ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives

Norway

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European Social Policy Network (ESPN)

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While formal care arrangements are relatively well developed in Norway, there is still a considerable scope for informal care. Arguably the recent trend towards more care provided in the home, and less institutionalised care, has increased the need for informal care. There are however few legal obligations to undertake such care: parents have an obligation to care for under-age children, and spouses to care for each other, but no other legal obligations exist. Social norms and moral obligations are however a very different matter.

The statutory rights to paid leave in order to care for chronically ill and severely disabled family members – including children – are limited. If a child is critically ill, however, the right to paid leave is in principle unlimited in time.

Three forms of benefit are relevant in this respect: attendance allowance (*pleiepenger*), attendance benefit (*hjelpestønad*), and carer's wage (*omsorgslønn*). Attendance allowance and carer's wage are paid to the carer, while the attendance benefit is paid to the person with caring needs. Attendance allowance is in most cases a relatively short-term benefit, designed to cover acute situations (such as acute illness in a child or other close relative, or terminal illness), while the two other benefits can be paid for as long as the caring relationship lasts. Carer's wage is a municipal arrangement, and eligibility and priority criteria can vary from one municipality to the next.

A study from 2011 indicated that employment rates among mothers with severely disabled children (aged 9–14) were relatively high: 75 per cent were in employment – 44 per cent worked part-time, 31 per cent full-time. 4 per cent were undertaking education, and 21 per cent were neither in employment nor education. Corresponding figures for fathers are not available. Mothers often set the availability of respite support as a precondition for their employment.

There is little political discussion of the arrangements described here. Generally, they are not seen as problematic, and certainly not in the sense that they provide disincentives to paid employment or disrupt employment careers. For attendance allowance, the period is too short to create perverse incentives, and for attendance benefit, the level is too low. Carer's wage, on the other hand, does appear to be seen as an alternative to formal employment among some recipients. However, these recipients are typically in situations that would make them marginal in the labour market anyway, and in order to quality for carer's wage they must have very demanding care obligations. Also, the number of recipients of carer's wage is low.

The report does not suggest any substantial policy changes. It is suggested that respite support could be used more actively for elderly carers, in order to increase their quality of life. It is also suggested that there is a discrepancy between the generous right to leave with full wage compensation during one's own illness, and the meagre rights to income compensation when taking leave in order to care for someone else.

1 Description of main features of work-life balance measures for working-age people with dependent relatives

1.1 Overall description of long-term care regime

Long-term care services in Norway are the responsibility of the municipalities, and have been so since the 1980s. The municipalities finance these services out of their tax revenue and general grants from the state. Previously a major part of the state's financial support for a range of municipal services was given in the form of earmarked grants, but over time a clear priority has been to increase municipal autonomy by giving general grants instead. To compensate for the loss of influence that earmarked financing gave it, the state has emphasised governance through legal obligations and contractual agreements with the Norwegian Association of Local and Regional Government (KS). The municipalities (through state grants and tax revenues) provide most of the financing of elder care within and outside institutions, but residents in long-term care institutions pay income-related user charges.

The right to receive care is stated in the Act on Municipal Health Care Services. The municipality is obliged to provide care, including a place in a nursing home to a frail elderly person, but only if this is deemed to be necessary based on a concrete evaluation of the situation of the applicant. The decision is made by the municipality, but applicants can appeal to the County Governor.

Most recipients of long-term care services are frail elderly people, and improving care services for the old has been a political priority in Norway for decades. It is however important to note that Norway does not have a welfare state sector labelled as "services for the elderly": Norway has care services, operated by municipalities, that are available to all residents who need longer-term care. Traditionally, these services have in practice been used almost exclusively by the frail elderly, but in recent years users under 67 have made up an increasing proportion of the users. In the period 1992-2006, the number of people (full-time equivalents) in care services increased (nationally) by 92 per cent (Brevik 2010), which indicates a major investment. Broken down by characteristics of recipients, it turns out that services targeted at the under-67s increased by 121 per cent, while services for the over-80s increased by a mere 20 per cent. The majority of users are still over 80, but the number of users under 67 increased from 25,000 in 1992 to 55,000 in 2011 (Gautun et al. 2012:26). This is part of the background to the apparent stagnation of the development of services for the elderly, despite a long-standing political commitment – by successive governments – to strengthen elder care. Another explanation for this is the observation that increasing longevity is matched by an increase in health and physical ability in old age. In other words: the elderly remain healthier at higher ages, and hence the demand for care services does not increase at the same rate as increasing longevity (Moe & Hagen 2011).

Table 1: Take-up rates in 2008 according to type of service and age (%), 67+

	67+	80+	90+
1. Nursing home	6	14	36
2. Care home	5	11	22
3. Sum out of home (1+2)	11	25	57
4. Ordinary home	12	24	33
5. Sum all types of care (3+4)	24	49	90

Source: Otnes (2012:71)

An overview of the take-up of both institution-based and home-based care for the elderly (aged 67+) for the year 2008 is provided in table 1. These figures confirm that a substantial fraction of the elderly in Norway receive some form of publicly financed care service and that this fraction is increasing very rapidly with age. Among people above the age of 80, almost 50% receive care services – more or less evenly

distributed between home-based and some form of institution-based services including extra care housing.

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Institution-based care is almost exclusively given to users who are 67 and older. In 2011, an estimated 43,400 people lived in long-term care institutions in Norway. Only 4,700 (11 per cent) were younger than 67. Measured as a proportion of the entire population, 1 in 1,000 inhabitants under 67 was institutionalised. This is a deliberate development, as long-term institutions for the mentally disabled, psychiatric patients and people with drug addiction have been shut down systematically over the last 30 years, to be replaced with home-based support in the local community (Gautun, Grødem and Hermansen 2012).

This approach is also valid for families with disabled children and other children with extra care needs. By far the most common approach is that the child lives at home and is cared for by the parents, but that the parents receive respite support (see below) for a given number of hours – or days – per week. The parents can also receive some financial support, as described in section 1.3 below. In a very few cases, however, the families are overburdened by their caring obligations. It is possible for a child under 18 to live permanently in a children's home, which are homes designed especially for children with very significant care needs (Handegård et al., 2007). It is hard to determine how many places in children's homes are available nationally, since such homes can be registered under different names, but the overview by Handegård et al indicates that the figure is about 200 - in other words, very few. Children's homes are often merged with homes used for disabled children in (temporary) respite care, and should not be confused with housing for children taken into care by the Child Welfare Services. Handegård et al. suggest that such homes are "well-kept secrets" – municipalities do not advertise them – and that many families are exhausted by the time they ask for their child to be placed in such homes. Once the decision is made, however, most parents are happy with the way their child is cared for (Handegård et al. 2007).

Over the last decade there has been a continuous debate on the desirability of competition in the delivery of care services. Voluntary organisations have traditionally played a significant role in owning and running nursing homes for the elderly. However, while there still are quite a few privately owned nursing homes in Norway, most have been fully integrated into the public system and have become completely dependent upon public financing. The role for private companies in the provision of care is one of the few social policy issues on which there is a clear left-right divide in policies. There is general agreement that the financing of services should be a public responsibility, but the parties on the right have traditionally called for different forms of privatisation of delivery, while the parties on the left prefer that the municipalities

should maintain their virtual monopoly as providers of both institutionalised and home-based elderly care.

This outline highlights the public responsibilities for people in need of long-term care in Norway. There is however no doubt that there is a large informal sector. The trend towards less institution-based and more home-based care has been criticised for leading to an increased need for informal care: the services provided in the home are often relatively minimal, and informal helpers (parents, spouses, adult children, even neighbours) are expected to fill the gaps. This is despite the fact that parents and children over 18 have no legal obligation to provide care for each other.

Spouses do however have a legal obligation to provide for each other, and parents have an obligation to care for children under 18. Disabled children are almost always cared for by their parents. Caring family members, including spouses and children, can receive some help in the form of paid leave or compensation for heavy caring obligations. These arrangements are described in the next section.

1.2 Description of carers' leave

The right to take leave from work in order to undertake caring work is very limited in Norway, if we omit the comparatively long parental leave (49 weeks with full wage compensation for each child). Carers whose caring obligations are incompatible with employment thus have the choice between seeking unpaid leave, or opting out of employment entirely. In both cases, they may apply for attendance allowance and/or carer's wage (see below). Whether unpaid leave is granted, and for what period, is at the discretion of the employer. The employee has no statutory right to such leave. This creates dilemmas, particularly for people whose caring obligation is heavy, but assumed to be of limited duration (for example caring for a spouse or child whose illness is terminal, but where death is not imminent). Many organisations for the long-term/chronically ill and their families therefore recommend that carers overcome this dilemma by looking into the possibility of going on sick leave themselves. This is, for instance, the case for the Norwegian Cancer Society (2015:77). In giving this advice, it is emphasised that caring obligations do not in themselves give the right to sick leave, but that the strain of caring may lead to physical or psychological illness, in which cases the general practitioner (GP) can grant sick leave. The Norwegian sick-pay regime is generally described as generous, in that employees can take up to one year of sick leave with full wage replacement.

Parents with children under 12 have the right to up to 10 paid leave days per year to care for a sick child with full wage compensation up to the sickness benefit ceiling. This is a universal right for all working parents. In addition, parents have the right to leave, with no fixed limits on duration, when:

(a) the child is hospitalised and the employee (parent) resides at the health institution,

(b) the child has been discharged from a health institution and the employee (parent) must stay at home because the child needs continuous care and attention, or

(c) the child is suffering from a life-threatening or other extremely serious sickness or injury.

In situations described in (a) and (b), the main condition is that the right to leave concerns children under 12. In situations described in (c), extremely serious illness or injury, the right to leave exists up to, and including, the year the child turns 18, and regardless of age if the child has a mental disability.

In addition, there are some shorter leave arrangements. According to the Working Environment Act §12-10, employees have the right to 10 days leave per year to care for adult family members in need of care. Family members covered by this paragraph in the legislation are parents, spouses, cohabiting partners, registered partners, and children older than 18. The Act does not determine a right to a fixed level of pay

during the leave period, but the right to pay can be determined by agreement between employers and trade unions for each sector or workplace.

Also, the Working Environment Act §12-10 creates a right to leave for up to 60 days to care for a relative or other close person during the terminal stage of life. This part of the legislation relates to a wider group of people than the former: "other close person" can be a neighbour or a friend. The only requirement is that the person in the terminal stage wishes to be cared for by the employee asking for leave. Again, this leave is normally unpaid, but people on leave can receive attendance allowance (*pleiepenger*) from the National Insurance Scheme (see below). This is a flexible form of leave: the 60 days can be shared among several carers, and can be taken all at once or on a day-by-day basis over several weeks.

1.3 Description of carers' cash benefits

There are basically three forms of benefit targeted at informal care: attendance benefit (*hjelpestønad*), attendance allowance (*pleiepenger*), and carer's wage (*omsorgslønn*). Attendance benefit and attendance allowance are state benefits administered by the Norwegian Labour and Welfare Administration (NAV), while carer's wage is administered by the municipalities (under the Act on Social Services in NAV) and thus can vary between local contexts.

One crucial difference between attendance benefit and attendance allowance is that the former is paid to the person in need of care, while the latter is paid to the carer. Attendance benefit is frequently mentioned in the same breath as basic benefit (*grunnstønad*) (as in "grunn- and hjelpestønad"), as the two are thought of as twins: both exist to cover necessary extra expenses as a result of chronic illness, permanent injury or a congenital defect or disability. There is however a division of labour between the two: basic benefit is paid towards the cost of necessary aids (such as transport, assistive technology, guide dog etc.), whereas attendance benefit covers extra needs for care and supervision.

It is a requirement for receiving attendance benefit that the recipient has private care arrangements, or that attendance benefit will allow them to make private care arrangements. By private care arrangement is meant informal care by the spouse, children, parents, other relatives, neighbours or others. In other words, being a blood relative is not a requirement. When applying for the benefit, a declaration from a medical expert (doctor) must be supplied, spelling out the extent of the applicant's disability and care need, and how time-consuming care for the person is assessed to be.

When the need for assistance is being assessed, importance will also be attached to the need for stimulation, education and exercise in the home. The need for assistance must be permanent. As a general rule, it must last 2-3 years or more due to the medical condition. A person is said to have a special need for care and supervision:

- where they are not able to cope without supervision, at home and out and about, day and night;
- where they need help with personal care and hygiene and in eating situations.

The attendance benefit is flat-rate, payable at a rate of NOK 14,412 per year (EUR 1500). It is not taxable. Children under 18 can receive a higher rate, up to NOK 86,472 (EUR 9,000) per year.

Attendance allowance (*pleiepenger*) is payable directly to carers. It exists to compensate for loss of earnings, and is payable on the same eligibility criteria as sick pay (that is, to employees who have been in employment for a minimum of four weeks). It is mandated in the National Insurance Act, and can be paid in the following circumstances:

- where someone has a severely ill child (§§9-10 and 9-11); or
- where someone is caring for a relative or other close person during the terminal phase of life (§9-12).

The circumstances under which attendance allowance is payable are parallel to the circumstances under which someone has the right to leave under the Work Environment Act, as described above. When a child is severely or terminally ill, attendance allowance is paid with no limit of duration up to and including the year the child turns 18 (unless the child is mentally disabled, in which case there is no age limit). Parents who have received the benefit for three years or more are entitled to an additional three months after the caring relationship has ended because the child passed away. Attendance allowance paid under paragraph §9-12 – caring for a terminally ill relative or other close person (who is not one's own child under 18) – is limited to 60 days. A form must be completed by the patient's doctor giving the name and address of the patient, describing the diagnosis, and stating that the illness is presumed to be terminal. In both cases the allowance can be used flexibly, and can be scaled down to 50 per cent if the care is combined with part-time work.

Attendance allowance is paid at the same rate as sick pay, that is, at full wage compensation from day one. It is also taxed as income. Unlike sick pay, however, there is no employer's period in attendance allowance, thus the allowance is financed by the National Insurance Scheme from the beginning.

Carer's wage was introduced in Norway in 1986, and is currently determined by the Act on Social Services in NAV – that is, the Act that regulates the municipal services administered by NAV. People can apply for carer's wage if they undertake care work that the municipality would have to do, had the carer not done it informally. There is no statutory right for the individual to receive this benefit, but the municipalities are obliged to offer it. Municipalities, however, decide for themselves what the eligibility and priority criteria should be. In order for carer's wage to be paid, the municipality must accept that private informal care is the most desirable way to provide care for the client in question. This understanding must be reached through a dialogue with the carer. The wage can be paid to carers with no statutory obligation to care (e.g. adult children caring for ageing parents) as well as to parents caring for their own children with special needs. It is not linked to any loss of income; thus it is available irrespective of recipients' current employment and work history.

Carer's wage is secondary to attendance allowance. This implies that when a potential recipient applies for carer's wage, the municipality can demand that they also apply for attendance allowance, and the any such allowance received is deducted when carer's wage is calculated. Apart from this, the wage is not means-tested or income-tested.

When calculating how much carer's wage should be awarded, municipalities normally take the annual wage of the lowest-paid municipal employees as a starting point. Carers apply for payment for a specific amount of care work per week, determined by the needs of the person cared for. Applications for carer's wage will thus normally be relatively detailed with regard to care needs. Carer's wage is taxed as income.

1.4 Description of carers' benefits in kind

Under the Act on Municipal Health Care Services (§3-2), people who provide care for people with demanding care needs have the right to respite support (*avlastning*). The right to respite support exists for the benefit of the carer, not the person being cared for. This implies that when respite support is sought, the applicant needs to convince the municipality that they carry a significant burden and need a number of respite breaks. They do not need to argue that this is something the cared-for person needs, although the form and scope of respite support obviously take the needs of the cared-for person into account. The aim of respite support is to prevent exhaustion among carers, and to allow then to go on occasional holidays and have a normal social life.

A corresponding arrangement is “support person” (*støttekontakt*), which is targeted at the needs of the cared-for person. In order to get a “support person”, the applicant must convince the municipality that they have social needs that are not being met. Since this is an in-kind benefit for the person being cared for, rather than the carer, we do not give further details here.

Carers may accrue old-age pension rights. The Norwegian old-age pension system offers both a minimum guarantee and earnings-related benefits. Earnings-related pension rights are also awarded - for certain unpaid activities – among them care work. In cases where a chronically ill or disabled person needs care that is estimated to exceed 22 hours per week for six months or more, the carer can be awarded pension rights equivalent to rights granted to a full-time worker in a low-paid job, and similar to the pension credits awarded to people who care for children under 6.

Parents with chronically ill or disabled children under 18 have the right to reimbursement of expenses related to education and training targeted at better managing their child’s condition. It is a requirement that this training takes place in a previously approved institution.

2 Analysis of the effectiveness of work-life balance measures for working-age people with dependent relatives

2.1 Assessment of measures

2.1.1 The form and scope of informal care

By the very nature of the services, it is impossible to get precise information about how much informal care work is actually carried out in any society. The Level of Living Survey 2012 contained some questions about care provided to people within and outside the household (Statistics Norway 2013). The results, for a representative sample of the Norwegian population aged 16 and over, are shown in table 2.

Table 2: Proportions undertaking informal care work, Norway 2012.

	Per cent, 2012	Change 2008-2012, percentage points
Belongs to a household with at least one member with care needs	6	2.2
Regularly provides unpaid care or supervision	16	0.6
Regularly provides care or supervision to a person with care needs within the household	3	0.3
Regularly provides care or supervision to a person with care needs outside the household	14	0.8

Source: Statistics Norway 2013

The table indicates a small increase in the proportion of the Norwegian population who provided informal care services between 2008 and 2012, but – as would be expected for such a short time span – the differences are small. As many as 14 per cent reported that they regularly provided care and/or supervision to a person outside their own household, while 3 per cent provided such care to a person living in the same household. Those who provided care or supervision to a person living outside their own household indicated that they did so on average for about four hours per week. Women, and respondents living in rural areas, provided more such care than men and

residents in urban areas (Statistics Norway 2013). People between 45 and 66 years old provided more such care then people who were younger or older.

Who were the recipients of such care? The most common situation was that of people providing care for their own parents. 8 per cent of the population who had living parents provided such help. 7 per cent provided help to relatives other than parents, and 4 per cent provide help to neighbours or friends.

It was more common to help with practical issues than to provide care. Of the population who had living parents above the age of 67, 9 per cent had helped them with grocery shopping and 5 per cent with cleaning, while 10 per cent had provided other forms of practical help. Correspondingly, 5 per cent had provided care or supervision for their ageing parents, and 4 per cent had been involved with the municipal home-care services on a parent's behalf.

The estimates given in table 2 are absolute maximum estimates of the scope of informal care in Norway, and most of the support referred to will not interfere – except perhaps for brief periods – with carers' work obligations. A study with data from 2003 examined explicitly how important care obligations are as causes of longer-term (more than 6 months) absence and early retirement (Midtsundstad 2009). The results indicated that only 0.5 per cent of private sector employees, and 0.3 per cent of state employees, surveyed had had long absences, at any point during their career, that were related to care obligations for persons other than their own young children (see Annex). Similarly, for the respondents who had reached an age where such issues must be assumed to be most pressing (63-66 years), 2.6 per cent of private sector employees, and 3.9 per cent of state employees, said they had had close relatives with significant" care needs. And among those who had taken early retirement (which by 2003 was available between 62 and 66), only 2-3 per cent said that having a close relative in need of care was an important reason. These figures clearly suggest that while it is common in Norway to undertake some care work, or at least help out ageing family members, such obligations are unlikely to interfere with working careers.

The above figures however only cover those who are already in employment. A study published in 2011 showed that 21 per cent of mothers with severely disabled children were not in education or employment.[1] Of those who were in employment, 31 per cent worked full time and 44 per cent worked part time (Finnvold 2011). Although participation in employment was lower than among mothers with children in this age group in general, this does not suggest widespread marginalisation. It is worth noting that in the recent hearing document (Department of Health and Care 2015) on arrangements for persons with caring obligations, the risk of labour market exclusion is not discussed.

The arrangements described to support people with severe caring needs and their attendants are relatively limited. By 2015, the attendance benefit was paid to approximately 74,000 recipients: 37,000 men and 37,000 women. 42 per cent of recipients were under 18, which suggests that attendance benefit is to a very large extent used to compensate parents with severely disabled children. 22 per cent of recipients were over 67, while the rest were spread relatively evenly between 18 and 66 (NAV 2016). Just under 10,000 people received carer's wage in 2013 (Statistics Norway, undated table).

2.1.2 Coverage and take-up

There are no figures for estimated take-up (that is, recipients as a proportion of all who might be eligible), but it is likely that take-up-rates for the attendance allowance and the attendance benefit are high, as these are national arrangements with reasonably clear eligibility criteria, and because all eligible individuals and families are

[1] The mothers surveyed had children aged 9-14 who received attendance benefit at the highest rate, that is, who were severely disabled.

in contact with health personnel who can inform them about the benefits and help them apply. The municipal carer's wage is a different matter. Municipal practices vary, both with regard to how much money is allocated to this measure and how the eligibility criteria are construed and applied. However, the number of appeals cases for applications for carer's wage is not particularly high, and occasional state checks on municipal practices do not suggest that this arrangement is particularly problematic (Helsetilsynet 2009).

It is worth noting in this context that municipal practices regarding respite support and allocation of support persons was sharply criticised by the Norwegian Board of Health Supervision in 2007 (Helsetilsynet 2007). A supervision report found that elderly people in need of care, and their carers, were not informed about these arrangements in many municipalities; and that, if they applied, they were often rejected. The Board of Health Supervision pointed out that this indicated discrimination in access to services based on age and diagnosis, which is illegal and "a serious matter" (Helsetilsynet 2007: 4). Despite the sharp criticism from the board, practices appear to have changed little: in 2013, just over 8,000 people were awarded respite support; only 2,5 per cent of these were 67 years or older. Corresponding figures for support persons were 30,000 and 18 per cent (Statistics Norway, undated table).

2.1.3 Employment effects

As mentioned previously, the employment effects of the arrangements described here are currently not a political concern in Norway; and from an expert point of view it also seems highly unlikely that such effects should be anything but marginal. The rights to leave of absence to care for relatives in need only give the right to short periods of leave at critical periods, such as when a child under 12 is hospitalised. Only critical, potentially life-threatening illness in a child under 18 gives the right to a longer period of leave – and these will be situations where parents are likely to be absent from work anyway. If anything, therefore, the statutory right to leave helps them maintain a foothold in the labour market in a desperate situation. The right to attendance allowance in such cases is dependent on previous employment, thus the existence of this allowance can act as an incentive to take up employment and acquire this social right.

Attendance benefit payable to people with severe care needs can be a helping hand to families with a disabled child or parent, but the benefit – even at the highest rate – is far too low to be more than that. The family will need other sources of income, and thus this benefit too is unlikely to create disincentives to work.

Carer's wage is a slightly different matter, as this is paid at the same level as a low (municipal) wage, and is regarded as taxable income – carer's wage is a wage. Finnvold (2011) found in his enquiry that mothers in receipt of carer's wage were less likely than other mothers with children in the same age group and with the same level of disability to work outside the home. This held true even after controlling for other factors. He also found that mothers who received carer's wage had a lower education level than average, and expressed little interest in paid employment. He thus concluded that carer's wage can be used as an opt-out strategy by women who were marginal in the labour market in the first place, and who placed little value on employment. Given that carer's wage is received by fewer than 10,000 people with very heavy caring obligations, and the recipients who use this as an opt-out strategy typically are marginal in the labour market in any case, it is debatable how problematic this is.

Finnvold (2011) also found that employed mothers whose children had demanding care needs emphasised the availability of respite support as a precondition for continued employment. The total package of municipal services, then, including both carer's wage and respite support, allows some room for mothers in this situation to "pick and mix" according to their preferences, which may be more or less employment-oriented.

2.2 Policy recommendations

As mentioned, the Department of Health and Care has initiated a process designed to strengthen the rights of informal carers in the municipalities. The main proposals are to move carer's wage from the Act on Social Services in NAV to the Act on Municipal Health Care Services, and to tighten up the municipalities' obligation to provide information and training. In practice, this amounts to little more than a more precise expression of current practices.

From an expert point of view, the limited availability of respite support for elderly carers – which was sharply criticised by the Norwegian Board of Health Supervision in 2007 – is worrying. Despite the criticism, practices appear to have altered little. Better access to respite support might be an important measure to improve quality of life for carers, particularly those who care for ailing spouses late in life.

It has been argued that the eligibility criteria for attendance allowance introduce restrictions that are neither logical nor reasonable (Haveraaen and Diseth 2012). The allowance can only be awarded for relatively short periods, and it is explicitly stated that it should not be awarded to parents with children whose care needs are long-lasting. It can only be awarded to parents whose children are chronically ill or severely disabled in periods where the child's condition is worsening or seen as unstable. If the child's extra care needs lasts beyond two years, the relevant benefit is attendance benefit, which is paid at a much lower level. This discussion can be seen in the context of the liberal sick-leave regime in Norway, as mentioned above. It is likely that care for relatives with severe caring needs – which give limited rights to leave and benefits – is sometimes masked as an employee's own "sick leave". While this is mainly a matter of cost-shifting between different parts of the social welfare budget, such strategic action may undermine the legitimacy of both arrangements.

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Working Environment Act (Lov om arbeidsmiljø, arbeidstid og stillingsvern mv. (arbeidsmiljøloven))

Annex

Table A: Main causes of longer absences (6 months or more) in the course of the working career, for men and women employed by private enterprises or the state.

	Private sector			State		
	All	Women	Men	All	Women	Men
Education	9.1	2.2	11.1	11.7	10.6	13.0
Working at home with care for one's own children <18	12.2	56.7	0.1	18.6	52.6	0
Working at home, no care obligation	0.5	2.5	0	0.6	1.7	0
Working at home, caring for relative	0.5	1.9	0.1	0.3	0.6	0.2
Unemployment	2.3	1.9	2.4	0.8	0.8	0.9
Illness	12.8	9.6	14.2	10.6	12.1	10.0
Other	1.4	2.5	1.1	2.5	4.7	1.3
No long absence	64.0	32.7	72.6	54.9	15.9	74.6
Total	100	100	100	100	100	100
N=	1474	321	1153	1722	633	1089

Source: Midtsundstad 2009, p.243

Table B: The proportion of married/cohabiting respondents (63-66 years) employed by private enterprises or the state, who at the time of the interview had a spouse or other close relative in need of care.

	Private sector			State		
	All	Women	Men	All	Women	Men
Significant need of care	2.6	3.3	2.4	3.9	6.8	2.8
Some need of care	4.5	7.1	3.9	5.1	3.9	5.5
No need of care	92.7	89.6	93.4	90.6	88.8	91.4
Don't know	0.2	0	0.3	0.4	0.5	0.4
Total	100	100	100	100	100	100
N	1235	212	1023	750	205	545

Source: Midtsundstad 2009, p.246