WELLBEING OF THE SANDWICH GENERATION IN SELECTED EUROPEAN COUNTRIES[1]

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Abstract
The paper presents the results of the analysis of relationship between support given to other people by individuals aged 50-69 years and their wellbeing/depression in the selected European countries. The study used the data for 16 European countries gathered in the 4th wave of the Survey of Health, Ageing and Retirement in Europe (SHARE). The wellbeing was operationalized by the use of the CASP-12 index and the depression by the EURO-D measure. We used the linear regression models. The results are in line with those described in the literature on wellbeing. The impact of the explanatory variables, which were significant at least for selected categories, was as expected according to the previous findings. The wellbeing increased with age, better educated people (in comparison to those with low categories of education) had significantly higher wellbeing, while those with some limitation in activities reported notably lower wellbeing than those without disability. The better subjective financial situation contributes to the higher wellbeing. People living with a partner in the same household were more satisfied with life than those living without a partner. Those engaged in work had significantly higher wellbeing than inactive ones. Persons giving support to other adults have lower wellbeing, and those caring for grandchildren have higher wellbeing than those not providing support to others regularly. The influence of the remaining category reflecting the so-called double burden of the analyzed population although insignificant, was negative, which means a reduced wellbeing of this subpopulation in comparison to those not supporting other people at all. Our results confirmed a North-West and South-East division of Europe with respect to wellbeing of people aged 50-69 years. The findings on depression document a similar impact of explanatory variables used in the model.

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Introduction

In the last few decades the issue of life satisfaction/ wellbeing and its determinants has been discussed in the literature (Blanchflower & Oswald, 2004, 2008; Böhnke & Kohler, 2010; Clark, 2007; Gerdtham & Johannesson, 2001; Helliwell, 2003). Individual life satisfaction, which is one of the component of quality of life, has become a crucial field of social policy, because it is an important element of overall evaluation of social and economic progress (European Commission, 2009; Stiglitz, Sen, & Fitoussi, 2009). Life satisfaction is one of the factors of broadly defined Subjective Wellbeing (SWB) (Diener, Eunkook, Lucas, & Smith, 1999). Determinants of life satisfaction may be assessed by the use of the cross-sectional, and more often, the panel data.

The results of empirical analyses show the impact of many individual socio-demographic and economic variables on wellbeing/life satisfaction. In the literature the relationship between age and life satisfaction is well documented, which approximately is U-shaped (with a minimum about 40 years of life). Higher level of education and better financial situation positively increase the level of life satisfaction/wellbeing of an individual. The health problems significantly lower satisfaction of life. Married people are more satisfied with life than those without partner. Moreover social activity and broad social network have a positive impact on life satisfaction.

One of the main consequences of the observed demographic changes (population ageing and changes in family model) is an increase in demand for care for the elderly on the one hand and stronger pressure on informal caregivers (mostly children and partners/ spouses). In the view of that changes the population aged 45-64/69, so called the “sandwich generation” seems to be in the most difficult situation. They are engaged in professional work, and care for the elderly relatives/ parents and frequently in care for grandchildren. The results of analyses show that carers of dependent adults (mostly the elderly) experience higher level of stress, worse health status and lower psychological well-being (Marks, Lambert, & Choi, 2002; Montgomery, Rowe, & Kosloski, 2007; Schulz & Sherwood, 2008). One may suppose that this double burden of family and professional obligations can cause lower wellbeing reported by this subpopulation.

This paper aims to analyse the determinants of wellbeing of people aged 50-69, identified here as the sandwich generation, taking into account their engagement in support provided to different people (adults and/or grandchildren) in selected European countries.

Theoretical background

In the last decades an increasing literature body has been devoted to the issue of subjective life satisfaction/ wellbeing and its determinants. Subjective wellbeing (SWB) is a broader notion, which comprises emotional reactions of people, domains of satisfaction and a general evaluation of life satisfaction (Diener et al., 1999). It should be noted that we use the notions such as subjective wellbeing, life satisfaction and happiness interchangeably as

they represent different aspects of quality of life/ wellbeing. Thus, the literature review presented here is based on selected publications related to mentioned above concepts. Determinants of life satisfaction and wellbeing are assessed on cross-sectional data and more often on panel data. The results on sex differences in life satisfaction are ambiguous: some results indicate that women are more satisfied with life than men (e.g. Abramowska-Kmon et al., 2011; Blanchflower & Oswald, 2004; Dear, Henderson, & Korten, 2002; Gerdtham & Johannesson, 2001), while the others show the opposite effect (opposite relationship) (e.g. Böhnke & Kohler, 2010), or even no differences in wellbeing between the two sexes (Palmore & Luikart, 1972). Moreover, Easterlin (2003) showed than younger women are more satisfied with life than young men, while in older age-groups this relationship is reversed. It seems that this ambiguity of results by sex can be related on one hand to other individual characteristics which differentiate the wellbeing among both men and women, e.g. health status, income and education, but on the other hand – to the size of social networks and a quality of relationships with other people.

The relationship between age and life satisfaction/ happiness is well documented in the literature. Most of the analyses on this topic show that this relationship is approximately U-shaped with a minimum about 40-50 years of life (Blanchflower & Oswald, 2004, 2008; Böhnke & Kohler, 2010; Clark, 2007; Gerdtham & Johannesson, 2001; Helliwell, 2003). These results are contradictory with the previous findings in psychological research, which indicated no relationship between age and life satisfaction/ happiness (por. np. Cantril, 1965 after: Frijters & Beatton, 2012; Palmore & Luikart, 1972). Furthermore, the recent analyses performed for Australia revealed a negative (although weak) relationship between these variables (Dear et al., 2002). Frijters & Beatton (2012) on the basis of three panel datasets[2] established a strong increase in happiness about 60 years of life, and its considerable deacrease after 75 year of life. They did not observe any changes in happiness level between ages 20-50 years. It is worth noting that López Ulloa et al. (2013) (López Ulloa et al., 2013) made an attempt to draw a clear-cut conclusion based on a detailed literature review on this topic. Unfortunately, they did not come to unquestionable findings in this respect. However, according to their recommendations the satisfaction with different life domains should be comprised in the analyses as well as the use of panel data is suggested, especially those collected for a long time.

The health status (measured objectively and subjectively) is another factor diversifying life satisfaction/well-being (Bergsma, Poot, & Liefbroer, 2008; Dear et al., 2002; Gerdtham & Johannesson, 2001; Heukamp & Ariño, 2011; Margolis & Myrskylä, 2013; Stuart-Hamilton, 2006). Health problems (disability, limitations in activities of daily living, different disorders) lower significantly subjective wellbeing.

A marital status and a family situation have also impact on subjective wellbeing. In general persons living with a spouse/partner are more satisfied with life than those living without partner (even if they live with other people) (Blanchflower & Oswald, 2004; Böhnke

[2] There were: the British Household Panel Survey (BHPS), the Household, Income and Labour Dynamics in Australia (HILDA) and the German Socio-Economic Panel (GSOEP).

& Kohler, 2010; Chłoń-Domińczak, Kotowska, Abramowska-Kmon, Kurkiewicz, & Stonawski, 2014; Dear et al., 2002; Easterlin, 2003; Helliwell & Putnam, 2004; Palmore & Luikart, 1972; Stuart-Hamilton, 2006; Waite, 2009). It may be related the fact that the health status (mental and physical) of married people is better that in case of unpartnered persons and the risk of dying is higher for the latter than for the single (Uhlenberg & Mueller, 2003; Verbakel, 2012).

Education is a further factor influencing significantly subjective life satisfaction/ wellbeing (Blanchflower & Oswald, 2004; Böhnke & Kohler, 2010; Dear et al., 2002). Abramowska-Kmon 2012). Higher education is not only a crucial condition for the labour market participation, including better job and as a result higher income, but also is essential for social integration and participation in modern world. Generally, the level of education is an important dimension of actual wellbeing and expected in the future.

In the literature the relationship between financial situation and life satisfaction/well-being is also broadly discussed. Generally, the rich seem to be more satisfied with life than the poor (Ferrer-i-Carbonell, 2005; Frijters, Haisken-DeNew, & Shields, 2004; Gerdtham & Johannesson, 2001; Margolis & Myrskylä, 2013; Mette, 2005; Palmore & Luikart, 1972; Waldegrave & Cameron, 2010). However, increases in income in absolute terms enhance life satisfaction (and this is true mostly for the poor people) (Ferrer-i-Carbonell, 2005; Helliwell & Putnam, 2004).

Also a presence on the labour market is positively correlated to life satisfaction/well-being (Dear et al., 2002; Helliwell & Putnam, 2004). In particular, persons working full-time are satisfied with life the most, while people working part time and inactive report lower life satisfaction. The unemployed (especially long-term unemployed) are satisfied with life the least. It may be related not only to the loss in income, but also to the loss in social capital in the workplace, the increase in stress level and lowering in self-esteem (Helliwell & Putnam, 2004).

Impact of giving support on wellbeing of people aged 50-69

A regular care provision to family members in need (spouses, parents, grandparents, grandchildren etc.) is an important factor influencing subjective wellbeing/ life satisfaction of people aged 50-69 years. The analyses document a negative impact of care of dependent adults (mainly the elderly) on mental and physical health, and life satisfaction of carers (Kaczmarek, Durda, Skrzypczak, & Szwed, 2010; Marks, Lambert, & Choi, 2002; Montgomery, Rowe, & Kosloski, 2007; Schulz & Sherwood, 2008). This negative influence may manifest itself by higher levels of stress and depression among caregivers than among non-caregivers. As a consequence a health deterioration can increase a risk of death among carers. It should be kept in mind, however, that this negative effect of caregiving on a health status is moderated by individual characteristics such as: a socio-economic status, a previous health status or a level of social support received. Furthermore, long-term care, especially provided to persons with the worse health status, may significant worsen the financial situation of care givers due to limited working hours or even the complete withdrawal from the labour market. What is

more, it may lead to the emergence of conflicts within a family. Notwithstanding the described above negative consequences of giving care to dependent family members can have a positive impact on quality of life/ wellbeing/ life satisfaction of carers (Montgomery et al., 2007). It may be triggered by a better emotional state resulting from the feeling of being needed, a possibility of acquire new competences or enhancement of relationships with other people.

Care provided to younger generations affects differently care givers. Litwin & Shiovitz-Ezra (2006) found that wellbeing of the elderly is to a smaller degree a result of what they do, and rather of that with whom they spend time and what they feel to those people. Thus, very often care of grandchildren is a source of a better emotional state and life satisfaction (Uhlenberg & Mueller, 2003). It is worth noting that individual marital and family histories (divorces, remarriages) experienced by members of all generations of a given family shape the quality relationship between adults children and elderly parents, significantly influencing the relation between grandparents and grandchildren and thereby life satisfaction of the former.

Our study aims at investigating the determinants of subjective wellbeing and depression among people aged 50-69 years, who constitute the sandwich generation. In particular, we intend to verify whether the determinants of life satisfaction are in line with those described in the literature either for the whole population or for the selected subpopulations (adults, the elderly). Our analyses are driven by the following research hypotheses:

1. Does the double burden of support reduce wellbeing of the sandwich generation?
2. Do people aged 50-69 engaged in a regular support provided to adults show lower life satisfaction than those who do not support other people?
3. Are those providing care to grandchildren more satisfied with life than those who do not care of other people at all?
4. Do differences in wellbeing between those providing support to other people and those not helping them differ significantly between countries?

Data and methods

Data. In order to carry out the analyses of quality of life/ well-being of people aged 50-69 in selected European countries the 4th wave of the Survey of Health, Ageing and Retirement in Europe (SHARE) is used. The 4th wave of the SHARE was realized in 16 countries (Austria, Germany, Sweden, the Netherlands, Spain, Italy, France, Denmark, Switzerland, Belgium, the Czech Republic, Poland, Hungary, Portugal, Slovenia, Estonia) between the years 2010 and 2012 (Börsch-Supan, Brandt, Litwin, & Weber, 2013; Börsch-Supan, 2013; Börsch-Supan, Brandt, Hunkler, et al., 2013; Malter & Börsch-Supan, 2013).

Dependent variables. For our purpose the quality of life is described by referring to its two dimensions: a positive one - wellbeing and negative one - depression.

Wellbeing. To define a variable we have used the list of 12 items from the CASP questionnaire (Control, Autonomy, Self-realization, Pleasure) implemented in the SHARE,

which is a short version of the original CASP-19 questionnaire (von dem Knesebeck, Hyde, Higgs, Kupfer, & Siegrist, 2005). Thus, this dependent variable ranges from 12 to 48 and the higher values are, the higher wellbeing is.

Depression. In the SHARE questionnaire there were 12 questions related to presence of different depression symptoms such as: depression, pessimism, wishing death, guilt, sleep, interest, irritability, appetite, fatigue, concentration, enjoyment, and tearfulness with possible answers 0-no, 1-yes. Positive responses signified the presence of a given sign of depression. The sum of coded answers gives the so-called EURO-D scale, which values vary from 0 to 12.

Independent variables. The basic socio-demographic variables (such as sex, age, health status, marital status, education level) and economic variables (subjective financial situation[3]) and employment status were incorporated into the model. As for educational level we created three categories: the low level corresponding to the following values of the ISCED-97 codes 0, 1 and 2, the mid-level– for the ISCED-97 code 3, and the high level related to the 4, 5, and 6 codes of the ISCED-97 scale. In order to produce a variable describing the health status we made use of the following question: *For the past six months at least, to what extent have you been limited because of a health problem in activities people usually do?.* We included those who reported any limitations in activities (severe and not severe limitations) into the category 1: "with limitations in activities", and the category 0 denoting "not limited". Also, a variable describing a country was incorporated into the model.

Moreover, we created a variable describing support given to adults and grandchildren. This variable based on several questions related to providing regular (almost daily) support to other people. First, we generated three separate variables describing support given to adults in the same household, to adults living outside the household and to grandchildren. Second, we generated a new variable "support" with four categories: (1) providing support to adults only, (2) to grandchildren only, (3) to adults and grandchildren and (4) to nobody. Those who were gave support, but not regularly (almost daily) we included to the 4th category.

Method of analysis. Due to the fact that both dependent variables may be treated as continuous our analyses make use of the linear regression models.

Empirical results

The results obtained are mostly in line with the findings presented in the literature on determinants of wellbeing, life satisfaction, happiness and depression. The parameter estimates for almost all variables incorporated into the models are significant (at 0.01 levels).

[3] In the SHARE the information on a household income was gathered. However, due to the fact that this variable is characterized by high response rate we decided to use a variable describing a subjective financial situation, which was based on the following question: "Thinking of your household's total monthly income, would you say that your household is able to make ends meet..." with possible answers: 1. 1. With great difficulty, 2. With some difficulty, 3. Fairly easily, 4. Easily. To sum up, the higher value of this variable, the better financial situation of respondent's household.

In the Model 1 (wellbeing) the estimate for sex is not significant. The wellbeing of analysed population increases with age. People with the mid- and high levels of education (in comparison to those with low categories of education) have the significantly higher wellbeing measured by the CASP-12 index. The wellbeing of persons living without a spouse in the household is lower than those living with a partner. As it could be expected people with limitations in activities report the notably lower wellbeing than those without any limitations. Those engaged in work also have the significantly higher wellbeing than inactive ones. Furthermore, the better subjective financial situation the higher wellbeing is.

As for the relationship between giving support to other people and wellbeing the estimates were significant only for two categories of this variable: support for adults only and care for grandchildren only. Providing support to adults almost daily lowers significantly the wellbeing in comparison to those not engaged in caregiving at all. Caring for grandchildren increases notably the wellbeing of the sandwich generation. The influence of the remaining category, which reflects the so-called double burden of this population, is negative although insignificant. It means a reduced wellbeing of this subpopulation in comparison to those not supporting other people at all.

With regard to differences between countries for Austria, Germany, The Netherlands, Denmark, Switzerland, and Slovenia the estimates are significantly higher than for France. It means that in each country wellbeing of people aged 50-69 was higher than in France. In Spain, Italy, Belgium, the Czech Republic, Portugal and Estonia wellbeing is significantly lower than in France. The estimates are not significant in three cases only (Sweden, Poland and Hungary).

As for the Model 2 (depression) it should be underlined than the estimation results are generally significant and mostly are consistent with those depicted above: the Model 2 gives the similar picture of determinants of quality of life as the Model 1. However, it should be emphasized that in contrast to the Model 1 the impact of sex is significant. Women are characterized by the significantly higher level of depression (measured by the number of depression symptoms) than men. Whereas with age the level of depression lowers. The level of education reduces the degree of depression: those with the medium and high levels of education have the significantly lower number of depression symptoms than those with the low educational level. The unpartnered persons have the higher level of depression than those living with a partner. People with disability report more symptoms of depression than those not experiencing such health problems. Similarly, persons with the better subjective financial situation declare less depression symptoms than those with the worse financial situation. Some differences between Model 1 and Model 2 may be observed with respect to impacts of two remaining variables: care and country. Contrary to Model 1, providing care to grandchildren is insignificant while support to both adults and grandchildren increases depression in comparison with those who do not help other people. The influence of providing support to adults is similar to that revealed in Model 1 – here significantly increases depression while previously significantly reduced wellbeing. In addition, in almost all countries (with exception for the insignificant estimates for Portugal and Estonia) the EURO-D index was

significantly lower than in France, which implies smaller number of depression symptoms reported by people aged 50-69 in these countries than in France.

Table 1. Parameter estimates of Model 1 and Model 2

	Model 1 (CASP-12)				Model 2 (EURO-D)			
	β	SE	p-value		β	SE	p-value	
Sex *(ref. men)*								
women	-0,055	0,069	0,418		0,660	0,028	0,000	***
Age	0,048	0,008	0,000	***	-0,028	0,003	0,000	***
Level of education *(ref. low)*								
mid	0,624	0,089	0,000	***	-0,280	0,037	0,000	***
high	0,697	0,094	0,000	***	-0,281	0,038	0,000	***
Partnership status *(ref. living with a spouse)*								
without a spouse	-0,588	0,075	0,000	***	0,251	0,031	0,000	***
Disability *(ref. without disability)*								
disabled	-2,728	0,073	0,000	***	1,100	0,030	0,000	***
Employment *(ref. not in employment)*								
in employment	0,756	0,088	0,000	***	-0,285	0,037	0,000	***
Subjective financial situation	2,163	0,043	0,000	***	-0,404	0,017	0,000	***
Care *(ref. none)*								
adult	-0,505	0,107	0,000	***	0,364	0,045	0,000	***
grandchild	0,327	0,173	0,060	*	0,060	0,074	0,416	
both (adult and grandchild)	-0,352	0,314	0,263		0,464	0,135	0,001	***
Country *(ref. France)*								
Austria	1,474	0,152	0,000	***	-0,854	0,062	0,000	***
Germany	0,560	0,220	0,011	**	-0,549	0,091	0,000	***
Sweden	-0,260	0,212	0,221		-0,453	0,085	0,000	***
The Netherlands	1,839	0,172	0,000	***	-0,851	0,074	0,000	***
Spain	-0,769	0,192	0,000	***	-0,406	0,085	0,000	***
Italy	-2,663	0,183	0,000	***	-0,501	0,078	0,000	***
Denmark	0,659	0,173	0,000	***	-0,558	0,073	0,000	***
Switzerland	1,046	0,154	0,000	***	-0,322	0,066	0,000	***
Belgium	-1,314	0,160	0,000	***	-0,242	0,067	0,000	***
the Czech Republic	-2,057	0,151	0,000	***	-0,998	0,065	0,000	***
Poland	-0,138	0,238	0,562		-0,269	0,099	0,007	***
Hungary	-0,223	0,202	0,270		-0,464	0,086	0,000	***
Portugal	-3,868	0,204	0,000	***	0,026	0,097	0,788	
Slovenia	2,718	0,193	0,000	***	-0,818	0,075	0,000	***
Estonia	-1,238	0,160	0,000	***	0,013	0,066	0,848	
constant	29,853	0,518	0,000	***	5,121	0,219	0,000	***
N	22 564				22 148			
R^2	0.349				0.197			

Note: β=parameter estimates, SE= standard error, p-value=significance level.

Significance level: *** 0.01, **0.05, *0.1.

Source: own estimations based on data from the 4th wave of the Survey of Health, Ageing and Retirement in Europe (SHARE).

To conclude, the results obtained partially confirmed that providing support to other people may be a factor influencing wellbeing of people aged 50-69. Both analytical approaches showed that wellbeing of those who support adults is much lower than wellbeing of non-carers (depression is higher). Moreover, care provided to the younger generations (grandchildren) seems to be highly rewarding and influencing positively life satisfaction. In addition, simultaneous up and down care transfers are significant for declared depression symptoms.

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