Carers@Work

Carers between Work and Care.

Conflict or Chance?

International Report

Based on National Reports of interviews with working carers for:

Germany (Susanne Kohler & Hanneli Döhner),
Italy (Sara Santini, Andrea Principi, Giovanni Lamura & Maria Renzi),
Poland (Justyna Stypinska & Jolanta Perek-Bialas),
United Kingdom (Kate Hamblin & Andreas Hoff).

Andreas Hoff & Kate Hamblin

Oxford Institute of Population Ageing,
University of Oxford

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1. Introduction: Research objectives and research questions

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.

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 per cent 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 that is on average 76 years old. On average, working carers spent 4-9 hours per week for care obligations primarily related to "general eldercare". However, nearly 50 per cent of the working carers are also involved in “personal care”. All in all, most studies show an overall proportion of about 10 per cent prevalence rate of workers with care obligations (Hamblin and Hoff, 2011).

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 understanding of the specific conflicts, strategies and demands of working carers. Therefore, semi-structured interviews with working carers were conducted in Germany, Italy, Poland and the UK to answer the following research questions:

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

In many cases working carers experience controversial expectations from the work place and the care situation. Thus, they might indicate high levels of physical and psychological burden, which could be the case when care-giving is externally 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.
2. **What strategies do carers use to reconcile work and care for an older individual?**

This research question tries to establish 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.

3. **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 care-giving 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.

4. **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 assists 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.

5. **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 negotiated.

6. **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.

7. **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 ultimate aim of this comparative report.
The findings of the research project “Between job and care – conflict or opportunity?” that was carried out by the ‘carers@work’ research consortium were published in nine separate research reports, dedicated to distinct objectives of the research programme: (1) state-of-the-art review of the international research literature (Franke and Reichert, 2010), (2) secondary analysis of statistical data (Principi and Perek-Bialas, 2010), (3) European social policy context (Franke, 2011), (4) economic costs of avoiding an enterprise-based reconciliation of employment and care (Schneider, Heinze and Hering, 2011), as well as four national reports based on semi-structured interviews with working carers in (5) Germany (Kohler and Döhner, 2011), (6) Italy (Santini, Principi and Lamura, 2011), (7) Poland, and (8) the United Kingdom. The present 9th report builds upon the four national reports and in part on the European social policy report and focuses on the international comparison of findings, and thus similarities and differences in reconciling work and care for an older person in the four countries studied.
2. Conceptualising European welfare state comparisons

In the second section we briefly discuss theoretical classifications of welfare state comparison in Europe, which motivated the selection of countries for our study. Whereas European ‘welfare state regime’ typologies based on varying degrees of institutionalization of labour markets and social security has a considerable pedigree dating back to the 1950s, consideration of gender, family and care as salient dimensions of welfare provision – and hence, welfare state comparison, has a more recent history. Explicit consideration of these dimensions resulted in the emergence of the European ‘care regime’ discourse whose beginnings can be retraced to the mid 1990s. Since the latter has much greater potential for adding value to cross-country comparisons in the context of the present research, we discuss this in a bit more detail than European welfare state regimes where we only summarize the most essential elements.

2.1. European welfare state regimes

*Decommodification and ‘worlds of welfare capitalism’*

The categorisation of welfare state regimes has a long lineage, initially focused on the spectrum between residual and institutional welfare states (Titmuss, 1958; Wilensky and Lebeaux, 1958), with nations at the former end of the range providing limited benefits both in terms of their generosity and target group, whilst the latter are more generous and universally available. Esping-Andersen (1990), in perhaps the most seminal regime-focused study, refined the categorisation of welfare states by focusing on the decommodification of labour, i.e. welfare state provision for individuals to enable their withdrawal from the labour market (Kvist, 2007). From his examination of European unemployment benefits’ generosity and eligibility criteria, Esping-Andersen found three ‘worlds of welfare capitalism’ including the social democratic with typically generous and universal benefits exemplified by the Northern European countries (Denmark, Finland, Norway, or Sweden), the liberal with typically low and restrictive benefits, typically represented by the United States, Australia or (in his view) Canada – in the European context Ireland and the UK are commonly seen as closest to this model, and the conservative-corporatist with stratified benefits regimes represented by the likes of France, Germany, or Italy.

However, Esping-Andersen’s categorisation has not been without criticism. Aside from its overly static approach to social policy, criticism focused on four main points (see Hoff, 2006): (i) methodological weaknesses, in particular his over-reliance on aggregate welfare state expenditure and mean scores (Castles and Mitchell, 1993; Kangas, 1994), his bias towards cash benefits over social services (Bambra, 2005), and concerns regarding the calculation of the decommodification index (Bambra, 2006); (ii) his emphasis of political-institutional over cultural differences (Castles and Flood, 1993; Pfau-Effinger, 2005); (iii) the omission of Southern European (Ferrara, 1996; Leibfried, 1992) as well as Eastern European (Deacon et al., 1992; Manning, 2004; Standing, 1996) nations; and (iv) his gender and family ‘blindness’ resulting from focusing entirely on labour markets and effectively ignoring welfare relevant activities outside the employment sphere (Lewis, 1992; Pfau-Effinger, 1998; Sainsbury, 1994, 1996) and outside the welfare state (Daly, 2000). Esping-Andersen’s focus exclusively on decommodification has been argued to neglect the state’s role in the informal sector through a process equivalent to decommodification – *defamilialisation*, as will be discussed in the following section.
Gender and family sensitive welfare state regimes

The publication of Esping-Andersen’s “Three Worlds of Welfare Capitalism” was greeted with calls for a ‘gender sensitive’ welfare state analysis by a number of feminist authors (see, for example, Leira, 1992; Lewis, 1992; Orloff, 1993; the authors in Sainsbury, 1994), some of them proposing gendered welfare state classifications instead. These typologies conceptualised women and men in their roles as ‘workers’ and ‘carers’. Typically, they revolved around the breadwinner notion: countries were classified according to the degree to which they would allow women vis-a-vis men to participate in the labour market (see, for example, Lewis’s (1992) differentiation of ‘strong’, ‘moderate’ and ‘weak’ male breadwinner countries). This dichotomous approach, however, soon became subject of criticism as well for over-simplifying matters (Daly, 2000; Knijn and Kremer, 1997; Sainsbury, 1996).

Apart from omitting gender, Esping-Andersen had also overlooked the family as a major welfare provider in contemporary welfare societies. By introducing the concept of defamilialisation (McLaughlin and Glendinning, 1994), Esping-Andersen’s feminist critics applied his line of argument to the family sphere. Accordingly, defamilialisation is defined as the degree of an individual’s independence of the family (rather than the market, as in Esping-Andersen’s concept of decommodification). Esping-Andersen later adopted the concept too (see Esping-Andersen, 1999). However, defamilialisation turned out not to capture empirically female independence of the family either (Bambra, 2004; Korpi, 2000).

2.2. European care regimes

In contrast, the introduction of the concept of ‘care regimes’ marked a more radical departure from Esping-Andersen’s original model and sparked the emergence of a whole new body of literature associating welfare institutional patterns with care. Caring/care-giving is the pivotal element of informal welfare provision by the family, which due to the traditional assignment of care-giving tasks to women has obvious gender implications. The care regime literature emphasises that the role states play in providing care (or not, as the case may be) has implications either for the family (which in turn impacts upon employment opportunities and gender relations) or the market as the provider of care (thereby not only making the reconciliation of work and care less problematic, but also making it financially necessary).

The state therefore is integral in determining how individuals reconcile work and care. However, though care has received attention in the regime-building literature, the focus has been more heavily on childcare policies. When care for older individuals is addressed, it is included alongside childcare (Anttonen and Sipilä, 1996; Bettio and Platenga, 2004; Keck and Saraceno, 2009; Simonazzi, 2008). Yet further studies have created typologies of care regimes based on other facets such as female labour market participation, accessibility and quality of care services, level of care responsibility for families, share of care tasks between both sexes, and cash-for-care benefits (Pommer et al., 2007). In the following, we will review the approaches most relevant for our research.
Informal vs. formal care-giving responsibility

Anttonen and Sipilä (1996) developed a ‘social care regime’ typology based on an informal/formal dichotomy. Social care services considered include both childcare and eldercare dimensions. They cluster countries according to the predominance of either informal or formal care provision, or a mix of both: (1) thus, the first cluster comprises of the Southern European countries that delegate care-giving responsibility almost entirely to the family (e.g. Italy, Greece, or Spain). Informal care clearly dominates in these countries, whereas formal care arrangements are less developed – this applies universally to the treatment of both the younger and the older generation. (2) The second cluster refers to another group of countries that place great importance on informal care in general, exemplified by the UK and the Netherlands. However, in contrast to the Mediterranean countries their approach towards the care of the younger and the older generation is quite different. Whereas childcare is largely privatised, there are more public services for older people. (3) The third cluster is also characterised by informal care strategies. However, the costs of this strategy are partly compensated by collective arrangements, as it is the case in Germany or Austria. They can, therefore, be classified as medium range providers in regard to parental leave and its financial provisions as well as in regard to the institutional care of older people. (4) The fourth and final cluster comprises of the Scandinavian countries, which provide moderate to high levels of formal care to both older people and children. An important characteristic of this care model is its universal approach. There is a broad range of public care services, covering a large segment of the population. The family plays only a modest role as a care provider.

In another study that addresses both childcare and eldercare, Bettio and Plantenga (2004) highlight the central role state policies play in mediating the amount of care provided within the family. The level of care in EU nations, the authors argue, varies according to cultural and political legacies. How care is organised reflects cultural attitudes about the family. Thus in some nations, care is considered a private matter for the family and thus policy treats it as such; in others, care is provided by the state or market to allow both parents to engage in paid employment.

Bettio and Plantenga’s article addressed the level of adult involvement in care activities in Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom. The study included care for children and elderly people to create an index of the level of informal care. The authors identify five clusters: (1) In the first cluster, Greece, Italy, Spain, Portugal and Ireland scored low on the index of formal care and high on the index of informal care, placing care within the sphere of the family. In Southern European nations, in terms of older individuals, the trend is to provide money in the form of pensions as opposed to the provision of services. (2) The UK and the Netherlands are in the second of these clusters where informal care is important though policy makes some distinction between the levels of support offered to those caring for either children or elderly people. In the Netherlands, families provide care for children whilst the state looks after older people; however in UK, the state will provide for older people in the last instance. (3) Austria and Germany focus on private and informal care but loss of income is protected through collective agreements and is thus medium in terms of leave and institutional care. Indeed in these nations, “The pattern that emerges could therefore be described as a publicly facilitated, private care model. Whereas there is a systematic reliance on the family for the provision of care work and services, based on the principle of subsidiarity, the family is actively encouraged to perform this role through receiving state support rather than direct interventions” (Bettio and Plantenga, 2004: 101). (4) In addition, in Belgium and France, the reliance is on formal care as opposed to strategies to allow for the combination of work and care. Thus the priority is on formal care services as opposed to leave arrangements for the provision of care. (5) At the other end of the spectrum from Greece,
Italy, Spain, Portugal and Ireland are Denmark, Sweden and Finland, characterised by moderate to high levels of universal formal services and therefore the state substitutes as opposed to supporting the family in care role.

Bettio and Plantenga (2004) contend these different care strategies have implications in terms of social and economic outcomes. For example, the cluster containing Greece, Italy, Spain, Portugal and Ireland, with its lack of provision for care, inhibits female participation in the labour market, which is particularly pronounced among those with low-skills whose employment would not allow for the purchase of care services. The authors argue that this in turn does not promote the creation of jobs in the care sector which is important as “public provisions of nurseries, kindergartens, etc., have two well-known advantages over the options of mothers taking time-off or of relying on relatives: they increase the demand for care workers and are more compatible with continuous, full-time patterns of participation” (Bettio and Plantenga, 2004: 103). However, this does nothing to redress the gendered division of labour, with women instead consigned to paid care roles which tend to be poorly remunerated and insecure. The authors also note that the provision of care also impacts upon fertility, though they acknowledge the picture is more complex than a simple linear relationship.

Gornick and Meyers (2004) have also argued that ideologies regarding work, care, family and gender relations are variable according to countries and time and are therefore spatio-temporal constructs. Thus countries classified by Esping-Andersen as social democratic have the most developed gender equal division of labour whilst the conservative-corporatist and liberal nations are laggards, but these classifications are not fixed and shift with policy changes (Kvist, 2007). State policies can mediate the division of care labour, and depending on whether they conceptualise care as a private family matter or not, dictates the degree of intervention.

Millar (1999), based on work in collaboration with Warman (1996) also created a typology of care regimes within which 16 nations were divided. In Millar’s typology, the ‘individual autonomy’ approach, as exemplified in the Nordic nations including Denmark, Finland, Norway and Sweden, sees care as the state’s responsibility and benefits are individualised. At the other end of the spectrum is the ‘extended families’ model whereby the family (and not just the immediate family) is expected to provide care and thus the state’s role is limited and entitlement are based on relationships i.e. marriage. Nations included in this category are Greece, Italy, Portugal and Spain. In the final type, the ‘nuclear family’, care is also provided by the family, but in a narrower, more immediate sense and the state does provide some discretion support. In the case of the UK, Ireland, Austria, Belgium, France, Germany, Luxembourg and the Netherlands, Millar argues, provisions focus on obligations spouses have to one another and parents have to children and therefore services support family care.

Care regimes and gendered employment opportunities

The following models are particularly relevant in the context of this report since they link the care regime discourse with that of gendered employment opportunities. We will discuss them in relation to the reconciliation of employment and care problematic addressed in our study. Pfau-Effinger (1999) returns to the breadwinner/carer dichotomy introduced by Lewis (1992) and links it to the respective cultural context, which has important implications for the development of care regimes. Although she does not make any explicit reference to older people, we feel that her chapter is highly relevant for our discussion.
Pfau-Effinger (1999) proposes five ‘gender cultural models’: two traditional ones and three more recent additions. The traditional ones are: (1) the first and most traditional model is the ‘family economic gender model’ in which men and women co-operate in their own family business (farm, craft business). Essentially, both sexes are dependent on each other, and the female contribution to the household is as valuable as the man’s. Since children as well as older people are fully integrated into the family business, there is no need for reconciling work and care-giving roles. (2) The second type is the ‘male breadwinner / female home carer’ model, in which there is a strict separation between the public i.e. paid work sphere (male responsibility) and the private i.e. unpaid care and home making sphere (female responsibility). There is no need for reconciliation either, since there is a clear separation between care-giving and employment roles. (3) The next type, is the ‘male breadwinner / female part-time carer’ model, which can be seen as a ‘modernised version of the male breadwinner model’ (Pfau-Effinger, 1999). Men and women are equally integrated into the labour market until the arrival of children or the need for long-term care provision – in which case women are expected to reduce their working hours to combine this task with their mothering or care-giving role. The ‘reconciliation problematic’ exists, but it is clear from the start that only women will have to combine their employment roles with care-giving. (4) Moving toward a more gender balanced relationship of shared responsibilities, the fourth ‘dual breadwinner / state carer’ model enables both sexes to fully integrate into their employment roles, even after birth of children or arising long-term care responsibilities, both earning a living and pursuing a career. Childcare (and presumably eldercare) are public responsibilities taken care of by the welfare state. (5) Finally, the ‘dual breadwinner / dual carer’ model reflects an equal integration of both sexes into both paid work and care-giving spheres and is thus the most gender-balanced model. It requires that both women and men reconcile their employment related roles with care-giving duties.

Crompton (1999) revised Pfau-Effinger’s (1999) model slightly by removing the historical, but today less relevant family business model (model 1 above). The ‘male breadwinner / female carer’ model thus becomes the most traditional model in contemporary European societies. Moreover, Crompton introduced a new model in-between the ‘dual earner / state carer’ and the ‘dual earner / dual carer’ categories – the ‘dual earner / marketized carer’ model, in which affluent workers of both sexes can solve the reconciliation problematic by purchasing care labour in the market (see figure 2.1 below). Another consequence of the ‘commodification of care’ is that social care services are targeted to those greatest in need only, with all others having to cope by their own means or supported by informal carers (Phillips, 2007). We would argue that Pfau-Effinger’s and Crompton’s model is still incomplete since it ignores the role of the voluntary sector in providing care that plays a significant role in instances described by Phillips above. Moreover, voluntary care-givers are set to play an increasing role in cases where older care recipients have no family living locally. The extreme poles of her ‘traditional’ (male breadwinner and female carer) vs. ‘less traditional’ (dual breadwinner and dual carer) continuum are most common in Southern and Northern Europe respectively, thus corresponding with the extreme ends in Anttonen and Sipilä’s (1996) and Bettio and Plantenga’s (2004) models.

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1 Neither Pfau-Effinger (1999) nor Crompton (1999) make any reference to eldercare – any such reference was added by the authors to clarify the relevance in the context of this report.
Figure 2.1: Crompton’s revised version of Pfau-Effinger’s typology of gender relations

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Less traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male breadwinner/ female carer</td>
<td>Dual earner/ female part-time carer</td>
</tr>
</tbody>
</table>

(Yeandle, 1999: 102)

Yeandle (1999), in accordance with this typology, addressed the UK, Germany and Italy. In the case of the former, Yeandle argues the ‘male breadwinner/ female carer’ model applied until the 1960s when there was recognition that male employment could secure a good standard of living for families. However, at the same time, “[t]he refusal of the state to accept the burden of care, especially since the mid-1970s, has forced other solutions on UK families. Among middle-income families there is now extensive use of private and often informal solutions to the burden of housework” (Yeandle, 1999: 102). Thus for Yeandle the UK was progressing towards a ‘dual breadwinner / dual carer’ model in the 1960s and 1970s, but the continued absence of state-provided care in actuality has meant it exemplified a ‘dual-earner / marketized-female-domestic-economy’ model. Yeandle argues Germany too has moved towards this model “in which domestic work becomes distributed across women outside of the kin network, creating new class divisions between women and new opportunities for mechanisms of exploitation for men” (Yeandle, 1999: 100). In these nations, families are polarised according to whether they can afford to purchase care services and assistance and those that cannot. In addition, the onus on purchasing care in the market results in an increasing demand for marketized female domestic labour and these jobs tend to be poorly paid and insecure. Thus though Yeandle agrees that the UK provides little state support for care, alternatives are not merely found in the family – the market too plays a role. Italy fits the family economic model with some moves towards the male-breadwinner / female-carer model. There could in future be a shift towards the dual-breadwinner / state carer model due to the fall in fertility.

2.3. Germany, Italy, Poland and the UK in the light of the care regime discourse

Concluding this part on the conceptualisation of cross-national comparison in the European context, we will apply some of the above discussed classifications to the four countries participating in the present research before clarifying selection criteria in the following section. Thereby, not every original source made reference to all of our four countries – in some cases we classified them according to our interpretation of the original’s meaning. Table 2.1 below sets the key concepts in relation to the four countries participating in our study.
Table 2.1: Selected countries and classification criteria of European care regimes

<table>
<thead>
<tr>
<th>Classification</th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decommodification</td>
<td>conserv.-corporat.</td>
<td>southern Europ.</td>
<td>post-commun.</td>
<td>liberal</td>
</tr>
<tr>
<td>Degree of ‘male breadwinner’</td>
<td>strong</td>
<td>strong</td>
<td>weak</td>
<td>strong</td>
</tr>
<tr>
<td>Defamilialisation</td>
<td>medium</td>
<td>medium</td>
<td>weak</td>
<td>medium</td>
</tr>
<tr>
<td>Social care regime</td>
<td>inf.+fml.</td>
<td>informal</td>
<td>informal</td>
<td>inf.+fml.</td>
</tr>
<tr>
<td>Gender-cultural care regime</td>
<td>dual earner / fem p-t / market. / state / carer</td>
<td>dual earner / fem p-t / market. carer</td>
<td>dual earner / fem. p-t / market. / state carer</td>
<td></td>
</tr>
</tbody>
</table>

Let us elaborate in a bit more detail on these classifications. First of all, Esping-Andersen (1990) included Germany, Italy and the UK in his analysis of decommodification variables. He placed Germany and Italy in the same category, which only a few years later, following the publication of Leibfried’s (1992) and Ferrara’s (1996) articles making the case for a separate Southern European welfare state regime, would no longer be seen as appropriate. Poland as well as the other Eastern European countries, however, was not discussed by Esping-Andersen at all. In our view it would not be correct assigning Poland, or indeed the other post-communist societies, to any of his three ‘worlds of welfare capitalism’. We thus suggest an alternative category tentatively called ‘post-communist welfare state regime’ (see Deacon et al., 1992; Manning, 2004; Standing, 1996).

Jane Lewis (1992) distinguished ‘strong’, ‘moderate’ and ‘weak’ male breadwinner regimes in her article, which she only discussed referring to four countries – Ireland and the UK as examples for a strong male breadwinner regime, France as example for a moderate breadwinner regime and Sweden as example for a weak breadwinner regime. Her central classification variable is to what extent women are enabled to participate in the labour market. A strong male breadwinner regime would discourage female employment and promote women’s home-based, unpaid care-giver and home-maker roles. Citing Davies and Joshi (1990), Lewis argues that Germany like Britain was also a strong male breadwinner oriented society (Lewis 1992: 165). If Britain and Germany are classified as strong male breadwinner societies, Italy would for sure also qualify for this category given its traditional division of labour in line with Catholic religion. Poland shares with Italy much of these Catholic traditions and ideology. On the other hand, however, Poland represents a former communist society with virtual female full-employment, which in our view justifies classification in the weak male breadwinner category. Communist societies would have been examples of ‘dual earner – dual carer’ models (Pascall and Lewis, 2004), an advancement of Lewis’ (1992) model. To what extent this still holds true today, almost 20 years later, is a different matter.

Defamilialisation was introduced as alternative concept to decommodification. While decommodification stresses the independence of the need to sell one’s labour as commodity to earn one’s living, defamilialisation emphasises policies directed at lessening the individual’s reliance on the family (Esping-Andersen, 1999). Thus, defamilialisation is particularly relevant in the context of our research. According to the defamilialisation concept, independence of family care duties is precondition for employment of mothers (McLaughlin and Glendinning, 1994; Lewis, 2001) – and thus care-givers for older dependents as well. In
table 2.1, we rely on Bambra’s (2004) defamilialisation index, although we acknowledge that this is not ideal in the context of our research since Bambra focuses on female labour market participation and maternity leave legislation, not making any reference to eldercare obligations at all. However, we see this approach as justified since cultural assignment of eldercare duties usually follows the same underlying logic as that of childcare duties. Clare Bambra used the same methodology for constructing her defamilialisation index as Esping-Andersen (1990) had used for constructing his decommodification index. Thus, it is hardly surprising that both Germany and Italy ended up in the medium category in both categories. Bambra’s analysis also resulted in the UK adopting a slightly more favourable position in regard to defamilialisation than decommodification – unfortunately, she doesn’t offer any explanation as to why that is the case. Poland was once again not classified at all. We would argue to categorise it as weakly defamilialised country. Rising mass unemployment during the 1990s and 2000s has considerably undermined previous full employment of female workers, a development that is even more dramatic in the older cohorts with care-giving responsibilities for their parents. The almost total lack of any formal care support infrastructure would suggest weak defamilialisation as well.

In contrast to the previous three concepts, Anttonen and Sipilä’s (1996) social care regime typology is based on both childcare and eldercare. They were primarily interested in the extent to which childcare and eldercare are delivered by informal or formal care providers or a mix of both. Noticeably, our four countries can be separated into two distinct pairs, one relying almost entirely on informal care provision, comprising Italy and Poland, and the other relying on an informal-formal care provision mix, consisting of Germany and the UK. There are, however, subtle differences between the latter two: Whereas the UK assigns responsibility for childcare almost exclusively to parents, the British welfare state accepts ultimate responsibility for eldercare if families are unable to provide care. Likewise, the German welfare state emphasises informal care-giving responsibility in line with the subsidiarity principle – however, it partly compensates family care-givers for childcare and eldercare services through parental leave benefits and the long-term care insurance respectively. Moreover, public childcare provision in Germany (particularly in former East Germany) is heavily subsidised by the state. If neither family nor long-term care insurance covers all eldercare related expenses and families are unable to cover these from their resources, the state will accept ultimate financial responsibility.

Finally, Pfau-Effinger’s (1999) and Crompton’s (1999) typologies combine two vital dimensions of any care regime classification – a gendered division of labour that makes its cultural origins explicit. It is fair to assume that some representation of most, if not all of their proposed types exist in all four countries. Even identifying a predominant pattern in any given country is getting increasingly difficult in our increasingly dynamic societies. We would argue that all of our four countries today represent variations of the ‘dual earner’ theme, all of which are combined with varying degrees of female part-time work, marketized care and (except in Poland) state care. What distinguishes them is the extent of state support available to them as well as the level of earnings from two earned incomes allowing them to employ a care worker in the market (or not).

The simplest and least satisfactory situation in our study is likely to be faced by Polish care-givers who typically don’t dispose of incomes sufficient to purchase care work (with the possible exception of some of the metropolitan areas in Poland, particularly Greater Warsaw) and don’t have access to any significant state support. If a family care need arises we assume that women would have little choice other than reducing their working hours, thus resulting in a ‘dual earner / female part-time worker’ scenario. The situation is likely to be similar in Italy, although family care-givers are much more likely to be able finding a market solution there, keeping in mind the existence of a well-established, though low-paid migrant care worker
market in Italy (Bettio, Simonazzi and Villa, 2006; Da Roit, 2007; Lamura, 2007). However, this scenario is more likely to apply to middle-class families, whereas working-class families would still have to reduce their working hours – hence we suggest a ‘dual earner / female part-time worker / marketized carer’ scenario for Italy. In contrast, both the UK and Germany could also add a ‘state carer’ dimension to this scenario – in the UK this would only apply to eldercare, in Germany to both childcare and eldercare. We will focus on the eldercare dimension here. Both countries would traditionally have expected female working hour reduction to cope with arising eldercare needs – today, we can see an increasingly complex interaction between family and marketized care provision, which is partly compensated and/or supplemented by the state.

2.4. Selecting countries for comparison

In this section we will outline the selection criteria leading us to select Germany, Italy, Poland, and the UK for comparison. As we will demonstrate below, some of these are related to the previous care regime discourse – other elements refer to demographic development, labour market characteristics or methodological considerations.

Sociology itself is argued to be implicitly comparative in that our knowledge of our social world is produced through comparison as “only by comparing can we order reality according to conceptual axes that will perhaps become as many explanations” (Dogan and Pelassy, 1990: 19). With regard to cross-national comparison, Hantrais (1999) outlines three traditions. The first, in the 1950s it was common to compare nations with the USA to the end of observing phenomena across these nations and as a result these studies were fairly descriptive and ignored the national contexts of these nations. Then at the other end of the spectrum, culturalist approaches focused on nation’s uniqueness with the aim of making cross-national contrasts. This tradition was followed by that which aimed to explain similarities and differences between countries whilst acknowledging the importance of national context. The final approach occupies the middle-ground and suggests social phenomena as a collection of systems and thus actors and structures cannot be separated, suggesting “social reality is also context dependent, but the context itself serves as an important explanatory variable and an enabling tool, rather than constituting a barrier to effective cross-national comparisons” (Hantrais, 1999: 94). This societal approach assesses the consequences of national differences and similarities as a means to either test a particular theory, define best practice with regard to policy and gain understanding of social practice. It is the latter of these approaches that was utilised for this project as it allowed us to explore similarities and differences and make recommendations of best practice.

The nations selected for comparison included Germany, Italy, Poland and the UK. These nations have been selected in line with Sartori’s argument “[t]he comparisons in which we sensibly and actually engage are thus those between entities whose attributes are in part shared (similar) and in part non-shared (and thus, we say, incomparable)” (Sartori, 1994: 17). These four nations have similarities in terms of their membership to the European Union. The EU also issues directives on policy areas, such as anti-discrimination legislation, which nations are then given a fixed amount of time to adopt. These directives tend to prescribe certain policy aims but leave the means to the judgment of the nation-states.

In addition, the four nations are undergoing similar demographic changes and are en route to becoming ageing societies. Thereby, however, they represent very different cases, thus adding credit to the value of comparing reconciliation patterns in various countries at different stages in the population ageing process. With Germany and Italy the two oldest societies of the European continent are included in the ‘sample’ (20.4 per cent of the German and 20.1 per cent of the Italian population are 65 years and older (IIASA, 2010)). The British
demographic profile also represents an ageing population, though the ageing process occurs at a less rapid pace than in Italy and Germany (16.2 per cent aged 65+ years, i.e. slightly below the EU27 average of 17.2 per cent (IIASA, 2010), which is mainly due to more favourable fertility trends in the UK. In contrast, the Polish population is still relatively young at present (13.5 per cent aged 65+ years (IIASA, 2010)). However, Poland – like other Central and Eastern European societies – is set to experience very rapid demographic ageing as a consequence of a very dramatic drop in fertility during the 1990s, combined with equally dramatic losses of its younger population due to emigration to Western Europe and continuous gains in life expectancy since the 1990s (Hoff, 2008a; Hoff, 2011).

The care regime discourse outlined in the previous section provided a crucial rationale for selecting countries participating in our ‘carers@work’ study. Thereby, historical-cultural considerations also played a major part, in particular the role of religion in shaping the cultural attitude towards care-giving responsibility. The four countries chosen – Germany, Italy, Poland, and the UK – represent four different welfare state (conservative-corporatist, Southern European, post-communist, and liberal) as well as care regimes (the first, second and third cluster in Anttonen and Sipilä’s (1996) classification plus a fifth post-communist cluster not included in their model, which we believe is different from the other four (Hoff, 2008b)).

All four countries share the requirement of private responsibility for organising care, albeit for different reasons. Whereas Italian and Polish societies – and thus their welfare states and care regimes – are heavily influenced by Catholicism, the origins of the British and the German welfare states are more of a secular nature
2. This makes the case for a pair-wise comparison, with the UK and Germany on the one hand, and Poland and Italy on the other, sharing more similarities with each other than with the other two countries. Likewise, employment patterns of older workers (55-64 years) in the four countries support this proposed pair-wise comparison. Research evidence suggests that the likelihood of caring for an older, disabled or long-term ill person increases with age to peak in middle age (45-64 years) (Evandrou and Glaser, 2003). If we compare the employment status of older women in their late 50s / early 60s, the following pattern emerges: whereas about half of 55-64 years old British and Germans are employed, only about a fifth of their Italian and Polish contemporaries are in employment too (Aliaga and Romans, 2006).

In the following, we will discuss some characteristics of the national welfare state / care regimes in a bit more detail in the light of justifying a viable comparison. We begin with the two secular welfare societies, Britain and Germany. The British welfare state emerged from the tradition of poverty relief as institutionalised in the ‘Poor Law’ (1598, 1601) and in particular the ‘New Poor Law’ (1834), which was heavily influenced by liberal individualism that advocated individual responsibility (Alcock, Erskine and May, 2002; see also Polanyi, 1944; Fraser, 1973; Powell and Hewitt, 2002). The German welfare state was ‘invented’ by Bismarck as a means of politically integrating the working class movement into German society (Alber, 1987; Kaufmann, 2003; Lampert and Althammer, 2004). In contrast, the influence of Protestant and particularly Catholic religion in supporting traditional care-giving norms and values is clearly visible in the dominant German care regime of the ‘male breadwinner / female part-time carer’ (Pfau-Effinger, 1999). The British care regime is yet again in line with the secular individualist tradition, but needs further explanation to understand its subtleties.

2 Historically, both Catholic and Protestant church influenced the emergence of the German welfare state – but they were not the main driving force (see, for example, Lampert and Althammer (2004)).
As discussed in the previous sections, the United Kingdom and Germany are both characterised by the dominance of informal care provision and private responsibility for organising care. What sets them apart, however, is the degree to which this is seen as an entirely private matter or as an issue that deserves societal support. To slightly complicate matters, the UK does not apply the same rigour in demanding individual responsibility to both childcare and eldercare. Whereas childcare is seen as an entirely private matter, the British welfare state provides reasonably wide coverage of social care services for older people and accepts ultimate, though limited responsibility for eldercare as a last resort if all other (private) means fail (Yeandle, 1999; Bettio and Plantenga, 2004). The latter would be entirely compatible with the subsidiarity principle on which the German welfare state and care regime rests. Germany also provides a reasonably wide range of social care services for older people. Additionally, and perhaps more substantially, it introduced a comprehensive new pillar of its social insurance system, the long-term care insurance (Pflegeversicherung), which was introduced with the intention to lift older care recipients above the poverty line and make them independent of German poverty relief systems and the social stigma associated with using them (Gerlinger and Röber, 2009). Nevertheless, the German long-term care insurance was never meant to relieve families of the ‘care-giving burden’ entirely. Primary care-giving responsibility remains with the family, and thus effectively with women – but German policy makers acknowledged the fact that families (women) need help with shouldering that burden.

From a German perspective the comparison with the UK is particularly fruitful since the British liberal work ethic and welfare state tradition was long seen as a model for inevitable welfare state reform in the context of increasing global economic competition, with consequences for future German labour markets and thus the reconciliation problematic addressed in this research. In addition, the United Kingdom has a long tradition of searching for innovative solutions for a better reconciliation of employment and care without explicit state intervention.

In contrast, both Italy and Poland represent examples of societies with almost exclusive family responsibility for care-giving tasks for children and older people alike. Although they share a strong influence of Catholic religion on their societies, and hence, on their care regimes, which results in some similarity in the situation of working carers in both countries, there are some subtle differences. First of all, as the present research will show, the Italian welfare state provides some support for working carers, whereas the latter are really left to their own devices in Poland. Moreover, a fascinating aspect of Italy’s strategy of combining care-giving duties with labour market participation is the employment of migrant care workers by Italian families (Bettio, Simonazzi and Villa, 2006; Da Roit, 2007; Lamura, 2007). Admittedly, this strategy only works for people who can afford to pay a care worker, which – even considering the modest wages migrant care workers typically receive – effectively excludes the working class. Employing a migrant care worker thus becomes a middle-class phenomenon. Another link between the Italian and the Polish case is that a substantial number of migrant care workers in Italy originate from Poland.

Like Italy, Poland’s care regime relies almost entirely on family care-giving for their elderly (Bien et al., 2001; Synak, 1990). Interestingly enough, the role of individuals caring for family members is not explicitly defined (Pedich, 2006). In sharp contrast to the otherwise high female labour market participation in Poland – a legacy of the country’s communist past – the proportion of older women aged 55-64 years in employment is rather low at 19.2 per cent, which is the third-lowest participation rate in the EU (Aliaga and Romans, 2006).
To comply with Hantrais and Mangen’s (1996) assertion that “a study can be said to be cross-national and comparative if one or more units in two or more societies, cultures and countries are compared in respect of the same concepts and concerning the systematic analysis of phenomena, usually with the intention of explaining them and generalising from them” (Hantrais and Mangen, 1996: 1-2), this research focused on the same definitions of work and care. With regard to care, we utilised the EUROCARERS definition whereby a carer is “a person who provides unpaid care to someone with a chronic illness, disability or other long lasting health or care need, outside a professional or formal framework”, with caring activities including: physical care, instrumental support, household tasks (ADL and IADL), emotional care, and organization of care (excluding financial help only). The focus was narrowed to include those caring for individuals over 60 years of age on an unpaid basis. In terms of work, we included individuals who worked more than 10 hours per week in regular employment (therefore seasonal or occasional employment was not included). Details of the methodological approach are outlined in the subsequent chapter 3.
3. Methodology

In this chapter, we outline the methodology used to realise the research project. Overall, all partners were using the same research methods, research instruments and data analysis approach. However, it turned out that the same recruitment strategy would not work in all four countries. Specific local settings required some adjustment and thus variation of the jointly agreed recruitment strategy, which illustrates once more the effects subtle cultural differences and local context settings can have on conducting cross-nationally comparative research.

3.1. Data Collection: Problem centred Interviews according to Witzel

With regard to the data collection, all four partners employed the same topic guide, formulated in line with ‘problem-centred interviewing’ as outlined by Witzel (2001). This method was selected as it allowed for the combination of the narrative presented by the interviewee whilst also drawing on existing empirical data in the topic to provide a focus for the interviews. In addition, advocates of problem-centred interviewing also argue the approach allows the interviewer to utilise a number of techniques within one interview as they first begin with a narrative approach, then a thematic interview and finish with the collection of ‘socio-statistical information’ at the end. However, this strength can also be a weakness as it places significant demands upon the interviewer in terms of their ability to employ three styles of interviewing in one session (Scheibelhofer, 2005)

Not unlike the biographical narrative approach, a problem-centred interview begins with a pre-formulated introductory question. Witzel argues this initial question should be sufficiently broad and is then followed up with exploratory questions to draw out more details of particular aspects of the interviewee’s narrative. It is therefore key that the interviewer takes field notes to allow them to return to important issues once the interviewee has finished their narrative. 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 additional questions, proposing varying possibilities to answer, etc.” (Scheibelhofer, 2005: 23). This is followed by the second questions which are ‘ad-hoc’ questions. Scheibelhofer (2005) argues their name is misleading 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, based on the review of the literature. These questions in the topic guide should act as prompts, as opposed to a rigid structure. In addition, the interviewer should aim to follow the narrative presented by the interviewee when asking these ad hoc questions. They also assist with the comparability of results and as a consequence, they are in fact ‘supplementary questions’ or prompts. It is important at this stage for the interview not to conform to a ‘question-and-answer game’ style of interviewing and should instead fill in gaps not included in the narrative and raised by the examination of the literature. Finally, there are questions that allow the interviewer to clarify any points raised during the interview. For Scheibelhofer, the interview should finish with a questionnaire related to socio-economic characteristics of the interviewee. The inclusion at the end of the interview allows the interviewers to “keep the more unstructured part of the interview as unrestricted as possible” (Scheibelhofer, 2005: 23). Therefore, in line with Witzel’s assertions, for each interview the researcher had:
- The appropriate consent forms and information on the project;
- 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, the following research questions were formulated:

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

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 are answered in each national report whilst Question G has to be left to this comparison report. In order to utilise the problem-centred interviewing technique as the method of collecting data, the research questions had to be operationalised to provide the basis for the topic guide. The first six research questions were edited to become pre-formulated introductory questions and were intended to stimulate a narrative from the interviewees. Each of these pre-formulated questions was connected with a series of supplementary questions to enable the researchers in each nation to prompt for more
information, highlighted as pertinent by the review of the literature. Thus the topic guide was structured around the pre-formulated questions which allowed the interviewee to provide a narrative and once the interviewee has answered a particular pre-formulated question, the interviewer could then address the areas that were not been included. Therefore, the interviewer did not necessarily proceed in a linear fashion through the supplementary questions or revert to a ‘question-and-answer’ game, but the topic guide still provided an ‘anchor’ to the research questions and ensured that the data produced would be comparable across the four nations.

Each interview began with some initial informal conversation before the project was outlined and two copies of the consent form were presented, one for the interviewer and one for the interviewee. The interviewees were given the opportunity to ask questions, or withdraw from the study entirely. The interviewers also ensured the interviewees had their contact details on a signed copy of the consent form, should they wish to contact them with further questions. With regard to the interview, the first pre-formulated research question was designed to give an insight into the care situation and was as follows:

(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?

If not covered in the narrative, the supplementary questions addressed the interviewees’ motivation to care, the reasons for the current care arrangement and any changes that may have occurred over time. The second set of questions concerned the work and work history, and how care affected these arrangements:

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

With the third package of questions, the focus was on the core of our research in terms of the 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?

The following section addressed Question B in terms of the services carers use and support they receive at home and at their work place:

(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:

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

Both questions helped to answer research question B and F. The last block of questions aimed to allow the carers to summarize some thoughts developed during the interview, and also strove to end on a positive note:

(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, cross-cutting analysis had to be undertaken and some sub-questions were added to the pre-formulated 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 in providing a comparative framework across nations, 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. From discussions with advisory boards in the partner countries, it became clear that firstly most carers would not be willing to reveal their income to strangers and secondly it is not only income which matters, but also savings, property and pensions. 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. Correspondingly the research question has to be changed here.

3.3. Sampling and recruitment

The sample frame used by this project focused on employment/income status and educational qualification in line with the research questions. Table 3.1 below demonstrates the theoretical sampling frame utilised for each country. In actuality, the number of interviewees recruited varied from 50 in the UK, 60 in Italy, 58 in Poland and 58 in Germany. A detailed comparison of these contingencies is presented in chapter 4.

Table 3.1: Level of qualification and family / income structure

<table>
<thead>
<tr>
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<th>COUPLE, BOTH WORKING</th>
<th>COUPLE, ONE WORKING</th>
<th>SINGLE EARNER</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>Higher level of qualification (ISCED 4-6)</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Lower level of qualification (ISCED 1-3)</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>60</td>
</tr>
</tbody>
</table>
3.4. Similarities and differences in recruitment strategies

In the four partner countries, the German and UK partners used broadly similar recruitment techniques. In the UK, flyers and posters were distributed to a number of carers centres in the South of England, churches in Oxfordshire, day centres in Oxfordshire and West Berkshire and to third-sector organisations such as the Clive Project (now Young Dementia UK, a charity for those suffering from early on-set dementia [http://www.youngdementiauk.org/]), Rethink (a mental health charity), the Princess Royal Trust for Carers and Age Concern Oxford (now Age UK: http://www.ageuk.org.uk/). In addition, a number of the carers centres in Oxfordshire, Berkshire, Wiltshire, Windsor and Maidenhead, Reading, Swindon and Somerset included a piece about the research in their newsletters. The UK team also advertised for interviewees in a number of free papers including the Reading Chronicle, Oxford Gazette, Oxford Daily Info and the Surrey and Hampshire Express. An advert was also placed on the Alzheimer’s Society charity’s message board. The inclusion of carers centres from counties neighbouring Oxfordshire allowed for the comparison of different local authority and voluntary sector provision. This publicity strategy also allowed the UK team to recruit individuals living in both urban and rural locations. In addition, interviews have been conducted by the UK team with employers identified as exhibiting ‘best practice’ with regard to providing support for working carers including Oxfordshire County Council, BT, British Gas/Centrica, Sainsburys, Bombardier and Marks and Spencer. These companies also placed articles on their intranet sites, publicised the project through their carers’ networks and involved local HR departments to assist in finding interviewees. The involvement of these employers meant the sample took in working carers from other parts of the UK including Scotland and Wales. The German team too utilised gatekeepers from organisations such as day care centres, residential homes, care services, hospitals, Alzheimer association, Parkinson league, “We care”, “Living without barriers” and “Living with a handicap”. In addition, they also sent flyers to employers renounced for ‘family friendly’ policies. The German team also attempted to recruit more interviewees from low-income groups by offering an incentive of €20 but found this was largely unsuccessful.

In terms of the Polish and Italian partners, they too used similar recruitment techniques. The Italian team recruited almost half of their sample through snowballing or the contacts of the research team. Unlike in the UK sample, the flyer was much less successful in recruiting interviewees. The Polish partners too relied on snowballing to recruit the majority of their sample, in addition to assistance from the Municipal Social Welfare Center in Krakow and flyers.

3.5. Data analysis

The interviewees produced a huge amount of text and thus a mode of analysis needed to be used which could allow for the exploration of the data in within a very limited time span as well as to ensure the partners in all of the four participating countries would be able to use a strategy which was as comparable as possible. Therefore we decided to evaluate our interviews with the method of qualitative content analysis according to Mayring (2000, 2008). For Mayring, 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)

In our analysis, the method used was “structuring with regard to content”, in order to “filter... 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). At the centre of the qualitative content analysis are categories, which can be gained either
inductively or deductively, and in this study, we utilised “
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 passage of text” (Mayring, 2000: 4).

The interviews were transcribed in accordance with the recommendations of Kuckartz et al. (2007), as they suggest a quite simple way of transcription, which however meets the requirements of our analysis. Thus the transcription was carried out literally and 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 order to ensure the data was anonymised, 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.

To develop categories according to the deductive category approach, we utilised the topic guide. The topic guide itself was theory driven (see above) and thus provided a good 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 decisions based on their own data. As suggested 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.

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 established. 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).

In the latter stages, to remain grounded in the data, we used two strategies. First, we put a ‘headline’ for each interview which consisted of a key summarising quote from the interview. These quotes immediately would bring the picture of the interviewed carer back to the interviewers/ researchers mind. Second, we prepared small vignettes on each case as recommended by Witzel. In these, we describe briefly the main contents of the interviewee’s situation, 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 to assist with the classification, connections and combination of data. It also has the memo function which allowed for the recording of key quotes and the short vignettes. The results from our post-interview 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. This list of variables was of great help by developing the different types of carers.
4. Comparison of key socio-demographic variables

Chapter 4 is the first analytical chapter of this report. The socio-demographic variables (age of carer and care recipient, gender, marital status, number and age of children, level of education/qualification, and employment status) presented here are almost exclusively descriptive, providing essential context information for more thorough investigation in each country, as well as the cross-national comparison. Crucially, it enables us to see to what extent circumstances of working carers in the four countries are similar or different, which has implications for the interpretation of data.

4.1. Age

According to the literature, the majority of older people’s care-givers is aged 45-64 years (Evandrou and Glaser, 2003). This pattern is also reflected in the four country samples of this study – most carers were in their 50s (see table 4.1 below), particularly in Poland and Italy where they represented nearly two thirds of all interviewed carers. Another quarter in the UK and another fifth in Germany and Italy were in their 40s. The UK sample had a particularly large share of older carers in their 60s (nearly a quarter of all working carers interviewed there). Looking at mean ages, however, the pair wise pattern discussed in chapter 2 emerges: The German and British working carers in our samples are slightly older (54 years) than the Italian and Polish working carers (52 years).

Table 4.1: Age of working carer (absolute numbers, percentages)

<table>
<thead>
<tr>
<th>Age group</th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29 years old</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
<td>4 (7%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>30-39 years old</td>
<td>1 (2%)</td>
<td>5 (8%)</td>
<td>4 (7%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>40-49 years old</td>
<td>12 (21%)</td>
<td>11 (19%)</td>
<td>5 (9%)</td>
<td>11 (24%)</td>
</tr>
<tr>
<td>50-59 years old</td>
<td>33 (56%)</td>
<td>38 (63%)</td>
<td>38 (65%)</td>
<td>22 (48%)</td>
</tr>
<tr>
<td>60-69 years old</td>
<td>10 (17%)</td>
<td>5 (8%)</td>
<td>7 (12%)</td>
<td>11 (24%)</td>
</tr>
<tr>
<td>70-79 years old</td>
<td>1 (2%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mean age care-giver</td>
<td>54.1</td>
<td>51.8</td>
<td>51.9</td>
<td>53.9</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>46</td>
</tr>
<tr>
<td>Non-response</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>50</td>
</tr>
</tbody>
</table>

The target group of this research project was people in employment and caring for an older person who we defined as someone aged 60 years and over. This selection criterion was slightly relaxed in Germany and in the UK to allow inclusion of a number of cases with care recipients in their late 50s (58-59 years old) to meet the recruitment criterion of interviewing 60 working carers. Apart from being 1-2 years below the formal age threshold of 60 years they shared the same care-giving and working situation. But 4 of the 5 individuals caring for someone under 60 were also caring for someone 60+. The UK sample had the highest number of respondents caring for multiple individuals.
Table 4.2 below informs us about the care recipients’ age. The majority in the Polish and Italian samples were in their 80s. They also formed the largest age groups in the German and British samples, but represented less than half of care recipients. British working carers were also looking after a substantial number of people in their 70s (30 per cent), which is mirrored by the situation in Poland. In contrast, the German and Italian carers had about a fifth of persons in their 90s in their care, which may partly reflect the demographic structure (the two European countries with the oldest population) there.

Table 4.2: Age of care recipients (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59 years old</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>-</td>
<td>-</td>
<td>7%</td>
</tr>
<tr>
<td>60-69 years old</td>
<td>9</td>
<td>3</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>16%</td>
<td>6%</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td>70-79 years old</td>
<td>9</td>
<td>13</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>16%</td>
<td>21%</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>80-89 years old</td>
<td>25</td>
<td>33</td>
<td>36</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>43%</td>
<td>55%</td>
<td>59%</td>
<td>35%</td>
</tr>
<tr>
<td>90-100 years old</td>
<td>13</td>
<td>11</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>22%</td>
<td>18%</td>
<td>7%</td>
<td>13%</td>
</tr>
<tr>
<td>Mean age care-recipient (years)</td>
<td>81.6</td>
<td>83.7</td>
<td>81.7</td>
<td>78.2</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>61</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Non-response</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>61</td>
<td>76</td>
</tr>
</tbody>
</table>

Considering once again mean scores, we find that working carers in our Italian sample had the oldest care recipients on average (84 years), followed by the Polish and German (82 years) and British care recipients (78 years). The comparatively low mean age of British care recipients in our sample comes a bit as a surprise, but is in part an artefact resulting from inclusion of five cases below the age of 60 years.

4.2. Gender

Gender is the most important factor in determining whether an individual alters her/his working arrangements or quits employment altogether to provide care (Crompton et al., 2003). Although care-giving by men has become more common over recent years, care-giving has remained predominantly a female occupation (Mooney et al., 2002). This is also reflected in our study, in which the vast majority of more than 80 per cent of all interviewed care-givers in the British, German and Polish samples were women. Only the Italian sample included a relatively larger share of male care-givers (32 per cent), which nevertheless implied a predominance of female care-giving (see table 4.3 below).
Table 4.3: Gender of care-giver (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>50</td>
<td>41</td>
<td>47</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>86%</td>
<td>68%</td>
<td>81%</td>
<td>82%</td>
</tr>
<tr>
<td>Male</td>
<td>8</td>
<td>19</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>14%</td>
<td>32%</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Gender is a crucial variable in shaping work and care situation as well as reconciliation strategies. Thus, men largely remain in full-time employment whilst providing care (Carers UK, 2007) while women tend to reduce working hours for combining work and care (Evandrou and Glaser, 2005). Likewise, men under state pension age are less likely than their female counterparts to provide informal care (Hutton and Hirst, 2001).

4.3. Marital status

A clear majority of working carers in our four country samples was married or living in long-term cohabitation. Married / long-term cohabiting couples were most dominant in the German sample (78 per cent), followed by the Italian (70 per cent) and the British sample (68 per cent) (see table 4.4 below), compared with only 60 per cent in the Polish sample. This may seem to contradict traditional family values in Polish ‘Catholic society’. However, considering proportions of widowed carers (at 17 per cent twice as much as in the UK and more than five times higher than in the demographically oldest European societies Germany and Italy) highlights demographic characteristics of Polish society that set it apart from the other three (Western) European societies studied: a significantly lower life expectancy compared with the other countries, particularly for men, which inevitably results in a larger share of widows who survived their husbands.

Table 4.4: Marital status of carer (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married / long-term cohabitation</td>
<td>45</td>
<td>42</td>
<td>35</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>78%</td>
<td>70%</td>
<td>60%</td>
<td>59%</td>
</tr>
<tr>
<td>In a relationship, but not co-habiting</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8%</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>2</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>3%</td>
<td>17%</td>
<td>8%</td>
</tr>
<tr>
<td>Single</td>
<td>8</td>
<td>13</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>14%</td>
<td>22%</td>
<td>19%</td>
<td>21%</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Non-response</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>50</td>
</tr>
</tbody>
</table>

4 The UK sample included four individuals who lived in a long-term relationship but were not living in the same place.
Also worth mentioning is a share of about a fifth in the British, Italian, and Polish samples who described themselves as being single. Only in the German sample their share was lower (14 per cent). This gives a first indication of difficulties working carers find in living normal lives – some said explicitly that they felt incapable of maintaining ‘romantic relationships’ as a consequence of their constant overburdening with care-giving responsibilities: “The romantic side of life doesn’t exist, I couldn’t invite someone into my life. It wouldn’t be fair”, as one of the British respondents commented. In contrast, divorce did not feature prominently at all, with only very few cases reported in all countries under investigation.

4.4. Children

Working carers with care-giving responsibilities for both the older and the younger generation – in the research literature this is commonly referred to as ‘sandwich situation’ – are very likely to face a particularly stressful situation, almost inevitably not doing justice to the needs of either generation. We know from recent publications that the prevalence of ‘sandwich’ care-giving constellations was previously overestimated. In reality, this scenario only applies to a minority of parents. In contrast, a situation in which older people have dual care-giving responsibility for their parents and their grandchildren is much more common (Grundy and Henretta, 2006; Küнемund, 2006). Nevertheless, due to the extreme nature of the burden resulting from competing caring responsibilities we felt it useful to have a closer look at the number of children working carers had (see table 4.5 below).

Table 4.5: Children living in household of carer (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children aged older than 16 years</td>
<td>33</td>
<td>17</td>
<td>14</td>
<td>N/A5</td>
</tr>
<tr>
<td></td>
<td>57%</td>
<td>27%</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Children aged younger than 16 years</td>
<td>5</td>
<td>14</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>9%</td>
<td>23%</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>No children in household</td>
<td>20</td>
<td>31</td>
<td>38</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>34%</td>
<td>50%</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>626</td>
<td>58</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Unfortunately, a misunderstanding between the British and the other research teams resulted in a different interpretation of the question asking about children living in the carer’s household. As a consequence, the British data on children are not comparable with the other samples. In the remaining three countries it is striking that two thirds of the Polish and half of the Italian carers had no children living with them, while the majority of German carers reported to live with (adult) children.

4.5. Education and qualification

Although the project partners decided in favour of semi-structured qualitative interviews as the most appropriate research method for answering the research questions, a theoretical sampling frame was used nevertheless in an attempt to guarantee inclusion of vital categories

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5 No information on children aged older than 16 years and still living in the carer’s household was collected in the British interviews.

6 The total exceeds the number of interviewed care-givers since some of them have both a child under and over the age of 16 years.
of working carers. Two categories deemed to be particularly salient were working carers in high-qualification vs. those in low-qualification jobs. A strong correlation between higher levels of education/qualification and better employment prospects, also for older workers, was repeatedly shown in the literature (see, for example, Naegle, 1996; Wolff, Spieß and Mohr, 2001; Aliaga and Romans, 2006), which is often aggravated by gender specific disadvantages in case of women (Bosch and Schief, 2005). It seems plausible to assume that highly qualified workers will find it easier to combine work and care (for example, by working from home).

Qualification level was measured using the ‘International Standard Classification of Education’ (ISCED) scale, which was developed for the purpose of allowing international comparisons of education/qualification data. The current version, ISCED97, which was implemented in the EU for collecting data starting with the 1997/98 school year, combines both education and vocational qualification levels (Eurostat, 2011). To simplify matters, we combined the three highest categories 6 ‘tertiary education (second stage)’ i.e. an advanced research degree (Ph.D., doctorate), 5 ‘tertiary education (first stage)’ i.e. a higher education degree (Bachelor, Master) and 4 ‘post-secondary non-tertiary education’ that typically represents the level of education allowing students to enrol in higher education institutions (A-levels, Abitur, etc.) into one category of ‘Higher level of qualification’. This was compared with a ‘Lower level of qualification’ category combining the three lowest education levels (except those with less than 3 years of formal school qualification i.e. ISCED level 0, which were not included) level 3 ‘upper secondary education’ with a typical entrance age of 15-16 years, level 2 ‘lower secondary education’, which represents the end of compulsory education and level 1 ‘primary education’ typically beginning at an age of 5-7 years and covering 6 years of full-time schooling. The findings are presented in table 4.6 below:

Table 4.6: Level of qualification of carer (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher level of qualification (ISCED 4-6)</td>
<td>41</td>
<td>24</td>
<td>40</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>71%</td>
<td>40%</td>
<td>69%</td>
<td>71%</td>
</tr>
<tr>
<td>Lower level of qualification (ISCED 1-3)</td>
<td>17</td>
<td>36</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>29%</td>
<td>60%</td>
<td>31%</td>
<td>29%</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Non-response</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>50</td>
</tr>
</tbody>
</table>

A variety of recruitment strategies was used to avoid recruitment biases (for details see chapter 3). However, this multiple recruitment strategy resulted in biased samples in Germany, Poland and the UK nevertheless, with about 70 per cent of respondents having higher qualifications (see table 8). Only the Italian team managed to recruit a majority of respondents (60 per cent) from lower qualification backgrounds. INRCA, the Italian research partner, is unique in combining a research institute with social care services for the elderly within the same organisation/building, which provides care-related services for older people in the region. This unique position certainly helped INRCA to establish contact to people with lower levels of qualification.
4.6. **Household structure and income**

Likewise, the case was made for taking into consideration the income situation in the household. Three theoretical scenarios were identified as particularly relevant for the present research: (1) The first scenario included a couple who both are earning an income, i.e. both being ‘workers’ in the welfare state / care regime terminology introduced in the second chapter. In the context of our study that would imply that at least one of them was combining employment with care-giving responsibilities i.e. that at least one of them was both ‘worker’ and ‘carer’. (2) The second scenario included a couple, in which one person was employed while the other was not. It would seem plausible that one of them was ‘worker’ while the other one was ‘carer’ in the welfare state / care regime terminology. However, in the context of our study the ‘worker’ would have to assume both roles – otherwise s/he wouldn’t be a working carer. The other, not working person would typically be the care recipient. (3) Finally, the third scenario refers to a single person being both ‘worker’ and ‘carer’.

As Evandrou (1995) notes, an individual’s employment – and subsequently her/his financial circumstances – may be affected by their decision to provide care and, at the same time, the individual’s employment status impacts upon their likelihood to provide care. In our samples, dual earner households dominate in Germany and in Italy (see table 4.7 below). In contrast, there is almost parity between double-earner and single earner households in Poland and in the UK. In the Polish sample, this is a reflection of the large share of single/widowed carers. Somewhat unexpectedly, the scenario with one person only working in a couple household was relatively rare, particularly in Poland, though they constituted more than a quarter of the sample in Germany and in the UK. The latter could be interpreted as remains of the ‘strong male breadwinner’ care regime identified by Lewis (1992) about 20 years ago. However, dual earner situations are more common. It is perhaps worth noticing that there is no clear dominance of any of the three scenarios in the British sample, which reminds us of Phillips’ (2007) observation of an increasing plethora of care situations in the British context.

<table>
<thead>
<tr>
<th>Scenario Description</th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Couple, both working</td>
<td>29</td>
<td>27</td>
<td>26</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td>45%</td>
<td>45%</td>
<td>35%</td>
</tr>
<tr>
<td>(2) Couple, one working</td>
<td>16</td>
<td>14</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>28%</td>
<td>22%</td>
<td>14%</td>
<td>28%</td>
</tr>
<tr>
<td>(3) Single earner</td>
<td>13</td>
<td>20</td>
<td>24</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>22%</td>
<td>33%</td>
<td>41%</td>
<td>37%</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Non-response</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>50</td>
</tr>
</tbody>
</table>

Concluding this section on socio-demographic characteristics we are in the position to report great variety of circumstances in the four country samples. The care-givers could be grouped into pairs (Germany/UK and Poland/Italy) by their age, whereas age of the care recipient varied from nearly 84 years mean age in the Italian sample to 78 years in the UK. Unsurprisingly, the vast majority of care-givers were female. Only the Italian sample included a slightly larger share of male care-givers. Married couples were the predominant family form in all four samples, though a significant minority of about a fifth reported being single –
except in the German sample, where their share was only 14 per cent. All national teams except our Italian partners reported great difficulty in recruiting participants with low education/qualification levels, which is reflected in the sample structures. Highly educated/qualified care-givers are overrepresented in the British, German and Polish samples. The dominance of married couples as family form is reflected in the combined household structure/employment status: Dual earner couples clearly dominate. What remains unclear is whether this is a result of changing family values as the care regime literature would suggest or if this is driven by the need to earn a considerable amount of money to be able to foot the bills associated with the care recipient’s condition.

Setting the socio-demographic scene in chapter 4 will be followed by slightly more detailed analysis of the care situation (chapter 5) and the work situation (chapter 6) in the four participating countries.
5. Care situation

Beside the ‘work situation’, the ‘care situation’ is the other crucial side of working carers’ circumstances that need to be described in some detail to fully appreciate their situation.

5.1. Cause of care need

As we pointed out in the UK National Report, the care situation is mainly determined by the way it came about, i.e. whether it was the result of a slowly progressing disease (dementia or frailty, for example) or was created by a sudden illness (e.g. stroke, brain tumour, amputation) (Hamblin and Hoff, 2011). Correspondingly, level and nature of care varied. While a sudden, very serious condition like a stroke, heart attack, or a tumour would unexpectedly require substantial care-giving commitment, the care-giving burden could well be reduced over time as the person in their care recovered. It is an entirely different matter in case of a slowly progressing condition. Whereas the care-giver would have the advantage of gradually adjusting to growing care-giving demands, there is no prospect (or hope) of ever returning to previous levels free of care. Demands on the carer would continue to rise until reaching a climax after which it would begin to decline as more support was received or the care recipient entered residential care. The care-giving trajectory would thus form a bell curve.

There is no single dominant condition, rather a variety of conditions that was not always reported in the same way across the four countries. Thus, the contents of table 5.1 below can only give a rough indication and is not comparable in every respect. What the table clearly shows nevertheless is that the majority of the working carers in our samples had to cope with caring for someone suffering from a combination of cognitive and physical impairment (not only the first row, also the residual category ‘other’ includes a combination of various physical and cognitive impairments). So, presence of physical impairments traditionally associated with old age like walking deficiencies or susceptibility to falls were significantly more prevalent in the Polish and the Italian samples, whereas stroke related incapacities seemed to be more prevalent in the Italian sample.

Table 5.1: Causes of care need (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia/Dementia plus additional physical/mental problems</td>
<td>29</td>
<td>24</td>
<td>11</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td>40%</td>
<td>18%</td>
<td>34%</td>
</tr>
<tr>
<td>Old Age/Falls</td>
<td>8</td>
<td>17</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>14%</td>
<td>28%</td>
<td>30%</td>
<td>13%</td>
</tr>
<tr>
<td>Apoplexy / Myocardial Infarction (stroke-Ischemia)</td>
<td>7</td>
<td>13</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>22%</td>
<td>-</td>
<td>12%</td>
</tr>
<tr>
<td>Other(^7)</td>
<td>14</td>
<td>6</td>
<td>32</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>24%</td>
<td>10%</td>
<td>52%</td>
<td>41%</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>61</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

People faced with a sudden, unexpected event resulting into the need to care for a family member found it particularly hard to cope since they had to come to terms with the new situation emotionally while organising/providing care at the same time. The intensity of care-giving changes over time – but the very beginning of care-giving was almost universally

\(^7\) Other conditions included multiple system atrophy, schizophrenia, depression, amputation, visual impairment, cirrhosis of the liver, cancer, arthritis and multiple sclerosis.
reported as the most difficult time. Moreover, this phase often involves other tasks that need to be resolved within a very short period of time, such as dissolving, renovating, and letting/selling the care recipient’s former home, or adjusting the care-givers home to the needs of the care recipient moving in with them.

5.2. Care-giving tasks

In the following, we will focus on similarities and differences across country borders in our four samples. It is not intended to repeat in detail what was reported in the four national reports already. Apart from pointing out commonalities universally applying to the situation of working carers, we will also refer to cases unique to one or two samples highlighting differences.

Paperwork

Care tasks for those looking after a person with a degenerative disease often began with administrative responsibilities, namely an older person’s growing inability to manage her/his finances. Many of the working carers in our study had power of attorney which allowed them to take control of the cared-for individuals’ finances. What sounds pretty straightforward was in reality often extremely time consuming and frustrating due to the necessity of interacting with various institutions (banks, care providers, food delivery services, benefit agencies, hospitals, etc). Communication breakdown was a frequent occurrence, resulting in additional frustration and increased coordination effort. Moreover, the sheer amount of paperwork that needed to be mastered within tight deadlines put a severe strain on working carers. Apart from financial management, filling in application forms to be submitted to local authorities, care providers, health care and long-term care insurers, social services, etc took an enormous amount of time and was associated with a great degree of frustration. Many carers experienced the attitude of and the service provided by staff working for these institutions as rather unhelpful and a source of constant frustration. This irritation was shared by most carers in all four samples. The Italian team reported that dealing with administrative matters was a care task male working carers accepted particular responsibility for (Santini et al., 2011).

Another key task was keeping track of hospital and doctors appointments and accompanying the care recipient there, which again could be very time-consuming. Although transportation was clearly an issue here, it was often even more important to act as an advocate on the care receivers’ behalf, particularly if the latter were confused or intimidated by the medical setting. The German team found that hospitals were ill-prepared for dealing with people suffering from dementia (Kohler and Döhner, 2011). A similar statement can be found in the British report where lack of stimulating the patient to improve his/her condition was claimed (Hamblin and Hoff, 2011). This is likely to be an issue elsewhere too.

Universally, carers felt that dealing with the medical services took a lot more of their time than was necessary. Many of them were looking after someone with a chronic condition whose regular prescriptions would not change over longer time periods, but had to wait in a doctor’s surgery each and every time for up to two hours for merely collecting a repeat prescription nevertheless. The following quote from Germany is a perfect illustration:

“The doctors for example shouldn't let relatives wait for hours if they're going to get a prescription. I've waited for two hours to get the prescription for the decubitus mattress and then it contained a wrong diagnosis so that I had to apply again. And had to come again the next day. And had to wait again.” (Germany, DD107)
Understandably, many carers felt that this could be handled more sensibly, for example, by allowing them to collect repeat prescriptions from the reception desk or by making use of modern communication technology like the internet, thus reducing bureaucratic effort for both carer and health care services.

**ADLs/IADLs**

Most, if not all interviewed carers in the British, German, and Polish samples fulfilled tasks associated with either ‘activities of daily living’ (ADL), which include self-care tasks like personal hygiene, bathing, dressing/undressing, feeding, or so-called ‘instrumental activities of daily living’ (IADL) i.e. activities required for living independent lives, such as meal preparation, taking medications, house work, shopping, telephone use, or financial management⁸. What we take for granted in our daily lives becomes a laborious task with a care recipient, as the following quote illustrates:

“In the morning I take him out of bed and take him to the shower. Presently I take him to the shower in the evenings, but normally I take him in the mornings, personal hygiene, give him incontinence care (…) yes, get him dressed, brushing teeth, washing hair, everything around personal hygiene, I don't need to tell all the details. Well, it takes about an hour until he, well, from the bed, shower, dressing, the whole programme one hour.” (Germany, HH3)

The situation was somewhat different in the Italian sample where assistance with ADLs/IADLs was typically provided by a migrant care worker employed by the care recipient’s family (Santini et al., 2011). Another cross-country difference was in the frequency of providing help with ADL vs. IADL. The vast majority of Polish working carers in our study were preoccupied with IADLs (Stypinska and Perek-Bialas, 2011: 30), which, although common in the German, Italian and the UK sample as well, was nowhere else as dominant as in the Polish sample.

The degree of involvement in providing assistance with ADL/IADL depended on the overall extent of care-giving. Working carers delivering care on a daily basis had a lot to do with ADLs/IADLs. It was a slightly different matter for those providing care on a weekly basis only who tended to provide less physical care (Kohler and Döhner, 2011). On the other hand, the latter had to spend more time on organising care since they typically did not live locally. The level of assistance with ADLs/IADLs changed over time. As the cared-for individual’s condition progressed, so did the care tasks associated with it:

“I think the tasks fall into different headings because obviously there’s what you might call background maintenance, which is like paying bills, checking her bank statements, paying the milkman, organising everything around that. Then there are more hands on tasks, like we do all her shopping, um I do all her washing, so take her washing away, wash it, fold it and bring it back. ... In a way it feels like we are running a one-woman care home, with one resident and we are doing all of the caring but the house is now organised like that.” (UK, No. 3).

The progression of care duties in line with a deteriorating condition increasingly became a strain on a working carer’s resources. If this resulted in the necessity of providing intimate personal care for a parent, emotional turmoil was often a consequence. The following quote is typical, and could be found in similar ways in all four samples:

---

⁸ The ADL/IADL scales are well-established instruments initially developed by Katz et al. (1970) (ADL) and Lawton and Brody (1969) (IADL), which provide an internationally accepted standard of measurement.
“You never in a million years think that you’re going to be washing your father, you know, or doing his bits, you know, that’s something you’ll never think you’ll do...” (Female respondent caring for her terminally ill father, UK, No. 14).

**Supervision**

But active interventions were not the only means of support. Supervision or overseeing an older person’s efforts of maintaining some degree of independence also turned out to be time-consuming and requiring a considerable degree of attention, which is perhaps most obvious in case of older people suffering from dementia. Thereby, concern about the care recipient hurting herself/himself as well as causing an accident by leaving a cooker turned on or the inability to turn off the washing machine were just two sides of the same coin.

“You always have, I live up there [yes], an ear and a foot downstairs [yes, yes] and permanently watch and do and have to be there around the clock, because she can’t walk any more, but she always has the feeling she can still do it and then she [yes] always tries to get up [to get up, yes]. Then she sometimes lies in front of the wheelchair or the couch. Well, that means you have to be there.” (Germany, HH26)

Given that assistance with ADLs/IADLs was usually delegated to a migrant care worker in the Italian sample it is not surprising that most Italian working carers reported that organisation of care tasks as well as supervision as described above was their main occupation in this context.

**Socialising**

Aside from practical assistance, carers also became the main source of social interaction and entertainment for the individuals they cared for. Care-givers in our samples were acutely aware that the care recipients would be on their own whilst they were at work. Therefore, they were keen to ensure the person in their care was not lonely or bored wherever possible, as one interviewee noted:

“In order to keep mum as mentally alert as possible and to get her out of the house because an inability to walk means you do get fed up with the four walls and spend more and more time sleeping, we go out. Not necessarily to do anything in particular, just push her around in the wheelchair in the park in the sunshine, or round the shops, or drive through the countryside, constantly finding things to do, going to friends houses ... We do things like cinema trips - if she forgets about the film, it doesn’t matter because you have fun while you’re there. And I’m fortunate in that most of my friends think she’s wonderful and love her to bit and don’t mind at all doing stuff with her so it’s not ‘ugh, you’ve got to bring your mum out’ – it’s not like that.” (UK, No. 1).

This socialising element of caring was particularly important when the cared-for individual was bereaved or had relocated to be nearer to the carer and had thus lost her/his social network. Another facet of the socialising theme is efforts to keep care recipients fit and active. Going for a walk thus became a physical exercise rather than a socialising activity. Likewise, as the above quote illustrates, visits by friends were seen as means of cognitive stimulation.

**Dementia**

As pointed out in section 5.1, a significant proportion of the interview participants were looking after dependents suffering from dementia, particularly in the German and the Italian samples. Many working carers only realised later in the process that they were (a) giving care rather than providing some assistance here and there and (b) that the person in their care had indeed developed some form of dementia. Typically, the carer noticed at some point that
her/his parent was struggling with some administrative tasks (mail, banking, etc.) or had developed some memory problems. The following quote is a good illustration of that process:

“I think with the early stages of dementia, with the power of hindsight you realise things have been going weird for a while but you’ve been either not aware of the signs you should be looking for or misattributing them, and I suddenly realised that my mother’s correspondence and paperwork was all over the place. She was running out of money, that was one of the first things, because she would be writing £20 cheques to charities...she would write a cheque to the donkey sanctuary and obviously that got a mailing list that was then syndicated to another...So, every time she got these begging letters she would say, ‘Oh, that’s a good cause, I’ll write a £20 cheque,’ which of course meant that she went into the red and then there were bank charges...So, the whole thing was getting into a mess and I suddenly realised there was an issue here so we took control of her finances...and really that was the beginning I suppose” (UK, No. 3).

As the condition progressed, some of the carers had to implement measures to ensure the safety of their relative, which impacted upon their wellbeing:

“So then, well, the catalyst was that she set the microwave on fire, and that meant I had to have the microwave taken away and I’d already had her fire turned off so she couldn’t put the gas on. And so, it was getting to the point where in order to make her safe, I was leaving her without any quality of life. So she had to move ...” (UK, No. 14).

Both examples were taken from the British report, but they apply equally to all samples.

5.3. Amount of care

Care situation and underlying condition determined frequency and intensity of care. Nevertheless, it is very difficult to estimate the amount of time needed for care accordingly, and much depends on what activities are considered as care-giving as opposed to other forms of assistance, which varies depending on cultural context. Moreover, care needs – and thus time needed for care-giving – vary over time (Romoren, 2003; Keck and Saraceno, 2009).

In our study it is striking to see that – with the exception of the Italian sample – a significant proportion of working carers provided care around the clock (see table 5.2 below). We defined this as meaning more than 50 hours weekly. This situation appears to be the ‘worst-case scenario’ in terms of care intensity and resulting stress and overload for the care-giver. A third of the Polish and the German sample were in that situation. In the British sample, a stunning 60 per cent of all respondents were in this circumstance, which seems to suggest some selectivity in the recruitment process.

All of these working carers shared their home with the person in their care – but it is impossible to determine if the reported ‘around the clock’ caring is the result of this living arrangement or if cohabitation was arranged to cope with a strenuous care task. In any case, it can be said that the vast majority of interviewees was heavily involved in caring, including personal care – most, if not all of them were primary care-givers.
Table 5.2: Weekly hours of care (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a week</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Several times a week</td>
<td>16</td>
<td>NA</td>
<td>26</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>28%</td>
<td></td>
<td>45%</td>
<td>16%</td>
</tr>
<tr>
<td>Everyday</td>
<td>16</td>
<td>NA</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>28%</td>
<td></td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>Nights only</td>
<td>-</td>
<td>NA</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2%</td>
</tr>
<tr>
<td>Around the clock (50+)</td>
<td>21</td>
<td>1</td>
<td>19</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>36%</td>
<td>2%</td>
<td>33%</td>
<td>60%</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Due to a misunderstanding, the Italian team measured the amount of care in hours of care, and thus differently from the other three teams. In the Italian sample, the vast majority of 44 cases or 73 per cent were faced with light to moderate levels of care commitment amounting to 10-20 hours per week. Another 3 cases were caring for 21-30 hours per week and 10 cases (17%) for 31-40 hours per week. Three working carers had to shoulder very substantial care burdens with 41-50 hours (n = 2) or in excess of 60 hours (n = 1) (Santini et al., 2011). This comparatively light care burden in the Italian sample is partly explained by the role of migrant care workers who would take care of much of the labour intensive hands-on tasks. Moreover, the substantial share of male care givers in the Italian sample may also in part explain the lesser involvement in personal care tasks and the overall smaller number of hours spent on care-giving.

The Polish sample also contained significant numbers of working carers with a relatively light care burden (45% with care commitments several times per week, but not on a daily basis). This was, however, in most cases the result of a long-distance caring relationship where the working carer and the care receiver did not live in the same locality. As a consequence, the care-giving relationship was different from those living with the care recipient and providing daily care. Given their inability of being present all the time they had to spend more time on care management and organisation.

5.4. Care duration

Another indicator of ‘care burden’ is the duration of care-giving responsibility. In our four samples care duration ranged from under a year to a maximum of 20 years (one case each in Germany and Italy). These particularly long care-giving spells are a reflection of some people having had several care-giving commitments over their life course. Thus, durations of care-giving spells were combined. The majority reported having cared for an older person for up to 9 years, with the largest shares clustered around 3-5 years care-giving experience (see table 5.3 below). However, it is remarkable to note that a third of the British and Polish samples had experienced care-giving duties in excess of 10 years, including 10 per cent with care-giving commitments exceeding 12 years. On the other hand, the German sample included a slightly more substantial proportion (14 per cent) of care-givers who only recently had found themselves caught in trying to combine employment and care-giving duties.
Table 5.3: Care duration (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>14%</td>
<td>2%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>1-2 years</td>
<td>12</td>
<td>11</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>21%</td>
<td>18%</td>
<td>9%</td>
<td>20%</td>
</tr>
<tr>
<td>3-5 years</td>
<td>21</td>
<td>30</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>36%</td>
<td>50%</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>6-9 years</td>
<td>12</td>
<td>9</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>21%</td>
<td>15%</td>
<td>26%</td>
<td>18%</td>
</tr>
<tr>
<td>10-12 years</td>
<td>4</td>
<td>6</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>7%</td>
<td>10%</td>
<td>22%</td>
<td>20%</td>
</tr>
<tr>
<td>More than 12 years</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>1%</td>
<td>5%</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Obviously, table 5.3 does not contain representative data for the four nations involved in our study – so, variation in care duration is subject to chance. Nevertheless, care duration could be an indicator for the seriousness of the condition, and availability (or rather the lack of) viable alternative care provision arrangements. Demographic factors don’t seem to have played a major part in this.

5.5. Number of care recipients

Another factor determining the care situation is the number of care recipients a working carer is looking after. It is hardly unexpected that most people who combine paid work with caregiving look after one person only. More surprising given the tedious nature of this task is that as many as more than a third in the UK sample and about a fifth in the Polish and German samples were caring for more than one person whilst in employment (see table 5.4 below). In contrast, the Italian sample only included five cases with care-giving responsibility for two care recipients, and none for more than two people.

Table 5.4: Number of people being cared for (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 person</td>
<td>45</td>
<td>55</td>
<td>47</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>78%</td>
<td>92%</td>
<td>81%</td>
<td>64%</td>
</tr>
<tr>
<td>2 people</td>
<td>10</td>
<td>5</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>17%</td>
<td>8%</td>
<td>17%</td>
<td>22%</td>
</tr>
<tr>
<td>3 people</td>
<td>3</td>
<td>-</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>-</td>
<td>2%</td>
<td>12%</td>
</tr>
<tr>
<td>4 people</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Particularly striking is the British sample of which six people had care-giving responsibilities for three people (typically mother and mother-in-law in combination with another relative (father, father-in-law, husband, aunt, great aunt); one was even caring for four older individuals (her–his mother, father, mother-in-law and father-in-law). Hamblin and Hoff
(2011) provide the following explanation for this: once an individual had started to provide care for one person, s/he became the ‘designated carer’ within the family network and would subsequently be assigned care-giving responsibility for more than one person at a time, or several people in succession.

A constellation that does not show here but is particularly challenging occurs when both partners in a couple had care-giving responsibilities. Although in theory this could result in a situation where both spouses had only very limited capacity to support each, sometimes the opposite was the case due to a much better mutual understanding of the situation the other partner is in, as the following example illustrates.

“I think my husband and I are the greatest of friends, we’re real allies and we see this as being in it together. I supported him when his mum was very elderly and then she developed a terminal physical disability, we didn’t actually know what it was at the time, but went to a nursing home and died very quickly. We had many years of me supporting him, to support her” (UK, No. 12).

This example may seem extreme, but it was not particularly rare.

5.6. Relationship to care recipient

The previous sections already gave some indication of the complexity of relationships involved in care-giving tasks for some working carers. In this section we will have a closer look at the various relationships involved. Table 5.5 below gives an overview of the various people working carers cared for in our study.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>absolute numbers</td>
<td>percentages</td>
<td>absolute numbers</td>
<td>percentages</td>
</tr>
<tr>
<td>Mother</td>
<td>35</td>
<td>47%</td>
<td>43</td>
<td>67%</td>
</tr>
<tr>
<td>Father</td>
<td>12</td>
<td>16%</td>
<td>17</td>
<td>26%</td>
</tr>
<tr>
<td>Mother-in-law</td>
<td>6</td>
<td>7%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Father-in-law</td>
<td>4</td>
<td>5%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Spouse</td>
<td>13</td>
<td>18%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Brothers &amp; sisters</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Grandparents</td>
<td>2</td>
<td>3%</td>
<td>3</td>
<td>5%</td>
</tr>
<tr>
<td>Other relatives</td>
<td>1</td>
<td>2%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Friend</td>
<td>1</td>
<td>2%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100%</td>
<td>64</td>
<td>100%</td>
</tr>
</tbody>
</table>

As we have seen in the previous section, some carers had care-giving responsibility for more than one person, resulting in more care-giving relationships than respondents (see row of total numbers in table 5.5 above). Multiple care-giving relationships were most common in the British sample where 50 interviewees looked after as many as 76 care recipients, followed by
the German sample with 74 and the Polish sample with 70 care-giving relationships. Only the Italian sample comprised of fewer care-giving relationships (n = 64) due to only five cases with more than one person in their care (see table 5.4).

Mothers were the persons most frequently cared for, which due to the overrepresentation of female care-givers (see table 4.3) in the four samples resulted in a dominance of mother-daughter-care-giving relationships in all four samples, which is in line with expectations based on the international research literature (Bernard and Phillips, 2007; Lewis and Meredith, 1988; Walker et al., 1992). It is perhaps worth noticing that this predominance was particularly pronounced in the Italian (67 per cent of all care-giving relationships) and in the Polish (58 per cent) samples. In contrast, a substantial minority of working carers in the British and German samples were looking after spouses – compared with no such case in both the Italian and the Polish samples. Other more frequently mentioned care recipients included the working carers’ fathers, particularly in the Italian sample.

Overall, it is striking to see that intergenerational care-giving relationships clearly dominated. Spousal care was the exception in the two samples where it occurred (the British and German samples) and non-existent in the other two. Care-giving for friends were very rare exceptions only reported in the Polish and in the German samples.

5.7. Reasons for taking over care

Motivations for taking over a care-giving role were as manifold as the various facets of care-giving itself. Moreover, it is hardly possible to identify a single motivation – usually it was a combination of various reasons. If we present reasons and motivations in the following separately nevertheless, we do so for the sake of clarity.

It may sound old-fashioned or romantic, but love was almost always at the forefront of a care-giving decision:

“Because it is Mom. Not just for a sense of duty but for love as it is mother.”
(Italy, IT-4)

Of course, many relationships also included some element of ambivalence, which, given the hardship of the care-giving situation, especially for a working carer, is hardly surprising. A sense of family obligation or family solidarity as well as obeying to the reciprocity norm was most frequently cited as crucial motivations for providing care. Statements like the following were common:

“My reasons for being a carer is because that’s my dad, you know, and that’s what I will do for my dad and that’s what my mum, that’s how we are as a family, you know, if it was my mum I would do exactly the same, if it was anybody else, I would probably think about it because it takes an awful lot of your time, your energy” (UK, No. 14).

This did not only apply to intergenerational kin-based relationships like that with one’s parents – this sentiment also extended to parents-in-law or partners/spouses. In other cases provision of care was seen as a natural progression of ‘looking after’ a family member. Many were unaware as to when looking after someone turned into care-giving.

Another set of reasons revolved around the decision as to why the working carer had taken on that role as opposed to other family members, namely brothers and sisters. One line of argument made them ‘the most logical choice’ due to geographical proximity:
“Most of my family works abroad, i.e. in Germany, so obviously they are in Poland only three or four times a year. That’s why everything is on my shoulders, the grandson’s shoulders.” (Poland, PL 52)

Still common was the assumption that someone would take over the care-giving role because of her gender (female). Another common pattern was to assume that someone would continue a previous care-giving role. In some cases the working carer found herself/himself being ‘the only choice’ as an only child. An interviewee who had cared successively for his parents and parents-in-law noted:

“In some ways it’s a great thing being an only child because you get all the attention ... but it does mean that when this situation arises and you have frail parents you are the only one bearing the load” (UK, No. 13).

A major factor in deciding to become a family carer was also lack of trust in public or commercial care services and the (lack of) quality of care they provided, some of it based on previous bad experience, as the following quote illustrates:

“They wanted to go into a care home, however, that would have meant probably that they went up there, it would have taken all their money, I was not keen for that because I had seen my mother-in-law die in a very poor nursing home and I wanted to try and make the best quality of life for them as possible for the last, however long they’ve got left. So, that’s why we did it” (UK, No. 12).

This quote also gives a hint at economic motivations like the cost of public care that sometimes influences care-giving decisions. Some carers, however, simply felt that they would know better what would be best for their loved ones than a care worker employed by an agency. And in some instances carers referred to the cost of paying for care as so prohibitively high that they could not afford to stop paid work.

Although these examples were taken from different samples, they were not representing any particular country. It is probably fair to say that the facets discussed in this section applied to all four countries universally. There were no country-specific motivations for care-giving.
6. Work situation

We discussed the care-giving situation in much detail in chapter 5. Obviously, the other side of the coin for a working carer is her/his work situation. As the research literature on reconciling employment and care for an older person has repeatedly shown, workplace culture, in particular sympathetic line managers and work colleagues, are crucial for a successful combination of paid work and care-giving responsibilities (see, for example, Bernard and Phillips, 2007; Yeandle et al, 2002, 2003).

6.1. Employment status

A good starting point is to consider the employment status of a working carer. Employment status can significantly influence to what extent combining employment and care-giving becomes a stressful experience. For example, the self-employed or students have much more flexible working hours than workers on a conveyer belt or in a supermarket.

Most working carers in our samples were in ordinary blue-collar or white-collar jobs: 84 per cent in the British, 74 per cent in the Polish and 67 per cent in the German samples (see table 6.1 below). The only exception to this observation was the Italian sample where the majority (55 per cent) was in permanent public sector white-collar jobs as civil servants. This percentage is extraordinarily high and indicates a highly selective Italian sample, which we need to keep in mind when analysing the Italian findings. This judgement is supported by the total lack of self-employed in the Italian sample, contradicting official data on the structure of the Italian labour market. There was some representation of self-employment in the other countries though. In the German and Polish samples a fifth of the working carers reported being self-employed.

Table 6.1: Employment status (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil servant</td>
<td>4</td>
<td>33</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>7%</td>
<td>55%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>39</td>
<td>25</td>
<td>43</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>67%</td>
<td>42%</td>
<td>74%</td>
<td>84%</td>
</tr>
<tr>
<td>Self-employed</td>
<td>11</td>
<td>-</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>19%</td>
<td></td>
<td>21%</td>
<td>10%</td>
</tr>
<tr>
<td>Student</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>2%</td>
<td></td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Unemployed/retired</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
6.2. Employment sector

In a next step we will compare in which sectors of the economy the working carers in our samples were employed (see table 6.2 below). As the work by Yeandle et al. (2002, 2003) has shown, flexible working hours to combine work and care-giving duties is much more likely to be granted in public sector organisations than in the private sector. With the exception of the German sample, public sector workers were overrepresented in our study. This was particularly striking in the Italian sample where they represented a stunning 70 per cent of the sample (!). But also in the British and Polish samples nearly half of the working carers came from the public sector. This reflects a recruitment bias resulting from the selection of the main fieldwork locations in Poland and the UK. Most of the UK interviews were conducted in Oxford/Oxfordshire, with its two universities (University of Oxford, Oxford Brookes University) being the biggest employers in the area. Likewise, the main fieldwork site in Poland, Cracow, is a city with several universities and large public administrations.

Table 6.2: Employment by economic sector (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private sector</td>
<td>21</td>
<td>16</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>36.5%</td>
<td>27%</td>
<td>31%</td>
<td>26%</td>
</tr>
<tr>
<td>Public sector</td>
<td>17</td>
<td>42</td>
<td>25</td>
<td>24</td>
</tr>
<tr>
<td>(incl. education)</td>
<td>29.5%</td>
<td>70%</td>
<td>43%</td>
<td>48%</td>
</tr>
<tr>
<td>Voluntary sector</td>
<td>6</td>
<td>-</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>(NGOs, churches)</td>
<td>10%</td>
<td></td>
<td>2%</td>
<td>10%</td>
</tr>
<tr>
<td>Self-employed</td>
<td>11</td>
<td>-</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>19%</td>
<td></td>
<td>21%</td>
<td>10%</td>
</tr>
<tr>
<td>Not employed</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Although the same could be said about Hamburg and Dresden, the main fieldwork locations in the German study, the German team managed to recruit a larger share from the private sector, amounting to more than a third, followed by the Polish sample with nearly a third and the Italian and British samples with about a quarter of working carers in the private sector. Additionally, the Polish and German samples also included a fifth of workers in self-employment.

6.3. Occupational status

Next, we will have a slightly more differentiated look by comparing occupational statuses in the four samples. Thereby, we used the International Standard Classification of Occupations (ISCO) advocated by the International Labour Organisation (ILO), more specifically ISCO-88. The advantage of the ISCO-88 scale is that it groups together ‘aggregate groups mainly on the basis of the similarity of skills required to fulfil the tasks and duties of the jobs’ (ILO, 2011a).

Table 6.3 below gives an overview of the occupations represented in the four country samples, which turns out to be a much diversified picture.
Table 6.3: Occupational status according to ISCO-88 classification (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislators, senior officials and managers</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>6.5%</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Professionals</td>
<td>22</td>
<td>15</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>38%</td>
<td>25%</td>
<td>48%</td>
<td>44%</td>
</tr>
<tr>
<td>Technicians and associate professionals</td>
<td>11</td>
<td>7</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>19%</td>
<td>12%</td>
<td>10%</td>
<td>22%</td>
</tr>
<tr>
<td>Clerks</td>
<td>11</td>
<td>28</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>19%</td>
<td>47%</td>
<td>9%</td>
<td>16%</td>
</tr>
<tr>
<td>Service workers and shop and market sales workers</td>
<td>7</td>
<td>4</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>6.5%</td>
<td>17%</td>
<td>-</td>
</tr>
<tr>
<td>Skilled agricultural and fishery workers</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>-</td>
<td>-</td>
<td>2%</td>
</tr>
<tr>
<td>Craft and related trades workers</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Plant and machine operators and assemblers</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>2%</td>
<td>-</td>
</tr>
<tr>
<td>Elementary occupations</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>2%</td>
<td>-</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>2%</td>
<td>-</td>
<td>-</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>60</td>
<td>58</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

There are three occupational groups with a more substantial representation across all four samples: ‘professionals’, ‘technicians’ and ‘clerks’. ‘Professionals’ are defined as “…occupations whose main tasks require a high level of professional knowledge and experience in the fields of physical and life sciences, or social sciences and humanities. The main tasks consist of increasing the existing stock of knowledge, applying scientific and artistic concepts and theories to the solution of problems, and teaching about the foregoing in a systematic manner. Most occupations in this major group require skills at the fourth ISCO skill level.” (ILO, 2011b) In other words, anyone with a higher education degree falls into this category, whether s/he is a doctor, solicitor, manager, or academic staff at university. Nearly half of the Polish and the British samples were professionals, closely followed by the German sample (38 per cent). Only in the Italian sample their share was slightly lower at 25 per cent.

The Italian sample, however, is leading the way in regard to another main occupational group in our study – clerks. Nearly half of the Italian sample were characterised as ‘clerks’ i.e. “…occupations whose main tasks require the knowledge and experience necessary to organise, store, compute and retrieve information. The main tasks consist of performing secretarial duties, operating word processors and other office machines, recording and computing numerical data, and performing a number of customer-oriented clerical duties, mostly in connection with mail services, money-handling operations and appointments. Most occupations in this major group require skills at the second ISCO skill level.” (ILO, 2011b) White-collar office jobs that do not require a higher education degree fall into this category. A fifth of the German and a sixth of the British sample had such jobs, compared with less than one in ten in the Polish sample.

The third major occupational group represented in all four samples were ‘technicians’. Technicians “…include occupations whose main tasks require technical knowledge and
experience in one or more fields of physical and life sciences, or social sciences and humanities. The main tasks consist of carrying out technical work connected with the application of concepts and operational methods in the above-mentioned fields, and in teaching at certain educational levels. Most occupations in this major group require skills at the third ISCO skill level.” (ILO, 2011b) In a way, this group is similar to that of professionals. The main differences are the slightly lower qualification level required as well as the focus on technology related work. Technicians were well represented in the British and German samples where they accounted for a fifth of interviewees. In the Italian and Polish samples their share was much lower at 10-12 per cent.

Additionally, the Polish and German samples had some representation of ‘service workers and market sale workers’ i.e. “...occupations whose main tasks require the knowledge and experience necessary to provide personal and protective services, and to sell goods in shops or at markets. The main tasks consist of providing services related to travel, housekeeping, catering, personal care, protection of individuals and property, and to maintaining law and order, or selling goods in shops or at markets. Most occupations in this major group require skills at the second ISCO skill level.” (ILO, 2011b) About 17 per cent of the Polish and 12 per cent of the German working carers fell into this category. Interestingly, not a single person in the British sample was from this category.

6.4. Working hours of carers

Working hours can be an indicator of a working carer’s ability to cope with combining paid work and care-giving. If care-giving becomes too labour and time intensive, reducing working hours becomes almost inevitable. A sampling criterion was regular employment for a minimum of 10 hours per week. However, there was at least one case per country that did not quite fit into this categorisation: some people were working less than 10 hours per week, but on a regular basis, for example.

Listing the hours of work may look like a straightforward task – however, translating them into popular categories like full-time or part-time employment turned out to be a lot more complicated than initially thought due to different legal definitions of what constitutes part-time or full-time work. A Polish worker has to work for at least 40 hours per week to be seen as working full-time. In Germany, the number of hours to be worked for full-time employment varies subject to specific regional regulations between 38.5 and 40 hours. A British worker needs to work for a minimum of 35 hours to qualify for full-time work. And in Italy any regular employment exceeding 30 hours per week would be seen as full-time employment.

Identifying what constitutes part-time work was even more opaque. Consulting official government sources did not necessarily help: The official website of the British government ‘Directgov’, for example, suggests the following definition of part-time work: “A part-time worker is someone who works fewer hours than a full-time worker. There is no specific number of hours that makes someone full or part-time, but a full-time worker will usually work 35 hours or more a week.” (Directgov, 2011) The German government website was not more specific either (see BMAS, 2011). Due to the above described variance in setting a lower threshold for full-time employment, the upper threshold of part-time employment varied accordingly across national borders.

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9 At this point we gave up and did not attempt to consult the appropriate Italian and Polish government resources.
In an attempt to make comparable what is, strictly speaking, not comparable, we set the lower threshold of full-time employment at the lowest level in any of the four countries, i.e. at more than 30 hours as in Italy. Everything else qualified as part-time employment. This was also seen as conceptually justified in other countries. As the German team commented, 30 hours per week commonly translate into four days of full-time work, leaving the fifth working day free for sorting out administrative matters, seeing the doctor, etc., which would have made all the difference to some working carers. The subsequent table 6.4 summarises our best efforts to resolve this conundrum.

Table 6.4: Working hours of carers (absolute numbers, percentages)

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Italy</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 10 hours regular employment</td>
<td>2 3%</td>
<td>1 1%</td>
<td>-</td>
<td>1 2%</td>
</tr>
<tr>
<td>Part-time, up to 20 hours</td>
<td>2 3%</td>
<td>-</td>
<td>8 15%</td>
<td>6 12%</td>
</tr>
<tr>
<td>Part-time, up to 30 hours</td>
<td>15 26%</td>
<td>12 20%</td>
<td>9 16%</td>
<td>8 16%</td>
</tr>
<tr>
<td>Full-time (more than 30 hours)</td>
<td>38 66%</td>
<td>47 78%</td>
<td>38 66%</td>
<td>25 50%</td>
</tr>
<tr>
<td>Other(^\text{11})</td>
<td>1 2%</td>
<td>-</td>
<td>2 3%</td>
<td>10 20%</td>
</tr>
<tr>
<td>Total</td>
<td>58 100%</td>
<td>60 100%</td>
<td>58 100%</td>
<td>50 100%</td>
</tr>
</tbody>
</table>

Due to the classification problems outlined above, table 6.4 may not be an exact reflection of the reality. However, it is certainly sufficient to indicate some main trends across the four samples. If someone had expected to see predominance of part-time employment to reconcile care-giving and work commitments, s/he would be disappointed. The vast majority was working full-time – more than three quarters in the Italian, and two thirds each in the German and Polish samples. Only in the UK sample their share was ‘only’ half. Given the huge proportion of civil servants with their advantageous and flexible working conditions in the Italian sample, this extraordinarily high share is perhaps less surprising.

If working carers in our study were working part-time at all, they were working substantial hours and were most likely to be found in the 21-30 hours per week category. Most Polish working carers in the lower part-time category worked exactly 20 hours per week. Thus, the only sample with a considerable share of working carers working less than 20 hours per week could be found in the British sample. As many as 10 cases with unconventional work arrangements (‘other’) added to the impression of the British sample as being somewhat different from the rest in this respect.

\(^{10}\) More than 28 hours per week.

\(^{11}\) Including one on leave of absence, two recently unemployed, one retired, five self-employed engaged in consultancy work (and therefore without fixed hours), one who worked in term time only and one currently writing a book.
7. Typical conflict situations for working carers

In this chapter, we will discuss in detail typical conflict situations faced by working carers as well as factors that made their lives more stressful. Thereby, the focus is on comparing the situation in the four samples in Germany, Italy, Poland and the UK. Most conflict situations and stressors applied to working carers universally, regardless of country of residence. However, there were also some subtle differences, which we will point out in the following discussion.

7.1. Lack of time

Lack of time – for oneself, to take a break, to relax – was mentioned universally by all interviewed working carers as a main deficiency of their lives. Time pressure was the single factor that caused most stress for them.

“And the time...I feel as though the time’s ticking every day. It’s like a clock that beats in the morning and you think, right I’ve got to get this done by the night.”

(Self-employed female, UK, No. 24).

The hours of care were identified as the main culprit. The constant demand on their time – all day, every day, every day of the week, every week, every month – without the slightest shimmer of hope that they may be able to afford a little break for themselves, without being alert all the time, that’s what really made life difficult for them. Whereas even the busiest worker without care-giving commitments would have time to herself/himself at least once a week, over the weekend, a working carer could never afford to ‘switch off’. We used the following quote before (in section 5.2 ‘care tasks’), but we feel it perfectly illustrates the permanent restlessness many working carers experienced.

“You always have, I live up there [yes], an ear and a foot downstairs [yes, yes] and permanently watch and do and have to be there around the clock, because she can’t walk any more, but she always has the feeling she can still do it and then she [yes] always tries to get up [to get up, yes]. Then she sometimes lies in front of the wheelchair or the couch. Well, that means you have to be there.”

(Germany, HH26)

Another issue that caused them stress was their inability to unwind after work before taking over their care-giving responsibilities. All too often they had to dash off from work straight to care, which caused additional conflicts. Even in the rare instances when they had a bit of a break, there was always the risk of being interrupted, actually quite often by the care recipient, as the following quote illustrates:

“She will ring me up two or three times an evening just to tell me she’s really lost and can’t remember quite why she rang me up. She’ll ring me up and say, ‘Should I be doing something?’ and then half an hour later she’ll ring me up and have forgotten that she rang me the first time to be saying ‘Should I be doing anything?’”

(UK, No. 3).

Restricted opening hours of public authorities, doctors’ surgeries, etc. added to the time pressure. Thus, working carers would have to take flexi-time or annual leave to be able to visit these institutions during normal opening hours. Many single days of annual leave taken for this purpose quickly added up and were taking away time urgently needed ‘to recharge their batteries’. Flexi-time offers an alternative to taking annual leave. However, knowing that one would have to make these hours up at some point would add to the overall time pressure, resulting in a vicious cycle of time pressure.
But problems with time were not restricted to time pressure. The complexities of combining work and care also required meticulous time planning. Nothing could be left to chance, especially when visits to the doctor or other business had to be arranged. Some may in principle have had the chance to get a break if somebody was looking after the person in their care during their absence. However, preparing this would have taken a considerable amount of their time and energy, so they never came round to do it. Working carers in all samples stressed that they missed most some spontaneity, which was effectively impossible, as the following quote illustrates:

“*What's difficult for me, or let's say, I'd say becomes more and more difficult ... inflexibility. That you can't say spontaneously 'Look here, the weather is really great, I quickly want to run up a hill', see, something like that. You can't do this anymore, because you haven't planned it beforehand and nobody else is there.”* (Germany, HH21)

We could not identify any country specific time issues. All issues mentioned above were an adequate description of a burdensome situation experienced by most of them in all four countries.

### 7.2. Work-related conflicts

**Daily work**

The most immediate negative effect care-giving had on their work performance was lack of concentration or fatigue due to restless nights, for example in case of those caring for a person prone to wander or suffering from disturbed sleep. Overall lack of rest and relaxation may contribute to this predicament as well.

“*If you only get three hours sleep you're not fit early in the morning or yes, if being afraid has an influence on concentration, quite certainly. With this somehow my routine for years was a help, with which I had some steady, well, no insecurities turned up there.”* (Germany, HH23)

“*It's quite stressful being in this situation, and when you're stressed, that's when you do start to make the mistakes at work. Without really realising it, you'll send an email and send it to the wrong person and stuff like that, because you're trying to be quick or you're slightly distracted”* (UK, No. 37).

Care-related emergencies had a big impact on work. People working in jobs allowing for some degree of flexibility were in a better position that those who could not easily leave their workplace. While some had become self-employed to be better able to reconcile their work and care-giving commitments that decision had the unintended effect that emergencies put them at an even greater risk if they coincided with a deadline or an appointment. They were very aware that this could have an immediate effect on their income and a long-term effect on their reputation, and thus on their income, too.

**Relationship with line managers and work colleagues**

What working carers were more concerned about immediately was how to secure their line managers (continued) good-will and support. We know from Yeandle et al.'s (2003) pioneering study of the crucial importance of a sympathetic line manager. This was reflected in our study too. Many reported having understanding line managers who sympathised with their difficult situation at home.

What was nevertheless important, however, is that the working carers had developed a relationship of trust with their line managers over time. This implied that they were making
up for lost working hours as soon as they possibly could, as well as working over-time when they could afford to do so, or accepting responsibility for extra work. Therefore, working carers felt very vulnerable if there was a change of line managers. In big companies, this could happen relatively frequently, thus increasing the likelihood of being faced with an unsympathetic line manager.

“I’ve had five different Managers over the past two and a half years and different Managers have adopted different tacts to the situation. Some have been very sympathetic and very supportive, and others think you should leave work, which isn’t an option” (Female interviewee caring for her husband with early on-set dementia and her father with terminal lymphoma, UK, No. 35).

A cultural norm of perceiving care-giving responsibility as an entirely private matter, which is not supposed to affect work performance in the first place, was unhelpful in these circumstances. Many working carers had internalised this norm so that they were unwilling to give an explanation for mistakes they had made at work when challenged by their line manager or to ask for help. This attitude was particularly common in the Italian and in the Polish samples where working cares felt unable even to admit that it may possibly affect their work. It was also mentioned by working carers in Germany:

“And then my line manager asked ‘Why have you been making so many mistakes recently?’ I say ‘Well, I can’t tell really’. You can’t say ‘I’ve got more things to do at home than usual. That’s why I’m making mistakes.’ That’s actually not the reason. Mistakes simply happen. You can’t find a real reason for it. I can’t say ‘It doesn’t happen if I go to bed half an hour earlier. Or ‘It doesn’t happen if I...’” (Germany, DD104)

Even in big companies or public sector organisations where formal work and care reconciliation policies were in place many carers felt apprehensive about asking for leave for this purpose. This was particularly the case when they were working in an unsympathetic workplace culture i.e. surrounded by work colleagues who had no sympathy for their situation. Judging by the response in our interviews (see Kohler and Döhner, 2011) problems with work colleagues appear to be more common in Germany, which is however a finding we have to treat with some caution since we did not collect a representative sample. Several German respondents reported negative attitudes by work colleagues as well as by line managers who expressed a view that people with care-giving responsibilities ought to stay at home and stop working. This may be an indication of the pervasiveness of a traditional care regime advocating a strict separation of work and care spheres (see chapter 2).

Even neutral, but unhelpful comments like the following could raise the pressure experienced by working carers considerably:

“So there is always pressure, and the colleagues, they don’t understand what you are going through. If I go in late after getting my mum on the bus, and then walk in, and because I work in Central London it takes me an hour and a half to get there, so by the time you get into work you hear certain comments made at me like ‘Are you like are you on half day, or something?’ It doesn’t help” (UK, No. 43).

However, the majority of carers in our samples reported to be working in supportive environments.
Career progression

Obviously, combining work and care did not exactly help someone’s chances of career progression, though this was not a major issue for the working carers in our study. Some commented on promotion being out of their reach, but at the same time felt that their circumstances may not have allowed for a position with more responsibility (and work) anyway. It was interesting to note that British carers working with one of the publicly recognised ‘best practice employers’ in the UK were reluctant even to consider a move to another company (Hamblin and Hoff, 2011).

If missed career opportunities were mentioned, it was in a retrospective manner – not referring to the current situation. It was a slightly different matter for those who had been caring for someone for a very long time, in some instances since their early adulthood.

“I didn’t do well at school because my mother was in complete crisis and I got very patchy A’ Level results and I did have a university place but frankly it wasn’t possible to leave my mother alone during a day, let alone a term, so that kind of went out the window... if I had been a graduate - it’s two things - if I’d been a graduate and I hadn’t had the kind of difficult experiences I would have done a lot of different things and I would have progressed further because of my capabilities but I haven’t...” (UK, No. 42).

In summary, the work related issues discussed in this section applied to working carers in all four national samples. It was, however, striking to see that difficulties with line managers and in the workplace overall appeared to be more common in the German sample, which was partly caused by the inability of German workers to speak openly about care-related ‘family problems’, a sentiment shared by their Italian and Polish counterparts. Apparently, the British respondents reported negative incidents at work far less frequently.

7.3. Financial conflicts

British interviewees were however more explicit about the detrimental effect combining work and care had on their finances. These were mainly reflecting the loss in income caused by the onset of care-giving.

“I was earning about £30,000 [a year] full-time and I now earn £10 an hour” (UK, No. 19).

Additionally, costs associated with care became a drain on their finances. If the person in their care either was not eligible for state-provided adjustments or was not willing to apply for means-tested benefits, the costs would have to be borne by the working carer (Hamblin and Hoff, 2011). Overall, the response by the British interviewees reflected the lack of support provided by the British welfare state.

“There is a financial cost, and there is very little assistance from the state. If you are reasonably well off as we are, but nevertheless, we are not that rich that we can afford to spend a lot of money on carers, and especially there is always that sort of fear that longer term it will all come back, and we will be back where we were in 2008 – wheelchairs and stuff. That is a sort of constant fear and not only the physiological impact of that, but the financial impact of it” (UK, No. 28).

Particularly challenging was finding the right balance between additional paid work and the cost associated with it. In economic terms, it was not always easy to find out if the marginal utility of an extra hour of work would exceed the cost for organising care in the meantime.
German working carers were better off financially thanks to the financial support provided by the Long-Term Care Insurance (LTCI) (Pflegeversicherung), which is not means-tested. Every care recipient in need of care for more than 14 hours per week is eligible. It has to be emphasised, however, that German LTCI was never meant to cover all care related expenses – ultimate responsibility for care-giving would remain with the family, in line with the subsidiarity principle on which the German welfare state rests (for more details on the underlying policy rationale see our discussion on welfare state and care regimes in chapter 2).

In the German sample, slightly more than half (n = 32) reported financial difficulties as a result of care-giving, whereas the other 26 cases claimed not to have experienced financial hardship as a consequence of care-giving (Kohler and Döhner, 2011). Interestingly enough, the better off working carers explained this with working in well-paid jobs rather than the benefits of LTCI.

“Let me put it this way, luckily we’re quite well off financially. I’d be lying if said it was not the case. And I also must say, with the savings we have, that helps. Well, let me put it this way, if you don’t have a job, perhaps, and then you have such a nursing case and at home and there’s not money, well, I think it would be worse then.” (Germany, DD101)

Nevertheless, it still seems to be a different story from what we have seen in the quote from UK interviewee no. 28 on the previous page who also claims to be earning a decent salary and is struggling financially nevertheless. What is noteworthy too is the implicit claim that combining work and care actually puts them in a better care-giving position since it enables them to purchase care services and products they could not afford otherwise.

However, financial hardship was no stranger to the other half of German interviewees. Financial difficulties were common among those on poor incomes, those who had to reduce working hours in order to cope with care-giving and those whose partner had passed away, thus effectively halving (or worse) their household income.

“Very very tight, because my savings are gone, his savings are gone ... they're gone now, can't help it.” (Germany, HH31)

In the Italian sample, the key financial issue for working carers was the question who was paying the migrant care worker – the care recipient or the working carer. If the care recipient’s pension to cover the cost and/or the care allowance provided by the Italian welfare state were insufficient, the working carer would have to help out or foot the bill altogether, which caused financial hardship to some of them.

“My mother is a housewife, so she benefits from my father’s reduced pension, but she gets the state care allowance up to this amount, I'll add my 200 Euros per month and I can bear the costs”. (Italy, IT-55)

Generally, the conversion of a person’s home into a barrier-free home or any other adaptation of their homes could easily turn into a cause of financial hardship. In many such cases, eventual total costs turned out to be much higher than it was calculated initially. This applied universally to all four countries. Another financial issue that applied to all four countries was loss of income due to the necessity of taking unpaid leave to sort out care-related issues.

The varying degree of financial support or care service provision by the four welfare states impacted upon the financial situation of working carers in the four countries studied. Thus, similar financial issues resulted in different outcomes for working carers in Germany, Italy, Poland, and the UK.
7.4. Stress, health and well-being

It is hardly surprising that many participants in our study complained about health problems as a consequence of their attempts to combine two structurally opposing worlds – work and care. Moreover, being constantly overburdened without the opportunity of taking enough breaks inevitably takes its toll at some point. Thereby, we have to differentiate physical and mental health problems. What is being said in this section applies to working carers in all four countries. There was no significant difference.

Among the physical disorders frequently reported were digestive disorders, weight loss or gain in weight, or psychosomatic disorders. Sleep disorders like disrupted sleep or fatigue were very common among working carers in our study, which seriously affected their overall wellbeing.

“Sometimes I get very depressed, very upset. I’m not suffering from depression, been through all the checks, but I can get very, very, very miserable. There’s some nights when you can’t get through to them, you’ve have a bit of an argument because they can’t understand where you’re coming from and you’ve answered the same question 400 times and you feel you’re something like a slave or an encyclopaedia and it’s all getting on top of you. And you just go to bed and you cry. You cry for them, and you cry for you.” (UK, No. 1).

The above quote also shows how close a reduced wellbeing can get to more serious mental health problems. The most common mental disorder working carers suffered from were depressive symptoms. Some used antidepressants or psychotherapy to overcome these problems.

Realising that one was no longer able to cope, set into motion another vicious cycle. What would happen to the person in their care if the working carer was getting ill? Not knowing an answer to this question made them continue regardless of the consequences, often until a physical or nervous breakdown prevented them from carrying on any further.

Seeing no escape, the overall hopelessness of their situation while still feeling highly committed to the cause of care-giving or the person in their care, desperately longing for help that was not coming, was reflected in a number of quotes like the following:

“What happened was that I gradually became more and more stressed out trying to hold all these different things together and in June I got a nasty virus followed by pneumonia so I was pretty much...and I’m usually a really, really happy person, you know, I’ve always gone, ‘I don’t do ill,’ and in June I was flattened for the first time in my life ever, I was bed-ridden for a month” (UK, No. 8).

Eventually, many carers had to face up to the reality that they could no longer cope – and had to find a solution, even if that meant ‘betraying’ previous promises never to allow the person in their care to go into institutional care ...

“All these quotes were taken from the UK National Report – but similar quotations could be found in the other three national reports too.
7.5. Social and family life

Health is of course closely related to wellbeing. Another crucial aspect of the latter is one’s social and family life. The working carers in our study reported unanimously significant repercussions of combining work and care-giving on both their family and their social life. We talked at some length about lack of time at the beginning of this chapter. This was having an impact on working carers’ social and family life too.

Social life

Many working carers stated that they had no longer a life of their own. In the rare instances working carers could take a break, they were too tired to go out with friends and socialise. Another problem was their lack of mobility. Unless they managed to organise a replacement carer for the time period they were away from home – which often turned out to be a source of additional stress and difficulties (Stypinska and Perek-Bialas, 2011), they felt they could not go out. This was particularly common among carers of people suffering from dementia or Alzheimer’s disease.

“The biggest impact is that basically I’m tied to the house; I am tied to the house until my husband goes to bed in the evening. I can go out then, but that tends to be 9pm at night and by the time you’ve done a full day’s work and then a couple of hours of caring, you’re not really in the mood for doing much socialising” (UK, No. 6).

Unless working carers had friends or family members supporting them, they hardly had any social life at all. Leisure time, let alone time spent on hobbies or individual interests simply wasn’t there.

“Over time I’ve kind of fallen out of contact with any friends I had. I don’t have a circle of friends who I can sort of call upon or have a girly night out with or anything... At the beginning of the process you think, ‘Oh, I must devote myself to [cared-for],’ and then you suddenly realise two years down the line, ‘Oh, I’ve found myself here and I haven’t got any friends.’ And that’s a bit of a nasty place to be” (UK, No. 37).

Others, however, managed the transition from a previous social life outside their home to a home-based social life. Moreover, care-related activities like the interaction with people at day-care centres opened up avenues for new friendships (Hamblin and Hoff, 2011). However, overall support from friends was patchy. Only in the Italian report there was a hint of slightly more frequent support with care-giving provided by friends (see Santini et al., 2011). But overall, the Italian carers were faced with the same predicament as their counterparts in the other three countries.

Romantic life

Another issue some carers mentioned was the impact caring had on their romantic life. This was partly another facet of the ‘lack of time and energy’ problematic. Some carers also felt that their life was difficult enough as, so they felt reluctant to add another set of complexity, as one of the British carers put it. The following quotation illustrates a common sentiment felt by many carers, with some regrets:

“The romantic side of life doesn’t exist, I couldn’t invite someone into my life. It wouldn’t be fair” (UK, No. 1).

But the partners in married couples suffered too. Lack of time spent together, lack of attention, or lack of intimacy was very common consequences of a partner combining care and paid work, sometimes with dramatic implications for the relationship. Nevertheless, many
interviewees stressed that their partners were very understanding and supportive, so the shared strain of care-giving was actually shared by the partners and strengthened the relationship.

Family life

Combining work and care-giving had a detrimental effect on family life, to put it mildly. Quoting the Italian report: “Family relationships are damaged by the work and care reconciliation...” (Santini et al., 2011: 49) would be a less polite, but equally valid statement. Since working hours are set and a considerable amount of time spent on care-giving was unavoidable, family life was suffering. Family conflicts were common. According to Santini et al. (2011) four directions of family conflict can be distinguished: (1) with children, (2) with spouses, (3) with brothers and sisters, and (4) with/about grandchildren. Two conflicts were intergenerational by nature (with children and grandchildren), the other two occurred within the carer’s generation (with spouses and brothers and sisters).

Family conflicts were particularly prone to happen in settings where the care recipient was cohabiting with the care-giver and her/his children – a situation most common in the Italian and in the British samples (though it only affected a minority of care-givers there too). If the person in their care was living in their own home, other conflicts emerged though. A frequently recurring theme of conflict was when the carer spent more time at the care recipient’s home than previously agreed.

“It may have affected the relationship with my husband, certainly it did as caring absorbs so much of my time ... The time I spend with my family is more than halved, that is I spend so very little time with them, as now during my free hours I am with mom, so both the relationship with the children was affected by it, who are more nervous, more irritable, more whining, as well as the one with my husband, although he is an understanding person ...” (Italy, IT-17)

The Italian team pointed out a subtle gender difference: Whereas male care-givers found it particularly hard to reconcile care-giving and family life as such, female care-givers found it most challenging to reconcile the times of different family tasks (including care-giving) (Santini et al., 2011).

Unlike with other family members, there were no open conflicts with grandchildren. It was more the personal regret a working carer felt for not being able to spend as much time with her/his grandchildren as s/he would like to.

“I have three children and five grandchildren, so um I suppose I haven’t been able to get involved as I would have liked to with the grandchildren and look after them and have them over to stay and all that sort of thing, so that again has been a problem. So yes I would say that’s the biggest problem actually” (UK, No. 2).

Arguments over the division of labour in providing care were a major source of conflict within the family, particularly among brothers and sisters. Typically, there was some resentment by the care-giver towards her/his siblings who in her/his view did not do their fair share of caring. Conversely, some brothers and sisters expressed resentment towards the carer for insisting to combine care-giving with paid work. In their view, s/he ought to give up employment to focus on her/his care-giving responsibilities. Typically, this was an expectation addressed towards female care-givers. The following quote summarises both sides of the coin:

Conflicts between brothers and sisters were particularly common in the British and the Polish samples, whereas it was not explicitly mentioned in the Italian sample. In the German sample, conflicts with brothers and sisters were not mentioned initially, but when prompted evidence of serious rifts emerged in some cases.
8. Benefits of combining work and care

When we set out to carry out this research, we were motivated by the idea of analysing how people caught between two contradictory forces – labour market and care-giving – would cope and overcome their difficulties by employing specific coping strategies. We were taking for granted that this situation would inevitably result in overburdening of the carer and thus an overall negative perception of the situation by the care-giver. What did not cross our minds at the time was the possibility that reconciling work and care could also have a positive side for the working carer. We realised that this one-sided approach was slightly mistaken when piloting the topic guide for the interviews. The working carers reported a number of benefits from combining employment and care-giving they had experienced. Thus, we included a question asking for positive outcomes of reconciling paid work and care in the topic guide. This chapter summarises our findings on this. The chapter will be much shorter than the previous one since the working carers study reported far more difficulties than benefits, which was to be expected. However, we feel that the presentation of findings from our study would be incomplete and somewhat distorted if we would not talk about their rewarding experiences too. Reported benefits fell into three categories: benefits from work, benefits from care-giving, and benefits from reconciling employment and care.

8.1. Benefits from work

There were four benefits reported as a result of engaging in paid work despite of the high demands on their resources through care-giving: (1) work as respite, (2) work as a means of increasing financial flexibility, (3) work as an instrument counterbalancing care, and (4) work as a source of skills beneficial in care-giving situations.

Contrary to our initial expectations, many working carers expressed the view that for them work was a respite from care-giving rather than a burden! Many perceived working as “time off” from caring. The opportunity to continue having another identity, an identity as a worker, kept them going in providing care. This was the single work-related benefit was frequently mentioned. These views were particularly often expressed by British and German working carers.

“But that's how I saw it, when I still went to work, this was my compensation, which also gave me power, so that at home, so that I could do all this at home. Well, this was a (...) a well from which I could take. This was the feeling, that you can do something else, that you can still do things. (...) This was also important for me. And did me good, because you could exchange ideas with others and because you realised, that you were appreciated, you, your opinion was respected.” (Germany, DD106)

Another benefit was of course the increased financial flexibility. Quite a few of our respondents commented that they simply could not afford to quit work, or that continued employment enabled them to purchase care-related services they would not have had access to otherwise.

Some working carers stressed that continuing to work gave them more control over their lives. Such expressions were not directly associated with any particular aspect, whether it was counterbalancing the impact of care-giving on their lives, enhanced financial flexibility, staying in touch with their job and work colleagues – it was more a positive feeling of providing them with some degree of independence.
“It’s had a positive effect. I mean I’ve got much more control over my life now I’m working for myself, and it makes us able to actually sort of do things, although they need more planning. ... So, I mean in some ways quality of life has actually improved” (UK, No. 27).

Finally, people who were employed in health or social care jobs indicated that their professional skills and resources helped them considerably in coping with the demands of care-giving.

 „Well, it was also a relief, to have knowledge there, how I deal with all this paperwork there, where I have to make complaints, where I have to act at once. Where there’s a really precarious sphere. Which care needs there are. Well, that’s the positive thing, the advantage of my profession, to know all about it.” (Germany, DD105)

8.2. Benefits from care-giving

Benefits from care-giving were the most frequently cited benefits. The most frequently mentioned care-related benefit, which was explicitly stressed by British, Italian and Polish carers, was an improvement of their relationship with the person they cared for. The changing dynamic within the relationships often resulted in a new appreciation of each other.

“I was the daddy’s girl, you know, I was very close to my dad. I never felt that close to mum really, by comparison...but when dad was ill that was when I got close to mum and so in a way that helped. So, yeah, I got to know mum and I got to appreciate her much more, you know, because I left home when I was 18 and I never went back, you know, and when I was 17, 18 I couldn’t wait to leave home and I probably wasn’t very nice to mum...whereas now, you know, when I look back, I think actually mum was a really good mum and she deserves that care” (UK, No. 11).

In this example, care-giving became the catalyst for improving strained relationships with other family members, in particular with brothers and sisters.

“My brother, we get on better, we had a major fall-out when my dad died and we’re both very stubborn and so we kind of, you know, weren’t talking very much, until we needed to look after mum” (UK, No. 11).

Another theme that was frequently mentioned was that care-giving put things into perspective. Many commented that the necessity to care for another person had reminded them that their previous work was too much focused on work. Quite a few also felt somewhat relieved that work-related pressures were no longer as important as they used to be. This may have been a coincidence, but this view was particularly common in the German sample.

“Yes, I think it’s simply a bit of, perhaps the pressure from the job, I think this has become less because of this, because it’s put it into a perspective, perhaps it’s also something else ...” (Germany, HH34)
8.3. Benefits from combining work and care

Many working carers in all four samples stressed that they had experienced personal growth as a result of combining work and care. Some commented that they had become more patient and could much better sympathise with work colleagues in difficult circumstances. An important element was realising the finiteness of their lives. Others felt that the experience had pushed them beyond their limits, which in itself was enriching.

"Well, for one thing it's a part of experience of life, where I say 'It does me some good.' It's damn important for me, to go to my limits. The experience, that patients always have, that feelings are stronger and faster than the brain, I had never experienced to such an extreme. Well, I think, it's good, my existence as a human, to experience my limits and it's very good for my job and also, also to see there, to say OK, without reflecting, you really can't change anything, because the old reflexes are still there (...). This means, finally, it won't make me worse in my job, but rather better." (Germany, HH12)

"The most positive thing is that now I understand many people when they're having problems. And one becomes kinder because one understands better, in many different situations." (Poland, PL 8)

"The good thing ... a paradox! That this story helps me in my work, if you knew how many people I understand better. It is an enrichment for me. Also people with parents suffering from Alzheimer came to me so I could give them human advice and sharing human sufferings, intimately understanding certain things. This has enriched me, let's say". (Italy, IT-18)

Moreover, the ability to overcome a very challenging situation like combining work and care made them grow in confidence. Some of this related to their jobs. Some female carers also indicated that this situation had forced them to do things previously only their husbands were dealing with, such as driving a car or dealing with financial matters. Finally, a number of working carers from Poland reported their satisfaction of fulfilling a moral duty.
9. Informal reconciliation strategies

We have discussed at some length the difficulties faced by working carers. In this and the following chapters we will focus on strategies employed by the carers to overcome these. The present chapter will focus on informal reconciliation strategies, i.e. support mobilised from informal sources such as friends and family, self-help groups and the like. In contrast, the subsequent chapter 10 will deal with support mobilised from formal sources, including formal company policies, legislation and the welfare state. However, not all support sources fit into the informal-formal dichotomy. Hence, we will discuss strategies and support sources that sit somewhere in between under the heading ‘semi-formal strategies’ in a subsequent separate chapter 11, namely migrant care workers (informal context, but formal employment) and ‘bank of trust’ developed with line managers (formal work relationship, but often personal relationship as well).

9.1. Seeking family support

Family solidarity has been the most reliable source of support for people in need for centuries. Although the family’s capacity to provide support is arguably under increasing strain in ageing societies with globalised economies, the first and perhaps most obvious context in which working carers were seeking to mobilise support were their families. Thus, it is hardly surprising that the majority of working carers in our four samples pointed out that practical and emotional support by their families were extremely important to them. Where it was available, it became the most important source of support for working carers. Where it wasn’t, lack of family support was a source of substantial grievance to them, as our elaboration in chapter 7 has shown. This will not be repeated here. We will focus on strategies employed by working carers in their family environment, and how effective these were.

A strategy commonly used was sharing the burden of care among several family members. It was striking to see that success of this strategy largely depended on two factors: (1) availability of family support and (2) relationship quality. The first factor refers to family structure, namely family size. When there was a big family, support was usually easier forthcoming, as the following quote from the Polish sample shows:

“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 my brother-in-law then my niece, so there’s always somebody who has time, right? Or my cousin, right? It happened a few times that my cousin got ... got involved.” (Poland, PL 6)

Counting on the extended family network may sound too obvious to call it strategy – however, we are beginning to see first indications that we cannot take this for granted anymore, as an example from the Italian sample involving a single child adopting the role of sole care-giver shows (there were several ‘only children’ in the Italian sample, possibly the result of low fertility in Italy since the early 1980s (Eurostat, 2006)):

“Yes, because I am an only child. Without an aid it is ... unless one has brothers and sisters, relatives who can give a hand ... It is not easy without help. The advice is to get help from someone. I found it by paying, those who do not have the opportunity have to ask those around. I did not even have any relatives around”. (Italy, IT-19)

However, in a considerable number of cases asking for family support was working rather well. In some instances, division of labour was based on abilities and experience. In other
cases, the decision was based on availability – in terms of geographical distance as well as in terms of time.

“We all deal with different aspects of his care, like me the personal hygiene, bits of stuff like that; my sister can’t do that, whereas I can’t do my dad’s feet. My mum, she’s like, ‘I don’t want to do none of that,’ um and I suppose with the manoeuvring of him as well because I’ve had that sort of practice and that teaching, you know. I’ve taught my sister how to deal with my dad when it comes to manoeuvring him from side to side because we can’t rely on the carers because they don’t turn up on time or they just don’t do what you ask them to do, you know, and so yeah...We’ve had to sort of like, what’s the word, adopt certain jobs that we do where it concerns my dad” (UK, No. 14).

The above quotation is exceptional in one respect: Normally, the person doing personal care was reluctant to share this particular task. In the UK sample, several carers commented that they would never entrust this task to either younger or male members of the family. Moreover, certain conditions like dementia made it difficult for family members other than the primary care-giver to become involved.

But working carers involved their family members in other ways to save time they would otherwise need for dealing with affairs of their own, including doing the chores, shopping, or looking after the carer’s children. The most important source of support in this respect were spouses/partners.

“I’m over at my mother’s house emptying the bins, doing her dustbin, or whatever it is, and my wife is doing the same thing on our side of the road. So, whilst I’d be cleaning my mother’s house she would be cleaning our house and so really I’m supporting my mother and my wife is putting effort into support our life and that really, really is a massive help. To be able to discuss it with my wife, um, that you can shut the door and whatever, and just have a bloody good moan sometimes ... generally speaking living with somebody, a partner or someone who is sort of on your side, is incredibly important in life actually ... I really think having a life-partner is a massive advantage, you know, somebody whose actually sympathetic and helpful. That really is part of the whole kind of strategy” (UK, No. 3).

This quotation points toward a specific gender dimension of care provision. The gender division of labour was particularly visible in the Italian sample. Although Italian working carers predominantly used migrant care workers for handling personal care issues (for a detailed discussion see section 11.2), they nevertheless stressed the importance of seeking emotional support from other family members, which was a common feature in the other three samples too. Anything to do with personal care would be done by a female person, either a migrant care worker or in families who could not afford employing one a female family member. In contrast, all financial matters would be handled by a male member of the family. It was also quite normal to expect female family members to provide more support than men. Thus, spouses of the (female) primary care-giver would be far less involved in care-giving and deal with less time-consuming tasks like finances, prescriptions and paperwork instead (Santini et al., 2011). Similar expectations were also reported in the German sample, where male spouses typically freed the (female) primary care-giver of the above described duties as well as the chores, shopping, preparing meals, etc (Kohler and Döhner, 2011).

When men had to assume the role of primary care-giver this is of course different. Men caring for a parent could normally rely on their female partners’ support, which was particularly explicit in the German sample (Kohler and Döhner, 2011). The British quotation above (UK No. 3) is an example-par-excellence for this constellation. However, male partners did not necessarily support their wives in care-giving – some did, others did at least accept
their female partners’ preoccupation with care-giving tasks. However, there was a third group of male partners demanding more attention for themselves whose attitude was particularly unhelpful and became an additional burden for female working carers. In other words, whereas male carers could typically expect to use their female partners as auxiliary support, female carers could not reliably expect using an equivalent support strategy with their male partners.

Brothers and sisters are potentially an important source of support. But there was a very specific pattern of involving them depending on who the care recipient was. Working carers would not expect their siblings to help them with spousal care at all. However, when care-giving concerned their parents, division of labour among brothers and sisters was expected (Kohler and Döhner, 2011) – and perceived reciprocity in contributing to their parents’ care was extremely important, possibly the most important factor in explaining the working carer’s life satisfaction / well-being. Precondition was, however, that siblings were getting on with each other reasonably well. Unfortunately, brothers and sisters turned out not to be a reliable source of support. In many cases, working carers felt left alone by their siblings, a situation that was far more common than a good working support relationship with brothers and sisters. The following quote from the German sample exemplifies the distress resulting from unsupportive sibling relations:

„My own health, yes, it went down the drain (laughs). Apart from the overload, where I, in fact, was signed off sick for three weeks and had to get medical care myself ... One reason was, that, let’s say, the support within the family of my, of my family and of my, of my sister then somehow (coughs) wasn’t there and I had the feeling ’They leave me alone with all this’.” (Germany, HH16)

Having the opportunity to ask for emotional support was also incredibly important for working carers. Not everybody would qualify as true emotional supporter though. Genuine emotional support required more than simply listening and giving the care-giver a chance to vent off some pressure. Crucially, the emotional supporter had to be aware of the specific care-giving context and valuing the support provided by the care-giver. The following quote from the British national report exemplifies the specific relationship between care-giver and her/his emotional supporter (Hamblin and Hoff, 2011: 88):

“My older daughter rings me every day, and she’s a nice support. My younger daughter, fairly often. Son, less often, but that’s the difference between boys and girls [laughter]. I think everybody finds that. But yes, that is important, I think, being able to ‘Oh he [cared-for] was dreadful today’” (UK, No. 23).

In summary, members of the working carer’s family were an extremely important source of support for them, which they strategically used. However, many carers also reported problems with their families in the sense that help and support they had expected from them was not forthcoming. The support relationship with brothers and sisters appeared to be particularly problematic – reports about disappointed expectations were common in the British, German and Polish samples. If it wasn’t in the Italian sample, this may be explained by the use of migrant care workers who eased much of the pressure on Italian working carers.
9.2. Friends and neighbours as support of last resort

Although we would not normally consider friends and neighbours as belonging to the same category, we grouped them together in their role as supporters of working carers. Actually, they share a characteristic that makes them valuable for working carers – closeness. In case of friends this is referring to relationship quality, in case of neighbours to geographical proximity. Both qualities have the same implications – they make them into ideal supporters of last resort.

Friends

When asked for help, friends were typically providing one or more of three forms of support: (1) emotional support, (2) practical assistance and (3) respite care. Respite care is usually associated with giving carers a break. However, sometimes this break is not voluntary, as the following example illustrates:

“Yes, I’ve got three or four very good friends that basically, when things get too much, would allow me to scream at them. I’ve got one friend who is there as a backup, if I’m ill or anything then [friend’s name] is there ready to step in.” (UK, No. 6).

There was great variance in our study in regard to the extent working carers involved friends. Whereas they played an important role as reliable supporters in the British sample, namely in spousal care, where carers did not typically involve their children to a great extent, the German team reported shrinking friendship networks as a consequence of care-giving, resulting in some hesitance by working carers to approach them for help. In the Polish sample, friends were commonly used as ‘standby help’ in emergencies, while they were exclusively seen as emotional supporters in the Italian sample.

Neighbours

Since neighbours lived literally next door to the care recipient they could be entrusted with small practical or monitoring tasks. In the Polish sample it was reported that neighbours were partly compensated for delivering such services, including preparing simple meals, doing shopping, checking on the older person, accompanying her/him, or housekeeping:

“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.” (Poland, PL 49)

But generally speaking, neighbours acted as help of last resort, which could be relied upon, but not too often. Both friends and neighbours were strategically used as help of last resort.

9.3. Time out

A vitally important reconciliation strategy for working carers was taking a break and rest. This opportunity was essential precondition for retaining their mental strength (Stypinska and Perek-Bialas, 2011). Therefore, we were asking the working carers in our study explicitly, in a separate question, what they did to relax. This question was meant to find out if working carers employed specific strategies for taking a break and if so, how they relaxed. No doubt, taking a break is much easier said than done for a primary care-giver of a person needing a substantial amount of care. Thus, it is hardly surprising that our interviewees really struggled with finding time to take a break. Precondition was finding someone who could take over care-giving in the meantime, even if it was only for a couple of hours. This was not easy,
since that person had to be someone who could be trusted to provide appropriate care and the care recipient needed to be comfortable with this arrangement.

Every working carer in our study referred to attempts of creating time for them to relax. But likewise, every interviewee also reported that they really struggled finding that time. Kohler and Döhner (2011) identified three distinct patterns of organising spare time to relax:

1. In the first group, working carers did not find time for going on a holiday trip – however, they managed to engage in one or more leisure activities during the week. Typical activities included sports, singing in a choir, or meeting friends. Other activities involved giving themselves a treat, such as having their hair done, cosmetic treatment, or enjoying a massage.

   “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”
   (Poland, PL 31)

The following quote gives an excellent example of time management by working carers:

   “That means you practically have your time divided into five parts. That under these circumstances, well, when you see the different legs to stand on, you don’t only have two supporting legs, you have five, basically. Family, I consciously name it first, care, traditional profession, voluntary work and passionate job. So and these five spheres are shifting in a different way every day and you must see, of course, that you existentially provide for yourself, that’s also clear. You can’t do it by cutting back on care because there are care necessities. Well, the spheres family, voluntary work, and the passionate part of your job are shifting.”
   (Germany, HH8)

2. The second group of carers felt unable either to go on holidays or to find time to relax during week time. In most cases, they don’t feel able to entrust the respite care to somebody else. Typically, this was found among female carers who doubted their husbands’ willingness or ability of taking over even for a few hours. Many working carers in this group reported experiencing growing pressure and the approaching prospect of total overburdening.

3. The third group, however, which turned out to be the biggest of the three in the German sample, managed to find time during week time as well as going on holidays once a year. These working carers could either rely on their support networks or had learned their lesson to take their own needs seriously enough to actively create time for them. However, this always required meticulous planning and had to be arranged well in advance. Quite a few of them used institutional respite care.

Many working carers were very conscious of their need ‘to recharge their batteries’ on a regular basis and actively created time for that. Precondition was a reliable support network. However, this strategy did not work for all of them – some did not manage to find suitable support for giving them a break.
10. Formal reconciliation strategies

In contrast to the previous chapter, this chapter discusses reconciliation strategies addressing formal support sources, most prominently the various layers of the welfare state as well as legislation and formal company policies. Thereby, we differentiate between reconciliation ‘legislation’ that allows for more flexibility (section 10.1) and legislation that establishes cash benefits (section 10.2).

10.1. Reconciliation legislation

Concern about care-giving issues in employment first emerged in relation to mothers of young children. In contrast, concern about care-giving obligations toward older family members is still a very recent phenomenon. Policymakers are only beginning to comprehend the full implications the extension of working lives will have for future care-giving. What was mainly intended to save expenditure for public pension funds turns out to have significant implications for care provision too, since older workers (defined as 55-64 years old by the European Commission today) represent the generation of those giving care to their mothers and fathers in their 80s and 90s.

Flexible working-time arrangements

We have shown that flexible working time arrangements are extremely beneficial for working carers. Today, the right to request flexible working hours has been enshrined in legislation in a number of countries. Since the mid 1980s, flexible working hours as well as reduced working hours began to play an important role in German collective bargaining. Key legislation in this respect was the 1994 Working Time Act (Arbeitszeitgesetz), which was enacted to comply with the European Directive on Working Time (Demetriades et al., 2006). In the UK, the statutory right to ask an employer for flexible working if caring for an adult was introduced in 2007, following the introduction of similar rights for working mothers in 2002. In addition, the 2004 Carers (Equal Opportunities) Act ruled that local authorities in their assessment of carers’ needs must take into account whether they were working or in education or wished to work or enter education. This represents a significant shift away from the assumption that care should be provided by the family, irrespective of the effect this would have on the carer. Now, local authorities would have to respect the carer’s preferences (Hamblin and Hoff, 2011).

Less obvious for working carers are the benefits of the 2001 Work Council Constitution Act (Betriebsverfassungsgesetz) in Germany. This legislation, however, is important since work councils are required to promote the “reconciliation of work and family life”. Disparity between trade unions and employers in this regard has revolved around a preference for universal, collective (trade unions) or informal, company-based solutions (employers) (O’Reilly and Bothfeld, 2003). Although it has not (yet) resulted in legislation, it is perhaps worth mentioning that the reconciliation of work and care has become an important element of trade unionism. Increasingly flexible interpretation of collective agreements between trade unions and employers has resulted in various models of flexible working time arrangements. Thus, the first sectoral agreement on ‘Working Life Time Accounts’ (Lebenszeitkonten) was signed in October 2000 in the German steel industry. A year later, ‘IG Metall’ (representing workers in the engineering industry - one of the largest and most powerful German trade unions) discussed the reconciliation of work and family as a key issue in their ‘Debate on the Future’ (Zukunftsdebatte). In the same year, the German government and the employer's associations stressed the importance of equal opportunities policy by signing an agreement about the implementation and promotion of family-friendly measures (Franke, 2011).
Working carers in our study reported that ensuring employer support was essential to creating a supportive / enabling work environment. But the following strategies were required for making the reconciliation of employment and care work. First and foremost strategy was working flexible hours (‘flexitime’) to make their work requirements fit their less flexible care-giving arrangements. However, if the former strategies failed or if the care recipient’s condition deteriorated resulting in higher demands on the carer’s time, reduction of working hours i.e. working part-time rather than full-time was a common strategy.

Care Leave schemes

Care Leave legislation is another popular arena of policy intervention on behalf of working carers. Some progress has been made in terms of acknowledging the need for care leave, and subsequently, the introduction of care leave schemes in Germany, Italy and in the UK. However, where it exists care leave is almost universally unpaid.

The reconciliation of work and care is perhaps not at the forefront of British politics, but in line with the underlying liberal work ethic of British society labour market participation was seen as key to alleviate poverty and social exclusion (Hoff, 2008c). After New Labour had come into office in 1997, the government implemented various so-called ‘New Deal’ programmes targeted at specific sub-groups that were particularly likely to be affected by deprivation and social exclusion (lone parents, young unemployed, long-term unemployed and their partners, disabled people, older workers) (for a thorough evaluation of New Labour’s early New Deal programmes see Millar, 2000).

This built on a string of care-related legislation in the healthcare area, namely the NHS and Community Care Act in 1990 that marked the beginning of reform of British care policies, followed by the Carers (Recognition and Services) Act in 1995, and the National Strategy for Carers in 1999 (Hoff, 2008c). But only the implementation of the Carers and Disabled Children Act in 2000 gave family carers the right to assess for themselves what would constitute the best reconciliation strategy for their specific individual circumstances (Bernard and Phillips, 2007).

Subsequently, the UK became one of the frontrunners in terms of introducing care leave schemes in international comparison. This concern featured in Tony Blair’s first speech as Prime Minister as well as in the 1998 White Paper ‘Fairness at Work’, which both made reference to the reconciliation of work and family life. As elsewhere, the initial and primary concern was with working mothers. Within the first few years in office, New Labour expanded childcare provision and introduced parental care leave as part of this policy strategy (Hamblin and Hoff, 2011).

The 1999 Employment Relations Act, which introduced the right to take time off during working hours for ‘dealing with a domestic incident’ (Employment Relations Act, Part II, Schedule 4, section 57) marked the beginning of policies addressing the needs of older workers caring for older dependents (for a more detailed account see Hamblin and Hoff, 2011). The discourse shifted in 2000 away from ‘family-friendly’ policies to the promotion of a ‘work-life balance’ with the launch of the document ‘Work Life Balance: Changing Patterns in a Changing World’ (DfEE, 2000), which was however mainly intended to raise employers’ awareness of these issues (Lewis and Campbell, 2008).

The latest New Deal programme was the New Deal for Carers that was announced in 2006 (DoH, 2006). All New Deal programmes come with a variety of different support measures. A common feature, however, is the focus on treating people as individuals, taking into account their individual circumstances and needs, as well as providing information and guidance through Personal Advisors (Millar, 2000).
The German government introduced the ‘Care-giving Time Act’ (Pflegezeitgesetz), in 2008, which entitles family carers to take temporary leave from work for supporting their close relatives in need of long-term care. The new legislation offers two distinct types of support targeted at working carers in subtly different situations:

1. The first option targets people who are faced with a sudden ‘care crisis’ and need time for organizing care in the first instance. They are entitled to 10 days leave for this purpose. Similar regulations exist in the UK where carers have the right to take (unpaid) time off work for dependants in cases of emergency.

2. The second option has in mind people with a significant care commitment already. Precondition is that the care recipient is entitled to LTCI benefits, with the minimum level 1. They are entitled to take up to 6 months of unpaid care leave to care for a close relative.

Given that both options are unpaid leaves, it is hardly surprising that only very few carers in the present study in Germany reported to have enquired about this option. Nevertheless, care leave legislation has remained high on the political agenda in Germany. In the meantime, the central government department responsible, the Federal Ministry for Families, Senior Citizen, Women and Youth (Bundesministerium für Familie, Senioren, Frauen und Jugend (BMFSFJ)) publicized a proposal for a new paid leave scheme (Familienpflegezeitgesetz). This policy initiative responds to widespread criticism that unpaid care leave would not be a financially viable option for working carers. According to this new proposal, full-time working carers would be entitled to reduce their working hours for two years from full-time to part-time (50 per cent) in order to care for a family member part-time, but would nevertheless earn 75 per cent of their wages. After these two years, employees would return to full-time employment but would continue to get paid only 75 per cent of their wages until their virtual ‘account’ is re-balanced.

No doubt, this is a highly innovative proposal. Nevertheless, it was greeted with widespread criticism. Employers perceived it as placing substantial financial risks with them; carers’ representatives claimed that it was still unrealistic to assume that working carers could afford a substantially reduced income (Franke, 2011); and others again pointed out that only workers in permanent positions could take advantage of this initiative – but it was rather unlikely that the growing number of employees on temporary contracts would effectively be excluded.

If our point of departure was to assume that neither Italy nor Poland would provide any care-related welfare state support to working carers, we were surprised to find a few interesting support measures. Most strikingly, Italy was the only country among those studied in our research that had implemented a paid care leave scheme (Law 104) – neither British, nor German working carers can resort to a similar package. In Italy, employees are entitled to three paid leave days per month to care for a disabled relative up to the third degree (i.e. spouse, children, parents, brothers and sisters, grandfather-grandchild, uncle-nephew). Of these 36 days per year, 25 are recognized in terms of pension benefits. Given the relative generosity of this programme, compared to standards prevailing in other European countries, the take up rate of this measure has been very high. The current Italian government has repeatedly attempted to restrict the number of people eligible.

Furthermore, employees may take up to two years of unpaid care leave, which could be split into shorter periods, to assist their dependent relatives. This care leave would however not count towards pension benefits. Thus, it is not really surprising that this measure was far less popular in our sample.

Poland is clearly the laggard in terms of carer-friendly legislation as well as welfare state support of the four countries studied in our research. Very little help is available. There
are some tender beginnings of care leave options, which entitle employees to two weeks of care leave per year to care for a disabled adult family member. What is striking, though, is that this care leave can be paid. People taking this care leave may apply for a special caring allowance (zasiłek opiekuńczy).

10.2. Mobilising welfare state support

Beside the family, the welfare state is the most prominent source of support for working carers in highly industrialised European societies. Social policies on care-giving and labour market policies in the four countries studied varied widely. This was probably the area with the highest degree of variation between the four countries. Doing all differences justice by explaining them in detail would require a separate report. Acknowledging this need, the carers@work research consortium produced a stand-alone report “Carers@Work - The Reconciliation of Work and Care in Europe. The Social Policy Context” (Franke, 2011). However, the focus of the subsequent section is on the ‘mobilisation of support from welfare state sources’ as an individual reconciliation strategy for working carers rather than a complete state-of-the-art account of welfare state support available in this respect.

Care Services

The central instrument of German care policy is the Long-Term Care Insurance (LTCI) (Pflegeversicherung), which was implemented in 1995 as the fifth pillar of the German welfare state. A word of caution is perhaps necessary: as indicated in chapter 2 and in line with the German care regime, LTCI was never meant to cover all care-related expenses. It is expected that German families would still have to shoulder part of the financial burden.

LTCI provides financial support to both informal carers (normally family carers) and professional care providers. People in need of care can apply for support from LTCI, subject to assessment of their care needs by medical assessment teams of the sickness funds, which administer the funds of both Healthcare Insurance and LTCI. Following that, people in need of care will be placed in either of three categories of care need, representing medium i.e. at least 1.5 hours daily on average (level 1), high i.e. at least 3 hours daily on average (level 2) and very high i.e. at least 5 hours daily on average, including times at night (level 3) care need, if they are deemed eligible in the first place. Payments depend on assessed care need and whether or not payments go to informal, professional home carers, or care institutions. Professional home care providers generally receive higher payments than informal carers, thus effectively giving an incentive for employing professional carers. Payments to informal carers range from € 225 (level 1) to € 430 (level 2) and € 685 (level 3) per month; payments to professional carers from € 440 (level 1), € 1040 (level 2) and € 1510 (level 3) per month. Institutional care providers like care homes generally receive the highest payments since care provided by them involves much higher costs than home care. Institutional care providers are eligible to payments of € 1023 (level 1), € 1279 (level 2), € 1510 (level 3) and € 1825 (level 3+ for cases with particularly high care needs). Following a comprehensive review of LTCI in 2008 higher payments apply in cases where home care is combined with institutional care, which is considerably more expensive than home care. The following rates apply in these cases: € 660 (level 1), € 1560 (level 2) and € 2265 (level 3)12. This combined institutional-home care model would for example apply to working carers who leave the person in their care in institutional day-care while they are at work. More detailed information on German LTCI can be found in the literature (see, for example, Gärtner, 2009; Gerlinger and Röber, 2009; Lampert and Althammer, 2004).

12 The rates in this chapter are applicable as of 1 January 2010.
How did German working carers make use of LTCI? The majority of working carers in the German sample used home care services delivered by professional care providers and paid for by LTCI. Carers did not only ask for support by professional care services because they were seeking relief – some did not want to be involved in physical care if they could help it. Less well known was a relatively new benefit added to LTCI during the 2008 comprehensive reform that provides an additional up to €200 per month to people looking after a person with cognitive impairment. Likewise, the new ‘low-threshold assistance services’ (Niedrigschwellige Angebote) that offer payment of €200 per month to volunteers looking after a cognitively impaired person was not particularly well known yet, but greeted with some enthusiasm (Kohler and Döhner, 2011). The following quote illustrates how it works:

“(…) they were two women, who did it voluntarily: give help relatives, to give some help in the home sphere at home. And they came, as agreed, once or twice a week for two to three hours, depending on (…). And they were also, you could agree on this, if they were to sit down in that time and read something out to mum and simply cared for her, so that I could look after my own things. Or if we also, because mum wasn’t to be looked after, and I didn’t have anything to do, or I simply had to talk, I sat down with them and simply talked. Well, this came out of the situation.” (DE, DD109)

Although established some time ago, respite care and short-term care were relatively less well known among the German carers in our study. Those who used it, however, were very appreciative.

Overall, satisfaction with care services varied widely – statements of utter gratitude were as common as statements about dissatisfactory care provision outcomes (for more details see Hamblin and Hoff, 2011; Kohler and Döhner, 2011; Santini et al., 2011; Stypinska and Perek-Bialas, 2011). The main difference in international comparison was that the German welfare state provided substantial help with care-giving through LTCI, the British and the Italian welfare states to those most in need, and the Polish welfare state hardly anything at all.

Institutional care is of course a key element of care services provided by the state. However, due to the nature of our study, which was interested in working carers combining home or family care with employment, we did not discuss this here.

Cash benefits for carers/care recipients

The other countries in our study did not have a comprehensive LTCI in place. However, all had established some care policy measures addressing the needs of carers and care recipients, including cash benefits for care recipients and/or care-givers.

British governments decided in favour of a variety of cash benefits for carers rather than implementing an all-encompassing social insurance scheme. If giving care to somebody, carers are entitled to ‘Carers Allowance’, provided the person in their care gets one of the following benefits: (a) Attendance Allowance, (b) Disability Living Allowance at the middle or highest rate for personal care and/or (c) Constant Attendance Allowance at or above the normal maximum rate with an Industrial Injuries Disablement Benefit, or basic (full day) rate with a War Disablement Pension. Similarly to the German LTCI, entitlement depends on meeting a number of additional entitlements or passing certain thresholds (see the qualifying level 1 needs assessment in the German LTCI (Pflegestufe 1)). In contrast to other benefits, Carers Allowance is not affected by any savings the person claiming it may have – but it is means-tested: only people earning less than £100 a week after money has been taken off to allow for expenses are entitled.
Otherwise, the closest British equivalent to the German LTCI is the ‘Attendance Allowance’ which targets the care recipient, and not the care-giver, as Carers Allowance does. Eligibility to Attendance Allowance depends on the care recipient (a) having a physical or mental disability, or both; (b) the disability being severe enough for the care recipient to need help; and the care recipient being aged 65 or over – otherwise, they would qualify for Disability Living Allowance. In both cases, cash benefits are rather moderate, varying between £ 49.30 and £ 73.60 per week (2011/12 rates), translating into approximately € 227 and € 339 per month respectively.

A similar benefit exists in Poland where all people over the age of 75 years who are not living in an institution get a general universal right to the attendance allowance (zasiłek pielęgnacyjny). However, at a rate of € 45 per month this is a very modest amount even by Polish standards and does not nearly cover all care-related expenses. As recently as January 2010, a new cash benefit was introduced in Poland for persons caring for a disabled member of the family and quit a paid job in order to do so – the so-called care benefit (świadczenie pielęgnacyjne), amounting to 520 PLN (€ 125) per month, which is paid via social assistance. However, only single or widowed older people are eligible to apply for this benefit.

‘Direct Payments’ are a relatively recent addition to the variety of British cash benefits in the area of care, once again aiming at supporting the care-giver, and not the care recipient. Direct payments are local council payments available for anyone who has been assessed as needing help from social services. Direct payments can be used to buy services from an organisation or to employ somebody to provide assistance. Carers can use a direct payment to purchase services to support them in their caring role, including respite care, domestic help, etc. Slightly confusing is the fact that direct payments cannot be used to buy services for the person in care.

‘Carer’s Credit’ was introduced in 2010 to allow carers building up qualifying years for the basic State Pension and additional State Pension while caring. People on very low incomes or without any income who claim Income Support (the British equivalent of Social Assistance) and are also entitled to Carers Allowance may be able to get an extra amount included in Income Support called a ‘carer premium’.

Overall, the British respondents in our study were not particularly happy with the support their received from the welfare state. The Carers’ Allowance was felt to be insultingly low and the earnings threshold meant it was out of the reach of many of the interviewees. This was argued to be a reflection of the status of carers in society. Many of the interviewees were upset arguing that the amount of money they saved the state in terms of expenditure of residential care was not acknowledged (Hamblin and Hoff, 2011). One interviewee commented:

“I think the position of carer in society is a very devalued one, I think it’s a devalued one whether you’re a paid carer looking after us service users or you’re a family carer. I think we are a very forgotten and potentially socially isolated and marginalised” (UK, No. 12).

Somewhat counter intuitively in the light of the care regime discussion at the beginning of this report, the Italian welfare state provides at least some cash benefits for working carers and the older people in their care. Cash-for-care schemes represent, together with the three paid leave days per month, the real ‘pillar’ of Italian reconciliation policies. There are two types of cash transfers: those provided by central government and those by local/regional government. The central State Care Allowance of € 472 Euros per month is granted to severely disabled persons regardless of the user’s income level and can be used in an unrestricted way. It is by far the most widespread measure to support older people, as currently approximately 10 per cent of those aged over 65 receive it. More recently, however, the government started to
impose various restrictions. Many local and regional administrations provide their own care allowances, often even on top of the State Care Allowance. Since these allowances can be freely used, many families use the money to employ a migrant care worker (see chapter 11.4).

Information on care policies

In the UK, much attention was paid to informing working carers of their entitlements and rights to request state support. Judging by the response we received from participants in our study, this is much needed in the light of a vast plethora of contradictory measures, as the following example shows. Many of the respondents had tried to receive support from the state, but were often frustrated. Interviewees found the forms extremely complex, and were often given conflicting advice on what they could claim. Even for the interviewees who worked in the public sector and felt fairly well connected argued they were often confused by the system:

“The main way I access Social Services is by knowing people and ringing them up and luckily I work for the Council and so I have an idea of how these departments are organised and that is a massive advantage in terms of being able to achieve things. The NHS, I don’t work for them, and that’s a total mystery, but Social Services, I have an idea of roughly how it works and I still have a real struggle. The thing is, I’m not stupid, I’m well educated, I’ve got time, and so on to actually pursue this. Anybody without any of those advantages and I’ve got insider knowledge, of the Council, and I really think a lot of people just fail to get what they need and the whole point of the system is to deliver the service to people of it...you’ve got to fight all this bureaucracy and stuff you know, who needs it”

(UK, No. 3).

Thus, the right to access appropriate information was partly institutionalized. Under the ‘Carers and Disabled Children Act 2000’, carers aged 16 or over who provide a regular and substantial amount of care for someone aged 18 or over have the right to an assessment of their needs as a carer. Building on this, the 2005 Carers (Equal Opportunities) Act places a duty on local authorities to ensure that all carers know that they are entitled to an assessment of their needs, and to consider a carer's outside interests - work, study or leisure - when carrying out an assessment. Thus, local authorities that also commission formal care provision and assess (means-tested) entitlement to public care provision have an obligation to take individual interests into consideration, even if it comes at a higher cost to them.

Day-care centres

Another popular strategy was using day-care centres, usually complementing home care. This applies equally to Germany and the UK. These centres would make sure that older people in need of care were looked after and entertained while working carers were at work. Thus, it was somewhat surprising that only 11 (19 per cent) working carers in the German sample used this service.

“Well, it's still like that, well, my husband goes to day care from Monday to Friday, he's picked up at 7:30h in the morning, by a driver, and is brought home again at about 5:30h pm. He gets food there and yes, stays there. The blood sugar is measured, blood pressure is taken, he's weighed once a month, then in the house, where he stays, the day care facility, there are therapists. An occupational therapist comes there from somewhere else (...). And there's a programme, events of all sorts, mostly music events, that's good for him and once a week there's a woman with a visit dog or with two visit dogs and then they take a walk, depending on the weather, that's good for him, he likes it a lot, and once a week
somebody from the public library comes, they have a voluntary project, they read to them. That's what the care situation in day care is like. “ (Germany, HH3)

Other complementary services included home help, respite care or short-term care. Home care workers provide assistance with care-giving, while care assistants carry out tasks like cleaning, shopping and preparing meals. Domiciliary care workers provide ‘personal care’, for example helping someone going to the toilet or get washed and dressed.

In the Italian context, less than five per cent of those aged 65 and over receive home care services. The latter are basically limited to very fragile patients, so that Italian home care recipients are on average characterised by a much higher level of dependency compared to other European Countries. There are some specific measures addressing the needs of working carers – but this is still very rare and limited to some local authorities in the wealthy north of the country.

10.3. Workplace-centred formal strategies

We have discussed the crucial importance of support by line managers and work colleagues in chapter 7. We will not repeat this discussion here. Instead, we will focus on workplace-related strategies based on formal company policies employed by working carers to enable them combining paid work and care. Other work-place related reconciliation strategies that rely on a mix of formal setting (workplace, workplace regulations) and informal relationships (with work colleagues, with line managers) will be discussed separately in chapter 11.

Formal policies

The first step toward a conscious reconciliation strategy in the workplace was collecting information on formal company policies on flexible working hours and/or combining work and care (Hamblin and Hoff, 2011). This was necessary since many carers had heard rumours about policies but were not really aware of their rights and entitlements. This applied to both British and German workers, although German working carers’ entitlements were mainly governed by legislation. However, many German workers reported difficulties in obtaining information on specific company policies (Kohler and Döhner, 2011).

The situation for Italian and Polish working carers was completely different. In Italy, a strict separation of work and care-giving spheres is expected. Care-giving is considered a private matter. Hence, there is no point in offering any enterprise level support. Even social policies with entitlements based on legislation in Italy did not change this situation, as the following quote illustrates:

“My employers know, however it is a burden I hold inside, if I need a leave I rather go on holiday. I do not need to take advantage of laws. I also benefit from the 104 Law but being a small company, we are five, I’ve never addressed the issue of being absent even if it is a right granted by the Law because it would be a problem. ... I do not know maybe I will. ... I didn’t have the courage to do so, it is a problem, it is a company in which it is fine if you are there, otherwise one risks ... Do you know what I mean? To speak about a problem everyone is good and dear ... but so far I've made it with the only help of the migrant care worker, I did not want this thing to have an impact on work. I’ve tried to avoid it as much as possible”. (Italy, IT-12)

In contrast, people working for bigger employers in the UK sample used the strategy of registering with them as carer that entitled them to taking advantage of a number of benefits, including Carers’ Leave and Emergency Leave. There was great variety in the time allowed to
be taken off for such purposes, ranging from 15 hours to 5 days annually (Hamblin and Hoff, 2011). The following quotation illustrates how the system works:

“I put my name on the carer’s register, if it’s the case I need to go to the hospital with my mother in the morning and then I can go back to work, I know that’s not a problem. I know it and I could work it back and I can just do it. No question, just book the appointment, done, and then get back to work. So that’s a lot of stress off me now. Because when she had cancer, that was the worst. Working all those hours back and knowing as well we had more to work back because cause we had more appointments for her to go to and that was the worst. I don’t worry too much about it now” (UK, No. 32).

Additionally, within big companies and public sector employers there were carers’ networks which provided advice and in case of public sector organisations feedback on carers’ policies. Moreover, a particular British firm sought to ameliorate the risk of line managers misinterpreting company policies by introducing a ‘Carers’ Passport’, which identified the needs of their employees with care responsibilities, which turned out to be particularly helpful when workers moved positions within the company, or a new line managers was introduced. The Carers Passport fostered a sense of security in that should a new line manager move to their team, they would be aware of the demands the carer faced:

“I now tell people that I’m a carer, I’ve got the [employer’s name] Carer’s Passport. I got some very good advice from someone who was one of my coaches about four or five years ago with [employer’s name], she said when you go for a job tell them up front you’re a carer. Just say, ‘you need to know that I’ve got this carer responsibility’ and you need to kind of put your stake in the ground so that when you get very busy and they want you to travel and you need flexibility, you do need to be able to go back and say ‘but I did tell you that I couldn’t travel, you know, eight nights a week; once a week is one thing but you know, I can’t do this’” (UK, No. 42).

Workplace and home

Working from home was another strategy enabling the working carer to reconcile their caregiving and work commitments and saving time for going to work. Obviously, this strategy only works with office jobs – it is of no use to those whose jobs require their physical presence.

Another strategy of reducing work-related pressure was moving home to live closer to work. This could affect the working carer’s as well as the care recipient’s home. Thus, time (and money) was saved on travelling to/from work or to/from home and the care recipient’s home. Both strategies were common in all four countries studied.

In contrast, Polish working carers in our study did not mention this opportunity. Quite to the contrary, in the absence of any formal reconciliation policies and faced with a rather unsympathetic workplace ethic, a significant number of working carers in Poland decided that the only strategy that would allow them enough flexibility to combine work and care was to become self-employed. As many as 12 respondents in the Polish sample were self-employed (Stypinska and Perek-Bialas, 2011).
The above discussion may appear a bit UK-centred. British society as a more market oriented society than the other three countries in our study, and indeed most other European societies, assigned greater responsibility and discretion to employers in resolving the reconciliation problematic. As we have seen in chapter 7, working carers face very similar conflict situations in the workplace in all four countries studied. However, not every society places ultimate responsibility for sorting out these issues with employers. Most of the above discussed strategies are relevant in the German context as well – however, they are predominantly regulated through central government legislation. In contrast, neither Italian nor Polish working carers could rely on any support from their employers since care-giving was regarded a private matter.
11. Semi-formal reconciliation strategies

We decided to dedicate a separate chapter to reconciliation strategies that do not unequivocally fit into either informal or formal support categories. These include: (a) workplace related strategies that rely on the goodwill of other people (line managers, work colleagues) rather than formal policies; (b) support from the voluntary sector, which is often difficult to classify as either formal or informal support; (c) services purchased in the private market that are provided formally in the sense that they are based on a formal contract, but require private payments; and finally (d) migrant care workers who operate in the home environment carrying out duties typically assigned to informal carers.

11.1. Workplace-centred strategies

In contrast to work-place related policies discussed in the previous chapter, strategies discussed here are based on personal relationships, and not on formal entitlements.

Line managers

In most cases, line managers acted as ‘gatekeepers’ to company policies in the UK. Thus, the most promising strategy was developing and maintaining a good working relationship with one’s line manager. Key to this strategy was building a ‘bank of trust’ with the line manager. The following quotations illustrate quite well how it works:

“‘They tend to do it on you scrub my back I’ll scrub yours sort of thing. If you put yourself out to help them they will be more lenient with you, but if you stick by the rules you start at quarter to eight and you go at five, and say no I can’t work at dinnertime and I can’t do this and I can’t do that, then when you ask them for a favour, they’ll say no, but like I fill in at any time, I have my at lunch time, I have my breaks whenever it fits in, they are very lenient on me that way, so yes, basically you help them, they’ll help you’” (UK, No. 44).

“We have a formal policy in place, but it is a very small organisation, we’ve only got thirteen people in the office and not all at one time, but yes, I mean there is no hesitation. The informality is, ‘No, you go and deal with it’… I have to say my manager is usually very good because of how we work. I think we all work above and beyond the hours that we’re supposed to, well I know we do, in good will gesture almost, and she is actually very good at saying, ‘No, you’ve only gone for a couple of hours, don’t worry about that bit, the number of times you’ve come in early or you’ve done that’” (UK, No. 48).

Other than that, most working carers in the British sample regarded honesty as the best strategy of securing their line managers’ support, arguing that they could only offer support if they were kept abreast of developments at home.

In the absence of any formal company policies, line managers could not act as gatekeepers in the Polish and Italian samples. To make things even worse, Polish line managers were usually regarded as ensuring profit maximisation for the company and were thus not seen as being approachable about care-giving issues (Stypinska and Perek-Bialas, 2011). Nevertheless, it was important to maintain a good relationship with line managers since it opened the door for informal arrangements. Such arrangements could be relied upon in times of need and included practices such as arriving at work an hour later / leaving work an hour earlier, taking some work home, etc. But in contrast to the British and German samples, line managers were not trying to be sympathetic – they were seen as “turning a blind eye” on these matters. Polish working carers tried not to use these arrangements whenever
possible since they did not want to appear as being unreliable workers unable to perform well. Similar sentiments were reported in the Italian sample.

**Work colleagues**

Quite a few working carers made an effort to vow their work colleagues in their favour. Strategies employed included taking over more tasks than necessary, thus relieving their colleagues of work, to build a ‘bank of trust’. They calculated that colleagues would be more willing to cover in their absence if they had to attend to urgent care-giving issues. But building a relationship of trust with work colleagues also made sense for another reason: some of them may have been more familiar with company policies and/or knowledgeable about the reconciliation problematic. Colleagues who had been in that situation before commonly were a sympathetic source of support. This applied universally to all four samples to some extent. However, it is noteworthy that some Polish and Italian workers decided to keep it a secret from their colleagues.

### 11.2. Mobilising help from the voluntary sector

About a third of the British working carers in our study made use of care services provided by the voluntary sector (Hamblin and Hoff, 2011). Typically, these were very specific care services tailor-made for the specific needs of particular patient groups. Examples include the Clive Project in Oxford which focuses on early-onset dementia; Macmillan nurses dedicated to cancer care or Age Concern (now Age UK) for any age-related issues. Age UK is a national organisation with a nationwide network of local branches, which was recently formed from a merger of the two biggest advocacy organisations catering for the needs of older people in the UK – Age Concern and Help the Aged. Additionally, there is a plethora of small local organisations, many of which emerged from self-help groups initially set up by people affected by or caring for someone affected by a particular condition. Similar organisations exist in Germany and were utilised by working carers in a similar way as by their British counterparts.

Another important set of voluntary organisations that working carers deliberately used were ‘carers groups’ specifically addressing the needs of care-givers rather than those of people suffering from a particular condition. The city of Oxford alone had three such centres that provided advice and information as well as practical support for (working) carers. Some even provided (limited) financial support. The following quote illustrates how these centres operate to improve the wellbeing of carers:

“The Oxford Carers’ Centre’s got this policy of giving every carer, every three years, £150. They used to do it every year, but for reasons of increasing numbers of carers they can’t [laughs]. And what they do with £150 - it’s not literally a blank cheque: you can either use it for a series of massages; you can use it for a series of six counselling sessions with a counsellor that they arrange; or you can have the money to go and do your own counselling elsewhere” (UK, No. 26).

Some interviewees used the services these groups were offering more frequently – but most felt somewhat uneasy about using them too often. Apart from the overall strain of the care-giving situation that did not allow them taking advantage of services on offer too often anyway, many felt that their situation did not justify an overreliance on them.

Somewhat counter intuitively given the lack of formal policies, the voluntary sector did not play a major role in supporting Polish working carers. Awareness of these organisations and their services was generally low. Some voluntary organisations were providing care services. However, the working carers in the Polish sample reported that they
had some doubts about the qualifications of these care-givers. Conversely, care recipients did not feel too comfortable about letting a ‘stranger’ enter their homes (Stypinska and Perek-Bialas, 2011).

Likewise, the voluntary sector was not very popular in the Italian sample either. Thus, it was interesting to note that a number of Italian working carers in our study suggested a greater role for the voluntary sector, particularly in care provision as well as in organising local neighbourhood or community support networks (Santini et al., 2011).

In the German context, it is sometimes difficult to distinguish care service providers belonging to the voluntary sector from public service providers. Part of the answer to this can be found in the German care regime as described in chapter 2, which provides public compensation for services provided by other social actors, including families, voluntary sector and private care providers. Another part to the answer is that these welfare providers historically evolved as welfare branches of bigger organisations. A substantial share of public care services are thus delivered by one of six big welfare associations (‘Wohlfahrtsverbände’) that formally belong to the voluntary sector. These include the welfare branches of catholic and protestant church – Caritas and ‘Diakonisches Werk’ – as well as the equivalent of Jewish religious communities plus another three secular organisations: the German Red Cross, the welfare branch of the historical working class movement (‘Arbeiterwohlfahrt’) and a big conglomerate consisting of a great variety of more than 10,000 smaller organisations (‘Paritätischer Wohlfahrtsverband’). Thus, much of what was said in the previous section also applies to these big welfare providers.

11.3. Purchasing support from the private sector

Those who could afford it purchased various services in the private market to improve the quality of life of the person in their care and to increase the flexibility of care provision. Typically, private care providers are agencies providing care services at a fixed hourly rate. In the British sample, if working carers turned to private care providers this was mainly motivated by either of two reasons: (1) lack of availability of or non-eligibility for state provision and (2) quality of care (Hamblin and Hoff, 2011). If someone did not qualify for public support, this would soon become a costly exercise. Private care providers tended to be much more expensive than their public equivalents. On the positive side, they provided flexible services unavailable elsewhere. British working carers were also very appreciative of the consistency and quality of care provided by private market organisations. One who could afford to pay commented:

“The agency as well, I couldn’t do without because I know they will always send someone in the morning to get him up and I mean, even last year, with all the snow, they keep me informed if there’s a problem ... So, we work well together but you know, it’s a commercial agreement that I pay them money and they provide me with a service” (UK, No.7).

What was remarkable in the British sample was an apparently strong preference for formal agreements with private providers, whereas working carers in the German, Italian and Polish samples did not hesitate much in coming to semi-formal, informal or even illegal arrangements with private care providers, as the example of migrant care workers shows (section 11.3). Only a very small minority of working carers in the UK sample had a private arrangement where they personally hired a carer. Of course, German, Italian and Polish working carers also made use of formal care provided in the private market, though Polish carers to a lesser extent due to the prohibitively high costs involved in this.
The situation was subtly different for German working carers who could largely rely on the publicly funded Long-Term Care Insurance (LTCI). LTCI payments could be used for purchasing care services from private market providers. Likewise, Italian working carers could use their State Care Allowance for purchasing private services. However, since LTCI in Germany does not cover all financial costs of care-giving some financial issues were still on the agenda for working carers. More than half of the working carers in the German sample (n=30) reported that they purchase services from private market sources. This included cleaners, privately organised drivers, home help, and migrant care workers (see separate section 11.4 on migrant care workers). Like in the UK, private market sources were mainly used to provide relief to the primary care-giver for a couple of hours.

In the Polish sample use of private care providers was very limited due to the high expenses involved – only very few could afford it. Occasionally, home visits by doctors or private nurses had to be paid for. Only one respondent could afford living in a private nursing home – at a cost equivalent to an average monthly salary, i.e. € 900-1000 (Stypinska and Perek-Bialas, 2011).

Some services / products considerably enhancing the care recipient’s quality of life were unavailable from public sources and had to be purchased privately. Some of these came at a considerable cost, such as adaptations of the care recipient’s home. Acquiring a stair lift is a good example: being able to use the entire house rather than just the ground floor makes a huge difference to an older person with walking difficulties. It also relieves the working carer who would have to walk the person in their care upstairs/downstairs otherwise. And the purchase of a stair lift is a rather costly exercise.

“I funded the stair lift, the wheelchair came provided [by the agency]. Basically they have provided for handrails and grips and various bits of equipment but if it’s things like a stair lift I have to provide. I provided the standing frame so he can stand and try and build some strength in his legs, so yes. I think I calculated it as it costing me in the region of £8,000 since he’s been out of hospital” (UK, No. 7).

Purchasing private care services was a strategy many had to use for covering gaps in care provision from other sources. Moreover, certain services / products that constituted a significant improvement of quality of life for care recipient and/or working carer could only be purchased privately, often at considerable cost. Not many could rely on purchasing private care services frequently due to its costly nature.

11.4. Migrant care workers

Employing a migrant care worker is a reconciliation strategy that belongs to the family realm. However, due to its specific nature – based on an informal agreement, semi-formal or formal contract in a family setting – we felt it appropriate to dedicate a separate section to this strategy and to place it in the ‘semi-formal chapter’.

Employing a migrant care worker can be seen as inexpensive alternative to extending coverage of the welfare state. The metaphorical dichotomy of ‘low road’ (care provision by families) vs. ‘high road’ (care provision by comprehensive welfare states) solution was suggested to describe the two extreme ends of a care-giving continuum coinciding with the Mediterranean vs. Scandinavian approach in European care regimes. Employing a migrant care worker could be seen as ‘in-between solution’ (Leeson and Hoff, 2009) that allows the continuation of the traditional family mode of care provision by means of employing someone else to do it. Nevertheless, the family retains ultimate responsibility for care-giving. However,
the nature of care-giving changes: personal care is now delivered by a migrant care worker overseen by the primary family care-giver.

Many migrant care workers actually live in the care recipient’s home, allowing them to provide care up to 24 hours a day, seven days a week (24/7), thus significantly relieving the primary care-giver. In terms of hours of care delivered, the migrant care worker effectively becomes the primary care-giver in this setting – however, the family member dedicated to be primary care-giver continues to be that in terms of overall responsibility, though her/his main task is now *organising and managing* care. Employing a live-in migrant home care worker may be a convenient solution for families with around the clock care-giving needs. However, there are a number of problems associated with this constellation, putting the wellbeing of both migrant care worker and care recipient at risk. Migrant care workers employed by families are in many cases not appropriately compensated for their long hours of work. Additionally, they often depend on the care recipients and their families for accommodation, which is aggravated in case of foreign workers who entered the host society illegally. On the other hand, care recipients as well as working carers depend on them delivering the care. Since most migrant care workers were not formally trained as care workers, there are issues of assuring quality of care. Other problems reported include limited language skills as well as lack of sensibility towards cultural subtleties in the host society (Leeson and Hoff, 2009; Hoff, Feldman and Vidovicova, 2010).

The popularity of migrant care workers in Italian families is well documented in the research literature by now (Bettio, Simonazzi, and Villa, 2006; da Roit, 2007; Lamura, 2007). Migrant care workers in Southern Europe typically originate from Eastern Europe (Poland, Romania, Ukraine, etc.), Latin America (Brazil, Mexico, Peru, etc.) or from Asia (e.g. Philippines). Thus, it is not really surprising that employment of a migrant care worker turned out to be the main reconciliation strategy in the Italian sample, as the following quote shows:

“With regard to strategies, the only right one was to find a person, who is there day and night in the sense that I can relax also at night, whereas before I used to close the gate ... The only strategy, being able to pay, is to find someone who helps and you can trust. It is the only strategy!” (Italy, IT-19)

It was a widely accepted strategy, almost taken for granted. No fewer than 35 out of 60 interviewees (58 per cent) were using a migrant care worker (Santini et al., 2011). Of these, the majority (n=22) were live-in home carers, employed on the assumption that they would be there to provide care on a 24/7 basis if necessary. Two people were employed for mornings and afternoons, plus another nine for half a day. Only two migrant care workers were merely employed on an hourly basis. In other words, the Italian working carers relied heavily on migrant care workers, as the following quotations illustrate:

"The help of Alina, I cannot rely on the family. If Alina is missing, I'm finished”. (Italy, IT-4)

“I must say we found a good balance with these migrant care workers. Clearly, if they were not there it would have been impossible to reconcile work and care”. (Italy, IT-60)

However, migrant care workers were not normally employed on 24/7 basis straightaway. This was usually the culmination of a longer evolution process of overburdening experienced by the primary care-giver who eventually resigned into extending a short-term contract with a migrant care worker or employing someone else after some previous short-term experience with migrant care workers.

"Earlier this summer we hired a permanent migrant care worker. Before I had a part-time girl and after it was not enough anymore, I got sick due to stress and
then we had to decide in this way ... In the end I had to take anti-stress drops. At night sometimes mom needs to be changed, and in the morning for me to go to work the migrant care worker became necessary ... I thought a lot about it, in a few months I had spent so much money on professional care by the hour in order to avoid having a permanent stranger at home but it was not enough, it was only my brain which was always working .... that is why after a number of things broke out, agitation, anxiety, heart pounding ... I did the heart check-ups but in the end it was just stress and anxiety [...]. I went to a neurologist and I am having a treatment and now I'm feeling good ..... before at night I was shaking and could not sleep then during the day of course ... I was already tired when getting out of bed. Now it's better”. (Italy, IT-41).

In contrast, there is only anecdotal evidence about German families employing migrant care workers. The German authorities do not tolerate informal agreements between German families and migrant care workers and prosecute anyone caught doing that. They insist that migrant care workers would have to pay income tax and social insurance contributions like everybody else, which makes this a prohibitively expensive exercise for families on low incomes and with high care needs. We need to recall that the German Long-Term Care Insurance (LTCI) does not cover all expenses related to care – there is often a substantial gap between the real cost of care and the amount of financial support provided by LTCI, to be covered by the family. Furthermore, German trade unions are weary of potential competition for formal care workers arising from migrant care workers who are commonly paid well below tariff. This is an important concern, especially when we consider the comparatively low wages care workers are being paid even under collective agreements in Germany.

Advocates of formal contracts, which include German authorities as well as trade unions, argue that formal contracts would safeguard the migrant care workers’ interests by making sure that they earn entitlements towards a pension, health care insurance and unemployment benefit in Germany, protect them from exploitation, and would make them less dependent on the families employing them. Given the illegal nature of this business it is hardly surprising that there is not much research evidence on migrant care workers in the German context (exceptions are Hillmann, 2005; von Kondratowitz, 2005; Lutz, 2008).

A recently published book by an author with the pseudonym Justyna Polanska (Polanska translates into ‘the Polish’ and Justyna is a very popular name in Poland where most migrant care workers in Germany originate from) estimates that as many as 200,000 Polish household helpers (most of them working as cleaners, but quite a few are thought to be working as migrant care workers as well) work in the German capital Berlin alone, 95 per cent of them being illegal workers (Polanska, 2011). According to this book, an illegal full-time cleaner or care worker would be earning between € 1,500-2,000 per month, costing the German state and insurance companies an estimated € 150 billion per year in foregone social insurance and income tax payments.13

Nevertheless, the German team came across employment of live-in migrant care workers on 24/7 basis in the German interviews. This was reported in the context of a variety of privately organised assistants, ranging from a driver to cleaners and indeed migrant care workers. However, only one respondent was explicit about employing a migrant care worker:

“You know, these, they're Polish assistants i.e. ladies (...). There were two, two in turns. And they knew, well young people, you had to, but only instruct. The, well, the ladies, who came in turns, they were there permanently, for cooking, keeping

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13 Polanska (2011) would be appropriately classified as ‘popular science’ rather than science. Thus, these figures ought to be treated with some caution.
things tidy and for some company for him, company keepers, in a true sense. [And did you nevertheless have a care service in addition to this?] They yes, always, certainly. Always, always, because of the pills, because the ladies weren't allowed pills. I could also handle it well, also got Pjotr (male migrant carer) quite quickly. Well, a really fantastic person.” (Germany, HH31)

Another five interviewees admitted that there were considering employing a migrant care worker.

„If my mother was in need of ... then I would do it this way, that I get a care person in my house (...). I would see to this, because it exists [Yes.] Somehow, I believe Poles or somehow they're [Yes, yes.], who you can get home, because my mother always used to say, she doesn't want to go into a home and I also said it. 'This way, we will manage, that you don't need to go into a home.' [Yes.] Today she sometimes says, if it can't be helped.” (Germany, HH15)

In contrast, employment of migrant care workers does not seem to be a coping strategy in the British and Polish samples. There is some evidence of migrant care workers from Belarus and the Ukraine operating in the metropolitan region of Greater Warsaw (Fratczak, 2007), but overall family members working as migrant care workers abroad seem to be substituted from within families.

In conclusion, employment of a migrant care worker is a very effective reconciliation strategy where this option is available. However, it comes with specific (ethical) problems for migrant care worker, care recipient and working carer.
12. Conclusions and Policy Recommendations

The main objective of this report was to compare reconciliation strategies employed by working carers in Germany, Italy, Poland and the UK. Furthermore, similarities and differences in typical conflict situations, work and care situation, as well as specific sociodemographic factors were also considered. In this context, cultural and institutional differences in societal division of labour in care provision between family, welfare state, private markets, and voluntary sector are crucial. In this final chapter of the comparative report we will first summarise some key findings of this report. We will then propose several policy recommendations to enable future working carers combining paid work and care for an older person more easily. Concluding, we will discuss implications for our ageing societies as well as for future research.

12.1. Summary of findings

Cultural factors, welfare state and care regimes

We began this comparative report with a brief review of the European welfare state literature with a specific focus on European care regimes since they reflect cultural traditions and institutional solutions for the societal organisation of care provision in Europe. Germany, Italy, Poland, and the UK each represent a different welfare state regime. Thus, four out of the five existing welfare states in Europe identified based on the ‘decommodification concept’, i.e. the degree of independence of earning a living in the labour market (Esping-Andersen, 1990; Deacon et al., 1992; Ferrara, 1996) were covered in our study – the liberal-residualist (United Kingdom), the conservative-corporatist (Germany), the Southern European (Italy), and the post-communist (Poland) welfare states. Due to financial restrictions the Northern European or social-democratic model could not be included in our study. Nevertheless, thanks to close collaboration with our sister project WoCaWo “Working Carers and Caring Workers: Making Paid Employment and Care Responsibilities Compatible?” we are in the position to compare our findings with theirs on Finland, thus incorporating the fifth type as well in a later joint report.14

Using an alternative, gender-sensitive concept, the ‘defamilialisation index’, i.e. the degree of independence of the reliance on the family (Bambra, 2004) or the ‘male breadwinner classification’ (Lewis, 1992), we have two out of three welfare states included in our study – Germany, Italy and the UK as countries with a medium degree of defamilialisation and Poland with weak defamilialisation due to the lack of effective support mechanisms for family carers. In contrast, the WoCaWo findings on Finland represent a strong defamilialisation country. Likewise, Germany, Italy and the UK can be classified as ‘strong male breadwinner’ countries, in which traditionally there has always been a clear gendered division of labour between ‘the male breadwinner’ and ‘the female home-maker’. Both Poland and Finland, however, represent ‘weak male breadwinner’ countries due to virtual full employment of women, which is a post-communist inheritance in Poland.

Utilisation of the care regime typologies proposed by Anttonen and Sipilä (1996) and Pfau-Effinger (1999) also results in a good representation of countries in our study. The combination of gender and cultural factors in Pfau-Effinger’s (1999) ‘gender-cultural care regimes’ resulted in great variance overall. Today, the reality of both partners earning an

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14 Partners in the WoCaWo research project include Teppo Kröger (University of Jyväskylä, Finland), Sue Yeandle (University of Leeds, UK) and Yueh-Ching Chou (National Yang-Ming University, Taiwan).
income has become the norm in all countries studied. More interesting, however, is what happens when a care need arises. The cultural norm in Poland would expect the female worker to reduce her working hours and to take on care duties as well. Although traditionally the same has been the case in the other three countries as well, family carers have more options there. In Italy, family carers could hire a care worker, typically a migrant care worker, instead. However, this option presupposes availability of a decent income, which effectively excludes Italian family carers from poorer backgrounds. Additionally, British and German family carers can rely on care services provided by the welfare state and/or by the voluntary sector. Access to public care services in the UK, however, is restricted and limited to those on low incomes – everybody else is expected to pay for care services privately. Although the German Long-Term Care Insurance (LTCI) does not cover all care-related expenses either, it offers the most generous package of the four countries studied.

A dual pattern emerges when we consider Anttonen and Sipilä’s social care regimes: Whereas Italy and Poland represent examples of informal eldercare provision, Germany and the UK exemplify societies with a welfare mix between informal and formal care. This pair-wise pattern also becomes evident when we compare two important background variables: (1) Cultural tradition and care regimes in both Italy and Poland were shaped by Catholicism, whereas the public influence of Christian religion (Catholicism and Protestantism) on care in Germany and the UK is there, but less evident in the societal division of care labour. (2) The share of older workers is another dimension of this pair-wise comparison: Whereas about half of 55-64 years old British and Germans are employed, only about a fifth of their Italian and Polish contemporaries are in employment too (Aliaga and Romans, 2006).

Socio-demographics

The main features of the socio-demographic comparison are outlined below. It is perhaps worth reminding ourselves that these data are of course not representative of the four countries studied. They are presented here to illuminate the socio-demographic context in our study, which has implications for the interpretation of our findings. Considering the average age of working carers in our study we end up with our familiar pair-wise pattern again: working carers in the British and German samples were slightly older (mean age of 54 years) than their Italian and Polish counterparts (mean age of 52 years). However, if we compare the age of the people in their care a different picture emerges: care recipients in the Italian sample were oldest (mean age 84 years), followed by those in the German and Polish sample (82 years). Working carers in the UK sample were looking after slightly younger people (mean age 78 years). This variation may be a reflection of overall population ageing, which has farther advanced in Italy and Germany, the two oldest societies in Europe, than in Britain and Poland.

As expected, the vast majority of more than 80 per cent of working carers in our study were women, with the exception of the Italian sample where they only represented two thirds. This is very likely to be a consequence of migrant care workers taking over care-giving duties in Italian households. Thus, the nature of care-giving changes from delivering personal care to organising and monitoring care-giving by the care workers, i.e. tasks more commonly associated with men.

Most working carers were married, with their share being highest in the German sample (80 per cent) and lowest in Poland (60 per cent). The latter finding may be somewhat counter intuitive given the strong influence of Catholic tradition in Poland. However, the underlying cause is the comparatively low life expectancy of Polish men, resulting in a larger share of widowed working carers in the Polish sample (20 per cent).

A sampling bias that has to be acknowledged relates to educational status. Although the carers@work consortium applied various measures (e.g. specifically targeting working
carers from working class backgrounds, financial incentives) to increase the share of less well educated carers in the sample, approximately 70 per cent in the British, German and Polish samples came from higher education backgrounds. Only the Italian team managed to recruit a majority of working carers from less well educated backgrounds (60 per cent). The Italian partner INRCA was in the unique position of uniting a research institute with a local care service provider within the same organisation, which obviously helped them to recruit people from the desired backgrounds. The other teams tried to utilise self-help groups and carers groups to achieve the same, which was however less successful.

The theoretical sampling criterion ‘couple, both working’ was most prevalent in the German and in the Italian samples where it was the dominant household structural feature. In the UK and Poland, however, the shares of couples with two earners and those with a single earner were almost equal. In Poland, this was a reflection of the higher share of widowed carers; in the British sample a significant number of working carers indicated that they found it impossible to live with a partner due to the burdensome nature of care-giving. Interesting to note was also that the breadwinner concept (‘couple, one working’) was most common in the British and German samples (28 per cent each).

Care situation

The care situation in the four countries studied was strikingly similar. For example, having to cope with a sudden illness and subsequent care need was described as being particularly difficult in all four countries. Likewise, many carers across all four samples commented on the frustration associated with excess bureaucracy and frequent breakdown of communication with various administrative bodies they had to deal with. This included unnecessary waiting times at GP surgeries or in hospitals. Most working carers were looking after their mothers and most were providing care on a daily basis – with the exception of Italian working carers who could rely on migrant care workers instead. On average, they had provided care for five years.

Perhaps reflecting the overall demographic context of representing the oldest European societies and the associated higher risk of developing a cognitive impairment, looking after a care recipient suffering from Alzheimer’s disease or dementia was more common in Germany and Italy than in the other two countries. The care situation for Italian working carers seemed to be slightly advantageous compared with the other countries thanks to the widespread employment of migrant care workers, which saved Italian working carers the burden of personal care (ADLs/IADLs). In sharp contrast to that, particularly Polish working carers were preoccupied with delivering personal care, which is a reflection of the absence of effective public support mechanisms. Furthermore, long-distance care-giving relationships were a lot more common in the Polish sample than elsewhere, which includes working carers living several hundred kilometres away within Poland, as well as cases where the working carer actually lives abroad (in Germany, for example).

Work situation

Again, the work situation was similar for most working carers across the four countries. Most of them were employed by an ordinary employer – self employment was relatively rare. It was slightly more popular in the Polish and German samples were a fifth reported being self-employed. Somewhat surprisingly, self-employment did not feature at all in the Italian sample. Another striking peculiarity of the Italian sample was that as many as 55 per cent of the sample was civil servants (!). Accordingly, the vast majority of working carers in the Italian sample were working in the public sector. Public sector workers were also the largest contingent in the British and Polish samples – only in the German sample the share of private sector workers exceeded that of public sector workers. If we consider occupational status according to the ISCO-88 classification, ‘professionals’ represented the largest contingent in
all countries studied except in Italy where ‘clerks’ accounted for the largest share. If we had expected that significant numbers of working carers had reduced their working hours to part-time to better reconcile employment and care obligations, we were in for a surprise: the vast majority of working carers in our study was working full-time!

Typical conflict situations

Once again, similarity was the common feature. Most typical conflict patterns of combining paid work with care for an older person applied universally to all four countries. These included lack of time, the inability to ‘switch off’, lack of spare time, too much stress and adverse implications for personal health and well-being of the working carer, as well as lack of time for family and social life.

Cross-country variation occurred in the following respects: British working carers were particularly conscious of the detrimental financial effects of their situation. Many of them could not afford reducing working hours because of the high costs of private care provision, which most of them had to rely on since public care provision was limited to people on very low incomes. Stopping work altogether and taking on a full-time role as family carers was not a realistic option either since the income was needed for covering other expenses as well. German working carers were a lot better off financially. Unexpectedly, this was not so much a result of comparatively generous Long-Term Care Insurance (LTCI) benefits; it was mainly caused by the majority of them working in rather well-paid jobs. However, German working carers reported more frequently mobbing in the workplace than anyone else in our study. It remains unclear whether this is an indication of a less tolerant working climate, positions with greater responsibility, greater sensitivity of the working carers, or pure coincidence.

Reconciliation strategies

While certain conflict patterns applied universally to almost all working carers across country borders, reconciliation strategies for solving the dilemma varied more widely. Confirming the pair-wise comparison of Italy and Poland on the one hand, and Germany and the UK on the other yet again, was the way working carers approached (or not) their reconciliation problematic in the workplace. Whereas Italian and Polish working carers regarded their care-giving obligations as an entirely private matter and thus avoided telling anyone in the workplace, British and German working carers made sure that at least their line managers were aware of their situation and invested substantially in building or maintaining a relationship of trust (‘bank of trust’) with their line managers. In line with this strategy, working carers in the UK employed by a publicly recognised ‘best practice employer’ were reluctant to leave their jobs there since they (a) appreciated specific company policies directed at enabling working carers to combine employment and care-giving and (b) expressed an expectation that things could only get worse elsewhere. They were even prepared to accept slight disadvantages (e.g. comparatively lower earning opportunities, less career opportunities) in exchange for the benefits offered by a ‘best practice employer’.

The paramount Italian reconciliation strategy was employing a migrant care worker. Many migrant care workers actually live in the care recipient’s home, allowing them to provide care up to 24 hours a day, seven days a week (24/7), thus significantly relieving the primary care-giver. In terms of hours of care delivered, the migrant care worker effectively becomes the primary care-giver in this setting, with a dedicated family member overseeing the migrant care worker. Although this may seem a very convenient arrangement, there are several problems associated with it (Leeson and Hoff, 2009; Hoff, Feldman and Vidovicova, 2010). Migrant care workers in Italy typically originate from Eastern Europe, Latin America or the Philippines, which may result in cultural misunderstandings between care recipient and care worker. Moreover, migrant care workers typically lack any qualification in care-giving,
which has obvious implications for the quality of care provided. On the other hand, the care workers may be subjected to ill treatment by care recipient or his/her family. Typical is also a mutual dependency between care recipient (who requires care) and care worker (who needs the money and frequently entered the country illegally).

Using welfare state support was a vital support mobilisation strategy in countries where such mechanisms exist. Thereby, two main types of support can be distinguished: (a) care services and (b) cash benefits. Relatively generous cash benefits for working carers are available in Germany thanks to the Long-Term Care Insurance (LTCI) and – somewhat counter intuitively – in Italy. The British welfare state also provides some financial support to working carers on low incomes – however, these cash benefits are rather modest, only ‘rivalled’ by the even more modest financial support available to Polish carers.

Public care services are available in all countries studied – however, the degree of availability varied widely. The main difference in international comparison was that the German welfare state provided substantial help with care-giving through LTCI based on medical needs assessment, the British and the Italian welfare states to those most in need who could not afford it financially otherwise, and the Polish welfare state hardly anything at all. Using day-care centres in complementing home care was a popular strategy in Germany and in the UK.

The introduction of flexible working hours and more recently care leave schemes is at least equally important for working carers. Legislation allowing for more flexibility in arranging working hours as well as legislation enabling employees to work from home has made a huge difference for working carers. Respondents in our study commented how helpful that was in organising work and care related obligations. These comments came mainly from the British and German sample, whereas Italian and Polish workers strictly separated the work and care spheres in their lives.

Care leave legislation entitling people with care-giving responsibilities for older dependants taking time off for organising or delivering care is still a very recent addition to welfare state legislation. In the countries we studied, Britain, Germany and Italy had introduced such measures – Polish working carers had no such opportunity. Where such entitlements exist, care leave is typically unpaid. Italy was the only country that had introduced a paid care leave scheme! Italian care leave legislation is strikingly generous: it allows working carers taking up to three days paid care leave per month. Moreover, 25 out of these 36 days per year also earn them pension entitlements.

Apart from these different strategies in line with diverging institutional contexts, a number of reconciliation strategies were similar in all four countries. The most important source of support was the family – at least, where it was available and accessible. Where it was not, it soon became a major source of disquiet and conflict, and thus an additional burden on the working carer. Good relationship quality with other family members, namely with brothers and sisters, was precondition for a successful division of care-related labour within the family. Working carers typically expected their brothers and sisters’ support when caring for parents. Thus, they became either crucial sources of support or veritable sources of irritation if they did not offer as much help as was expected by the working carer.

The boundaries of a gendered division of care labour have become somewhat blurred – men are doing personal care these days too, although this tends to be the case more often in spousal care, whereas traditional gender roles prevail in intergenerational care. A gendered division of care labour was most pronounced in the Italian sample where personal care was almost exclusively a female activity (though often delivered by a migrant care worker), whereas financial issues were typically dealt with by men. A subtle difference could be seen, however, in the availability of external support. While male carers could typically rely on
support from their female partners, the opposite scenario was far less often the case for female carers.

**Benefits of combining work and care**

When we set out to plan this research we started off from the hypothesis that the reconciliation of employment and care would impose a substantial burden on working carers. This assumption was confirmed. Nevertheless, many working carers also reported benefits they had experienced from combining care-giving with paid work.

Most importantly and most frequently mentioned was the function of work ‘as respite from care-giving’. In other words, switching into the worker role helped them gaining confidence, safeguarding their identity, maintaining social relationships outside the home, and counterbalancing the role of care-giving in their lives. Increased financial flexibility was another, obvious benefit of work. For those working in healthcare or social care professions work also became a source of care-related skills.

The other side of the coin were benefits resulting from care-giving. Most frequently mentioned were improved relationships with care recipients. In some cases, the care-giving relationship helped to overcome a long-lasting family trauma and made the care-giver seeing their mother/father in a different light.

Finally, many reported personal growth as a result of mastering the challenge of combining work and care, as well as from the care-giving situation itself.

**12.2. Present: Most effective support measures for working carers**

In our study, we asked the working carers (1) which support measures they regarded most effective at present and (2) what support mechanisms and policies they would propose to relieve working carers more effectively in future. In this section, we will present their opinions as to which currently available support sources they regarded most helpful.

**Cash benefits**

Both the German and the Italian working carers commented very positively on relatively generous cash benefits through Long-Term Care Insurance (LTCI) (Germany) and State Care Allowance (Italy). Nevertheless, in many cases this state support was insufficient to cover all care-related expenses.

**Care services**

Likewise, German working carers were very appreciative of the services provided through LTCI. Overall, the various care services available in the four countries were of course seen as helpful, even if they only provided ‘respite’ for a couple of hours. Care services available for longer periods throughout the day were of course even more popular – but they often entailed substantial costs. People on low incomes generally were more likely to have access to free or relatively inexpensive public care services, which were then of course seen as very effective means of support.

Most important in this context was a perception of care services as providing high quality care. From a carer’s perspective high quality care implied reliability, punctuality, flexibility, quality care (according to established medical and professional care-giving standards), continuity of staff, and a partnership relationship between professional care worker and family care-giver.
Day-care services

Where they existed, day-care services were praised as making a crucial difference for working carers who could leave the people in their care there during daytime in the knowledge that they were properly looked after.

Respite care and short-term care

Likewise, where they existed, respite care and short-term care facilities provided much needed assistance in giving working carers a break. Moreover, these facilities could be used for intermediate arrangements in-between home care and institutional care spells and vice versa.

One stop shop for information

So-called one stop shops for accessing all relevant information is a demand made across the board, particularly in the UK and Poland, as will be explained in section 12.3. The 2008 reform of German LTCI already established such one stop shops or ‘Care Assistance Offices’ (*Pflegestützpunkte*)\(^{15}\) in response to similar demands in the past

Paid care leave

Italian working carers were full of praise about Law 104 that established the paid care leave discussed in previous sections of this report and regarded this as a very effective support mechanism.

Migrant care workers

The Italian working carers were particularly appreciative of the opportunity to employ a migrant care worker. This was even seen as more important source of support than the family (Santini et al., 2011), which is a very radical departure from Italian care-giving tradition. Nevertheless, Santini et al. (2011) emphasise that *ideally* Italian working carers still regard the family as most important source of support. However, in terms of practical support, migrant care workers have proved to be more reliable, though family members are still vital sources of emotional support and advice.

12.3. Future: Recommendations for improvement

In this section, we follow up from the previous one that discussed the working carers’ views on presently available support mechanisms to present their wishes and expectations, into which direction policies and measures to support working carers ought to be developed.

Cash benefits

Despite of availability of relatively generous cash benefits for care recipients in Italy, many of the working carers in our Italian sample demanded an increase in financial support from government sources, which they intend to use for purchasing ‘more appropriate services’ (Santini et al. (2011), p. 75). Likewise, Polish working carers asked for an increase in the care recipient’s pension benefits, which would enable them to purchase certain healthcare services and thus relieve working carers who would have to bear the costs otherwise.

\(^{15}\) Care Assistance Offices (*Pflegestützpunkte*) have been established all over Germany since the 2008 LTCI reform – except in the federal state of Saxony that opted out claiming that sickness funds already provided that kind of service.
Better quality care services
Mistrust of public care services was common across the board and in the Italian sample in particular. However, rather than asking for better care services, the Italian working carers demanded higher cash benefits to enable them purchasing better services in the private sector.

Longer hours of care services
Limited hours of care services posed a serious problem to working carers in all four countries – but it was most explicitly mentioned in Poland. The overall impression was that public services provided insufficient time for care-giving – a change of this situation was much needed.

Day-care centres
The introduction of day-care centres where care recipients could spend the day and were properly looked after was seen as a very effective way of enabling working carers combining work and care. This wish was particularly common in the Italy and Poland where day-care centres are less common than in Germany and in the UK. An issue expressed in rural Poland was inaccessibility of day-care centres in areas not in the vicinity of urban centres. It seems sensible to establish day-care centres in rural areas as well and in combination with free transport services to enable older people from a greater catchment area to attend these services. Needless to say that working carers living in rural areas would benefit significantly from such services.

Crisis help
An issue of great concern to working carers was what would happen if a sudden crisis occurred. Thus, a suggestion made was to establish care crisis support teams that could be approached via the emergency phone number in the respective countries and would provide immediate support.

Home visits
A service generally advocated was the suggestion of home visits by care professionals that would provide information, healthcare as well as social care services, deal with prescriptions and other administrative issues, etc. While some suggested that healthcare services would be best suited to handle such visits, others suggested social care services or local authorities to provide this service.

Holiday homes
A very innovative proposal from the Polish report suggested the establishment of holiday homes run by central government to enable working carers taking a rest in popular holiday resorts knowing that the person in their care would be properly looked after by professional care services that are part of the same resort. Similar holiday homes established to enable multigenerational families to go on holidays together are reality in France, for example (see Hoff, 2008d).

Sheltered housing
Sheltered housing where older people in need of care could combine the benefits of living at home with care services on a call-by-call basis were seen as an alternative arrangement to the need of combining work and care.

Assisted Living Technology (ALTs)
A few participants in our study also pointed out the benefits of using ALT to ease the pressure on working carers. Modern monitoring, surveillance and communication technology connected to their mobile phones, for example, would enable them to stay in touch with the
person in their care on an almost permanent basis and would allow them to resolve a crisis very quickly. Using the same technology, care recipients could be connected to professional care services. Finally, contemporary sensor technology has the potential to enable people in need of care continuing to live independently for much longer, with little assistance from others.

**Less bureaucracy**

Working carers in all four countries complained bitterly about the amount of paperwork they had to deal with. Reducing the amount of forms to be filled in for receiving/renewing cash benefits, care services, prescriptions, etc. would constitute an inexpensive but very effective way of relieving working carers and the persons in their care of a significant stressor.

**More information on available support**

Several working carers expressed the wish that information on existing support and services was more easily available. This interest was particularly pronounced in Poland and in the UK. Thus, demands for the establishment of ‘one stop shops’ that would advise working carers on all relevant information around care-giving and reconciliation issues were common, and the introduction of this service was very highly regarded.

**Healthcare services**

Healthcare services were another major source of frustration. Thus, many working carers commented on an urgent need for improvement in the medical services, including reduction of long waiting lists, lack of attention and consideration to people with a disability, in particular those with cognitive impairments. The Italian working carers also expressed their anger about poor organisational processes within the Italian healthcare system.

**Better collaboration between professional and family carers**

‘Integrated care’ referring to closer collaboration between family and professional carers on the one side, and between healthcare and social care workers on the other, has been a buzzword for delivering high-quality care for many years by now. Still, lack of communication and/or sympathy for the other’s situation continues to hamper care provision. Awareness courses allowing both sides to adopt the other’s perspective may be a helpful instrument for facilitating better communication, interaction and mutual support.

**Better collaboration between health care and social care services**

The same applies to an ‘eternal’ conflict within the professional care sphere that tends to be biased towards the medical world, still somewhat underestimating the importance of social care services. Where both worlds collaborate, they can make life a lot easier for care recipients and their families. Examples include social workers employed by hospitals for co-ordinating the transition of care recipients between institutional and home care or institutional and social care respectively, and vice versa.

**Flexible working hours**

Flexible working hours were seen as crucial by many working carers. While appropriate regulations existed in Britain and Germany – though carers in both countries felt that there was still much room for improvement – no such regulations were reported in the Italian report. Nevertheless, quite a few Italian working carers suggested that a more flexible working time regime would make an enormous difference for them.

**Flexible workplace arrangements**

Likewise, the opportunity to work from home was seen as a very effective way of relieving working carers of pressure, which applied universally to all countries studied. According to
some British working carers greater flexibility in moving to a more suitable workplace within the same company (position with less responsibility, more flexibility overall) was seen as equally important. This would also include flexibility in allowing a return to the former position once the care-giving situation was resolved and the employee wished so.

**Care leave schemes**

Considerable progress has been made in regard to the introduction of eldercare leave in some countries (Germany, Italy and the UK in our study). However, many working carers still felt that they lacked flexibility to be adjusted to real-life situations. Moreover, care leave is of little value to working carers as long as it is unpaid. The minimum working carers in the German sample would expect is compensation for lost contributions towards their pensions. Some suggested using LTCI payments as income in exchange for care-giving, which – if they did not do it – would have to be provided by professional care workers anyway. Generally, working carers rely on their earned incomes for paying for various expenses, including paying for complementary care services purchased in the private market. Furthermore, a fixed-term care leave does not really help in a situation where duration and future level of care commitment is unpredictable. As pointed out earlier, average duration of care commitments in our study were 5.4 years – no care leave could be extended over such a long period!

**Company policies**

There was no clear-cut opinion on how formal company policies on reconciling work and care should be realised. Preferences varied across country borders. British working carers felt that too much was left to the discretion of line managers. They therefore demanded clear policies that would unequivocally apply to everybody in this situation, which was particularly important in case of an unsympathetic line manager or a line manager unaware of appropriate company policies. In contrast, the total absence of any demands for care-related company policies in Italy was indeed striking. The strict separation of care and work by Italian working carers we referred to on several occasions throughout the report appears to be so strong that the carers did not even consider this to be an option.

**Migrant care workers**

The employment of migrant care workers is politically a very sensitive topic in some countries, including Germany. Formal arrangements in the private care market would be tolerated, but informal arrangements that do not include payment of social insurance contributions are seen as illegal economic activity that is prosecuted by the German authorities. Nevertheless, employing a migrant homecare worker could be part of the solution for working carers as the Italian example shows. But even there working carers expressed the view that the government ought to pay a substantial cash subsidy that would allow them to come to a formal arrangement with a working carer or to afford paying her for more hours.

Employment of a migrant care worker may constitute part of the solution for working carers elsewhere. The main advantage for families with care-giving responsibilities of employing a migrant care worker is a much greater flexibility, specifically in regard to long working hours and physical proximity (live-in carers), than formal home-care services are able to provide. The prohibitively high financial costs associated with purchasing similar services make it virtually impossible to use the latter for many working carers. But even the costs of paying a migrant care worker can be substantial. Thus, Italian working carers were suggesting the introduction of a cash benefit that would allow care recipients and/or carers to employ a migrant care worker. In the German context it may be worth considering using payments from the Long-Term Care Insurance for that purpose. At the end of the day, finding a solution for the predicament of carers that would allow them to continue employment, which would not be in conflict with social and legal norms of wider society, would make a
substantial contribution to mastering the care-giving challenge resulting from demographic ageing.

Community care

Another suggestion from both the Italian and the Polish samples referred to the establishment of local community-based support networks. These networks are thought to re-invoke a sense of neighbours and the wider local community looking after each other. The voluntary sector was seen as playing a key role in facilitating such networks.

Greater involvement of voluntary sector

Calls for a greater involvement of the voluntary sector were made in all four countries. Apart from the above-mentioned community care networks, Polish working carers advocated volunteer visiting services. Similar schemes already exist in Germany where financial support for such activities has been available from within the Long-Term Care Insurance since its 2008 reform. Many carers also felt sorry for the lack of entertainment their older relatives enjoyed and proposed using the services of voluntary organisations for that purpose.

Societal recognition

Many working carers missed public recognition of their significant contribution to the common good by actually combining two very demanding jobs – employment and providing high-quality care to an older person. German working carers were particularly conscious of this deficit and expressed a desire for more societal dialogue about these issues.

12.4. Implications for future research

Our study provided deep insights into how working carers make decisions about balancing work and care and which reconciliation strategies they use in different institutional and cultural contexts for achieving that – a previous gap in academic knowledge identified, among others, by the EUROFAMCARE study (Mestheneos and Triantafillou, 2005).

The findings of our research have also shown that a static analysis of welfare state and care regimes (see Esping-Andersen’s original model) does no longer reflect the realities of our ageing societies. It thus made a significant contribution to European social policy and comparative welfare state analysis, adding credit to the claim that future welfare state or care regime classifications would need to be based on dynamic analyses. Moreover, our research also highlighted the importance of considering regional variation, another area of research that is still somewhat underdeveloped, despite of growing availability of regional statistical data.

The Italian case is an example-par-excellence illustrating the increasingly dynamic nature of social change in European societies. Deep-rooted Catholicism may suggest the persistence of traditional care-giving patterns – however, the reality is far more complex. In the light of the above described policy measures, it is not surprising that in Italy the care of older people is still a “family affair”, impacting mainly on women, as these bear this responsibility more frequently and extensively. However, due to recent socio-economic and demographic changes, the scenario is increasingly shifting from the family to privately paid migrant care workers, thus deeply changing the traditional Italian family care model. This change is characterised by three parallel phenomena: (a) a growing female participation in the labour market; (b) a widespread employment of migrant care workers by private households; and (c) the increasing availability of both state and local care allowances (which substantially contribute to the two previous trends).

Albeit relevant, the level of financial resources made available to Italian households by public cash-for-care schemes is still insufficient both to ensure a high quality support of
dependent older people and to represent an incentive for Italian women to leave (or not search) paid work, at least in the Central and Northern regions of the country. In the South, instead, given the lower living costs and the lower availability of profitable jobs, such care allowances might indeed play the role which has been observed also in other countries, where economic supports accessible (directly or indirectly) to carers end up “trapping” them out of the labour market. Another Italian peculiarity which should be considered concerns the retired status of many older adult women, due to the relatively low retirement age in Italy, which allows many of them to start caring without having to solve a reconciliation problem.

These trends make today’s Italian care regime similar to the American model, consisting of "low cost" access to care, based on migrant workers willing to endure disadvantaged and irregular conditions of work in order to gradually gain some citizenship rights. This considerable irregularity represents an adaptation "from the bottom" of the traditional system of family care, and not driven from – marginal – normative or political intervention. Under such circumstances, the main strategy for reconciling care and profession is based on the employment of a paid home care worker, resorting to institutionalisation only as a last – and indeed very rarely used – resort.
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