INTRODUCTION

Informal care plays an important role in providing care to persons with health problems. There is therefore a great deal of public interest in Europe focusing on this type of care (Pavolini & Ranci, 2008; Spasova et al., 2018). In the Netherlands, the access to support for people living independently who have disabilities is regulated by law via the Social Support Act of 2015. This...
legislation assigns the primary responsibility for such care to the social network. Policies in other countries are generally similar (Lüdecke et al., 2018; Verbeek-Oudijk et al., 2014). Policies are in part a response to the increasing costs of care, which is largely due to the growing number of older people in the general population (Verbeek-Oudijk, 2019).

One of every three persons in Europe is an informal caregiver (Verbakel et al., 2017). The Netherlands is no different in this respect (De Klerk et al., 2017). Research makes it clear that not only family but also non-kin provide a substantial part of the informal care being given (LaPierre & Keating, 2013). A review of the relevant literature shows that a great deal of attention is focused on informal care for the family (Barker, 2002; Pinquart & Sorensen, 2011). Besides the partner, children are an important source of care. However, older people increasingly have fewer or no children at all due to the decreasing birth rates. Separated parents have less contact with children compared to parents who continue to live together (Van der Pas & Van Tilburg, 2009). There is an increasing rate of divorce among older people (Brown & Lin, 2012). The changing structure of families can therefore lead to a decrease in the amount of informal care by children (Ryan et al., 2012).

There are indications that the importance of non-kin within the framework of informal care is on the rise. Barker (2002) showed that other family members, friends and neighbours are increasingly taking on the role of informal caregiver. Ulmanen and Szebehely (2015) confirm that, in Sweden, since 2000 not only the help provided by children but also the help of friends has increased. There are also indications that older people are increasingly receiving more emotional and practical support within the framework of friend-based networks (Suanet & Antonucci, 2017). The contribution made by non-kin to the total of informal care is not yet clear (see, e.g., Siira et al., 2019). A great deal is already known about which factors promote or hinder the provision of informal care (see below), but not yet about the associated differences as a function of social relationship (kin and non-kin). This article aims to provide insight into the characteristics that are associated with the provision of informal care by persons over the age of 18 for various social relationships between the provider and the recipient.

1.1 | Determinants of providing help in general

We use the Informal Care Model (ICM) as a basis for explaining the differences in the provision of informal care. This model was designed to study the determinants for providing informal care in the general population, since becoming a caregiver is not a random process (Broese van Groenou & De Boer, 2016; Kietzman et al., 2013). Within the context of this paper, three factors associated with the need to provide care are distinguished, namely sociodemographic characteristics, experiencing barriers and beliefs.

Sociodemographic characteristics play an important role. A general finding is that women provide more informal care than men, but care provided by men should definitely not be underestimated (Broese van Groenou & Tolkacheva, 2014; Haberkern et al., 2015; Kahn et al., 2011; Vanbrabant & Craynest, 2006; Verbakel, 2015). Age is also an important factor, because persons in certain age categories more frequently know someone who needs help than persons in other age categories (Dahlberg et al., 2007; De Klerk et al., 2015). Lower educated people provide and get more informal help than higher educated people (Broese van Groenou et al., 2006).

Barriers refer to difficulties and restrictions experienced by people in relation to providing informal care. Such barriers may, for example, consist as competing tasks such as caring for children (Henz, 2006). Women with two or more children in the household have a lower rate of taking up caring than women with fewer children (Hank, 2011). Singles are less likely to provide informal care than couples, because of the lack of a partner or parents in law who may need care (Broese van Groenou & De Boer, 2016; Carmichael et al., 2010; Henz, 2009). A better health correlates positively with the probability of providing social support to children and grandchildren (Igel & Szydlik, 2011). Others find the role of multimorbidity in care provision ambiguous (Hank, 2011). Research into the relationship between having a paid job and providing care shows varying results. Some researchers do not find any correlation between having a paid job or the number of hours worked on the one hand and providing informal care to parents on the other hand (Bonsang, 2007; Dykstra & Van Putten, 2010; Henz, 2006), whereas others do (Bauer & Sousa-Poza, 2015; Carmichael et al., 2010; Verbakel, 2015).

‘Beliefs’ refers to the sum total of norms, attitudes and expectations with regard to informal care. There is not much known yet about the influence of a person’s attitude on providing informal care, but there are indications that religious beliefs do play a role (Broese van...
Groenou & De Boer, 2016; Peng & Anstey, 2018). This also applies to the informal care given to non-family members (Barker, 2002). A frequently mentioned factor is the norm that people should take care of family members (Silverstein et al., 2006). There are indications that altruism also plays an important role for specific non-kin relationships such as friends (Stewart-Williams, 2007).

1.2 | Determinants of informal care in relation to type of social relationship

There is still little knowledge available about the determinants of informal care of various types of social relationships. In the economic literature, the provision of care to specific people is assumed to be free choice. Other literature indicates that the choice to become an informal carer is not always free of pressure (Aneshensel et al., 1995). Psychological theories emphasise individual characteristics such as emotional attachment or the sense of obligation to specific relations (Kietzman et al., 2013). In sociology, the specific context of the provider, like barriers or social norms, of informal care is taken into account. The following question is central: to what extent is the provision of informal care to various types of social relationships correlated with different characteristics (sociodemographic characteristics, barriers and beliefs).

If a person in need of care has a partner, the partner will most likely provide help (Jacobs et al., 2016). Persons helping their partner are on average older than persons helping their parent (in law) (Pinquart & Sörensen, 2011). Because of their age, we do not expect barriers like having children or a job to play a role in the provision of spousal care. There are indications that this care-giving is related to socioeconomic status, in so far that extra cash may encourage outsourcing care-giving arrangements (Bertogg & Strauss, 2018).

With regard to gender and care for a partner, research is inconclusive. Since women, on average, live longer than men, but also have more often chronic diseases and impairments than men, one may expect that more men care for a sick partner than the other way around (Glauber, 2016). There are also studies which suggest that men resist reordering gender roles when their spouse becomes ill (see, e.g., Langner & Fürstenberg, 2020). Partners generally take it for granted to help each other, as an expression of mutual commitment and loyalty, so we do not expect beliefs to play a role. Our first hypothesis, therefore, is that regarding partner care sociodemographic characteristics are far more important than barriers and beliefs.

Many people provide care to their parents. Middle-aged persons more frequently have parents who need help than others (Dahlberg et al., 2007; De Klerk et al., 2015). Women provide more care to family members than men do (Haberkern et al., 2015). There is evidence that higher educated persons live further away from their parents (Grundy & Shelton, 2001; Kalmijn, 2006), which means they have more access to the ‘legitimate excuse’ of distance not to get involved in care. Because of higher wages, they are able to pay for private care (Carmichael et al., 2010; De Koker, 2009).

Other studies show that filial norms are related to being a family caregiver (Dykstra & Fokkema, 2012; Silverstein et al., 1995, 2006). Regarding first-degree family members, our hypothesis is that sociodemographic characteristics are more important than barriers, which are more important than beliefs (hypothesis 2).

The literature on informal care-giving is almost never about informal care being given to distant family or friends or neighbours (LaPierre & Keating, 2013). In more distant family relations, there may be more broader network of potential—partner, children, brothers and sisters—family helpers available. We therefore expect that not only sociodemographic factors, but in particular barriers, such as full-time work, poor health or having young children, are associated with (not providing) help in more distant relatives, and that beliefs such as filial obligations or religious norms are positively associated with distant family care. It is imaginable that this is also true for non-kin relationships (Barker, 2002). Therefore, our third hypothesis is that besides sociodemographics, beliefs and barriers correlate with the provision of distant family and non-kin care.

2 | METHODS

2.1 | Sample

In 2014, a random sample of 18,000 persons 18 years and older living independently was taken from the municipal personal records database, which contains all residents of the Netherlands, and in 2016, a sample was taken of almost 19,000 persons 16 years and older. They were invited to fill out an Internet questionnaire. If they had not yet responded after two written reminders, they were interviewed by telephone if a phone number was available. The fieldwork was carried out between 11 September and 31 December 2014 and between 13 September and 11 December 2016 by Statistics Netherlands. The response rate was 43% in 2014 and 40% in 2016 (Janssen, 2017). For this article, we pooled the data of 2014 and 2016 and selected the individuals 18 years and older. A total of 14,589 persons participated, of whom 13,165 answered all the questions. The analyses in this paper are based on 13,165 persons. Because of this large sample size and the concomitant power, we report only results significant at a 1% level. Among the respondents, men, single persons, persons between the ages of 18 and 35, persons in very urbanised areas, persons with a low income level and non-Western individuals with a migration background were underrepresented. A weighting factor was used to correct for this selectivity (Janssen, 2017; Roels & Braams, 2015). The sample of the Dutch 18 plus population is a good reflection of the population in terms of sex, age, household type, education or participation in the employment market. All respondents participated in the study voluntarily after being informed about the aims of the study. According to Dutch law, formal approval (e.g., from a medical ethics committee) was not required. Data collection was in strict accordance with the national standard and Statistics Netherlands Act 2003. At no time did the data set contain direct identifiers.
2.2 Providing informal care

There is a wide variation in the descriptions of informal care (Roth et al., 2015). In the study at hand, we use the following definition: informal care is all help given to a person in need of care by someone from his or her immediate social environment (Canadian Caregiver Coalition, 2001; Triantafillou et al., 2010). This includes all (unpaid) support given due to health issues. Examples include assistance for making appointments or applying for support, transport, household help, personal care and administrative assistance.

The question used in the survey to identify persons who provide informal care was: The following questions concern providing help to friends or family with health problems. These can, for example, include your partner, family members, friends or neighbours who need help due to physical, psychological or mental limitations or old age. Examples of such help include household activities, washing and dressing, companionship, transport and odd jobs. Help provided within the framework of your profession or volunteer work does not count in this regard. Have you given this type of help in the last 12 months? (yes/no). This question was formulated in order to identify as many persons as possible who provide help to persons with health problems, even if they do not recognise themselves as informal caregiver.

The question was tested in terms of cognition by telephone, modified and again tested in approximately 35 persons, and by e-mail among the Dutch and Flanders field of informal care researchers (De Klerk & De Boer, 2015).

2.3 Nature of the relationship between the giver and the recipient

The persons surveyed were asked, among other things, if they provide any kind of help. Respondents who indicated that they rarely or only incidentally provided informal care were not considered to be informal caregivers. Respondents who stated to give help were asked to whom they give this (select the person whom you are giving the most help to at present/have helped the most in the last 12 months). The respondents could choose from 10 categories, which were combined into the following dependent variable: 0 = not an informal caregiver, 1 = informal caregiver for partner, 2 = informal caregiver for first-degree family member (parent, parent-in-law or child); 3 = informal caregiver for other family member (aunt, uncle, grandparent, nephew, niece), 4 = informal caregiver for friends/neighbours/acquaintances.

2.4 Sociodemographic characteristics

Gender, age and level of education are the sociodemographic characteristics tested in our model. The age of the (potential) informal caregivers was divided into 10-year categories, whereby the category of individuals older than 75 was not further subdivided due to the small number of such respondents. The educational background of the (potential) informal caregivers refers to the highest level completed and is divided into three categories: (a) low (lower and intermediate technical/vocational) education, (b) intermediate (senior general secondary) education and (c) higher (professional/university) education.

2.5 Barriers

In this study, we consider lacking time as a barrier, as well as a limited access to people with health problems. We identify two indicators of lacking time: whether the person has a (paid) job and whether he/she share a household with small children. Participation in the employment market is subdivided into the following categories: not working, working 1–11 hr per week, working 12–31 hr per week and working 32 hr or more per week. Household type is subdivided into three categories: single persons, households with at least one child under the age of 12 and households without young children. Being single is an indicator of having less chance to know someone in the need of care, since there is neither partner nor parents in law. Respondents were asked to what degree they experienced obstacles in daily life as the result of an illness or chronic condition (no obstacles, minor obstacles and serious obstacles).

2.6 Beliefs

Factors that we consider indicators for a ‘willingness to provide care’ include affinity with providing care and religion, as well as personal opinions (Broese van Groenou & De Boer, 2016). The question whether the respondent has ever worked in the care and welfare sector and provided help to clients or patients is considered to be an indicator for affinity with providing care (Boumans & Dorant, 2014). We asked respondents how often they visited a church or mosque, and we considered monthly visits to the church or mosque to be an indicator of religious values.

We used three statements to measure informal care standards: (a) Family members have to help each other in case of health impairments; (b) Friends have to help each other if they need help due to health impairments and (c) Neighbours have an obligation to help their neighbours if they need help. The first statement is used before (Hamon & Blieszner, 1990; Silverstein et al., 2006); similar statements were included in this questionnaire with regard to friends and neighbours. Respondents were asked to indicate to what degree they agreed or disagreed with the statements with regard to informal care of a five-point scale. The answers given were subdivided into two categories: in agreement (very much in agreement or in agreement) as opposed to the remaining answers (neutral or (very much) in disagreement).

2.7 Analyses

Descriptive analyses were first carried out (Table 1). Multinomial logistic regression analyses were carried out to identify the
determinants (sociodemographic factors, barriers and beliefs) for providing or not providing informal care to various social relationships. The marginal effects are presented in Table 2. These indicate what the expected impact is of a change in the background characteristics on the dependent variable (i.e. the probability of giving informal care to one of the social relationships concerned). The major advantage of marginal effects compared to odd's ratios is that it reflects relatives to one category of our dependent variable, but marginal effects represent each category of our dependent variable. The analyses were carried out in Stata 15.

3 | RESULTS

Table 1 shows the distribution of the background variables in the sample. About one of three respondents helps a family member or friend with health impairments within one year. People are most likely to provide informal care to a first-degree family member (usually a parent) (16%), and less likely to provide informal care to a partner (4%), a distant family member (6%) or a friend or neighbour (6%). Sociodemographic factors, barriers and beliefs play a different role in providing informal care to various social relationships (Table 2).

Regarding the help to a partner, sociodemographic factors are important: men are more likely to provide spousal help than women. Younger people are less likely to help a partner and elderly people are more likely to do so, compared to 45–54 years old. The difference between those over 75 and those 45–54 years old is substantial (almost 10% points). Household composition also is relevant: Persons in a multiple-person household are more likely to provide help to a partner than persons living alone (around 5% vs. 1.3%). Beliefs are not important.

When it comes to helping first-degree relatives (parents, children), women provide informal care more often than men. The difference between men and women is considered as substantial, as it is 5% points (14.1% as opposed to 19.2% points). The youngest and oldest age groups are less likely to provide help to first-degree relatives, compared to those in the middle age brackets. The differences are large (sometimes more than 20% points). Persons with an intermediate or higher level of educational are a little more likely to provide help to first-degree relatives compared to those in the middle age brackets. The differences are large (sometimes more than 20% points). Persons with an intermediate or higher level of educational are a little more likely to provide help to first-degree relatives (difference to lower educational level is less than 5% points). Persons in a multiple-person household are more likely to provide help to parents (in law) than persons living alone. People who worked in the care sector help first-degree relatives more often and so do people who believe family should help each other.

Young persons are more likely to help second-degree relatives (e.g., grandparents) compared to elderly people. Barriers also play a role. Persons living with young children are less likely to help non-kin compared to people with- out a job. Having experience in the care sector or regularly going to

| TABLE 1 Background characteristics of respondents 2014–2016, 18 years and older |
|---------------------------------|---|
| Care-giving | % |
| No informal care | 67.1 |
| Partner | 4.4 |
| Parents or children | 16.1 |
| Other family members | 6.4 |
| Friend or neighbour | 6.0 |
| Sociodemographic factors | |
| Women | 52.8 |
| Men | 47.2 |
| 18–24 years | 8.7 |
| 25–34 years | 9.4 |
| 35–44 years | 13.5 |
| 45–54 years | 19.3 |
| 55–64 years | 21.2 |
| 65–74 years | 18.0 |
| ≥75 years | 9.9 |
| Lower level education | 33.1 |
| Intermediate level education | 33.5 |
| Higher level education | 33.4 |
| Barriers | |
| Single-person household | 17.8 |
| Multiperson household without child < 12 years old | 65.6 |
| Multiperson household with child < 12 years old | 16.6 |
| Without paid work | 36.7 |
| Working 1–11 hr per week | 6.7 |
| Working 12–31 hr per week | 19.8 |
| ≥ 32 hr per week | 36.8 |
| No health-related obstacles | 75.0 |
| Minor health-related obstacles | 15.2 |
| Serious health-related obstacles | 9.8 |
| Beliefs | |
| No monthly visits to church, synagogue or mosque | 81.9 |
| Monthly visits to church, synagogue or mosque | 18.1 |
| Has previous work experience in care sector | 25.1 |
| No previous work experience in care sector | 74.9 |
| Family members need to help each other (agree) | 60.0 |
| Friends need to help each other (agree) | 49.9 |
| Neighbours need to help each other (agree) | 22.5 |
### TABLE 2
Marginal effects of sociodemographic characteristics, barriers and beliefs on informal care in relation to the person in need of care, 2014–2016

| No informal care | Partner | Parents and children | Other family members | Friend, neighbour |
|------------------|---------|----------------------|----------------------|-----------------|
| Total (n = 13,165) | 67.1 (8,416) | 16.1 (n = 2,381) | 6.4 (n = 858) | 6.0 (n = 839) |
| Sociodemographic factors | | | | |
| Sex | | | | |
| Men (ref) | 69.4 | 5.2 | 14.1 | 5.9 |
| Women | 63.3 | 3.7 | 19.2 | 7.3 |
| Age | | | | |
| 18–24 years | 79.3 | 0.8 | 6.0 | 11.5 |
| 25–34 years | 73.3 | 2.3 | 9.8 | 9.8 |
| 35–44 years | 65.2 | 3.0 | 18.5 | 5.7 |
| 45–54 years (ref.) | 55.3 | 3.7 | 30.7 | 3.7 |
| 55–64 years | 59.8 | 4.9 | 23.5 | 5.3 |
| 65–74 years | 66.2 | 7.3 | 10.8 | 6.8 |
| ≥ 75 years | 77.0 | 12.5 | 1.8 | 3.7 |
| Education | | | | |
| Lower(ref) | 69.6 | 4.7 | 13.6 | 6.7 |
| Intermediate | 65.2 | 4.3 | 17.9 | 6.8 |
| Higher | 64.7 | 4.1 | 17.8 | 6.4 |
| Barriers | | | | |
| Household type | | | | |
| Single-person | 70.1 | 1.3 | 14.5 | 6.4 |
| Multiperson without child < 12 (ref.) | 63.4 | 5.6 | 17.8 | 7.2 |
| Multiperson with child < 12 | 70.1 | 4.9 | 15.4 | 5.1 |
| Work | | | | |
| Not (ref) | 65.8 | 4.7 | 16.2 | 6.8 |
| 1–11 hr per week | 65.6 | 4.7 | 15.4 | 7.8 |
| 12–31 hr per week | 64.0 | 3.6 | 17.6 | 7.0 |
| ≥ 32 hr per week | 68.4 | 4.3 | 16.6 | 6.1 |
| Health-related obstacles | | | | |
| No obstacles (ref) | 66.6 | 4.2 | 16.6 | 6.6 |
| Minor obstacle | 61.7 | 5.2 | 18.6 | 7.2 |
| Serious obstacle | 71.1 | 4.4 | 14.1 | 5.7 |
| Beliefs | | | | |
| Worked previously in the care sector | 68.3 | 4.1 | 16.1 | 6.0 |

(Continues)
church or mosque make it more likely to help non-kin. There is also a correlation between the norms and giving help: Persons who think that friends or neighbours should help each other more often provide help to these social relations.

Persons with specific sociodemographic characteristics (men, persons in the oldest and the youngest age brackets, persons with a lower education level), barriers (living alone or with young children, working full-time, experiencing health-related obstacles) and beliefs (no previous work experience in the care sector, no frequent visitor of church or mosque) are overrepresented in the group of non-caregivers.

The explained variance of our model showed that the Cragg–Uhler/Nagelkerke pseudo $R^2$ of the total model is 19% (Table 2). Sociodemographic factors explain the major part of the variance (15%), barriers includes 6% and beliefs 4%.

4 | DISCUSSION

Over a period of 1 year, about one of every three adults in the Netherlands provides help to loved ones with health impairments. The persons receiving such care are most often close family members such as a parent (in-law) or child (16%) or a partner (4%). However, a substantial percentage of the adults provide help to others such as distant family members (6%) or a friend or neighbour (6%). Help to partners, parents and children is, in general, associated with sociodemographic characteristics and barriers, while help to distant family members and non-kin is associated with sociodemographic characteristics and beliefs.

What are the most important differences in providing care to a partner, parent/child, distant family member or non-kin?

Our first hypothesis, that regarding partner care sociodemographic characteristics are far more important than barriers and beliefs, was partly supported by our results. We observed that being over 75 or being a man, make it more likely to help a partner. The outcome that older males are more likely to help their ill partner may be explained by the fact that women experience more often chronic impairments. Minor health obstacles of the caregiver seem not to be a barrier for providing the help to a partner, living in a single person household does (since these people do not have a partner). So, the expected sociodemographics associations in our first hypothesis were indeed found for the provision of partner care. Barriers play a very modest role here and beliefs no role at all. This might be an indication that the bond with partners is stronger than with other family members and non-kin, which decreases the importance of other arguments to provide informal care. To state it differently, partners provide care anyway, because of the primacy of their relationship.

The determinants of care to first-degree family members were in accordance with our expectations in hypothesis 2. Sociodemographics are important for the care for first-degree relatives; this can be explained by the health issues of these parents. Women, middle-aged people, persons sharing a household and persons with work experience in health care are more likely to help close relatives (like parents or children). So, besides sociodemographic
characteristics, barriers (household type) and beliefs (experience in care) enhance the chance to help close family.

Young people provide more often help to relatives like grandparents, compared to other age groups and less likely to help friends. Barriers were also associated with the care to friends and neighbours (living alone increases the likelihood; working full-time decreases the chance).

The results with regard to beliefs and social norms were mainly as expected (hypothesis 3). We found evidence for an association between filial norms and the provision of care to more distant family members. Also, people with strong beliefs (expressed by church or mosque attendance or work experience in care) are more likely to provide care to friends and neighbours. Care to friends and neighbours may be recognised as an expression of a high commitment and quality of these relations. We have demonstrated significant links between informal care norms and actual helping behaviour for specific social relationships.

4.1 | Reflection

In the Netherlands, like in many other western countries, there has been ongoing debate regarding the financial sustainability of long-term care. Partly in order to limit future cost increases, in many European countries reforms to long-term care have been accompanied by appeals to civic responsibility, encouraging citizens to care for their loved ones (Verbeek-Oudijk, 2019; Wittenberg et al., 2019).

The Informal Care Model (ICM) appeared to be a valuable approach to investigate determinants of informal care for specific social relations. Using a large national survey, it was shown that apart from sociodemographic factors, barriers and beliefs differ across informal care for partners, (first- and second-degree) family members and non-kin. It was already known from previous research that whether or not you actually know someone in need of help is an important determinant for providing help (Broese van Groenou & De Boer, 2016; De Klerk, 2003). To a certain extent, the need for care was reflected in the age-related effects that we found. Persons between the ages of 45 and 64 quite often have parents who need care. The parents of younger persons are often healthy and those of older persons are often already deceased. In neighbour relationships, the role of age is a less prominent determinant of providing care, because the age of neighbours (and related need for help) is generally more ‘at random’ than in networks of family or friends. This is the reason why sociodemographic factors, and especially age, are important in all examined types of care-giving-care-receiving relationships.

This paper provides building steps for how informal care to specific social relations differs, as we have evidence that barriers and beliefs play a more important role in relationships that are more distant from the caregiver. The underlying assumption may be that the strength of the bond concurs with barriers and beliefs.

In line with this, more theoretical work needs to be done on the freedom of choice in the care-giving decision, such as, how much choice specific social relations experience, what role the quality of the relation plays, whether people view their (potential) care role as obligatory or not and how the perception of choice is related to attitudes or beliefs.

With the exception of partner care, we showed that women are more likely to provide care to all kind of social relations. This raises the question why these differences still remain. We have included paid work and household status in our analyses but did not rule out gender-related role expectations (Broese van Groenou & De Boer, 2016).

A related issue is the combination of informal care and having a professional background in care. The study at hand supports previous research which concluded that persons who work in the care sector provide relatively more informal care during their free time (DePasquale et al., 2015). However, the fact that this involves also help to non-kin is a striking aspect. A possible explanation is that, as a result of their work experience and expertise, they are a more accessible point of contact within their network for care-related questions; they are also more likely than others to quickly identify situations that require care. A complete empirical assessment of the Informal Care Model would need to include more data on how much choice people perceive, the strength of the relationship, gender expectations, professional background, the need for care and the help provided by other persons.

4.2 | Implications for practice and policy

In future, due to the increasing number of persons with disabilities living at home, there will be a greater demand for informal care for persons living at home. Whether or not this help is available will depend on various factors. It is clear that sociodemographic factors such as age, gender and education level are important when it comes to providing informal care. However, other characteristics are also important. Barriers such as a full-time job and the presence of small children also have an effect, particularly with regard to help in family relationships. These types of factors are subject to external influences, for example, leave regulations at work or childcare opportunities.

In particular with regard to the help provided to other family members and friends, beliefs such as previous experience in the care sector and opinions or norms play a role. Beliefs may change over time, for example, by interventions, like campaigns, and may help to increase (non)kin informal care-giving.

5 | Conclusion

This study supports previous research showing that partner help was most likely provided by men and older persons, and that help to parents, parents-in-law and children was most likely provided by persons between the ages of 45 and 64. Providing informal care in more distant care relationships is more often related to barriers and
beliefs. In the future, with increasing numbers of people living alone who do not have children, the help provided by younger and older persons and the help provided within the framework of non-kin relationships will become increasingly important. Insight into the help offered in various types of social relationships will therefore continue to be an important focus of attention for policymakers who wish to prepare the way for a stable but at the same time varied palette of informal care. As many professionals often focus on clients and their family members, they face the task of broadening the support they provide and also taking into account non-kin members and (distant) family members from their clients’ social networks.

6 | Data availability statement

Data openly available in a public repository that issues data sets with DOIs.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

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