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research article

Variety in carers' views regarding care responsibilities from an intersectional perspective

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Challenges in keeping healthcare affordable make informal care increasingly important. It is essential to understand the context in which people provide informal care and gain insight into their wishes with regard to the division of care responsibilities. A total of 37 interviews and eight focus groups were conducted to investigate how Dutch carers' care attitudes are shaped. Results show that carers' intersecting social positions, such as gender, migration background, socio-economic status and stage of life, largely influence their care attitudes. Carers want to provide care but experience challenges in doing so. They request a government that takes the lead and facilitates cooperation with professionals.

Keywords informal care • care attitudes • division of care • intersectionality

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Introduction

As with other European countries, the Netherlands faces challenges in keeping healthcare affordable due to ageing, increasing care needs and workforce shortages in the healthcare sector. It is therefore expected that the demand for informal care will rise to the point

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where every Dutch citizen will be providing care to a loved one in 2040 (Ministry of Health, Welfare and Sport, 2022). This makes informal care increasingly critical and means that understanding the attitudes of people who provide informal care is essential (Wittenberg et al, 2021; Zarzycki et al, 2022). In this article, we refer to family members, friends, neighbours and other close ones who provide informal care to someone they know with long-term care demands as 'carers'. Care attitudes encompass citizens' opinions regarding the division of care responsibilities between family and/or social networks and the state (Wittenberg et al, 2021). As care attitudes are shaped by value patterns within the groups individuals belong to (Dykstra and Fokkema, 2012), an imperative question is the extent to which Dutch carers differ in their care attitudes. Insights into these differences can help policymakers and professionals meet a wide variety of expectations from carers.

The Dutch context

The Netherlands is an interesting country in which to investigate carers' attitudes because health and social care are relatively extensive and carers are well supported. The 2006 and 2015 reforms in public care consisted of both cost reductions and the reallocation of care responsibilities towards local authorities and from formal to informal care (Berkers et al, 2021; Duijs, 2023). Nowadays policies aimed at supporting carers assume that the family – not the state – is the main provider of care, and policies reflecting the belief that the state should be the principal responsible actor in care provision can be identified in the Netherlands (Verbakel et al, 2022). In practice, Dutch carers are entitled to relatively more state-provided support than in other countries, while publicly funded services for care recipients are still relatively extensive (UNECE, 2019; Verbakel et al, 2022).

Indirect support to informal carers arises from the help offered by health and social care professionals to care recipients. Professionals are increasingly assumed to collaborate in a relationship of equality to both support care recipients and look out for carers (The Council of Public Health and Society, 2022). This changing focus may result in a squeeze between prioritising the needs of care recipients and social activities, such as getting to know and supporting carers (Skinner et al, 2021).

Direct support for carers is arranged through the Social Support Act. Each municipality is allowed to determine the exact types and extent of the assistance (Berkers et al, 2021). Many municipalities translate this responsibility into financing carer support centres, which provide practical information and can match carers with consultants who help them arrange professional help or services. Support centres also organise courses on specific topics, such as combining work and informal care, as well as support groups in which carers can meet and exchange experiences. In particular, these courses and support groups often focus on specific groups of carers, which entails the risk of homogenising groups that are actually heterogeneous (Lapalme et al, 2020).

Differences in care attitudes

Several studies discern specific aspects of care attitudes, which are included in this study too. The first concerns caring norms. We broaden the often-used definition of filial norms and define caring norms as the recognised duties and obligations that define citizens' social roles with respect to close ones who need care (Gans and Silverstein, 2006). The second aspect concerns welfare state orientation: expectations

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concerning the relative responsibilities of the social network and the welfare state (Daatland and Herlofson, 2003).

Care attitudes are often socially shared, mirroring the socio-structural circumstances in which individuals live, as well as their cultural background and family culture (Dykstra and Fokkema, 2012; Kääriäinen et al, 2022). Previous research has demonstrated that care attitudes can be subject to change due to alterations in individuals' personal circumstances that impact the capacity to provide care (Gans and Silverstein, 2006). Furthermore, it is argued that care attitudes are shaped by the value patterns of social groups to which individuals belong (Gans and Silverstein, 2006; Dykstra and Fokkema, 2012). For instance, it is widely acknowledged that caring is a gendered concept, with women often being socialised to assume caring roles (Blieszner and Bedford, 2012; Tronto, 2013; Ahmad, 2022). Such mechanisms account for an asymmetric distribution of care tasks in society, as it may, for example, lead women to perceive caring as their responsibility while, at the same time, they receive fewer 'passes out' of these responsibilities than men (Tronto, 2013).

Comprehending variety in care attitudes allows professionals to better accommodate individuals' preferences and helps to identify segments of the population that may require targeted support (Quashie et al, 2022). Care attitudes are also noteworthy because they provide insights into how formal services should be adjusted to meet a diverse range of expectations and to potentially bridge any gaps between policy measures and public attitudes (Daatland and Herlofson, 2003; Dykstra and Fokkema, 2012).

Using intersectionality to study differences

Contemporary scholars in informal care research emphasise the need to move towards an intersectional exploration of the influence of a number of social categories when studying caring experiences (Hengelaar et al, 2021; Ahmad, 2022). As well as being gendered, caring is also deeply marked by other cultural and social values and formations. The use of one of the social categories without recognising their intersectionality is likely to distort social reality (Tronto, 2013). The concept of intersectionality was coined by Crenshaw (1989), and those who apply this approach recognise that everyone is simultaneously positioned within social categories, such as gender, migration background and socio-economic status. A full understanding of any social category requires the analysis of both differences and commonalities within and between groups (Crenshaw, 1989; Hankivsky et al, 2017).

Intersectionality thus rejects the idea that human lives can be reduced to separate categories. Instead, intersectionality seeks to understand what is created and experienced at the intersections of axes of oppression (Hankivsky, 2014). Thus, intersectionality also sheds light on how power relationships (re)produce social inequalities. It conceptualises these power relationships as comprised of:: (1) intersecting systems of power that shape social structures (such as laws and long-term care policies); and (2) intersecting social groups that experience privilege and/or oppression as a result of these social structures (Blieszner and Bedford, 2012; Lapalme et al, 2020). This focus on power structures is relevant in informal care research because care always occurs in a context, and among the most important elements of the context is the unequal distribution of power that is usually found in care practices (Tronto, 2013; Hankivsky, 2014). For example, carers with low socio-economic status may also be marginalised by other systems of inequality, such as migration status (Tronto, 2013). Consequently, some carers may hold disadvantaged

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positions based on the social categories they belong to. Literature on carers reveals three systems of inequality in which disadvantaged positions may arise. Before we describe these, we must point out that intersectionality rejects the prioritisation of hierarchical orderings of any social category (Hankivsky, 2014). Thus, we use them only as a starting point to determine how these categories intersect with others, as intersectionality can also bring other pertinent interactions to the fore (Hankivsky, 2014). First, as already mentioned, research has shown that caring is highly gendered, caused by and/or causing structural inequalities between men and women. Women are often more strongly socialised into and over-represented in caring roles and are likely to adopt more intensive care responsibilities. Women may consequently suffer more from negative outcomes of providing care, such as lower well-being, than men (Sagbakken et al, 2018; Tronto, 2013; Ahmad, 2022). Such gender differences may vary by migration background and socio-economic status (Cohen et al, 2019) but may also relate to other social categories. Second, caring is culturally constructed in society. Culture can have many effects on caring expectations and behaviours, and cultural norms regulating care attitudes can vary considerably both within and between groups (Zarzycki et al, 2022). In the Netherlands, cultural differences often relate to the question of whether someone has a migration background. Carer support is also often targeted at 'carers with a migration background'. Having a migration background may cause disadvantaged positions, for example, because this group experiences more barriers to using formal care and support services, often causing one female family member to provide most of the care (Ahmad, 2022). There is also some evidence that strong care attitudes among individuals with a migration background might isolate them, causing them to receive less outside help (Blieszner and Bedford, 2012). Furthermore, individuals with a migration background are generally known to have a more vulnerable socio-economic position than people of Dutch origin (de Regt et al, 2022). Lastly, socio-economically disadvantaged groups (with lower resources based on education, income and wealth) tend to provide informal care more often and at higher intensities (Abbing et al, 2021; Quashie et al, 2022). This may reinforce gender inequalities, as informal care can be costly and carers, especially women, often reduce paid work hours or exit the labour market (Quashie et al, 2022). Also, individuals with lower socio-economic positions may be more disadvantaged due to the increasing complexity of long-term care regulations and the focus on personal responsibility in care arrangements (Marangos et al, 2018, cited in Abbing et al, 2021).

The starting point of this article is that adopting an intersectional perspective is necessary to comprehensively grasp the interwoven mechanisms that underlie variations in carers' care attitudes. We also follow this approach because we want to put the lived experience of carers at the centre of our analysis (Bryman, 2016). Hence, we explored the question of to what extent Dutch carers differ in their care attitudes by organising focus groups while drawing inspiration from key assumptions of the intersectional approach: that multiple categories of difference contribute to carers' views on care attitudes; that these categories deserve equal attention and may intersect; and that within-group diversity can exist within categories of difference (Hancock, 2007).

Methods

During the focus groups, small groups of respondents were interviewed by a moderator using the group process to stimulate discussion and obtain information on the beliefs, attitudes and motivations of respondents on our research topic (Bryman, 2016).

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Data collection

Respondents were recruited by advertising through Dutch care and informal care support organisations. In addition, calls were shared on several social media platforms. To obtain a sample whose characteristics were similar to those of the whole population of carers while being heterogeneous enough to allow for inductive exploration (Hunting, 2014), we asked consultants allied with an informal care support organisation in Amsterdam to contact carers who might not be reached in the ways just described. To be included, respondents had to be providing informal care to someone they knew, regardless of the care demands the care recipient faced.

To be able to consider carers' social positions in relation to care attitudes, all respondents were interviewed individually prior to the focus groups and asked about the care situation. Additional questions used in these interviews had been used previously in a quantitative study that aimed to provide first insights into carers' care attitudes (Wittenberg et al, 2021). In total, 37 carers were interviewed individually, either face to face or by phone. Interviews typically lasted approximately 30 minutes.

After the individual interviews, respondents were invited to attend a focus group. Data were collected between November 2019 and June 2020. During data collection, the COVID-19 pandemic broke out and our research methods had to be adjusted. In total, eight focus groups were conducted in late 2019 and early 2020, of which four were face to face. The other four were conducted online via Zoom in 2020. In total, 30 of the original 37 respondents joined one of the focus groups. Others could not join, for example, because they had no time due to the needs of their care recipients. Focus groups comprised a minimum of two to a maximum of five respondents and lasted for about two hours.

During the focus groups, data collection was based on an intersectionality-informed approach. Questions that frame social categories as separate were avoided and questions had a broader focus on day-to-day experiences (Hunting, 2014). Carers were asked to elaborate on how care attitudes and differences in care attitudes among groups of people are shaped, as well as on the division of care responsibilities between family and/or social networks and the welfare state. In addition to the discussion about these normative views on the division of care, interviews and focus groups also addressed carers' practical preferences regarding sharing care with professionals. The present article focuses primarily on describing carers' normative views. The practical preferences of carers regarding the sharing of care will be the focus of a separate article.

Six social work students were involved in the data collection. They conducted some individual interviews themselves and were present during some of the focus groups to support the lead author, who moderated the discussions. Students were trained and supervised by the lead author during this process.

Analysis

All interviews and focus groups were audio recorded and transcribed verbatim while anonymising respondents. The transcriptions were conducted by the students involved and an external transcriber, under the guidance of the lead author, who reviewed all verbatim transcripts for accuracy. Qualitative content analysis was then conducted using a directed approach (Hsieh and Shannon, 2005). First, we used predetermined

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codes based on a previous study of care attitudes to categorise all text related to this subject (Wittenberg et al, 2021). Second, any text that could not be categorised with the initial coding scheme was given a new code using open coding. Third, we reflected on the specific role of intersecting diversity characteristics in carers' views and added codes that specified these diversity characteristics. Finally, we reassessed our coding scheme to make connections across the data and form a fuller explanation of relevant phenomena (Hunting, 2014). Using intersectionality, we moved beyond focusing on separate categories of difference and towards how social categories interact, which enabled us to better reflect the views and experiences of the carers involved (Hunting, 2014).

Coding was conducted by the lead author in continuous consultation with the second author to increase credibility. To begin, all quotations were read by the first two authors and the main subjects were discussed. Next, about 20 per cent of the data were coded by the lead author and codes were discussed with the second author; this led to several adjustments to the coding scheme. The remaining data were then coded by the lead author, after which the second author checked all applied codes for consistency. The final coding scheme is presented in Table 1.

Table 1: Coding scheme

Coding scheme	Quantity
Welfare state orientation	55
Caring norms	
Social network should provide care	68
Care obligations	45
Government's expectations	44
Differences in care attitudes	22
Causes	58
Professionals' attention to care attitudes	32
Attitude towards informal care	79
Carer diversity characteristics	
Gender	18
Age	21
Health	8
Religiosity	12
Own identity	12
Care recipient diversity characteristics	9
Contextual factors	
Ethnicity/culture	49
Family situation/upbringing	53
Financial situation	8
Employment	41
Living environment	9
Distance between carer and care recipient	18

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At the end of the study, respondent validation was conducted to confirm that the research findings were congruent with respondents' views on the research topic (Bryman, 2016). All respondents were offered the opportunity to read and respond to the final version of the article. No respondents objected, and some respondents explicitly agreed with the content of the research findings.

Results

Information about respondents' backgrounds and the backgrounds of care recipients and care situations is summarised in Figure 1, based on the visualisation of the dimensions of diversity in informal care research, as presented by Hengelaar et al (2021). In both the individual interviews and the focus groups, it immediately became apparent that carers found questions about the normative aspects of their views on sharing care difficult to answer and that what carers think about the division of care responsibilities is strongly context dependent. Respondents sometimes linked their normative views to more practical desires regarding the division of care. For instance, when the questions regarding care attitudes were posed, many respondents hesitated to select one of the provided response choices, indicating that the question had far more subtleties than could be encapsulated in the response options. They also indicated that various factors could impact their response, such as their relationship with the care recipient. Although these normative and more practical aspects of sharing care were sometimes difficult to separate during data analysis, the main focus in the following description of the results of the study is on the normative aspects of sharing care.

In our introduction, we identified gender, migration background and socio-economic status as social categories through which disadvantaged positions may arise for carers. We therefore build our results with these social positions as a starting point and elaborate on other, often intersecting, factors that influence carers' care attitudes to show their diversity of opinion. We then describe three recurring topics apparent in the discussions about care attitudes, despite the diversity among carers and their opinions.

Gender

Of the 37 carers we spoke to, 11 were male (♂) and 26 were female (♀). Several respondents stated that women are more likely to be expected to provide informal care than men. However, some respondents believe that male carers exist but are less visible or less likely to admit that they provide informal care. Some mentioned that they thought this was related to the relationship between carer and care recipient; daughters(-in-law) are primarily expected to take care of parents, while men are expected to help primarily in partner relationships. In this study, seven respondents cared for their partner (three ♂; four ♀), 13 for a child (one ♂; 12 ♀), 15 for a parent(-in-law), (five ♂; ten ♀) and nine for someone else, such as a grandmother or neighbour (two ♂; seven ♀). Five respondents (all ♀) provided informal care to two or more care recipients simultaneously. In the respondents' views, men, who more often work full time, were less likely to take the initiative to provide informal care. Respondents also thought that as increasing numbers of women are working, it may become more difficult for them to combine this with care.

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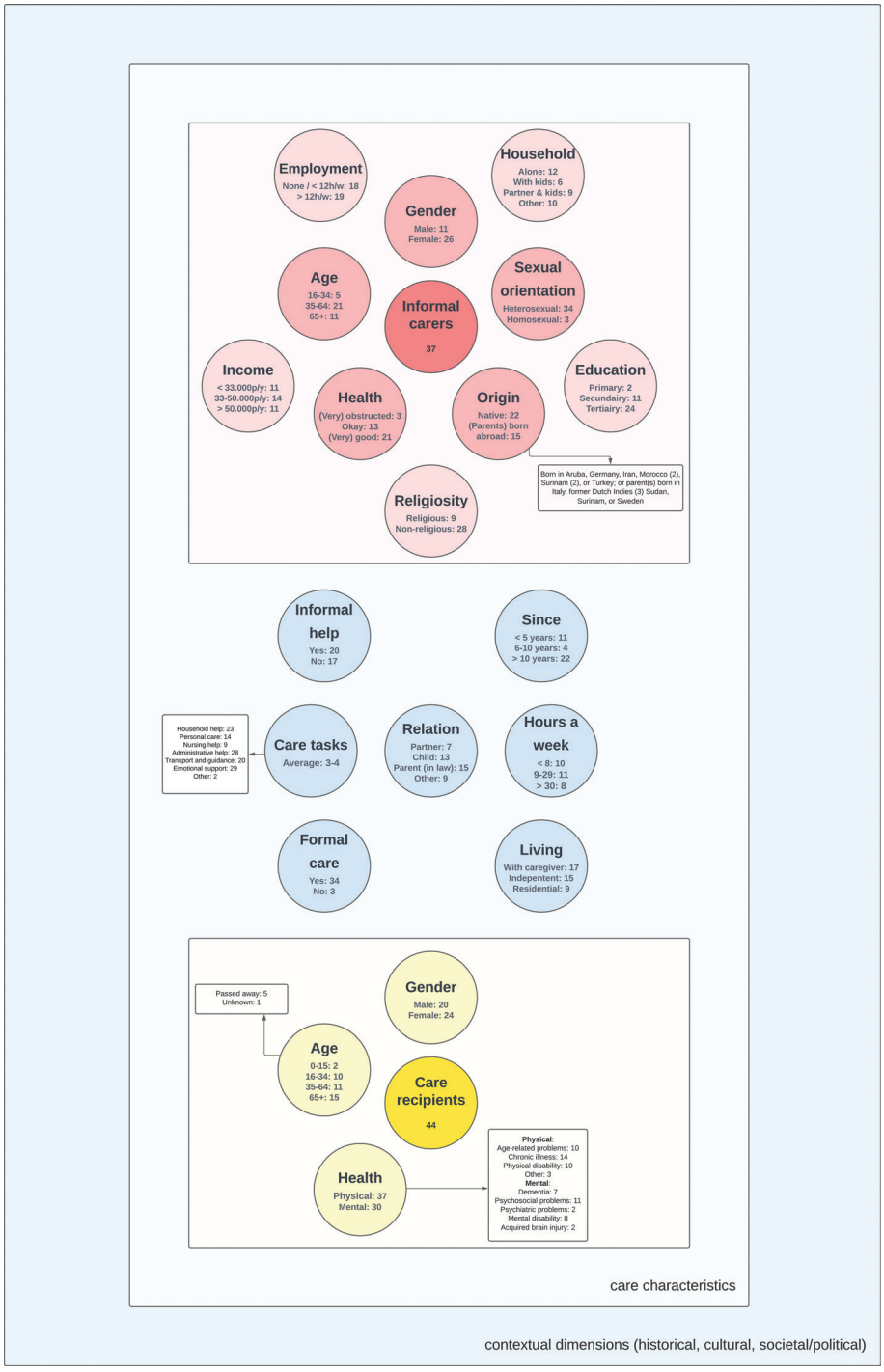
Figure 1: Diversity in respondents' care situations



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Migration background

In addition to their Dutch background, 15 respondents also had roots in another country. Respondents thought that women, especially those with a migration background, are accustomed to providing the largest share of informal care. According to respondents, their roots play a role in how they think about informal care. Often, this is based on the difference respondents ascribe to an 'I' versus a 'we' culture. Respondents with a migration background often identify with a 'we' culture, in which they say caring for each other is taken for granted: 'In our culture, it's really a family thing, but we live in a country where a lot is done for us in healthcare' (R18, ♂, 34 years old). Other respondents are aware of the Dutch healthcare context in which they also find themselves. The fact that they take care of someone is taken for granted, as dictated by culture, but people also think that professional care may be used because that is simply how it is arranged in the Netherlands. This does not, of course, apply to everyone, and not everyone with roots abroad experiences family orientation from a 'we' culture: 'Well, not with me. In general, Antilles is very family oriented. But I don't know that' (FG3, R21, ♀, 72 years old). Several respondents think that one's cultural background significantly influences care attitudes:

> If I had been born in a different kind of setting and perhaps also [with] a different character and different parents, a different environment … I would probably feel completely different. Every person is different. And how life has gone is also different; that has a huge influence on this. (FG5, R31, ♀, 25 years old)

Other key factors mentioned in relation to care attitudes were the norms and attitudes one learns during one's upbringing. People who are taught that it is good to take care of each other may be more likely to provide informal care themselves. This intersects with one's migration background; 'Yes, but as far as I'm concerned, you don't have the Moroccan with one parenting style. So, every family has its own way of raising children, has its own network' (FG4, R3, ♀, 48 years old). Although not specifically related to migration background, the role of family ties in deciding whether to provide informal care was also much discussed: 'If you have a good relationship with your family, for example, then it might be a bit more obvious or easier to provide care than if you had a less pleasant childhood, so to speak, or if you don't have a good relationship with your parents' (FG7, R34, ♀, 62 years old). Some believed that informal care should not be obligatory, as strained relationships may exist between family members.

In relation to migration background and upbringing, religiosity and one's own character were also mentioned as factors relevant to care attitudes. Persons raised to be religious are often taught that it is important to take care of each other: 'Maybe that's because of my background as a Moroccan. I grew up in Morocco, and also because of my religion, [I think] that you should take care of your parents' (R36, ♀, 42 years old). In this study, nine respondents identified themselves as religious and 28 as non-religious. In general, respondents believed that people who are religious tend to provide informal care more readily than those who are not. Caring was sometimes described as something intrinsic, something that is in one's own identity if they are a social person who wants to care for someone: 'Yes, that is part of your culture, that is part of your upbringing also, that it will happen at a certain moment. And I must say, I really want to do it too' (R35, ♂, 42 years old).

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Socio-economic status

Carers' employment status was mentioned several times in terms of care attitudes. In this study, 19 respondents did labour market work for more than 12 hours per week (eight ♂; 11 ♀). Some respondents felt that if the government expects people to take care of each other, it should be aware that other things will be more difficult to achieve: 'If we work, we cannot take care of our children at the same time, and I think the government will have to step in in that case' (R7, ♀, 50 years old). One cannot do everything at once. This also relates to gender, age and whether one has children: 'In my case, I work and also have two children and am still in the middle of life, having to pay a mortgage and so on. If you take care of your parents at the end of life, it is very different I think' (FG2, R4, ♂, 32 years old). Several carers described combining work and informal care as burdensome, and some had even started working less or consciously opted for a caring-friendly employer.

During the conversations, some respondents mentioned that their financial situation allowed them to provide informal care. They doubted whether this applied to everyone. Some thought that families with more resources could more easily pay for professional support and that these circumstances would influence their normative views on sharing care as well. Level and type of education and the type of work one does were also mentioned by respondents as factors related to care attitudes. According to respondents, providing informal care must suit the carer, which can sometimes be inferred from one's study or work background.

Stage of life

Apart from – but intersecting with – gender, migration background and socio-economic status, additional social positions related to carers' care attitudes could be identified in the data, which we summarise as the carers' 'stage of life'. This involves a person's age, health and whether the person has children. In this study, five respondents were between 16 and 34 years old, 21 between 35 and 64 years and 11 older than 65 years. Some believed that how people previously thought about providing informal care differed from today. For example, one woman thought that children today should not be obliged to take care of their parents when they need care, saying: 'My mother would have that feeling, but not me any more' (R8, ♀, 68 years old). These kinds of differences relate to the family life of the current generation: 'Because the tasks of young people now, of young families now, are much busier and heavier because of the way society works' (FG6, R30, ♀, 69 years old). One felt that young people were more likely to state that people should help each other because they may not yet have a realistic idea of how challenging a care situation can be. This also applies to people who are in good health. The idea is that if one's own situation is more challenging, one may start to think more realistically about caring. Ageing is sometimes seen as an obstacle to providing informal care, for example, because one's own health is deteriorating. If someone is in poor health and has a paid job, this negatively influences the possibility of providing informal care, according to some respondents, and they believed that this could then be reflected in their care attitudes as well.

Finally, one's household or family situation was mentioned as relevant to care attitudes. Some respondents thought that, especially in young families, people are very

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busy today: 'Everyone has to work a lot, children … they just have busy lives with children' (FG6, R30, ♀, 69 years old). If a carer has young children, this affects their ability to provide informal care. For some, this could also affect their normative views on sharing care. Finally, it also concerns family structures, such as whether sharing care with siblings is possible: 'I'm an only child. I can imagine this influences how I think care should be divided' (R2, ♀, 42 years old).

Recurring topics in discussions about carers' care attitudes

In this section, we describe three recurring topics apparent in the discussions about care attitudes, despite the diversity among carers and their opinions.

Carers want to provide care, but the government cannot withdraw entirely

Carers find it important to care for loved ones and generally do so out of love and with pleasure. Many respondents see it as something obvious, something that 'should be' and something they really want to do. Taking care of a loved one often feels good because the carer knows the care recipient and their care needs well and can thus offer them the best possible care. This proximity is important. If possible, many carers want to try to provide care themselves first. However, they felt that help should be available if desired, especially when long-term care is needed or when the care situation is (becoming more) complex. According to several respondents, the government should play a facilitating role for carers who need help. This way, the government can ensure that carers have space to develop themselves and that they can 'breathe' again. Some believe that they may also expect this help from the government because the Netherlands is a prosperous country in which citizens pay for care through the tax system and the health insurance law. Several respondents thus expect the government to ensure that care facilities are accessible, that care and support remain affordable, and that the government helps by providing facilities when no carers exist to support a care recipient or when they need help to be able to do so.

Resistance to (a feeling of) obligation to provide care

Some respondents did not think that it is the government's responsibility to tell them what they should and should not do when it comes to informal care. Carers want to be able to decide for themselves whether to help their loved ones: 'If I want to do it, I will. But I'm not obliged to provide care to my family members' (FG2, R1, ♀, 69 years old). The general opinion is that it should not become an obligation imposed by the government to provide informal care. This does not mean, however, that carers do not believe in a moral obligation. Some, for example, do not think that it is strange to expect children to care for older parents if necessary because of reciprocity between parent and child, for example:

> It is not mandatory because not everyone wants it. Look, I do see it as my duty because I have had a very good relationship with my parents. They

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> have also done a lot for me. [But] you can also have had a terrible childhood; well, then, you may not want to take care of that parent if they need help. (FG4, R24, ♀, 55 years old)

Despite the resistance to (a feeling of) obligation, some respondents do believe that the government can hold high expectations of carers. In other words, according to carers, the government can hope but cannot expect everyone to provide informal care. The government must 'make it possible' or 'facilitate', for example, by encouraging employers to implement informal care policies and schools to pay attention to young carers.

For some respondents, the ever-increasing appeal being made to carers in the Netherlands feels like a way to decrease healthcare costs. One calls it a bad thing that the government puts so much pressure on people to take care of others: 'It feels like, "Leave it to the family, then we don't have to worry about it"' (R19, ♀, 54 years old). Some call the government's high expectations from carers 'utopian' and think that the government does not have a realistic picture of providing informal care in practice.

Allowing professionals into the care network can be difficult

Respondents' opinions on sharing care with professionals varied. Several respondents stated that allowing professionals into care networks can be both difficult and scary. Moreover, not everyone wants help from professionals; admitting professionals into the private sphere is not pleasant for everyone. Some carers prefer to continue to provide care themselves because they do not want to depend on others.

If professional care is requested, professionals must see carers as equal partners, according to the respondents, who stated several times that customisation is important in this: carers would like professionals to inquire into their specific needs and discuss with them how professionals can help. Carers want to maintain control of the care. The level and intensity of the care needed seem to determine the question of where the boundaries lie in what the carer can and wants to do. If there is a long-term care situation with high-level care needs, it is desirable, according to several carers, that professionals are involved. This concerns, for example, personal care or nursing help: many carers prefer not to do this themselves and see it as a task for professionals.

Carers report rarely having conversations with professionals about how they consider the division of care responsibilities. Respondents generally recognised that discussing these care attitudes can be important for good collaboration with professionals. A relationship of trust with the professionals who help – and a listening ear and understanding from professionals – is necessary. Above all, carers want professionals to do what has been agreed upon and to be able to trust the professionals.

Some consider a discussion about the division of care responsibilities at the beginning of a collaborative relationship crucial: 'I think it is crucial you can do that together in the beginning.… How else can you collaborate well with each other if you don't know that?' (FG8, R27, ♀, 47 years old). However, some stated that it only makes sense to discuss care attitudes if professionals actually use this information. Carers think that professionals should hold a more coordinating function here. Continuity is expressed as important: if different professionals are involved each time, it is difficult to build a relationship of trust.

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Discussion

This qualitative study has focused on variety in carers' care attitudes. The first important conclusion is that many carers want to assist their loved ones themselves and feel a moral obligation to do so, but, at the same time, they also expect the government to play a role in caring for those in need. Three recurring topics appeared in the individual interviews and focus groups in relation to this conclusion. First, carers want to try to help their loved ones as much as possible, but they do think help from health and/or social care professionals should be available if needed, especially in long-term or complex care situations. Carers expect the government to ensure that this care is accessible, affordable and facilitated. Second, carers acknowledge feeling a moral obligation to provide care but generally believe that it should not become an obligation imposed by the government. The ever-increasing appeals for carers in the Netherlands spur negative feelings and doubt regarding whether the government understands the lived realities of caring situations. Third, allowing professionals into care networks is not always easy. It also became clear that care attitudes are rarely discussed with professionals. Carers seek a relationship of trust with professionals and want them to pay attention to their preferences as well, though good care for their loved ones is typically placed above carers' own needs.

A second important conclusion is that the intersecting social positions of carers influence their care attitudes. We clustered our results around the three main social categories of gender, migration background and socio-economic status and described how these categories intersect with others. This brought forward other, possibly less obvious, interactions with social positions as well (Hankivsky, 2014). First, gender influences care attitudes. According to our respondents, women are more likely to be expected to provide informal care. This confirms the notion that there are structural inequalities between men and women when it comes to caring (Tronto, 2013). Male carers are thought to provide informal care as well, but they are less visible or likely to admit that they are carers. Other research has shown that men are less represented and also less likely to use carer support systems (Lopez-Anuarbe and Kohli, 2019). For some, these gendered care attitudes intersect with the relationship between the carer and the care recipient and whether the carer has paid employment. In some cases, gender also intersects with one's migration background; in particular, women with a migration background are accustomed to providing informal care, as found in previous studies (Cohen et al, 2019; Ahmad, 2022), confirming that intersecting mechanisms of inequality (such as gender and migration background) can account for an asymmetric distribution of care tasks (Tronto, 2013). This migration background is a second important social category that influences care attitudes. Respondents in our study often framed this as their cultural background influencing how they think about providing informal care. For some, this intersected with upbringing, family ties or religiosity. Respondents also stated that in every family, upbringing and family ties differ, which underscores the notion that even people in the same family may have different ideas about the best way to provide care (Tronto, 2013). Third, as previous studies have indicated (Abbing et al, 2021), socio-economic status influences care attitudes. Whether a carer works, the carer's financial situation and the type of study conducted all matter. Whether one can and wants to provide informal care alongside their job also intersects with other factors, such as gender, age and whether one has children. Finally, we presented a fourth category that influences care attitudes,

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summarised as carers' 'stage of life'. This concerns one's age, health and whether one has children. Conversations about these subjects underlined the fact that both the willingness to provide care and the possibility to do so are crucial.

These findings confirm that care attitudes are shaped by individuals' intersecting social positions (Gans and Silverstein, 2006; Dykstra and Fokkema, 2012). They also illustrate how mechanisms of inequality intersect concerning care attitudes. As Tronto (2013) described, even individuals from the same families may have different ideas about the best way to care and thus about how to divide care responsibilities. Deepening these differences across social positions allowed us to get a better understanding of the composition of particular care attitudes among carers. However, despite the differences in care attitudes, several universally applicable desires regarding the role of the government could be recognised as well.

Strengths and limitations

This study has several strengths. First, we discussed care attitudes in detail with carers with various backgrounds in various caring situations, giving us a nuanced understanding of how care attitudes are shaped. Using intersectionality, we found multiple intersections between the main social categories and other, sometimes less obvious, social categories influencing care attitudes. This gives us a better understanding of the heterogeneity both within and between groups of carers (Lapalme et al, 2020). Second, using focus groups allowed us to describe *why* carers hold certain care attitudes because respondents were able to probe each other's reasons for expressing certain care attitudes. Using the focus group method was thus helpful in eliciting a variety of different views in relation to care attitudes (Bryman, 2016).

Limitations include that all respondents had to be able to communicate in Dutch and that almost all respondents already used some type of professional help. Combining this with the relatively high number of well-educated respondents, we conclude that we mostly involved respondents who proved capable of finding and organising help for their loved ones and/or themselves. With this, we missed a potentially vulnerable group of carers who are not yet familiar with support systems. In future research, one should contemplate how to engage with hard-to-reach populations like these.

Although the use of intersectionality provided useful insights into differences both between and within groups of carers, we must also point out limitations in our application of the intersectional approach. As we aimed to investigate differences in carers' care attitudes and not necessarily to contribute to the scientific knowledge about the usefulness of intersectionality within informal care research, we did not perform a full intersectional analysis on our data, as suggested by, for example, Stuij et al (2020). As a result, our results focus on differences but less on inequalities or disadvantaged positions between carers.

Finally, an unforeseen event relevant to this research was the COVID-19 pandemic, necessitating adjustments to our research methods. Half of our focus groups were delayed and had to be organised online. To assure research quality, the methodology and examples of online audio-visual focus groups were studied by the lead author. This led to the decision to provide extensive pre-focus group information to respondents to increase the chances of stability in group numbers, as well as to prevent technical problems and distractions during the sessions (Daniels et al, 2019). Despite these measures, group

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numbers were somewhat smaller compared to the face-to-face focus groups, and sessions were occasionally disrupted due to technical matters. While analysing the data, both the lead and second author compared the richness of data generated in the face-to-face and online focus groups. Respondents attending the online focus groups showed less socialising with others but, simultaneously, were less likely to interrupt during discussions, which corroborates with other research comparing focus group methods (Abrams et al, 2015). However, the data collected during the online focus groups still had depth and, by our judgement, were reliable for helping to answer our research questions.

Policy implications

Due to the variety in carers' views on care attitudes, professionals providing indirect support to carers should invest in getting to know the carer and their situational circumstances, despite the high workloads of the professionals related to providing care for the care recipient. For example, by learning more about carers' family ties, working conditions and parental status, mutual understanding can arise about what the carer can and wants to do for their loved one in a specific care situation. Discussing expectations regarding the division of care can ensure that the carer feels involved as an equal in decision making (Hengelaar et al, 2018; Wittenberg et al, 2018; Skinner et al, 2021; Hovenga et al, 2022). Furthermore, professionals cannot assume certain care attitudes based on the specific social categories to which a carer belongs. Professionals should be wary of stereotyping and generalising groups through 'othering' ideologies and rather try to explore, understand and adjust to the present and often-fluctuating set of needs of carers (Sagbakken et al, 2018). This includes having an eye for less obvious groups of carers. Both health insurance companies and national and local policymakers should promote and facilitate time for professionals to be able to do so.

Professionals providing direct support to carers should also be careful not to homogenise groups when support is organised around specific groups, such as older carers. As our results show, such social categories often intersect, and less obvious categories sometimes cause differences both within and between groups. At the same time, it is important to emphasise that although persons within particular social categories can have different experiences, this does not imply that they do not share common experiences (Hunting, 2014). Policymakers should also consider making direct support services aimed at specific groups accessible to carers who, at first sight, do not belong to that defined group but who would benefit from the services.

Besides investing in these existing support systems, both national and local policymakers should continue to encourage relevant partners, such as employers, to facilitate combining informal care with other life domains. Even if individuals are willing to care for their loved ones, the practical possibilities of shouldering heavy care obligations are becoming increasingly limited (Kääriäinen et al, 2022). To meet the growing demand for informal care, space must be created to provide this care.

Conclusion

Carers' social positions, such as gender, migration background, socio-economic status and stage of life, mutually influence the way they think about the division of care responsibilities. Although many carers can and want to do a lot for their loved ones in

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need, they believe this should not become an obligation imposed by the government. Carers expect the government to ensure professional care is accessible, affordable and facilitated. Professionals should invest in getting to know the carer and their situational circumstances, as this creates an understanding of what carers can and want to do in specific care situations. Professionals and policymakers should also be careful not to homogenise groups of carers based on (some of) their social positions, as carers have different care attitudes, experiences and needs. This also applies to support for carers: instead of aiming at one specific group of carers, support should be organised to be as personalised as possible.

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Conflict of interest

The authors declare that there is no conflict of interest.

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