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Discussion Paper No. 880

**FAMILY CARE-GIVING AND RELIGION:
EVIDENCE FROM MICRO-DATA
IN THE UNITED STATES**

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Family Care-giving and Religion: Evidence from Micro-data in the United States*

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Abstract

Purpose: Examining the linkage between self-reported ethnicity and the propensity for family-based informal health care, this study considers cultural connections to religion as a possible explanation for ethnic difference.

Design and Methods: Nation-wide survey respondents (N = 2,126) were selected on the basis of having a parent requiring long-term care now or in the near future, and weighted according to age, gender, and self-reported Hispanic ethnicity. A probit analysis tested the association of Hispanic ethnicity, as well as several other explanatory variables, with the possibility of the respondent assuming the primary caregiving role for the elderly family member.

Results: While there was a significant association between Hispanic ethnicity and family elder care, there was no significant relationship between religion and family elder care. There was additionally no significant association with level of income.

Implications: This research reiterates, using recent micro-data, that there is indeed a connection between ethnicity and family elder care. However, we show that religion is not one of the facets underlying such ethnic difference. While we have taken an initial step in quantitatively defining cultural attributes, more research is needed to determine where ethnic differences may originate.

Keywords: family care-giving, religion, ethnicity, household survey, population aging
JEL classifications: I30, Z1

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Introduction

Elder care in the United States is not delivered in a uniform way. Where some may be more likely to utilize the formal services of retirement homes, doctors and hospitals, others have a stronger propensity toward informal home care. In considering the likelihood of using home care from the macro level, cultural differences are often implicitly assumed to play some role. Yet “cultural differences” are frequently vague and undefined. This article seeks to refine one aspect of these cultural differences in elder care, looking at the relationship between ethnicity and religion. Specifically, we will consider whether there is a connection between religion and the commitment to family caregiving in the United States.

While eldercare within the family was a common occurrence throughout much of American history, the advent of the modern healthcare system has brought an increased reliance on medical professionals (Buhler-Wilkerson, 2007). However, care within the home has remained a constant, particularly for those suffering from long term conditions. Home care will further play a greater role in the future as the country ages and demographics change. The US census estimates that the fastest growing section of the population will be elderly adults, and that the percentage of racial and elderly adults of ethnic minorities will increase at a much higher rate than elderly non-Hispanic white adults (Dilworth-Anderson, 2002; Navaie-Waliser, 2002; US Census Bureau, 2010). As such, consideration of the circumstances surrounding the use of informal home care, its effects and costs is warranted.

The informal health care market in the United States remains extremely large, with estimates of the informal healthcare market value ranging from \$196 billion in 1997 (Arno et al, 1999) to \$257 billion in 2004 (Levine, 2004), easily dwarfing

expenditures on formal healthcare and nursing home care, and likely to dramatically expand as the elderly population grows. As informal, typically family-based care makes up such a large portion of total healthcare in the US, a considerable amount of research has already been conducted on the topic. A number of studies have examined the connection between ethnicity and informal caregiving, concluding that there are considerable ethnic differences in the preferences for and types of elderly care received (Bradley et al, 2004; Burton et al, 1995; Chung, 2008; Mui & Burnette, 1994; Nazroo, 1997). Additionally, those self-describing as “Hispanic” are much more likely to participate in informal family home care (Bookman & Kimbrel, 2011; Navaie-Waliser, et al 2001; Weiss et al, 2005). Where there is disagreement, however, is in the explanation as to why Hispanics are more likely to engage in informal healthcare compared to other ethnicities. This disagreement is where we focus our attention.

The vast majority of cases studying ethnic differences in informal caregiving use small, non-representative samples to draw their conclusions (Clark & Huttlinger, 1998; Henderson & Gutierrez-Mayka, 1992; Peng et al, 2003; Shaw, 2005). While such conclusions should be considered cautiously at best, there is often a vague cultural explanation of difference at their heart. For example, Henderson & Gutierrez-Mayka (1992) observe a cultural norm among Hispanics that women provide care to elderly family members. Hinojosa et al (2009) provide evidence supporting a “cultural basis” for family care of disabled elderly adults. Weiss et al (2005) note a positive correlation between ethnic Latinos and the number of informal healthcare hours received, yet posit that “like cultural values and norms regarding responsibilities toward elders” may play a role in higher levels of informal care. In their comprehensive review of 59 articles published between 1980 and 2000, discussing the connection between ethnicity and

informal care, Dilworth-Anderson et al (2002) conclude that while there is a cultural connection with the use of informal care services, culture is often “measured implicitly or inferred by researchers”. Clearly, a more concrete definition of what constitutes these cultural differences is necessary.

Where attempts at defining the cultural explanation for differential informal care have been given, most researchers point to values such as reciprocity, filial obligation (Dilworth-Anderson et al, 2002), mutual exchange and interdependence (Bookman & Kimbrel, 2011) and collectivism (Hinojosa et al, 2009) as defining characteristics. These terms, while perhaps useful to a degree, have severe limitations in terms of measurability and quantification.

As the preceding review shows, culture is a vague term that can encompass a wide variety of facets. While we do not set out to define culture in its entirety or lay out every aspect of its connection to informal caregiving, we do aim to elucidate one portion of it: religion. Religion, while perhaps closely associated with particular ethnicities and informing cultural norms, has been less commonly considered as an aspect of culture. Levkoff et al (1999) provides a rare exception, yet looks at only a very small number of cases. Others have considered the connection between eldercare and religion (Karlin 2004; Markides 1983; Picot 1997), but often fail to make any connection to ethnicity. In fact, of the 83 articles analyzed in Herbert et al’s review of the published literature on the association between religion and elder care (2006), only ten articles (12%) looked at connections between religiosity and elder care in different ethnicities. Of these, eight articles found higher levels of religiosity, higher frequency of religious behaviors, or higher scoring on religious variables for ethnic minorities compared to non-Hispanic whites (p. 513). Demonstrated by the dearth of literature

available, religious connections to culture in the context of elder care remains largely understudied.

Self-reported religion has the advantage of being easily quantified. Combined with reasonable measures of ethnicity and elder care provision, connections between ethnicity, culture, religion and informal caregiving can be made more readily apparent. Beyond merely alluding to broad terms such as collectivism, interdependency or filial piety, our aim here is to see if there is in fact an association between popularly espoused religious morals and their concrete manifestation in family eldercare. While values such as collectivism, interdependency and filial piety may be important to a group of people, there is also some benefit in determining where these values originate.

Methods

This study uses data gathered from a nationally representative sample of Americans conducted by the University of Osaka in 2011. The sample target was individuals aged 18 and over, living in all states but Alaska and Hawaii. Surveys were conducted via mail, with a response of 5,313 individuals out of a total of 7,046 surveys mailed (response rate = 75.4%). Respondents were asked to self-identify if they are Hispanic and their religion, if any. They were also asked whether they will be the primary caregiver for their parent(s) when they require long-term care. From the dataset, we selected the 2,126 respondents that had parent(s), who required long-term care or had the possibility to require long-term care in future, and had no missing answers.

Asking respondents to self-identify whether or not they are Hispanic helps to avoid some of the problems of classifying ethnicity from earlier studies. Self-identification as Hispanic can allow for multiple ethnic classifications, where one may

identify with multiple ethnic groups including Hispanic. Respondents were included in the Hispanic group so long as they self-identified into it. All others were included in the non-Hispanic group. For our purpose here of considering religion as one aspect of Hispanic culture dictating the use of informal eldercare, this classification seems to be the most appropriate.

The variables used in this research are shown in Table 1. We set the variable “caregiver” as explained (dependent) variable. The others are explaining (independent) variables. Among them, the variables listed from “Protestant” to “Noanswer” indicate respondents’ religious affiliation, if any.

Table 1: Variable Descriptions

Variable	Description
(Explained)	
Caregiver	Who will be the primary caregiver for your parent(s) when they need a long-term care? (1=You, 0=others)
(Explaining)	
Male	Respondents' gender (1=male, 0=female)
age	Age
educ	Years of Education
Sedu	Spouse's Years of Education
Houseincome	Household income (unit: 1,000 USD)
Nosiblings	1=no sibling, 0=otherwise
Protestant	1=Protestant (Baptist, Episcopalian, Evangelical, Lutheran, Presbyterian, United Methodist, and Other Protestant), 0=otherwise
Catholic	1=Catholic, (Roman Catholic, Orthodox Christian, and Other Catholic) , 0=otherwise
Otherchristian	1=Other Christian, 0=otherwise
Otherreligion	1=Other religion (e.g., Buddhism, Hinduism, Islam, Judaism Scientology), 0=otherwise
Nonreligion	1=no religion, 0=otherwise
Noanswer	1=no answer (not "missing answer"), 0=otherwise
Hispanic	1=hispanic, 0=otherwise

Descriptive statistics are indicated in Table 2. In this survey, 38 percent of the respondents identified their religion as Protestant, followed by 23 percent for Catholic and 12 percent for no religion. According to the Pew Research Center (2012), about 48 percent of U.S. citizens identify as Protestant, followed by 22 percent as Catholic and 19 percent Unaffiliated (= no religion). The sample we used for this paper thus roughly represents the U.S. religious figure. In addition, whereas 12 percent of the respondents are Hispanic in this research, the U.S. Census Bureau (2010) indicates that 16.3 percent

of the U.S. citizen is Hispanic. Again, the sample we used for this paper roughly represents the U.S. demography. Additionally, 89 out of the 247 Hispanic observations (36%) self-identified as Catholic.

In order to minimize sampling bias, we organized the sample using two sampling weights provided by Osaka University. According to the Pew Research Center (2012) and the U.S. Census Bureau (2010), both religious and Hispanic demographics greatly differ by region and generation. We needed to control for these aspects. The first weight we used was an Age and Sex Weight (Table 3). Dividing the U.S. population into 99 universes according to age groups, sex, and geographical region, this study calculates the sampling weight based on the American Community Survey 5-Year Estimates (2006-2010). The second weight was a Hispanic Weight (Table 4), also based on the American Community Survey 5-Years Estimates (2006-2010). We then added the Hispanic weight to the Age and Sex Sampling Weights.

Table 2: Descriptive Statistics

	Mean	Sd	Min	Max	Obs
Caregiver	0.23	0.42	0	1	2126
Male	0.42	0.50	0	1	2126
age	49.84	11.19	20	70	2126
educ	14.53	2.39	10.5	21	2126
Seduc	14.42	2.46	10.5	21	2126
Houseincome	87.57	47.79	10	200	2126
Nosiblings	0.07	0.25	0	1	2126
Protestant	0.38	0.48	0	1	2126
Catholic	0.23	0.42	0	1	2126
Otherchristian	0.09	0.28	0	1	2126
Otherreligion	0.06	0.23	0	1	2126
Nonreligion	12	0.33	0	1	2126
Noanswer	0.06	0.23	0	1	2126
Hispanic	0.12	0.32	0	1	2126

Table 3: Age and Sex Weight

	Northeast	Middle Atlantic	East North Central	West North Central	South	East South Central	West South Central	West	Pacific
Male 18-24	1	12	23	34	45	56	67	78	89
Male 25-34	2	13	24	35	46	57	68	79	90
Male 45-54	3	14	25	36	47	58	69	80	91
Male 55-64	4	15	26	37	48	59	70	81	92
Male 65-74	5	16	27	38	49	60	71	82	93
Male 85+	6	17	28	39	50	61	72	83	94
Female 18-24	7	18	29	40	51	62	73	84	95
Female 25-34	8	19	30	41	52	63	74	85	96
Female 45-54	9	20	31	42	53	64	75	86	97
Female 55-64	10	21	32	43	54	65	76	87	98
Female 65-74	11	22	33	44	55	66	77	88	99

Table 4: Hispanic Weight

		Northeast	Middle Atlantic	East North Central	West North Central	South	East South Central	West South Central	West	Pacific
Hispanic	Male 18-24	1	23	45	67	89	111	133	155	177
	Male 25-34	2	24	46	68	90	112	134	156	178
	Male 45-54	3	25	47	69	91	113	135	157	179
	Male 55-64	4	26	48	70	92	114	136	158	180
	Male 65-74	5	27	49	71	93	115	137	159	181
	Male 85+	6	28	50	72	94	116	138	160	182
	Female 18-24	7	29	51	73	95	117	139	161	183
	Female 25-34	8	30	52	74	96	118	140	162	184
	Female 45-54	9	31	53	75	97	119	141	163	185
	Female 55-64	10	32	54	76	98	120	142	164	186
	Female 65-74	11	33	55	77	99	121	143	165	187
Non-hispanic	Male 18-24	12	34	56	78	100	122	144	166	188
	Male 25-34	13	35	57	79	101	123	145	167	189
	Male 45-54	14	36	58	80	102	124	146	168	190
	Male 55-64	15	37	59	81	103	125	147	169	191
	Male 65-74	16	38	60	82	104	126	148	170	192
	Male 85+	17	39	61	83	105	127	149	171	193
	Female 18-24	18	40	62	84	106	128	150	172	194
	Female 25-34	19	41	63	85	107	129	151	173	195
	Female 45-54	20	42	64	86	108	130	152	174	196
	Female 55-64	21	43	65	87	109	131	153	175	197
	Female 65-74	22	44	66	88	110	132	154	176	198

Finally, the model we used for analysis is described by the following equation:
$$\text{Probit (caregiver=1)} = a + b (\text{male}) + c (\text{age}) + d (\text{educ}) + e (\text{seduc}) + f (\text{houseincome}) + g (\text{nosibling}) + h (\text{protestant}) + I (\text{catholic}) + j (\text{otherchristian}) + k (\text{otherreligion}) + l (\text{nonreligion}) + m (\text{noanswer}) + n (\text{hispanic}).$$

Results

The estimation results are illustrated in Table 5. Model 1 shows the result with no sampling weight, whereas Models 2 and 3 indicate the results with the Age and Sex weight and Hispanic weights respectively.

Table 5: Estimation Results

	(1) with no- weight caregiver	(2) with Age and Sex weight caregiver	(3) with Hispanic weight caregiver
male	-0.491 ^{***} (-7.66)	-0.489 ^{***} (-6.81)	-0.445 ^{***} (-5.20)
age	-0.00581 ^{**} (-2.08)	-0.00746 ^{**} (-2.36)	-0.0103 ^{***} (-2.70)
educ	-0.00384 (-0.25)	-0.00829 (-0.49)	-0.00707 (-0.35)
seduc	-0.0392 ^{***} (-2.71)	-0.0384 ^{**} (-2.24)	-0.0356 [*] (-1.90)
Houseincome	0.00105 (1.42)	0.000945 (1.10)	0.00130 (1.26)
nosibling	0.631 ^{***} (5.55)	0.613 ^{***} (4.70)	0.574 ^{***} (3.57)
protestant	0.115 (0.87)	0.145 (1.03)	0.137 (0.84)
catholic	0.0947 (0.68)	0.161 (1.08)	0.116 (0.67)
otherchristian	0.162 (1.02)	0.241 (1.38)	0.258 (1.30)
otherreligion	0.215 (1.23)	0.195 (0.97)	0.261 (1.11)
nonreligion	0.0102 (0.07)	0.0280 (0.17)	-0.0401 (-0.22)
noanswer	0.0608 (0.34)	0.132 (0.68)	-0.00408 (-0.02)
hispanic	0.182 [*] (1.93)	0.215 ^{**} (2.02)	0.251 ^{**} (2.00)
_cons	0.0993 (0.34)	0.197 (0.58)	0.263 (0.66)
<i>N</i>	2126		1656

t statistics in parentheses

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Based on the results above, we find that gender, age, spouse's education, number of siblings and Hispanic ethnicity are all significantly associated with the

likelihood of the respondent being the primary caregiver for an elderly parent. A discussion of the implications of these results follows.

Discussion

This analysis has endeavored to show the connection, if any, between ethnicity, religion and elder care. We have attempted to test the premise that ethnic difference can lead to differences in family elder care, with particular attention to Hispanic vs. non-Hispanic populations. In so doing, we have utilized a nationally representative sample with a fairly new collection of data and weighted the data appropriately. Where many studies of Latinos and health in the United States rely on older surveys or base their findings on colloquial, regional statistics, this study has aimed to incorporate a macro-level, national study utilizing recent data.

What we have found is that while there is indeed a connection between self-identified Hispanic ethnicity and the likelihood to care for elderly family members, there does not appear to be a religious connection. In other words, commitment to family caregiving is significantly influenced by Hispanic ethnicity, but not by religious affiliation. Hispanics typically identify with the Catholic religion, and had a significant association in this study, yet we observed no statistically significant connection between Catholicism and elder care, even when controlling for Hispanic identification. Some other aspect(s) of Hispanic culture appears to be playing a role in the propensity for family elder care.

One of the major contributions of this research is that it has successfully tested the connection between Hispanic ethnicity and the propensity toward family care using micro-data that includes detailed attributes. Much of the literature correctly identifies

ethnic differences in elder care, but as previously mentioned, often utilizes small, non-representative samples. This study confirms that there is indeed a significant association between the Hispanic ethnicity and the likelihood to care for elderly family members at home.

Because the “cultural” justification for ethnic difference in family-based elder care has remained largely undefined or only done so in abstract, unquantifiable terms, we have considered a possible underlying facet of cultural difference: that of religion. What we have ultimately found is that religion does not appear to play a significant role in ethnic difference in this case. Future research of this nature can examine other quantifiable factors that may have a greater impact in explaining ethnic difference.

Additionally, another common yet untested explanation for ethnic difference in family care is related to income. Some have posited (Lillie-Blanton et al, 2000; Mui & Burnette, 1994) that income inequalities between ethnicities account for the propensity toward family elder care. In fact, our data shows there to be no significant association between income and elder care. Again, the income discrepancy explanation appears to be unwarranted. Further research can help to establish or refute such a connection.

Limitations to this study should also be considered. For one, the data provided is merely a snapshot in time, albeit a recent one. Longitudinal data would help to give a more complete picture of the connection between elder care and ethnicity, as well as any fluctuations over time. Additionally, the self-reporting of the likelihood that the respondent will be the primary caregiver is perhaps not the best indication of the procurement of family elder care. The question could have been worded more specifically, as it is possible that there could still be considerable outside medical involvement with the elderly family member. Perhaps most importantly, this study does

not concretely establish the underlying bases for cultural difference in family care or provide quantifiable means to assess it. Rather, we have refuted cultural measures based on religion and have provided some indication of a lack of association with income. Future research should continue to consider the cultural connection, perhaps examining other quantifiable facets of conventional explanations of cultural difference.

In sum, while religion may appear on the surface to provide a reasonable explanation for some cultural difference in the procurement of family-based elder care, this is in fact not the case. There are likely other, perhaps deeply-rooted, cultural mores underlying the decisions individuals make regarding their elderly family members. In ruling out the religious explanation, researchers can look to other possible aspects of culture, with the ultimate aim of matching care with culturally-appropriate circumstances.

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