Carers@Work

Carers between Work and Care.

Conflict or Chance?

Results of Interviews with Working Carers

Justyna Stypińska
Jolanta Perek – BiaŁas
Jagiellonian University, Krakow
April 2011
1 INTRODUCTION .................................................................................................................. 4

1.1 AIMS AND DESIGN OF THE WHOLE PROJECT ............................................................... 4
1.2 AIMS AND RESEARCH QUESTIONS OF THE CARERS STUDY .................................. 5

2 INCLUSION OF THE LITERATURE REVIEW: SOME FINDINGS FROM THE NATIONAL LITERATURE ACCORDING TO THE RESEARCH QUESTIONS .......................................................... 8

3 METHODOLOGY .................................................................................................................. 12

3.1 DATA COLLECTION: PROBLEM CENTRED INTERVIEWS ACCORDING TO WITZEL ................................................................. 12
3.2 RESEARCH QUESTIONS AND TOPIC GUIDE ............................................................. 13
3.3 SAMPLING AND RECRUITMENT .................................................................................. 16
3.3.1 Sampling strategies .................................................................................. 16
3.3.2 Ways of recruitment ................................................................................. 18
3.4 DATA ANALYSIS ......................................................................................................... 19
3.4.1 Theoretical approach for data analysis ...................................................... 19
3.4.2 Transcription of the interviews ................................................................. 20
3.4.3 Procedure of analysis ........................................................................... 20

4 RESULTS .............................................................................................................................. 22

4.1 INTRODUCTION ............................................................................................................ 22
4.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF SAMPLED CARERS AND CARED-FOR PERSONS .............................................................. 22
4.3 DESCRIPTION OF THE CARE SITUATIONS .................................................................. 30
4.3.1 Main care tasks .......................................................................................... 30
4.3.1.1 Area (basic and instrumental) activities of daily living, medical care .......... 30
4.3.1.2 Supervision ...................................................................................... 33
4.3.1.3 Hospital / doctors ........................................................................... 34
4.3.1.4 Management .................................................................................. 35
4.3.1.5 Bureaucracy .................................................................................. 35
4.3.1.6 Normal visits ................................................................................. 36
4.3.1.7 Summary of main care tasks ............................................................ 37
4.3.2 Amount of care .......................................................................................... 38
4.3.3 Reasons for taking over care ................................................................... 41
4.3.4 History of care .......................................................................................... 43
4.4 DESCRIPTION OF WORK SITUATIONS .......................................................................... 44
4.4.1 Sector of activities .................................................................................... 44
4.4.2 Number of working hours ....................................................................... 47
4.5 IMPACT OF RECONCILIATION ON THE LIFE OF THE WORKING CARER ................. 51
4.5.1 Typical conflict- and stress situations between work and care among carers .......... 51
4.5.1.1 Impact on Daily Work .................................................................... 51
4.5.1.2 Impact on private life ..................................................................... 55
4.5.2 Benefits from reconciliation .................................................................... 62
4.5.2.1 Satisfaction .................................................................................. 62
4.5.2.2 Personal benefits ......................................................................... 63
4.5.2.3 Good relation to the cared-for ....................................................... 64
4.5.3 Summary .................................................................................................... 64
4.6 SUPPORTS AND STRATEGIES CARERS USE TO RECONCILE WORK AND CARE FOR AN OLDER PERSON .............................................................. 65
4.6.1 Support measures .................................................................................... 65
4.6.1.1 Family ......................................................................................... 66
4.6.1.2 Workplace ................................................................................. 71
4.6.1.3 Support services ......................................................................... 74
4.6.1.4 Time out .................................................................................... 80
4.6.2 Possible strategies to use ......................................................................... 80
4.6.3 Summary: Which kind of support at the public, company or societal level is most efficient for the reconciliation of employment and care for older individuals? .................. 87
4.7 WORKING CARERS’ RECOMMENDATIONS FOR IMPROVEMENTS ............................. 89
4.7.1  FORMAL CARERS - LONGER HOURS ................................................................. 89
4.7.2  DAY CARE CENTERS – LONGER HOURS & IN VICINITY ..................................... 89
4.7.3  INFORMATION CENTERS (INCLUDING TRAININGS FOR CARERS) .................. 90
4.7.4  EMERGENCY ASSISTANCE .............................................................................. 91
4.7.5  “VACATION HOMES” FOR OLD PEOPLE ......................................................... 91
4.7.6  HEALTH CARE IMPROVEMENTS: HOME VISITS, PRESCRIPTION FACILITATION,
       TRANSPORTATION ......................................................................................... 92
4.7.7  BUREAUCRACY LIMITATION ......................................................................... 93
4.7.8  STATE PENSIONS INCREASE ......................................................................... 93
4.7.9  WORK FROM HOME ..................................................................................... 93
4.7.10 FLEXIBLE WORKING HOURS/(INCLUDING: BREAKS AT WORK, ADDITIONAL LEAVES, ONE
       DAY OFF) ........................................................................................................ 94
4.7.11 VOLUNTEERS – COMPANY TO THE OLDER PEOPLE ..................................... 94
4.7.12 „FRIENDLY NEIGHBOUR” ............................................................................. 95

5  PROFILES OF WORKING CARERS ........................................................................ 96
5.1  GROUP 1 – “LOW BURDEN”, 8 CARERS ............................................................ 96
5.2  GROUP 2 – “CARE-ORIENTED” ......................................................................... 97
5.3  GROUP 3 – “WORK-ORIENTED” ....................................................................... 98
5.4  GROUP 4 – “HEAVILY BURDENED” ................................................................. 99

6  CROSSCUTTING RESULTS .................................................................................... 100
6.1  INFLUENCE OF THE QUALIFICATION LEVEL OF THE CARERS WITH REGARD TO
    THE RECONCILIATION OF WORK AND CARE FOR AN OLDER INDIVIDUAL? .... 100
6.1.1 Influence of employment and financial situation on the level of the carers’ households.............................. 101
6.1.2 Influence of employment and financial situation on the level of the carers .................................................. 104
6.2  WITHIN THE CONTEXT OF THE ACTUAL PARAMETERS OF EMPLOYMENT AND
    FAMILY WORK, WHAT KIND OF GENDER INEQUALITIES ARE THE RESULTS
    OF THE RECONCILIATION PROBLEMATIC? ..................................................... 106
6.3  ARE THERE ANY DIFFERENCES BETWEEN WORKING CARERS IN RURAL AND
    URBAN AREAS? ............................................................................................. 108
6.4  INFLUENCE OF THE KIND OF CARE NEED? .................................................... 109
6.5  INFLUENCE OF FAMILY STRUCTURE ON RECONCILIATION? ....................... 111

7  CONCLUSIONS ...................................................................................................... 112
8  DISCUSSION ......................................................................................................... 115
9  RECOMMENDATIONS ......................................................................................... 117
10 LITERATURE ....................................................................................................... 119
11 ANNEXES ........................................................................................................... 123
11.1 DESCRIPTION OF THE 60 CASES .................................................................. 123
1 Introduction

The reconciliation of work and care for an older relative is highly relevant for future societies undergoing socio-demographic change since it affects the future working environment as much as the future provision of care for older people – both areas facing particularly serious challenges in the future. Moreover, the division of labour and roles within the family will also be affected, thereby impacting on an equal “work-life balance” for men and women. Therefore, innovative concepts are needed to exploit the existing capacity of our society. To this end, joint efforts by all societal actors concerned are required. Thereby, family carers and their employers share particular responsibility. Employment and family care are commonly seen as incompatible. The present research wants to show that the reconciliation of employment and family care is possible if accompanied by support measures at enterprise and social policy level. Thus, a forward-looking and sustainable care provision can be guaranteed in an ageing society, and new productivity potentials in form of highly motivated employees can be made accessible.

1.1 Aims and design of the whole project

The project “Carers@Work” aims to identify transferable, innovative solutions that promote the reconciliation of work and care in four EU-member states:

- Germany
- Italy
- Poland
- United Kingdom

Hence, this project compares four different “care regimes” regarding typical conflicts and strategies to enable the combination of work and care obligations. The project intends to identify gaps in existing knowledge about successful measures to enable informal carers to combine paid work and care and to analyse the reconciliation problematic at the enterprise level as well as at the carers’ level.

That is the starting point of this research “Carers@Work”, which considers both the perspective of family carers and that of enterprises. Thus, the project “Carers@Work” refers to the central challenges of demographic change, namely “ageing workforces” and increasing longevity, which is very likely to result in rising numbers of people in need of long-term care. Furthermore, the research focuses on the “babyboomer” generation to which most family carers belong and changing life courses as an increasing female employment, the necessity to reconcile employment and care in several life phases (this is no longer limited to young parents), extension, differentiation and prolongation of old

---

1 This introduction was written by Annette Franke & Monika Reichert, project coordination.
age, as well as receipt of care as a distinct phase in old age. Finally, the “new reconciliation variant” has been explored in relation to different family and life forms and the resulting new family contexts of old age. Those living in a “sandwich constellation” will still be a small minority – studying them will nevertheless have major implications for the future when their prevalence is likely to increase. The research embraces the following methods:

a) International literature review;

b) Secondary data analysis of survey data (SHARE and EUROFAMCARE);

c) 60 topic-guide interviews with employed family carers in each of the four participating countries regarding individual reconciliation strategies;

d) Case studies, examples of “good practice”, and topic-guide expert interviews with representatives of works committees, trade unions and employers associations as well as documentary analyses of collective bargaining and enterprise agreements

e) Economic expertise as an assessment of the resulting costs for the companies in Germany.

1.2 Aims and Research questions of the carers study

The reconciliation of paid employment and informal care is not a rare phenomenon among the workforce and becomes of increasing relevance within the next years. Working carers are characterised by typical factors: They are most often married women between 40 and 50 years, from whom about 25% cohabitate with their teenage children. A number of working carers also occupy several roles as spouse, parent and employee. Furthermore, care is mostly provided from daughters to their older mother/mother-in-law, who is on average 76 years old. On average working carers spent 4-9 hours/week for elder and care obligations are primarily related to "general eldercare". However, nearly 50% of the working carers are also involved in "personal care". All in all, most studies show an overall proportion of about 10% prevalence rate of workers with care obligations.

Even when an increasing number of international researches address the importance of the reconciliation of elder care obligations and employment, most studies emphasise more on the impact on private life and strain of care giving itself. In contrast, there is still a lack of knowledge about how an unsatisfactory reconciliation becomes visible at the working place (e.g., absenteeism, lack of capability, reduced possibilities for career and promotion) and which strategies working carers use to enable the balance between job and care (e.g., working time reduction and re-organisation of work). Some studies also disclose the “respite function” of work, which can buffer the carer’s isolation and depression.
The research project “Carers@Work” aims to get a deeper look into the specific conflicts, strategies and demands of working carers. Therefore, semi-structured interviews with working carers have been conducted in Germany, Italy, Poland and the UK to answer the following research questions:

- **What conflict- and stress-situations between work and care are typical among the carers?**

  In many cases working carers experience controversial expectations from the workplace and the care situation. Thus, they might indicate high levels of physical and psychological burden, which could be the case when caregiving is external motivated and/or if there is no help available accompanied by interpersonal problems between care receiver and carer. Furthermore, the work-care-situation is vulnerable for unforeseen crises, e.g. due to a decreasing health status of the care receiver. In all, an insufficient reconciliation of work and care has an impact on the carer’s health status and wellbeing. Private life is also affected by the combination of work and care in forms of less time for the family, social contacts, hobbies and phases of regeneration. This research question asks for typical stress-situations which occur from an unbalanced reconciliation of work and care.

- **What strategies do carers use to reconcile work and care for an older individual?**

  This research question tries to found out which strategies at the workplace, in private life and regarding care are the most common and most successful. To enable the balance between job and care working carers need various strategies to facilitate this reconciliation, e.g. the re-organisation of the work schedule, working-time reduction and seeking for the help of others, e.g. social services as a substitute or in addition to help from the family.

- **What kind of influence does the qualification level of the carers have with regard to the reconciliation of work and care for an older individual?**

  A high qualification level is associated with flexible working conditions regarding working time and work organization. On the other hand, lower qualified employees might be more likely to get affected by caregiving obligations in their families. This research question aims to highlight the influence different qualification levels have regarding the possibility

  a) to combine work and care in general and

  b) to use different workplace related strategies.
What kinds of influence do the employment status and income situation of the caregivers’ households have on the reconciliation of work and care?

It can be assumed that a higher economical status subserves the reconciliation of work and care, because these households might be more likely to purchase professional help from other, e.g. care service. In addition, the employment status – working full time or part-time – might play an important role as well, when it comes to combine work and care.

Within the context of employment and care, what kinds of gender inequalities are produced by the reconciliation problematic?

Gender is one of the most important factors in determining which family member takes over the role of the main carer and whether an individual alters their working arrangement or give up employment so as to provide care. Thus, eldercare is still marked by gender inequalities, because male carers are usually the “secondary care person” or “the alternative” when no female carer is available. However, the rate of male carers increased within the last years. This questions aims to find differences between male and female carers and/or how sharing of caring tasks are negotiation.

Which kinds of support at public, enterprise or societal level best enable the reconciliation of employment and care for older individuals?

This question puts emphasis on the carers’ wishes, expectations and demands to the society, their employers as well as social policy makers. Furthermore, this question refers to existing measures, instruments and services on all three levels and their effectiveness for a better reconciliation of work and care.

Are there any specific individual conflicts or strategies related to the reconciliation of work and care for an older individual when comparing different countries?

Against the background of different care regimes the last question highlights the cultural differences among the four countries. On the one hand all four countries share also similar conditions, e.g. the core role of the family, but also there are remarkable differences, e.g. female labour force participation rate. To examine to which extent similarities and differences with regard to overall framework conditions in the four countries influence individual conflicts or strategies is the aim of a comparative report and not of this national background report.
2 Inclusion of the literature review: some findings from the national literature according to the research questions

In the nearest future, as all demographic analyses show, we will experience a dramatic increase of older people in the population of Poland, similarly as in other European countries. The phenomenon will impact many areas of social and political life, especially however, it will have major influence of the labour market and the supply of the work force. In other words, the labour market will be decreasing. On the other hand, a growing number of seniors in society, even though enjoying better health, will need care in many forms. The basic care needs have so far been mostly covered by the family members, however due to many changes in family patterns (higher divorce rates, growing geographical mobility, solitary widowhood, fewer multi-generational families, split households) the family will not be able to provide for all the senior members of society.

Similar effect is predicted by the increase of the statutory retirement age and the limitations to the eligibility of the early retirement benefits. The many people in their retirement age will have to continue working in order to obtain full retirement pension, which otherwise would be much lower, and might in the future result in social exclusion due to poverty. Therefore, the needs of the older people will have to be catered for by public and private institutions (Pietruszek 2006, Krzyszkowski 2006, Kotowska et al. 2008). This public sector of help and care for older people does not reflect the needs for care, and will thus have to be reformed in order to meet the needs of growing group of seniors.

The final recommendations stemming from the research carried out by Kotowska et al. (2008) concerned the types and quality of caring services which would significantly decrease the caring burden of the people in their 50s and 60s. Kotowska mentions four major solutions:

1. non-stationary forms of care (day care centres for seniors, senior clubs, etc)
2. “at home” services, including the proper training for carers of older persons
3. various forms of support based on neighbourhood or local networks
4. development of stationary care and health-care institutions

Another set of recommendations was proposed by Dorota Głogosz (2008) in the framework of project “Flexible Employee- Family based on partnership” within the EU EQUAL INITIATIVE. She mentions four major areas and activity types which are closely related to achieving balance between work and care:

1. flexible forms of work
2. special leaves of absence and allowances
3. support in care giving obligations
4. special bonuses from employers
One more set of recommendations concerning the older persons care needs to be evoked here. These were made by Bojanowska (2008), who identified five major systems of support in the eldercare basing on study carried out in 2008 in co-operation with Social Insurance Institution (ZUS). The propositions below are the answers of respondents asked for the best support that the caring family could obtain. These support solutions were (with the percentages of respondents’ indications):

1. organization of trainings and workshops dealing with the practical problems of caring for an older person (45,8 %)
2. enabling non-full time employment (42,8 %)
3. remuneration for the persons caring for their old relatives (55,9%)
4. assuring (by the State) public services for the care givers (54,8%)
5. social actions promoting family bonds and raising awareness about the duties towards old parents (36,2%).

All in all, the existing literature pointed to the fact that the need for care of the older persons will increase dramatically in the coming years and will not be sufficiently provided by the members of the families. The need for more and better institutional solutions is necessary. The institutional care needs to be supplemented by increase in the motivation of the employers who will have to deal with the growing problem in the future (CSO 2006).

Answers to the research questions in brief:

A) What conflict- and stress-situations between work and care are typical among the caregivers?

Long-term care giving together with temporary or permanent withdrawal from the labour market can result in major stress and conflict situations. These include: psychological stress, as well as stress related to the financial situation of the family.

B) What strategies do carers use to reconcile work and care for an older individual?

The most popular strategy mentioned by the respondents, which would make it easier for them to combine the duties was the possibility to work at home and the decreasing of the working hours.
C) What kind of influence does the qualification level of the carers have with regard to the reconciliation of work and care for an older individual?

The research carried out by Kotowska et al. (2008) found out that there were no major differences in the influence of qualification level of the carers on the fact of caring and reconciliation processes. On the other hand, however, the study of CSO (2006) showed that the relation between the qualification level and the reconciliation possibilities is indeed very strong. **There is no agreement as to this matter.**

D) What kind of influence do the employment- and income situation of the caregivers’ households have on the reconciliation of work and care?

The distribution of the income of the households having caring responsibilities tends to be shifted in the direction of lower classes of income in comparison to the households with no caring duties. On the other hand, the situation of the families with elder care obligations are still better that the material situation of the families with young children.

E) Within the context of the actual parameters of employment and family-work, what kind of gender inequalities are the results of the reconciliation problematic?

The general results of various surveys did prove that there are disparities among the genders as far as elder care is concerned. These include mostly the increased burden over women. It was proved that the women who are carers are more probable to be financially dependent than women in the whole population.

F) Which kind of support at the public, company or societal level is most efficient for the reconciliation of employment and care for older individuals?

The support given to the carer is not sufficient. The State’s support is mostly described as poor and sometimes ineffective. The support from the family members, third sector organizations, the Church seems to be gaining more importance. The support from the companies is still assessed mostly in relation to the care over children, but could be generally estimated as going in the right direction of more flexible working arrangements.
G) Are there any specific individual conflicts or strategies related to the reconciliation of work and care for an older individual when comparing different countries?

The traditional patterns of Polish family roles were underlined by many researchers as one of the main obstacles to the full development of partnership-based families. The strong role of Catholic Church in Polish society is also one of the factors differentiating the situation of Poland in comparison to different countries.
3 Methodology

3.1 Data Collection: Problem centred Interviews according to Witzel

The semi-structured interviews employed followed the model of ‘problem-centred interviewing’ as outlined by Witzel (2001). This approach offered a means of reconciling deductive and inductive research methods as researchers using this method are receptive to the narrative presented by the interviewee yet at the same time are aware of the existing empirical data on the topic which provides the focus for the interviews. Scheibelhofer (2005) argues the approach allows the interviewer to utilise a number of interviewing techniques within one interview in that they begin with a narrative approach, then a thematic interview and finish with the collection of ‘socio-statistical information’ at the end. In terms of the disadvantages of this approach, it places significant demands upon the interviewer in terms of their ability to employ three styles of interviewing in one session.

A problem-centred interview begins with a pre-formulated introductory question not unlike the biographical narrative approach. This initial question should be broad and is then followed up with general exploration to draw out more details of particular aspects of the interviewee’s narrative. As a result, it is key that the interviewer takes field notes to allow them to return to important issues once the interviewee has completed their narrative. The second type of question included in Witzel’s approach are ad-hoc questions. Scheibelhofer (2005) argues their name is a misnomer in that they should actually be prepared in the form of an aide memoir to ensure all topics related to the research question are covered, and to assist with the comparability of results (as a consequence, they are in fact ‘supplementary questions’ or prompts). These specific explorations utilise knowledge from the literature to produce additional questions on areas that may not have been included in the narrative, but should avoid reverting to the ‘question-and-answer game’ style of interviewing. Finally, there are questions for understanding whereby the interviewer seeks clarification on earlier statements in the interview. Scheibelhofer argues the interview should finish with a questionnaire related to socio-economic characteristics of the interviewee. For Scheibelhofer, this should be presented at the end of the interview so as to “keep the more unstructured part of the interview as unrestricted as possible” (Scheibelhofer, 2005: 23).

In terms of the interviewers’ conduct during the interviews, Scheibelhofer argues the pre-formulated introductory question “should stipulate a narration without intervention by the interviewer…the interviewer should encourage the interviewees to dwell in their own ideas without making any substantive contribution such as asking

---

2 The section 3.1. was written by Kate Hamblin and Andreas Hoff from Oxford University.
additional questions, proposing varying possibilities to answer, etc.” (Scheibelhofer, 2005: 23). The ad hoc/ supplementary questions in the topic guide should provide prompts, as opposed to a rigid structure. Indeed, the interviewer should endeavour to follow the narrative presented by the interviewee when asking these ad hoc/supplementary questions. In the final stages of the interview, the interviewer should summarise the main points of the narrative to allow the interviewee to elaborate or clarify any points made. Witzel also advocates the use of a questionnaire to gather data on the interviewee's characteristics. Therefore, in line with Witzel’s assertions, for each interview the researcher had:

- A short questionnaire to gather data on the social characteristics of the interviewee;
- Guidelines or ‘a supportive device to reinforce the interviewer’s memory on the topics of research and provide a framework of orientation to ensure comparability of interviews’ (Witzel, 2000: 4);
- Tape recorder;
- Post-scripts to accompany tape recording.

3.2 Research questions and topic guide

Based on the aforementioned method, the topic guide contained three elements:

- the pre-formulated introductory questions: these were designed to encourage the interviewee to provide a narrative;
- the supplementary questions: these followed on from the pre-formulated introductory questions, and should be asked if the interviewee has not already included the answers in their narrative; and finally
- the questionnaire: this was presented to the interviewee after the interview as a means of collecting data on their social characteristics without interrupting the flow of their narrative.

The idea is not to revert to a ‘survey’ format during the interviews, but to encourage the interviewee to provide expansive answers through the pre-formulated introductory questions with the supplementary questions providing prompts if these areas are not covered by the participant’s narrative.

In the project proposal, we set out to answer the following research questions in our study, which were proven by literature to be the most relevant ones within our context.

A. What conflict- and stress-situations between work and care are typical among the caregivers?

---

3 The sections 3.2 and 3.4 were written by Susane Kohler and Hanneli Doenner from Hamburg Medical University.
B. What strategies do carers use to reconcile work and care for an older individual?
C. What kind of influence does the qualification level of the carers have with regard to the reconciliation of work and care for an older individual?
D. What kind of influence do the employment- and income situation of the caregivers’ households have on the reconciliation of work and care?
E. Within the context of the actual parameters of employment and family-work, what kind of gender inequalities are the results of the reconciliation problematic?
F. Which kind of support at the public, company or societal level is most efficient for the reconciliation of employment and care for older individuals?
G. Are there any specific individual conflicts or strategies related to the reconciliation of work and care for an older individual when comparing different countries?

Question A-F should be answered in each national report. Question G has to be left to the comparison report.

By deciding to use problem-centred interviewing according to Witzel as the method of collecting data we had to operationalize the research questions into questions usable in the topic guide. Therefore we transmitted the research question into six main questions in the topic guide, which however, did not simply resemble them. The six questions had to be asked in exactly this way in each interview in all four countries and were meant to give interviewed carers a stimulation to narrate their situation. Each of the main pre-formulated questions was connected with a series of supplementary which should help the interviewer to ask more deeply when the conversation got stuck or answers were not satisfying and make sure that all relevant issues were touched by the interviewed person. The supplementary questions act as prompts for the interviewer to ask the interviewee should they not be addressed organically in their narrative. Thus the topic guide was structured around the pre-formulated questions which allowed the interviewee to provide a narrative. Once the interviewee has answered a particular pre-formulated question, the interviewer could then address the areas that were not been included in the narrative. As a result, the interview did not revert to a ‘question-and-answer’ game, or necessarily proceed in a linear fashion through the supplementary questions. The idea was not to produce an overly structured interview, yet at the same time we have to collect data relevant to the research questions. Thus the supplementary questions act as an ‘insurance policy’, in case the interviewee did not include details of these areas in their answers.

As a warm up question which also should enable the interviewer to get a first impression of the care situation and be able to adequately interpret the later mentioned costs and conflicts we asked about care history and care situation.
(1) Care History: Can you tell me something about your role providing care - how did this come about? / Care Situation: Can you tell me something about your actual care situation - how did this come about?

In this context we also directly asked about motivation to care and the reasons for this care arrangement. Usually by asking this question we got already a first insight into costs and conflicts. The second block of questions concerned the work and work history, where carers described their actual work situation and gave a short inside into their working career and their educational background as well as a short insight into their partner’s situation, if available.

(2) Work and work history: Can you tell me about your current work situation?

With the third package of questions we reached the first core of our research, about impact of combining work and care which mainly provided us with information on research question A, about costs, conflicts and benefits.

(3) Costs, conflicts and care: Could you describe the impact of combining work and care on your life?

This was followed by questions about services carers use and support they receive at home and at their work place. With additional sub-questions we tried to find out strategies carers use.

(4) Strategies: What support/services do you use to overcome these problems (or at least attempt to) and reconcile work and care?

This was followed by questions concerning further improvements of reconciliation:

(5) What could make reconciling work and care easier?

Both questions helped to answer research question B and F. The last block of questions was a wrapping up phase and enabled us to make carers to sharpen and summarize some thoughts developed during the interview, and then slowly fade out of the interview situation

(6) Wrapping up

What is the most difficult aspect of combining work and care for you? What is the most positive aspect of combining work and care?

If you look back, what would you have done differently?

In the light of your experience, if you met someone combining work and care, what advice would you give them?

What do you do to unwind / take timeout?

What are your wishes for the future? In a year’s time?
To be able to answer the questions C, D and E we had to do some cross cutting analysis. To receive all relevant information we added some sub-questions to our main topic guide questions. By preparing the topic guide we had to make some slight changes in our phrasing concerning the research questions: The first amendment relates to the question about the “level of qualification”. The operationalisation of high and low level of qualification was decided to be done with support of the ISCED scale. This scale is very helpful but uses education instead qualification as a measure. Correspondingly we decided to analyse the level of education and not the level of qualification in our study, which may be a difference in several countries.

The second amendment relates to the income situation of carer’s household. Already during discussing the research questions with our advisory board it became clear that firstly most carers would not be willing to unveil their income to strangers and secondly not only income matters, but also fortune, property and pension. Accordingly it was decided to not ask about the income situation, but more generally about the influence of the care situation on the financial situation of carer and carer’s household.

3.3 Sampling and recruitment

3.3.1 Sampling strategies

The data collected encompasses 58 in-depth interviews with working carers. The interviews were carried out in the period of September 2009 until June 2010 by the main interviewer, who was being aided by two local interviewers in Kielce and Witnica rural area. The interviews were carried out in three geographical areas – in a big city – Krakow (32) and Warsaw (1), in medium – sized city – Kielce (11), and in rural area – Witnica (15). This geographical diversification proved to be beneficial to the data gathering due to various reasons. First of all, the socio-economic situation in the areas is quite different, since the labor market structure is different which is due to the size and type of the inhabitation areas. Therefore, the situation of the working carers might differ from a macro perspective. Second of all, the local contexts of institutional help and assistance are also varying, since it is mostly the local Welfare Centers which deliver the services for the carers. Therefore, the focus on three localities with their own separate institutional settings will enrich the further analysis.

The interviews were carried out according to the topic guideline agreed to by all project partners, and therefore standardized in all four countries. The interviews on average took about one hour twenty minutes, with the shortest of 30 minutes and the longest taking over two hours. After each interview, a short questionnaire was filled out by the interviewer.

4 We would like to express thanks to the persons who helped us carrying out the interviews in those areas: Katarzyna Wojnicka in Witnica area and Hanna Strzalkowska in Kielce.

Carers@Work - National Report Poland: J.Perek-Białas, J. Stypińska, December 2010
The sampling procedure was following the guidelines agreed on by the consortium. The initial pattern to be followed is pictured in Table 1a. However, some of the recruitment criteria needed to be altered due to the difficulties encountered in the field work. It turned out that it is extremely difficult to find and recruit working carers who would fit into the lower level of education in Poland. The question arose: what is the reason for such a situation? The preliminary answer was found in the analysis of the literature concerning the working carers, as well as in the secondary data analysis of the SHARE data. The older people carers are in general primarily persons over 50 years of age, and in Poland this age cohort has very low employment rates in comparison to other countries of Europe, as well as to other age groups in Poland (Eurobarometer, 2009). The employment rates of Polish persons over 55 are approximately 40% for men, and 20% for women. Most of this population has high education, as persons with high education remain longer in the workforce. The lower the education level the smaller the probability to remain in employment after the age of 50 or 55. Therefore, it needs to be bear in mind, that this low employment rate of this age group hinders also the recruitment of persons working with lower education level.

The final number of the carers with higher qualification level was 40, and with lower qualification level was 18. Another change to the original plan of the recruitment was difficulty to find carers who lived in households with only one person working. The reason for this might be similar as in the case of the education level, namely – most of the working carers have higher education level, and thus it can be assumed that their partners might have higher level of education as well. Therefore, they would also continue working.

In the relation to the family structure, the biggest number of households were the double earner households (N=26) and the single households (N=24), where the older people either lived with the carer or not.

Table 1a. Level of qualification and family / income structure (expected)

<table>
<thead>
<tr>
<th></th>
<th>Couple, both working</th>
<th>Couple, one working</th>
<th>Single</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 1 b. Level of qualification and family / income structure (realized)

<table>
<thead>
<tr>
<th></th>
<th>Couple, both working</th>
<th>Couple, one working</th>
<th>Single</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher level of qualification (ISCED 4-6)</td>
<td>18</td>
<td>5</td>
<td>17</td>
<td>40</td>
</tr>
<tr>
<td>Lower level of qualification (ISCED 1-3)</td>
<td>11</td>
<td>3</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>29*</td>
<td>8</td>
<td>21</td>
<td>58</td>
</tr>
</tbody>
</table>

* Three of these households were of different family structure (no couple), but were inhabited by more than one family member and all of them were working. Therefore we classified them as “double working”, since in this sense of the research scheme they fit this category.

#### 3.3.2 Ways of recruitment

The total number of contacts collected for the purpose of the interview was 78. Out of this group 58 interviews were carried out. The recruitment of the respondents for the interviews was done with the help of two major methods. Firstly, the snowballing method was used and allowed for recruiting 42 (see: Table 2) working carers. The informal way proved to be the most efficient in case of Poland. The second method used was via the institution of Municipal Social Welfare Center in Krakow (Polish acronym – MOPS). The director of the institution was asked to help us contact the working carers of older people. In result we received a list of 25 carers. From the total number of 25 carers, only 13 were interviewed. The rest responded either negatively to our contact or did not exactly meet the criteria (i.e. were already retired for many years). Some of the contacts were not responding at all. The last, but least efficient method was the flyers, which were handed in at various meetings or events concerning the topic of care or
seniors, or during the lectures for social workers in Sociology Department. This method allowed us to recruit only 2 persons. Additionally, announcement was put on the Polish Forum for Alzheimer Disease (http://www.alzheimer.pl/). Two carers contacted us, but only one interview was carried out. Total number of successful methods is presented in the Table 2.

Table 2. Ways of successful recruitment

<table>
<thead>
<tr>
<th>Ways of recruitment</th>
<th>Number of Interviewee/Carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welfare Organizations, Associations of shareholders and private associations</td>
<td>13</td>
</tr>
<tr>
<td>Carers Organizations/Self help groups (Alzheimer Forum)</td>
<td>1</td>
</tr>
<tr>
<td>Private contacts/ Colleagues</td>
<td>42</td>
</tr>
<tr>
<td>Flyer</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
</tr>
</tbody>
</table>

3.4 Data analysis

3.4.1 Theoretical approach for data analysis

3.4.1.1 Qualitative Content Analysis according to Mayring

To evaluate the collected interview material we needed a method which enables us in the one hand to cope with a huge amount of text (transcribed interviews contain more than 1200 pages) within a very limited time and on the other hand make sure that partner in all of the four participating countries would be able to use a strategy of analysis as comparable as possible. Therefore we decided to evaluate our interviews with the method of qualitative content analysis according to Mayring (Mayring 2000, Mayring 2008).

Qualitative content analysis is defined “as an approach of empirical, methodological controlled analysis of texts within their context of communication, following content analytical rules and step by step models without rash quantification” (Mayring 2000)

For our purpose the most interesting procedure offered by Mayring is the method of “structuring with regard to content”, which aim it is to “filtering specific topics, contents and aspects out of the material and to summarize it. Which content it is that
should be extracted, will be named by categories, (and as far as necessary) sub
categories, which were developed theory driven.” (Mayring 2000:89 - own translation).
In the centre of the qualitative content analysis are categories, which can be gained
either inductively or deductively. According to the approach of “structuring with regard
to content” it made sense to use the deductive category application:

“Deductive category application works with prior formulated, theoretical derived
aspects of analysis, bringing them in connection with the text. The qualitative step
of analysis consists in a methodological controlled assignment of the category to a

3.4.2 Transcription of the interviews

The interviews were transcribed in the style of Kuckartz at al. (2007), as they
suggest a quite simple way of transcription, which however meets the requirements of
our analysis. Most important rule was that transcription was carried out literally and not
in vocalisation, expressions in dialect or spoken language expressions are carefully
transformed into High Polish. After every turn taking there should be a blank line for
better understanding. Affirmative vocalisations like “oh”, “eyh” were not transcribed.
Affirmations which underline the importance of a statement like laughing or sobbing
were transcribed in round brackets. Interruptions by the interview partner were set in
squared brackets.

In consideration of the fact of anonymisation and the quite big fear of some
interviewed carers that somebody would be able to expose them it was decided to
anonymise the quoted passages in an adequate way. This means that it was not only
necessary to change all names and places but also slightly alter age, disease or number
of employees at a company, to make sure that no interviewed carer can be recognised in
the citations.

3.4.3 Procedure of analysis

To develop categories according to the deductive category approach, we used the
topic guide, which was developed theory driven (see above) as a first structure to
establish a system of categories and develop a first draft with main categories the same
in all countries. Afterwards two further levels with subcategories were built, which
seemed to be relevant in all countries, from the third level on, countries made own
decisions.

As demanded by Mayring (2008) the definition of the units of analysis were
made, and the code unit (smallest component of the material - a word), the context unit
(the biggest component of the material - the whole interview and the evaluation unit
(order of evaluation - case by case) was decided. Although the agreements were that
quotations belonging to a category should be always as short as possible, but as long as necessary.

In the next step in all countries several pilots were conducted and evaluated with the aid of the theory driven developed system of categories. In doing so not only the topic guide was tested, but also the usefulness and appropriateness of the category systems was proved. After this first passage through the interviews several feedback loop with the whole group were conducted and necessary amendments at the category system were made: "The aspects of text interpretation, following the research questions, are putted into categories, which were carefully founded and revised within the process of analysis (feedback loops)" (Mayring 2000:3).

To not lose track on our data, we used two strategies. Firstly we put a headline over each interview which consisted of the most remarkable sentence of the interview. It should be a sentence which immediately would bring the picture of the interviewed carer back to the interviewers / researchers mind. And secondly we decided to prepare small vignettes on each case as recommended by Witzel, were we describe briefly the main contents of the case, like care situation, work situation, central conflicts and benefits, support services and strategies. The evaluation of such an amount of interview material in such limited time was only possible because of computer assisted evaluation methods. In all countries the programme MAXQDA was used. It does not do any evaluation but is of great help in classifying, connecting and combining data. The function of setting up memos, allowed it to prepare the key sentences and the short vignettes. The results from our post questionnaire could be set up in an additional list of variables which can be combined with texts and codes as well as exported to SPSS. Especially this list of variables was of great help by developing the different types of carers.
4 Results

4.1 Introduction

This section of the report will elaborate on the findings of the interviews with working carers in Poland. It will first explore the data gathered in terms of the description of the sample characteristics before examining the conflict and compromises made by the working carers. The impact of the combination of work and care will also be elaborated on before the strategies employed will be discussed.

4.2 Socio-demographic characteristics of sampled carers and cared-for persons

The sample of the working carers recruited for the interviews was relatively diverse; however, few characteristics of the sample need to be underlined, as they might be distinguishing for Poland when compared to other countries. As has been underlined above the working carers are mostly people with higher levels of education due to the fact that they stay longer in employment in contrast to the persons with lower education levels, who retire earlier or receive pre-retirement benefits or another type of allowances. Therefore in the sample of Polish carers, almost one two thirds (N=40) are persons with higher level of qualification, and almost one third (N=18) with lower level of qualifications.

Table 3. Living area (urban, rural, male, female)

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Big city (Krakow, Warsaw)</td>
<td>24</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Town (Kielce, Gorzów Wielkopolski)</td>
<td>10</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Rural (Witnica and surroundings)</td>
<td>13</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>11</td>
<td>58</td>
</tr>
</tbody>
</table>

Table 3 presents the geographical distribution of the respondents in three areas. Over half of the sample (N=31) was recruited in Krakow, a big city of approximately 755,000 inhabitants. One interview was carried out in capitol city – Warsaw. 11 interviews were carried out in Kielce, which is a middle-sized city of 204,000 inhabitants, located 117 km from Krakow. One interview was carried out in Gorzow
Wielkopolski, a middle-size city, in the region of Witnica. 14 interviews were carried out in Witnica and the surrounding areas. Witnica is a small town of 6000 inhabitants located near the Polish-German border.

In the sample, most of the male carers (8 in 11) lived in Krakow. It is perhaps too soon to draw conclusions from such a small sample, but it might be true that it is likely for men to be cares in the urban areas than in rural regions. This might stem from the more traditional lifestyle of the people living in rural areas of Poland in comparison to the inhabitants of larger cities. It might also stem from the fact that women have more working opportunities in larger cities than in smaller towns or villages, and thus it is sometimes men who take over the care over an older person.

The marital status of the carers is presented in Table 4. Out of the total number of 58 carers, 35 were married, 11 were single, 10 were divorced, and two persons were widowed.

<table>
<thead>
<tr>
<th>Marital status of carer</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married/partnership</td>
<td>30</td>
<td>5</td>
<td>35</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Divorced</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Single</td>
<td>10</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>11</td>
<td>58</td>
</tr>
</tbody>
</table>

Among the working carers, 38 lived without their children (see: Table 5). This meant that they either never had children or that the children lived alone, sometimes in another city or even in another country. In the interviewed group of carers 14 lived with their children who were older than 16 years, whereas only 6 lived with their children who were younger than 16. The role of the children in caring tasks is discussed further in this report.
Table 5. Children living with the carers

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without children</td>
<td>31</td>
<td>7</td>
<td>38</td>
</tr>
<tr>
<td>Children &gt; 16</td>
<td>11</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Children &lt; 16</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>11</td>
<td>58</td>
</tr>
</tbody>
</table>

Table 6. presents the most basic demographic characteristics of the sample. The total number of interviews was 58. The ratio of female to male carers is almost 4:1, which means that almost one fifth (11) of the sample were men and 48 were women. The age of the carers was ranging from the youngest – 26 years old to the oldest – 64. The greatest number of carers - 38 persons – was in the age group ‘50 – 59’. This is a natural consequence of the character of the care over older person, which is usually a parent. Out of 58 respondents 56 were working and two persons were no longer economically active.

Over half of the respondents lived in households with their partners (N=34). Among these, were families living with or without children, as well as families living with or without the older person. The number of single households was 19, out of which 15 were cases when the carer lived with the older person. In the total sample 3 carers lived without a partner, but with children. In two cases carers lived with other family members.

The hours of care were a number very difficult to estimate for most of the carers, and it ranged from 6 hours (the minimum criterion was ten, but some respondents estimated “between 6 and 10” and were still included in the sample) to the maximum number of estimated 100 hours per week. Very many respondents were hesitant to explicitly say how many hours they cared, as some activities were not considered by them as “care” per se, but as “help” or “assistance”. Some of the respondents answered “24 hours”, which meant all the time when they are not at work. These were mostly situations when the carer lived together with the older person, and the care included also for example waking up in the night to check on the older person. If these were the answers, the respondents were not ask to estimate the exact number of hours they spend caring, since it was simply impossible. Several respondents (N=8) estimated the caring hours to be more than 60, what could actually also be synonymous to “round the clock”, but they themselves did not use this expression. Those carers would be naturally the most burdened ones. On the other hand, quite a significant number of carers in the sample (N=27), almost half, estimated their caring hours between 10 and 20 per week.
Therefore, the description of the caring hours here is less accurate in terms of numbers, but more related to the situation of care.

The minimum age of the person cared for was one of the basic criterion for recruitment and was supposed to be 60 years old. None of the persons cared for was under the age of 60. Most of the older people in need of care were in their eighties (N=36). Almost one fourth of them were in the age between 70 and 79 (N=18). Only 3 persons in need of care were younger than 70 years old, and 4 persons were older than 90.
Table 6. Socio-demographics of the sample

<table>
<thead>
<tr>
<th>Gender</th>
<th>F</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>47</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>20 - 29</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30 - 39</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>40 - 49</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>50 - 59</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>60 - 69</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>70 - 79</td>
<td>0</td>
</tr>
</tbody>
</table>

| Living situation of Carer | Single            | 4 |
|                          | Single and cared-for person | 15|
|                          | Partner            | 13|
|                          | Partner and children | 11|
|                          | Partner and cared-for person | 6|
|                          | Partner, children, cared-for | 4|
|                          | Cared-for person and migrant | 0|
|                          | Other              | 5|

| Weekly hours of care | Once a week | 0 |
|                      | Several times a week | 26|
|                      | Daily               | 13|
|                      | Around the clock    | 19|

| Weekly hours of work | 0 - 18 | 4 |
|                      | 19 - 29 | 10|
|                      | 30 - 34 | 3 |
|                      | 35 - 40 | 27|
|                      | more than 40 | 14|

| Age of cared-for person | 60 - 69 | 3 |
|                         | 70 - 79 | 18|
|                         | 80 - 89 | 36|
|                         | 90 - 100 | 4|

| Total                  | 58/61 |

\(^5\) Three of the respondents take care of two persons.
The distribution of the sample according to the relation of the carer to the older person is presented in the Table 7. As can be observed, almost three fourth of the carers in (N=47) in the sample took care of their parent; 40 carers of their mother and 7 carers of their father. In 8 cases this was a mother or father in law. Five of the respondents were taking care of their grandparent, out of which four carers were women. One person was taking care of her aunt, which is the only case in which the relation to the older person was not more distant. In the sample of Polish carers we did not find any person taking care of his or her spouse, as has been the case in Germany. This finding should also be examined further in order to find reasons for such a discrepancy.

Table 7.Relationship to person in need and gender of carer

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>32</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>Father</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Mother-in-law</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Father-in-law</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Spouse</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Grandparents</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Other relative</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>58/61</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The primary reasons for care are listed in the Table 8. below. These numbers should also be looked at with precaution, since it were descriptive answers given by the respondents, and were later aggregated for the purpose of this report. They can however be only treated in a guarder manner, since very often it were multiple reasons for taking over care and it was either difficult or impossible to name one major reason. However, most often the respondents (N=21) reported multiple reasons as the major cause for care, including few types of diseases or other disorders. 11 carers mentioned cognitive impairments as the primary reason for taking over care, which most of the time meant Alzheimer disease or dementia. “Old age” or in other words “lack of self-reliability, mental or physical independence due to old age” was mentioned by 13 carers. 5 persons needed care due to an accident, fall or stroke.
Table 8. Causes of care need and number of people cared-for

<table>
<thead>
<tr>
<th>Reasons for Care</th>
<th>Person in Need of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Impairment (including dementia)</td>
<td>11</td>
</tr>
<tr>
<td>Apoplexy / Myocardial Infarction</td>
<td>0</td>
</tr>
<tr>
<td>Cancer</td>
<td>0</td>
</tr>
<tr>
<td>Old Age (walk deficiencies, blindness, deafness)</td>
<td>13</td>
</tr>
<tr>
<td>Falls, stroke</td>
<td>5</td>
</tr>
<tr>
<td>Psychological problems (anorexia, depression)?</td>
<td>1</td>
</tr>
<tr>
<td>Multiple reasons</td>
<td>21</td>
</tr>
<tr>
<td>Others</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>61</strong></td>
</tr>
</tbody>
</table>

In terms of duration of care, most of the carers cared for less than 10 years (N=41). There were 10 carers in our sample who declared that they cared for 10 years, and 9 carers who cared for over 10 years; one of whom stated that she provided care for over 20 years.

Table 9. Duration of care in years

<table>
<thead>
<tr>
<th>Duration of Care in Years</th>
<th>Number of Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>2</td>
</tr>
<tr>
<td>1 year</td>
<td>0</td>
</tr>
<tr>
<td>2 years</td>
<td>5</td>
</tr>
<tr>
<td>3 years</td>
<td>6</td>
</tr>
<tr>
<td>4 years</td>
<td>4</td>
</tr>
<tr>
<td>5 years</td>
<td>7</td>
</tr>
<tr>
<td>6 years</td>
<td>5</td>
</tr>
<tr>
<td>7 years</td>
<td>2</td>
</tr>
<tr>
<td>8 years</td>
<td>8</td>
</tr>
<tr>
<td>9 years</td>
<td>0</td>
</tr>
<tr>
<td>10 years</td>
<td>10</td>
</tr>
<tr>
<td>11 years</td>
<td>1</td>
</tr>
<tr>
<td>12 years</td>
<td>2</td>
</tr>
<tr>
<td>More than 12 years</td>
<td>6</td>
</tr>
</tbody>
</table>
The Table 10 below presents the distribution of the carers according to the number of persons they cared for, as well as the relation to the cared-for person. It shows that most of the carers (N= 47) cared for one person at a time. In case of 10 carers, the care was provided to two persons, but not necessarily at the same time due to fluctuations of care need of the older people. In the sample, there was also one person who took care for 3 persons.

Table 10. Number of people cared-for and their relationship to carer

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Person 1</th>
<th>Person 2</th>
<th>Person 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Grandmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Mother-in-law</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Father-in-law</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Aunt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 People</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Mother</td>
<td>Mother-in-law</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mother</td>
<td>Father</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mother</td>
<td>Sibling</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Mother</td>
<td>Mother's friend</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Father</td>
<td>Aunt</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Grandmother</td>
<td>Grandfather</td>
<td></td>
</tr>
<tr>
<td>3 People</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Mother-in-law</td>
<td>Mother</td>
<td>Parent’s friend - rarely</td>
</tr>
</tbody>
</table>
4.3 Description of the Care Situations

4.3.1 Main care tasks

4.3.1.1 Area (basic and instrumental) activities of daily living, medical care

The INSTRUMENTAL ACTIVITIES OF DAILY LIVING were most frequently reported by the cares as their main caring tasks. In the sample of 57 respondents only 5 did not mention it as the type of help and assistance they provide to the cared-for person. By definition these activities include: feeding, bathing, and cleaning, dressing, homemaking (like cooking, cleaning, laundry, shopping). Most of the times, these are the most time consuming activities for the carers.

Cleaning all the time, tidying up all the time, wiping the floor all the time (PL 31)

The most commonly reported activity was shopping, which was reported by almost all respondents. It did not appear to them as a very burdening task, since they combined it with doing grocery for themselves or their families. It was usually regarded as a simple activity. The exception to this were the cases where the older people needed some special dietary products due to their illness (e.g. diabetics). Sometimes the old people themselves expressed some particular wishes as far as doing grocery was concerned.

Well, for example yesterday morning I had to go to pick up some fresh bread, and not just any bread but the one that my mom likes, so it can’t be from a regular shop(), because she won’t eat it, and that’s why I have to go to a special bakery where they have a spelt bread. Then I have to pick up farm eggs, because she won’t eat regular ones also (PL 2)

Even though, most of the carers did report ADL as their main caring tasks, there can be distinguished three levels of assistance in this area. The first one would be the carers taking care of an adult who is not capable of doing any type of the ADL on his own, which most frequently is the case with immobilized people who do not leave their beds or wheelchairs. This level of care is naturally determined by the health situation of the cared-for person. The help in these cares includes all types of ADL and is frequently compared to taking care of an infant who is completely dependable on the carer.

It was not the among the main research questions of the CARERS@WORK project to assess the ADL of the older persons and therefore this term is only used as a general description of the activities, and not used precisely as a measurement of the health professionals.
Especially as mom is right-side paralyzed, which is why she doesn’t speak. Therefore it’s a kind of difficulty but when you’re someone’s child you know this person’s habits right? (PL 32)

Simply we’re like a one person. We’re just like a shadow. With my mom is like... like taking care of a child, you have to do everything for her. That includes dressing her because she can’t do it by herself. At the beginning I... I even had to help her with underwear. (PL 27)

This care is most of the time also referred to as “24/7”, which means that the carers are responsible for the person cared-for in all aspects of their lives and at all times. Most of the times they were describing this type of care as “doing everything”. In this group there was the highest level of the “un-balanced” carers, which stems from the fact that this type of care – “24/7” is the most burdening for the carer. This type of care – over an immobile adult, which included all the nursing activities, was also described as the most burdening, and moreover it caused damage to the health of the carers themselves due to heavy lifting.

My sister weighed a bit, she was inert. So I had to bathe her, wash her, dress her and well, she resisted and all. It took a lot of effort and... and everything. Well it’s obvious, she’s a woman – I had to wash her and her intimate parts because there were nappies and all, it was horror. It was just horror (PL 28)

The second type of the carers in regard to the ADL are the carers of the people who are relatively self-sustainable and can perform some of the ADL on their own. This especially concerns the hygienic activities, like going to toilet or washing themselves. These types of cared-for persons are usually walking and relatively fit, whereas they do need assistance with more complicated activities, like hairdressing or nail cutting or more energy consuming activities in homemaking, like sweeping the floor or vacuum cleaning. In these cares the carers are responsible for majority of the home keeping activities, like preparation of meals, cleaning, laundry, washing the dishes, etc. however, these are sometimes “shared” with the older adult.

She washes her clothes by herself. Regularly. And if it comes to sheets it’s obvious that I wash those for her. In a washing machine. And the cleaning? Well, I absolutely don’t expect mom to clean up, however when she’s home all day she’ll vacuum and sweep the floor. She even tidies up the yard if it’s necessary. (PL 46)
Some of the older people, who were still fit or relatively fit, found it even disturbing that the carers were taking over some of „their” work, since it was perceived as becoming redundant to the family, which could increase the level of isolation and raise the feeling of inadequacy.

Yes, mom can handle it. Laundry goes to washing machine, I just take it out and hang it, and cooking, it’s mom’s, well I must say she’s reluctant towards help with cooking (PL 44).

There seems to be a significant problem in the eyes of the carers as to what extend should they perform these activates for their cared-for persons, as there is evidence, that the more they do, the more the older people withdraw from doing these activities, what often can cause the worsening of their health condition. This happened to some of the respondents, and one of the things they regretted was to take over too many of the household duties, which was caused by their worry not to burden the older person with any work. However, it turned out that is reduced their physical strength and willingness to get up from bed for example, and would in long run deteriorate their health. Some of the respondents seemed to be aware of this process and would ascribe certain activates (like cooking or cleaning) only to the older person, so that they would feel needed and would stay fit for longer time.

Interviewer: So basically you share responsibilities?

Respondent: Yes, yes, yes... we tidy up together also... My father’s-in-law apartment is pretty big, much bigger than ours, quite a lot of square meters... so there’s a lot to do. I do the laundry, ironing and all... We dine out and so does my father-in-law, therefore, because he wants to feel needed, he buys groceries every morning so he’d have something to do during the day, he can still walk and he might meet somebody, it’s like an attraction. (PL 55)

The third type of the carers according to the amount of ADL care they provided would be the carers who needed to only facilitate the ADL by supporting the older person or doing these activities from time to time. Some of the cared-for persons were fit enough to perform almost all the ADL, and some of them were supported by the professional carers working for the social services agencies or by private housekeepers/maids.

Personally I don’t cook, do the laundry or clean because my maid does that for me. But I earn for it. I haven’t been doing that my entire life... I mean my house is well maintained but I don’t do it by myself. I hate chores, so I decided that this will work. (PL 5)
Medical help provided by the carers is directly related to the health status of the cared-for person. Majority of the respondents reported that the older person in need of care does take some sort of medication. In some cases, this type of care was especially underlined by the respondents and they explicitly said they need to control if the older person take their medicine. In the case of persons with Alzheimer disease, this was particularly a difficult task due to limited awareness of the illness of the older people themselves. Sometimes the cared-for would hide the medication somewhere, and pretend they took it, which could even be dangerous to their health.

Because grandma thinks that if she doesn’t feel any pain she’s not sick. The same thing is with her medicines – why does she need to take them if… if she doesn’t feel any pain (PL 27)

Another type of medical condition which needed special care as far as taking medicine is concerned were the diabetics, whose medication (insulin) needs to be given at the precise time of the day, what was described as an additional difficulty to the working carers.

She needs [to take] that insulin three times a day, because she’s [diabetic], the proper amount has to be prepared so she would take it, and the medicines have to be prepared also on dinner time (PL 42)

In case of persons with physical disabilities or malfunctions, the respondents also cared for the rehabilitation process what occurred most often after surgeries (hips, legs).

So I always encourage her to exercise and (...) walk (...) (PL 54).

4.3.1.2 Supervision

Supervision as one of the main caring task was reported by some of the respondents who took care of the most sick and disabled old people. This type of activity was related to the lack of self-control of the older persons themselves stemming for their mental or physical condition. All of the working carers taking care of persons with Alzheimer disease reported that they were not only the carers, but they also felt as guardians of the older persons, who due to the nature of the disease would be able to run away from the house or behave in a childish, uncontrolled way, which could be dangerous to themselves.

Well we already had a situation when we had to change handles for locked ones. (PL 23)

Some of the respondents who were taking care of adults with medical conditions such as Alzheimer disease, dementia, Parkinson or other related to the mental condition,
needed to take care of the financial safety of the older persons, since they could no longer properly manage their income, what could end in losing it or spending recklessly.

At some point I came to a conclusion that, unfortunately, I have to keep all the money, because mom gets her pension, that I’m the one to control all expenses and keep the money, don’t leave it to her. She would let anyone into apartment. There’s no way that… There’s even a note on the doors – I sticked it – under no circumstances open the door to strangers. But mother opens (PL 21)

4.3.1.3 Hospital / doctors

The medical care of the older persons was reported by most of the respondents as one of their main caring tasks. They felt responsible for and concerned about the health of the old person and they feel they need to “control” it. This type of concern was very often expressed by the respondents. The assistance with medical care is also viewed as necessary due to the lack of understanding of the older person of the sometimes complicated talk of the specialists and the carers are the “connectors” between the doctor and the patient.

On average the respondents organized the whole medical care over the aged persons, which included most of the times: the visits to family practitioners, specialists, visiting the older person during their stays in hospitals, transportation to the doctors, as well as buying the prescribed medicines and other types of medical assortment.

Because you have to go to a clinic, to see a doctor. You have to go to a pharmacy and buy medicines. You have to go [and buy] nappies. (PL 19)

However, the medical care carried out by the respondents could also be more complex and include the help of a nurse and weekly visits to doctor in order to dose the medication properly. Sometimes it could also include rehabilitation, which in some cases was not properly assured by the public health services.

During those couple months of rehabilitation after the second surgery, all that time, I was that nurse, ward maid and physiotherapist because the actual physiotherapist was coming over once a day and the exercises had to be done couple times a day. (PL 53)

The care includes also transportation to the doctor, which may be very problematic for some older people who are immobile and need to be transported. Very often the immobile older person need to be carried by the carers themselves since the transporting assistance of the hospitals is very poor. Another problem faced by the carers is the large distance they need to travel to get to the specialist, which was
reported by the carers living in rural areas or in smaller towns, but it would also happen in case of a big city - Kraków.

In some cases, the carers had the possibility of having a doctor home visit, but it was usually regarded as “luck” and not a common practice in case of older person who are immobile. Some of the working carers ordered paid specialist home visits, what was an additional expense.

4.3.1.4 Management

The feeling of responsibility for the older person shared by most of the respondents made them arrange all the spheres of the lives of the old people. This was understood as some sort of “management” of care multiple, sometimes very challenging caring tasks. The dependency of the older person on the carer was observable mostly in “public” sphere of life, including contacts with public offices, doctors, or traveling.

_Bills, doctors. () There weren’t many of them. But... the medicines, all those things around the house and allotment, some payments, some organizational things: parish priest, some collection, this and that you know, things you need to organize, so... Well in fact I ran the house while living somewhere else (PL 14)._ 

4.3.1.5 Bureaucracy

Among the researched cases, only 7 respondents were explicitly mentioning the bureaucratic activities as their caring tasks. However, these types of tasks were performed by larger group of carers, who might however not consider it as “care” explicitly, and would thus not mention it directly.

The first type of these activities are the tasks, which used to be the normal tasks performed by the older person, but are currently performed by the carers since the old people cannon handle them any more due to their old age and limited capability in this respect. The types of tasks include: taking care of the bank accounts, paying the bills, handling the issues with various public agencies.

_It’s obvious that these matters, I don’t know, financial in administrative sense or bank matters, can no longer be handled by grandma (PL 19)_
The second type of the bureaucratic activities includes the work which needs to be done in order to arrange proper care for the old people. This was usually somewhat novel to the respondents and they felt it was too complicated, burdening, frustrating and time-consuming.

*There are all those papers that need to be handled in the Local Social Welfare Office, there are also those agreements, (...) (I) called many times, I’m telling you: I don’t have time, I’m not going anywhere (PL 17)*

These types of caring tasks were mostly directly related to the provision of the institutional care, which is either professional home care or a nursing home. As far as organizing a place in a nursing home, which was reported as an extremely lengthy bureaucratic process, it needs to be underlined that in the case of older persons who are not communicative any more; a procedure of incapacitation needs to be carried out. This involves complex court procedures and is a stressful experience for the carer.

*Everything had to be done – submitting cases, but first he needed to be incapacitated, then was the matter of legal guardianship, then once again... to put him in a Social Care Centre and it’s not done yet, and then all those papers, tests, interviews – and of course the matter of financing this Centre from our money and his as well. And then finally the papers can be submitted and something can be done. Well yes, we can’t skip all that. But unlucky it all extends in time so much. (PL 23)*

Another type of bureaucratic task was ordering adult diapers with a special discount provided by the local social welfare centers. It involved much paperwork, but was necessary for the respondents since it reduced their financial costs of care.

*If it’s necessary to handle all the paperwork, recently with those nappies, because there’s this whole procedure so you could reach this, you know... limit and get nappies little bit cheaper. So you have to go there, wait in the line, there are some documents, papers you have to sign, fill something... I don’t know, because it’s been two, three years that [I haven’t been interested in this] (PL 17)*

### 4.3.1.6 Normal visits

Visiting an elderly person as their caring task was reported by half of the respondents, most of those who did not live with the cared-for person. The visits are mostly described as “keeping the company” to the older persons, which was found
especially crucial in cases when the older persons lived on their own. The conversations with the cared-for were very important to most of the carers and were paid special attention.

The respondents also found it very uplifting for the elderly, who often spent much time alone and needed this contact with the outside world. They often underlined its therapeutic function. The carers were also some sort of “messengers” between the older persons and the outside world.

Well yeah and there’s this thing that you come in, talk for half an hour: how are you, what do you need, what can I get you? You can actually see that mentally she seems... cheered up a little bit. Yeah. She’s just getting back her life (PL 34)

But when... well, when I have those days that I work till noon I try to spend the afternoon with them and talk, because I know that for mom it’s very important, especially to have a conversation, cause it’s not working, so this relationship is practically minimal (PL 38)

Apart from the time when the respondents spent time on conversation, it was often pointed out that mere “company”, presence at home is also crucial for the older people. This “being together” could take on different forms; more active like: gardening, going for walks, attending some cultural events, visiting family, cooking together. Or more passive activities, like: reading newspapers and books, watching TV, playing Scrabble.

For most of the respondents this type of care was not described as troublesome, but was rather referred to as “relaxing”. Sometimes it was not even regarded as “care”.

Besides taking care of grandma is some kind of relaxation itself. For example we watch House together (PL 1)

However, sometimes it was perceived as too time consuming, and thus problematic, especially when the carers were tired after work and did not have energy to talk.

However I have less and less time for conversation. And mom wants to talk. She thinks that first thing after work I should come over, discuss everything with her, and talk. Because she’s all alone at home the whole day (PL 2)

4.3.1.7 Summary of main care tasks
All in all, the most important tasks of the working carers are related to the INSTRUMENTAL ACTIVITIES OF DAILY LIVING, which was reported by all respondents with varying levels of engagement. Three types of provided care could be distinguished here: the carers whose obligation was to fulfill all the duties related to ADL; the carers who did greater part of these tasks, but were sharing them with the older people; and the carers who only facilitated or slightly assisted.

The second type of main caring tasks were the visits to doctors and hospitals and the medical care provided by them at home. Depending on the health status of the older person, these activities could vary in complexity and time needed to arrange.

The third most frequently reported task was keeping the company and simply spending time with the older person, either by visiting them at their house if they lived apart, or by spending time together at home. The activities were also divided into more active or passive ones. Some respondents did not even consider spending time with the older people as care and did not find this type of activity burdening.

The tasks of “management” and “supervision” were mentioned by few respondents, and were mostly related to the people who needed permanent care or the ones who could hurt themselves and were not mentally stable.

As far as bureaucratic tasks were concerned, only few working carers reported it as their task. It included mostly managing the financial assets of the older people or preparation of the necessary documents for the Welfare Centers in order to obtain additional help.

4.3.2 Amount of care

The amount of care among interviewed respondents varied from several (8-10) hours per week up to 100 hours, or the situation where care was provided 24 hours per day and could no longer be counted in hours by the respondents. It needs to be bear in mind, that for most of the carers it was very difficult to estimate the number of hours they spend on caring for verity of reasons, one of them being the impermanent nature of the care, which meant different hours of care depending on the need for care as well as on the possibility of providing care. Therefore, the estimations by the carers need to be taken carefully only as approximations rather than objective and hard data.

The amount of care provided by the working carer is an outcome of series of variables, such as the health status of the older person, working hours and flexibility of work of the carer, the support the caregiver receives from outside sources, the living situation.

24/7

As far as the health status of the older person is concerned, the greatest amount of care was provided to the ones who are bedridden. The approximate percentage of these
persons in our research sample was 30%. The illnesses which were most frequent in these cases were: Parkinson disease, very advanced Alzheimer, strokes resulting in paralysis, bone fractures (hips, legs), osteoporosis, or general weakness due to old age. This help was usually described as “24/7” or “all the time” or “from morning to evening”. The only time the carer was not performing care duties was the work hours. All the rest of the time of the week was devoted to the care.

Well, practically – except my working hours – all the time (PL 57)
Because this is twenty-four-seven care. And sometimes, according to my book about Alzheimer’s, it’s even more than twenty four hours a day (PL 27).

Another factor influencing the amount of care is the housing situation of the carer and the older person. In cases when the older person live with their carers, the estimation of the hours of care is not possible for the carer, since it is difficult to separate the “care” from other types of for example household activities.

It’s impossible to determine. Impossible to determine because it’s an inseparable part of my life so I can’t say how much... practically we live together and we’re together all the time, I take care of her all the time, you have to do this and that, or... or open the window or... or wipe her mouth, get her something to eat. It’s impossible to determine. (PL 37)

In cases where the older person lives alone and needs permanent care, the carer is caught not only between work and care, but also between two households.

Respondent: From six p.m. till the morning. From six... I go there let’s say five, six p.m. I come here first, eat something, take a short rest, handle some things because there’s always something to handle and then I go there.
Interviewer: Is it every day?
Respondent: Everyday! Frankly, it’s exhausting (PL 3)

At this point I sleep over at mom’s every second day. I spend there entire afternoon and night, and in the morning I go to work. When I’m on my duty like tonight I spend the afternoon and night at work, till eight a.m. so I’m not there. (PL 26)

Another variable to add to the outcome of how many hours are spent on care is the support obtained by the respondent from other sources. The person might need a 24 hour care, but if divided by two carers it only needs to be 12 hours per person.

EVERYDAY BASIS
The amount of care, which can be described roughly as „everyday basis” is characterized by every day visits to the older person, which are relatively short in duration (2-4 hours), and additional hours over the weekend. The weekends are perceived as more problematic for the cares, since usually there is no institutional care provided at that time, and the carers need to provide the older person with help on their own. However, most of the time, it is done without conflict with work; unless the carers work on the weekends as well, in shift work system (e.g. in hospitals).

This care was easier to count for the respondents and was estimated between 20 and 50 hours per week.

Well weekly, counting seven days a week, it’s let’s say two hours a day times five till Friday... so it’s ten hours, then on Saturday and Sunday let’s say 5 hours. It’s weekend, I don’t work so we spend more time together. So it gives us about twenty hours in total of time spent together (PL 46)

Some of the carers were caring every day, with the exception of the weekends, which was usually a result of family agreements, where the other members took care of the older person on their free days.

MIXED

Many respondents were declaring the amount of care as approximately 15-30 hours per week, but not on every day basis. This would mean visiting the older person few (3-4) times per week and spending there several hours.

Three times a week. Well sometimes four, it depends. If he feels ill then we go more often, you know. Last time when he was sick I was coming over almost every day (PL 35).

Another type of caring schedule was when the carers spend some hours during the week, and most of the weekend at the older person’s house. This arrangement was related to the working hours of the carers (during the week).

RELAXED

In the sample of interviewed carers, some were stating that the care they provide is only few hours per week (around 8-10), and would account for short visits few times per week and perhaps some additional time on the weekends. This type of care could be referred to as “relaxed”, since it was not colliding with any other activities of the carers, and was easily manageable.

Well I try to visit during the week, at least one hour. And on Sunday, well that’s... that’s my duty. (PL 34)
Additionally, it is not easy to precisely define the number of hours cared due to the “double nature” of the care, which could be understood as “real” and “virtual” care. The first one being the caring tasks, whereas the second one being the “thinking” about the care, which is a natural part of the caring process, and as pointed out by respondents – is also time consuming.

I mean it’s... well maybe physically if you summed that up it’s not much. However mentally, you just can’t stop thinking about it... (PL 12)

4.3.3 Reasons for taking over care

Two categories of reasons can be distinguished in the beginning - **objective and subjective** ones. The objective reasons are resulting from “demand” for care, and can be directly related to the health of the older person, which are the reasons beyond the control of the cares.

Another category of reasons are subjective ones, which include the reasons why it is the carers who take responsibility of providing care for the older person, and are more related to the individual motivations of the carers (like emotions), rather than factual circumstances. The reasons for taking over care were varying across the sample; however several major traits could be distinguished in thinking about the carers’ motivations.

In the category of **objective reasons** for care, the most common were: the illness of older adult, a sudden accident (e.g. a stroke), and simply – advancing processes of old age. As far as illnesses were concerned, not many of them appeared suddenly, and thus, the carers were more or less aware of the fact they would need to take over the care.

*When the sickness started. Before she had been doing just fine on her own. She had been even able to do a lot of things around the house. And then we just... I have sister – and she noticed that something’s wrong, that something’s going on. My mom started to lose her memory. She couldn’t handle basic things. And then I just... I had to take care of her by myself. I had to take the burden (PL 41).*

*It all started with the doctor’s diagnosis, which confirmed that my dad has Alzheimer’s, and that was like... like a first phase of mental preparation, because he didn’t need any care yet and we didn’t realize the gravity of the disease (PL 11)*

*For me it was just like a bolt from the blue. I was coming back from holidays when I heard that mom’s in hospital. At first I was shocked: how am I going to deal with it? (PL 22)*
In some cases, the **death of the spouse** was the instant reasons for taking over the care, which was earlier provided by the spouse or was not necessary at all, but at the moment of loss the mental or physical condition of the older adult person deteriorated.

*We started to take care of my mother-in-law three or three and half years ago when, after her husband passed away, she stopped going out (PL 49)*

Apart from objective illnesses of the older persons, the carers referred to the **family situations** as the reasons for taking over care. Among this type of reasoning, the large distance of the place of living of other family members was reported most frequently. Another major reason was the lack of any other member of the family who could take care of the aging person, which was most common in case when the carer was the only child.

*Most of my family works abroad, that is in Germany, so obviously they’re in Poland three or four times a year. That’s why everything is on mine shoulders, the grandson shoulders (PL 52)*

*Because I’m the only one that can. I have no brothers and sisters, my father is dead for a long time now. So I’m the only one (PL 22)*

As far as the **subjective reasons** are concerned, the interviewed carers mentioned variety of reasons, such as: love and concern about the older person, feeling of attachment, wish to repay the care they got when they were younger, the empathy, feeling of moral obligation, feeling that it is natural and normal to take care of the older parent.

*First of all it should be said that we’re very close together. I just love her so much (PL 8)*

*Well, considering the fact that I’m alone – because it’s not without meaning that I raised my daughter on my own and I’m on my own – my life is related to grandma’s life practically all the time, you know (PL 13)*

*Well actually we don’t consider this as an obligation because, as I said, we got so much from our grandparents that it’s just a normal thing for us (PL 19)*

Some of the emotions the respondents had towards the care when talking about the reasons they take care were not positive, but rather stemmed from desperation or lack of choice.
I was just ashamed. I was ashamed; I had guilty conscience, locking my mom, police or social welfare center interventions (…) and my husband. He said that we had to take mom (…) so we took her (PL 7)

4.3.4 History of care

The average length of the care of the interviewed respondents was 10 years. The longest care was approximately 20 years, whereas the shortest periods were 1, 5 months.

The history of care of the more experienced (2 years) carers was usually directly linked to the health status of the older adult and how it changed during the years. Another factor influencing the history of care was the work changes experienced or undertaken by the working carers what was, however, not that common in this researched group.

The most common tendencies in the history of care was either increase or decrease in the amount of care. Most frequently, the respondents declared that the amount of care was increasing due to the deterioration of health condition of the older person.

At the beginning it wasn’t so absorbing because she could still make her own meal and do the cleaning, but after a while, well she needed cardiac pacemaker. There were also problems with her back and automatically we had to take over more responsibilities (PL 43)

Sometimes however, the deterioration in health was translated into reduced amount of care, what mostly concerned the persons suffering from Alzheimer and is directly related to the different stages of this disease. The first one being more demanding in terms of care and supervision of the sick person requires constant alertness of the carer. In the later stages the sick person is known to calm down and be less vigorous.

It used to be like that, but not anymore because grandma is older now and isn’t strong enough so she sleeps all night. But I used to wake up three times at night. And you don’t know what to do when such person is still let’s say full of life (PL 27)

I’m expecting nothing more because now it’s not necessary to look after mom all the time. She’ll eat, lie down and just… stay like that. Before you had to be around non-stop, so grandma didn’t do anything. You had to turn off the taps, electrical (PL 16)

The decrease in the care duties was made possible usually by introducing some additional care takers or improvement in management of the care tasks.
Two years ago it was more often, until the situation became stable. There were less people who could help out so I was there at night and whenever I was needed, that is from morning till about noon, (...) Now I'm there once or twice a week with service or other help (PL 49)

Some working carers were faced with situation dramatic change in the amount of care they needed to provide caused by sudden deterioration in health condition or accidents such as strokes or bone fractures. Oftentimes, the care needed to be provided or increased directly as a result of a death of the spouse.

She sat down wrong on sofa and broke her thigh bone. It was three years ago. And that was it. Pretty dramatic end because although the surgery went smoothly and the bone knitted nicely she couldn’t walk on her own after that (PL 57)

**Potential changes**

Quite large group of the respondents were also concerned about the future care which they felt they needed to provide. The greatest worry of the carers was the deterioration of the health of the older person, which would immobilize the person permanently what would dramatically worsen the situation of the carers. In this case, they would need to rearrange the caring tasks significantly.

There might be a problem if mother stopped walking, well then for sure; it would be [way harder]. I would have to hire someone because I wouldn’t make it on my own (PL 54)

Because, God forbid, if mom stopped walking and lie down I wouldn’t handle that. I have no back, no shoulders so... I definitely can’t pick up and carry her, no way. (PL 7)

### 4.4 Description of work situations

Almost all the respondents in our sample were employed or self-employed (N=56). Only two carers were no longer economically active, and were receiving pensions. Most of the respondents were working as employees in either private or public companies, and 12 respondents were self-employed. A few carers were employed part time, what included half-time employment contracts or short-term contracts.

#### 4.4.1 Sector of activities

The Table 11 presents the occupation of the carers with approximate distributions among the sectors. The biggest number of carers was working as
professionals (N=28). Most of them were teachers, in both lower and higher levels of schooling. This fact of greater concentration on the education sector stems from the recruiting method, which included snowballing among the colleagues and friends who were related to the education system. The second biggest group of carers (N=10) were employed as service and sales workers. In the sample there was also a group of 6 persons whose job description would suit “managers” or senior officials. Same number of carers (6) was qualified as technicians or associate professionals. 5 working carers were described as clerks, and 3 were performing elementary occupations or were craftsmen.

Table 11. SCL - International Standard Classification of Occupations for European Union purposes (ISCO-88(COM))

<table>
<thead>
<tr>
<th>Type of occupation</th>
<th>Number of carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislators, senior officials and managers</td>
<td>6</td>
</tr>
<tr>
<td>Professionals</td>
<td>28</td>
</tr>
<tr>
<td>Technicians and associate professionals</td>
<td>6</td>
</tr>
<tr>
<td>Clerks</td>
<td>5</td>
</tr>
<tr>
<td>Service workers and shop and market sales workers</td>
<td>10</td>
</tr>
<tr>
<td>Skilled agricultural and fishery workers</td>
<td>0</td>
</tr>
<tr>
<td>Craft and related trades workers</td>
<td>1</td>
</tr>
<tr>
<td>Plant and machine operators and assemblers</td>
<td>1</td>
</tr>
<tr>
<td>Elementary occupations</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

As far as the status of employment is concerned, most of the working carers were employees (N= 43), 12 were self-employed and 2 were retired (early retirement). One person was a student.

Table 12. Status of employment
<table>
<thead>
<tr>
<th></th>
<th>Female Big City</th>
<th>Female Town</th>
<th>Female Rural</th>
<th>Male Big City</th>
<th>Male Town</th>
<th>Male Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee</strong></td>
<td>19</td>
<td>7</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>43</td>
</tr>
<tr>
<td><strong>Self employed</strong></td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td><strong>Student</strong></td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Retired/Pensioner</strong></td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>24</td>
<td>10</td>
<td>13</td>
<td>8</td>
<td>2</td>
<td>1</td>
<td>58</td>
</tr>
</tbody>
</table>
4.4.2 Number of working hours

The working situation of the carers is one of the most important dimensions of the analysis. In the total sample of 58 respondents, only 2 persons were not working at all. As far as distribution of the working hours is concerned, most of the respondents (N=39) worked fulltime, which means 40 hours per week (or less in cases of some occupations). There were also 16 respondents working in part time jobs, and 1 worked “occasionally”.

<table>
<thead>
<tr>
<th></th>
<th>Female Big City</th>
<th>Female Town</th>
<th>Female Rural</th>
<th>Male Big City</th>
<th>Male Town</th>
<th>Male Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full-time</strong></td>
<td>19</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>39</td>
</tr>
<tr>
<td><strong>Part-time</strong></td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td><strong>Occasional employment</strong></td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Hours worked per week noted with &quot;0&quot;</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>11</td>
<td>13</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>58</td>
</tr>
</tbody>
</table>

The number of working hours was an important factor in assessing the job by the working carers. Nevertheless, the more important was the flexibility in working hours, which was always underlined as a great facilitator in the process of reconciliation of work and care. The flexibility was understood as either ability to adapt the working hours accordingly to the needs of the carer, or it was understood as ability to combine work in the office with working from home.

*My situation is a comfortable one, because I don’t have many classes. On average I have 20 hours of classes per week, but it differs. Plus the office hours, and ... I try to consolidate these hours together during three and a half days. So, in general, I have two days free. And the weekends, of course, so I can spend more time with my mother, and take care of some other things as well (PL 25)*

Majority of the working carers worked full-time jobs, which amounted to 8 hours daily. However, in case of the teachers the full –time position amounted to
approximately 20-30 hours per week and some hours they worked at home. In case of academic teachers, the number of hours could even be less, however, the preparation time (work at home) was greater. Additionally, the teachers had extra jobs, which allowed them to obtain additional income.

For many years, as far as my work is concerned, it has been 5 hours per day on paper. Additionally, I work as a teacher. I graduated from oligophrenic pedagogy, so I can work with mentally disabled children, and so I have these additional two hours there (PL 50)

In the group of **office workers, clerks**, either in public or private enterprise, there was some possibility of coming to work little later or leaving the work sooner. However, these hours needed to be worked off on some other day. The hours are also fixed and most of the time, the work cannot be “taken” home.

The hardest situation as working hours was the case of persons working in **shift work** system. The shift work system does not allow for almost any alterations and moreover, it often involved long shifts (10-12 hours), when it is not possible for the carer to leave work in case of emergency. This type of working schedule is least flexible and also disorganizes the lives of caregivers due to unusual working hours.

Like I say, it’s not like twelve hours per week of workday, and then another workday.. it is all very different. For example there is one workday, and then there is a night shift, and then two days off – it all changes constantly (PL 21)

In the case of **self-employed**, the situation was specifically interesting, since on the one hand, they could maneuver as far as their working hours were concerned, and most of the time they could some work home. However, on the other hand, they complained that this type of work is more demanding from them because they “never leave work” and it is very problematic to divide work from private life.

I have to think about it all the time. Sometimes I work two hours physically, and sometimes, when everyone brings their sick leaves (laughter), or there is high season for example, I need to work 12 hours per day (...) but being the owner it is like that. It is not only the physical work, but the problem is in your head, right? (PL 25)
Table 14. Changes of the work situation because of care

<table>
<thead>
<tr>
<th></th>
<th>Female Big City</th>
<th>Female Town</th>
<th>Female Rural</th>
<th>Male Big City</th>
<th>Male Town</th>
<th>Male Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction of working hours because of care</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Changed position because of care</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Quit job because of care</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Lost job because of care</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Self-employment because of care</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No change</td>
<td>17</td>
<td>9</td>
<td>12</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>47</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>10</td>
<td>13</td>
<td>8</td>
<td>2</td>
<td>1</td>
<td>58</td>
</tr>
</tbody>
</table>

Among the working carers, most of them declared no changes to their work situation due to the caring obligations. The changes in their working lives were due to objective reasons, such as liquidation of the workplace, financial incentives, etc. Only few respondents declared that they needed to either change work or reduce working hours.

*This intensely as in this moment, I think it’s been over a year. Because of that I changed my workplace. I had to quit more ambitious workplace, which was in line with my education, so that I could have this more flexible attitude of the employer (PL 30)*

*Even when I talk about it now I have tears in my eyes… because I just realized that my professional career has somehow got stuck. And then I quit my PhD, and then I reduced the work time to part-time, and it is very very difficult to be only a deputy for administrative issues (PL 53)*

Only few respondents admitted they would like to change job or work longer hours/more, but due to care obligations this was not possible to accomplish for them. This included also going abroad to work, which was not possible for one of the
respondent in Krakow, but was manageable for respondents living on the Polish-German border who commuted to work to Germany.

I need to say – I considered once an option of going abroad to work in this sector, because...well, I just thought about it before my mother got sick. But at this moment, such option was put off. I don’t consider it any more (PL 20)
4.5  Impact of reconciliation on the life of the working carer

4.5.1  Typical conflict- and stress situations between work and care among carers

The majority of the carers strongly felt that the care they provide is causing stress and some sort of conflicts in their lives. The level of stress differed greatly among the carers, varying from slight (or hardly perceivable) to severe depressions. The conflicts, which were mostly, reported by the respondents concerned the constant lack of time, pressure, family relations, and work. However, most of the conflicts were of private nature and many respondents admitted there is little influence on their daily work.

4.5.1.1  Impact on Daily Work

The impact on work of the carers was depending mostly on the type of work they were carrying out. In general, several trends can be distinguished.

One of the impacts of care on daily work was the worsened physical condition (e.g. spine aches), tiredness and stress of the carer, which were perceived by the working carers as a hindrance to effective job performance. It is often closely connected to the lack of sleep suffered by some carers, who need to support the older person during nights as well.

I mean the only thing is that sometimes I'm very tired. And that's all. But if it comes to work or something like that, then it doesn't affect this. It's just I'm really tired and sometimes have problems with my back (PL 39)

Most of the carers did not report that the caring obligations posed a heavy burden on their everyday working lives, but described it as a “hindrance” or “limitation” to their professional development and career or working opportunities. This impact was only observable in the long run of working careers when the carers were deliberating on what types of job opportunities they had to resign from due to care.

If it’s Alzheimer’s disease I already knew that it’s incurable, that it might slow down a bit but still will be progressing. And there was this dilemma: what with my PhD? I postponed it and then finally gave up (PL 53)

Well if it comes to work difficulties I had to give up trainings and conferences – those that last longer and which are very attractive and beneficial in official sense and alongside give you an opportunity to relax among colleagues (PL 57).
I had to give up English course at my office, and it’s been a year since I did that. We have such [opportunity] at work so I attended it for two years, but then I had no time (PL 17)

The care was sometimes a hindrance to taking on additional jobs, such as: part time jobs or summer jobs (for teachers) what negatively influenced their financial situation. Some respondents declared that if they were not carers, they would work longer hours in order to increase the income.

_Interviewer:_ So is that how you moonlight from time to time?
_Respondent:_ Well I managed to do that from time to time but now it’s less frequent than it used to be
_Interviewer:_ And what is the reason for that?
_Respondent:_ The reason is that, well I have to visit my mom. Because I… sometimes when you want to make some extra money you have to be available all day long. It’s not just one hour thing. Well you have to be available all day long only during the summer period. (PL 21)

It affects in the way that I can’t, even if I wanted to, drive longer hours, so I have to pass on that because I have to prepare a meal for my mom and also change her, you know? (PL 16)

One dimension of this type of limitation to the working lives was lack of possibility to take on a full-time job, which would suit the carer better than the present one, and would be also financially more beneficial.

_Well for instance it limits me in the way that I can’t take a job where I would have to work eight hour shifts and be around at the same time. I think it wouldn’t work especially that mom is getting older and needs more attention and care with every day. It won’t get better; it can only get worse (PL 54)_

Changes to organization/hours of work

Some of the respondents, whose working hours are not strictly fixed (like in the shifts system) needed to rearrange their working schedules (e.g. reduce work time) or make some day-to-day alterations in their agendas. These changes were possible due to the nature of work, and could perhaps be understood as strategies to cope with the caring obligations, however, most of the time they were evaluated negatively by the respondents, since they destroyed their planned schedules and decreased productivity.

_This is one of the situations when I’m torn out of a context and I have to get to my parents as fast as possible. That makes... It’s hard to get back to your thing after this kind of situations. It doesn’t matter, if I was checking tests then that are_
nothing, but if I was trying to solve a problem, well hard luck. This is a burden – it’s a matter of a mental burden if you ask me (PL 11)

Another type of change could be “bringing work home” or working late at nights when there was no need for them to care.

Another impact on working live which was described by the interviewed carers was the need to take a day off from work to arrange a visit to a doctor or another issue. This also included coming to work later or leaving earlier. Sometimes they would be forced to take a sick leave in order to accommodate the care needs of the older person.

Or for example I have to give up something: either a trip or interview or something like that or even leave work earlier if I’m needed right away. Such situations did happen. Simply there was nobody to take care of her in the morning so I had to be available and I showed up to help (PL 49)

One of the difficulties reported by the carers was the uncompassionate attitude of the managers or directors in their workplaces, who did not understand the specificity of situation of the working carer and were not willing to facilitate the work and care anyhow. The respondents were not able to fulfill the extra orders of the managers, what lead to conflicts. Moreover, sometimes they could even make difficulties, like withholding the motivation bonus to an employer due to late-comings, what happened to one of the respondents working as a teacher.

Therefore the headmaster does not understand that I cannot be away with students for three days. I tell her I can’t go for entire day. In the afternoon – no problem at all. Until noon – be my guest. But I just cannot be away for the whole day. I even can’t be anywhere far from home. Practically I don’t go anywhere (PL 31).

The greatest conflict and hindrance to balanced reconciliation was declared by the respondents who had fixed working hours and they had no possibility of a slight change. This situation was perceived as very stressful and definitely influenced negatively the overall reconciliation process. Such cases concerned most often the work in shifts system, which included sometimes working at night, where there was almost no possibility of a substitution by a co-worker. A slightly better situation, but also difficult to manage, was the work in public offices or in services open to the public at certain time.

I work shifts. Either I work twelve hours during the day or twelve hours during the night. It depends on the work schedule and the worst part is that... that I have to work on Saturdays-Sundays. Day shift. I can’t wake up mom at six and... and give
her medicines, but that I can handle somehow. And in fact I come back home in the evening (PL 21)

One of the most frequently reported impacts on the daily work of the carers was the lack of concentration and constant “thinking” about the care and the older person.

*Interviewer:* Do you experience any problems with concentration, or...?
*Respondent:* You bet I do! What did you think? There’s this general rule – some personal problems affect your work and the other way round! If there are no successes at home it follows you at work; if the atmosphere in your working environment is simply bad then sometimes you bring that to your home and act all irritated. It affects one another (PL 3)

It is hard because for three years I used to work as a drudge does and then, while I was at work I couldn’t stop thinking about mom, what was going on, because she was all alone... I just was not able to switch my thinking from mom to work (PL 26)

Yes, I think yes. When I’m at work I’m constantly thinking about home. And when I’m at home I’m constantly thinking about work. And I always feel guilty that I’m absent somewhere (PL 2)

**The no-impact answers**

The group of informal carers who explicitly said that care had no impact on their working lives was quite significant and consisted of 21 persons. The carers were not worried about the jobs and had no difficulty in reconciling them with care. They were flexible with their jobs and could always accommodate most of the needs of the older person, as well as the work tasks.

*I work in a foundation. Thanks to that I can fix my schedule properly and don’t show up that morning. We live in the world of Internet and computers. I have mine at home, it’s just that I have to carry it with me sometimes (PL 32)*

*I always had time for everything that was related to my work and professional life. There were no objections whatsoever, even from my mom (...) if it comes to work related matter she’s extremely tolerant and understanding. (PL 44)*

*No, no, no. In my opinion no. No, because it was just an offer to change my position () I didn’t get any to go somewhere (PL 29)*

**Work as relax**
Among the working carers, some persons not only did not feel any negative influence on their work lives, but on the contrary – claimed that their work has only benefited from the reconciliation process. The work was perceived as a sort of “escape” from the problems of everyday life, or was even considered to be relaxing in comparison to the caring tasks. The respondents were considering working as a process of successful reconciliation saying they needed to work in order to be able to continue providing help.

Respondent: I like my job very much. That’s why I like to work, I like being around colleagues... I like chatting and all... And that’s my stepping stone, because if I had no work probably I wouldn’t make it (PL 41)

I don’t work for money because I count every hour. I just do it so I have some sort of activity, to be around the people and... and I think that if I stayed home all the time it would spoil relations between me and my mom. (PL 44)

The self-employed as special category

The self-employed persons were among the ones who were declaring almost no impact of care on their working lives. The situation of self-employment was considered rather as a facilitator of the reconciliations, since they could decide about their working hours and had more flexibility in this respect.

Well in my case it’s not so hard because I run my own company. When you have your own business you can figure out everything (PL 32)

For example, when we were just getting started with our business my mom was fine. We were going to all types of expos – Vienna, Poznan... [and now] sometimes there are trainings and I would love to go but I just can’t (PL 13)

4.5.1.2 Impact on private life

Care

The working obligations of the carers had naturally some impact on the care they provided, however; most of the time the respondents declared that work did not influence care as much as care influenced work. Very many of the respondents were convinced they did all they could to provide the best care to the older person, since it was the priority in their reconciliation strategies.
Many working carers mentioned that the older person would like them to spend more time with them, which the carers understood and considered a natural need of an older person, whose personal contacts are largely limited and who are prone to loneliness. However, these needs were not always possible to be satisfied due to many obligations of the working carers.

*It’s not as much time as my mom would wish or… well obviously from her point of view it’s not enough. However I think that’s as much as I can give her, and unfortunately I can’t give her more, no matter how cruel that sounds. (laughter) (PL 30)*

Asked about the influence on care, the respondents referred most of the time to the attitudes of the old people to their work obligations, which differed from very positive, reluctant to relatively negative and uncompassionate.

*Mom just… she’s not as much absorbing that I couldn’t go to work and she understands (...) she’s even proud that her children and grandchildren work. It’s not like… Mom was just raised that way (PL 44)*

*Older people are very despotic, I must say. They have big expectations if it comes to… I remember how [was it] even… even before, it was: “what do you mean? You have to take care of me! What do you mean you go to work...” – sister or me. “End of discussion… what does that supposed to mean!” We had to stay around all day long and that’s that. You can’t even... There were big fights sometimes (PL 17)*

**Family Life**

The family life was probably the sphere of life where the impact of reconciliation of work and care was most clearly visible to the carers, since the older persons were mostly either parents of the carers or close relatives (such as grandparent or parent in law). The influence was noticeable on two levels: on the level of nuclear family (spouse and children) and on the level of extended family, which most of the time included siblings. Several married carers admitted that it had largely influenced their marital life, and that it were their spouses who suffered the most because of their care obligations.

*That’s where the problem starts. My wife say: “Why are you going with your mom? Maybe you should move in with her? You have your family too.” I have a wife and a*
child. It would be nice to take them on holidays too. It’s hard to make this work (PL 21)

I mean it’s like that – if it comes to weekend trips we’d rather don’t go, you know, or holidays – it’s definitely not possible that she could go somewhere. My husband is getting very angry and all because he would love to go somewhere. I don’t know – I think I got used to that and so did he (PL 9)

The negative impact of care provision on the family life was diversified and could mean: the lack of time for normal family life, the stress situations, the conflicts with other members of the family; or - in extreme situations - could also result in the total degradation of family life.

It’s obvious that it takes my time, isn’t it? And it’s at my closest family expense; I mean my wife and daughter. Because practically if I visit my parents everyday it all comes down to this, (that) I can’t be at home in that moment, can I? My daughter is at the certain age that it would be nice to have a conversation from time to time – but it happens I guess (PL 18)

Many interviewed carers complained about the stress, which became the part of their everyday family life since the new caring obligations appeared. This was mostly visible in the families where the elderly person lived with the carer and particularly in the few situations when the cared-for person needed to move in to the house of the carer. The presence of another person influenced largely the family households and the relations between the members of the family.

There were a lot of tensions between us. Everyone (was) annoyed and in bad mood, stressed. Everyone just tried to get out of the room where grandma used to be. () it was very annoying (PL 40)

The caring obligations gave rise to conflicts with siblings or other family members, and most frequently they concerned the division of caring duties or different conceptions about the care and its provision. In cases where the older person was a parent and had more children, the care would either be carried out by all of them more or less equally, or one of the children would be the main carer due to various factors. In these cases, many respondents felt they were “left alone” by their siblings, felt regret and had hard feelings towards them.
When I started to be more and more involved in taking care of my mother, my brother… well he stopped speaking to me. He assumed that I’m hurting mom, and he didn’t want to maintain relations with such sister. We lost contact when she broke that other hip, when his help and support was most needed. Then, paradoxically, when my mom was already in the social welfare center, I got in touch with my sister again. Our relation improved and now she supports me. Everything is starting to shape up well (PL 53)

I’m not going to ask my brother for help anymore. No… I can’t humiliate myself any longer. It’s just a humiliating situation to me (PL 26)

Some of the respondents were complaining that other members of family are not willing to participate in caretaking and present complete lack of interest in this respect. The lack of support in care from the closest relatives was an additional stress factor in the situation of the working carers.

They stopped coming over, my brother speaks only with mom, my sister-in-law and my mom were never getting along well, like most mother’s in law and daughter’s in law, children have they own lives now, so they stay rather out of this (PL 13)

In most extreme cases, the respondents were declaring a complete disintegration of the family life. These situations were not common, however, in their results they could be the most detrimental to the carers, as they lost, what is believed to be the fundamental support – the family. The disintegration could be within the nuclear family – it related to the souse, not to the relations with children; or it could occur to relations with members of the further family.

Tragic! Just tragic because the family is torn apart. I’ll tell you my story at the end. Children – stress all the time, it was not possible to function normally in the house (PL 56)

Well yes, I’m a guest in my own house. I’m the guest. It’s not something you could envy. My husband is alone. There’s a lot of stress and irritation because practically I’m not home but stay with grandma (PL 27)

Another type of impact on family life could yet be identified, namely re-organization of family life according to the needs of the care recipient. This was described by most of the carers in less negative light, and was treated as an obligation of all the family members.
Entire family... I’m telling you, generally we were subordinated to mom, every one of us to some point because of that disease, but we’re not complaining. I would say we’re putting up with it like it should be done. We don’t mind (PL 32)

Well, my daughter has her friends, night outs and so on. Sometimes she gets angry, that she’s had enough, that she wants to go out somewhere but it’s grandpa, grandpa, grandpa all the time. Practically we have set our whole life in his favour. That’s the true. He’s always at the first place. We... we have to make everything so he doesn’t stay alone in the house (PL 29)

Family no, because everyone got involved, whether they like it or not. I mean I did that. I’m authoritarian in this matter, therefore my daughter was raised in the sense of responsibility, to take care (PL 4)

Social Live

The social life is the sphere of life, which was somehow “abandoned” by the working carers. Majority of the interviewed working carers were declaring that they basically do not have time for social life anymore, because of the overload with many duties. Some of the respondents completely resigned from this type of activities, others have barely found time to keep in touch with friends.

There’s none. Just doesn’t exist. I even don’t want that. I’ve had enough, I’ve lost my eagerness, I even don’t have anything to say. They have normal holidays. I haven’t travelled for years now because my mom is afraid to be alone. It’s been five years now I think. Nothing. (PL 2)

The last trip we took was to Mazuria, it was... in two thousand three or four (PL 29)

Some respondents did try to find time for occasional meetings with friends, which were however almost always troublesome. Some of the problems were: difficulty to find substitute care for the time out, pangs of conscience for leaving the older person alone, negative attitude of the older person to being left alone, tiredness and lack of motivation.

Besides that I don’t travel at all, although I like it very much. And I had to cut on that. Even if I do manage to take a little trip I have to prepare everything at home: all the cooking, security, dozens of phone numbers and... and then I can go (PL 25)

I used to feel guilty even if I went to the cinema and my mom wanted me to come over (PL 38)
There was also a group of working carers, **who did not have any problems** with finding time for leisure activities and declared that care did not affect their social lives at all. These were usually the ones whose care was more flexible and shared with other carers, as well as the ones who provided only several hours of care per week. Additional facilitation was relatively good condition of the older person who could be left home alone.

Sometimes working carers were more **active** in the field of arranging their social life and were careful to assure they have possibilities to relax, since they considered it a vital part of their reconciliation process. Very often they admitted that they need to have time off, or otherwise they would not be able to provide care.

> Well yes, when I take two weeks of holiday leave, for example last year… last year my sister came to visit. But I had to tell her: “I’m sorry but I just want to go somewhere, I need to relax, because I’m… I’m simply losing it” (PL 21)

However, distinction needs to be made between two types of social life activities and relaxation. The first one is **“local activities”**, such as: the meetings with friends, going to cinema, theatre, sports, etc. The second type of leisure activities are the **“out of the town”** holidays or weekends. As far as the first type of activities was found troublesome by only some of the working carers, the possibility of longer absence (more than 3-4 days) from home was not possible for most of the carers.

> And we have a problem – I won a two-week trip. (…) I can’t leave for two weeks (PL 45)

**Wellbeing and health**

**Stress and depression**

Among the interviewed carers many suffered from some sort of psychological distress, ranging from minor mood swings to severe forms of clinical depression.

**Psychological well-being** of the carers was the first to be mentioned during the interviews. It concerned women, as well as men. The older carers were more prone to be suffering from depression than the younger ones. Another important factor influencing the mental health of the carers was the type of care they were providing. It seemed that the more the intensive and burdening the care, the more probable was that the carer would be suffering from some type of depression. Both – the mental and physical health status of the cared-for was important in assessing its influence of the psychological wellbeing of the caregiver.
It was me and my depression… there were situations when I… in my consciousness I would never do that, but I had such thoughts and I don’t know how could this happen that at some point it was so hard and I had suicidal thoughts, not that I… [crying]. (PL 53)

Sometimes when I’m upstairs, well it happened few times that I cried, I just couldn’t hold it anymore because… never in front of her. We all have these moments, sometimes it’s not possible to put up with it. It goes away of course but then, in those moments, when I went upstairs I just burst and I cried and cried and cried (PL 48)

Some of the respondents were aware of this impact and have already taken some measures in order to improve their mental health situation. These were either methods of relaxation, like sports or leisure, or in more serious cases – a visit to a doctor and prescription of anti-depressant pills.

I know few techniques of coping with stress, exhaustion and tension. It might be because I finished psychotherapy in Szczecin and neuro-linguistic programming in Lublin. I also did hypnosis (PL 50)

I used to take antidepressants. At the beginning it was intensified... caused by my brother’s passing away. Then I have been taking them for six months and I stopped. But it’s obvious – constant tension and stress have their toll (PL 40)

Physical condition

The most commonly reported health problems experienced by the working carers were: the increased blood pressure, spinal problems, heart problems, stomach and intestines disorders, overall tiredness and exhaustion of the organism. The care provided to the immobile old people was causing most damage to the spinal cord or limbs of the caregivers due to heavy physical work they were performing while assisting the older person with moving.

I started to feel pain in my back because all of that. I don’t know for how long. All that bending while helping my mom, and then I had to have some treatments and so on. Well the back is getting a hard time (PL 33)

Obviously it has an impact on your health. Definitely. I feel that, my heart feels that and I’m starting to have problems with it. Not to mention physical ailments: my back or other things. And the exhaustion is just unbearable (PL 30)
Quite frequently the respondents were complaining of both physical and psychological disorders, which were interrelated.

*I got sick as well. After a while I ended in hospital. All in all I stayed in bed, caught different illnesses... There was also depression plus problems with stomach and bowels* (PL 56)

**Financial Situation**

The overall assessment of the financial situation of the carers was rather positive. Only 12 persons described their situation as “poor” or “average”. Most of the respondents were describing it as “fairly good” or “enough”.

All in all, the financial situation of the carers was not greatly influenced by the fact they were providing help. In most cases, the pension of the older person was sufficient to cover most or all of the costs of medication, housing, etc. In other cases, the respondents admitted they had to cover extra expenses in relation to care, such as accommodation of the house to the needs of an older person, visits to private doctors or hiring additional home carers.

*What can I say? I have been named the vice dean so I earn more and spend all of that on home help. Basically speaking I live from hand to mouth* (PL 57)

*I had to extend the house, adjust it for a handicapped person. We have a special shower pan, special handrails, and special chair in the pan so she could sit during the shower. That cost me a bit* (PL 31)

4.5.2 Benefits from reconciliation

The reconciliation of work and care does not always need to be a painful experience for the carers. Quite frequently, it is also a positive experience, which benefits the carers in other spheres of their lives or simply gives satisfaction and pleasure.

4.5.2.1 Satisfaction

The carers asked about the positive sides of combining work and care were most frequently mentioning the satisfaction it gave them. Respondents felt they were fulfilling
their moral or family obligations well by taking good care of the older person. They considered care they were providing as some sort of “payback” to the older person who usually were caring for them when they were younger or were helping them out with their small children.

_Morally I’m perfectly fine [laughter], because I do what I’m supposed to do. And it’s rewarding when my mom says to me: “it’s wonderful to have you around, where would I be without you” (PL 54)_

_The most important thing for me is that I can help grandma. She helped me dozens of times and now I can show my gratitude (PL 52)_

The positive side of the reconciliation process had also another dimension, namely the appreciation of the work situation, which was quite frequently reported by the carers. The work was not considered to be such a burden as care, and was evaluated positively as a source of satisfaction and self-fulfillment.

4.5.2.2 Personal benefits

Many carers felt that the care was giving them some additional value, such as learning new things or personal growth. On the one hand, the carers were mentioning practical skills they learn while caring for an older adult, like better time management and organization skills.

_The teacher needs to think about his students, about future and so on. What I learned at school was organization. First of all. And I have noticed one thing about myself: the more responsibilities the better organization. And that just helps me (PL 52)_

On the other hand, working carers found that they in general became more patient, more understanding what helped them in other life situations, not only in the care. In few cases, the experience of work with an older adult was seen as beneficial for the professional work of the carers, whose jobs were somehow related to social problems (worker in a Social Welfare Center or a psychologist).

_The most positive one is that now I understand many people when they’re having problems. And one becomes more kind because understands better. Many different situations (PL 8)_
Yes, of course. I teach within medical faculties. I teach psychology within medical faculties. Being around an older person, especially with dementia helps me understand better. And I also have more compassion (PL 14)

4.5.2.3 Good relation to the cared-for

Another positive dimension of the reconciliation process was the appreciation and improvement of family relations. It concerned both – the relations to the person cared-for and the relation with other family members, who were also members of the “caring network”. The families where the caring tasks were more or less equally distributed among many persons were experiencing a growth of family bonds and trust, which they valued very highly.

My mom gives me warmth, a lot of it. Even though she’s not conscious, even though... sometimes she doesn’t recognize me, thinks (...) But she gives me much more warmth than anyone around and it’s some sort of compensation for that lack of warmth from the others (PL 26)

Frankly, I must say that at least it brought the children together. They were very concerned and got really involved. I was even surprised [laughter] (PL 32)

4.5.3 Summary

The caring obligations were almost never assessed by the carers as easy. The constant lack of time, pressure, the feeling of being “torn” apart by many duties of working life and private life made the situation of carers difficult. The sphere of live which suffered the most was the private life of the carers, who often considered that they were abandoning their families and had no time for being together with them.

Another sphere of life which suffered the most from the reconciliation process was the health and wellbeing of the carers, most of whom declared that they felt the impact of care on their mental condition. It could be relatively limited impact, or in some cases lead to nervous breakdowns and depression. The lack of psychological support for the carers in this regard needs a fundamental improvement from the public authorities.

The work life of the carers was also influenced by the fact of care, however, not as much as might have been expected in the beginning. 21 carers reported that they felt no impact on their working lives. Most of the carers felt some kind of distraction or stress at work, since they were concerned about the older adult. Nevertheless, they assessed that
the overall impact was not greatly disturbing their quality of work or possibilities for development.

4.6 Supports and strategies carers use to reconcile work and care for an older person

4.6.1 Support measures

In the case of Poland, the support was first and foremost coming from the family. Most of the respondents declared that it was the family who helped them out at all times. Second, also fundamental support for the working carers was the home carers from Social Welfare Centers. These could be typed as the two main sources of help, whereas the working places were never mentioned as formal facilitators of the reconciliation process.

In general, some distinctions need to be made with regard to the concept of help itself in order to facilitate the understanding and assessment of different types of support. Three dimensions of help and support can be distinguished. The first dimension is related to the receiver of the help – it can be both – the older adult person or the carer.

A. Help in the caregiving („sharing” care tasks)
B. Help TO the caregiver (e.g. exemption from other types of household duties)

The second dimension describes amount and degree of help:

A. On every day basis
B. Occasional
C. Emergency

The third dimension of help reflects the type of help received and could be roughly divided into three types:

A. Active help (in caring tasks)
B. Psychological help
C. Financial support

This typology is only a tool to describe different types of support which are available to the working carers from their families, from the state, from workplace and from other sources – formal and informal.
4.6.1.1 Family

The help from the family members was certainly the most important for the carers, and they always mentioned it as the first source of support. The help was provided by either members of close family, such as spouse or children; by more distant family members – siblings, siblings-in-law, grandchildren; or by farther relatives such as nieces, nephews.

The family was the fundamental help to the working carers also due to the fact that the close members of the family supported the carers psychologically, which was very often underlined by the caregivers as crucial.

The situation described by the carers as most comfortable was when the carer had large family with many persons who were willing to help. Such circumstances allowed for "substitution" in caring duties in cases when the main carer was busy.

*I can count on my sister, right? Because it’s like, I don’t have to be limited and I can call her. There’s always somebody – if not her then my brother-in-law, if not brother-in-law then niece, so there’s always somebody who has time, right? Or my cousin, right? It happened few times that my cousin got… got involved (PL 6)*

*Well like I say, at least we have this comfort that there’s not only me, my mom and dad but also a brother and his wife and granddaughter, so these responsibilities are not only on one person’s shoulders but… well practically on the whole family (PL 19)*

**Partners**

The partners of the main carers who were living in the same household were usually actively supporting the working carer with different types of jobs. This was either care over the older person, or help in the common household, or sometimes psychological help was just enough.

*If it’s necessary then yes, I’m not here and he is, he’ll go. So we complement one another. And he knows that too. Well I must say that… my husband is very emotional if it comes to that. (PL 51)*

*My husband took over few chores, the ones that I hate like, you know, ironing or something like that (PL 4)*
However, not always was the help provided by the spouses, since in few cases, the partners declared a total unwillingness to help in caring tasks, which was mostly motivated by negative feelings to the parent-in-law (most frequently). In most extreme cases, the marriages were almost at the brink of breaking.

**siblings**

The support from siblings was assessed very differently by many interviewees. Since the most common caring situation was the care over a parent, the siblings were a natural type of support. The most common help was: active help in caring obligations, visits, transportation, and financial help. In many cases, nonetheless, the care over one parent caused great conflicts between the siblings, what sometimes led to a complete disintegration of family bonds.

Most frequently, the majority of care was left to one sibling only, and the situations where the duties were equally distributed among the siblings was not so common.

*My brother is on call only. On call if it’s necessary… when I go away or go out, you know? He’ll hand something or even look in… But it’s not on a regular and committed basis (PL 12)*

*And it was like we had this bed, this rehabilitation one, which was rented and a mattress. It was thirty zloty for the bed and thirty for the mattress. So sister paid every month for all that (PL 24)*

*My sisters rather do that. They have cars and if mom has to go to see a doctor, then it’s just a call and one of them takes her. (PL 46)*

*I’m not the only person in the house because I have two sisters, who live in Kielce, and we take care of mom (PL 32)*

*Well it doesn’t change anything, I mean… It’s not a problem. It’s not a problem at all. If I have a trip or something then my sisters can substitute for me, you know? Like I said, it’s beyond me and I just have to. But normally it’s... it’s not a problem (PL 32)*
My sister, well it’s a different story – she looked after mom on Saturdays and Sundays, once or twice a month… and she calculated that it would be ten zlotys a day for food. So I give her these ten zlotys which she calculated, right? I give her these ten zlotys along with grandma, and if it’s two days then I give her twenty. And... this is help. This is what you call... help. She did the counting. So I give her these ten zlotys and she looks after her, usually for a day or two – Saturday and Sunday - I give her these twenty zlotys along with grandma. And I’m calm again because all I say is “hello” and “good bye”. You see what you have to do to stay calm? You have to say “hello” and “good bye” to your sister, and that’s it (PL 27)

**Own children**

The children who were still living together with the carers were very often included in the caring “regimes” in the family. The care tasks of the children were usually easier and “lighter”, such as accompanying the older person, preparing food, or doing the shopping, since the parents did not want to overburden the children with the heavy caring duties.

Well, I must say when I feel like going to the cinema then, well... my daughter will come over, prepare a dinner for grandpa and I go out, you know... But I have to get back quickly... It’s hard for me to leave nappies and all to my daughter, you know? I’d just feel guilty (PL 15)

The interviewees did not complain from the lack of help from children, and in cases, they the children were not able to provide support, the respondents excused them from doing these tasks.

I work from Monday till Friday so I have to transfer some responsibilities to my sons or daughter, the grandchildren of mom. And together, we deal with it somehow (PL 7)

The adult children, who were no longer living with the carers themselves were also providing help, sometimes quite substantial and on almost every day basis.

**Friends, neighbours**

Next to the family, the friends and neighbours were the second source of providing informal care to the old people. This type of help was mostly described as “on call” or “emergency” help. This meant that in a case if absence of the main carer the friends or
neighbours were willing to look after the older adult for some time or just visit to check on the older person.

Friends were also paying a role of psychological support to the carer, and for many of them were a very important element in the organization of a care by the main carer.

> And I have this possibility that, if it’s necessary then there’s my friend. She came so I go to the hospital. It’s always fixed, there are always calls and always somebody’s waiting. I have friends that I can count on. (PL 36)

On the other hand, the neighbours were very handy due to the vicinity of housing and thus were easily accessible. Sometimes, the carers were paying some sums of money to take care of the older adult. The help would include: preparing simple meals, doing shopping, checking on the older person, accompanying, or house keeping.

> There’s a neighbour who takes care of her, but it’s on call when it’s necessary and if no one’s there they communicate using this cane. My mother-in-law simply taps the table with it and if that lady’s at home she comes over because she lives next door. And there’s also this other neighbour who sleeps over (PL 49)

**Reasons for lack of support**

Sometimes, however, the need for help expressed by the carer to his family members was not recognized or even rejected. Such situations caused additional distress and conflicts in the family.

> Family support is... well I can’t count on my family. And even... when I speak or even when I look at this family of mine I lose my nerves. It would have been better if they had stopped speaking to me at all. (PL 33)

Some carers considered the help from other family members as more problematic than helping in fact and would rather try not to resort to asking them for help. This referred to both – the closest family members (partners or children) or distant relatives.

> Interviewer: Does anyone else from the family helps you with all the care?
> Respondent: Well if I ask then yes, but you know how it is – the best way is to keep the distance, isn’t it? (PL 21)

The reasons for lack of support from family members were various. Some of them were of more personal nature, such as: unwillingness to take on some additional duties, negative feelings toward the older person, lack of empathy and consideration about the
older person. In such cases, the respondents were particularly aggrieved at this situation what exacerbated the feeling of loneliness and sadness.

On the other hand, there were interviewees whose members of the family were not participating in the care as much either, but due to objective reasons, which were easier to understand and tolerate by the working carers. In these situations the reasons for lack (or limited) of help were:

- living abroad or far away
- having someone else to look after
- working long hours
- being sick themselves
- having their own families and their own problems
According to our respondents, and what was also found in the literature, the employers do not offer any **formal solutions** to the working carers which would facilitate their reconciliation process. The workplace is not considered by most of the carers as an arena for improvement either, since it is usually associated with the logic of maximization of profit natural for free market economy. Some working carers have never considered asking employer for any type of enhancement to their situation as working carers.

*I mean... I haven’t even inquired about it. If it comes to social care - I don’t know how does it work these days or if it even exists – maybe the situation will change – for worse – well then taking an interest in it would be a good idea* (PL 43)

**Company agreements**

As far as official politics of companies, the interviewed carers were not aware of existence of any company politics directed to carers of older people. The only solutions they were aware of were the solutions for working parents. Often, the respondents were not looking for such solutions in their working place.

*No, employer no. Employer won’t do anything, will he? Well, I mean what? Nothing* (PL 33)

*Well, the only convenience is for nursing mothers, but it’s a legal convenience. So they’re legally entitled to leave work one hour earlier or to show up later. I haven’t heard about anything else at my workplace* (PL 19)

**Informal offers**

In the absence of formal solutions the only ones available were informal agreements with the line managers or co-workers. These informal measures were available to most of the working carers who needed them. However, the carers admitted they rarely used them as they did not wish to appear unreliable in the eyes of the employer. The measures they used were as follows: flexibility of working hours (coming to work later or leaving earlier), leaving the work for one hour during the day, taking some work home, having work hours adapted to their needs (in case of teachers). These informal solutions were described as “turning a blind eye” by the employer.

Although these practices were informal and were not institutional anyhow, the employers were willing to use them what was very much appreciated by the working carers.
Well, not officially means for example an agreement with my boss that I can’t come
to work or that I can be two hours late. But I think it’s acceptable. (PL 2)

I can, let’s say, pop out for a while or go out somewhere. It’s obvious that I have to
work it off later. Nothing’s free. But then I do my best… stay after hours and I just
work it off (PL 37)

**Attitudes of colleagues**

Most colleagues were aware of the situation of the carer, and were supportive to
different extend. In some cases, the carers did not inform their co-workers about the
situation and preferred to keep it as their private matter.

*It’s not a secret, besides they’re very supportive and understanding and the help me,
they understand that for example, I have to rush home because I called an ambulance
and they’ll show up in a moment to take my father-in-law. And basically this is how it
is* (PL 55)

At this moment they’re just trying to make my schedule in a way I can handle all that.
People in the secretary’s office also know the situation and are trying to help me as
well. So, I have to admit that at work they’re all very supportive (PL 8)

*When I didn’t take my leave yet, and I was in a really bad shape, I mean I couldn’t
take it anymore, they said: “Just take care of the house and your mother and we will
handle everything here”. And they took all my classes. Just like that! They split it
between themselves. I even didn’t have to... didn’t have to take any leaves, nothing.
They just took over everything, all substitutions. (PL 8)*

**Attitudes of line managers**

The aforementioned informal practices are mostly coherent with the positive
attitudes of the line managers. The positive approach towards the problem of
reconciliation of work and care of the employees and warm atmosphere in the
workplace were among the working conditions which were described as the most
beneficial to the working carers.

*However my immediate superior knows what’s going on and, well she knows that I
take care of my mom, she knows about my dad and she doesn’t have a grudge*
against me, that I’m not getting involved in some weekend trainings this year (PL 25)

I say: “I might be late”, “can I leave earlier”, “I have something to handle” – and they let it slide, you know? “You can do that later”, or sometimes... I even do some paperwork at home, if I have to (PL 24)

Interviewer: So if something like that happened your superiors wouldn’t...
Respondent: No, they wouldn’t. I just call them and explain that this and that has happened, that I need something and it’s fine. All I have to do is to leave the note that shop is closed and that’s it. (PL 47)

Although the managers and superiors were usually quite positive towards the needs of the working carers, there were few complaints about the unfriendly or unsympathetic managers. Their obstruction was harmful to the carers who considered it an additional problem, next to the already existing ones.

I’m a teacher and I have problems because of that. The headmaster says that if I’m in this position, that if I have to take care of my sick mom then I should retire. And I don’t want to retire. The reason is simple – if I retire I’ll get a pension of nine hundreds zlotys and it’s not enough to provide for the house and my mom, and I won’t be able to help her. I have no one who could help me. (PL 31)

With the previous director I could say: “Listen!” – because we were on familiar terms – “Listen, I’ll be late today.” Of course we all were fair and so on. If I didn’t have anything urgent and show up at two I could say to her : “Listen, I can’t make it two, I’ll be there at three.” (and she said): “No problem”, you know? But things were different with this new director (PL 14)

In some enterprise, the carers were reporting that there were no measures of facilitation of the reconciliation process due to objective determinants, such as small size of the company (too few co-workers to replace an absent carer) or fixed working hours (shift system), which made it impossible for any flexibility at work. Nevertheless, the working carers did not perceive this as a hindrance, but as a natural condition which could not be tackled otherwise even in case of very positive attitudes of the line managers.

It’s not possible to take a leave here, you know. As you can see there’s one person in the kitchen and one here, so there are two and there’s no way to take a leave. (PL 7)
Situation of self-employment

In our research sample, there were 12 self-employed respondents. Their situation was usually characterized by more flexibility in working time and possibility to arrange the work according to their needs. The freedom in this respect was certainly greater than in the case of employees; however, it was also limited due to the nature of the business itself, which was often simply dependent on other partners and their working schedules.

Moreover, the self-employed reported more frequently than the employees that they were able to bring some paperwork home what was very convenient in their situations. On the other hand though, this work was described as “never-ending” work which was also quite exhausting due to higher level of responsibility.

Generally, I think that you own your time. However, on the one hand you do and on the other hand you don’t; but I can, well I'll put it like that: you don’t own it completely but you can organise it. (PL 12)

The self-employed who were also employers have also reported that their situation, in comparison to the situation of the employees, was far worse with regard to the rights and privileges in area of social care and social insurance policies. The employers were not eligible to the same amount of sick leave or care leave. The different legal status of the employers and employees in this area is considered a discrimination against the employers.

Because there’s no help for employers... no help at all. Frankly, even an employee has more rights than an employer. Employer has no rights at all. At all. There’s no support whatsoever. And when you run your business in a fair and honest way, you’re getting harassed by different offices – I mean tax office, Social Insurance Company, labour inspectorate. And... it’s just not fair. We’re not treated fairly (P 13)

But you know what? I’m not sure, but I know that during the year a regular employee can take care of himself like I take care of my mom., while I, as an employer, have no such thing. (PL 13)

4.6.1.3 Support services

In general, there are two types of formal support services available to the working carers – served at home of the older person or in institutions. The formal home services include: formal carers, community nurses, and rehabilitative help. The
institutionalized support include: day care centers and nursing and palliative homes. All of them can be either private (not substituted financially) or public (fully or partially substituted by local governments).

**Formal carers**

Most of the respondents received help in form of home carers from local Welfare Centers (MOPS, MOPR or OPS). This took in most cases the form of professional carers visiting the older person at home. The number of hours they were available ranged from 1,5 to 8 hours per day and depended on the health condition of the individual. They were available mostly on the weekdays; however, in very severe cases there was possibility of having home carers on the weekends as well.

The range of tasks: from washing the person and doing other nursing activities, to shopping and house work.

_So there’s a lady that comes over for two hours, twice a week to help with bathing – because it’s, frankly it’s hard, so she’ll help with that bathing, with the bathtub and all. Like I say, a specialist or how you call it, () she’s educated in this and she has a better approach to a sick person (PL 34)_

The opinions about the home carers are divided; however, most of the carers considered them to be a large support and were satisfied with their help. One of the complaints regarding this type of support was that there were not assigned sufficient number of hours and that this help should be extended.

_Simply, I have my life back since we have this lady – a carer (PL 33)_

They, however, underlined that the formal carers were not always fully trained or apt for the job what came as shock to some respondents, who needed to report such cases to the Social Welfare Centre.

_Well like I say – this Social Welfare Office is just... These carers that come over, they’re... I don’t want to mention extreme situation... alcoholics, and they show up drunk. I know that because people are talking. Recently one of them got arrested. Police gets involved because they steal from these old ladies... It’s a horror, all of this. It’s a polish hell, you know. I shouldn’t mention that you know – but that’s how it is. (PL 3)_

**Day care centre**
Among the interviewees, only few persons were using the support in form of day care centers, and only in case of older persons with Alzheimer disease. This was not a common solution to be used due to several factors. The first and foremost - the scarcity of such centers available. Even when there were such centers in town (in case of Krakow), the carers were not aware of their existence. In rural areas, these were only mentioned as “possible improvements” in the situation of working carers, what meant there were no day care centers known to the carers.

Another hindrance to the successful usage of this type of support was the difficulty in bringing in and picking up the older person from facilities due to large distance and fixed working hours of the carer. A solution to this would be “pick up” services available, which would gather the older person and bring them to the center.

But it... it’s not that, because it’s only for six months maximum, but she also said, the doctor offered me this centre, to take him there at seven a.m. but it wouldn’t agree with my working hours, well I can’t change them, and they’re open till three only. They had these different activities. Supposedly they go out to the cinema, theatre, or on walks (PL 21)

Yes, she offered me this as well, but unfortunately I had to pass on that because he would need to be [taken] there and picked up after, and there’s no one who could do that. (PL 23)

Naturally, there were also objective barriers to the usage if day care centers such as the health status of the older individual, who needed to be in relatively good physical condition to be able to move on their own. Nevertheless, in situations where the carers were using this help, the opinions about them were quite enthusiastic. The working carers found this facility a great support in their everyday reconciliation practice.

Since couple days now. The first time was just before Christmas, mom found (there) this day centre for people with Alzheimer’s. It’s on Prokocim and dad went there few times so far and apparently he was very... I think it’s really helping him and I also think that it’s a great thing. (PL 11)

Private assistance (service providers)

Some of the respondents used the support of private sector in combining their work and care duties. The forms of such help were also different and included: formal carers, private nursing homes, professional rehabilitators, private visits of nurses and
Some respondents were hiring additional help in form of formal carers from time to time or only for few hours, since this type of support was considered relatively expensive in daily budget. Only one respondent could afford a private nursing home, which was found extremely expensive (the approximate amount of a full average monthly salary, i.e. 900-1000 EURO).

Nursing homes

The nursing homes as a sort of support were considered by most of the respondents as an absolute last resort in the reconciliation process. They only regarded it in situations where they would themselves not be able to provide care due to illness or disability. The option of putting an older person in an institution was viewed by most of the carers as very off-putting and almost inhuman. This result of the interviews correlates well with the results from literature review, which strongly implicates that the Polish carers were extremely negative towards institutionalized care, and felt that it was the responsibility of the family to provide care to the older relatives.

Not only the moral obligation to care for the older relatives was an obstacle for the carers to use this support, but also the lack of such facilities in the vicinity or lack of well-adapted facilities, which would for example accept older persons with Alzheimer disease.

So they’re in these nursing homes, and for example in Kielce they don’t accept people with Alzheimer’s anywhere.

Interviewer: To nursing homes?

Respondent: Yes. They don’t want to. There’s only one ,I think, on Jagiellońska street. But this ward is for such cases... It’s not pleasant over there. That’s why there’s no such care for people with Alzheimer’s (PL 40)

Additionally, bad opinion about the nursing homes and the quality of care offered there was the yet another reason of not considering it as a type of support. Moreover, the process of acquiring a place in a public nursing home took on average two years and was filled with bureaucratic procedures, which was another hindrance.
But if you want to place such person in a public nursing home you need... his/her consent and it's obvious that he or she is not fully agile... There are two options: legal guardian or incapacitation. It has to be done through the court, and you need all these opinions from psychiatrists, neurologists and these... psychologists. And we gave up on that because the difference in costs between public and private nursing home was like three or four hundred zlotys a month. They take the pension, plus they check the income of the family, you know, of the children, and they set an extra charge you have to pay them. So we decided that all this paperwork and other arrangements it’s just pointless. Besides the attention is, well frankly is much worse because they simply care less and basing on the information from other people, who – well when I got interested in this, some opinions about this care were very negative. So we chose the private one. (PL 56)

However, few of the respondents decided to put the old person in such an institution due to the lack of possibility of carrying out the care on their own. These situations were not easy for the carers, and some of them postponed the lodging in a nursing home for later. In one case, the carer has already put the cared-for person in a nursing home, but was still performing caregiving tasks, which were necessary even under such circumstances.

**General practitioners**

A good and easy contact with doctors and specialists was definitely among the supports which were considered very important for the carers. Majority of the older persons suffered from medical conditions which needed permanent treatment and prescribed medication supply. The prescriptions were sometimes difficult to obtain due to long lines at the doctor offices. This has been solved in some of the health care centers by simple measures.

Another simplification of the process of combining work and care was the possibility of telephone contact with the general practitioner who would advise on some minor issues, such as cold.

*We have very good relations with doctors and nurses, who prescribe medicines, or sometimes there’s even distance treatment, it’s like... I just go and describe the symptoms and if the doctor knows what it is more or less he’ll give me, you know, not antibiotics, but... something else. And if not and my mom is not feeling well or whatever, a doctor will come so it’s very nice. Community nurse is always available if you need anything, no problem at all (PL 37)*

**Volunteers**
The third sector did not play a great role in supporting the working carers. Some of the formal carers were hired through special foundation helping older persons, but there was no mention of purely voluntary help.

The problems were, first of all, the lack of trust towards volunteers and their professional training in caring tasks. It concerned the persons with greater disability level. Moreover, the older persons themselves were not willing to let a “stranger” into the house as they were not comfortable in this situation.

In general, the respondents were not aware of any possibilities if volunteer support in elderly care, as well as they were not seeking this type of assistance on their own. Sometimes however, they considered it to be a potentially good solution and would be willing to try it out if some conditions were met.

*A volunteer work would be really appreciated. Because our carers can keep up, cause there’s a lot of seniors in Lipnica, who need help. The only thing is that people who are still agile won’t let anyone in their house. They’re afraid. Well you never know who can show up at your door, right? We don’t have any volunteers. We just don’t. In bigger cities, maybe, especially in Gorzów in this hospice they have for sure. But we don’t.* (PL 41)

*Volunteer’s data base… volunteer’s centre, let’s be honest that really doesn’t exist in Krakow. Well, it does but only in theory, just try to get a volunteer from there* (PL 4)

**Other types of support**

Among other types of support mentioned by the working carers in the interviews were: the financial and in-kind help received from the state or special fund (PEFRON) for people with disabilities. The financial support could be used for a certain purpose – such as for example renovation of the bathroom to adopt it to the needs of a disabled person.

*Well I had a bathroom done with PEFRON funds. I received thirteen thousands. This is... this is significant financial support* (PL 31)

Another useful measure was a special car sticker, which allowed the car to be parked in special spots for disabled persons, which allowed the carers for easier transportation in the city, which was especially important in big cities with lot of traffic.
Well my car is registered to my mom as well, and I have this sticker. I can drive up everywhere and it’s important for me when I take her to a hospital or anywhere else, well she can’t walk too much, right? (...) And it just saves me time (PL 31)

4.6.1.4 Time out

The last type of support, which could already be considered a strategy, was the time out which the carers used to regain energy and stamina for further reconciliation. It was mostly used by the carers in order to calm down or restore their mental health balance. They were sometimes offered to go out or relax by their family members or friends who offered help during this time.

For me it’s also relaxing because it’s aromatherapy, and music therapy and the idea of meeting my friends. Because it has its own atmosphere, you know? There are no strangers, only people who know my problem – my friends, they know my problems and this conversation is on a different level than if it was with a stranger. And it’s definitely some... Maybe it’s also a form of my therapy (PL 31)

I think that even a one week rest would be a great cure, some sort of way to improve this bad mood... sometimes it’s a bad mood. It would be great to change that mood, for while even (PL 30)

4.6.2 Possible strategies to use

The Polish interviewees presented many types of different strategies which they are using, deliberately or not, to reconcile the work life with elderly care obligations. The need to manage the variety of different tasks makes it necessary for the carers to think of - and in fact act so - some sort of reconciliation strategy. Thus, some of them were explicitly declaring that the management of support they used was a strategy they introduced. Some of the respondents did not name their efforts to reconcile “a strategy”, but nevertheless classified their actions in the analysis as strategies.

A lot of people ask me: “You must sit at work thinking how are things at home?” No! I, well no! I don’t. There’s somebody at home taking care and I’m at a university, and I think that this is most important. It helps you deal with it somehow (R 8)

Among the different strategies used by the working carers two types of strategies were most vivid, named by us as: instrumental and – psychological strategies. The
**instrumental** strategies are the ones dealing directly with care provision and its organization on everyday basis. It includes using all types of support (formal and informal) by the carer for caring person, with a combination of using different sources of help (namely received from different actors engaged in his/her activity). The aim of these strategies is primary securing the wellbeing of the cared for person and proper time management in order to fulfill all the duties with limiting or even no impact on work arrangement.

The second type of support - **psychological** – is directed more towards the carer himself/herself and its primary objective is to reduce the stress and being overburden because of care and work in order to be able to continue caring. These strategies could be seen as one step further that the instrumental ones – first instrumental ones are used or even in majority mostly are used together with instrumental ones. All in all, the subject of the instrumental strategies is the cared for person, whereas the subject of psychological strategies is the person of the carer.

**Instrumental strategies**

These types of strategies are focused on the caring tasks that needed to be carried out and the organization of the care. The aim of these strategies is mainly to provide good care to the older person by means of good organization the care. Therefore, the major example of one type of an instrumental strategy which could be identified among our interviewees is the “good organization”, which includes logistics and so-called “thinking ahead”.

**Good organization (logistics and “thinking ahead”)**

Some carers admit that in the face of multiple tasks related to their work and care, they need to come up with certain strategies to tackle all these issues. The carers often described themselves as “good organizers”, what meant that they had to learn new skills like time management when they have to manage both care and work. They often say they need to plan every day very well so that they can feel they have control over their lives.

> Well she can handle herself around the house, it’s even like, sometimes I have to take care of something, I have to go out from time to time so I won’t go (crazy). And I do it like this, I set the alarm for the next meal after I leave, so she would know, if she lied down, what time it is. Everything’s prepared in one place, and generally I try to have two meals prepared. (PL 13)

> Because I planned it all. Consciously and reasonably. I’m a Taurus and like every Taurus I have my feet firmly on the ground, I don’t have my head in clouds, I’m well organised and reasonable. When I have something to handle I can organise myself, I
can have it all planned and figured out, do this and that – it has to be my way, end of story. And it’s like that. It always... always, I mean it works for me. (PL 31)

Well yes... I organised it this way. Dinners are being brought. A parish-priest from Carmelites parish is helping me with that. He agreed to serve those meals and it’s been three years now. I’m partially charged for that (PL 26)

**Thinking ahead** is another type of organization strategy, but directed to the future rather than present time. It appears to be very important to the carers who are not sure about their future income or health situation. In these cases, they try to assure proper care over the elderly in advance in case something unexpected happens.

*And when I say to him: “Listen, February eight I’m going away for three days”, right? So I tell him that and I feel like – well I’m being a little bit manipulative, but I know that he even prefers that way, right? Because he already knows that it’s February eight, and he says: “All right!” I know that he won’t screw up. And I’m calm. (PL 14)*

Respondent: Yes. I’ve been to South and North India, Peru – half the world. Kenya... I did that when I still could. Because I knew that it will end this way. Because I’m a organising and farsighted person I knew that it will happen sooner or later, that I won’t be able to leave the house. So when I could I travelled to far places. And now I just can’t, so I penetrate here, on the spot.

Interviewer: Aha, so it’s a considered strategy?

Respondent: Considered strategy. (PL 12)

Another type of instrumental strategy is related to the family support and could be practiced in cases when the carer has at least few family members or relatives who participated actively in the process of care. Among so called here ‘The family strategies’ two can be distinguished, namely: the “family network” and “substituting/replacing”.

**Family**

In case of the carers who could count on their families with regard to the caring obligations, two major strategies could be identified. The first one is the organization of a “family network”, which seems to be the most successful strategy, since it has very positive impact on the carer, on the elderly person and on other family members. In this strategy, the responsibility of the care is more or less equally divided among many family members in form of duty hours ascribed to a certain person on a certain day. The most important aspect of this type of solution is that the carer do not feel isolated and left alone with all the caring tasks, but could always count on other family members.
No one has ever tried to wriggle out somehow, that there’s no time and so on – these responsibilities are so equally divided that, for example we, I mean my dad and I, have Mondays, Wednesdays, Fridays, and others, I mean mom, I don’t know husband and so on, have Tuesdays, uncle has Thursdays, and weekends, well this is something different because there is a matter of going away, but it all comes to arrangements. (R 19)

The second type of family strategy could be named a “supplementing/replacing” strategy and is described by most of the carers as the possibility of asking someone from the family for help in case when the main carer is not able to perform his or her tasks. This strategy is less “formalized” that the “family network” strategy, and it was still the main carer who is responsible for the overall care, however, the help from other family members is always possible and never questioned or problematic. The main carer acts here as the manager of other persons in fulfilling the needed duties.

And do you have any opportunities for trainings or business trips?
Respondent: Well if there’s something like that going on then my sister has to come over and that’s it! End of story. Sometimes she gets angry that(), I say: “hard luck.” (PL 17)

Of course if it’s necessary, If we couldn’t drive grandma, then either my daughter will do it or my son-in-law or my second son, who according to grandma is the best grandson ever (PL 5)

We complement one another. If I can’t then there’s my son or my sister-in-law or grandson... there’s a granddaughter who can come by car or something... or drive them to church and all. So we complement one another. (PL 51)

The last type of instrumental strategy is “linking”, which could be roughly described as combining different measures in order to make the whole reconciliation process works successfully.

Linking

The family strategies, even though the most successful, are naturally only available to the carers who could count on other family members. Those of the carers, who do not have families or the families refuse to provide help in caregiving, have to reach for different strategies. The equivalent of family strategies of networking or supplementing could be the “linking” strategy, which was used by few respondents. It could be described as a linking of several different types of help and support in order to arrange the care throughout the day, and sometimes the night. In these cases, the most important elements of the strategy are the friends and neighbors, but also the formal
carers, however here the income situation (the material situation) could have an impact on it. The main carer usually asks for help and organizes it within friendly network of people of good will who were willing to participate in the care.

> During the week, this lady who lives with mom, well she has weekends off, right? So during the week it’s all settled, but these two days it’s necessary to, and there’s the other lady who is on call and she can always stop by. There’s also this neighbour, so somehow we make it work (PL 22)

> Well there are from work and it’s a matter of day or two, and sometimes there are like holiday trips... two weeks maximum, but then we have a carer over for longer, mom’s friends are stopping by more often or they’ll take her for couple days (PL 20)

> Mom stays alone, she has phone numbers to my friends and they have ours and of course they know that they should call from time to time. (PL 25)

**Work strategies**

The last instrumental strategy which is mentioned by the working carers is related strictly to work hours and is used when the carer needs to handle some caring issues during the working hours. The most common strategy is in these cases to take a sick leave or one day off from their holidays leave. Many respondents declare it is the only possibility for them to manage to go to a doctor with the elderly or tackle some caring tasks in the working hours of public offices.

> Interviewer: So you take a leave from time to time, yes? If you want...
> Respondent: If it’s necessary then I take a leave.
> Interviewer: And it’s... it’s a holiday leave, yes?
> Respondent: Yes. (PL 3)

This type of strategy could be described as rather passive and on a day-to-day basis, which suggests that there is no strong will from both the employers, but as well the employees to undertake some strong actions in order to obtain some special rights as working carers. Moreover, the interviewees often declared that they have no expectations from the employer to take special care of them and their family obligations. The privacy of the family life and family problems was considered quite important. Even though the working carers in many cases did inform their managers about their caring situation, they did not want to use this situation as an explanation of their coming late or taking a sick leave as they thought this was not fair towards the colleagues.
Hence, there is room for improvement of the situation in this care, however, as shown by the German experiment of …. Company7, there might be little interest in new solutions, since people are often not eager to use formal strategies in such situations.

**Psychological strategies**

The second group of strategies called psychological strategies mostly (or most typical, most often found) used by the carers are: positive thinking and ability to manage/deal with stress, professional psychological/psychiatric treatment, doing sports, taking time out, work as balance.

**Stress management and positive thinking**

This strategy could be described as a sort of „mental experimenting”, which mean that the carers are actively thinking about the care in a positive way or are trying to divide/separate care from work. Such psychological measures allow them for reduction of the stress level, what in the long run make the reconciliation process possible and not so stressful and overburdening duty.

*Interviewer: So is a dose of egoism…*

*Respondent: Necessary! Necessary. A little bit. Otherwise you’ll go crazy, I guess. (PL 43)*

As rather almost all of the carers (with different tone or less or more hidden words expressed in their talks) complain about the stress and constant worrying about the proper provision of help to the elderly, the need to reduce their personal stressful situation is one of aim and also the way to approach to the successful reconciliation.

The stress management strategies use by the carers are either professional (as in the case of one carer who is a psychologist herself) or very intuitive. The carers are also trying to remain optimistic about the situation and think positively and to avoid negative thoughts and worries.

7 We are referring to the yet unpublished results from the research carried out by Angelika Kummerling within the framework of CARERS@WORK project, among the German employers who introduced some solutions for working carers. The innovative solutions were not used by the carers at all since they considered their caring tasks as very private matter and did not wish for any type of help from the employer, who they perceived as an outside actor.
I mean, I try to separate the time for my mother-in-law from the time which is just for me. I try not to think about things that stress me out, that she’s getting more and more sick, that she moves less, that she’ll need to be carried in a while, and... she won’t get up on by herself. This is very stressful. And I try to set my mind on something else, leave those things behind. When I go out and handle my own things it’s a little bit easier (PL 49)

I mean, I know few techniques of coping with stress, exhaustion and tension. It might be because I finished psychotherapy in Szczecin and (neuro-linguistic) programming in Lublin. I also studied hypnosis in Lublin. And they were teaching us how to... how to cope with professional burnout. And all those things cost me a bit, because it was three years of going back and forth, and it was all private studying, so these skills a person can have, well they are being used in some pretty difficult situations (PL 50)

You know what? For all these years of my work and personal life I learned to separate work from family responsibilities and not to mix these two things (PL 7)

**Physical activities**

One of the very successful strategies undertaken by some working carers is practicing different kind of sports and other types of psychical activities, such as hiking, biking, travelling. The carers very often resort to this type of activities since they feel they are beneficial to their wellbeing and are also easily accessible and such activities are in general in relatively low cost in terms of money and time.

*Sometimes I go out to play squash or for a jog and... It’s just a moment and I’m ready for the rest of my day (PL 52)*

*But I found myself new passion to deal with this difficult work situation in the institute. I started to occupy myself with something different, I started to move, exercise. And finally, not so long ago, I’ve become a Pilates instructor (PL 53)*

*Physical work after hours is something that helps me in life. I even have a small garden here, so I could go out for a while and do something. I don’t like sitting and wondering what will be tomorrow or a day after tomorrow (PL 44)*

**Professional help**

Few respondents report that they need to look for a professional psychological or medical (psychiatric) help for themselves when they realized they are no longer able to
provide care effectively. Some of working carers declare they would like to use such help, but they lack the time for regular visits at the psychologist.

*I couldn’t… I couldn’t take it anymore mentally so I just went to see a doctor and I got some pills. I take them and try not to run out.* (PL 15)

**Work as balance**

Another psychological strategy which was mentioned by few respondents is the work itself. In their view the activities connected to work are of a very different nature that the ones connected to care, and thus are interesting, new, fresh or even relaxing. The respondents declared they could not imagine their lives without the job, because it was the only the “time out” of care that they have and they appreciate it very much. In these cases, the most important impact of work was positive and is described as “having contact with people”, “doing something valuable”, “personal development”. It is the work that give them power and energy to deal with the difficult caring tasks, since they are not only thinking about the care at work. Thus it could be treated as a separate type of psychological strategy. In context of the reconciliation this is very important to notice that having a job and possibility to work do not socially exclude such carers. It also shows that both tasks are treated and perceived as very important parts of life of the working carer, and that the possibility to reconcile is needs to be guaranteed.

*And I go to work, calmly, I’ll do what I have to do anyway. And then I come back all positive. Calm. And it’s all good* (PL 41)

What needs to be underlined here is that the potential of successful reconciliation of work and care in very big within the working carers themselves. They very rarely express the willingness to resign from neither of the tasks, and therefore the strategies recommended for them should not be aiming at proposal: “EITHER WORK OR CARE”, but “BOTH WORK AND CARE.” This postulate will be reiterated in the “Recommendations” part of this report.

4.6.3 Summary: Which kind of support at the public, company or societal level is most efficient for the reconciliation of employment and care for older individuals?

Among the Polish caregivers the support which seems to be the most efficient at the societal level is definitely the traditional support received from the family in majority from the close family members (like daughters, sons, daughters – in law and others). Based on the literature analysis and existing surveys we know that in Poland the dominant model of care is still the traditional model – family care. As also in Kotowska’s (2008) study most of the respondents expressed the opinion that it is the
family, which is responsible for taking care of an older adult. Our research also shared this opinion and thus most of the carers are resorting to family for help and assistance. Here, however additionally based on our research we can say that also for those who work and have care tasks the most efficient in sense of organizing this reconciliation (with a lot of trust and confidence in it) it is rely and use family members with in some situations small public support (formal carers) and almost no company formal support.

Additionally the working carers are receiving help also from public institutions, such as Local Welfare Centers (nursing services, formal carers for hours), Funds for the Disabled (subsidies), local governments or health care system (system of additional financial support and subsidies). All of them are also available for the non-working carers as they are given for the cared person not just because of the fact that someone who is caring is working or not - the most important support at the public level is the access to formal carers who are visiting elderly on every day basis. The hours of provided care varied from 2 h per to 8 h per day, and most of the formal carers are assigned for approximately 2-3 hours per day. The number of hours depends on the health status of the elderly, the income of the working carer and the relation of the carer to the elderly person.

At the company level, the only sort of support which is possible is the informal agreement with the line manager who would usually allow the carer for more flexibility in working hours. The additional help at the company level are support of the other coworkers who are willing to substitute the working carer at work.
4.7 Working carers’ recommendations for improvements

The respondents asked about the possible improvements to their situation referred most of the times to the improvement of the solutions they already knew and used. Only rarely did they come up with very innovative solutions, but these were usually the most inspiring and should certainly be taken into consideration. The current system of state help directed to the working carers is relatively traditional and rigid, and perhaps some innovative and flexible solutions could benefit the group of working carers, since it needs to be bear in mind that the number of working carers will increase and therefore be more diversified and demanding.

The possible improvements mentioned by the respondents were directed towards all the state and local government agencies, as well as the third sector and civil society. Some improvements were considered to be important with regard to the employer. The respondents did not mention the family very often as an area for improvement, since they already managed to deploy this kind of support quite extensively.

4.7.1 FORMAL CARERS - LONGER HOURS

RESPONSIBLE: SOCIAL CARE SERVICES

As far as solutions on the side of the state and local governments were considered, the respondents often referred to the improvement of the already existing methods and support. First of all, most of the working carers who received formal care from the local social care centers expressed the wish for longer hours “prescribed” by the social worker. Most of the time, the formal carer came for 2-3 hours per day and this was considered insufficient.

“Yes! But with partial, or even full price of some kind, because me for example, if I would like to have two caregivers, then with some full charge, only if I wouldn’t have to look for them by myself, but just go there, report and pay”. (PL 53)

“Well, I think that if this MOPS-nurse was coming here for longer, it would be better. For sure. So that she could stay longer with mom. No need to do any work there, just … just sit back.”. (PL 21)

4.7.2 DAY CARE CENTERS – LONGER HOURS & IN VICINITY

RESPONSIBLE: SOCIAL CARE CENTRES, EMPLOYERS
Another potential improvement mentioned by some respondents was access to day care centres in places where there were no such institutions or they were localized far away. This was mostly the care in rural areas of Poland, where the research was carried out. Another wish was that such day care centres had longer opening hours so to afford more flexibility to the working carers of bringing and picking up the older person from the centre.

“Well, if not this, I think it would be a good solution, that day-care unit. It’s... it would be in some stages even more attractive than home nurse. I do not know, anyway, this would be good, and that too. Both”. (PL 53)

The respondents who already used this type of support (there were only few in our sample) were very satisfied with the services they obtained in these centers. However, some of the working carers could not use these facilities due to the restricted hours of bringing the older person to the facility in the morning, since they would not manage to do it before work or they would need some special arrangements which were difficult to be set up.

4.7.3 INFORMATION CENTERS (INCLUDING TRAININGS FOR CARERS)
RESPONSIBLE: STATE, HEALTH CARE SYSTEM
RESPONSIBLE: LOCAL GOVERNMENTS

A very innovative and seemingly important idea was to create INFORMATION CENTRES for the carers of older people, especially the working carers. It was suggested by many respondents that the lack of good and clear information was one of the factors, which caused them many troubles. The information available is very scattered and can partially be found at the GP, in the local social care centres, in the municipalities, in the Internet, in pharmacies or other places related to the health care system. The lack of one solid and reliable source of information caused a lot of frustration among the working carers. There is no evidence that there are no such centres in the whole country, since they could have been founded at the very local level, however, our respondents had no access to such centres.

The functions carried out by such centre would be of a wide range, from information about receiving basic help to trainings in medical or psychological issues related to the subject of caring over an old person, which often demands certain level of skills, as well as knowledge.

“If someone had provided such a psychological support, such as "how to deal with such a sick man".... And it seems to me that if it was just such a psychological help,
after taking away this man from the hospital, someone told you, that this is already a chronically ill person, and that you should be distanced to some things, right?” (PL 13)

“However, I think that ... that would be nice, if there was such a center, where you could come and... get an advice, consult and obtain such assistance, even - even just application for this, um, this aid, subsidized by the City, like this caretaker” (PL 22)

4.7.4 EMERGENCY ASSISTANCE
RESPONSIBLE: SOCIAL CARE CENTERS

One of the situations some of the working carers defined as frightening was losing the ability to provide care for the older adult in case something happens to them. There were cases when the respondents knew she would need to go to the hospital for a month and had no replacements or any possibility of obtaining help in this time. Another troublesome situation were various emergency cases when there is no possibility of receiving instant, one-time help. The formal care from the social care centres was always pre-scheduled, and there was no possibility of getting professional help “on demand”. It seems that such help is crucial to the psychological comfort of the working carers, who face unexpected situations and have no support from family or friends in such situations.

“Well... like so... that there are no such emergency procedures for emergency situations of a guardian, a person who is under the care of the MOPS. - For a short day-long stay” (PL26)

“Interviewer: That is such a family-nurse, for example, you could call and she would come, I don’t know, on the same day, or even next day, and not necessarily according to the schedule, right?
Respondent 1: Yes, as ... an additional. I was thinking about something like that, for example - if we wanted to go on vacation and just leave him under some care somewhere, I do not know ... “(R23)

4.7.5 “VACATION HOMES” FOR OLD PEOPLE
RESPONSIBLE: STATE

Another suggestion from the working carers was the institution of holidays for the older people. The benefits from such a solution are twofold: first of all, the older person can rest in a quiet and pleasant place, and improve health. Secondly, the carer
him- or herself can rest from the everyday duties and regain energy needed to work and care at the same time. Such a solution was mentioned by quite many respondents who in one form or another had opportunity to take longer time out, and remembered it as a great relief, which made it possible for them to go back to their caring tasks with more energy and strength. The possibility to send an older person for holidays or rehabilitation is naturally dependent on the health status of the older person, and would thus needed to be carefully analysed. However, the benefits to the carers themselves could be of great importance to their psychological and physical wellbeing.

“Well, as I said. Well, the only thing is, just hand him over to a nursing home, I do not know at least for a month, just to let us take a rest”. (PL 23)

“for the weekend to the dormitory, so they could rest. Then she says: "Well, he came back, at once it was so different, he calmed down, we rested a little." There is such a possibility - we don’t have such a possibility and will not have." (PL12)

“only such trips should be every year that () the old people, who don’t walk, you know, not to somewhere, where they have big - I mean, no meadows, but some kind of (green areas), so they can take these people to this ... to the fresh air and...” (PL16)

4.7.6 HEALTH CARE IMPROVEMENTS: HOME VISITS, PRESCRIPTION FACILITATION, TRANSPORTATION

RESPONSIBLE: HEALTH CARE SYSTEM

The respondents often mentioned the health care system as an arena for lot of improvements, one of them being the easier access to the specialist doctors, the possibility of having home visits, the facilitation of obtaining prescriptions.

“Well, for sure! You know, if you would be able to approach the window at the register, leave this filed in piece of paper, right - I print it always, sign my name, I write thank you, please, come in two days - I have a prescription. It certainly would be a great convenience”. (PL15)

“Well I know that, for example in Switzerland, a medication can be ordered by phone and will be brought home. In case of the illness of the person it is quite important.” (PL8)

“I think, they [the doctors] should ... not once for a month, because it may be too often, but every six months they should come to such a patient and look - after all do some basic examination!” (PL 41)
Another vital obstacle in successful using all the forms of health care (doctor visits, examination, running tests, hospital visits) were the lack of easy access to transportation services. In cases of immobile persons (in bed rest or in wheelchairs) the transportation to the health care institutions cannot be organized by the carer himself, since it requires professional equipment and staff. The easier access to such transportation services is sometimes inevitable to carry out all the necessary medical procedures and tests, which cannot be performed at home.

4.7.7 BUREAUCRACY LIMITATION
RESPONSIBLE: SOCIAL CARE CENTRES, LOCAL GOVERNMENTS

Another burden for the carers, which could somehow be minimized was the overwhelming amount of bureaucratic procedures and mechanism needed to obtain some service or allowance. The respondents considered it as a needless hassle to fill in the same forms every month or travel to the doctor only to get a stamp in a special booklet for discounts in pharmacies. There were plenty of examples of such practices, which were not only time consuming, but also very frustrating for the carers.

“Really, simplifying the bureaucracy would be the best solution here.” (PL 23)

4.7.8 STATE PENSIONS INCREASE
RESPONSIBLE: STATE

Some of the respondents suggested that the increase in state pensions would benefit the older person and his or her carer, since it is mostly the lack of financial resources which bars them from hiring professional help or the necessary medical equipment.

“Overall, I think, there should be increased funds for retirement or disability pension for old people. Because these people are often not married - usually widows or widowers - which pension is very small. And they have to restrict their expenses so much.” (PL47)

4.7.9 WORK FROM HOME
RESPONSIBLE: EMPLOYER

In the not-state area of support for the working carers, the respondents
mentioned the alterations to the workplace, and more specifically the possibility to work from home. This kind of support was already used by some of the respondents, who considered it a significant facilitation in the reconciliation process. However, still, some respondents said they would gladly accept such a offer if it was possible.

“Some work at home. Just to be able to work at home. Because I say that this is a cheaper solution than, for example, providing a volunteer, it is also known, that these are difficult issues, or environmental caretaker for this time, I think it’s just much more expensive than providing work opportunities at home.” (PL 54)

4.7.10 FLEXIBLE WORKING HOURS/(INCLUDING: BREAKS AT WORK, ADDITIONAL LEAVES, ONE DAY OFF )
RESPONSIBLE: EMPLOYER

Other suggestions towards the employer considered changes in the time schedule and more flexible solutions for the working carers.

“Or some break ... so I could leave and come back, drive, this too ... But for example such a shortened time, or even an extra holiday, or such care, for example, as it is for small babies.” (PL 17)

“The solution would be a shorter work-time, but it also, let’s say, hard to win this one day or so, that... I would not come to work, because you know, that something may happen the other day, not just when ... I was not at work. It would certainly simplify life to work at home.” (PL 20)

Wishes for such improvements were however expressed quite quietly because the working carers were not sure the employers would like to agree to such arrangements or sometimes they thought that in a capitalistic market it was not the employer’s task to facilitate their work and care obligations. Nevertheless, the more flexibility at work in terms of working hours and possibilities to work from home would certainly benefit the working carers and need to be included in further recommendations.

4.7.11 VOLUNTEERS – COMPANY TO THE OLDER PEOPLE
RESPONSIBLE: THIRD SECTOR

Very few respondents viewed the third sector as an area for potential improvements in their situations. The help from volunteers was used by small number of carers (3-4), and was not considered a fundamental and necessary element of the care
system, but rather as experimentary and additional “attraction” for the older person. Therefore, only few respondents pointed to the engagement of volunteers.

“Interviewer: volunteers, who would come, for example, spending time socializing?
Respondent: Socializing? It would be nice” (PL 43)

“But surely these people could, for example, bring books - if that person reads - exchange these books or even newspapers? Well, after all, it does not necessarily have to be up-to-date, or even to make such small shopping. Well, even this. Perhaps if it was needed - bring some coal, timber” (PL 47)

4.7.12 „FRIENDLY NEIGHBOUR”
RESPONSIBLE: CIVIL SOCIETY, NEIGHBOURS

An interesting idea for improvement referred to the social area of civil society and the neighbourhoods as valuable potential in arranging the systematic care for the older persons. The rule of exchange of goods (both material and non-material) was evoked as a good ground for founding systems of help for the older people in the local neighbourhoods. This idea came from respondents living in rural areas, however, it could be extended to the urban areas as well. This type of support is not a novel one, but some level of institutionalization of this help is convincing, since it might offer a solution also to lonely older persons, and not only to the ones who have carers. Therefore the network of help and support could be extended to more people in need.

“I say: it would be best to... such an old lady, retired, lonely, that has simply a lot of time. And, oh by the way, she could earn some money, right? And then they would talk, drink tea, and in summer they could sit in the garden, ate some fruit and that would be very good. They could even play something.” (PL 41)

“even such institutional things, like for example, that if there is a wider group of neighbours who deal with such a person, it is measurable, so you can check, that they should have some financial support. Because this is their time, it is their readiness, resulting only from the fact, that ... that they live together and feel responsible for ... this, and it is normally not an obvious situation” (PL 49)
5 Profiles of working carers

Description of the procedure of experiment:

In the course of our experiments, we have found a way to combine the two previously discussed experiments into one. We have divided all the carers into 4 groups according to 2 criteria: work load and care load (which is the outcome of the number of hours cared plus (in controversial cases) – the need for care. For example, the respondent declared that she cares for 10 hours per week, but in the interview it came out that she lives with the cared for person and she performs many care tasks – therefore she was classified into HIGH CARE). Some of the most problematic cases were discussed, and agreement was found.

The second step, which draws from the experiment method number I, was to see how many "balanced", “unbalanced”, or "mixed" persons we had in all the 4 groups. Some of the trends became apparent instantly. We then described the MAIN strategy in each group to see what is the most relevant for the whole group.

5.1 Group 1 – “low burden”, 8 carers

- BALANCE: Balanced: 7, Mixed: 1, Unbalanced: 0

<table>
<thead>
<tr>
<th>Low CARE</th>
<th>High CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low WORK</td>
<td>9\textsuperscript{8}, 2, 1, 38, 44, 54, 48, 56 (change from box 3 due to institutional care)</td>
</tr>
<tr>
<td></td>
<td>GROUP 1: 8 persons</td>
</tr>
<tr>
<td>High WORK</td>
<td>49, 43, 18, 10, 53, 4, 5, 11, 6, 19, 20, 34, 35, 40 (changed from box 4 due to institutional care), 52, 47, 50, 55, 20, 46, 33 (Change from box 4, and from unbalanced to balanced due to formal carer), 51 (migrant worker)</td>
</tr>
<tr>
<td></td>
<td>GROUP 3: 22 persons</td>
</tr>
</tbody>
</table>

\textsuperscript{8} The numbers refer to the identification number of the interview, which can be found and compared in the Annex at the end of this report.
• Households:
  Double, both working: 5
  Double, one working: 2
  Single: 1

• Education level:
  High: 6, Low: 2

• Strategies used most frequently by the carers to reconcile:
  1. Family + simple work “measures”\(^9\) (flexibility, friendly atmosphere, good quality of work) (5 carers)
  2. Family only (2 carers)
  3. Family + other support (1 carer)

• Summary:
  Group 1 - low on the level of care and low on the level of work. This group seems to be the most “balanced”, since 7 in 8 persons were described as such. Due to low demand for care, they also were not eligible for formal carers, and thus the lion share of the caring duties was on the family. However, some work informal policies were reported to be helpful in their cases, such as flexibility. Their relatively good situation could also be influenced by the fact that most of them lived in “double earner” households, and presumably their financial situation was OK (reported by 6 carers as “fine”).

5.2 Group 2 – “care -oriented”

• BALANCE: Balanced: 5, Mixed: 2, Unbalanced: 3

• Households:
  Double, both working: 0
  Double, one working: 0
  Single: 10

• Education level:
  High: 7, Low: 3

• Strategies used most frequently by the carers to reconcile:
  1. Formal carer + other types (3 carers)

\(^9\) We write „measures“, since these are not formal measures, but rather informal facilitations for the working carers
2. **Friends/neighbours** + Health Care System + work measures (3 carers)  
3. **Family** + HCS + financial support (3 carers)  
4. **Day care center** + family (1 carer)  

- **Summary:**  
  This group can be characterized by relative balance in terms of care and work deriving from the fact that the work load was low, and thus made it possible for easier reconciliation. The stunning result of this analysis is that ALL of the carers in this group were single earners living alone or with the cared for person. The probable explanation to this situation is that the high care need caused the distortion in the family structure and sometimes resulted in splits between partners (separation, divorce), which happened in some cases.  
  The main strategies used by this group were the strategy of formal carer combined with other supports. Another one was the system of support from friends and neighbors combined with other types, or the combination of family help with other measures. This group was less dependent on the family, which is quite naturally also the result of the fact they live in single households.

### 5.3 Group 3 – “work-oriented”

- **BALANCE:** Balanced: 16, Mixed: 6, Unbalanced: 0  
- **Households:**  
  Double, both working: 13  
  Double, one working: 3  
  Single: 6  
- **Education level:**  
  High: 17  
  Low: 5  
- **Strategies used most frequently** by the carers to reconcile:  
  1. FAMILY + WORK (friendly, flexible, self-employed) (7 carers)  
  2. FAMILY only (5 carers)  
  3. FORMAL CARE+ FAMILY + other types of support (10 carers)  
- **Summary:**  
  In this group the stress in terms of strategies used for reconciliation was definitely on the family as the main provider of help. In many cases however, it was also the work
which provided the carer with some further possibilities for reconciliation, like being self-employed or flexible at work. The most common strategy used by the carers in this group was however the combination of formal care with family support and other additional measures. This group was, in opposition to “heavy burdened” group more “balanced” since 16 in 24 carers were defined as balanced. The smaller amount of care provided by them (in terms of hours, but also in terms of care need of the elderly person) was certainly the major determinant of the more balanced situation. However, additionally, many carers reported work as the strategy of bearing with the situation of care. This group was also characterized by higher level of qualification, which could also explain their “work – orientation”.

5.4 Group 4 – “heavily burdened”

- BALANCE: Balanced: 7, Mixed: 5, Unbalanced: 5
- Households:
  - Double, both working: 7
  - Double, one working: 5
  - Single: 5
- Education level:
  - High: 10
  - Low: 7
- Strategies used **most frequently** by the carers to reconcile:
  1. FORMAL CARE + multiple solutions/ many strategies (4 carers)
  2. FORMAL CARE + “friendly” work (4 carers)
  3. FORMAL CARE + family (6 carers)
  4. FAMILY + friends (1 carer)
  5. FAMILY only (2 carers)
- **Summary**:

  This group, called “heavy burdened” is the most diversified in terms of being “balanced” unbalanced or mixed. There are carers within this group which are on the verge of quitting care (none of them reported wish to quit work), and are waiting for formal decisions about the nursing homes.

  The most important strategy undertaken by these carers is to use the formal carers to a large extent. This is possible due to usually high demand for care of the older person, which is acknowledged by the social care centers which provide the family with formal care in this point. Usually the formal care is combined with other types of help: “friendly
work” environment or family support. The family support was a large portion of strategy, however, not as dominant as in the groups number 3.

Among these carers, many had multiple strategies used to reconcile, which might suggest the innovative and active way of dealing with the problem of reconciliation. The carers were also not afraid of more experimental ways of help, such as volunteers or palliative care, which was not mentioned in other groups.

6 Crosscutting results

6.1 Influence of the qualification level of the carers with regard to the reconciliation of work and care for an older individual?

Almost 1/3 of all our respondents had had lower level of education and 2/3 had higher level of education (tertiary/university level). In terms of the influence of the qualification level on the reconciliation process, the direct assessment of the influence of qualification level on the reconciliation process is not easy. The sole variable of qualification did not seem to have as much impact as the joint variables of qualification level and type of occupation of the carer.

The carers with higher qualification level were also among those with professional occupations, as managers, teachers or private entrepreneurs. These types of jobs, in turn, provided more flexibility at work, as well as allowed for working from home more often than in the cases of lower qualified carers. In this respect, it could be concluded that the higher the level of qualification, the more flexibility at work was possible and thus the more efficient the reconciliation process.

“Well in my case it’s not difficult, because I can work in the afternoon, in the evening, I can work at my mother’s-in-law place, having my computer and writing articles for the newspaper” (PL 49)

In case of lower qualified carers, the flexibility at work was not available so often and thus they needed to manage the reconciliation otherwise. In many cases, the carers depended on the family members more, especially the ones living in rural areas, where the formal care was less available. In bigger cities, the carers with lower qualification level had usually lower income, and were therefore eligible for receiving subsidized formal care workers. By means of this help, they were able to reconcile the work and care.
These two factors – the possibility to work flexible hours and relatively better financial situation of the persons with high education level are the two main determinants of their objectively more comfortable situation. However, the influence of high education level was not observable at the level of negative impact on health situation and stress, which is another vital dimension of successful reconciliation process. It is therefore more precise to say that some positive impact of the higher qualification level can be observed in a more the practical dimension of the reconciliation of work and care, and has little or no influence on the wellbeing of the working carer.

It can be therefore concluded that the sole variable of qualification level does not influence the reconciliation process in a substantial way. What seems to be of more important meaning to the reconciliation of work and care is the occupation and the kind of work actually performed in terms of responsibility, duties, satisfaction from work, as well as the time schedule, flexibility, possibility to be substituted by other colleague. Influence of the employment- and financial situation of carers households on the reconciliation of work and care

The influence of the employment situation and the financial situation can be deliberated on two levels. Firstly, on the level of the household, where the employment situation is regarded as the differentiation between the households where both partners are working, one of them is working or the household is a single one. On individual level of the carer, the employment situation might mean the exact working conditions of the carers, in other works: the working hours, possibility of flexible hours, possibility of working from home and other dimensions which create different “employment situation” of the caregiver. As far as financial situation is concerned, we do not refer to the income level of the households or the wages of the carers, since such information was not asked for during the interviews. The research aim was only to evaluate the general feeling of the carers about their financial situation. Therefore the general description of the financial situation of the caregivers is rough and approximate and can only be described in descriptive way, such as: “good”, “fair/ok” or “poor” financial situation. However, it needs to be taken into consideration that these are only subjective descriptions of the carers and cannot be used as exact proxies of the situation.

6.1.1  Influence of employment and financial situation on the level of the carers’ households.

The research scheme planned the division of the carers’ households into three types of households – couple working, couple one working and single. In our research sample there were 29 households with a couple where both of the partners were working, 8 households where one of the partners was not working, and 21 single households. Among the 29 “double earner” households, there were 3 families of
different structure than a couple, but since all the adults in the house worked and had common budget we decided to categorize them as double earner households.

The natural assumption, which was made at the beginning of the research process was that in the households where one person was working, the other person would be participating largely in carrying out the caring duties. Another assumption was that the households with double income would be having better financial situation and thus could afford hiring formal carers or be more flexible in other care-related expenses, which are usually quite high in the everyday budget of a household.

Among the 29 households with two persons working, it turned out that it was still the partner who was the main support in the system of providing care, even though he/she was a working person as well. More often, such households were depending on other members of the family than double households with one working person. The partners were providing help to either the cared-for person or directly to the carer.

“I mean, fortunately, my husband also works at the university and I can rely on my husband too, and it occurred two or three times during that time when I had classes and parents needed help and then my husband replaced me. So that I did not have to go out during the classes, for example”. (PL 11)

The double households with two persons working were certainly challenged with more logistic issues due to the limited amount of free time. Most of the time, this was managed by the carers relatively well and lead to an increased ability to organize the time and all the duties in such a way that the reconciliation was possible. These types of households were also more frequently using the help of formal carers who usually cared for the older person while they were at work.

As far as the financial situation was concerned, almost two thirds (N=19) of the respondents in the households with two working persons described their situation as “OK” or “average”; 7 described it as “good”, and 3 said it was “below average” or “bad”. In most of the cases the interviewees mentioned that they did not need to spend additional money on the care since they used the retirement pension of the cared-for person, which usually was enough to cover the cost of care. Only in the case of very high expenses, such as 24-hour formal carer or a private nursing home, did the respondents said they needed to participate largely in the costs.

In the case of 8 double households with one person working, the partner who was not working was most often retired or on receiving disability pension. In these cases it was easier for the carer to arrange the care for an older adult since more free time of the partner allowed for greater flexibility. The carers recognized the help of the non-working person as a great support.
“because my husband is from the beginning in very good relations with his father and when I work on Saturdays and Sundays too, so for example when I am not home, my husband makes dinner and plays this holy Scrabble and takes him for a walk, if necessary, drives over.” (PL 4)

“while the husband regularly, the whole week and together, like I say, we travel together in the morning before my work, and later he goes still before noon, or stays there a few hours as needed, and later me after work and in the evening we come together again”. (PL 30)

It was not always the case that the non-working partner of the carer helped much in the provision of carrying tasks. However, only few respondents declared that their partners were not involved in caring tasks due to other family obligations or lack of sympathy towards the cared-for.

In the case of households where only one person was working (N=8), the financial situation was described as “average” by 3 respondents, “good” by 2 interviewees, and “below average” by 2 persons. Of compared with households with two working persons, there do not seem to be very different. The similarity of the two groups would rather stem from the type of care provided and how many medical items (including medication) were needed for the cared-for person. In cases of the more advanced diseases these expenses could rise to a very high amount, which only at this point was mentioned by the respondents.

“Drugs, a bed, well that’s without saying, bed, deposit, that’s all, a mattress was there, everything. But such special hygienic wipes for elderly people, getting wet or something, well, you have to buy it. Creams. All patches, bandages, ointments, and such things, I say, so we use to relieve the pain. Some balm. Well, that’s all we buy for our money”. (PL 30)

A sound characteristic of this group of carers is however difficult due to a small number of such households, where only one person was working.

The third type of households studies in this research were the single households represented by 21 respondents. Most of the respondents (N=17) in this group lived in a shared household with the cared-for person; sometimes with more family members (children).

“If I had my family and children, It would ... it certainly would be a problem, wouldn’t it? I mean what if - I’d have to take my mother to my place, or to move over
there... On the one hand, it could be easier - if I had a good family, it would be easier. (....) It’s not like I have to go somewhere with the child or the husband or the mother, you know ... I do not have this dilemma. For me it is obvious, isn’t it? That... that this is my family, right? Mama ... Well, when it’s Christmas Eve, well, that’s with mom, right? There is not at all... (kind of) it is natural”. (PL 14).

In these types of households, the main support was provided by the formal carers (subsidized by the local welfare center). One respondent mentioned however, that it was too expensive for her to pay even a small amount of money to have a formal carer. It was however very frequent that it was the children of the carer who participated fundamentally in the caring duties. The respondents mentioned very often that their sons and daughters (often with already new families) helped. However, it was not always on an every day basis. In the cases when the carers had no children, it was still other family members who participated in care provision. It seems also that the single carers include their friends, acquaintances, colleagues from work and neighbors more in the process of reconciliation of work and care.

As far as the financial situation of these households was concerned, difference between the double and single households is more clearly visible. Among the 21 respondents, 8 described their financial situation as “average” and the same number described it as “under average” or even “bad”. 5 of the interviewees said it was “good”. In this very descriptive manner, it can perhaps be concluded that the subjective financial situation of the single households is slightly worse than of the double (with both working and one working person) households.

To summarize the general impact of the employment and financial situation on the process of reconciliation of work and care on the level of households, it seems that there are only few examples of differences between these types of households. The first one is the less time available in the households with two working persons for caring, and thus more reliance on formal carers. The second one is the more flexibility in arranging the care in the families when only one person was working. And, in the last case - more reliance on the network of friends, neighbors, and family by the single carers. In many cases the financial situation was not worsened by the fact of providing care, but in the single households the subjective assessment of the financial situation was slightly worse that in double households.

6.1.2 Influence of employment and financial situation on the level of the carers

The employment and income situation of the carers is directly linked to their qualification level. However, as has been mentioned above, the sole influence of
qualification level on the reconciliation is not easily traced; it can be observed that the employment status does in fact impact the process of reconciliation.

The number of carers in the group classified as professionals (managers, teachers, doctors, entrepreneurs) was 34. In the semi-professional or service group there were 22 persons, and 3 persons were of elementary occupations, whereas 2 persons were no longer economically active.

In the researched sample, there were 17 carers working as teachers, at school or university level. This professional group was thus slightly overrepresented in our sample, but on the other hand, it is perhaps the result of successful reconciliation strategies that this professional groups has that allows them to carry on the caring obligations as well as their jobs. The teachers had usually smaller amount of work hours per week, ranging from 8 to 30. These were however the teaching hours when the teachers needed to be at school/university. The rest of the hours, including preparation, could be performed at home. This was by many carers regarded as a very “comfortable situation” and certainly facilitated the reconciliation of work and care.

The persons employed in offices (semi-professionals, clerks or service providers) whose working hours were fixed found it more complicated to reconcile the work and care due to the lack of possibility to work from home or work in different hours. They were usually dependent on the opening hours of the offices and very small flexibility was probable, so as this obstacle of having flexible working time is evident. These carers could usually use the “informal agreements” of little flexibility of working hours, however these were not institutionalized practices and the carers were always very careful and rather reluctant to use them on every day basis, but would only refrain to them in occasionally or in case of emergency.

The influence of income on the reconciliation process is also a problematic relation to be easily discernable. The most evident interrelation is naturally the possibility of greater financial freedom in case of the carers with higher income. Therefore, the persons in good financial situation were able to afford hiring private professional carers, rehabilitators or home visits of doctors. This financial freedom was usually considered as facilitation in reconciliation, but by many carers was not even mentioned.

Analogically, the situation of the carers whose financial situation was described as “poor” or “below average” was harder in terms of possibility to hire a formal carer from private sector, or even to pay the share for the subsidized carers from Welfare Center. Some carers reported they would like to increase the hours of formal care, but they were not able to afford it. On the other hand, the carers with lower income were eligible for higher subsidies from the Welfare Centers to cover the expenses of the formal care. However, the difference was not a significant one as to make them feel better off.

In terms of employment and income and its influence on the reconciliation of work and care, a different interrelation - an opposite one – could be observable. Namely,
it was the care situation that influenced the professional careers and income situation of the carers. Among the working carers with professional jobs, one of the impacts on their working lives was the limitation of their career and development opportunities. The carers frequently needed to resign from more ambitious tasks which would allow them to be promoted. Similarly, they were not able to participate in trainings, conferences of business trips due to the caring obligations, which they felt was a huge loss.

On the other hand, the carers with non-professional jobs and lower qualification level did not complain about losing potential opportunities for development and vocational growth. The types of their jobs were more stabilized in terms of possible improvements or promotions, and therefore the influence of care on their work situation was smaller.

As far as income was concerned, few respondents, of both professional and not professional occupations, were complaining that the caring duties prevented them from taking on additional jobs which would improve their financial situation.

However, most of the carers declared that the care itself did not hugely influence their financial situation, since the elderly were most of the time participating in the costs of their living, medication and formal care with their state pensions.

Yet another characteristic of the employment status is relevant to the reconciliation process of the working carers. As it has been mentioned before, it is the situation of the self-employment which facilitates largely the process of reconciliation. It was underlined by most of the self-employed carers as a real advantage and a “comfortable situation”. The flexibility (in terms of working time and even place sometimes), the lack of fixed schedule were mentioned as core advantages of being self-employed.

“So really, in my case it is not difficult to reconcile, because I run the company. So at the time when you run the company, then you can plan everything to your advantage, in short”. (PL 12).

6.2 Within the context of the actual parameters of employment and family work, what kind of gender inequalities are the results of the reconciliation problematic?

The sample in our research consisted of 47 female and 11 male carers. The proportion is not a surprising one, since it is evident from literature analysis and social practices that it is mostly the women who are the primary caregivers in the families. The traditional model of Polish families influenced greatly the gender balance with regard to care obligations, as it was mostly the women who were “supposed” to undertake the caring tasks. The research showed that this expectation was expressed by the society,
but also by the women themselves, who socialized such attitudes in their own families: “it is such a model here, that my mother took care of her mother and I am doing the same now” (PL 2)

The interviewees were stating that the caring tasks are the “women’s job” or that men are less apt for this type of activities: “Especially my daughter, daughter. Well, you know, my son can bring something, but my daughter can also bath the grandma and do everything I do” (PL 54). It were mostly the common nursing tasks like bathing, changing clothes, changing nappies that were considered purely “female” tasks, also due to the fact the elderly were mostly women and they felt uncomfortable being taken care of by the men. Men were more likely to perform other types of caring activities, such as preparing meals, going to the doctors, transporting, taking care of the bureaucratic issues.

“No, because try rather hard while I’m in the place and practically many of the things that I am able to provide for my father-in-law, my husband cannot provide. I just with the eye and the hand of a woman can look at some things and see something more than my husband could see, so that, I’m doing my best just when I am by that person maximally to stay with him. And know everything and see” (PL 55).

The gender inequality in the caring tasks would also manifest in conflicts among the siblings, where it was the sister who took care over the elderly person, and the brother was not willing to participate in the care activities thinking that it is “natural” for a daughter to provide care.

“We have a family dilemma, since I have a brother who is unemployed. He suffers from neurosis from many years, and he and my mother, they think it’s my duty to care” (PL 13)

This type of gender inequalities within the family were reported quite frequently by the carers, however, not all of them complained about it since they partially agreed with this division of care labour.

In terms of employment context, 10 male cares were employed; 8 had higher qualification level. 5 male carers were of professional occupation, 5 were technicians or skilled workers. As far as the influence of care obligations on the work of the male carers is considered, no strong impact has been observed. The male carers were similarly burdened with work and care as the female carers, and in the workplace did not obtained too much support.

More influenced by the care provided, in the case of the men, was their family life, since few men complained about conflict within family – with either wives or sisters.
The men complained that the wives were not willing to help them in their caring tasks due to previous conflicts or lack of sympathy towards the mother-in-law. One of the male carers admitted that it was the reason for his marriage to break up.

6.3 Are there any differences between working carers in rural and urban areas?

The interviews in Poland were carried out in 4 different locations:

- 32 in big cities (31 in Kraków and 1 in Warsaw)
- 12 in middle size towns (11 in Kielce and 1 in Gorzów Wlk)
- 14 in rural areas (in small town of Witnica and the surrounding villages)

The differences between the urban and rural areas were mostly visible in context of access to formal care services offered by the local welfare centers. In urban areas the provision of these services and their availability to the working carers was much more evident than in rural areas. The respondents in rural areas were aware of the possibilities of utilization of formal carers, but had no knowledge of existence of any day care centers. The interviewees were aware of the possibilities for help for the disabled, which were probably advertised more broadly than help in elderly care.

Among the 14 carers who live in rural areas, only 3 persons used institutional help – one elderly was in a palliative care house for several months, the other two carers utilized the help of formal carers.

Another difference between the rural and urban areas which was discussed during the interviews was the support from the 3rd sector, namely from volunteers. In Witnica, the respondents were complaining about the lack of volunteer help, which would be of great importance because due to the small amount of formal carers, there are shortages of possibilities to help older people.

“Yes, the voluntary workers would be very welcome here. The formal carers cannot keep up, because there is so many old people in Witnica, who need help (...) No, there are no volunteers here in our village. In bigger towns perhaps there are, like in Gorzów in hospice. But not here, not here...” (PL 41)

On the other hand, however, an interesting positive side of the rural areas came up in relation to the possible types of support available. The respondents from Witnica considered that the private sector representatives could be a good source of help for the elderly since private companies could also benefit from helping the elderly. The private sponsors from local companies were already subsidizing some sort of social help.
because then they could advertise their companies on the local markets and their brand would be more recognizable to the local community.

“The sponsors, well, what can I say, these are people from my town who are entrepreneurs, they run some companies and then they help in organizing such events. They are private parties, like shop owners or wholesalers. .. they help, because their names are later read out loud during these events.. who was sponsoring..”(PL 46)

In general, the access and variety of formal support is greater in the bigger cities with a developed network of formal carers and care centers for elderly, as well as a fair share of third sector organizations. The carers from big cities complained about the short hours of formal carers of the lack of day care centers in their vicinity, but they did not complain of total absence of these services, whereas the carers from rural areas were reporting their absence.

6.4 Influence of the kind of care need?

One of the most vivid distinctions between the care givers was the type of care they were providing. It ranged in terms of hours from only few in the week up to a 24/7 care. It ranged in terms of difficulty of caring tasks – from spending time together and going for walks to more complicated medical tasks or heavy lifting’s. All of these differences depended naturally on the physical and mental condition of the cared-for person. Therefore as far as physical condition of the older person is concerned we divided the cared-for into two groups, namely – the mobile and the immobile ones. The mobile group could however still be divided into the self-sustainable and the assisted ones, depending on how much help they needed while walking. The fully mobile persons were usually able to meet their own physiological needs by themselves, were also able to go out on their own, and do simple things. The assisted persons needed help in walking, but were still able to move around the house or outside of the house sometimes. The third group was the older persons who were bedridden and could not move on their own, who needed most help and assistance in all the activities of daily living. In our sample there were 17 respondents who took care of a bedridden person, and 12 persons, 19 were self-sustainable, and 27 needed assistance in moving.

The respondents who took care of the bedridden persons felt usually much more tired, depressed and worn out than the carers of more mobile persons. The situation of these carers was also more difficult since they could not leave the cared-for person without any help, and thus this care usually needed to be a 24/7 care.
“If someone stays in bed, well, a man cannot just leave this man alone. Because you need to do different things - something falls, you must provide something to drink, well, even once every three hours or something.” (PL 12)

Another serious problem for these carers was the great difficulty to transport the person to a doctor or for specialist examination which needed to take place in the hospital. The carers complained there was not enough help from the health care institutions to transport the immobile person.

“You know, it is ... This is a big problem, for example: my dad left the hospital two years ago, after which the recommendation was to do x-ray of the abdomen. Well, that was it, because no one will do this for me at home. I have to bring him there. Where and how? Moreover, you know, everything is fine when it’s a block of flats with a lift” (PL 15).

The second dimension which needs to be discussed here is the mental health of the cared-for person. In this case, the situation of the carers (N=11) of persons with Alzheimer disease was certainly the most difficult one. Not only can it be physically exhaustive for the carer, but the psychological toll which takes this disease is extremely big.

“But then I did not cope with it. The reason is that Alzheimer’s disease is so terribly straining for the guardian that I just noticed that (.4) oh I’m exhausted. While initially it was difficult to understand this disease, because ... because a man is told ... such senile dementia, isn’t it? Mom forgot something, well then, at the beginning I was so angry : ”Mom, I told you this, Mom, now I have repeated” “(PL 27).

Among other diseases described as the most difficult to treat and deal with was the diabetes, which demanded extremely precise timing in terms of giving meals and medications, as well as general increased care of variety of related health issues.

“And if only it was another disease perhaps, but this is it... and it is also diabetes, which is all the time, everything on time”. (PL 13)

All in all, it needs to be underlined that the variable of the general health status of the cared-for person is certainly one of the most important factors influencing the type and amount of care which needs to be provided, and in the long run, it is one of the primary factors deciding about general wellbeing and reconciliation process of the carers.
6.5    Influence of family structure on reconciliation?

In the research the different family structures were discussed and their impact on the care giving. It was assumed that the bigger the family (close and distant relatives, social networks existence) the easier it was for the carer to reconcile work and care. This hypothesis was positively tested and it the research proved that the more the family support there was the better the reconciliation process and the less stress there was for the carer.

The family network including many members of the family proved to be the most efficient strategy to continue caring over an older adult. However, similarly important was the support given by the partner of the carer who was able to provide care on everyday basis, as well as in emergency situation, when the family network was less flexible in this respect.

The different types of support stemmed from the type of care needed as well as from the very characteristic situation of the family. Therefore, some partners helped in most of the caring tasks, whereas some provided direct help to the carer in order to facilitate the reconciliation of the work and care by the carer him or herself.

"I mean, I emphasize this all the time, that I have a quite forgiving husband, so I can practically ... someone comes, I can fully realize my plans, because recently practically without a break I was attending the course in pedagogy in Zielona Góra, education - care pedagogy - as it turned out I started to work in the commons and these qualifications were necessary". (PL 55)
7   Conclusions

Summing up the results of the analysis, first of all, it can be noticed that the majority of the carers strongly felt that the care they provide was causing stress and specific sorts of conflicts in their lives. The level of stress differed greatly among the carers, varying from slight (or hardly perceivable) to severe depressions (it was also found in our secondary data analysis based on SHARE data, Perek-Bialas, Turek, Stypinska, 2010). In fact, the conflicting issues in reconciliation work and the elderly care are: the constant lack of time, pressure, weaker family relations. Our analysis showed that most of the conflicts were of private nature and many respondents admitted there is little influence on their daily work. Here, we only refer to the results related to these two key words.

However, it can be observed that the impact on work of the carers was depending mostly on the type of work they were carrying out. The most frequent negative effects could be identified as: the **worsened physical condition** (e.g. spine aches), permanent **tiredness** and **stress** of the carer. On the other hand, most of the carers did not report that the caring obligations posed a heavy burden on their everyday working lives, but described it as a “**hindrance**” or “**limitation**” to their professional development and career or working opportunities. The care was sometimes interference to taking on additional jobs, i.e. part time jobs or summer jobs (for teachers) what negatively influenced their **financial situation**. One dimension of this type of limitation to the working lives was **lack of possibility to take on a full-time job**, which would suit the carer better than the present one, and would be also financially more beneficial. It is also important to notice that in case of not having fixed working hours the carers had possibility to **rearrange working schedules** (e.g. reduce work time) or make some day-to-day alterations in carer and worker agendas. However, it is clear that such changes are possible only due to the nature of the work (more flexible), and could perhaps be understood as strategies to cope with the caring obligations. Another type of change mentioned by the carers was “**bringing work home**” or working late at nights when there was no need for them to care. Besides of such a strategy there is also a need sometimes to take a **day off** from work to arrange a visit to a doctor or another issue for the cared-for person. This also included coming to work later or leaving earlier. The option used sometimes is a must to take a **sick leave** in order to accommodate the care needs of the older person.

If we look at the issue of reconciliation from the perspective of the workplace in Poland it was identified that working carers may face **uncompassionate attitude of the managers or directors** in their workplaces, who did not understand the specificity of situation of the working carer and were not willing to facilitate the work and care anyhow. The greatest conflict and hindrance to balanced reconciliation could be found among working carers who had **fixed working hours** and they had no possibility for even a slight change in their work schedules. This situation was perceived as very stressful and definitely influenced negatively the overall reconciliation process. Such cases concerned most often the work in **shifts system**, which included sometimes
working at night, where there was almost no possibility of a substitution by a co-worker or possibility of a formal (subsidized) carer to fill in. A slightly better situation, but also difficult to manage, was the work in public offices or in services open to the public at certain time. The problem of lack of concentration in the workplace and other as constant “thinking” about the care and the older person is also an important and frequently mentioned issue. Therefore, not having a feeling that when they are at work, the person is adequately cared for, creates additional stressful situations, as well as the feeling they are not as effective as someone who do not have to think about the care of an older person in work.

In context of looking at the balance between work and care, it is also possible to notice that for some persons having a possibility to go to work it is quite a desirable and needed escape from caring obligations. Hence, the reconciliation of work and care does not always need to be a painful experience for the carers. Quite frequently, it is also a positive experience, which benefits the carers in other spheres of their lives or simply gives satisfaction and pleasure, even though the caring obligations were almost never assessed by the carers as easy. The constant lack of time, pressure, the feeling of being “torn” apart by many duties of working life and private life made the situation of carers difficult. The sphere of live which suffered the most was the private life of the carers, who often considered that they were abandoning their families and had no time for being together with them.

The Polish interviewees presented many types of different strategies which they are using, deliberately or not, to reconcile the work life with care obligations of older persons. The need to manage the variety of different tasks makes it necessary for the carers to think of - and in fact act accordingly - some sort of reconciliation strategy. Thus, some of them were explicitly declaring that the management of support they used was a strategy they introduced. Some of the respondents did not name their efforts to reconcile “a strategy”, but nevertheless their actions could be classified in the analysis as strategies.

And at the end we would like to repeat that among the different strategies used by the working carers two types of strategies were most vivid, named by us as: instrumental and –psychological strategies. The instrumental strategies are the ones dealing directly with care provision and its organization on everyday basis. It includes using all types of support (formal and informal) by the carer for caring person, with a combination of using different sources of help (namely received from different actors engaged in his/her activity). The aim of these strategies is primary securing the wellbeing of the cared for person and proper time management in order to fulfill all the duties with limiting or even no impact on work arrangement.

The second type of strategies – the psychological ones were directed more towards the carer himself/herself and its primary objective is to reduce the stress and being overburden because of care and work in order to be able to continue caring. These strategies could be seen as one step further that the instrumental ones – first
instrumental ones are used or even in majority mostly are used together with instrumental ones. All in all, the subject of the instrumental strategies is the cared for person, whereas the subject of psychological strategies is the person of the carer.
Discussion

In this final section of the report, at least a few issues have to be mentioned, however, firstly- the relevance of our study with other studies and an overall evaluation of the whole project. It needs to be underlined greatly that the topic of reconciliation work and care for an older adult, according to our best knowledge, was undertaken for the first time in Poland. Even though, some similar issues have already been analyzed in some way (i.e. in EUROFAMCARE project), the direct link between the working carers and older population has been innovative. Hence, there are also limits to our comparability with other studies of this topic in Poland. Therefore, in general it was fairly clear that some results will be similar to expected, for example the fact that most family members who are workers and carers try to find the best reconciliation strategy since they feel that only they can and should take care of an older person who is most often a close relative.

It needs to be stressed that almost all the respondents in our sample were employed or self-employed (N=56), and only two carers were no longer economically active, and were receiving pensions. Most of the respondents were working as employees in either private or public companies, and just 12 respondents were self-employed which also is important in looking at the problem of reconciliation of work and care. Probably for future it could be better to analyze such cases according to sectors and type of work as it also leads to different individual situations, however, affected by the external conditions.

Rather unexpectedly to other countries, it was found that the group of informal carers who explicitly said that care had no impact on their working lives was quite significant and consisted of 21 persons. The carers were not worried about the jobs and had no difficulty in reconciling them with care. They were relatively flexible with their jobs and could always accommodate most of the needs of the older person, as well as the work tasks.

The results of our study are comparable with the results from other studies mentioned in the beginning of the report (Kotowska, et al, 2008, Głogosz, 2008, Bojanowska, 2008). In our analysis respondents in a free way - without indicating by us or suggesting anything - spoke about their preferred solutions of better reconciliation or help in being a worker and a carer. Even though our recommendations are not the result of surveys (quantitative representative surveys) and opinions mentioned here are not representative for all persons in such a situation, they can serve as a qualitative endorsement of the other studies and recommendation. Moreover, the results of our study support the aforementioned recommendations, such as: need to increase the number of non-stationary forms of care, need for more support in care giving obligations etc.

In attempt to answers the research questions, we can say that as secondary data analysis showed the situation of combining work and care can lead to stress and conflict,
the analysis of 58 in-depth interviews, shows that it was mostly the psychological stress, which was underlined by the interviewees. It also confirmed that for those professions which could use the option of working at home it was possible, however decreasing the working hours was not often used as it could be, as probably it is related to lower income which is neither acceptable nor desired by the carers. As aforementioned, the general question about education level is not at all relevant to his study, and therefore, the variable of qualification was used by us, and as well factors such as: type of work, sector, employer, which in fact have major impact on better or worse reconciliation. Similarly, for future there is a need to combine such an analysis with more cost-benefit also include into analysis such variables as income and expenditures of households having caring responsibilities. The gender aspect is very significant and relevant since it is marked by worse situation of women. However, in order to be more concrete it should be suggested to continue a more gender balanced research on a group of male working caregivers.

To summarize, our study showed that the state is not helpful in supporting the working caregivers of older persons. This is naturally not a representative survey, however still this issue is mentioned and without a serious public debate on the role of state in Poland, we will not be able to better organize and facilitate the lives of working carers, not only for the sake of care receiver but mostly for the benefit and wellbeing of the care giver.
9 Recommendations

In the summary of the previous analysis, is time for a critical evaluation which of the recommendations could be mentioned for consideration and hopefully some of them for introduction in the future.

It may be a topic for other additional expertise, which recommendations should be discussed in the future, but it was confirmed in our study that the current system of state’s help directed to the working carers is highly rigid and traditional, and certainly some innovative and flexible solutions could benefit the group of working carers, since it needs to be bear in mind that the number of working carers will increase and therefore be more diversified and demanding. The possible improvements mentioned by the respondents were directed towards all the state and local government agencies, as well as the third sector and civil society. Some improvements were considered to be important with regard to the employer. The respondents did not mention the family very often as an area for improvement, since they already managed to deploy this kind of support quite extensively.

As a result, below is list of some recommendations geared to aid working carers:

- a possibility to receive more formal care from the local social care centers expressed the wish for longer hours “prescribed” by the social worker, which is certainly rational for the carer, but from the economic point of view raises a question of who and why it could be financed;
- an easy and wide access to day care centers in places where there were no such institutions or they were localized far away;
- an establishing of a special, dedicated information centers for the carers of older people, particularly for the working carers;
- having assistance in case of the lack of ability to provide care for the older adult in case of emergency situation of working carers (especially those who cannot rely on family);
- a possibility to organize/participate in rehabilitation/holidays for the older people;
- improved organization of different health service via the health care system (i.e. more home visits, prescriptions facilitation or transportation);
- reducing complicated and bureaucratic procedures and to create easier mechanism for obtaining some service or allowance;
- a possibility to work at home (if applicable).

However, working from home is not possible for all, and hence a good question: what instead of such a measure could be suggested? The results of research do not provide one clear answer, but certainly there is room for finding the best compromise and
solutions for all, not only for some. This recommendation is directed only towards the sector of employers and is related to other recommendations, like flexible working hours etc.

The role of the third sector organizations could be better used, as it is an area for potential improvements in working carers individual situation, since it is still not widely used and treated rather as an additional “attraction” and not as a real substitute for services from other sources. It is also related to the friendly neighbourhood, which could be an important source of help for older persons if their working carers cannot provide care all the time because of work.
10 Literature


Krzyszkowski, J. (2006). Usługi opiekuńcze dla ludzi starych w miejscu zamieszkania w krajach UE i w Polsce. [In:] Jerzy Kowaleski, Piotr Szukalski (eds). Starość i starzenie się jako doświadczenie jednostek i zbiorowości ludzkich. Łódź: Wydawnictwo UŁ.


### 11 Annexes

#### 11.1 Description of the 60 cases

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Age</th>
<th>Cared-for person/s</th>
<th>Causes of care need</th>
<th>Level of qualification</th>
<th>Family / income structure</th>
<th>Kind of work</th>
</tr>
</thead>
<tbody>
<tr>
<td>PL 1</td>
<td>Female</td>
<td>31</td>
<td>Grandmother</td>
<td>Disability</td>
<td>High</td>
<td>Single</td>
<td>PhD Student</td>
</tr>
<tr>
<td>PL 2</td>
<td>Female</td>
<td>50</td>
<td>Mother</td>
<td>Death of a spouse</td>
<td>High</td>
<td>Couple, both working</td>
<td>University Teacher</td>
</tr>
<tr>
<td>PL 3</td>
<td>Male</td>
<td>61</td>
<td>Mother</td>
<td>Dementia</td>
<td>High</td>
<td>Couple, one working</td>
<td>Electrical Engineer</td>
</tr>
<tr>
<td>PL 4</td>
<td>Female</td>
<td>60</td>
<td>Father</td>
<td>Old Age</td>
<td>High</td>
<td>Couple, both working</td>
<td>University Teacher</td>
</tr>
<tr>
<td>PL 5</td>
<td>Female</td>
<td>60</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Couple, both working</td>
<td>University Teacher</td>
</tr>
<tr>
<td>PL 6</td>
<td>Female</td>
<td>51</td>
<td>Mother</td>
<td>Old Age</td>
<td>High</td>
<td>Single</td>
<td>Enterprise, gastronomy</td>
</tr>
<tr>
<td>PL 7</td>
<td>Female</td>
<td>54</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>Low</td>
<td>Couple, one working (+ two sons, cared-for person)</td>
<td>Gastronomy worker</td>
</tr>
<tr>
<td>PL 8</td>
<td>Female</td>
<td>64</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Single (+ cared-for person)</td>
<td>University Teacher</td>
</tr>
<tr>
<td>PL 9</td>
<td>Female</td>
<td>54</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>Low</td>
<td>Couple, both working (+ cared-for person)</td>
<td>Enterprise, Insurance</td>
</tr>
<tr>
<td>PL 10</td>
<td>Female</td>
<td>27</td>
<td>Grandmother</td>
<td>Old Age (walk deficiencies)</td>
<td>High</td>
<td>Three people (parents), all working</td>
<td>Civil Servant (MOPS)</td>
</tr>
<tr>
<td>PL 11</td>
<td>Female</td>
<td>46</td>
<td>Father</td>
<td>Alzheimer</td>
<td>High</td>
<td>Couple, both working (+son)</td>
<td>University Teacher</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>----</td>
<td>--------</td>
<td>-----------</td>
<td>------</td>
<td>-----------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>PL 12</td>
<td>Female</td>
<td>51</td>
<td>Aunt</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Couple, both working (+cared-for person)</td>
<td>Enterprise, photography</td>
</tr>
<tr>
<td>PL 13</td>
<td>Female</td>
<td>54</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Single (+cared-for person)</td>
<td>Enterprise, Gardening</td>
</tr>
<tr>
<td>PL 14</td>
<td>Female</td>
<td>51</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Single (+cared-for person)</td>
<td>Psychologist</td>
</tr>
<tr>
<td>PL 15</td>
<td>Female</td>
<td>51</td>
<td>Father</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Single (+ cared-for person)</td>
<td>Teacher</td>
</tr>
<tr>
<td>PL 16</td>
<td>Male</td>
<td>53</td>
<td>Mother</td>
<td>Alzheimer</td>
<td>Low</td>
<td>Single (+ cared-for person)</td>
<td>Taxi Driver</td>
</tr>
<tr>
<td>PL 17</td>
<td>Female</td>
<td>55</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Single (+daughter 20, cared-for person)</td>
<td>Civil Servant</td>
</tr>
<tr>
<td>PL 18</td>
<td>Male</td>
<td>51</td>
<td>Father</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Couple, one working (+daughter)</td>
<td>Enterprise, Gardening</td>
</tr>
<tr>
<td>PL 19</td>
<td>Female</td>
<td>31</td>
<td>Grandmother</td>
<td>Alzheimer</td>
<td>High</td>
<td>Couple both working</td>
<td>Banker</td>
</tr>
<tr>
<td>PL 20</td>
<td>Male</td>
<td>28</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Single (+cared-for person)</td>
<td>Engineer, Designer</td>
</tr>
<tr>
<td>PL 21</td>
<td>Male</td>
<td>50</td>
<td>Mother</td>
<td>Alzheimer</td>
<td>Low</td>
<td>Couple, both working (+two children)</td>
<td>Electrician</td>
</tr>
<tr>
<td>PL 22</td>
<td>Male</td>
<td>39</td>
<td>Mother</td>
<td>Falls</td>
<td>High</td>
<td>Couple, one working</td>
<td>Enterprise</td>
</tr>
<tr>
<td>PL 23</td>
<td>Male</td>
<td>41</td>
<td>Father</td>
<td>Neurological sickness</td>
<td>Low</td>
<td>Couple, both working (+daughter+cared-for person)</td>
<td>Operator</td>
</tr>
<tr>
<td>PL 24</td>
<td>Female</td>
<td>56</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>Low</td>
<td>Single (+cared-for person)</td>
<td>Office Worker</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>----</td>
<td>--------</td>
<td>------------------</td>
<td>-----</td>
<td>---------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>PL 25</td>
<td>Female</td>
<td>57</td>
<td>Mother</td>
<td>Old Age</td>
<td>High</td>
<td>Single (+cared-for person)</td>
<td>University Teacher</td>
</tr>
<tr>
<td>PL 26</td>
<td>Female</td>
<td>52</td>
<td>Mother</td>
<td>Alzheimer, Multiple Reasons</td>
<td>High</td>
<td>Couple, both working</td>
<td>Laboratory Diagnostician</td>
</tr>
<tr>
<td>PL 27</td>
<td>Female</td>
<td>57</td>
<td>Mother</td>
<td>Alzheimer</td>
<td>Low</td>
<td>Single (+cared-for person)</td>
<td>Shop- Assistant</td>
</tr>
<tr>
<td>PL 28</td>
<td>Male</td>
<td>61</td>
<td>Mother</td>
<td>Alzheimer</td>
<td>High</td>
<td>Single (non-working)</td>
<td>Office Worker (doesn’t work anymore)</td>
</tr>
<tr>
<td>PL 29</td>
<td>Female</td>
<td>42</td>
<td>Father in law</td>
<td>Neurological Sickness</td>
<td>Low</td>
<td>Couple, both working (+daughter and cared-for person)</td>
<td>Dressmaker</td>
</tr>
<tr>
<td>PL 30</td>
<td>Female</td>
<td>56</td>
<td>Mother</td>
<td>Alzheimer</td>
<td>High</td>
<td>Couple, one working</td>
<td>Accountant</td>
</tr>
<tr>
<td>PL 31</td>
<td>Female</td>
<td>53</td>
<td>Mother</td>
<td>Hepatic cirrhosis</td>
<td>High</td>
<td>Single (+cared-for person)</td>
<td>Teacher</td>
</tr>
<tr>
<td>PL 32</td>
<td>Female</td>
<td>58</td>
<td>Mother</td>
<td>Stroke</td>
<td>Low</td>
<td>Couple, one working</td>
<td>Foundation Director</td>
</tr>
<tr>
<td>PL 33</td>
<td>Female</td>
<td>57</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Couple, both working (+ working daughter)</td>
<td>Teacher</td>
</tr>
<tr>
<td>PL 34</td>
<td>Female</td>
<td>53</td>
<td>Mother + Mother in law</td>
<td>Old Age/ Varicose veins</td>
<td>Low</td>
<td>Couple, one working</td>
<td>Accountant</td>
</tr>
<tr>
<td>PL 35</td>
<td>Female</td>
<td>56</td>
<td>Father</td>
<td>Asthma</td>
<td>Low</td>
<td>Couple, both working</td>
<td>Gastronomy Director in hospital</td>
</tr>
<tr>
<td>PL 36</td>
<td>Female</td>
<td>52</td>
<td>Mother</td>
<td>Multiple strokes</td>
<td>High</td>
<td>Single (+ daughter)</td>
<td>Enterprise, Distribution</td>
</tr>
<tr>
<td>PL 37</td>
<td>Female</td>
<td>53</td>
<td>Mother</td>
<td>Falls</td>
<td>High</td>
<td>Single (+working)</td>
<td>Office Worker</td>
</tr>
<tr>
<td>No.</td>
<td>Type</td>
<td>Gender</td>
<td>Age</td>
<td>Condition</td>
<td>Employment Status</td>
<td>Occupation</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
<td>--------</td>
<td>-----</td>
<td>-----------</td>
<td>-------------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Female</td>
<td>52</td>
<td>Mother</td>
<td>Old Age</td>
<td>High</td>
<td>Daughter, + cared-for person</td>
<td>(public administration)</td>
</tr>
<tr>
<td>38</td>
<td>Female</td>
<td>26</td>
<td>Granmother</td>
<td>Falls</td>
<td>High</td>
<td>Couple, one working (+daughter)</td>
<td>Dentist</td>
</tr>
<tr>
<td>39</td>
<td>Female</td>
<td>60</td>
<td>Mother</td>
<td>Old Age</td>
<td>High</td>
<td>Couple, both working (+son 26, non working)</td>
<td>Secretary</td>
</tr>
<tr>
<td>40</td>
<td>Female</td>
<td>55</td>
<td>Mother</td>
<td>Alzheimer</td>
<td>High</td>
<td>Couple both working (+cared-for person)</td>
<td>Enterprise, Pharmacy</td>
</tr>
<tr>
<td>41</td>
<td>Female</td>
<td>55</td>
<td>Mother</td>
<td>Alzheimer</td>
<td>Low</td>
<td>Single (+cared-for person)</td>
<td>Shop-Assistant</td>
</tr>
<tr>
<td>42</td>
<td>Female</td>
<td>55</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>Low</td>
<td>Single (+cared-for person)</td>
<td>Shop-Assistant</td>
</tr>
<tr>
<td>43</td>
<td>Female</td>
<td>44</td>
<td>Mother in law</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Couple both working (+two children, + cared-for person)</td>
<td>Teacher</td>
</tr>
<tr>
<td>44</td>
<td>Male</td>
<td>57</td>
<td>Mother</td>
<td>Old Age</td>
<td>High</td>
<td>Single (+cared-for person)</td>
<td>Teacher</td>
</tr>
<tr>
<td>45</td>
<td>Female</td>
<td>54</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>Low</td>
<td>Couple, both working (+cared-for person)</td>
<td>Shop-Assistant</td>
</tr>
<tr>
<td>46</td>
<td>Female</td>
<td>54</td>
<td>Mother</td>
<td>Disability</td>
<td>Low</td>
<td>Couple, both working (+cared-for person)</td>
<td>Shop-Assistant</td>
</tr>
<tr>
<td>47</td>
<td>Female</td>
<td>52</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Couple, both working (+cared-for person)</td>
<td>Teacher</td>
</tr>
<tr>
<td>ID</td>
<td>Gender</td>
<td>Age</td>
<td>Relationship</td>
<td>Reasons for Care</td>
<td>Degree of Care</td>
<td>Marital Status</td>
<td>Occupation</td>
</tr>
<tr>
<td>----</td>
<td>--------</td>
<td>-----</td>
<td>--------------</td>
<td>------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>PL 48</td>
<td>Female</td>
<td>54</td>
<td>Mother in law</td>
<td>Psychological Problems</td>
<td>Low</td>
<td>Couple, both working</td>
<td>Nurse</td>
</tr>
<tr>
<td>PL 49</td>
<td>Female</td>
<td>56</td>
<td>Mother in law</td>
<td>Old Age</td>
<td>High</td>
<td>Single (+ex-husband)</td>
<td>Journalist, Retired</td>
</tr>
<tr>
<td>PL 50</td>
<td>Female</td>
<td>48</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Couple, both working (+son)</td>
<td>Teacher (pedagogue)</td>
</tr>
<tr>
<td>PL 51</td>
<td>Female</td>
<td>56</td>
<td>Mother/Father</td>
<td>Old Age/Old Age</td>
<td>Low</td>
<td>Couple, both working</td>
<td>Carer (older people)</td>
</tr>
<tr>
<td>PL 52</td>
<td>Male</td>
<td>27</td>
<td>Grandmother</td>
<td>Old Age</td>
<td>High</td>
<td>Single</td>
<td>Teacher</td>
</tr>
<tr>
<td>PL 53</td>
<td>Female</td>
<td>57</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Couple, both working (+son)</td>
<td>Research Institution Worker</td>
</tr>
<tr>
<td>PL 54</td>
<td>Female</td>
<td>51</td>
<td>Mother</td>
<td>Falls</td>
<td>High</td>
<td>Single (+cared-for person)</td>
<td>Pollster</td>
</tr>
<tr>
<td>PL 55</td>
<td>Female</td>
<td>36</td>
<td>Father in law</td>
<td>Old Age</td>
<td>High</td>
<td>Couple, both working (+child)</td>
<td>Teacher</td>
</tr>
<tr>
<td>PL 56</td>
<td>Male</td>
<td>58</td>
<td>Mother/Mother in law</td>
<td>Falls/Alzheimer</td>
<td>High</td>
<td>Couple, both working (+son 26 non working)</td>
<td>Accounting in wife’s enterprise</td>
</tr>
<tr>
<td>PL 57</td>
<td>Female</td>
<td>63</td>
<td>Mother</td>
<td>Multiple Reasons</td>
<td>High</td>
<td>Single (+cared-for person)</td>
<td>University teacher</td>
</tr>
<tr>
<td>PL 58</td>
<td>Female</td>
<td>53</td>
<td>Mother in law</td>
<td>Old Age</td>
<td>Low</td>
<td>Couple, both working (+son)</td>
<td>Cleaning lady</td>
</tr>
</tbody>
</table>