural values for long-term care provision in China (*see* sections 10.2.1 and 10.2.2), in this section I examine whether these cultural values impact long-term care provision regarding the policy process embedded in the unique central-local government interaction in China (*see* section 10.1), providing a response to RQ4. Based on the frameworks proposed by Pfau-Effinger (Figure 3.1 and Figure 3.2), in this section I investigate how and why cultural values influence the care policy within the care arrangement in contemporary Chinese society (Figure 3.3). Based on the case study in which family had been included in the long-term care provision pattern, this section offers an original adaptation of Pfau-Effinger's framework (2004a, 2005a) (*see* section 3.2) for interpreting long-term care within the care arrangement in China, as depicted in Figure 10.1. Figure 10.1 illustrates how cultural values influence the provision of long-term care in China. including the cultural values discussed in sections 10.2.1 and 10.2.2.

When proceeding with long-term care insurance in such a pilot phase, under the interaction between central and local governments in China, the local government is the leading actor, primarily showing the principle of pragmatism. Social systems, including the welfare system and social structures, are impacted by long-term care insurance and cultural values. Different institutions, including the public sector and labour market, contribute to care provision, which is also taken into account by political actors. Social inequality is concerned mainly with caregiving for people in households with different financial capacities and with rural-urban variations (related to the insurance reimbursement caps). The gender division of labour is also included in the long-term care provision. Given that the local government is the policy decision-maker whilst others have limited access to the policy-making process in the fragmented long-term care exploration in China (*see* Chapter 8), the compromises of the ideas and interests of other social actors do not seem significant to the government. Instead, the local government collects and selectively employs the ideas and interests of all the social actors involved in promoting particular discourses to the public. This is consistent with the discourses shaped by political actors for public compliance in the welfare values discussion of Pfau-Effinger (2008). Correspondingly, the changing care policies reflect and are influenced by the local governments reorienting policy priorities.

Figure 10.1 Long-term care provision within the care arrangement in China



As stated in section 3.2 with Figure 3.3 analysing the role of cultural values in the care arrangement, this study develops an analytical framework to capture how cultural values have an impact on long-term care provision in China. Figure 10.1 is established with empirical evidence based on the case study to reveal the care arrangement within long-term care provision in China. There are primarily two differences compared with Pfau-Effinger's frameworks (Figure 3.1 and Figure 3.2), highlighting the uniqueness of cultural values and their impacts, as well as the political system in China.

On the one hand, political institutions play a decisive role in whether cultural values are considered in policy design and implementation. Political institutions are dominant in the Chinese framework. Unlike Pfau-Effinger's frameworks with two-way influence processes between welfare policies and the cultural system, there is no direct impact of cultural values on long-term care insurance in China. Instead, cultural values show their impact on long-term care in a more invisible manner. Political institutions play a decisive role in determining whether the impact of cultural values is taken into account in long-term care policies. In this vein, political actors are mediatory for illustrating the culture's impact on the care arrangement. Other elements (cultural system, social system, social practice of individuals) do not directly influence long-term care insurance. However, they are all considered by the political actors in the policy design, as the political actors, mainly the local government, are decisive in the policy process in such a pilot phase of long-term care insurance implementation in China. Particularly, pragmatism is the key principle in developing long-term care insurance for the local government (*see* section 10.1.2).

On the other hand, cultural values affect other elements within the care arrangement in a more indistinguishable but irreplaceable way. Figure 10.1 shows how cultural values shape long-term care provision, in which political institutions play a pivotal role. The impact of cultural values on care policy is acknowledged but given less weight than economic and political considerations by political actors. For long-term care provision in China, cultural values, including both welfare values and family values, are sort of the instrument for convincing the public to continue its caring function, even with the public insurance supposed to lead to defamilialisation. In this situation, family obligations for welfare provision have been designated an extraordinary responsibility by the state (Pascall and Sung, 2014). Those emphasising family function in caring for older adults can be understood as the narratives of the government's intention. They are readily acceptable to the public, impacting their general adaptive preference and compliance with adopting the ongoing care scheme (*see* section 8.3.2). There is some kind of rhetoric in both policy discourse and mainstream social media urging older people to rely on their family members rather than any other provider, mainly the social welfare system. In this case, whether welfare values impact social policy depends on how social actors apply them (Hvinden, 2008). It also reveals the pragmatism of the local government in developing long-term care using cultural values, as the findings of the case study demonstrated, mainly concerning its capacity for managing care demands as the cornerstone of policy design and development.

Given these differences within the care arrangement in China, the government intentionally utilises cultural values to convince the family to play an important role in the provision aspect. The family is assumed to be the primary care provider despite changing social values (*see* section 5.1). Individuals, especially older adults, usually take this for granted and are willing to provide care to their older family members even without support from the state. It is more than a practical and feasible option for individuals, their families and policymakers (*see* sections 9.1 and 10.1), but also a sort of distinctive cultural characteristic in China. To expand long-term care provision in China, the local government somehow takes advantage of the culture's values to encourage the family's care function fulfilment. This suggests that Pfau-Effinger's conclusions can partially explain the impact of culture in China, as discourses are mainly decided by political elites to gain acceptance from the public. These political and public discourses essentially respond to public attitudes towards the care responsibility division between state and family.

Regarding Figure 10.1, based on the evidence of the case study, this chapter fills the research gaps by demonstrating the interplays between cultural values and care policies in the Chinese context, focusing on the unique political system in China.

However, despite the crucial role of local government during the pilot phase of long-term care insurance, given China's political centralisation system, the role of the central government within the care arrangement should be particularly predominant after the pilot phase. As the discussion in this chapter is based on evidence from the case study at the local level, Figure 10.1 requires additional research.

Notably, the case study of this study is reflective of the interrelationships between cultural values and other elements within the care arrangement in China. Guangzhou was chosen as the case study in order to gain an insight into local government, and its long-term care provision funded by the public insurance explicitly emphasises the family's function, although the unique characteristics related to cultural factors in this case study compared with many other cities in China should also be considered. It is mainly about self-identity and trust derived from language, such as Cantonese in Guangzhou. Cantonese is only used in some cities in Guangdong Province, one of which is Guangzhou, but language is the mediator in constructing individual and socio-cultural identities (Sharifian, 2014). Residents prefer to receive care from those who speak the same language. The family is the optimal option due to the high cost of Cantonese-speaking carers and those with relatively lower costs who speak Mandarin. Thus, the family has been considered to play a more crucial role in caring for the older generations, and the case study has outlined the more distinctive and critical function of the family in caring for older adults.

10.3 Conclusion

This chapter has presented an examination of the interplay between cultural values and long-term care provision within the care arrangement in China, addressing RQ4.

With regard to long-term care policy in China, mainly the public long-term care insurance as the funding mechanism, its design and implementation are complex, reflecting the interaction between the central and local governments. During the pilot phase, the local government has the final say in developing long-term care in accordance with national guidelines (Zhu and Osterle, 2019), exploring the schemes based on local circumstances, especially the available resources (Chan and Shi, 2022). Given the local exploration for economic consideration due to the shortage of workforce, cultural values used by the government reflected the pragmatism regarding productivist construction to a certain extent (Mok,Kühner and Huang, 2017), but it was also driven by social consideration for satisfying individual care demands. This chapter has shown that the central-local government interaction is crucial for understanding policy experimentation in China (Zhu, 2016, Guo and Zhao, 2022), just as it is for the analysis of long-term care insurance.

Specifically, in the public insurance-funded long-term care system covering care provided by the family, shifts in the sectoral division of function, labour and responsibility have been observed between the family, the market, the state and the third sector. In addition to being the rational option for individuals and their families, as demonstrated in Chapter 9, the family is the most feasible and essential actor in care provision in contemporary China for the local government (*see* sections 10.1.2 and 10.1.3), where cultural values are significant. In this situation, alongside the development of informal care by the local government, cultural values emphasising the family's caregiving function have been addressed. Cultural values have shown a profound but invisible impact on public attitudes and decisions regarding care (*see* Figure 10.1), contributing to an increase in the use of informal care to better meet the urgent care needs of disabled older people due to a shortage of formal care workers. Accordingly, narratives regarding family care responsibilities for disabled older people have been constructed. It is somehow consistent with the observation of the increasing policy emphasis on traditional moral values such as filial piety in China (Krings et al., 2022).

During the pilot phase of long-term care insurance schemes, political actors, particularly the local government, have acknowledged the significance of cultural values, including welfare values and family values, in relation to RQ4. In place of the negotiations of various social actors within the care arrangement in western European countries, as summarised in the previous frameworks (Pfau-Effinger, 2004a, 2005a), the government in contemporary China, embedded in the complex central-local government interaction, plays a decisive role in developing long-term care policy. Cultural values have had a more visible effect on care policies, whereas political actors have utilised them to encourage the family to reclaim, maintain, or even strengthen its caring role in the provision aspect. In other words, for RQ4, rather than shaping care policies, policymakers have used cultural values as a tool to encourage the family to provide care, and the precondition is that the invisible influence of cultural values emphasising the family's role remains significant for individual care decisions in contemporary Chinese society.

Considering cultural factors, this study makes two major contributions to the advancement of knowledge regarding long-term care insurance, as illustrated in Figure 10.1. On the one hand, this study renews the analytical framework established by Pfau-Effinger specifically concerning the unique characteristics of the Chinese context. Compared to her work illustrating culture as one of the factors explaining the differences in care provision through comparative studies in European countries, this study has specifically focused on the case of China. A comprehensive and thorough picture has been outlined, showing the interrelationships between culture and long-term care provision within the care arrangement with regard to the country's distinctive political and cultural ecologies. The use of cultural

values to urge and encourage the public to continue or even retake the traditional caring function corroborates the effects of cultural values on the provision of long-term care. On the other hand, it clarifies that the formalisation of informal care in long-term care has been developed to tackle the shortage of care workers, reflecting the pragmatism of social policy development. It provides additional information on the design and implementation of policies in China, especially in light of the decisive role of the local government.

Nonetheless, the conclusion of this chapter is primarily driven by the case study at the local government level due to its dominant role in the current pilot period of the long-term care insurance scheme. Concerning the core role of the central government in the policy-making process in China (Kostka and Nahm, 2017), it should be noted that additional research is required to investigate whether there are any differences in the roles of the central and local governments in long-term care provision when the pilot programme ends and turns into a national scheme. However, as with the vast regional differences and fiscal decentralisation in China, it is anticipated that the local government will continue to play an important role in the future development of long-term care provision.

Summary of Discussions in Part Three

With the development of public insurance-funded long-term care provision in China, the changing roles of the family in providing long-term care are found in the combination of money-familialisation and labour-defamilialisation in Chapter 9. Multiple considerations are summarised, including available care support and cultural values that highlight the family's responsibilities to its members.

Cultural values, including welfare and family values, are valuable in encouraging the family to sustain and strengthen the caring role (Figure 9.2). The significance of cultural values is acknowledged in developing long-term care provision (Figure 10.1), and the essential role of the family has been emphasised. Therefore, these two analytical frameworks demonstrate that cultural values are important not only for individual care decisions indicated in Chapter 9 but also in the care arrangement within long-term care provision in China, as Chapter 10 indicates.

Combining the discussions in China targeting four research questions in this study, these discussions contribute to revealing the story surrounding the keywords: family, long-term care, and cultural values. As long-term care provision has been developed with public insurance as the primary funding mechanism, particularly with the informal care included in the long-term care system, the family, which performs as the conventional care provider for its older members, has adjusted its role in care provision. This is reflected in the money and labour dimensions from the (de)familialisation perspective. Although

social attitudes towards care provision have changed over time, the family remains regarded as the principal care provider for older people. Cultural values emphasising family responsibilities and obligations are essential for family care provision, and their significance has been recognised when developing long-term care provision. Therefore, the findings of Chapter 9 and Chapter 10, based on two analytical frameworks, explain the current story of the changing family's role in providing long-term care considering the cultural values in contemporary China.

11 Conclusion

This chapter sums up the key issues regarding the role of the family, long-term care provision and cultural values discussed in this thesis, providing explicit and evidence-based responses to the four research questions. This chapter has seven sections. The first provides a summary of this thesis by reiterating the key points from the preceding chapters. The second to fifth sections respond separately to the four research questions. The section which follows summarises the empirical and theoretical contributions of this study and describes how its findings echo those of prior research. The final section outlines the limitations of this study and concludes with recommendations for future research.

11.1 Summary of the thesis

This study examined the role of the family in providing long-term care to older people in contemporary China, taking into account the impact of changing cultural values within the care arrangements.

In an era of global ageing, the care provision for the ageing population has placed a tremendous strain on the current care system, especially in China, which has the world's largest ageing population but a late start-up development of a long-term care system. Given the long-lasting family-centred care provision pattern and the deeply rooted cultural values emphasising the family's responsibility, it remains to be determined whether and how the family adjusts its role in response to these transitions. These answers are crucial for developing long-term care provision mechanisms in China. This study was therefore an investigation of the family's role in long-term care provision in the Chinese context (*see* Chapter 1).

Given that the family is always a key actor in supporting its members, its role can be defined from a defamilialisation perspective, which captures the shifting of responsibility between the state and the family. Despite China's developing care system with more actors' involvement, the family appears to continue its important role for a variety of rationales (*see* Chapter 2). As one of the reasons for family providing care, cultural values have long been debated for their impact on social policy, but they are rarely placed in the Chinese context, despite the fact that they are widely accepted values regarding the family's function (*see* Chapter 3).

In the light of the importance of these key issues, this study addressed four research questions based on research gaps identified in the existing literature. In this study, a combination of quantitative and qualitative methods was used to collect data (*see* Chapter 4).

The overall picture of changing social attitudes regarding care responsibilities towards the state and the family was described. According to data from national databases in the 2010s, an increasing proportion of people had higher expectations of the state in providing care, but the conventional family-dominant care pattern had not been reversed in care attitudes and care decisions (*see* Chapter 5).

How the family's role in care provision changes and how cultural values impact individual care decisions and policy designs were analysed, primarily through the lens of a case study of Guangzhou in which care provided by the family had been incorporated into the publicly funded long-term care system.

For older people with disabilities receiving care from part-time caregivers, the insurance-reimbursed care was typically preferred for a variety of reasons. Because the insurance was generally viewed as a cash benefit due to their disabilities, the family was expected to sustain its caregiving function. The family's role as the direct care provider had not significantly changed from their views (*see* Chapter 6).

For part-time caregivers in the case study, who were primarily family members of care recipients, more diverse incentives and enforcements for providing informal care were identified, including the affordability of care alternatives to family care and family values. Intergenerational differences in care attitudes were found compared with the findings from care recipients. The family continued to provide uncompensated care surpassing the reimbursement cap. The family's caregiving role had been either strengthened in the provision aspect or shifted with insurance reimbursement in the funding aspect (*see* Chapter 7).

For other actors in the long-term care system, the care homes, insurance enterprises and local government, the findings have shown various reasons for developing family care from their perspectives and how they became involved in the long-term care system. Notably, for the local government, the workforce shortage was the principal reason for developing care delivered by informal (or semi-informal) actors. Cultural values were considered in the policy process (*see* Chapter 8).

Based on the case study, two analytical frameworks revealing the role of the family in care provision and the role of cultural values within the care arrangement in the Chinese context were developed.

Regarding the family's role in providing care in China, a combination of money-familialisation and labour defamilialisation in the public insurance-funded long-term care system covering family care was found. For a more in-depth understanding of the changing role of the family, intergenerational differences and the gendered division of labour in terms of family care provision were examined, but only the former was evident in individual care decisions (*see* Chapter 9).

Regarding the cultural values within the care arrangement for long-term care provision, an analytical framework was developed based on the work of Pfau-Effinger, capturing how cultural values, including

welfare values and family values, were considered in developing long-term care embedded in the complex interaction between central and local governments in China. The political institution in China is a unique element within the care arrangement (*see* Chapter 10).

Overall, the findings have shown that the role of the family in providing long-term care has been more explicitly divided into the money and labour dimensions, and cultural values are important for maintaining its caregiving function, as acknowledged by individuals and their families as well as other actors beyond the family. The findings of this study thus contribute to improving the care policy with better fulfilment of the role of the family to meet the rising care demands.

11.2 How have social attitudes towards the role of the family in providing care changed over time?

This question sought to elucidate the shifts in Chinese social attitudes towards care responsibility. The answers were derived from descriptive analyses of the CGSS and CFPS databases and regression analyses of the CGSS database (*see* Chapter 5).

Since the 2010s, there have been observable shifts in social attitudes regarding care responsibility between the state and the family, between generations and between males and females within the family. An increasing proportion of the public agreed that the government should assume greater care responsibility for older people, but the majority of the public continues to believe that the family should bear the primary responsibility. Evident intergenerational differences in care attitudes exist. According to data from the CGSS from 2010 to 2017, there were a variety of variables associated with these shifting care attitudes. Available care support from the family and the public sector and attitudes towards gender roles were significantly correlated with changing care attitudes over time. The results from the regression analysis were generally consistent with those of the descriptive analysis and with previous arguments on the role of family in care attitudes and care provision patterns (Chappell and Funk, 2012, Lin and Yi, 2013, Feng et al., 2020).

This study thus contributes to demonstrating how specifically the social attitudes towards care provision have changed in China, given that the social attitudes have been usually ignored in previous studies. The answer to this research question has provided a more up-to-date interpretation of the changing care attitudes in contemporary China on a national scale than previous research.

11.3 How has the role of the family in providing long-term care changed following the implementation of long-term care insurance schemes?

With the public insurance funding long-term care provided by the caregivers from and beyond the family, the family's role in providing care to its older members was examined from the defamilialisation perspective based on the case study (*see* Chapter 9). Based on the work of An and Peng (2016), a framework was developed which would capture the combination of money-familialisation and labour-defamilialisation in long-term care provision.

For the cases reflecting money-familialisation, the family had strengthened its role as the direct provider of care. Given that insurance reimbursement was generally viewed as a cash benefit rather than a benefit-in-kind for the compensation of family effort, the care provided by family carers was the rational option for both care recipients and their families following the formalisation of informal care. Due to the reimbursement cap, the family continued to provide unpaid care for its older members despite receiving insurance reimbursement. For those showing labour-defamilialisation, the family had shifted its role as the sole care provider to being the organiser of care support. Due to the increased financial capacity for care alternatives made possible by the insurance reimbursement, the family was able to alleviate some of the care burden.

Combining money-familialisation and labour-defamilialisation, various considerations for family providing care were found (*see* Figure 9.2). The unaffordability of care alternatives and cultural values were significant for the care decisions of individuals and their families (Chappell and Funk, 2012, Liu, 2017, Zhang,Clarke and Rhynas, 2019). Due to the limited alternatives (Schulz et al., 2012, Piggott, 2015, Hu and Wang, 2019), family care was thus the last bastion for many (Shi, 2017a). This study further reveals that the family usually performs as the last resort for supporting its members, and the cultural values addressing family responsibilities and obligations could help encourage the family to sustain its caring function. Despite the long-debated gender issues in care provision (Yi et al., 2016, Wang et al., 2020), they were given less weight than the available family support. The findings also demonstrated the impact of China's one-child policy on available family support (Settles et al., 2013, Zhang, 2017b, Cai and Feng, 2021), thus shaping individual care attitudes. Particularly for long-term care, the formalisation of informal care in the case study, such as through training and supervision, can be viewed as significant support for family carers in terms of increasing individual preferences for care provided by the family (Lobanov-Rostovsky et al., 2023).

These results showed that the family remains a socio-economic actor for its members in terms of resource allocation and redistribution (Papadopoulos and Roumpakis, 2017, Papadopoulos and

Roumpakis, 2019), in which insurance reimbursement and the available family workforce were considered family resources. The family was demonstrated to be adaptable in response to social changes to fill the welfare provision gaps of its members (Jankowiak and Moore, 2016). In particular, the formalisation of informal care in the case study showed that the family was capable of addressing the shortage of care workers outside the family (Zhang et al., 2018).

So even with long-term care insurance as the state intervention, the family's role as the direct care provider in the care provision mechanism had not fundamentally changed in many cases (Feng et al., 2020) although its role had been more intricately divided into money and labour dimensions.

11.4 Are there any intergenerational differences in the care attitudes and care decisions for the family providing long-term care support?

Following the answers to the previous two questions, the intergenerational differences in attitudes towards care provision are also evident (*see* Chapters 5 and 9).

The findings of Chapter 5 showed that age was significantly associated with care attitudes regarding the care responsibilities borne by the state and the family. The findings of Chapter 9 based on the case study showed that the older generations, regardless of whether they were care recipients or caregivers, were typically assumed to have greater family care responsibilities, particularly regarding filial piety and the intergenerational contract (*see* section 9.3). They were more likely to take it for granted due to family values. The younger generation acting as part-time caregivers was correspondingly more pragmatic. Although they too acknowledged the importance of those cultural values addressing family responsibilities and obligations, the family's capacity to afford the alternatives to family care was the deciding factor in favour of family care. With the implementation of long-term care insurance, there are options between money-familialisation and labour-defamilialisation; however, the family typically maintains its role as the direct care provider for a range of factors, given that the family was the socio-economic actor with intergenerational social reproduction.

The findings of the quantitative analysis generally concurred with those of the qualitative analysis and with prior assertions (Gruijters, 2017a, Bedford and Yeh, 2019, Hamamura et al., 2021), and different age groups have different conceptions and expectations regarding family interactions (Jankowiak and Moore, 2016). These findings were also associated with the rising individualism observed in contemporary China (Yan, 2016, 2018). Notably, regarding available family support in the light of China's worsening demographic structure (Bao et al., 2022), given that the younger generation, as well as the

future old generation, are more pragmatic towards care responsibility, care policies should take these factors into account for the sustainability of family-centred care provision patterns in the long run.

11.5 Has the care arrangement been impacted by culture?

Regarding the significance of cultural values emphasising the family's role in supporting its older members, this question explored whether and how they were considered in developing long-term care, given that care provided by the family has been incorporated into the insurance-funded long-term care system in some pilot cities in China (*see* Chapter 10).

During the pilot phase of the long-term care insurance scheme, the local governments played a crucial role in implementing a localised care provision pattern in accordance with their specific conditions. Based on the analytical framework established by Pfau-Effinger (2004a, 2005a) for welfare and care arrangements in western European nations, this study developed a framework (*see* Figure 10.1) that captured the role of cultural values in long-term care policies, embedded in the complex central-local government interaction in the Chinese context. The findings showed that policymakers recognised the significance of cultural values for individual care decisions made by families providing care, given that the family providing care is not just a rational care option for individuals and their families, but also for developing long-term care provision due to the shortage of workers. Despite changing social attitudes regarding the division of care responsibilities between the family and the state, the local government has used cultural values to encourage the family to maintain or even retake its conventional caring function for its older members, demonstrating its pragmatism in policy design and implementation. These findings are also consistent with the recent trend of an increasing policy emphasis on the traditional virtue of filial piety in China (Krings et al., 2022).

This study has shown that the impact of cultural values on long-term care provision within the care arrangement was more invisible and incremental in the Chinese context. Specifically, the findings have emphasised the decisive role of political institutions as the dominant ones and the mediatory role in connecting cultural values and other elements within the care arrangement for long-term care provision, thereby extending previous frameworks in the Chinese context.

11.6 Contributions of the study

This study examined the role of the family in providing long-term care taking into account the impact of cultural values in contemporary China and makes empirical and theoretical contributions, as well as policy implications.

The empirical contributions primarily consist of crucial considerations for individual (family) care decisions, intergenerational differences and the gendered division of labour in the provision of family care in comparison with the previous literature.

This study investigated the motivations for individual care decisions in China, particularly for family care. In addition to family values associated with filial piety and familism (Sun, 2017, Bedford and Yeh, 2019, Falzarano et al., 2022), the capacity to afford care alternatives (Schulz et al., 2012, Piggott, 2015, Hu, 2019), the intergenerational contract and exchange (Bianchi et al., 2006, Cong and Silverstein, 2008, Cong and Silverstein, 2012a) and the demonstration effect model (Cox and Stark, 2005) in previous studies were all demonstrated in the analysis of care decisions between formal care and informal care in the Chinese context. Specifically, the findings showed that the economic constraint related to the affordability of care alternatives was the determining factor based on the evidence from the case study. They further illustrated that all these factors were family-based rather than individual, affirming that the family is the socio-economic actor in social reproduction (Papadopoulos and Roumpakis, 2017). The family is the last resort for the individual to resist risks in Chinese society (Shi, 2017a). The findings of this study thus set these arguments in the Chinese context.

The findings also showed the intergenerational differences regarding care expectations from the family (Gruijters, 2017a, Bedford and Yeh, 2019). The younger generation are more likely to prefer care provided from beyond the family with the rise of individualism and neo-familism (Yan, 2016, 2018). Explicitly in the Chinese context, the findings also illustrated the impacts of the one-child policy in China on care attitudes and expectations (Gustafson and Baofeng, 2014, Cai and Feng, 2021), showing a more egalitarian and reciprocal parent-child relationship (Fu,Xu and Chui, 2020) and enriching the discussion about care provision for older people and family planning policies.

Despite the long-argued gendered care provision pattern shaped by cultural factors (Yi et al., 2016, Wang et al., 2020) and the fact that they are the core topic of the analysis of defamilialisation (Saxonberg, 2013), the findings have shown that they were less valued in individual care decisions and long-term care policies in China (*see* section 9.2). The case study showed that compared with gender issues, the family's capacity for care alternatives and individual preferences appeared to be more significant in individual care decisions. The family economic models concerning gender roles (Pfau-Effinger, 2004b) were not the case in long-term care provision compared to the availability of care provision. It was also found that the gendered care provision was complex in the Chinese context. The early retirement ages of women, the changing family structure affected by the one-child policy and underdeveloped long-term care system in China were possible explanations for this. The vested gender role expectations for

female care providers somewhat oversimplify the gender division of labour in China, given the long-existing but fading son preference and available family support in China.

In addition to the empirical contributions, theoretical contributions can be outlined based on the two analytical frameworks developed in the Chinese context in this study.

From the defamilialisation perspective, this study developed a framework combining money-familialisation and labour-defamilialisation for long-term care provision with evidence from the case study, summarising how the role of the family had changed in the public insurance-reimbursed long-term care system covering care provided by the family in China (*see* Figure 9.2). This framework was developed based on An and Peng's (2016) work about childcare policies in East Asian societies. This study transferred the framework for childcare to long-term care and specifically focused on the family's response in the Chinese context. Rather than analysing the family's role in the context of the welfare regime typology, this study narrowed the focus on the care responsibility division between the family and the state in China from the defamilialisation perspective, addressing the critical role of the family in money and labour dimensions in the provision aspect. The family is adaptable in adjusting its role in supporting its members, with both familialisation and defamilialisation patterns in response to the developing long-term care provision in China.

Regarding the role of cultural values in care policies, this study developed another framework capturing the interactions between cultural values and long-term care policies within the care arrangement in China, based on the work of Pfau-Effinger rooted in western European nations (Pfau-Effinger, 2004a, 2005a). In addition to identifying the essential elements of the care arrangement in the Chinese context, the findings showed that cultural values exerted their influence in a less visible manner. The political institution was a dominant element in the Chinese framework, serving as the mediator between care policies and other elements within the care arrangement (including cultural values) due primarily to the government's decisive role in the country's policy-making process. During the pilot phase of long-term care insurance in China, local governments played a crucial role as part of the interaction between the central and local governments (Zhu, 2013, Chan and Shi, 2022).

These two analytical frameworks highlighted the family's role in providing long-term care in China, thereby enhancing our understanding of the ongoing Chinese story based on the findings of this study (*see* Summary of Discussions in Part Three). Given that the development of long-term care is still in its early stage in China, the findings of this study also contribute to the policy debate on further family policy design concerning the family as the socio-economic actor and the significance of cultural values, possibly entailing repercussions for care policies targeting older people.

In addition to empirical and theoretical contributions, the findings of this study provide empirical evidence for policymakers to develop the long-term care system in contemporary China, with the implementation of public long-term care insurance as the primary funding mechanism.

This study demonstrates that the family is a feasible care option for older people in the short term, given the evident gap between the soaring care demands and the long-term care provision system at the early development stage. Regarding the multiple motivations for family caregivers, various forms of support for family caregivers, such as increasing economic incentives, especially the wages led by the higher insurance reimbursement caps, professional support (training) for care provision, and the emphasis on cultural values in policy and public discourses, may all be significant in fulfilling the family's function in providing long-term care services. The formalisation of informal care demonstrated in the case study may also be a possible policy solution to target the care demands of older people.

Considering the sustainability of family care and the more pragmatic care attitudes of the future old generation revealed in this study, developing a comprehensive care system based on the collaboration of multiple actors is essential in the long run. So does connecting formal and informal care resources, particularly those delivered in the community, as with the individual ageing-in-place preference found in the case study.

Given that the discussion of this study is situated in the pilot phase of public long-term care insurance, in which the local government plays the primary role in designing the localised care provision pattern, these policy implications may also contribute to long-term care provision at the national level in the near future.

11.7 Limitations and suggestions for further research

Acknowledging the limitations of this study is essential for future research. In this section, I discuss three limitations of the study which are primarily attributable to the methodology, as stated in section 4.5.

First, the degree of generalisation of the study's findings is limited due to the restricted access to a wider range of case studies. The original research plan had to be modified significantly due to the sudden outbreak of the global COVID-19 pandemic in 2020 and its effect on the feasibility of conducting fieldwork based on travel restrictions and ethical concerns. Guangzhou City was chosen as the sole case study to thoroughly capture the family's caregiving role where family care is included in the public insurance-funded long-term care system in China. Two analytical frameworks about the defamilialisation and role of cultural values within the care arrangement were developed primarily with evidence from the case study, but the specific characteristics of the case study, such as its financial

capacity and language differences, might lead to nuanced differences in interpreting individuals' care decisions and the local government's considerations in the analysis. Other (de)familialisation patterns might emerge in other pilot cities in China as with the diversified care provision patterns in the current pilot phase (*see* Table 1.2). Therefore, additional case studies with varying long-term care provision patterns might contribute to a more complete understanding of how the family adjusts its role in providing long-term care in China.

The second limitation is the absence of an empirically evidence-based discussion of the role of the central government in this study. This study investigated the impact of cultural values on the role of local government in developing long-term care, given that local policymakers dominated long-term care development during the pilot phase of the public long-term care insurance scheme. Despite the importance of the central government in China's policy-making process, the role of the central government was discussed based on previous literature and the insights shared by the local government in the case study, leading to lack of empirical evidence. The considerations and priorities of the central government are therefore somewhat in a 'black box'. Taking into account the potential differences in local exploration of long-term care provision with family involvement due to China's vast internal heterogeneity and regional differences, discussion with representatives of the central government could contribute to a more comprehensive picture of long-term care development in China, particularly when the current pilot phase concludes in the near future.

Third, the limitations of the secondary data to examine the changing care attitudes in quantitative analysis. This study sought to capture the social attitudes regarding care responsibility from the family and the state in China, despite the fact that the question measuring these issues was not available until the 2010 version of the question was adopted in the survey for the CGSS database. Given that social attitudes may have changed incrementally over a relatively long time period, the data only available from 2010 to 2017 used in the regression analysis in this study might have resulted in the absence of a more general trend in social attitudes. Thus, a follow-up analysis of the social attitudes about the care responsibility divided between the state and the family with a longer time period might help future researchers to identify changes and associated explanations over time.

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Abbreviations

ADL	Activity of Daily Living
CCP	Chinese Communist Party
CFPS	China Family Panel Studies
CGSS	China General Social Survey
CODID-19	Coronavirus disease 2019, a contagious disease caused by the virus SARS-CoV-2
e.g.	Latin phrase exempli gratiā, meaning "for example"
et al.	Latin phrase et cetera, meaning “and others”
FSA	Family Support Agreement
GDP	Gross domestic product
GR	Gender role
IADL	Instrumental Activity of Daily Living
ibid	Latin word ibīdem, meaning "in the same place"
i.e.	Latin word id est, meaning “that is”
LTC	Long-term care
PPS	Probability-proportional-to-size
RQ	Research question
SOE	State-owned enterprise
UEBMI	Urban Employee Basic Medical Insurance
UEPS	Urban Employee Pension Scheme
URRBMI	Urban and Rural Resident Basic Medical Insurance
URRPS	Urban and Rural Pension Scheme

Appendices

Appendix 1 Interview Questions Lists

1.1 Care recipients

Introduction	1. Repeating the information from the participant information sheet, highlighting the purpose of the research, the information anonymization, the confidentiality of personal information, and the free withdrawal of the interview. 2. Asking permission to record and begin the interview.
Public insurance-funded care received	1. Who is your current caregiver? Are you satisfied with the long-term care you are receiving? 2. Why do you choose the care services provided by the family? 3. Which family members do you prefer as your carers, and why? 4. Have you ever thought of other care options, such as institutional care, and why? 5. How often do your family members (primarily adult children) contact you? What kind of support do they provide for you? 6. Have you heard of the long-term care insurance scheme? Since the implementation of long-term care, what do you think of the care you are receiving, particularly the care from your family. Any impacts due to the COVID-19? 7. What are your expectations from the ongoing long-term care policies?
Care attitudes and preferences	1. Who do you think should take responsibility for taking care of older people? Whether your care expectation towards the government has changed over time (one-child policy)? Why? 2. If there is an affordable care alternative, will you choose other care options but not family care, and why? 3. Do you agree with the saying that raising a child to secure life in old age? 4. What do you think of the care obligations between sons and daughters?

1.2 Part-time caregivers

Introduction	1. Repeating the information from the participant information sheet, highlighting the purpose of the research, the information anonymization, the confidentiality of personal information, and the free withdrawal of the interview. 2. Asking permission to record and begin the interview.
Public insurance-funded care received	1. Personal information about herself or himself and the care recipient, such as age, gender, hukou type, health status, marital status, number of children, employment status, and relationship between the care recipient and carer. 2. How long have you been working as part-time carers? Could you describe your daily routine for providing long-term care? 3. Who takes care of the disabled care recipient before the implementation of long-term care insurance? Why does your family choose to provide insurance-funded care? 4. Why do you choose to become a part-time carer instead of other family members? 5. Since the implementation of long-term care, what do you think of the care the older people are receiving, particularly the care from your family? Are there any differences in the family's function in providing care? Any impacts due to COVID-19? 6. What if the health status of your disabled family member worsens? Will you change the care provision pattern? 7. What are your expectations from the ongoing long-term care policies?
Care attitudes and preferences	1. Who do you think should take responsibility for taking care of older people? Whether your care expectations towards the government have changed over time (one-child policy)? Why? 2. If there is an affordable care alternative, will you choose other care options but not family care, and why? 3. Do you agree with the saying that raising a child will secure a life in old age? 4. What do you think of the care obligations between male and female family members, especially between sons and daughters? 5. What will be your future care plan when you require care provided by others, and why?

1.3 Care homes and insurance enterprises

Introduction	1. Repeating the information from the participant information sheet, highlighting the purpose of the research, the information anonymization, the confidentiality of personal information, and the free withdrawal of the interview. 2. Asking permission to record and begin the interview.
Interaction with other actors	1. Could you please describe your work in the long-term care system, and are there any differences in your work between before and after the implementation of long-term care insurance and any impact of COVID-19? 2. How do you interact with other actors in the long-term care system (particularly the local government)? 3. What are your expectations from the ongoing long-term care policies?
Family's role in providing care	1. What do you think of the ongoing long-term care provision pattern in the case study? 2. Why do you think the long-term care provided by the family has been included in the insurance-funded care system? What do you think of the family's role in providing care?

1.4 Local government

Introduction	1. Repeating the information from the participant information sheet, highlighting the purpose of the research, the information anonymization, the confidentiality of personal information, and the free withdrawal of the interview. 2. Asking permission to record and begin the interview.
Development of Long-term care provision	1. Could you please introduce the development of long-term care insurance in the case study? 2. What do you think of the ongoing long-term care provision pattern in China, and particularly in your city? 3. When developing long-term care, what are the primary considerations for the government, and why? 4. How do you interact with other actors in the long-term care system? 5. What do you think of the future development of long-term care provision?
Family's role in providing care	1. Compared to other cities, the care provided by the family has been included in the care system in Guangzhou. Why? Why are 'part-time caregivers' instead of 'informal carers' in the care system? 2. What do you think of the family's role in providing care? 3. What do you think of family values, such as those related to filial piety, in developing long-term care? Why?

Appendix 2 Participant Information Sheets

2.1 Care recipients and caregivers

Participant Information Sheet

Cultural Change and Long-term Care in China: Transition of the Role of Family for Care Provision

Who is undertaking the study?

I am Jiayu Zhang, a 2nd year PhD student of the Department of Social Policy and Social Work of the University of York, United Kingdom.

What is the purpose of the study?

The primary aim of the research is to investigate the changing role of the family for care provision for the elderly in China, considering the influence of social values on the development and implementation of care provision. The research project is undertaken for my PhD degree at the University of York, UK.

Why have I been invited to take part?

This research focuses on the care provided for the elderly, the long-term care insurance scheme to the elderly, the changing family values, and the family's role in supporting the elderly. Given that you are very familiar with this topic, it would be greatly appreciated if you are willing to participate in the research.

What does taking part involve?

The research will be conducted with interviews via WeChat or telephone concerning the care provided for the elderly, the long-term care insurance scheme to the elderly, changing family values, and the family's role in supporting the elderly.

The interviews will be arranged on a date and time convenient for you. It will be a single interview, generally about 60 minutes for each participant.

Do I have to take part?

Your participation is voluntary, and you can withdraw from the research at any time, without needing to provide a reason and without detriment to any service you may be in receipt of.

What are the benefits and risks of participating?

Your participation will contribute to the study that aims to understand better how to support family caring and implement the long-term care insurance scheme. You will receive a payment of 50 yuan as a thank you for participating in the research.

Some of the interview questions might relate to personal experiences about care and family. It is possible you may feel distressed during the interview as a result, but you can terminate the interview at any time during the interview or ask to move to another question, should this be the case.

Will I be identified in any research outputs?

All your identifying personal information (e.g., name, home address) will be anonymized in the research. Anonymized direct quotations from your interview may be used in final research papers, but this will be done without using and identifying information that might compromise your privacy.

How will you keep my data secure?

For how long will you keep my data?

Will you share my information with anyone else?

All data will be stored on the secure University of York file server, and they will not be shared with others except the researcher. The anonymized transcripts will be retained for ten years from the last requested access. More details are addressed in the Data Information Sheet.

Who is funding the research?

N/A

Who has given approval to conduct the research?

University of York.

How do I find out more information?

If you have any further inquiries, please contact me directly on XXX (anonymised).

How do I make a complaint?

If you have any complaints, please contact me directly on XXX (anonymised) / jz2101@york.ac.uk

If you are not satisfied, please contact:

My supervisors: John Hudson: john.hudson@york.ac.uk

Sabrina, Chai: sabrina.chai@york.ac.uk

University of York Department of Social Policy & Social Work Departmental Ethics Committee using the email address: spsw-ethics@york.ac.uk.

2.2 Other participants

Participant Information Sheet

Cultural Change and Long-term Care in China: Transition of the Role of Family for Care Provision

Who is undertaking the study?

I am Jiayu Zhang, a 2nd year PhD student of the Department of Social Policy and Social Work of the University of York, United Kingdom.

What is the purpose of the study?

The primary aim of the research is to investigate the changing role of the family for care provision for the elderly in China, considering the influence of social values on the development and implementation of care provision. The research project is undertaken for my PhD degree at the University of York, UK.

Why have I been invited to take part?

This research focuses on the care provided for the elderly, the long-term care insurance scheme to the elderly, the changing family values, and the family's role in supporting the elderly. Given that you are very familiar with this topic, it would be greatly appreciated if you are willing to participate in the research.

What does taking part involve?

The research will be conducted with interviews via WeChat or telephone concerning the care provided for the elderly, the long-term care insurance scheme to the elderly, changing family values, and the family's role in supporting the elderly.

The interviews will be arranged on a date and time convenient for you. It will be a single interview, generally about 60 minutes for each participant.

Do I have to take part?

Your participation is voluntary, and you can withdraw from the research at any time, without needing to provide a reason and without detriment to any service you may be in receipt of.

What are the benefits and risks of participating?

Your participation will contribute to the study that aims to understand better how to support family caring and implement the long-term care insurance scheme.

Some of the interview questions might relate to personal experiences about care and family. It is possible you may feel distressed during the interview as a result, but you can terminate the interview at any time during the interview or ask to move to another question, should this be the case.

Will I be identified in any research outputs?

All your identifying personal information (e.g., name, home address) will be anonymized in the research. Anonymized direct quotations from your interview may be used in final research papers, but this will be done without using and identifying information that might compromise your privacy.

How will you keep my data secure?

For how long will you keep my data?

Will you share my information with anyone else?

All data will be stored on the secure University of York file server, and they will not be shared with others except the researcher. The anonymized transcripts will be retained for ten years from the last requested access. More details are addressed in the Data Information Sheet.

Who is funding the research?

N/A

Who has given approval to conduct the research?

University of York.

How do I find out more information?

If you have any further inquiries, please contact me directly on XXX (anonymised).

How do I make a complaint?

If you have any complaints, please contact me directly on XXX (anonymised)/ jz2101@york.ac.uk.

If you are not satisfied, please contact:

My supervisors: John Hudson: john.hudson@york.ac.uk

Sabrina, Chai: sabrina.chai@york.ac.uk

University of York Department of Social Policy & Social Work Departmental Ethics Committee using the email address: spsw-ethics@york.ac.uk.

Appendix 3 List of Interviewees

3.1 Care recipients and caregivers

Care Recipient			Caregiver			
Code	Gender	Age	Code	Gender	Age	Relationship
RF1	Female	83	FC1	Female	52	Daughter
RF2	Male	82	FC2	Female	67	Wife
RF3	Female	80	FC3	Female	54	Daughter
RF4	Female	78	FC4	Female	49	Daughter
RF5	Male	71	FC5	Female	72	Wife
RF6	Male	66	FC6	Female	56	Wife
RF7	Male	74	FC7	Female	70	Wife
RF8	Female	74	FC8	Male	51	Son
*RF9**	*Female*	*78*	FC9	Male	58	Son
*RF10**	*Female*	*91*	FC10	Male	58	Son
*RF11**	*Male*	*72*	FC11	Female	60	Wife
*RF12**	*Female*	*94*	FC12	Male	62	Son
*RF13**	*Male*	*85*	FC13	Female	64	Neighbour
*RF14**	*Female*	*90*	FC14	Female	59	Daughter
*RF15**	*Male*	*89*	FC15	Female	64	Daughter
*RF16**	*Female*	*77*	FC16	Male	45	Son
*RF17**	*Male*	*92*	FC17	Female	60	Daughter
RO1	Female	81	OC1	Female	55	Private caregiver
RO2	Female	75	OC2	Female	58	Private caregiver

Note: All care recipients were identified as Level 3 recipients according to the ADL assessment. There was no cognitive impairment among care recipients. *Care recipients (RF9 to RF17) did not participate in the interviews due to their health circumstances. Caregivers OC1 and OC2 were excluded from the interviews because they were not family members of care recipients, but private caregivers recruited from the care market.

3.2 Other actors

Type	Position	Code
Care home A	Manager	CH1
	Care manager	N1
		N2
		N3
Insurance enterprise P	Manager	IE1
		IE2
		IE3
Government	Local government official	GO1

Appendix 4 Coding Frameworks

4.1 Care recipients

Theme	Code	Description
Care expectations from the state and the family	Current state's support	Attitudes towards the current support from the state (e.g., satisfaction and gratitude) and how they relate to individual care expectations
	One-child policy	Describe how the one-child policy impacts individual care expectations for the state's support
	Family values	Describe how family values (e.g., individual belief in filial piety and family tradition) shapes the individual's care expectations
	Gender role	How the gender role in care provision affects individual care expectations for the family
Reasons for choosing family care	Care alternatives	Whether any other alternative to family care provision is affordable for the family
	Available family care	Whether there are family members who can and are willing to provide care
	Care preferences	Individual preferences for receiving care at home, particularly from family members
	Family values	Describe how family values are taken into account in care decision-making
Changing family's role	Understanding of long-term care insurance	How individuals understand long-term care insurance and its policy outcome
	Financial support	Describe how the insurance reimbursement is seen as financial support for the family providing care
Policy expectations for long-term care	Financial support	Expectations for more financial support (including rising insurance reimbursement caps)
	Care support	Expectations for more care services provided outside the family
	No expectations	Describe why individuals do not have policy expectation

4.2 Part-time caregivers

Theme	Code	Description
Attitudes towards care responsibility division	Current state's support	Attitudes towards the current support from the state and how they relate to individual care expectations
	Higher care expectations towards the state	Reasons for why individuals have higher expectations of the state's support
Reasons for choosing family care	Care alternatives	Whether any other alternative to family care provision is affordable for the family
	Quality of care	The quality of care related to the care relationship between older people and the family
	Attitudes towards formal care	Attitudes towards the care provided beyond the family, particularly in the nursing home
	Attitudes towards gender roles	Attitudes towards caregiving responsibilities and caregiving between male and female members within the family
Reasons for providing long-term care	Family values	Describe how family values shape individuals care behaviours
	Intergenerational exchange	Describe how previous and current support from the older generation to the younger generation affects the younger generation's caregiving
	Positive returns from caregiving	Describe the possible positive returns of being a family caregiver
	Available family care support	Whether there are other family members who can provide care
Changing family's role	Financial support	Insurance reimbursement is interpreted as financial support for the family
	Increasing care support	Describe why and how family provides more care services
	Purchasing care services	Describe how the family's increasing financial capacity leads to the care purchasing
	COVID-19	Describe how family care provision was impacted during COVID-19
Future care plan	Care preferences	Describe individual care preferences between different options
	Expectations for the family	Describe the understanding of the adult children in providing care
Policy expectations for long-term care	Funding mechanism	Describe care expectations regarding funding care, particularly the higher insurance reimbursement cap
	Provision mechanism	Describe care expectations regarding providing care, such as support specifically for caregivers

4.3 Care homes

Theme	Code	Description
Involvement in long-term care provision	Role in providing long-term care	Describe how the care home plays its role in the long-term care provision mechanism
	Interplays with other actors	Describe how the care home works with the government and insurance enterprises
Family's role in long-term care provision	Care preferences	Describe how individual care preferences towards family care impact the family care provision
	Care alternatives	Describe how the lack of other care options led to the family providing care, considering the expenses
	Quality of care	The quality of care related to the care relationship between older people and the family
	Shortage of the workforce	Describe how the shortage of care labour force matters in local government development of family care

4.4 Insurance enterprises

Theme	Code	Description
Involvement in long-term care provision	Role in providing long-term care	Describe how the care home plays its role in the long-term care provision mechanism
	Interplays with other actors	Describe how the care home works with the government and care homes
Family's role in long-term care provision	Reasons for the care homes in developing family care	Describe why many care homes prioritise developing care provided by part-time carers
	Reasons for the local government in developing family care	Describe why the local government may develop care provided by part-time caregivers
	Quality of care	The differences between care provided by and outside the family

4.5 Local government

Theme	Code	Description
Reasons for developing family care	Shortage of the workforce	Describe how the shortage of care labour force matters in local government development of family care
	Financial capacity	Describe how the financial capacity of the local government impacts developing long-term care
	Advantages of family care	Describe the advantages of developing care in comparison with other types of care services
	Cultural values	Describe how cultural values are considered in developing the care provided by the family
Considerations of developing long-term care	Available workforce	Describe how the family can work as the available workforce in providing long-term care
	Family's role in providing care	Describe the family's role in providing long-term care with public insurance scheme

Appendix 5 Main Ethics Application Form

APPLICATION FOR ETHICAL REVIEW OF RESEARCH

Part 1: Overview of the research

1. Please provide details about the Principal Investigator (lead staff researcher or student).

Name	Jiayu Zhang
Course (students only)	Social Policy and Social Work
Supervisor (students only)	John Hudson, Sabrina Chai
Job title (staff only)	
Email address	Jz2101@york.ac.uk
Telephone	XXX (anonymised)

2. When do you expect the fieldwork to start and end?

Start Date: 01.09.21 End Date: 28.02.22

3. *For staff:* List any SPSW DEC member who might have a conflict of interest so should not act as reviewers for the project, such as those consulted in the development of the project, or close colleagues. *A list of members can be found in the Ethics for Research section of the Yorkshare VLE*.

N/A

4. What is the full title of the research project?

Cultural Change and Long-term Care in China: Transition of the Role of Family for Care Provision

5. Is the research funded? If so, please name the funding body(ies)

No

6. If the research is funded, does the funding source create any ethical concerns and/or actual or perceived conflicts of interest?
See section 4 "Funding" of the University's Code of practice and principles for good ethical governance

N/A

7. What are the research aims?

The primary aim of the research is to investigate the changing role of the family for care provision for the elderly in China, taking social values into account. Within this, there are several objectives, which are:
-To clarify the roles of the state and the family for supporting the elderly in China by exploring the current care schemes, especially the long-term care insurance scheme.
-To evaluate the changing social values related to the family's role in care provision for the elderly in China.
-To analyse the correlation between the changing social values and the care provided for the elderly in China.
-To explore how changing social values impact individual attitudes and choice of the care provision from the family and the state.
-To explore how the changing social values impact the care policy scheme, taking Guangzhou as a case study.
-To investigate how the changing care patterns of individual and institutional levels impact social values.

8. Please summarise the research methods, listing **each** research activity (e.g. focus groups, telephone interviews, online questionnaire etc)

This research will be conducted using quantitative research methods based on secondary public databases and qualitative research methods with interviews to capture more detailed data concerning the role of the family in caring for the elderly. (The quantitative element of the research uses archived secondary data only, so is not detailed in this application, as the guidance states this is outside the DEC review process, but I can provide further information if helpful).
The initial plan had been to conduct interviews face-to-face during a field trip to China, but ongoing travel restrictions and practical challenges in conducting interviews with vulnerable groups due to Covid-19 presented challenges. Having initially delayed the fieldwork planning in the hope that the situation would improve, it is clear now that face-to-face interviews will not be possible in the time scale for the PhD. Instead, it is proposed that interviews will take place via the social media app, WeChat, and by telephone.

I understand that there have been some concerns raised about the use of WeChat as a platform for data collection, so justify the choice here in detail. The WeChat interview will be the primary approach for collecting data for the following reasons:
-**Wide coverage in China**. WeChat is the most popular and widely used social media app in China, with its monthly active users of over 1.2 billion by 2020. WeChat is widely used in China, in much the same way as Facebook is used in the United Kingdom. It is routinely used for messaging, voice calls, and video calls for Chinese residents. Many older people contact their families by WeChat. Thus, it is practical for them to participate in the interview via WeChat on their own. This is important for my research project because many of the interviewees will be older people. Given that Guangzhou is one of the most prosperous cities in China, only a small number of people, even the elderly, have not had their own WeChat accounts. Thus, WeChat is very convenient for the potential participants.
-Accessibility for participants. Access to commonly used Western software for online interviews such as Zoom and Skype is restricted in mainland China. Thus, residents need to use a complex VPN route to access them. This is even more inconvenient for the older generations who are not so familiar with information technology. In addition, those getting access to the VPN need to pay the extra cost of doing so. Thus, the utilization of such software, including Zoom and Skype, may influence their willingness to join the project. WeChat is a more proper choice for conducting the interviews as it enables the participants to join the remote interview quickly and without additional cost to them.
-Convenient information sharing. Given the broad coverage of WeChat in China, I will share the information via links of QR codes on WeChat. The recruitment information, the information form, the consent form, and the cover letter will all be accessible. I will share the links and QR codes of the posts and documents (particularly the consent form and information sheet) with gatekeepers so that they could directly forward the information to potential participants (see Q13). Therefore, using WeChat would be convenient for all potential participants to search for more details about the research project before deciding whether they would be willing to participate in the interviews.
-Available incentive approach. Given that the participants live in mainland China, the commonly used incentive approach of other studies, the shopping voucher, cannot be used for them. Thus, this research will pay some participants (elderly and family members) with cash. Due to safety concerns, this will be paid through an online transferring function entitled “red pocket” by WeChat, which is widely used by Chinese people in daily life. It will be the most convenient approach for paying participants.

-No cost participation. Compared to participating in the interview via telephone, it is more preferential for potential participants to join the interview through WeChat. As the researcher is in the UK, it might be necessary for some of the participants to pay for international roaming when answering the phone for the interview, which might be a relatively high cost for them. Thus, some potential participants might not be willing to join the interviews if the interviews would be conducted via the telephone. Therefore, WeChat is an acceptable approach for them to take part in the project. However, the interview could also be organized via telephone if the participants prefer this mode of communication.
-Information safety. I understand that concerns around WeChat relate to the monitoring of content by authorities. This seems likely to be an issue relating to the monitoring of text messages on the platform in relation to politically sensitive topics and security-related issues. The interviews will be conducted via voice call on WeChat, whose content is difficult or even impossible to be detected technically. The interviews will be about the role of the family in care provision, so there will not be any politically sensitive issues mentioned. Thus, I believe there are no potential problems related to the information safety from interviewing via WeChat.

Participants of the interviews include the elderly gaining care from others, family members providing care for the elderly, professional carers from care institutions, representativeness of care institutions, and officials of related bureaus for the long-term care insurance scheme in Guangzhou. After the recruitment is completed, I will contact each participant to confirm the date and time of each interview and inform them of the procedures of the interviews. They will also be given the opportunity to raise queries about the interviews before the interview is conducted.

Participants will participate in a one-to-one interview via WeChat or telephone, depending on the participants' convenience. Each interview would typically last about 60 minutes. This research chooses to interview rather than the focus groups for two reasons: to ensure that the participant could share their own opinion without the potential influence from others given that the content of some interviews might relate to the relationship between the participants and their family members; to minimize the difficulty of interviewing arising from gathering the participants in the same place, especially ensuring social distancing due to the pandemic. Due to the restrictions of Covid-19, all the procedures of the interview will be conducted online. The researcher and the participants would take part in the interviews alone in two separate rooms.

Interviews will be conducted with a topic guide to ensure consistent collection of essential information needed for the project and to remind the researcher to conduct the interview properly with necessary procedures and cover all information needed.

Interviews will be recorded on an encrypted recording device, with the data being transferred to the University of York's secure file server as soon as possible. This would be the only copy of the audio file, and there will not be any copy stored on the recording device after the data is transferred.

The interviews will be transcribed by the researcher (being anonymized in the process).

The research will use Microsoft Word, Microsoft Excel, and NVivo to code and analyse the data.

9. Please briefly summarise the key ethical issues or risks that you have identified in this research.

There are standard ethical risks around the conduct of the research that I will address by following guidelines for good practice outlined by the DEC. I will introduce my research project to the potential participants in detail in their native language, explaining that all the data collected will be anonymized and will only be used for my PhD dissertation, related publications, or presentations. The participants' private information will be protected in each procedure, and all data will be coded and transcribed with anonymization. Participants will be informed that they could withdraw their data or terminate the interviews as long as they worry about personal privacy. I will also read all the content of the consent form for the participants and inquire whether they have understood the information and are willing to participate in the interview before it is conducted. This procedure will also be recorded on the encrypted recording device.

When recruiting the participants, particularly the elderly and their family care providers, I will identify each participant whether he or she could participate in the interview alone. Given that the interviews concern the care provided for the elderly, the elderly and their family members might feel upset or distressed when memorizing diseases or difficulties they are suffering. Before the interviews, I will inform all the participants that any information shared from the participants during the interviews will not be disclosed to any other participants. Participants will also be informed before the interviews that they could terminate the interview at any time without needing to give a reason. They may also feel upset when asked about the relationship with their family members. I will introduce my research project and some significant questions to the participants before the interviews, keep a close eye on the participants' emotions during each interview, and pause the interviews if I consider that they might need some time to release their emotions or calm down when observing participants' negative emotions. If there is any unexpected, continued degree of depression happening to the participants, I will also cautiously evaluate whether it would be necessary to turn to other questions or even terminate the interview in a gentle way.

Due to Covid-19, all the interviews will be conducted via WeChat or telephone, so it is vital to ensure that the participants take part in the interview in a quiet and separated room alone to avoid the risk of confidentiality compromised by the presence of others. The interview will be conducted via WeChat or telephone and may be that some participants, especially the elderly, might stay with their family members during the interview as they might need others to operate the electronic devices for participating in the interviews, or they may not live in a setting that makes it easy or possible for them to participate in a separate room, thus risking anonymity. To guard against this risk, I will inquire of each potential participant if there would be any risk of the participant being alone in a separate room to take part in the interview safely. This would be one of the criteria for selecting the participants for the interviews. I will address the necessity of taking part in the interviews alone via the consent form and information sheet and not start the interview until I ensure that the participants stay in a separate room to share their thoughts. The participants will also be informed that their answers will not be shared with any other, especially their family members.

Part 2: Research participants and activities

10. Please describe the research participants taking part in each activity listed in Q8.
If your study has explicit inclusion / exclusion criteria, please list them.

The research has specific inclusion criteria. All the participants must live in or work in Guangzhou, China. Criteria are different for each group of participants.
-**Elderly**: aged over 60; benefited from the long-term care insurance scheme; receiving care from others; able to express their thoughts; able to participate in the interview in a separate room alone.
-**Informal care provider**: aged above 18; providing care for his or her family member over 60; get paid by the long-term care insurance scheme.
-**Professional care provider**: aged above 18; hired by the care institutions; providing care for elderly in need.
-**Representative of the care institutions**: aged above 18; hired by care institutions delivering care for elderly who have benefited from the long-term care insurance scheme; have a clear understanding of Guangzhou's long-term care scheme implementation.
-**Official of related bureaus**: work at Bureau of the Civil Affairs or Bureau of Medical Insurance; participated in the policy design process or policy implementation of the long-term care insurance scheme of Guangzhou.

11. Approximately how many participants will take part in each activity listed in Q8.

The research aims to recruit 36 to 38 participants, and the sample size will be modified according to the data saturation.
The sample includes 15 elderly gaining care from others; 15 family members providing care for the elderly; 2 to 3 professional carers from care institutions; 2 to 3 representatives of the care institutions; 2 officials of related bureau for the caring scheme for the elderly.

12. If the research may involve 'vulnerable' populations or children, please describe the ethical challenges that arise and how these will be managed.
By 'vulnerable' we mean anyone disempowered and potentially susceptible to coercion or persuasion. This may include people vulnerable through social context (e.g. homelessness, poverty); through experiences (e.g. of trauma or abuse); through learning difficulties, dementia or mental health needs; or through other factors. Please also provide details of the relevant DBS checks and/or ISA registration that have been undertaken.

Elderly people receiving care will participate in the research, but the sample will not include people diagnosed with dementia or any other mental health issues.

Given that the elderly and their informal care providers might feel upset when recalling their memory about the difficulties they have experienced in daily life, I will pay close attention to the participants' emotions. As long as I find that they feel upset, I will evaluate if it is necessary to pause the interviews to have time to release their negative emotions and calm down before continuing the following section. If there is continued depression happening to the participants, I will consider changing to other questions or even terminating the interviews. They will also be informed that they could skip some questions or terminate the interviews without any reason.

13. Please describe how will research participants be identified, and who will be involved in the process?

Participants of the research project include the elderly, family care providers, professional care providers, and representatives of care institutions. I will contact them via the procedures below.
-Elderly and informal care providers: I will work on data research about the informal care development of the long-term care insurance scheme in Guangzhou from the data published on official websites. I will select four or five representative communities in Guangzhou considering the local aging situations in their administrative areas and the development of the long-term care insurance schemes (measured by the proportion of local elderly who benefited from the long-term care insurance scheme, especially those receiving informal care). These communities will be chosen as potential cases for the interviews. The contact information of the neighbourhood committees and the daily care centres of each community is accessible on the official government website. I will contact the staff of the corresponding communities to ask for help via telephone and email, introducing my research project. I will inquire with them about the implementation of the long-term care insurance in their communities, and ask them for help to share the links or QR codes of the posts of the recruitment information to the WeChat groups in their communities and hand out physical copies of information sheets to potential participants. I will ask these gatekeepers for help to forward the recruitment information directly to any potential participants. I will also emphasize in recruitment information that those interested in participating in the interviews should contact me directly via telephone or WeChat.
-Professional care providers and representatives of the care institutions: I will search the information about the care institutions providing long-term care for the elderly in Guangzhou via the information published on the official websites of the Bureau of the Civil Affairs and Bureau of Medical Insurance. I will then select three to four care institutions according to different criteria, such as the size of institutions, care types they provide, care coverage population, and communities they deliver care to. I will contact them via telephone according to the contact information available on their websites, introducing my research project. I will then ask them for help to share the WeChat posts of recruitment information to the WeChat groups of their care institutions. The gatekeepers I contact would directly forward the recruitment posts via WeChat instead of helping me identify any potential participants. Those who are interested in the interviews are supposed to contact me via telephone or WeChat directly.
-Officials of related bureaus: Given that the Bureau of the Civil Affairs and Bureau of Medical Insurance participate in the process of policy design and the implementation of the long-term care insurance scheme, I will identify the potential interviewees based on the available information published on the official websites and my previous research experiences. The email address announced on the official website is for public use instead of personal use in China. I have enquired about another Chinese PhD graduate who had done the fieldwork for his dissertation in China. And he used the similar way to conduct the interviews with ethics approval. I have also checked the GDPR about this issue, and there is no specific regulation or guideline about contacting officials for interviews. So I will contact the potential participants of officials via email.

Participants will be identified according to the criteria listed in Q10. And they will be recruited through the following routes:
1. Through text messages shared on the social media app, WeChat.
2. Through physical copy of information sheets handed in in the community care centres and care institutions.
3. Through emails from the researcher.

1. WeChat messages
Recruitment information will be shared via messages in WeChat groups. I will contact different target groups according to the contacts published on official websites to introduce my research project. Then I will share the links or QR codes of the recruitment information via WeChat or email to the gatekeepers I have contacted, asking for help to forward them to related WeChat groups. Anyone who is interested in participating in the interview could contact me directly via WeChat, telephone, or email. The messages are mainly for recruiting the elderly, their informal care providers, professional care providers, and representatives of the care institutions in Guangzhou.

2. Physical copy of information sheets
As I could not be back in China for face-to-face interviews due to Covid-19, I will also ask for help from some postgraduate students majoring in public administration from Sun Yat-sen University to hand out the physical copies of materials to potential participants in the home and community-based care centres and care institutions in Guangzhou. These postgraduates are local people and can speak and understand local languages and slang. I will introduce the research project to these students so that they can understand all the critical information of the project. I will provide proper training for them such that they understand how to identify potential participants of the research project. I will also follow up each procedure to ensure that their assistance would strictly follow the rules of the ethics committee. These physical copies of information sheets will target and be handed out to the professional care providers in care institutions.

3. Emails from the researcher
I will identify the potential participants from official bureaus according to the published information on the government official websites. I will contact them via the official emails published on official websites and send the recruitment information with the consent form and information sheet as the attachments. I will clarify to the recipients that all the data collected through the interviews are for academic purposes, and the participants would be anonymized. For officials, I will also send the draft data collected from their interview to the corresponding participant to review sensitive content, unless at the end of their interview they say this is not necessary, adding an additional layer for protecting their anonymity. They will have the right to withdraw from the research at any point up to and including the 14th day after the interview.

Once the target groups contact the researcher inquiring about the interview, I would clarify to the participants that participation is voluntary and confidential and introduce the research to them in detail, including the research aim, research process, data protection, and ethical issues. I would provide the consent form and information sheet as attachments via email to the participants before the interviews. I would also ask for consent from the participants by introducing the consent form and information sheet content and asking for permission to start the interview before conducting the interview. The interview would be recorded with the consent of the participants.

All the messages and emails would be in Chinese, and the English versions are as below. One of my supervisors is native Chinese, and she has already checked and confirmed the Chinese translation of the messages and email.

The text message to potential participants of the elderly and the informal care providers will be as follows:

Dear All. I am a PhD student at the University of York conducting a research project entitled Cultural Change and Long-term Care in China: Transition of the Role of Family for Care Provision. I am looking to interview people aged above 60 receiving cares from others (family members or professional carers from care institutions) and adults providing care for their older family members who benefited from the long-term care insurance scheme in Guangzhou. Each participant will be paid ¥50 via online transfer. If you are willing to participate in a 60 minutes

interview at a time convenient for you via WeChat or telephone, please contact me directly on XXX (Telephone number & WeChat) (Considering the department policy about not giving out personal mobile phone numbers when contacting research participants and personal safety protection, I will apply for a new number for the interview from the department before the fieldwork begins. The number will be added to the information sheet later). Please see more details via the service account on WeChat. Your participation would be very gratefully received. Please also feel free to contact me with any inquiries about the research. Thank you very much.
-Jiayu Zhang

The text message to potential participants of professional carers and representatives of care institutions will be as follows:

Dear All. I am a PhD student at the University of York conducting a research project entitled Cultural Change and Long-term Care in China: Transition of the Role of Family for Care Provision. I am looking to interview the carers (institutional care or home and community-based care) and representatives of care institutions familiar with the implementation of the long-term care insurance scheme in Guangzhou. If you are willing to participate in a 60 minutes interview at a time convenient for you via WeChat or telephone, please contact me directly on XXX (Telephone number & WeChat). Please see more details via the service account on WeChat. Your participation would be very gratefully received. Please also feel free to contact me with any inquiries about the research. Thank you very much.
-Jiayu Zhang

The paper sheets to potential participants of professional carers and representatives of care institutions will share the same information as the above text message.

The email to potential participants of officials will be sent with the cover letter attached. And the content of the email will be as follows:

Subject: Interview invitation about the long-term care insurance scheme in Guangzhou-Research Project with University of York

Main email:

Dear [name/job title]

I am a PhD student at the University of York, United Kingdom, and I am also a graduate of the School of Government, Sun Yat-sen University in 2019. My PhD research project is entitled Cultural Change and Long-term Care in China: Transition of the Role of Family for Care Provision. My project is supervised by Prof. John Hudson and Dr. Sabrina Chai.

I am sincerely inviting you to participate in this research and share your understanding of the implementation of the long-term care insurance scheme in Guangzhou, particularly the informal care delivered by family carers. Please find attached the information sheet and consent form of the research project. The interview would be 60 minutes at a time convenient for you via WeChat or telephone. All the data would be confidential and anonymized, and they will only be used for academic research. I am aware that your position as an official in government may require additional sensitivity in the use of direct quotations from an interview with you. Consequently, after the interview I will send you the data you share from your interview to ask for consent for the use of any direct quotations in my PhD dissertation and will not use any quotations you do not consent to the use of. In addition, you also have the right to withdraw from the research at any point up to and including the 14th day after the interview. Your participation would be very gratefully received.

Please also feel free to contact me with any inquiries about the research. I would share the information sheet and consent form online for you for your reference.

Thank you very much.

Kind regards,
Jiayu Zhang

Part 3: Choosing whether to participate

14. Please describe the process by which prospective participants will receive information about the research, including who will provide information, when and how.
If a different process will be used for different participants or different activities, please describe each separately.

Those interested in participating in the research will be invited to contact me for further introduction to the research project. Potential participants identified through the messages shared on WeChat or physical copy of the information sheet will get access to the information sheet and consent form shared on WeChat. Those recruited via email would receive these materials as attachments with the recruited email. Potential participants would be introduced to the information at least a week in advance of the planned interview date. They would also be informed of the content of the information sheet and consent form verbally before the interview. The process of asking for consent will be recorded. Participants recruited through email will receive the information sheet via email.

The interviews will be arranged on a date and time convenient for them if they are willing to participate. Each participant will be informed of the content of the consent form and information sheet before the interview. They will also be informed that they could terminate the interview at any time.

15. Please describe how prospective participants will give their consent to the research.
If a different process will be used for different participants or different research activities, please describe each separately.

The consent form would be shared via WeChat, and all participants would get access to it before the interviews a week in advance of the planned date of the interview. I will also send the consent form as an attachment to those who are recruited via email. Before each interview, participants will be introduced to the content of the consent form and information sheet verbally. They will also be inquired whether they have any questions about the coming interviews. The consent will be clarified verbally by inquiring whether the participants are willing to continue with the interview. This process will be recorded with the consent of the participants. The audio recording about the consent of participating in the interview will be kept after the end of the interview (see Data Information Sheet)

16. If you do *not* envisage providing an information sheet and/or obtaining a signed (or audio recorded) record of consent, please justify and explain the measures taken to compliance with data protection legislation.

N/A

17. If research participants are to receive any payments, reimbursement of expenses or other incentives for taking part in the research, please give details.

Elderly participants and informal carers will be offered cash benefits via the online transfer function of 'Red Packet' in WeChat after the interviews. Each of them will be rewarded ¥50 (approximately £5.50) per person. It will be self-funded by the researcher.
The professional careers, representatives of care institutions, and officials would not accept any benefits or incentives for participating in the interviews.

Part 4: Research activities

18. Please describe what participation in each research activity involves (e.g. what activities, how often / for how long, with whom, in what setting)?

The interview will be one-to-one via WeChat or telephone. This will be a single interview instead of being conducted in more than one part unless unforeseen circumstances such as the participants receiving an expected call or requesting to pause the interview. The interview will generally last about 60 minutes. The participants will be advised to participate in the interviews in a separate and quiet room alone. I will also organize the interviews in a separate room alone and not begin the interview before ensuring that the participants are ready for the interview.

19. Please provide a summary of the headings you will use in any research instruments eg topic guide / questionnaires.
You should ensure that these headings are included within the Participant Information Sheet

Topics for different types of participants are as below.

The following topics will be covered in the interview for the elderly:
-The care received from others.
-The choice of care type and the reasons.
-The thoughts about the advantages and disadvantages of the care type they are applying
-The attitudes towards family values, such as the attitudes towards the role of the family for care provision, the care provided beyond the family, and intergenerational contract.
-The future plan for the care arrangement and the reasons.

The following topics will be covered in the interview for the informal care providers:
-The care they are providing to their family members.
-The reasons why they provide care for their family members.
-The thoughts about the advantages and disadvantages of informal care for the elderly.
-The difficulties they faced when providing care for their elderly family members.
-The attitudes towards social values, especially the family values about the family supporting the elderly.
-The future plan for the care type of the older family members and the reasons.

The following topics will be covered in the interview for the professional care providers:
-The care they are providing to the elderly and their experiences of providing care.
-The opinions of the family values of the elderly they were or are providing care to.
-The thoughts about the advantages and disadvantages of formal care and informal care.
-The difficulties they faced when providing care for the elderly.
-The thoughts about the implementation of the long-term care insurance scheme in Guangzhou.

The following topics will be covered in the interview for the representatives of the care institutions:
-The care the institutions are providing to the elderly.
-The experiences of getting along with the elderly in the care institutions.
-The opinions of the family values of the elderly they meet in the care institutions.
-The thoughts about the advantages and disadvantages of formal care and informal care.
-The thoughts about the implementation of the long-term care insurance scheme in Guangzhou.
-The thoughts about the future development of the long-term care insurance scheme in Guangzhou.

The following topics will be covered in the interview for the officials:
-The thoughts about the implementation of the long-term care insurance scheme in Guangzhou.
-The thoughts about the changing social values, particularly the family values in Guangzhou.
-The thoughts about the consideration for the policy design with the consideration of family values.
-The thoughts about the future development of the long-term care insurance scheme in Guangzhou.

These are general topic guides and will be refined as the research progresses, with more specific questions being formulated under these headings. The interviews will be piloted and refined again based on the data collected.

20. Do you think research participants may be distressed by their involvement in the research? If so, what action will you take to mitigate these?

Although I will carefully identify and select the participants when recruiting the interviews, the participants from the elderly and the informal care providers groups may feel distressed or upset during the interview when memorizing the experiences related to conflicts with their family or even domestic violence.

In addition to introducing the research project and the topics that might be mentioned in the interview to these potential participants when recruiting them, I will provide the information sheets to the participants in advance so that they could have a clear picture of what they might be asked during the interviews. Before the interviews, all participants will be informed that they could pause or terminate the interview at any time, including if they are distressed.

During each interview, I will pay close attention to the participant' emotions. If I observe the participants feeling upset or depressed, I will cautiously consider whether it is necessary to pause the interviews so that the participants could have time to calm down before continuing the interviews. I will also consider adjusting the questions asked accordingly. If the interviews are paused, they will not be resumed until the participants feel comfortable to take part. I will even terminate the interviews if I notice that the participants cannot continue the interviews with unexpected continuing negative emotions even if they do not request that.

Participants will be informed via the consent form indicating that "I understand that if the researcher thinks that I or someone else might be at risk of harm, they may have to contact the relevant authorities. But they will try and talk to me first about the best thing to do". I will communicate with them if I think that they are in harmful situations and need further support. I will also ask for advice from my supervisors if needed.

21. Is any element of the fieldwork taking place outside the UK? If so, you should refer to the University of York 'Guidance on conducting research outside the UK' and paragraph 2.13 of the Code of practice and principles for good ethical governance and explain how you will take account of political, social and cultural sensitivities.

The participants include the elderly, family care providers, professional care providers, and representatives of care institutions. The research will not collect data related to political and social sensitives issues, given that the research focuses on the family's participation in the care provided for the elderly. Participants will also include officials from related bureaus in Guangzhou, but the interview for them will focus on the implementation of the long-term care insurance scheme but not any issues concerning the political and social sensitives.

There is no specific ethics approval requirement issued from the Chinese government for conducting the interviews in Guangzhou for the potential participants in the research project. In 2018, I interviewed elderly living in care institutions or their own homes and staff of care institutions in Guangzhou for the research projects supervised by Dr Jack Chan from Sun Yat-sen University, China. The research project had been conducted without any application for ethics approval required. Also, I conducted a research project supervised by my supervisor, Prof. Shen Shuguang from Sun Yat-sen University, for the master's dissertation in Guangzhou in 2019. I interviewed the officials of the Bureau of Medical Insurance in four cities in Guangdong Province (including Guangzhou). No specific application for ethical approval was needed for these research projects. I have confirmed with both Dr Jack Chan and Prof. Shen Shuguang that there have not been any new published rules or regulations about the requirements for ethics approval for conducting research projects for these participants since then. Thus, it is not necessary for this research project to apply for ethics approval for conducting interviews in Guangzhou.

Although cultural issues will be a concern for this research project as the research focuses on the changing social values related to the family and the role of the family in supporting the elderly, the interviews will be semi-structured, and I will also outline the open question lists for the interview. Furthermore, cultural issues mentioned in the research are majorly about family values, including familism, the intergenerational contract, and gender role attitudes. I will inform the participants about questions related to the cultural topics before interviewing them so they can prepare for it. They will also be informed that they could refuse to answer some questions that troubled them or even terminate the interview if they feel offended by the questions.

I am a native Chinese and have lived in China for 25 years, and I am also a local Cantonese. Thus, I am very familiar with the Chinese social and cultural norms, especially those in Guangzhou. I will not put forward any sensitive issues against the well-accepted custom and norms during the interview. Also, the interview will be conducted in Cantonese for the local Guangzhou residents to get closer to the participants, particularly the elderly. I will start the interview with some daily issues, such as their daily routines and habits in daily life, to gain their trust. In addition, I will avoid sensitive issues for the elderly during the interviews. For example, death is always a taboo topic, especially for the elderly in China. However, when discussing the care provided for the elderly, it is unavoidable to ask them the plan for the elderly's care provision if they suffer from severe diseases in the coming future. Thus, questions related to death will only be mentioned tactfully at the end of the interview instead of directly discussing the issues with them. I will also adjust the question depending on my judgment of each participant's situation during the interview.

I have prior experience in conducting interviews with different groups. I have organized interviews with participants, including the elderly and their families, in Mandarin or Cantonese, since 2014.

As an undergraduate and then MA student, I participated in more than 20 research projects. The interviews I have participated in are mainly about elderly care and long-term care insurance. The interviews were mainly face-to-face and via telephone calls. They were conducted for the elderly (in different health conditions), their family members (including informal care carers), social workers, professional carers, doctors, nurses, managers of the care institutions, home and community-based care centres, officials from different departments at various levels (provincial level, municipal level, prefecture-level, township-level, and village-level). Therefore, I have experience of handling interviews for various target groups by summarizing the communication skills to grasp the essential information points by the limited time interview with participants from diverse social and cultural backgrounds. Although I have not ever conducted remote interviews via WeChat before, I have participated in some training courses organized by White Rose Doctoral Training Partnership about conducting online interviews during the post-Covid-19 period. I am confident that I could carry out the interview online.

Part 5: Data processing and protection

***Please note**: all applications include a completed Data Management Plan. You should refer to the University's guidance on Research Data Management*

22. State any promise you will make to participants about how their data will be used, including in publications and dissemination, for example whether names, job titles, or direct quotations will be used, and state what protection of anonymity you are offering.
    Please be aware of your Funder's requirements for data to be made available for reuse. If your funder does not have a policy, the University Research Data Management Policy should be followed. This states: 'Where possible, relevant elements of research data must be deposited in an appropriate national or international subject-based repository, according to their policies. Data should be kept by the researcher in an appropriate manner when suitable subject repositories are not available.'

Participants will have the right to withdraw from the research at any point up to and including the 14th day after the interview (e.g., for interviews conducted on 01.09.2021, participants can withdraw at any point up to and including 15.09.2021). 'Withdraw' refers to the data being withdrawn from the research and securely destroyed. Their involvement with the research project will end at this point.

Data will be stored securely. The interview will be recorded as an audio file on my encrypted recording device. The file will then be transferred to the University of York's secure file server at the earliest opportunity. This will be the only copy. The recording will be securely deleted when the research project is finished.

All other files related to the participants' data will be stored on my personal file space on the secure University of York file server. The audio recording will be transcribed, and any information related to individual privacy will be anonymized. Each participant will be assigned an ID. As different groups of participants will be invited to my research. They will be assigned with a specific identity, such as "Elderly participant 1" for the elderly, "Informal carer participant 1" for the family members providing care, "Carer participant 1" for care providers from care institutions, "Representative participant 1" for those managing the institutions, and the "Official participant 1" for the official from related bureaus.

Direct quotations from the participants may be used in the final research paper. They will be paraphrased to ensure that anonymity is maintained if they contain any distinctive phrases. Participants will be informed about that before the conduct of the interviews. If they disagree with this, I will discuss with them to ensure they understand that all the information collected would only be used for academic purposes, and they would not be identified with the anonymization. The quotations will not be directly used without the consent of the participants.

If participants agree to this in the consent form, anonymized data will be archived for further research. Data will be withdrawn if the participants disagree after the communication with the researcher. Recording related to the consent from the participants will be retained for three years from the end of the research. The anonymized transcripts will be retained for ten years from the last requested access. Data will be archived securely on the University of York's file server, and the University of York will manage requests for access (to the anonymized transcripts only).

23. What will you do if information is disclosed to you that legally requires further action or where further action is advisable?

Before the interview, all participants will be informed of the consent form indicating that "I understand that if the researcher thinks that I or someone else might be at risk of harm, they may have to contact the relevant authorities. But they will try to talk to me first about the best thing to do". Some participants might share information about illegal or harmful behaviours, such as domestic violence within the family and corruption in the care institutions. Even if these participants have not realized these behaviours are against the law, I will discuss with them if any other legal requirement is needed after the interview, according to my judgment. I will also ask for advice from my supervisors for further action following the safeguarding procedures. If I believe that the illegal behaviours mentioned in the interviews might do harm to the participants, I will try to introduce the professional support they might need to them, such as psychological support from social workers. This will be addressed in both the information sheet and the consent form.

24. GDPR Declarations (please check box to confirm)

X I have considered whether any personal or special category data being collected is the minimum necessary to answer the research question(s)

X I have considered anonymising or 'pseudonymising' data to mitigate data protection risks.

X I have considered whether I need to consult with the Information Governance Office (e.g. where sharing data with third parties outside the university)

X I have considered whether the study requires a Data Protection Impact Assessment (see here)

25. Are there any other specific ethical problems likely to arise with the proposed study? If so, what steps have you taken or will you take to address them?

N/A