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PATTERNS OF HEALTHY AGING AND HOUSEHOLD SIZE DYNAMICS IN WESTERN EUROPE

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Abstract. The diversity of family structures and the quality of social relationships are closely tied to one another. Individual characteristics such as parenting, grandparenting, partnership, cohabitation, living apart together, living solo and other contextual factors (for instance, intergenerational help and care) shape partnership histories related to health dynamics; these histories vary greatly depending on gender and country. Over the last 20 years, researchers have considered the Northern Europe as a region of weak family ties and the Southern Europe as a region of strong family ties. This study interprets the household size as an age-related factor and focuses on two empirical questions: (1) Are there gender differences related to health patterns, and how do they change over time? (2) What kind of country-specific differences in the household size dynamics can be observed among West European men and women in the second part of life?

The study uses some descriptive elements of sequence analysis and regression analysis based on the panel data from seven waves of the SHARE project (the Survey of Health, Ageing and Retirement in Europe) collected between 2004

ПАТТЕРНЫ ЗДОРОВОГО СТАРЕНИЯ И ДИНАМИКИ РАЗМЕРА ДОМОХОЗЯЙСТВ В ЗАПАДНОЙ ЕВРОПЕ

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Аннотация. Разнообразие семейных структур и качество социальных отношений неразрывно связаны друг с другом. Такие индивидуальные характеристики, как родительство, статус (пра)бабушки или (пра)дедушки, партнерство, сожительство, жизнь «по отдельности, но вместе», жизнь «соло» и другие контекстуальные факторы (например, режимы межпоколенческой помощи и заботы) формируют относящиеся к динамике здоровья партнерские истории, которые существенно различаются в зависимости от гендера и страны. Последние 20 лет исследователи характеризуют Северную Европу как регион слабых семейных связей и Южную Европу — как регион сильных семейных уз. Данное исследование использует размер домохозяйства как относящийся к возрасту фактор и фокусируется на двух эмпирических вопросах: (1) существуют ли гендерные различия в связанных со здоровьем паттернах и как они меняются с течением времени? (2) какого рода межстрановые различия динамики размера домохозяйств можно наблюдать среди мужчин и женщин Западной Европы во второй половине их жизни?

and 2017. The study shows that there are gender differences in the life-course transition to a single-person household. This type of household become more common with time and with individual's increasing age. The statistical patterns can be helpful in identifying those life stages that are crucial to stabilization of functional health within the context of demographic change.

Keywords: healthy aging, gender, family relations, life-course sociology, sequence analysis

Ethics statement. The SHARE project has been running since 2002. It was originally established at the Mannheim Research Institute for the Economics of Aging (MEA) of the University of Mannheim. Since 2011, it is being operated under the umbrella of the Max Planck Society at the Max Planck Institute for Social Law and Social Policy and is centrally coordinated by the Munich Center for the Economics of Aging. The SHARE study was subject to several ethics reviews: The Ethics Committee of the University of Mannheim, Ethics Council of the Max Planck Society and by national ethics committees. This study was conducted in full accordance with the World Medical Association (WMA) (Declaration

В исследовании применяются описательные элементы частотного и регрессионного анализа, проведенного на панельных данных семи волн в рамках проекта SHARE (изучение здоровья, старения и пенсионирования в Европе), собранных между 2004 и 2017 гг. Исследование продемонстрировало, что существуют гендерные различия при переходе к домохозяйству, состоящему из одного человека. Такие домохозяйства становятся более распространены в обществе со временем, а также по мере повышения возраста индивидов. Подобные статистические паттерны могут быть полезны для идентификации таких фаз жизненного курса, которые особенно важны для стабилизации функционального здоровья в конкретном контексте демографических перемен.

Ключевые слова: здоровое старение, гендер, семейные отношения, социология жизненного курса, частотный анализ

Этическое заявление. Проект SHARE проводится с 2002 г. Изначально он был инициирован исследовательским институтом экономики старения университета Мангейма (MEA). С 2011 г. проект курируется Обществом научных исследований имени Макса Планка при Институте социального права и социальной политики имени Макса Планка, а также координируется центром экономики старения Мюнхена. Опросные методики SHARE контролируются различными этическими инстанциями: этическим комитетом университета Мангейма, этическим консульством Общества научных исследований имени Макса Планка и национальными этическими комитетами в конкрет-

of Helsinki, last revised at the 64th WMA Meeting held in Fortaleza, Brazil in October 2013). Written consents from all participants involved in this study were obtained.

ных странах. Сбор данных проведен в полном соответствии с международной медицинской ассоциацией WMA (Хельсинская декларация, последние правки занесены в октябре 2013 г. на 64-й WMA-встрече, состоявшейся в Форталезе, Бразилия). Письменное согласие всех вовлеченных в исследование участников было получено.

Introduction

The transformation of the traditional family has overlapped with population aging and increased the diversity of the life course trajectories. Moreover, partnership and family structures have become increasingly complex [Kalmijn, 2007; Oláh, Kotowska, Richter, 2018; Szydlik, 2016]. For example, many young and midlife adults experienced parental divorce as children. The likelihood of having married parents in adulthood has decreased during the past few decades. At the same time, the impact of typically life-long intergenerational support and exchange may become particularly vital in old age [Dykstra, Fokkema, 2011; Deindl, Brandt, Hank, 2016; Neuberger, Preisner, 2017].

Living into late old age has become, and will continue to be, a normal phenomenon in aging societies [Higgs, Jones, 2009; Höpflinger, 1999]. The quality of aging has to do the ways societies provide or fail to provide different health resources (economic, cultural, psychological, technical, and social) [Franks et al., 1992; Fingerman et al. 2020; Matthews, Manor, Power, 1999; Moss, 2002]. “Structural differences between youth and adults are [...] diminishing with regard to living arrangements; the proportion of one-person households in all age categories has rapidly increased, and marriage, in its legal form, has lost ground to cohabitation. Consequently, the age-heterogeneous group of “singles” and persons living together outside marriage indicates a reversal of the trend toward more strictly age-organized life stages” [Buchmann, 1989: 188].

Recent studies show that besides physiological differences of healthy aging, this discrepancy is related to different cultural and normative live conditions [Benson et al., 2018; Geronimus et al., 2006; Helfferich, 2017; O’Flaherty et al., 2016] and quality of the social environment [Antonucci, 2001; Umberson, Crosnoe, Reczek, 2010; Hank, Steinbach, 2018b; Temkina, Zdravomyslova, 2017]. This discrepancy may be also related to different psycho-social factors such as gender relationships and (dis) conformity [House, Landis, Umberson, 1988; Walker et al. 2009], intergenerational relationships [McLanahan, Percheski, 2008; Bertogg, Szydlik, 2016], intergenerational ambivalence [Lüscher, Hoff, 2013], “relational happiness” [Sarracino, Mikucka, 2014] and subjective dimensions of aging and health [Kneesebeck 1998; Kunst et al., 2005]. However, transition patterns into (late) adulthood show a greater variety. They become less age-graded, more extended, diversified, individualized, technologized, and digitalized. The language of “knowledge mobilization” could lead to partnering

with stakeholders such as government, patients and families and other service providers to promote needed changes [Ashmarina, Mantulenko, 2021; Dusseiller et al., 2006; Forrat, 2012; Guba, 2018; Klimczuk, 2015; Kuhlmann et al., 2018; König, Seifert, 2020; Margetts et al., 2015].

Although empirical evidence continues to show that the strongest predictor of health is the socio-economic status [O’Rand, Henretta, 1999; Grundy, Sloggett 2003], family and gender factors constitute an important intersection of health inequality that changes over time [Strauss et al., 1993; Calasanti, 2010; McDonough, Walters, 2001]. Private intergenerational relations are affected by societal circumstances, including welfare state regulations [Schmid, 2014; Isengard, 2018; Neuberger, Preisner, 2017]. Socioeconomic situation, health problems, and cultural norms contribute to intergenerational support patterns. This set of structures (systems of social stratification, institutional fields, social representations, and social policy arrangements) impacts opportunities to which a particular person is exposed [Rossi, Rossi, 1990; Bengtson, Roberts, 1991; Dykstra, Fokkema, 2011; Szydlik, 2012].

Relatively little research has examined the interplay between changing family dynamics and healthy aging [Doblhammer, Gumà, 2018; Nordenmark, 2004]. Interactions between collective experiences (in different welfare regimes and policy arrangements) and life situation (for example, help and care needs with age) lead to relevant questions: *How does the household size (variable “the number of people living in the respondents’ household”) change over time by gender and country in the context of healthy aging?* The purpose of this research is to discover empirically observable aging patterns with data from the SHARE project *among the same individuals in nine West European countries over 13 years.*

Theoretical background and previous studies

Human lives are typically embedded in social connections with family members, friends, and other social relationships across the lifespan. Social exchange, help, empathy, love, and support occur in part through these relationships. Many research areas include the relationship between the timing of lives, the biographical stage, linked or interdependent lives, a changing society [Arber, Evandrou, 1993; Henretta, 2010; Mortelmans, 2019; O’Flaherty et al., 2016].

Understanding social inequalities in health [Grundy, Sloggett 2003; Shanahan, Boardman, 2009; Blane et al., 2013] and overcoming vulnerabilities [Cullati, Burton-Jeangros, Abel, 2018; Spini et al., 2013] has been a central challenge in public health research and practice [Jacob et al., 2019]. The family life course framework articulates how the lives of individual family members are interconnected [Szydlik, 2012, 2016]. The connection between family and health should be also focused on the processes of kinship ties [Jakoby, 2008; Hank, Steinbach, 2018b], intergenerational transmission [Deindl, Brandt, Hank, 2016; Leopold, Kalmijn, 2016], and even romantic couple relationships [Verbakel, 2012; Kalmijn, 2017]. Lives of individuals within a family system, the events, trajectories, or transitions occurring within one family member’s life may have reverberating effects on the lives of the other members [Antonucci, 2001; Temkina, Zdravomyslova, 2017; Vorheyer, 2005]. A key facet of the process of cumulative inequality is

that early events set trajectories in motion that influence opportunities for future advancement [Studer, Liefbroer, Mooyaart, 2018].

Cultural norms may contribute to how parental transitions affect vulnerability and relationship quality [Cullati, Kliegel, Widmer, 2018; Umberson, Crosnoe, Reczek, 2010]. If we hope to achieve health equity for vulnerable populations the social environment must be taken into account. The concept of intergenerational ambivalence has become a widely accepted framework for the study of intergenerational relationships over the life course [Lüscher, Pillemer, 1998]. Ambivalence refers to experiences that occur between contradicting feelings, thoughts, desires, or social structures. This concept enables researchers to consider conflict and solidarity within one and the same relationship [Lüscher, Hoff, 2013; Spini et al., 2013; Widmer, Spini, 2017].

The welfare affects the capacity of how an individual can cope with critical events (help and/or care needs) and take advantage of social opportunities and intergenerational ambivalence [Abel, Schori, 2009; Agulló Tomás et al., 2013; Gazareth et al., 2018; Ilyin, 2019]. Governments have a key role to promote policy reforms to create a more egalitarian society by providing programs that support families. For example, family-centred care is an approach that defines the family as the unit of care. This philosophy serves to unite all healthcare providers in a common approach to working with families as partners in care. The goal of this discussion is to point to areas in need of development, with a particular focus on families in vulnerable circumstances [Arber, Evandrou, 1993; Cullati, Burton-Jeangros, Abel, 2018; Isengard, 2018; McNeill, 2010].

With the emergence of scientific evidence concerning the social determinants of health and overcoming vulnerabilities [Spini et al., 2013], governments, hospitals and formal care-providers must re-evaluate their role supporting families. Preventive planning helps to ensure that the diversity of families is respected and recognizes that equal care is often not enough to achieve health equity — that some family circumstances require additional understanding, support and services. A commitment to involving families in defining the important institutional parameters of family-centred care is of social importance. Combining health and social policy may be a fruitful way of achieving greater sectoral integration, re-balancing government support and simultaneously moving in a socially sustainable proactive way [Annandale, 2008; McNeill, 2010].

The life course approach has become a major research paradigm over the past decades. Life course research offers insight into the timing, mechanisms, and resources that shape observed inequalities in health. This framework is fundamentally concerned with the dynamic interaction between individual biography, structural context and cultural-historical time [Gabadinho et al. 2011; Kohli, Szydlik, 2000; Studer, Struffolino, Fasang, 2018; Ritschard, Studer, 2018].

Particularly longitudinal analysis is helpful for understanding, how intergenerational tensions change over time. The changing structure of the transition into (late) adulthood and aging in a cross-national perspective is “an appropriate testing ground for investigating the issue of age as a structuring principle of the life course. [...] A comparison of life course patterns in countries in which the state assumes a varying degree of responsibility would provide useful insight” [Buchmann, 1989: 189].

Empirical background

The empirical basis of this study is the balanced panel data from the Survey of Health, Ageing and Retirement in Europe (SHARE-project¹, released between 2004 and 2017, seven waves over 13 years). The data is conducted once every 2—3 years and provides a suitable basis for the investigation of family and cultural-contextual factors in a comparable manner across countries [Börsch-Supan et al., 2008; Börsch-Supan et al., 2013; Börsch-Supan, Gruber 2020].

The SHARE survey did not have a uniform sampling design and varied from a simple random selection of households. In some cases, for example Denmark and Belgium, samples were drawn from the country's central population register. Belgium has the largest sample. The aim of the SHARE survey design is to be able to draw inferences about the population of people who are 50 years and older across countries by using probability-based sampling. This is a complex process since the samples in each country must do justice to national characteristics but at the same time be internationally comparable. In the ideal case, all countries included in SHARE would have a probability-based sample based on an official person register covering the population of interest. The choice of conducting a refreshment sample is largely up to the countries because they have to apply for their own funding to their national funding agencies. Because funding and sampling resources vary across participating countries, SHARE does not define a minimum net sample size [Bergmann, Kneip, De Luca, Scherpenzeel, 2019].

For a panel survey like the SHARE project, its value is strongly determined by the long-term participation of panel members over waves. “Only if persons can be observed multiple times as time passes by, it is possible to understand their individual ageing processes and to learn how respondents adapt to the changing environment over time. It is therefore of utmost importance to keep former respondents participating in the survey in order to exploit the full potential of SHARE regarding longitudinal analyses and conclusions” [Bergmann et al., 2019: 30].

In this study, refreshment is not included. It also could be a limitation of this study (Table 1, percentage from baseline). On the other side, the idea of this research design is to follow the same individuals over time and to find patterns of their life change [Abbott, 1983; Ritschard, Studer, 2018].

The sample for Western Europe in this study has 38,248 unique observations (person-years), every person was included seven times. Here we can observe the percentage by year, gender and country and obtain an overview of sample structure (Figure 1).

¹ This paper uses data from the generated easySHARE data set (DOI: 10.6103/SHARE.easy.700), for methodological details see: [Börsch-Supan, Gruber, 2019]. The easySHARE release 7.0.0 is based on SHARE Waves 1, 2, 3 (SHARELIFE), 4, 5, 6 and 7 (DOIs: 10.6103/SHARE.w1.700, 10.6103/SHARE.w2.700, 10.6103/SHARE.w3.700, 10.6103/SHARE.w4.700, 10.6103/SHARE.w5.700, 10.6103/SHARE.w6.700). The SHARE data collection has been funded by the European Commission through the 5th Framework Programme (project QLK6-CT-2001-00360 in the thematic programme Quality of Life), through the 6th Framework Programme (projects SHARE-I3, RII-CT-2006-062193, COMPARE, CIT5-CT-2005-028857, and SHARELIFE, CIT4-CT-2006-028812) and through the 7th Framework Programme (SHARE-PREP, N211909, SHARE-LEAP, N227822 and SHARE M4, N261982). Additional funding from the U. S. National Institute on Aging (U01 AG09740—13S2, P01AG005842, P01AG08291, P30AG12815, R21AG025169, Y1-AG-4553-01, IAG BSR 06-11 and OGHA 04-064) and the German Ministry of Education and Research as well as from various national sources is gratefully acknowledged (see www.share-project.org for a full list of funding institutions).

Table 1. Sample size for balanced panel data by country and gender

Country	Total number of panel participants (7 waves)	Percentage from baseline sample (wave 1)*	Men	Women
Austria	304	19.4%	115	189
Belgium	1167	30.6%	514	653
Denmark	531	31.1%	232	299
France	568	18.2%	228	340
Germany	476	15.9%	211	265
Italy	831	32.6%	355	476
Spain	596	25.7%	234	362
Sweden	651	21.4%	271	380
Switzerland	340	34.1%	151	189
Total	5464	24.7%	2311	3153

* This percentage is based on the Table 8 from the Technical Paper [Bergmann, Kneip, De Luca, Scherpenzeel, 2019: 24].

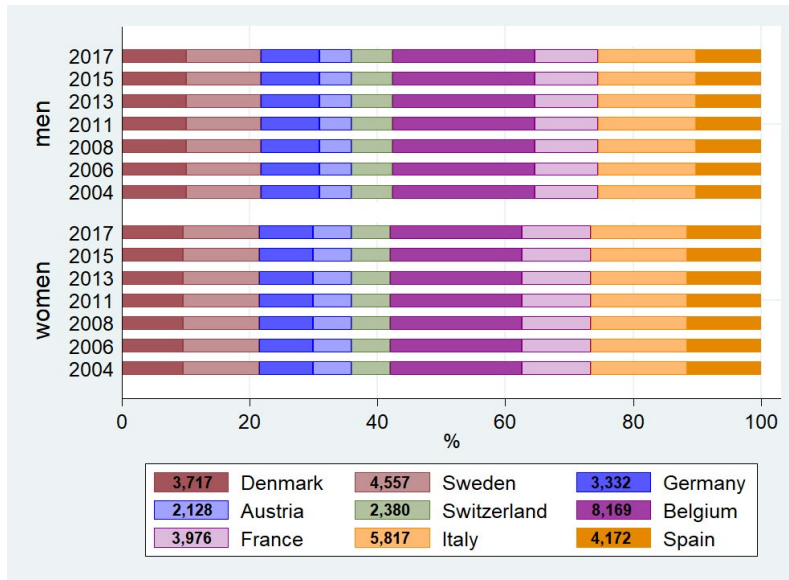


Figure 1. The balanced panel for men and women.

Source: SHARE, n (person-years) = 38,248, own calculation

The SHARE-survey took place in 2004—2017 among individuals aged 50 years (for this paper 40 plus years included possible younger partners of the respondents at the beginning of the survey). Computer-assisted personal interviews were conducted [World Medical Association, 2013]. Self-completion questionnaires and measurement of some biomarkers supplemented these interviews (here: maximum grip strength measure (kg) as an indicator of functional health). The gender gap in healthy aging could be demonstrated by the model from life course epidemiology proposed by

Strachan and Sheikh [Kuh, Shlomo, Ezra, 2004; Strachan, Sheikh, 2004]. This model stems from the argument that “[...] if differences in the social environment are related to health, then differences in social dimensions might be important for clarifying the social distribution of health deficits” [Stringhini, 2016: 153]. It also shows the constant gender gap in physical health with non-parallel trends [Shipovskaya, 2014].

Intergenerational family relations might impact individuals’ health just as health might affect intergenerational relationships in the family. “In the following, we consider both causal directions [...]” [Hank, Steinbach, 2018a: 30]. Moreover, the balanced panel allows us to deal with causality [Giesselmann, Windzio, 2012; Lopez, Weber, 2017]. How can we observe the data structure as the dynamic of functional health over the second part of life? A possible description is to take age as a large-scaled variable and to pool all observations with different health measurements together. Now it represents the time-axis including change of functional health over 13 years with hidden patterns of life course behind subpopulations (Figure 2, polynomial regression trendlines with 95 % confidence intervals).

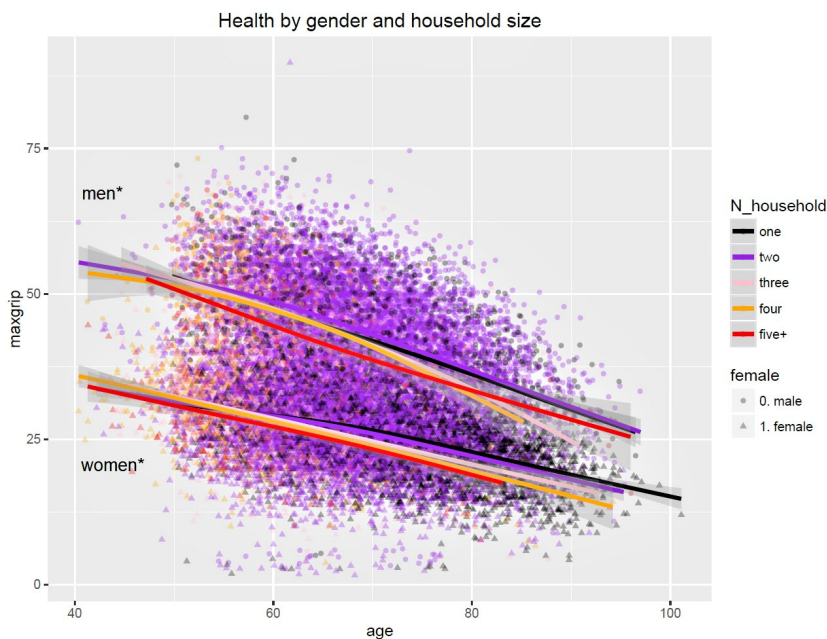


Figure 2. Gender-related functional health trajectories in Western Europe (predictions).

Source: SHARE, balanced pooled panel 2004—2017 (1—7 waves), n (person-years) = 36,354, excluded cases without (or not valid) measurement of the maximum grip strength (kg), own calculations

The decline of the biometrical indicator “maximal grip strength, kg” (maxgrip as OY-axis) is a valid indicator of functional aging [more about this non-disease biomarker — Andersen-Ranberg et al., 2009]. In order to discover the hidden patterns of the household size by gender, we plot functional health and age (age 40 plus as the OX-axis). The life course curves [Strachan, Sheikh, 2004] in the second part of life have some

differences by gender and inside gender. As pooled balanced panel data suppose, there is progressive aging of the sample, a part of this decline could also reflect life course and gender effects. This model shows the gender-related decline of functional health for different subgroups according to household size. The hidden patterns we can observe show that women living in the one-person household are most visible at the end of life. To find more patterns of household size dynamics is an empirical goal of this research.

Results and interpretation

Gender and household size as health-related resources

The relevance of the question “How individual life courses are culturally specific?” could have a health dimension [Shanahan, Boardman, 2009; Blane et al., 2013]. Normative constructions of femininity, masculinity, health, sexuality, age, and typical life-stage roles in aging societies might be socially or culturally determined as generational disagreements or conflict with different degree of essentialist ideas of who women are and what they are biologically wired to do [Bourdieu, 2001; Buchmann, 1989; Winkler, Degele, 2011; Winch, Littler, Keller, 2016]. The example of this essentialist viewpoint leads to a discursive definition of gender as a stable category with the consequence, that female relationships become domesticated and familial [Antonucci, 2001; Calasanti, 2010; Moss, 2002; Omel’chenko, 2000; Temkina, Zdravomyslova, 2017; Utrata, 2011].

Family relations in the second part of life usually include living in a couple in the same household. It could be the spouse, partner, other family member or kin/relative (intragenerational or intergenerational help and care community). As we can see, the dimension of social relationships “two persons in the same household” is most common. Of special interest could be the empirical insight into the household size pattern by gender (Figure 3 and Figure 4):

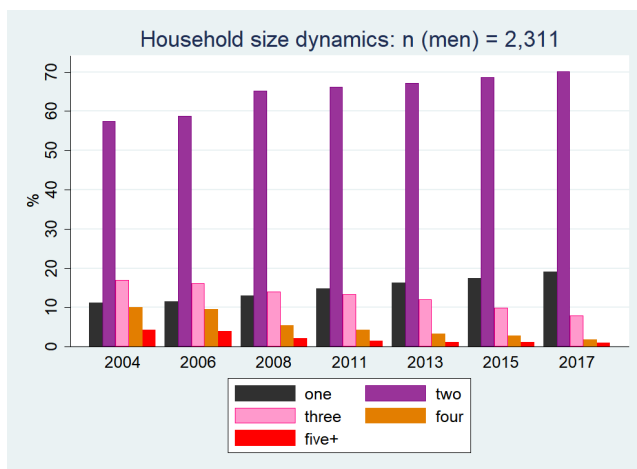


Figure 3. Men in Western Europe and their household size dynamics.

Source: SHARE, balanced panel 2004—2017 (1—7 waves),
 n (person-years) = 16,177, own calculation

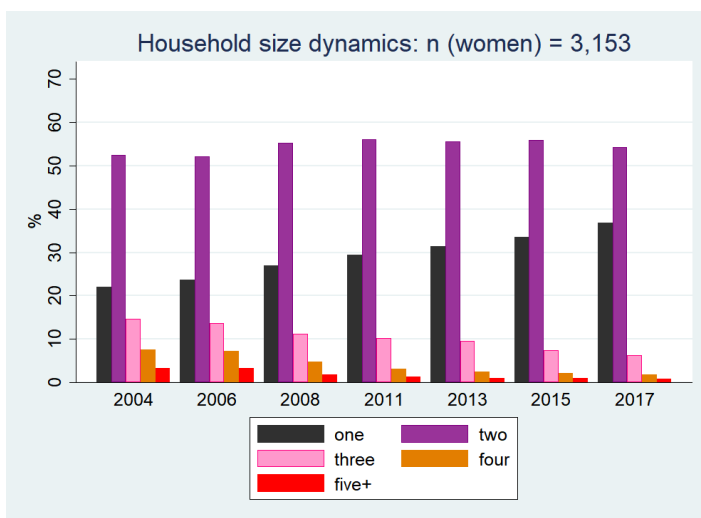


Figure 4. Women in Western Europe and their household size dynamics.
Source: SHARE, balanced panel 2004—2017 (1—7 waves),
n (person-years) = 22,071, own calculation

Families and social ties constitute the closest social environment. Scholars integrated the concepts of the individual life course and family development into the family life course framework. They focus on the intergenerational ties (e. g. between parents and grown children) and on the intragenerational ties (e. g. between siblings) in the context of broader societal changes. At the same time, growing family diversity requires careful consideration of family complexity including singlehood, nonmarital and same-sex unions, social parenthood, and post-divorce family arrangements [McLanahan, Percheski, 2008; Kalmijn, 2007; 2017].

Research and interventions need to understand gender relations as daily interactions shaped by the immediate forces of institutions and social ties [Antonucci, 2001; Hankivsky, 2012; Nordenmark, 2004; Umberson, Crosnoe, Reczek, 2010; Temkina, Zdravomyslova, 2017]. The phenomena of gender-related healthy aging (including femininity, masculinity, cross-gender attributes, living arrangements, social cooperation, etc.) can be consequently interpreted and understood by studying the development of health-related reserves [Cullati, Kliegel, Widmer, 2018]. Families shape health by providing resources and strains that protect or provide the health of their members with health-related opportunities for resilience. However, access to health knowledge and information does not necessarily change gender-based health behaviours. Furthermore, “[g]ender relations generally go unchallenged because they are embedded in taken-for-granted routines of such social institutions as paid work and family life” [Calasanti, 2010: 721].

On the other side, contemporary discourses on aging are usually “feminized”, and as such report little on the experiences of older men [Fleming, 1999; Schmid, 2014]. Older single men often have poorly developed social and family networks leaving them at a disadvantage. They could be literally “invisible” for the discursive praxis [Thompson,

1994]. Focus on gender relations could help us to understand how subpopulations experience similar health conditions in different ways [Annandale, 2008; Shipovskaya, 2014; Ramos Toro, 2017]. The pattern of household size dynamics in Western Europe is different for men and women: more women are living in a one-person household or making this transition. The next description shows us patterns of household size dynamics in a longitudinal format as sequence graphs [Gabadinho et al., 2011] for two genders (Figure 5).

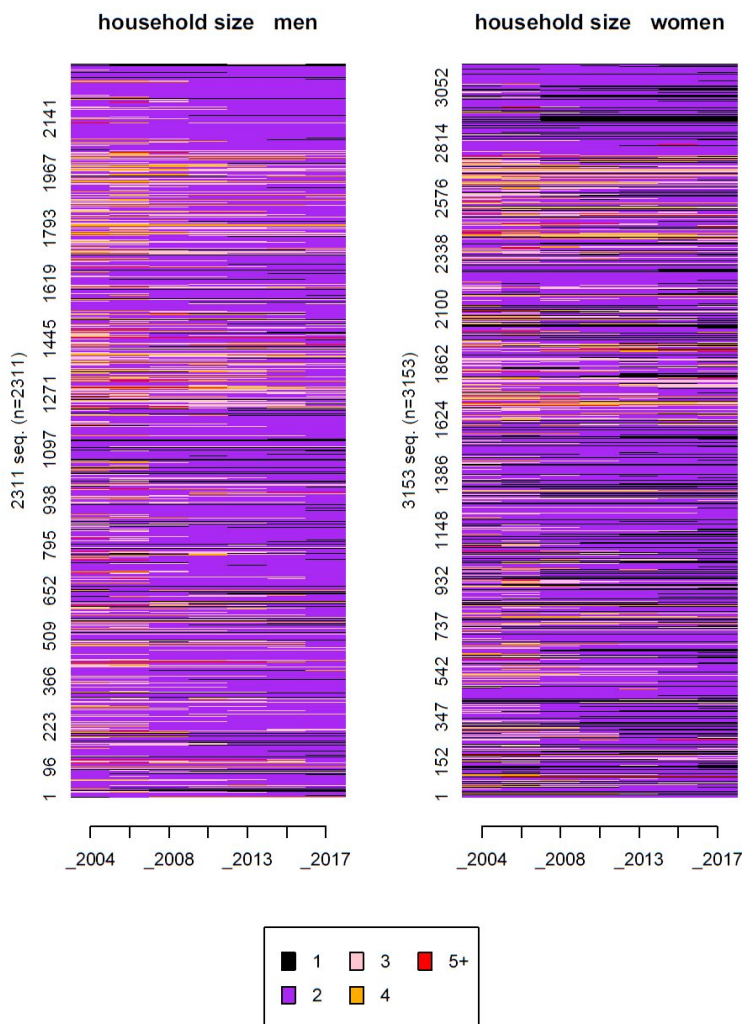


Figure 5. Sequence graphs of changing household size for two genders in Western Europe.
Source: SHARE, balanced panel 2004—2017 (1—7 waves),
 n (person-years) = 38,248, own calculations

Individual life situations show their statistical dynamics over time as the complex changes in positive and negative relationship qualities, ambivalence, and intergenerational support. We observe a decrease in family size, an increase in the rate of divorce, an increase in the number of children born outside marriage, a large rise of single-mother families, of paternal absenteeism, of cohabitation, of serial monogamy and different varieties of living arrangements [Fingerman et al., 2020; Isengard, 2018; Szydlik, 2016]. Linked lives and cumulative inequality discuss how intergenerational concepts could be integrated to examine the transmission of advantage and disadvantage across multiple generations. For example, the concept of vulnerability should incorporate the factors that protect people from health risks or may convert coping with vulnerability into growth [Spini et al., 2013; Widmer, Spini, 2017]. Future analyses need to account more generally for partnership status in different normative contexts [Schroedter, Rössel, Datler, 2015]. A better understanding of the socio-biological mechanisms involved in gender differences would be useful for better targeting public health interventions aimed at reducing health inequalities for men and women in different cultures. [Umberson, Karas Montez, 2010].

Country differences in household size dynamics

Paying attention to changing historical and normative conditions has an epistemic value for theoretical and empirical framing of intergenerational studies and their health impact [Arpino et al., 2013; Doblhammer, Gumà, 2018; Fingerman et al. 2020]. It gives us the first empirical insides into possible explanations, how macro structures intersect with unequal distributed opportunities. The integration of life course and welfare state theory help to link individual trajectories with their broader social contexts and the institutional factors that shape health inequalities over time.

The welfare state conditions and cultural context do have a different perception of family support [Brandt, Haberkern, Szydlik, 2009; Correia, Carapinheiro, Serra, 2015; Hank, Steinbach, 2018b]. According to theories [Dykstra, Fokkema, 2011] and previous studies [Kunst et al., 2005; Brandt, Haberkern, Szydlik, 2009; Schmid, 2014; Neuberger, Preisner, 2017], cultural-contextual structures have a decisive influence on support in the family, especially in countries with a high level of intergenerational care needs and a high degree of the family obligation norm (e. g. South Europe).

Differences in intergenerational family solidarity patterns in Western Europe tend to be described in terms of a north-south gradient. In weak family areas, individualistic values tend to dominate, whereas collectivistic values predominate in strong family contexts [Fingerman et al., 2020]. To better understand the country differences they were grouped into five clusters (the same logic as by Figure 1) according to the intergenerational help and care regime and family policy [Brandt, Haberkern, Szydlik, 2009; Dykstra, Fokkema, 2011; Esping-Andersen, 1999]:

1. *Denmark, Sweden*: the Scandinavian well-developed services for all citizens.
2. *Austria, Germany*: less developed family support (intergenerational transfers).
3. *France, Belgium*: family policy pioneers with pronounced childcare services.
4. *Italy, Spain*: the Mediterranean familialistic regimes (less support by the state).
5. *Switzerland*: a hybrid between a conservative and liberal regime.

As we can see (Figure 6 and Figure 7), the prevalence of the situation “more than one or two persons living in the same household” is higher in the Southern European

cluster (Italy and Spain). We can also notice more one-person households among women compared to men.

Generation, age and gender norms are conceptualized at a point in time to a large degree depend on normative cultural context and their change. Traditional family relations seem more fractured because of the intrusion of unpaid work into a family, the uncertainty of employment, and limited support of the welfare state to vulnerable social groups. The process of coping with ambivalence and vulnerability has the potential to develop new forms of common action in social creative forms [Widmer, Spini, 2017; Oláh, Kotowska, Richter, 2018].

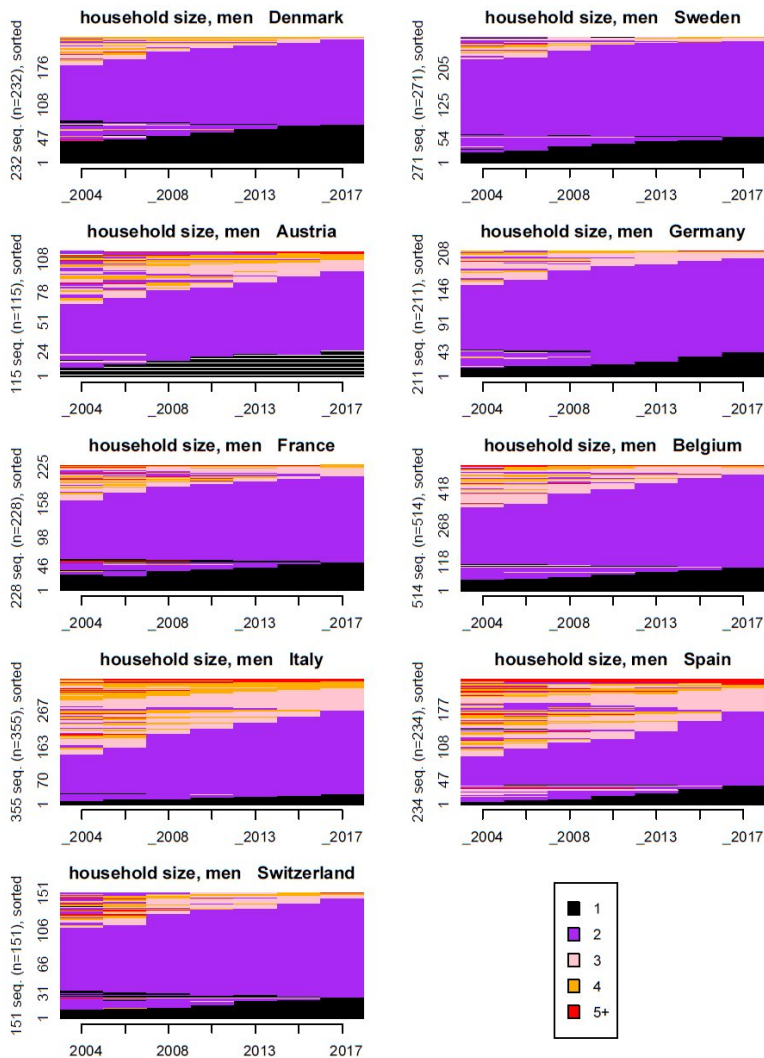


Figure 6. Sequence graphs of household size dynamics for men in different countries.

Source: SHARE, balanced panel 2004—2017 (1—7 waves), n (person) = 2,311, own calculations

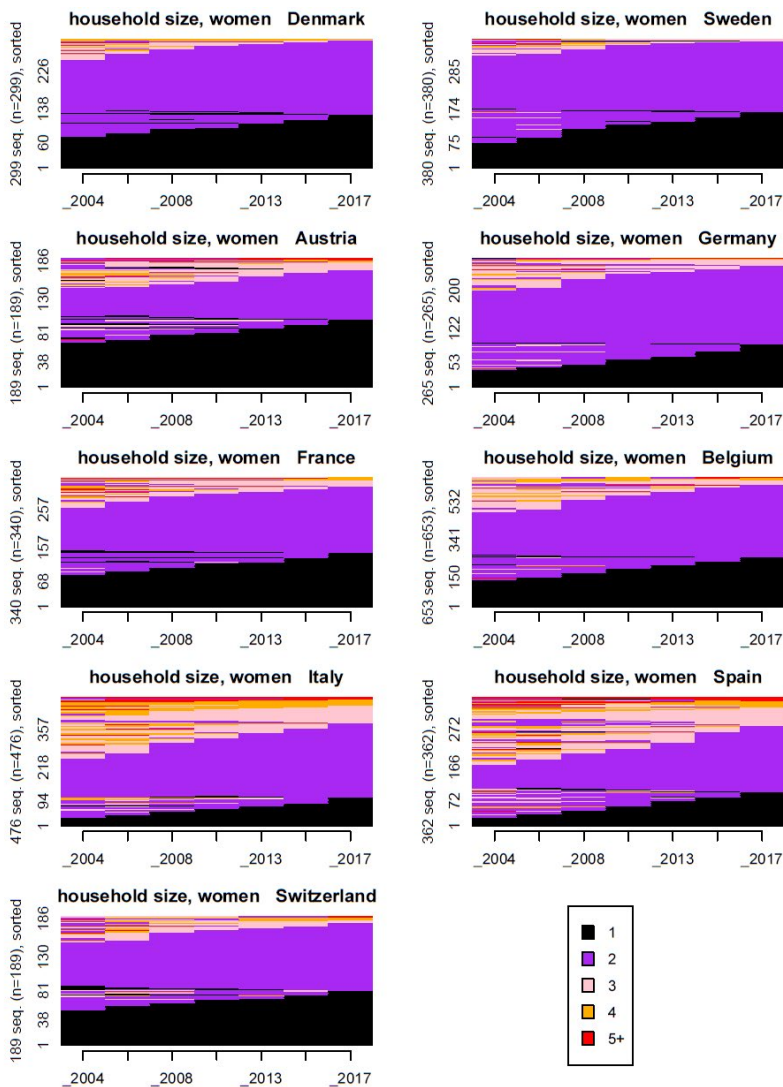


Figure 7. Sequence graphs of household size dynamics for women in different countries.
Source: SHARE, balanced panel 2004—2017 (1—7 waves), n (person) = 3,153, own calculations

Feminist gerontology can contribute to an understanding of “intergenerationality” and stereotypes connecting to health status, ageism and sexism [Moss, 2002; Winkler, Degele, 2011]. In intergenerational feminist studies issues of “generation”, “intergeneration”, and “transgeneration” are reflecting different languages of moral panic and identity politics [Winch et al., 2016] in connection to (re)productive cultures [Abramova et al., 2018; Lettow, 2011; Kosterina, 2011; Kuleshova, 2015], family-centred care and individual choices [Calasanti, 2010; Hankivsky, 2012; Henretta, 2010; Macmillan, Copher, 2005].

Conclusion

Life course epidemiology is now an established field in demography and social epidemiology [Jacob et al., 2019; Kuh, Shlomo, Ezra, 2004]. Patterns of family/household structures and partnership dynamics could be used to identify the life course trajectories at which health differences emerge [Cullati, Burton-Jeangros, Abel, 2018]. The present study adds to a growing body of research evidence indicating that gender differences are substantial, comparable across countries with diverse welfare conditions. Nevertheless, studying the family ties dynamics will help us to see beyond the complexity of healthy aging in different institutional and normative settings [Buchmann, 1989; Isengard, 2018; Kalmijn, 2017; Lüscher, Hoff, 2013; Mortelmans, 2019; Neuberger, Preisner, 2017; Szydlik, 2016; Willis, Martin, 2005].

Most social networks center on family. Family may play an important role in shaping health trajectories [Franks et al., 1992; Hank, Steinbach, 2018a; McLanahan, Percheski, 2008]. At the same time, the emergence of new social norms (singlehood or one-person household during the second part of life) has led to new typical family formation pathways and their consequences for aging [Studer, Liefbroer, Mooyaart, 2018]. The relationship between household structure and health does not follow a simple married-not married distinction [Kalmijn, 2007]. Multigenerational families with co-residence with children and grandchildren or others as a more complex case may be a response to economic support or may reflect cultural traditions that emphasize kin solidarity and kinship relations. Family process involves the bonds between the adults of different generations: midlife parents and young adult offspring, aging parents and midlife adult offspring, grandparents and grandchildren, and even great grandparents and great grandchildren [Haberkern, Schmid, Szydlik, 2015; Höpflinger, 1999; Igel, 2011; Nomaguchi, Milkie, 2020].

Social science is intended to predict the course of societal change. Demographic aging has led to de-standardization and diversification of family trajectories. Intergenerational ambivalence in typically biographical transitions can help us to explain how social structures create tensions in intra- and intergenerational relationships [Dykstra, Fokkema, 2011; Brandt, Haberkern, Szydlik, 2009; Hank, Steinbach, 2018b]. Factors regarding the constellation of family members and care needs are reflected in the qualities of ties between adults and parents and intergenerational relations in changing family contexts. The health consequences of non-traditional biographies could be the agenda for future researches. "Instead of the ideas of permanence, ultimate achievement, and commitment, the images of flexibility, choice, and self-exploration emerge. In this changed symbolic system, the individual is understood as an entity developing and growing throughout his or her lifetime. Thus, adult life in the private sphere is turned into a lifetime of choice instead of a period of stability reached by having made permanent achievements" [Buchmann, 1989: 61].

The structural framework of family roles is elaborated by the qualities of family relationships, which emerge from the day-to-day patterning of social interactions between and among family members [Hankivsky, 2012; Umberson, Crosnoe, Reczek, 2010]. Each family role and family period carries normative expectations and obligations. Normative prescriptions vary in strength to define personal identity [Antonucci, 2001; Calasanti, 2010; Temkina, Zdravomyslova, 2017]. We must re-evaluate our thinking

about the social functions of traditional marriage with their health protection aspects. Especially for those who are not married and do not have children, the question is how alternative sources of integration and intimate ties outside of the household can help people in leading happy and healthy life [Kalmijn, 2017]. Perhaps it is more the type of spouse and the quality of social interactions in a relationship (for example, positive reciprocity with the balance of the paid and unpaid work) that matters and not marriage itself. A life-course approach should incorporate values-based actions that are appropriate to transitions in life and confer benefits to the whole population across the lifespan and future generations.

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