Економіка

UDC 005.35:316

Elgabsy Yonatan
Postgraduate Student of the
Sumy State University;
Neve Gil Zahav Nursing Home (Nili, Israel)
Елгабсі Йонатан
аспірант
Сумського державного університету;
Будинок пристарілих Неве Гіль Захав (Нілі, Ізраїль)
ORCID: 0009-0000-5077-3317

ARAB CULTURE'S TRADITION OF KEEPING PARENTS AT HOME AMID MODERNIZATION
ТРАДИЦІЯ АРАБСЬКОЇ КУЛЬТУРИ ЗАЛИШАТИ БАТЬКІВ УДОМА В УМОВАХ МОДЕРНІЗАЦІЇ

Summary. *Introduction. In the context of demographic aging, effective management of elderly care systems has become a strategic priority. The choice between home-based and institutional care is determined not only by medical criteria but also by a range of managerial decisions, the level of economic burden on households, and the accessibility of social and healthcare infrastructure. This study explores caregiving models within Arab and Jewish families, with a focus on the economic factors that influence the preference for home care over institutionalization.*

The purpose of the study is to identify and analyze the cultural, economic, and systemic factors that shape caregiving choices among Muslim and Jewish families, with particular attention to resource allocation, financial strain, and

the underlying motivations for keeping elderly relatives at home versus placing them in specialized institutions.

Arab families, strongly influenced by Islamic teachings and collectivist cultural values, demonstrate a high degree of commitment to intrafamilial care. This approach requires considerable managerial efforts, particularly in coordinating caregiving activities, distributing responsibilities, and planning household expenditures.

Materials and Methods. The study employed a cross-sectional design based on a sample of 276 participants to compare caregiving burden and organizational models among Muslim Arab and Jewish families.

Results. Arab families were significantly more likely to employ 24-hour caregivers (40.3% vs. 24.5%) and involve elderly relatives in decision-making related to caregiving (33.8% vs. 15.8%), indicating a collective approach to management within the household. However, this preference for home care poses serious economic challenges: 52.1% of Arab households reported a substantial financial burden, compared to 26.5% among Jewish families. Moreover, despite more frequent engagement with community-based resources (e.g., weekly nurse visits – 25.0% vs. 9.3%), Arab families often face limited access to pre-institutional medical support.

These findings suggest that caregiving models are significantly influenced by managerial decisions within the family unit, economic capacity, and the availability of support services. Despite facing considerable financial and physical burdens, Arab families consistently demonstrate a strong commitment to home-based care, underscoring the need for comprehensive support policies tailored to such models.

Discussion. Given the results, public policy should focus on implementing culturally adapted managerial solutions. This includes providing financial subsidies, expanding community-based healthcare services, and developing educational programs for informal caregivers. Such measures would help

alleviate the burden on households and enhance the efficiency of care management processes, while respecting the cultural norms and values of Arab families.

Key words: *elderly, economic burden, arab families, family involvement, management.*

Анотація. *Вступ. У контексті демографічного старіння ефективне управління системою догляду за людьми похилого віку набуває стратегічного значення. Вибір між домашнім доглядом та інституційними формами обумовлюється не лише медичними показниками, а й низкою управлінських рішень, рівнем економічного навантаження на домогосподарства, а також доступністю інфраструктури соціальних і медичних послуг. У цьому дослідженні розглянуто управлінські моделі організації догляду серед арабських і єврейських родин з фокусом на економічні чинники, що формують перевагу домашнього догляду над інституціоналізацією.*

Мета дослідження полягає у виявленні та аналізі культурних, економічних і системних чинників, які визначають вибір моделі догляду серед мусульманських та єврейських сімей, з акцентом на розподіл ресурсів, фінансове навантаження та розумінні мотивації, що лежить в основі рішень про залишення літніх родичів під домашнім наглядом у порівнянні з поміщенням у спеціалізовані установи.

Арабські родини, значною мірою під впливом ісламських настанов і колективістських культурних цінностей, демонструють високий рівень прихильності до внутрішньосімейного догляду. Такий підхід вимагає значних управлінських зусиль, зокрема у сфері координації доглядової діяльності, розподілу обов'язків та планування витрат.

Матеріали і методи. Дослідження проведено за допомогою перехресного дизайну, з використанням вибірки з 276 учасників для

порівняння показників навантаження та організації догляду в мусульманських арабських і єврейських сім'ях.

Результати. Арабські родини значно частіше залучають цілодобових доглядальниць (40,3% проти 24,5%) і включають літніх родичів до ухвалення управлінських рішень щодо догляду (33,8% проти 15,8%), що свідчить про наявність колективної моделі прийняття рішень. Проте така орієнтація на сімейний догляд створює серйозні економічні виклики: 52,1% арабських домогосподарств повідомили про суттєве фінансове навантаження (проти 26,5% у єврейських сім'ях). Крім того, незважаючи на активніше залучення до ресурсів громади (зокрема, щотижневі візити медсестер — 25,0% проти 9,3%), арабські сім'ї частіше стикаються з труднощами доступу до доінституційного медичного супроводу.

Отримані дані свідчать про те, що управлінські рішення у межах родини, разом з економічною спроможністю та рівнем доступності підтримуючих послуг, суттєво впливають на моделі догляду. Арабські родини, попри фінансові та фізичні виклики, демонструють стабільну відданість догляду у межах домогосподарства, що підтверджує необхідність розробки комплексної політики підтримки таких моделей.

Обговорення. З огляду на результати, державна політика має орієнтуватися на впровадження культурно адаптованих управлінських рішень. Зокрема, доцільним є впровадження фінансових субсидій, розширення мережі громадських медичних послуг та створення навчальних програм для неформальних доглядальників. Такі заходи сприятимуть зниженню навантаження на домогосподарства та забезпеченню більшої ефективності в управлінні доглядовими процесами, одночасно зберігаючи повагу до культурних норм і цінностей арабських сімей.

***Ключові слова**: люди похилого віку, економічний тягар, арабські сім'ї, залучення сім'ї, управління.*

Problem statement. The Arab society in Israel is undergoing significant transformations driven by modernization and urbanization, reshaping traditional structures and affecting various aspects of life, particularly for elderly individuals. These demographic and social changes have profoundly impacted the role, status, and well-being of older adults in Arab communities, presenting new challenges and opportunities. Historically, Arab society was rooted in the *hamula* (extended family clan), where elderly individuals held a central role, managing family resources and maintaining authority within the household. This traditional structure ensured that older adults received robust social and economic support, fostering a sense of security and belonging.

However, the shift towards urbanization and the adoption of individualistic values have disrupted these familial and communal dynamics. Younger generations, influenced by modern lifestyles and Western norms, have moved away from the collective family model, weakening the traditional support systems for elderly members. As a result, the status of elderly individuals has transitioned from a position of authority and respect to one of vulnerability and dependency.

Despite these societal shifts, the Arab culture continues to emphasize home-based care for the elderly, reflecting deeply ingrained values of filial responsibility and respect for elders. However, this cultural commitment faces increasing strain due to economic hardships and changing family dynamics. Economic disparities are particularly pronounced, with elderly Arabs experiencing poverty rates three times higher than their Jewish counterparts. These financial challenges, coupled with the erosion of traditional support networks, have led to increased levels of loneliness and unmet healthcare needs among the elderly population.

This manuscript explores the intersection of modernization, cultural traditions, and elderly care in Arab society in Israel. By examining the challenges and opportunities associated with this transition, the study aims to provide insights into developing culturally sensitive policies and innovative care practices that uphold the dignity and well-being of elderly individuals in this unique context

Analysis of recent research and publications.

Transformations in Elderly Care within Arab Society in Israel.

The Arab society in Israel has undergone significant transformations in recent decades, profoundly impacting the status, well-being, and social perceptions of elderly individuals. These changes, driven by modernization and urbanization, have reshaped traditional support structures, presenting unique challenges for those aged 65 and older.

Economic hardships are particularly prevalent among elderly Arabs, with the poverty rate in this population being three times higher than that of their Jewish counterparts. Such financial disparities severely limit their ability to meet basic needs, including access to medication, healthcare, and adequate nutrition. Beyond the material consequences, economic strain correlates strongly with increased feelings of loneliness and depression, particularly for those with limited resources [11].

Historically, Arab society in Israel centered around the *hamula*, or extended family clan, which served as the foundation of social and economic life. Elderly individuals held significant authority, managing family resources and overseeing its functions as an economic unit. This role provided them with social standing, respect, and a robust support system that included close relationships with spouses, children, and other family members. However, in recent decades, urbanization and the growing influence of individualistic values have eroded these traditional structures. The younger generation, increasingly exposed to urban lifestyles and Western societal norms, has shifted away from

the collective family model, weakening the elderly's once-central role within both the family and the community. This transition has diminished the authority and social status of elderly individuals, leaving them more vulnerable and reliant on external support systems [7].

Loneliness is another pressing issue among elderly Arabs in Israel. Studies reveal that they are significantly more likely to experience loneliness than their Jewish peers. This sense of isolation stems from various factors, including the disintegration of traditional social and familial connections, the loss of a spouse, reduced participation in social activities, and declining health. Research has also demonstrated a strong correlation between loneliness and subjective health status, with poorer reported health linked to heightened feelings of isolation [11]. These findings highlight the critical need for expanded and culturally tailored support services for this population.

To address these challenges, innovative solutions that integrate traditional cultural values with modern care practices must be developed. Culturally adapted community centers could serve as vital hubs for providing medical, social, and psychological services while fostering a sense of community and belonging [5]. Training programs for family caregivers could equip them with the knowledge and skills needed to offer effective and dignified care to elderly relatives [6].

Additionally, fostering intergenerational engagement through educational and social initiatives could help bridge the gap between younger and older generations, preserving cultural traditions while strengthening familial bonds. Tailored government policies, such as financial subsidies and incentives for families caring for elderly members, would also alleviate economic burdens and encourage home-based care, a preference deeply rooted in Arab cultural values [14].

Cultural Foundations of Elderly Care in Arabic Society in Israel.

In Arabic society in Israel, elderly care is deeply rooted in cultural, religious, and social traditions that emphasize family-centered values and intergenerational solidarity. These cultural foundations create a framework in which the care of older adults is seen not only as a responsibility but as an intrinsic part of the social fabric. This section explores the primary cultural underpinnings that shape the practice of home-based elderly care.

The family serves as the cornerstone of Arabic society, where loyalty, respect, and obligation to kin are paramount. Filial piety – a concept rooted in both Islamic teachings and Arab cultural traditions – plays a central role in elderly care. The Qur'an explicitly encourages kindness and respect toward parents, particularly in their later years, stating: "And We have enjoined upon man [care] for his parents. His mother carried him, [increasing her] in weakness upon weakness, and his weaning is in two years. Be grateful to Me and to your parents; to Me is the [final] destination" (Qur'an, 31:14). This spiritual guidance reinforces the moral imperative to care for aging parents within the family context.

Furthermore, the cultural expectation to care for elderly family members extends beyond mere provision of basic needs. It encompasses emotional support, companionship, and ensuring their dignity. This tradition fosters a deep sense of familial duty, which in turn reduces reliance on institutionalized care facilities [6].

Islamic principles and Arab cultural norms intertwine to influence caregiving practices. In many Arab families, caregiving is regarded as an act of religious devotion and a means of earning spiritual merit [8]. The emphasis on collective welfare over individual needs further underscores the commitment to keeping elderly family members at home. For instance, in rural and traditional communities, it is common for multiple generations to live under one roof, creating an environment where caregiving responsibilities are shared.

The practice of integrating elderly individuals into the family unit is also linked to a cultural aversion to the idea of placing them in nursing homes, which may be perceived as a sign of neglect or failure to uphold familial responsibilities. As a result, families often prioritize home care even in the face of financial and logistical challenges [1].

The extended family structure prevalent in Arabic society provides a robust support network for caregiving. Within this structure, care responsibilities are often distributed among family members, particularly women, who traditionally assume primary caregiving roles [3]. Adult children, daughters-in-law, and even grandchildren contribute to the physical and emotional well-being of elderly relatives. This communal approach alleviates the burden on individual caregivers and reinforces the cultural norm of collective caregiving.

Moreover, this extended family network not only facilitates caregiving but also enhances the elderly's sense of belonging and purpose. Older adults often play vital roles in family decision-making and the transmission of cultural and religious values, which further strengthens intergenerational bonds [13].

Socioeconomic and Structural Factors Shaping Home-Based Elderly Care in Israel. The dynamics of home-based elderly care in Israel are shaped by a range of socioeconomic and structural factors, including income disparities, employment patterns, government policies, and the availability of caregiving resources. These factors interact with cultural values to influence caregiving practices and outcomes for older adults.

Socioeconomic status (SES) plays a pivotal role in determining the type and quality of care elderly individuals receive at home. Lower-income families often face significant challenges in accessing adequate caregiving resources, including hiring trained caregivers or purchasing essential medical equipment. In contrast, higher-income families are better positioned to provide comprehensive care. Studies indicate that disparities in SES contribute to unequal access to healthcare services among Israel's elderly population [15].

Cultural expectations in Israeli society, particularly in Arab communities, significantly influence home-based care practices. In these communities, elderly care is often viewed as a family responsibility, with women typically assuming the role of primary caregivers. While this cultural norm promotes strong familial bonds, it can also lead to economic and emotional strain for caregivers, particularly in low-income households [4]. The structure and availability of health services also shape home-based elderly care. Although Israel's healthcare system offers a range of services, including home care, there are notable gaps in service availability, particularly in rural and underserved areas. Enhancing the integration of healthcare services and increasing investment in community-based care can address these challenges [10].

Outcomes and Implications of Home-Based Care for the Elderly in Arab Society in Israel. Home-based care for the elderly in Arab society in Israel is deeply influenced by cultural norms, religious values, and socioeconomic factors. This care model emphasizes family involvement and often results in positive outcomes for the elderly while posing challenges for caregivers. Understanding these dynamics is essential for shaping policies that integrate cultural values and address the specific needs of Arab communities.

In Arab society, elderly individuals cared for at home often experience significant psychological benefits due to the family-centered nature of the care. The strong emphasis on family solidarity and intergenerational living arrangements ensures that older adults are surrounded by familiar people and environments, which fosters emotional security and a sense of belonging. Studies have found that elderly Arabs in Israel experience lower levels of loneliness and higher levels of life satisfaction compared to their counterparts in institutional settings [11].

From a physical perspective, home-based care can positively influence health outcomes, provided that family caregivers are adequately equipped to address the elderly's medical and personal needs. Many elderly individuals

benefit from personalized care routines and the emotional support that family members provide. However, challenges such as inadequate access to healthcare services, especially in rural areas, may lead to unmet needs, increasing the risk of health complications among elderly individuals in Arab communities [14].

The responsibility of providing home-based care in Arab society typically falls on female family members, such as daughters or daughters-in-law, in line with traditional gender roles. While caregiving is seen as a religious and moral obligation, it often imposes significant emotional and economic burdens on caregivers. Research has shown that informal caregivers in Arab families report higher levels of stress, anxiety, and depression, particularly when they lack support or respite opportunities [6].

Labor participation among caregivers is also affected. Many women reduce their working hours or leave the workforce entirely to care for elderly relatives. This not only impacts their financial independence but also exacerbates economic inequalities within the family and community. Additionally, the absence of formal caregiving support can create a strain on family relationships, particularly when caregiving responsibilities are unevenly distributed among siblings or relatives. However, caregiving can also strengthen familial bonds and foster a sense of purpose and fulfillment for caregivers who view their role as an act of devotion [4].

Despite the extensive body of research, the issue of Arab culture's tradition of keeping parents at home amid modernization remains insufficiently explored and requires further in-depth investigation.

The purpose of the article is to explore the cultural, economic, and systemic factors that shape caregiving preferences and practices among Muslim and Jewish families, with a focus on understanding the motivations behind in-home care versus institutionalization of elderly relatives. By examining these dynamics, the study aims to uncover how cultural values, healthcare accessibility, and financial burdens influence caregiving decisions, and to

identify strategies to support families in addressing these challenges while respecting their cultural and religious contexts.

Materials and methods. 276 families participated in this study. An online survey was sent and completed by caregivers of elderly people. 73 families were Muslims and 203 families were from a comparative control group of Jewish families. Table 1 presents the socio-demographic information of the sample.

Main research findings. The sample consisted of slightly more females (53.6%, n = 148) than males (45.3%, n = 125). The majority of participants resided in the Central region (56.9%, n = 157), followed by the North (18.5%, n = 51), Jerusalem (17.4%, n = 48), and the South (5.1%, n = 14). Most elderly participants were living in nursing homes at the time of data collection (78.6%, n = 217). A smaller proportion were living at home (15.2%, n = 42), and the remaining participants resided in assisted living facilities (4.3%, n = 12).

The sample primarily consisted of Jewish participants (66.1%, n = 203), with a smaller representation of Muslims (23.8%, n = 73). Regarding marital status, 44.2% (n = 122) of the elderly were widowed, while 38.4% (n = 106) were married. Smaller proportions of the sample were divorced (10.9%, n = 30), single (4.0%, n = 11), or separated (1.8%, n = 5).

Table 1

The socio-demographic information of the sample

Variable	Response	N	Percentage
Gender of the Elderly	Female	148	53.6%
	Male	125	45.3%
Residential Region	Central	157	56.9%
	North	51	18.5%
	Jerusalem	48	17.4%
	South	14	5.1%
Current Living Situation	Nursing Home	217	78.6%
	At Home	42	15.2%
	Assisted Living	12	4.3%
Religion of the Elderly	Jewish	203	66.1%

	Muslim	73	23.8%
Marital Status of the Elderly	Widowed	122	44.2%
	Married	106	38.4%
	Divorced	30	10.9%
	Single	11	4.0%
	Separated	5	1.8%

Source: developed by the author

The questionnaire included questions regarding the following topics: Involvement in Decision; Frequency of Visits; Time to Decision; Quality of Home Care; Influence of Hospitalizations on Decision; Influence of Condition Deterioration on Decision; Lack of Factor for Referral; Elderly's Ability to Walk at Home; Elderly's Need for Daily Assistance; Psychological Burden; and financial Burden.

Table 2 presents the comparison between the Muslim elderly sample and the control group (Jewish elderly sample). Results show that Muslims were significantly more likely than Jews to have a 24-hour caregiver before institutionalization (40.3% vs. 24.5%, $\chi^2 = 5.66$, $p = 0.02$). Additionally, Muslims reported thinking longer about transferring the elderly to an institution, with 38.9% deliberating for more than six months compared to 25.5% of Jews ($\chi^2 = 15.94$, $p < 0.001$). Muslims also reported greater involvement of the elderly in the decision-making process, with 33.8% of Muslims reporting that the elderly were "very much involved," compared to only 15.8% of Jews ($\chi^2 = 21.10$, $p < 0.001$).

Recurring hospitalizations or emergency visits were significantly more important in the decision to institutionalize the elderly for Jews (47.8%) compared to Muslims (44.4%, $\chi^2 = 11.74$, $p = 0.04$). Similarly, rapid deterioration in the elderly's condition was a more important factor for Jews (83.1%) than Muslims (69.4%, $\chi^2 = 7.82$, $p = 0.05$).

Jews were significantly more likely than Muslims to have seen a doctor or nurse at home more than six months prior to institutionalization (18.8% vs.

5.5%, $\chi^2 = 11.11$, $p = 0.03$). While living at home, Muslims were more likely to see a community nurse weekly (25.0% vs. 9.3%, $\chi^2 = 42.65$, $p < 0.001$) and were less likely to have never seen a physiotherapist (57.5% vs. 75.8%, $\chi^2 = 17.04$, $p < 0.001$). A similar trend was observed for geriatricians/psychogeriatricians, where Muslims were more likely to see them annually (24.3%) compared to Jews (14.9%, $\chi^2 = 7.19$, $p = 0.07$).

As for emotional and financial burden on family members, Muslims were less likely to report feeling a "very heavy burden" before institutionalization compared to Jews (27.8% vs. 51.2%, $\chi^2 = 16.99$, $p < 0.001$). However, Muslims were more likely to report a "heavy financial burden" due to caregiving responsibilities (52.1% vs. 26.5%, $\chi^2 = 25.63$, $p < 0.001$). Muslims were also less likely to report private expenses related to the elderly's care (65.8% vs. 77.1%, $\chi^2 = 3.03$, $p = 0.08$).

Table 2

Comparison between the Muslim and Jewish elderly samples

Variable	**Muslim (n=73)**	**Jews (n=203)**	**X^2**	**p**
Before institutionalization - was there a 24-hour caregiver? Yes	29 (40.3%)	48 (24.5%)	5.66	0.02
Before institutionalization - how often did you usually visit the elderly?			7.53	0.11
Did not visit	3 (4.1%)	7 (3.5%)		
Less than 1 time a week	4 (5.5%)	16 (8.1%)		
1-2 times per week	12 (16.4%)	52 (26.3%)		
3-4 times per week	23 (31.5%)	35 (17.7%)		
Every day	31 (42.5%)	88 (44.4%)		
In the two weeks before institutionalization, did you assist the elderly?			1.96	0.37
Personal care	46 (63.0%)	127 (62.5%)		
Managing home	14 (19.17%)	25 (12.3%)		
Arrangements	12 (16.43%)	40 (19.7%)		
How long did you think about transferring the elderly to an institution?				

1 month	10 (13.9%)	63 (31.5%)	15.94	0.00
2 months	9 (12.5%)	37 (18.5%)		
3 months	8 (11.1%)	26 (13.0%)		
3-6 months	17 (23.6%)	23 (11.5%)		
more than 6 months	28 (38.9%)	51 (25.5%)		
To what extent was the elderly involved in the decision to move to a nursing home?				
Not so much involved	10 (14.1%)	52 (25.7%)	21.10	0.00
Not involved	13 (18.3%)	76 (37.6%)		
Involved	24 (33.8%)	42 (20.8%)		
Very much involved	24 (33.8%)	32 (15.8%)		
Did you consider other alternatives instead of institutionalizing the elderly? (Yes)	49 (67.1%)	118 (60.5%)	0.73	0.39
To what extent were recurring hospitalizations or emergency visits important in the decision?			11.74	0.04
Not at all	3 (4.2%)	22 (10.9%)		
Moderate	22 (30.6%)	34 (16.9%)		
Little	8 (11.1%)	14 (7.0%)		
Very much	32 (44.4%)	96 (47.8%)		
To what extent was rapid deterioration in the elderly's condition an important factor in the decision?			7.82	0.05
Not at all	1 (1.4%)	5 (2.5%)		
Moderate	18 (25.0%)	25 (12.4%)		
Little	3 (4.2%)	4 (2.0%)		
Very much	50 (69.4%)	167 (83.1%)		
When was the last time the elderly was seen by a doctor or nurse at home?			11.11	0.03
2-3 months	12 (16.4%)	23 (11.7%)		
4-6 months	4 (5.5%)	7 (3.6%)		
During the last month	23 (31.5%)	39 (19.8%)		
During the last 2 weeks	30 (41.1%)	91 (46.2%)		
More than 6 months	4 (5.5%)	37		

		(18.8%)		
While living at home, how often did the elderly see a community nurse?			42.65	0.00
Every week	18 (25.0%)	18 (9.3%)		
Every 3 months	19 (26.4%)	26 (13.4%)		
Not at all	15 (20.8%)	127 (65.5%)		
Once a month	20 (27.8%)	23 (11.9%)		
While living at home, how often did the elderly see a physiotherapist?			17.04	0.00
Never	42 (57.5%)	150 (75.8%)		
Once a week	5 (6.8%)	21 (10.6%)		
Every 3 months	15 (20.5%)	18 (9.1%)		
Once a month	11 (15.1%)	9 (4.5%)		
While living at home, how often did the elderly see a geriatrician/psychogeriatrician?			7.19	0.07
Never	25 (35.7%)	81 (40.3%)		
Every 6 months	19 (27.1%)	41 (20.4%)		
Private	9 (12.9%)	49 (24.4%)		
Once a year	17 (24.3%)	30 (14.9%)		
Did the lack of someone to consult for medical issues influence the decision?			6.66	0.04
Little	18 (24.7%)	58 (29.1%)		
Moderate	27 (37.0%)	43 (21.6%)		
Very much	28 (38.4%)	98 (49.2%)		
Before moving to a nursing home, was the elderly under home care by the HMO? (Yes)	39 (54.2%)	66 (33.2%)	8.96	0.00
Did family members feel emotional burden before institutionalization?			16.99	0.00
Not at all	5 (6.9%)	13 (6.5%)		
Not so heavy	7 (9.7%)	26 (12.9%)		
Heavy burden	40 (55.6%)	59 (29.4%)		
Very heavy burden	20 (27.8%)	103 (51.2%)		

Did family members have private expenses related to the elderly's care? (Yes)	48 (65.8%)	155 (77.1%)	3.03	0.08
Was there financial burden due to the care of the elderly before institutionalization?			25.63	0.00
Not at all	9 (12.3%)	42 (21.0%)		
Not so heavy	11 (15.1%)	81 (40.5%)		
Heavy burden	38 (52.1%)	53 (26.5%)		
Very heavy burden	15 (20.5%)	24 (12.0%)		

Source: developed by the author

Conclusions and prospects for further research. The findings of this study reveal significant differences in the management approaches and economic aspects of elderly care within Muslim and Jewish families. These differences are not solely rooted in cultural norms but also reflect varying levels of access to resources, funding models, and household management strategies. Specifically, Muslim families tend to favor in-home care for elderly relatives, even when faced with substantial physical and financial burdens. This choice demands a high level of intra-family coordination and resource reallocation, underscoring a deep commitment to familial responsibility while posing challenges to time management, budgeting, and access to medical services.

In light of this, the research highlights the urgent need for economically viable and managerially sound solutions tailored to cultural contexts. Publicly funded caregiver support programs, flexible community-based healthcare financing models, and an expanded social services market could significantly reduce the financial burden on households. Moreover, implementing educational initiatives to strengthen families' managerial capacity—particularly in areas such as care budgeting, legal structuring of caregiving services, and care schedule optimization—would enhance caregiving effectiveness.

For Jewish families, who more frequently opt for institutional care, there is a need to strengthen management support in the pre-institutionalization phase.

This includes the development of services such as home visits by doctors and nurses, as well as early intervention programs to support decision-making around hospitalization and to improve quality of life for the elderly.

From a public governance perspective, there is a clear need for flexible policy frameworks that balance economic efficiency with caregiving effectiveness. Programs providing emotional support to caregivers should also be implemented to reduce stress and mitigate productivity losses among family members assuming caregiving responsibilities. Furthermore, investment in the training of healthcare professionals to deliver culturally sensitive care could enhance service quality and ease pressure on national healthcare systems.

However, this study is subject to several limitations. First, the cross-sectional design does not allow for causal inferences between economic conditions and caregiving models. Second, the reliance on self-reported data may introduce bias. Third, the research focuses exclusively on Muslim and Jewish populations within a specific geographic region, limiting the generalizability of the findings. Fourth, key managerial variables such as income level, household structure, and access to healthcare and social services were not fully accounted for.

In summary, the study underscores that household-level managerial decisions, chosen financing models, and access to care resources are closely intertwined with cultural norms. In Muslim families, in particular, there is a strong tendency toward self-managed care solutions, which highlights the need for support through economically efficient and administratively rational mechanisms. This caregiving analysis opens the door for policy development that seeks to reconcile cultural traditions with the contemporary demands of healthcare and social welfare systems.

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