International Journal of
Active & Healthy Aging

e-ISSN :3023-6045
https://ndpapublishing.com/index.php/ijaha

The Role of The Family in Elderly Care

Sorina Corman*[1] **and Dana Zamfirescu-Mareș**[1, 2]

[1]*University Lucian Blaga of Sibiu, Faculty of Social Sciences and Humanities, Romania*
[2]*West University of Timisoara, Doctoral School of Philosophy, Sociology and Political Sciences, Social Work Domain, Romania*

Article Info
Received: 19 November 2025
Revised: 01 December 2025
Accepted: 08 December 2025
Published: 30 December 2025

Keywords
Family Care
Elderly
Informal Caregiving
Social Support
Quality of Life

ABSTRACT

Purpose: This study explores the role of the family as the primary source of support in elderly care, focusing on its impact on older adults' well-being, quality of life, and social inclusion, as well as the challenges faced by family members in fulfilling caregiving responsibilities. **Method:** The paper is based on a narrative literature review of recent theoretical and empirical studies, international reports, and policy documents, using a conceptual framework drawn from the sociology of ageing, family studies, and social policy analysis. **Findings:** The analysis shows that family care encompasses emotional, social, physical, and economic dimensions that are essential to maintaining autonomy and dignity in later life. While consistent family involvement enhances psychological resilience and social participation among older adults, caregiving is also associated with financial strain, time constraints, and emotional exhaustion for family members particularly women. In contexts such as Romania, where institutional care remains limited, families compensate for systemic gaps, resulting in a highly familialized care regime. **Conclusion:** The family remains a key actor in elderly care; however, its effectiveness depends on the availability of formal support mechanisms and public policies that recognize and assist caregivers. Strengthening both family resources and institutional frameworks is necessary to ensure a balanced, sustainable, and inclusive caregiving model in ageing societies.

1. INTRODUCTION

The accelerating demographic transition toward an ageing population constitutes one of the most profound social transformations of the twenty-first century. The United Nations identifies population ageing as a defining global trend with far-reaching implications for economic productivity, intergenerational relations, and the sustainability of care systems [1]. Within this context, the family as a relational and moral institution retains a pivotal position in mediating the everyday experience of ageing. While policy frameworks increasingly advocate for integrated and community-based long-term care, empirical evidence consistently demonstrates that the family remains the cornerstone of both formal and informal support for older adults [2,3].

The UN Decade of Healthy Ageing (2021–2030) reframes ageing as a dynamic process influenced by individual trajectories, social determinants, and environmental structures. It emphasizes the enhancement of intrinsic capacity and functional ability, rather than the mere prolongation of life [3]. Parallel to this normative shift, the European Union's 2022 Care Strategy underscores the dual imperative of ensuring dignified ageing and supporting the growing number of family caregivers who sustain national welfare systems through unpaid, gendered labour [4].

Demographic data reinforce the urgency of this debate: as of January 2024, individuals aged 65 years and older represented 21.6% of the EU population, compared to just 16% in 2004 [5]. Population ageing is projected to substantially increase the burden placed on family caregivers in Europe over the coming decades, intensifying demands on households and care systems alike [6]. This demographic inversion is placing increasing pressure on social protection systems, healthcare services, and family networks, particularly in Central and Eastern Europe, where formal care infrastructures remain fragmented. In Romania, for instance, despite ongoing policy reforms such as the National Strategy on Long-Term Care and

***Corresponding author**

e-mail: sorina.corman@ulbsibiu.ro
ORCID ID: 0000-0002-7841-732X

How to cite this article

Corman, S., & Zamfirescu-Mareș, D. (2025). The Role of the Family in Elderly Care. Int. J. Act. Health Aging, 3(2), 98-111.

Review Article/ DOI: 10.5281/zenodo.18017100

Active Ageing 2023–2030 family-based care continues to represent the dominant form of support for older persons, often compensating for limited institutional availability and uneven territorial coverage [7].

Scholarly literature conceptualizes family care as a multi-layered social practice, simultaneously grounded in moral obligation, emotional reciprocity, and structural constraints [8,9]. Informal caregivers provide substantial amounts of unpaid labour estimated at 70–80% of all long-term care hours in Europe yet they frequently experience role strain, economic vulnerability, and psychosocial exhaustion [10,11]. Long-term care systems across Europe are increasingly challenged by rising demand, workforce shortages, and insufficient integration between health and social care sectors [12].These tensions reveal a paradox: while the family constitutes the first line of defence against exclusion and dependency in old age, it is also increasingly exposed to the very risks it seeks to mitigate.

Against this backdrop, the present literature review seeks to critically synthesize theoretical and empirical contributions published between 2020 and 2025 concerning the role of the family in elderly care. Specifically, it aims to: (a) elucidate the multidimensional impact of familial involvement on older adults' well-being and quality of life; (b) examine the socio-economic and gender-related burdens that constrain caregiving capacity; and (c) identify policy mechanisms capable of reconciling private responsibility with collective welfare.

By adopting a comparative European lens and situating the Romanian experience within broader continental dynamics, this paper contributes to the ongoing debate on care justice, intergenerational solidarity, and the sustainability of ageing societies. Conceptually, it integrates perspectives from the sociology of ageing, family studies, and social policy analysis to propose an interpretative framework in which family care is not a residual function of welfare retrenchment, but rather an integral component of a reconfigured, multi-actor care ecosystem.

2. THEORETICAL AND CONCEPTUAL BACKGROUND

2.1. From Biomedical to Socio-Ecological Conceptions of Ageing

For much of the twentieth century, ageing was primarily conceptualized through a biomedical lens, focusing on functional decline, morbidity, and the management of chronic conditions. Within this paradigm, older adults were positioned as passive recipients of care, while the family was regarded as an auxiliary health agent a private extension of the formal system. The paradigm shift initiated by the World Health Organization's (WHO) Active Ageing Framework and consolidated through the UN Decade of Healthy Ageing (2021–2030) reoriented this understanding toward a socio-ecological model [3]. Ageing was reframed as a lifelong process determined not only by biological factors, but also by the interaction between personal capacities, social networks, environmental supports, and policy frameworks.

The WHO's concept of functional ability defined as the interaction between intrinsic capacity and the surrounding environment serves as the cornerstone of this shift. Within this framework, the family emerges as a central socio-environmental determinant of health, providing affective, instrumental, and moral resources that sustain autonomy and identity in later life [13,14]. Rather than functioning as a residual safety net, the family constitutes a moral ecology of care, shaping the daily micro-contexts through which ageing is experienced and negotiated.

This socio-ecological turn aligns with broader transitions in the human development and capability paradigms, particularly the work of Sen and Nussbaum [15,16], which redefined well-being as the expansion of people's real freedoms to pursue valued life activities, viewing ageing through the lens of capability implies that older adults' flourishing depends less on the absence of disease and more on the availability of enabling relationships and environments. In this sense, the family functions both as a site of empowerment through emotional affirmation and practical assistance and as a potential constraint, when overprotective or coercive dynamics limit personal agency [17].

The shift toward a socio-ecological conception of ageing therefore introduces a dual expectation for families: to protect, but also to promote autonomy. Research indicates that intergenerational interactions that affirm competence and mutual respect foster psychological resilience and subjective well-being among older adults [18]. Conversely, familial overdependence can produce "care paradoxes," where excessive assistance undermines self-efficacy and accelerates functional decline [9]. Thus, the family occupies a liminal position serving simultaneously as an arena of solidarity and negotiated autonomy, a relational sphere where vulnerability and empowerment coexist.

By repositioning the family within the ecology of ageing, this theoretical shift challenges traditional welfare dualisms between formal and informal care. It highlights the need to conceptualize care not as a binary (state versus family), but as an interdependent continuum in which each domain reinforces the other. This recognition provides the foundation for rethinking family caregiving as part of the social infrastructure for ageing well, rather than as an informal substitute for formal systems.

2.2. Family as a Relational and Institutional Actor in Late Life

Beyond its biological and demographic functions, the family constitutes a normative and relational institution that mediates social reproduction, identity continuity, and emotional belonging across the life course. Classical sociological theorists such as Durkheim and Parsons viewed the family as a moral nucleus ensuring social cohesion through role integration and affective regulation [19,20]. In contrast, late-modern perspectives, particularly those influenced by Beck and Giddens, interpret family relations as products of reflexive choice and negotiated intimacy, embedded in fluid networks rather than rigid hierarchies [20,21]. This transition from the institutional family to the relational family mirrors the broader transformation of care from obligation to negotiation.

Within gerontology, the family systems theory [22] and ecological models of human development [23] provide analytical tools to understand how family structures and interpersonal processes influence ageing outcomes. These frameworks conceptualize the family as a complex adaptive system in which interdependent subsystems-spousal, filial, sibling-respond to the challenges of later life transitions such as retirement, widowhood, illness, or dependency. The capacity of a family to adapt to these transitions depends on its relational flexibility, communication patterns, and the permeability of its boundaries to external support systems [24].

Family caregiving, in this view, transcends the functionalist notion of duty and becomes an interactive process of meaning-making. Empirical studies demonstrate that caregiving relationships are shaped not only by necessity but also by symbolic and emotional investments what Finch and Mason [25] called the moral negotiations of care. These negotiations are influenced by social class, gender, cultural expectations, and institutional context. For instance, in societies with strong familialist welfare regimes, caregiving is embedded within normative discourses of filial piety and interdependence, whereas in liberal welfare regimes it may be framed as voluntary altruism [26].

From a psychological perspective, the caregiving relationship can also be seen as an intergenerational feedback system: caregiving for parents often reactivates earlier attachment patterns and life-course memories [27]. This continuity explains why the quality of early parent-child relationships predicts the likelihood and intensity of later life support. In this sense, caregiving both reproduces and transforms familial bonds, making the act of care simultaneously retrospective and prospective-a bridge between past obligations and future moral legacies.

However, the family's dual nature as both a relational and institutional actor introduces inherent tensions. While its intimacy enables empathic care, its embedded hierarchies may also perpetuate power asymmetries and emotional strain. Contemporary scholars increasingly describe the family as a care regime in miniature [28] -a microcosm reflecting the same inequalities and normative contradictions that characterize the broader social order. The gendered distribution of labour, generational authority, and socio-economic resources all mediate the quality and sustainability of caregiving. Thus, understanding the family's role in elderly care requires not only a functional analysis of support transactions but also a critical interrogation of its internal power dynamics, its moral economies, and its capacity to balance dependence with dignity.

2.3. Intergenerational Solidarity, Ambivalence, and the Moral Economy of Care

The study of intergenerational relations has long occupied a central position in the sociology of ageing, illuminating the ways in which social cohesion and continuity are maintained within families across time. Among the most enduring conceptual frameworks is Bengtson and Roberts' theory of intergenerational solidarity [29], which identifies six analytical dimensions affectual, associational, consensual, functional, normative, and structural that explain how families sustain connectedness and mutual support over the life course. Within this model, solidarity represents both an emotional bond and a patterned exchange system, balancing intimacy with obligation.

However, subsequent scholarship has questioned the idealized harmony implied in the solidarity construct. As Lüscher and Pillemer [30] argue, intergenerational relationships are often characterized by ambivalence the coexistence of affection and tension, altruism and resentment. The notion of intergenerational ambivalence reintroduces the idea that care is never a purely altruistic act but a site of negotiation where competing moral, emotional, and structural forces intersect [31]. Ambivalence, rather than undermining solidarity, becomes a constitutive feature of late-modern family life: it reflects the effort to reconcile contradictory imperatives such as autonomy versus dependency, equality versus hierarchy, and care versus self-determination.

In this regard, the family operates as what Finch and Mason [25] termed a moral economy of care, where decisions about who cares, how much, and under what conditions are mediated by implicit norms of fairness, reciprocity, and relational justice. These moral negotiations are neither fully voluntary nor wholly coerced; they emerge from the interplay between emotional intimacy and social expectation. For instance, the adult child's sense of duty toward an ageing parent often intertwines affection with cultural scripts of obligation, producing care as both a moral imperative and a relational burden. As Tronto [32] has emphasized in her political ethics of care, such negotiations reveal care not merely as a private sentiment but as a form of citizenship practice an activity through which moral and civic identities are constituted.

Empirical studies further suggest that the directionality and intensity of intergenerational exchanges vary according to social context and welfare regime. In the Nordic countries, where comprehensive long-term care services are publicly provided, family involvement tends to emphasize emotional and social support, aligning with a model of complementary solidarity [11]. By contrast, in Southern and Eastern Europe, where familialist norms prevail and public provision remains limited, functional and financial support dominate, creating what scholars describe as substitutive solidarity [26]. Romania exemplifies this pattern: while family ties remain strong, the limited institutional infrastructure compels households to internalize the bulk of care responsibilities, often at the expense of caregivers' employment and mental health.

The ambivalence embedded in these exchanges is not simply psychological but structurally produced. Socioeconomic inequalities, migration, and labour-market pressures generate divergent capacities for caregiving within and between families. When the ability to provide care depends on the availability of time, income, and proximity, solidarity risks becoming a selective privilege rather than universal obligation [33]. Thus, intergenerational solidarity in contemporary societies must be reinterpreted through the lens of care justicea concept that links family dynamics to macro-level distributions of resources and responsibilities [34].

Moreover, the increasing longevity of contemporary populations expands the temporal horizon of intergenerational relations. Families are now composed of four or even five living generations, giving rise to complex patterns of upward, downward, and lateral transfers [8]. This longevity revolution challenges traditional hierarchies of reciprocity: whereas in earlier cohorts parents provided lifelong support to children, today adult children and grandchildren often sustain prolonged phases of care for multiple elders simultaneously. The moral economy of care thus becomes intergenerationally stretched, creating overlapping obligations that strain both emotional and material capacities.

From a cultural perspective, intergenerational solidarity also reflects the evolving meanings of ageing and dependence. In post-industrial societies that emphasize autonomy and self-realization, accepting help or providing care may carry ambivalent moral connotationsalternatively valorised as love and stigmatized as burden [9]. Consequently, the social representation of caregiving oscillates between heroism and sacrifice, producing inconsistent recognition of its social value. This ambivalence underscores the need to reframe caregiving not as a private act of devotion but as a collective social function deserving institutional support and public validation.

In sum, theories of intergenerational solidarity and ambivalence reveal that family caregiving operates within a moral, affective, and political field. Solidarity provides the normative glue that binds generations together, while ambivalence captures the emotional and structural contradictions of care in late modernity. The moral economy of care, in turn, situates these tensions within a broader framework of social justice, inviting policymakers to view familial care as a shared responsibility that must be recognized, compensated, and integrated into comprehensive welfare architectures.

2.4. Gendered Care, Informal Labour, and the Care Diamond

The gendered organization of care is one of the most enduring and contested features of contemporary welfare societies. Feminist scholarship has long argued that the social division of care labour whereby women perform the majority of unpaid domestic and caregiving work constitutes both a form of structural inequality and a mechanism of welfare-state reproduction [35]. Financial strain represents a critical predictor of psychological distress among family caregivers of older adults using long-term care services [36]. As demographic ageing amplifies the societal demand for long-term care, the persistent feminization of caregiving exposes deep tensions between economic participation, gender equity, and social sustainability. Gender inequalities in caregiving remain substantial across European long-term care systems, with women providing significantly more informal care regardless of national public spending levels on care services [37].

Within this theoretical landscape, Razavi's [38] Care Diamond model provides a heuristic framework for analysing how care responsibilities are distributed across four key institutional domains: the family/household, the market, the state, and the community. Each vertex of the diamond represents a locus of care provision, and the balance among them determines the inclusiveness and sustainability of care systems. In welfare regimes where the state withdraws from direct provision, the diamond becomes asymmetrical, forcing families and particularly women to absorb the resulting deficit. Conversely, when public services and community networks are robust, care becomes a shared and socially recognized function rather than a private obligation.

Empirical research confirms that across OECD and EU member states, approximately 70 to 80 percent of long-term care hours continue to be provided informally, mostly by female family members [2]. This pattern, often referred to as the "care gap," reflects both economic rationality and cultural inertia: unpaid family care remains the invisible infrastructure underpinning formal health and social protection systems [39]. Despite its substantial social and economic value estimated at 2 to 4 percent of GDP in some European contexts it remains underrecognized in national accounts and policy design. The economic value of informal adult care in Europe remains largely unrecognized, despite its substantial contribution to social welfare systems and household well-being [40].

The gendered asymmetry of caregiving generates a series of interlocking disadvantages known as the care penalties [41]. These include interrupted employment trajectories, reduced lifetime earnings, lower pension entitlements, and heightened risk of poverty in old age. Moreover, the psychosocial dimensions of care emotional exhaustion, social isolation, and chronic stress disproportionately affect women caregivers, creating a gendered gradient in health and well-being [42]. A recent systematic review confirms that informal long-term care in Europe continues to be predominantly provided by women, reflecting persistent structural and cultural gender inequalities [43]. Female caregivers consistently report higher levels of physical and emotional burden than men when caring for community-dwelling older adults [44]. The persistence of these patterns reflects what feminist political economists identify as the commodification paradox: while care is increasingly commodified through market provision, its devaluation as unpaid "women's work" endures [34].

The intersection of care and labour markets further complicates the picture. Globalization and migration have generated transnational "care chains," whereby women from lower-income countries, including Romania, provide paid care in Western Europe while delegating their own family responsibilities to relatives or hired helpers at home [45,46]. This global care economy externalizes inequalities across borders, reproducing a hierarchy of dependency that links micro-level family practices to macro-level labour structures. The emotional costs of such arrangements long-term separation, guilt, and fractured family bonds illustrate how the gendered logic of care extends beyond the household to shape global social reproduction.

Within European policy domain, efforts to rebalance the care diamond have gained momentum through the European Care Strategy and the Barcelona targets on childcare and long-term care [4]. These initiatives advocate for a rights-based approach to care, emphasizing both the recognition of informal caregivers and the expansion of high-quality, affordable formal services. They also encourage the adoption of flexible work arrangements, paid care leave, and carer's allowances measures that aim to de-gender caregiving by enabling men to participate more actively in family care [4]. Yet the implementation of such policies remains uneven. In many Central and Eastern European countries, including Romania, fiscal constraints and conservative gender norms limit the transformative potential of these reforms [6, 24].

Romania's long-term care system illustrates the familialist bias characteristic of post socialist welfare regimes. Although the National Strategy on Long-Term Care and Active Ageing (2023–2030) [7] acknowledges the importance of supporting family caregivers, concrete mechanisms for respite, financial compensation, or training remain largely absent. Local social services are unevenly distributed, and rural households where demographic ageing is most pronounced are often left to rely exclusively on unpaid female labour [47]. Socioeconomic inequalities strongly influence both access to formal care services and reliance on informal caregiving across European countries [48]. As a result, caregiving becomes both a moral duty and a survival strategy, deeply embedded in gendered expectations of filial piety and maternal sacrifice.

At a conceptual level, feminist theorists have reframed the analysis of care through the lens of ethics and justice. The ethic of care articulated by Tronto [32] and Held [49] challenges the dichotomy between private affection and public obligation, insisting that caring is a political practice essential to democratic life. By making visible the interdependence inherent in human existence, this perspective contests the liberal ideal of the autonomous individual and posits care as a collective responsibility shared across genders, generations, and institutions. Integrating this ethical dimension into the Care Diamond transforms it from a descriptive model into a normative framework for care citizenship-a vision in which both caregivers and care recipients are recognized as subjects of rights as bearers of social value.

In practice, however, translating this vision into policy demands a radical revaluation of care labour. Scholars advocate for multidimensional strategies that combine three pillars: Recognition – embedding care in national accounts and gender equality frameworks; Redistribution providing income support, pension credits, and flexible employment options for caregivers; and Representation ensuring caregivers' voices in policymaking and workplace governance [34].

Such approaches move beyond the compensatory logic of "helping families cope" toward a transformative agenda that redefines caregiving as a cornerstone of social citizenship. Within this reconceptualization, the family is neither a residual unit nor an isolated caregiver but a nodal actor within an interdependent ecosystem sustained by public investment, community engagement, and equitable gender relations.

2.5. Conceptual Synthesis: Care as a Social Contract

The theoretical perspectives examined above active ageing, intergenerational solidarity and ambivalence, and the Care Diamond collectively reveal that family care operates not merely as a set of private interactions but as a moral, relational, and institutional practice embedded within broader social contracts. This synthesis proposes a conceptual reframing: family caregiving should be understood as an essential pillar of the social contract of ageing, situated at the intersection of ethics, policy, and lived experience.

Historically, care has occupied an ambiguous position within the moral economy of modernity. Liberal political philosophy, grounded in ideals of autonomy and rational agency, has traditionally marginalized dependency and vulnerability attributes associated with femininity, old age, and the private sphere [32,50]. The welfare state emerged in part to mediate this tension by institutionalizing collective responsibility for risk and need. Yet as demographic ageing intensifies and neoliberal reforms recalibrate state capacities, the balance between private obligation and public solidarity is once again under negotiation. Within this shifting landscape, the family becomes the arena in which the crisis of care is most visibly enacted.

To conceptualize care as a social contract implies acknowledging the reciprocal interdependence between individuals and institutions across the life course. Every citizen, at different points in time, embodies multiple care identities: care recipient, caregiver, taxpayer, and policy beneficiary. The sustainability of ageing societies therefore depends on the capacity of this implicit contract to equitably distribute the costs and rewards of care. In this sense, care represents both a moral resource sustaining trust, empathy, and cohesion and a political resource constituting the invisible infrastructure of welfare production [39].

From an ethical standpoint, conceiving care as a social contract challenges the notion of caregiving as an act of charity or familial duty. Instead, it positions care as a right and responsibility co-produced by multiple actors: the family, the state, the market, and civil society. This reconceptualization resonates with the principles of the UN Decade of Healthy Ageing [3], which emphasizes participation, inclusion, and equity as prerequisites for ageing well. The family thus functions not as a substitute for the welfare state, but as a partner institution in the collective management of ageing, requiring recognition, resources, and relational justice.

Moreover, this contract is not static but dynamic and negotiable, evolving alongside demographic, technological, and cultural transformations. Digitalization, for instance, is reshaping intergenerational care through virtual communication and tele-assistance, creating new forms of proximity that coexist with emotional distance [51]. Migration redefines care boundaries across transnational spaces, producing global care assemblages in which familial solidarity extends beyond national borders [52]. These developments compel scholars and policymakers to rethink care as a trans-scalar process simultaneously intimate and systemic.

At the core of this conceptualization lies the tension between solidarity and justice. While solidarity appeals to moral sentiment and kinship loyalty, justice demands institutional guarantees and equitable distribution. The challenge for contemporary societies is to reconcile these dimensions: to preserve the affective richness of familial care while ensuring that it does not perpetuate gendered or class-based inequalities. Achieving this balance requires a repoliticization of care, whereby caregiving is recognized as public work—economically valuable, socially necessary, and ethically central to democratic life [32,34].

In practical terms, framing care as a social contract suggests several policy imperatives: Institutional recognition the formal acknowledgment of family caregivers as partners in care provision, with legal status, training opportunities, and representation in decision-making bodies; Resource redistribution – public investment in respite services, income support, and pension credits to offset the economic and temporal costs of informal care; Relational justice – designing care systems that promote reciprocity and dignity, mitigating asymmetries of power and dependence within families; and Integrated governance building cross-sectoral mechanisms linking health, social services, and community networks to sustain mixed care systems that are both efficient and humane.

Such a model transcends the dichotomy between familialism and statism by envisioning care as co-governed social infrastructure. It aligns with emerging paradigms in social policy that treat ageing not as a burden but as a collective opportunity for civic renewal and social innovation [13]. Within this perspective, the family becomes not merely the last resort of care but the ethical nucleus of a participatory welfare system a locus where public and private responsibilities converge.

Ultimately, conceiving care as a social contract reaffirms the idea that ageing well is not solely an individual achievement, but a shared societal accomplishment. It calls for a renewed moral economy grounded in mutual recognition, interdependence, and collective accountability principles that should guide the reconfiguration of both family practices and welfare institutions in an ageing world.

3. FAMILY AS A PRIMARY CAREGIVER: EVIDENCE AND CHALLENGES

3.1. Roles and Functions of Family Care in Late Life

Empirical research consistently affirms that the family remains the primary locus of long-term care for older adults worldwide. Across OECD and EU member states, between two-thirds and four fifths of older persons with care needs rely primarily on family membersmost often spouses, daughters, or daughters-in-lawfor assistance with daily living, emotional support, and coordination of medical care [2,5]. Informal caregivers play a central role in patient safety and care coordination, yet they frequently remain undertrained and insufficiently supported by formal systems [53]. Far from being a vestige of premodern solidarity, family care persists because it integrates affective, cultural, and instrumental dimensions of well-being that formal systems cannot fully replicate.

At a functional level, family caregiving encompasses a continuum of tasks: personal care (feeding, bathing, mobility), household management, emotional companionship, and administrative mediation with health and social services. Each of these functions carries symbolic weight, sustaining identity and belonging for both caregiver and recipient. Scholars have noted that familial care generates what can be termed a “relational infrastructure of continuity” a web of practices that maintains older adults’ sense of self, history, and place in the world [9,39].

The affective dimension of caregiving is particularly salient. Studies show that emotional availability and perceived family cohesion are strongly correlated with psychological resilience and life satisfaction among the elderly [54]. The presence of close kin not only mitigates loneliness and depression but also moderates the effects of chronic illness by enhancing motivation for self-care [18]. This emotional scaffolding forms the bedrock of what the WHO calls “functional ability” the capacity to maintain well-being in interaction with one’s environment [3].

Economically, informal family care constitutes an immense yet largely invisible resource. Its estimated monetary value ranging from 1.5 to 4 percent of GDP in European countries often exceeds public expenditure on formal long-term care [4]. Yet this unpaid labour remains excluded from national accounts, producing a paradox: the more essential family care becomes, the less visible it is in economic statistics and social policy discourse. Recognizing and quantifying this contribution has therefore become a central demand of both feminist and ageing scholars seeking to redefine care as productive social labour.

Beyond its economic and emotional roles, family care also performs a moral and cultural function. In many European contexts, caring for ageing relatives is embedded in shared notions of duty, affection, and intergenerational reciprocity. Even in societies undergoing rapid individualization, moral discourses around “good family” and “proper care” continue to shape caregiving behaviour [52]. These norms sustain what Bengtson and Settersten [8]. describe as the “intergenerational contract” a tacit agreement binding generations through mutual responsibility. However, as demographic ageing prolongs periods of dependency, this moral contract is increasingly strained, generating tensions between obligation, affection, and self-preservation.

3.2. The Impact of Family Care on Older Adults’ Well-Being

Evidence from cross-national studies demonstrates that family involvement is one of the strongest predictors of well-being and quality of life in later life. Older adults who receive consistent support from relatives report higher levels of emotional security, life satisfaction, and sense of purpose [11]. Social interaction within families acts as a buffer against cognitive decline and functional loss, partly through mechanisms of motivation, supervision, and shared routines [14].

Immigrant families frequently face compounded challenges in caregiving, involving cultural, emotional, and systemic barriers to accessing formal care services [55]. However, it is the quality not merely the presence of familial support that is decisive. Support perceived as intrusive or overprotective may erode autonomy and self-esteem, leading to passive coping and learned dependency [9]. Conversely, empowering support-that which respects the older person’s preferences and competence-enhances agency and participation. In this sense, the family functions as a relational regulator of active ageing, capable of both enabling and constraining functional ability.

Recent longitudinal data suggest that the protective effect of family care is strongest when it complements, rather than replaces, formal health and community services [3,13]. Integrated care models combining informal and professional resources tend to yield the best outcomes in health, autonomy, and social inclusion. By contrast, exclusive reliance on informal care, especially in resource-poor contexts, can exacerbate inequalities in access and quality. This pattern is particularly evident in Southern and Eastern Europe, where familialism remains dominant but institutional support systems are unevenly developed [26,56].

In Romania, as in several other Central and Eastern European states, family care constitutes the de facto backbone of the long-term care system. Despite legislative progress such as the National Strategy on Long-Term Care and Active Ageing (2023–2030) [7] public services remain fragmented and under-resourced, especially in rural areas. Surveys indicate that more than 80 percent of dependent older persons rely exclusively on family members, most of them women aged 45–65 [47]. The consequences include gendered caregiving burdens, reduced labour-market participation, and limited opportunities for respite or rehabilitation. While strong family ties often buffer emotional distress, the absence of formal support perpetuates a cycle of hidden strain and silent resilience within caregiving households.

3.3. Challenges and the Caregiver Burden

While family caregiving is often idealized as an expression of love and solidarity, empirical evidence underscores its ambivalent and demanding nature. The literature increasingly portrays informal care as a “double-edged experience” emotionally rewarding yet physically, psychologically, and economically taxing [39,42]. Higher caregiving burden is significantly associated with poorer psychological well-being among family caregivers, particularly in contexts characterized by limited external support [57]. As populations age and the intensity of care rises, caregiver burden understood as the cumulative strain arising from prolonged care responsibilities has emerged as a key determinant of well-being for both carers and care recipients.

Caregiving challenges manifest across multiple domains. Physically, long hours of assistance, especially with mobility or hygiene, lead to fatigue and musculoskeletal disorders. Psychologically, caregivers experience high levels of stress, anxiety, and depressive symptoms, often compounded by social isolation [11]. Emotionally, the transition from a symmetrical relationship such as that between spouses or parents and adult children to one structured around dependency can generate grief, guilt, and identity loss [27]. Economically, caregiving frequently entails income loss due to reduced working hours or career withdrawal, perpetuating gendered labour-market inequalities [41].

The COVID-19 pandemic accentuated these dynamics by intensifying the reliance on family-based care and reducing access to professional services. Studies conducted in Europe between 2020 and 2022 have documented a surge in caregiver burnout, particularly among women balancing employment with multigenerational responsibilities [2]. The absence of respite opportunities and psychosocial support further amplified the risk of caregiver exhaustion a state of chronic physical and emotional depletion associated with deteriorating health and impaired care quality [18].

Beyond individual strain, the caregiving burden exposes broader structural inequalities. The uneven distribution of care responsibilities across gender, class, and geography reflects what Fraser [34] calls the “crisis of care” a systemic imbalance between the social demand for care and the institutional capacity to supply it. Low-income families, rural communities, and households affected by migration are disproportionately impacted, as they lack access to formal services or extended kin networks. Consequently, informal caregiving becomes not only a private struggle but a proxy indicator of welfare fragility.

In response, several European countries have implemented policies aimed at rebalancing the care load through carer allowances, flexible work arrangements, and psychological counselling [4]. Evidence suggests that such measures mitigate stress and improve health outcomes, yet their reach remains uneven. In many contexts, carers remain “invisible citizens”, whose contributions are essential but insufficiently recognized by social policy or labour legislation [58]. The normalization of unpaid care as a moral expectation perpetuates silence and guilt, obscuring the need for structural solutions.

3.4. The Romanian Context in Comparative Perspective

Romania epitomizes the dilemmas of familialist welfare regimes, where moral expectations of filial duty compensate for institutional underdevelopment. The demographic ageing process is among the fastest in Europe: by 2030, over 22 percent of the population is projected to be 65 or older [5]. Yet formal long-term care infrastructure remains embryonic. Public residential facilities serve less than 2 percent of older persons, and home-based social services reach fewer than one in ten [4]. Consequently, families particularly women absorb the majority of care work, operating with limited financial and informational resources.

Empirical studies highlight three interrelated features of Romania’s care landscape. First, care dependence is spatially uneven: rural regions face acute shortages of professional caregivers, while urban centres rely increasingly on migrant domestic workers, creating both class-based and territorial divides [47]. Second, care provision is generationally stratified: middle-aged women, often dubbed the “sandwich generation,” simultaneously support ageing parents and adult children, leading to chronic role overload [11]. Third, institutional coordination remains fragmented: the health, social welfare, and labour sectors operate in silos, limiting the effectiveness of integrated interventions.

Culturally, Romania retains strong normative frameworks of filial piety rooted in Orthodox ethics and rural communal traditions. These moral codes foster solidarity but also reinforce gendered expectations of sacrifice. Caregiving is often framed as a “natural” extension of women’s emotional labour, rendering policy interventions politically delicate. However, social attitudes are gradually shifting, especially among younger cohorts exposed to European norms of gender equality and work–life balance [26].

Comparative evidence places Romania within a broader Central and Eastern European pattern marked by informal-care dependency and policy inertia. While countries such as Slovenia or the Czech Republic have progressed toward more integrated long-term care (LTC) systems, Romania remains at an early stage of reform implementation. The National Strategy on Long-Term Care and Active Ageing (2023–2030) [7] represents a pivotal policy milestone, yet its success hinges on political continuity, sustainable funding, and capacity-building at local levels.

In this context, the family emerges as both the cornerstone and the constraint of elderly care. Its strength lies in affective commitment and cultural continuity; its vulnerability lies in overextension and lack of support. Understanding the Romanian experience thus illuminates the paradox at the heart of ageing societies: the very institution that safeguards dignity in later life is also at risk of collapse under unshared responsibility. This paradox forms the bridge to the next analytical section, which explores how policy and practice can transform familial caregiving from an act of endurance into a pillar of sustainable welfare.

4. POLICY AND PRACTICE IMPLICATIONS

The growing reliance on family-based care represents both an opportunity and a challenge for welfare systems seeking to ensure dignified ageing in the twenty-first century. As the preceding sections have sown, families constitute the moral and emotional core of long-term care (LTC) provision yet remain structurally under-supported. Addressing this imbalance requires a paradigm shift from viewing family caregiving as a private duty to recognizing it as a publicly shared responsibility integral to social citizenship.

4.1. Recognizing Family Care as a Public Good

Policy frameworks must begin by acknowledging family caregiving as a public good that generates measurable social value. The OECD [2] estimates that informal carers provide between 60 and 80 percent of total LTC hours across member states; yet their labour is rarely accounted for in national economic statistics. Recognition mechanisms such as including unpaid care in satellite national accounts or assigning "care credits" within pension systems are crucial to making this contribution visible [4]. Beyond symbolic legitimacy, formal recognition enhances carers' access to benefits, training, and representation in policy dialogues.

Creating legal definitions of the informal carer as implemented in countries such as France, the United Kingdom, and Finland provides a necessary foundation for coherent regulation. Such definitions clarify eligibility for financial support, respite services, and employment protection. Romania's National Strategy on Long-Term Care and Active Ageing (2023-2030) [7] introduces the category of "family caregiver," but operational mechanisms remain embryonic. Translating this conceptual recognition into enforceable rights represents the first critical step toward institutionalizing care as shared responsibility.

4.2. Redistributing Resources and Risks

Recognition must be accompanied by redistribution both of resources and of care risks. Unpaid caregiving imposes opportunity costs on individuals, particularly women, whose interrupted careers result in lower lifetime earnings and pensions [38]. Policy responses should therefore combine short-term income support with long-term social protection.

Effective instruments include: Carer allowances or stipends, indexed to minimum wages, compensating time spent in intensive care; Pension credits, ensuring that caregiving periods contribute to social security entitlements; Tax deductions or subsidies for households employing professional caregivers or purchasing assistive technologies; Respite services temporary institutional or home-based relief enabling caregivers to rest or maintain employment.

The European Care Strategy (2022) [3] promotes these mechanisms as part of a comprehensive care-mix approach. Countries such as Germany and Austria have already operationalized cash-for-care schemes coupled with professional supervision to guarantee quality. Their experience demonstrates that monetary support is most effective when it is integrated into a continuum of services rather than offered as isolated compensation.

In Romania, redistributive policies remain limited. Carer allowances exist only in pilot form and are managed unevenly by local authorities. Developing a multi-tier financing model, combining state, local, and community resources, could mitigate disparities and enhance sustainability. Importantly, redistributive efforts must also address the gender dimension of care by incentivizing male participation through paid parental and care leaves, flexible scheduling, and public campaigns that normalize shared caregiving.

4.3. Building Integrated and Community-Based Care Systems

The transition from institutional to community-based care requires coordinated governance across sectors. Fragmentation between health, social services, and employment policy undermines efficiency and continuity. Evidence from Nordic and Western European countries indicates that integrated care models yield superior outcomes in health, autonomy, and cost-effectiveness [11,13].

Key elements of successful integration include: Local coordination platforms that link family caregivers with multidisciplinary teams (nurses, social workers, therapists, psychologists); Single entry points for information, needs assessment, and service referral; Digital care and rehabilitation infrastructures shared databases, tele-assistance, and mobile applications facilitating communication between caregivers and professionals; and Training and certification pathways for informal carers to acquire basic medical and social competencies, fostering cooperation rather than substitution.

Romania's fragmented institutional landscape calls for decentralized coordination coupled with national oversight. Establishing county-level Care Hubs could serve as demonstration centres integrating home care services, training, and respite programs. Partnerships between universities, NGOs, and municipalities would further promote innovation and professionalization in community-based care.

4.4. Investing in Prevention and Age-Friendly Environments

Policies must also move upstream to address the determinants of care demand. Investing in preventive health, lifelong learning, and age-friendly environments can delay dependency and reduce caregiving intensity. WHO [3] emphasizes that functional ability depends not only on medical treatment but on accessible housing, transportation, and social participation.

Urban planning that incorporates "care-sensitive design" barrier-free housing, green public spaces, proximity services extends independent living and reduces the emotional and logistical burden on families. Community centres offering physical activity programs, social clubs, and volunteer networks enhance intergenerational interaction and resilience.

In Romania, such initiatives remain sporadic. Integrating active ageing principles into local development strategies would align with EU cohesion policy priorities and attract structural funding. Preventive investment yields high returns: every euro spent on fall-prevention or rehabilitation saves multiple euros in long-term care costs [2].

4.5. Supporting the Emotional and Mental Health of Caregivers

Caregiving is not solely an economic or logistical function; it is form of affective labour that requires emotional intelligence and psychological resilience. Policies must therefore address caregivers' mental health as a matter of public concern. Evidence shows that peer-support groups, psychological counselling, and mindfulness-based interventions significantly reduce stress and burnout [18].

Employers and community organizations can play a pivotal role by providing workplace flexibility and psychosocial resources. Digital platforms caregiver forums, digital-therapy, mobile applications for self-monitoring expand access to support networks, particularly in rural areas. Integrating mental health modules into caregiver training programs further normalizes emotional self-care as a professional and ethical responsibility [59].

4.6. Fostering a New Ethics of Shared Responsibility

Ultimately, the sustainability of care systems depends on cultivating a new social ethic of shared responsibility. The discourse must shift from guilt and sacrifice to recognition and cooperation. Families, the state, and civil society form a care triad each indispensable yet insufficient on its own. Educational campaigns promoting gender equality, civic responsibility, and intergenerational solidarity can reshape societal narratives about who cares and why. Incorporating care literacy into school curricula and community programs would foster early awareness of ageing, empathy, and collective preparedness.

From a policy perspective, embedding the ethic of care within national development strategies positions ageing not as a demographic threat but as a catalyst for social innovation. Recognizing caregiving as skilled, meaningful, and socially productive work reframes it as a domain of empowerment rather than obligation.

4.7. Strategic Directions for Romania

Building on these principles, Romania's path toward sustainable elder care should pursue the following strategic directions: Legal codification of family caregivers' rights and responsibilities, accompanied by enforceable standards of support; Creation of a National Carer Register, enabling targeted training, respite, and financial benefits; Development of community-based care hubs at county level, integrating social and medical services; Expansion of tele-care and digital inclusion programs for older adults and their families; Gender-sensitive policy design, ensuring equitable distribution of care roles; Cross-sectoral funding mechanisms linking health, labour, and social welfare budgets.

Implementing these measures would align Romania with EU objectives under the European Care Strategy and the Decade of Healthy Ageing. More broadly, it would mark a transition from reactive to preventive, from private to collective, and from invisible to recognized caregiving.

4.8. Toward Sustainable and Equitable Care Systems

The transformation of care policy requires more than administrative reform it demands a reimagining of care as social infrastructure. Sustainable systems must balance efficiency with empathy, cost with dignity, and autonomy with solidarity. Meaningful involvement of informal caregivers in health policy processes improves responsiveness and legitimacy of care systems [60]. As Fraser [34] argues, the "crisis of care" is not merely a fiscal or demographic issue but a moral and civic challenge. By embracing an ethic of co-responsibility, societies can convert ageing from a narrative of decline into one of renewal and reciprocity.

In this sense, supporting families is not an act of welfare generosity but a strategic investment in the resilience of ageing democracies. Building inclusive, integrated, and gender-just care systems stands as both a social imperative and a measure of collective maturity.

5. Conclusions

The analysis presented in this article reaffirms that the family remains the cornerstone of elderly care, yet one that operates within increasingly complex demographic, economic, and moral environments. Far from being a vestige of traditional solidarity, family caregiving embodies a dynamic interplay between private affection and public responsibility, between emotional labour and structural inequality.

The literature reviewed demonstrates that familial care contributes decisively to the well-being, autonomy, and dignity of older adults. It provides irreplaceable affective and moral support, preserves identity and belonging, and sustains social cohesion. However, the same institution that enables dignity in late life is often overstretched and under-recognized, bearing the hidden costs of welfare retrenchment and gendered expectations.

The theoretical synthesis developed here drawing from the frameworks of active ageing, intergenerational solidarity, and the care diamond advances an integrative understanding of care as a social contract grounded in reciprocity, justice, and shared responsibility. This conceptualization invites policymakers to view caregiving not as a private contingency but as a form of civic participation and social investment.

Practically, the findings underline the urgency of: Recognizing family caregivers as partners in the provision of long-term care; Redistributing resources and risks through financial compensation, pension credits, and flexible employment policies; Building integrated community-based systems that bridge the divide between informal and formal care; and Promoting a new ethics of care that reframes ageing as a shared social achievement.

For Romania and similar familialist welfare regimes, these recommendations have particular resonance. The country's strong family bonds and moral traditions offer a reservoir of resilience, yet without structural support, this resilience risks turning into exhaustion. Sustainable ageing therefore requires a dual strategy: empowering families through recognition and resources, and building public infrastructures that ensure equity, accessibility, and dignity for all older persons.

In conclusion, the role of the family in elderly care must be reinterpreted through the lens of care justice and interdependence. Families should not stand alone at the frontlines of ageing societies but be accompanied by responsive institutions and inclusive policies. Only through such partnership can societies transform the moral weight of care into a collective strengthturning the challenge of ageing into an opportunity for solidarity, renewal, and social cohesion.

Acknowledgement

The author expresses sincere gratitude to the family caregivers and social workers who dedicate their time, empathy, and professional commitment to supporting older adults in need of care. Their everyday work embodies the values of solidarity, compassion, and human dignity that inspired the reflections developed in this article.

This research was carried out within the framework of the Community Development Laboratory, whose activities aim to strengthen participatory approaches and social innovation in local welfare practices. The author also wishes to thank all practitioners and community organizations who continue to advocate for better recognition and support of caregiving in Romania and beyond.

Conflict of Interest

The authors declare that there is no conflict of interest.

Author Contributions

Study Design: SC and ZMD; Data Collection: SC and ZMD; Statistical Analysis: SC and ZMD; Data Interpretation: SC and ZMD; Manuscript Preparation: SC and ZMD; Literature Review: SC and ZMD. All authors have read and approved the published version of the manuscript

REFERENCES

1. United Nations. (**2023**). *World population ageing 2023: Challenges and opportunities of population ageing in the least developed countries*. United Nations Department of Economic and Social Affairs.
2. OECD. (**2023**). *Health at a glance: Europe 2023*. Paris: OECD Publishing. [CrossRef]
3. World Health Organization. (**2021**). *Decade of healthy ageing: Baseline report. Geneva*: World Health Organization.
4. European Commission. (**2022**). *Communication on the European Care Strategy*. Brussels: European Union
5. Eurostat. (**2024**). *Population structure and ageing*.
6. Cattaneo, A., Vitali, A., & Regazzoni, D. (2**025**). The burden of informal family caregiving in Europe, 2000–2050: A microsimulation modelling study. *The Lancet Regional Health Europe*, 53, 101295. [CrossRef] [PubMed]
7. Government of Romania, Ministry of Labour and Social Solidarity. (**2022**). *National strategy on long-term care and active ageing 2023–2030*.
8. Bengtson, V. L., & Settersten, R. A. (Eds.). (**2016**). *Handbook of theories of aging (3rd ed.)*. Springer.

9. Toptaş Demirci, P., & Lourenço, C. (**2024**). Effect of Exercise and Nutritional Lifestyle Intervention on Weight Control and Behavior Change Processes in Among Inactive Older Adults. Int. *J. Act. Health Aging*, 2(1), 1–9. [CrossRef]
10. Haberkern, K., Schmid, T., & Szydlik, M. (**2015**). Gender differences in intergenerational care in European welfare states. *Ageing & Society*, 35(2), 298–320. [CrossRef]
11. Knezevıc, S., Toptaş Demirci, P., Stajıc, D., Güven, E., & Jandrić-Kočić, M. (**2024**). Exercise Self-Efficacy, Body Image, and Perception of Health-Related Quality of Life in Older Adults. *Int. J. Act. Health Aging,* 2(1), 18–24. [CrossRef]
12. Barreira, L. F., Paiva, A., Araújo, B., & Campos, M. J. (**2023**). Challenges to systems of long-term care: Mapping of the central concepts from an umbrella review. *International Journal of Environmental Research and Public Health*, 20(3), 1698. [CrossRef] [PubMed]
13. Walker, A. (**2020**). The future of ageing in Europe: Making it a human rights issue. *Journal of Population Ageing*, 13(4), 383–398. [CrossRef]
14. Kendig, H., Phillipson, C., & Hoffman, R. (**2021**). Population ageing and intergenerational relations: A global perspective. *Journal of Population Ageing*, 14(4), 347–366.
15. Sen, A. (**1999**). *Development as freedom*. Oxford University Press. https://books.google.com.tr/books/about/Development_as_Freedom.html?id=NQs75PEa618C&redir_esc=y
16. Nussbaum, M. C. (**2011**). *Creating capabilities: The human development approach*. Belknap Press. https://books.google.com.tr/books/about/Creating_Capabilities.html?id=Gg7Q2V8fi8gC&redir_esc=y
17. Baltes, P. B., & Smith, J. (**2003**). New frontiers in the future of aging: From successful aging of the young old to the dilemmas of the fourth age. *Gerontology*, 49(2), 123–135. [CrossRef]
18. Hämäläinen, H., Tanskanen, A. O., & Danielsbacka, M. (**2024**). Who are 'multi-helpers'? Profile of older adults engaging in multiple help-giving activities. *Journal of Population Ageing*, 17(3), 579–597. [CrossRef]
19. Durkheim, É. (**1995**). *The elementary forms of religious life (K. E. Fields, Trans.).* Free Press. https://monoskop.org/images/a/a2/Durkheim_Emile_The_Elementary_Forms_of_Religious_life_1995.pdf
20. *Beck, U. (**1992**). Risk society: Towards a new modernity.* Sage. [CrossRef]
21. Giddens, A. (**1991**). *Modernity and self-identity: Self and society in the late modern age*. Polity Press.
22. Carter, B., & McGoldrick, M. (Eds.). (**2005**). *The expanded family life cycle (3rd ed.).* Allyn & Bacon.
23. Bronfenbrenner, U. (**2004***). Making human beings human: Bioecological perspectives on human development.* Sage.
24. Antonucci, T. C., Ajrouch, K. J., & Birditt, K. S. (**2014**). The convoy model: Explaining social relations from a multidisciplinary perspective. *The Gerontologist*, 54(1), 82–92. [CrossRef] [PubMed]
25. Finch, J., & Mason, J. (**1993**). *Negotiating family responsibilities.* Routledge.
26. Saraceno, C. (**2016**). Varieties of familialism: Comparing four Southern European and East Asian welfare regimes. *Journal of European Social Policy*, 26(4), 314–326. [CrossRef]
27. Silverstein, M., & Giarrusso, R. (**2010**). Aging and family life: A decade review. *Journal of Marriage and Family*, 72(5), 1039–1058. [CrossRef] [PubMed]
28. Kröger, T. (2022). *Care poverty: When older people's needs remain unmet*. Springer. [CrossRef]
29. Bengtson, V. L., & Roberts, R. E. L. (**1991**). Intergenerational solidarity in aging families: An example of formal theory construction. *Journal of Marriage and the Family*, 53(4), 856–870. [CrossRef]
30. Lüscher, K., & Pillemer, K. (**1998**). Intergenerational ambivalence: A new approach to the study of parent–child relations in later life. *Journal of Marriage and the Family*, 60(2), 413–425. [CrossRef]
31. Connidis, I. A., & McMullin, J. A. (**2020**). Ambivalence, aging families, and the transformation of intimacy. *Journal of Family Theory & Review*, 12(1), 6–21. [CrossRef]
32. Tronto, J. C. (**2013**). *Caring democracy: Markets, equality, and justice.* NYU Press.
33. Leitner, S. (**2003**). Varieties of familialism: The caring function of the family in comparative perspective. *European Societies*, 5(4), 353–375. [CrossRef]
34. Fraser, N. (**2016**). Contradictions of capital and care. *New Left Review*, 100, 99–117.
35. Daly, M., & Lewis, J. (**2000**). The concept of social care and the analysis of contemporary welfare states. *The British Journal of Sociology*, 51(2), 281–298. [CrossRef] [PubMed]
36. Honda, A., Nishida, T., Ono, M., Tsukigi, T., & Honda, S. (**2025**). Impact of financial burden on family caregivers of older adults using long-term care insurance services. *SAGE Open Nursing*, 11, 23779608251383386. [CrossRef] [PubMed]
37. Almeida-Meza, P., Di Gessa, G., Lacey, R., Xue, B., & McMunn, A. (**2025**). Gender inequalities in care across long-term care public spending systems in Europe: Evidence from the European Health Interview Survey. *International Journal of Care and Caring*, 9(3), 490–503. [CrossRef]
38. Orloff, A. S. (**2009**). Gendering the comparative analysis of welfare states: An unfinished agenda. *Sociological Theory*, 27(3), 317–343. [CrossRef]
39. Razavi, S. (**2007**). The political and social economy of care in a development context. UNRISD Gender and Development Programme Paper No. 3. United Nations Research Institute for Social Development.
40. Costa-Font, J., & Vilaplana-Prieto, C. (**2025**). The hidden value of adult informal care in Europe. *Health Economics*, 34(4), 791–812. [CrossRef] [PubMed]
41. Fine, M. (**2019**). *Care: Setting the agenda*. Agenda Publishing.
42. Budig, M. J., Misra, J., & Boeckmann, I. (**2016**). Work–family policy trade-offs for mothers?

Unpacking the cross-national variation in motherhood earnings penalties. *Work and Occupations,* 43(2), 119–177. [CrossRef]
43. Gösenbauer, B., Braun, A., & Bilger, M. (**2025**). Informal long-term care and its gender distribution: A systematic review. *Journal of Integrated Care*, 33(5), 17–35. [CrossRef]
44. Sigurlaugardottir, S. S., Sigurdardottir, S. H., Aspelund, T., Bjornsdottir, K., Jegermalm, M., Olafsson, K., & Hjaltadottir, I. (**2025**). Elements of burden among informal caregivers of community-dwelling older adults receiving home care nursing: A cross-sectional study on health status, well-being, and gender differences. *BMC Geriatrics*, 25(1):623. [CrossRef] [PubMed]
45. Quashie, N. T., Wagner, M., Verbakel, E., & Deindl, C. (**2022**). Socioeconomic differences in informal caregiving in Europe. *European Journal of Ageing*, 19(3), 621–632. [CrossRef]
46. Hochschild, A. R. (**2000**). *Global care chains and emotional surplus value. In W. Hutton & A. Giddens (Eds.), On the edge: Living with global capitalism* (pp. 130–146). Jonathan Cape.
47. Lutz, H., & Palenga-Möllenbeck, E. (**2012**). Care workers, care drain, and care chains: Reflections on care, migration, and citizenship. *Social Politics*, 19(1), 15–37. [CrossRef] [PubMed]
48. Szenkurök, V., Weber, D., & Bilger, M. (**2025**). Informal and formal long-term care utilization and unmet needs in Europe: Examining socioeconomic disparities and the role of social policies for older adults. *International Journal of Health Economics and Management*, 25(1), 87–106. [CrossRef] [PubMed]
49. Corman, S. (**2023**). An Overview of Communication System of the Elderly after Retirement. *Recent Trends in Arts and Social Studies*,7 72-80. [CrossRef]
50. Held, V. (**2006**). *The ethics of care: Personal, political, and globa*l. Oxford University Press.
51. Kittay, E. F. (**1999**). *Love's labor: Essays on women, equality, and dependency*. Routledge.
52. Lima, D. P., Queiroz, I. B., Carneiro, A. H. S., Pereira, D. A. A., Castro, C. S., Viana-Júnior, A. B., et al., (**2022**). Feasibility indicators of telemedicine for patients with dementia in a public hospital in Northeast Brazil during the COVID-19 pandemic. *PLOS ONE*, 17(5), e0268647. [CrossRef] [PubMed]
53. Abed, N., Knezevic, B., Sousa, P., Tella, S., Srulovici, E., Strametz, R., & Mira, J. J. (**2025**). Defining informal caregivers by their characteristics, safety roles and training needs in Europe. *Scientific Reports*, 15, Article 24375. [CrossRef]
54. Baldassar, L., & Merla, L. (Eds.). (**2014**). *Transnational families, migration and the circulation of care*. Routledge.
55. Shrestha, S., Arora, S., Hunter, A., & Debesay, J. (**2023**). Changing dynamics of caregiving: A meta-ethnography study of informal caregivers' experiences with older immigrant family members in Europe. *BMC Health Services Research*, 23, Article 43. [CrossRef] [PubMed]
56. Albertini, M., & Kohli, M. (**2022**). Intergenerational support and the changing family. *Annual Review of Sociology,* 48, 169–188.
57. Bongelli, R., Busilacchi, G., Pacifico, A., Fabiani, M., Guarascio, C., Sofritti, F., Lamura, G., & Santini, S. (**2024**). Caregiving burden, social support, and psychological well-being among family caregivers of older Italians: A cross-sectional study. *Frontiers in Public Health*, 12, Article 1474967. [CrossRef] [PubMed]
58. Lowenstein, A. (**2007**). Solidarity–conflict and ambivalence: Testing two conceptual frameworks and their impact on quality of life for older family members. *The Journals of Gerontology: Series B*, 62(2), S100–S107. [CrossRef]
59. Toptaş Demirci, P. and Demirci N. (**2024**). *Rehabilitation and Utilization of Digital Technologies for the Disabled*. Current Approaches in Exercise and Rehabilitation Applications for the Disabled, pp. 7-20. Efe Akademi Publications, Istanbul.
60. Kolade, O. R., Porat-Dahlerbruch, J., Makhmutov, R., van Achterberg, T., & Ellen, M. E. (**2024**). Strategies for engaging older adults and informal caregivers in health policy development: A scoping review. *Health Research Policy and Systems*, 22(1):26. [CrossRef] [PubMed]