Peer Review on Improving Reconciliation of work and long-term care

Thematic Discussion Paper

Combining paid work and family care; the impacts of care leave and other measures to improve work-life balance

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1 Introduction

Across developed and developing countries, families are the most important sources of help for people requiring practical, personal and/or psychological support because of age, disability or limiting long-term illness[1]. Estimates of numbers of family carers across the EU vary according to the definitions and methods used to identify carers. According to one estimate, in 2005 there were 19 million people across the EU providing at least 20 hours a week help to a disabled or adult or older person; of these, around 9.6 million provided at least 35 hours a week care (Glendinning et al 2009). Estimates of the economic contribution of unpaid family work range from 20.1% to 36.8% of European GDP (Colombo et al 2011). Within families, women are more likely than men to carry the main responsibility for providing this support, particularly to disabled children and older relatives. Yet, at least in part because of assumptions about women's and family responsibilities, family care-giving is often hidden, with relatively little attention given to its impacts on the care-givers, their families or the wider economy.

Reflecting pressures to promote gender equality, legislation, policies and other arrangements to protect the employment, career prospects and incomes of women (and to a lesser extent men) with care-giving responsibilities for young (non-disabled) children are well-established across EU and other countries (Kröger and Yeandle 2014). The relative invisibility of people caring for disabled children, adults and older people in labour market, workplace and human resources policies is now also being challenged – not least by organisations representing carers themselves (see for example Eurocarers n.d. a). There is growing interest within the EU and member states alike in how formal paid work and family care for disabled, long-term sick or frail elderly people can be combined. This interest reflects several linked trends:

- Population ageing. Numbers of older (and very old) people, and consequent demands for care, are increasing. At the same time there is a corresponding decrease in the size of working age population available to provide this care or fund it through earnings-related taxation.
- Workforce trends. Partly in response to population ageing, there are growing imperatives to maximise the economically active population by encouraging and maintaining women's labour market participation, as well as other policies aimed at increasing labour supply such as welfare conditionality and later retirement.
- Changing family structures. Smaller families, geographic mobility and increases in unstable partnerships, lone parenthood and reconstituted families all affect the potential supply of family care.
- Trends in long-term care policies, particularly the active promotion of non-institutional care which increases demand for labour-intensive care in the community and in people's own homes.

These trends are discussed in more detail in Section 2.

How can growing demands for care be reconciled with decreases in the availability of family members to provide the very substantial amounts of support on which long-term care systems widely depend? What can be done to reduce labour market pressures on the potential supply of care? Tensions between labour market participation and care-giving have an important additional policy objective – the promotion of gender equality through the 'reconciliation' of work and family life. Thus

[1] In this paper the terms 'family care (-giving)' and 'family carer' are used to distinguish this help from that provided by formally organised social, personal and healthcare services (whether provided through the welfare state or privately purchased). The term does not exclude help given by friends, but reflects the fact that the most intensive, intimate and long-duration care is generally provided by close relatives.

over the past three decades the EU has introduced rights to parental leave and job security, primarily for women (and men) with responsibilities for young children.

More recently, both EU terminology and policy commitments have shifted to focus on the work-life balance of those caring for disabled and chronically ill children, adults and older people (Bouget et al 2017). Not surprisingly given demographic trends, the focus has been primarily on the care of frail older people and their family care-givers, currently predominantly women in their 50s and 60s. Here, the contexts and trajectories of care-giving and the potential impacts on care-givers' labour market participation and work opportunities are rather different from those faced by the carers of (non-disabled) dependent children, not least because people undertaking care for adults and older people are themselves generally older, and therefore at later stages of their working lives, than the parents of young children.

2 Policy context

2.1 Demographic trends

Across OECD countries, populations are ageing rapidly. By 2050 almost 10% of the total population will be aged 80-plus (compared with just 1% in 1950) although there are variations between countries in projections of disability-free old age. Overall, the number of people aged 80-plus per 100 population aged 15 to 80 will increase from about 4 in 2010 to 12 in 2050 (Columbo et al 2011). Within the EU27, the population aged 65+ as a percentage of the population aged 15-64 is projected to increase from 26% in 2010 to 53% in 2060. In other words, there will be just two people aged 15 to 64 for every person aged 65 or more in 2060, compared with four in 2010 (SCP and EC 2014).

Increased longevity among spouses (particularly men) will to some extent offset the decline in caring capacity among the working age population, as more men become carers for disabled spouses in later life. However, this will not fully compensate for the anticipated decrease in the supply of working age carers; moreover, it also increases the likelihood of increasing numbers of couples in which both partners need support. Although there are significant between-country variations, the total number of family care-givers would need to increase by 20% to 30% across OECD countries simply to maintain the current ratio of carers to adults with disability or age-related restrictions - and by up to 40% in Germany and 50% in Italy (Columbo et al 2011).

These demographic changes have the potential to significantly increase public expenditure pressures. By 2050, public spending on long-term care as a share of GDP is expected to at least double in EU member states, from 1.2% to 2.2-2.9% (Columbo et al 2011; SCP and EC 2014). Healthier ageing and delays in (or avoidance of) the onset of support needs may reduce some of these public expenditure pressures. Conversely reductions in the availability of family care-givers will increase demand for more expensive formal care services (Columbo et al 2011).

Other demographic changes are altering the nature of care-giving and its impact on paid work. Social and occupational mobility mean potential care-givers may live a considerable distance from frail elderly parents (or, indeed, children who begin to need support during adulthood). US studies have found between 10% and 26% of carers support someone living at least an hour's travel away (Neal et al 2008). Because care-giving is generally assumed to depend on close proximity, care-giving at a distance risks remaining invisible. The nature of distance care-giving is likely to be different too, with greater emphasis on organising and managing local sources of help, greater stress and increased costs (Neal et al 2008).

2.2 Labour supply

Since the Lisbon Strategy agreement of 2000, the EU has been committed to pursuing growth through high levels of employment and a skilled, entrepreneurial workforce.

Both measures are intended to increase productivity and address the twin challenges of an ageing population and the competitive pressures of a globalised economy. These goals were restated in the Europe 2020 Strategy, continuing the commitment to high employment, improving the match between labour demand and supply (including labour mobility) and investing in education, training, qualifications and skills (Bongardt et al 2010). Increasing women's labour market participation is central to the Europe 2020 objective of 75% of the population aged 20-64 being employed by 2020.

All EU countries have experienced increases in female labour market participation; in 2016 the average EU28 female employment rate was around 61%. Rates are higher in countries with extensive long-term care welfare provision (at least 70% in Sweden, Denmark, Germany and the Netherlands). Although female labour market participation rates are lower in Greece, Italy, Malta, Romania and Spain, at less than 55%, even here they are increasing (Bouget et al 2017). Across the EU, women are much more likely than men to work part-time; opportunities for part-time work may be crucially important in enabling paid work and care-giving to be combined. However, working part-time is widely associated with lower hourly pay and earnings.

Pressures to extend women's labour market participation are particularly acute in countries such as Greece, Italy, Malta, Croatia, Spain, Romania, Slovakia and Poland that have both low female employment rates and severe demographic ageing pressures. Increasing the workforce (and particularly women's participation) is one way of funding growing demands for long-term care. However, it also risks further reducing the supply of family carers.

Encouraging women to enter and remain in the labour market is not the only way of expanding the workforce. Discouraging early retirement, delaying retirement age and offering flexible retirement options are also important, particularly in view of the age at which family care responsibilities, for older people at least, typically arise. Flexible or partial retirement schemes, in which partially lost earnings are replaced by partial pensions, may have particular benefits for people with care commitments that arise in late middle age (Eurofound 2016a)

On the other hand, practices designed to increase flexible labour supply such as shift work and zero-hours contracts can create major barriers to combining work and care. Self-employed people are also likely to miss out on workplace-based measures to support work and care-giving.

2.3 Combining paid work and care-giving

Across Europe and other developed welfare states, care-giving clearly has an adverse impact on paid work. Family carers are less likely to be in paid employment, even after controlling for other socio-economic variables such as education and marital status. Carers are also likely to work fewer hours than non-carers. The impacts of family care-giving on employment generally become apparent when carers support someone in the same household for at least 20 hours a week (Columbo et al 2011). However, recent UK population survey data shows that providing care for as little as 10 hours a week has a demonstrable impact on paid work (Pickard et al 2015).

Care-giving has greater marked impact on women's labour force participation than that of men. Across the EU28 in 2016, caring for children or disabled adults and older people was the main reason for economic inactivity among 5.4% of women aged 50-64, but only 1.4% of similarly-aged men; 10.1% of women working part-time report this is because of care responsibilities, compared with only 3.6% of men working part-time (Spasova 2018).

Reducing hours and leaving the workforce altogether are only two of the ways that care-giving can impact on paid work. Other responses include not seeking (re-)employment after redundancy/job loss (Courtin et al 2014); changing to a less demanding job or one closer to home/the person needing care; becoming self-

employed; altering working hours; and using lunchtimes/breaks/holiday entitlements or sick leave for care-related commitments. Productivity may decrease; from the employer's perspective, care-giving can lead to absenteeism, irregular attendance, lack of concentration and ultimately a loss of human capital (Courtin et al 2014). These impacts are harder to document, particularly at population or cross-national levels.

Changing work patterns in response to the pressures of care-giving increase the risk of lower earnings or loss of income altogether. OECD analyses have found only small impacts on carers' wages, although working age carers (particularly women) are at higher risk of poverty (Columbo et al 2011). UK analyses have found particularly marked income effects among male carers and those living in the same household as the person receiving care (the latter being a robust proxy indicator of intensive care-giving) (Arksey et al 2005). Risks to income can extend beyond retirement, as without adequate protection private and occupational pension entitlements may be reduced (Glendinning 1986; Ginn and Arber 2000; Evandrou and Glaser 2003). Conversely, the availability of a full occupational pension or other favourable retirement deal may affect decisions, particularly among male carers, about leaving or staying in work while meeting substantial care responsibilities Mooney et al 2002).

Care-giving (especially if it is intensive and/or unsupported) is known to adversely affect care-givers' mental health and this can be an indirect factor influencing carers' capacity to continue in paid work (Columbo et al 2011). Conversely, carers report that being able to continue regular, purposeful activities outside the home, as epitomised by paid work, constitutes an effective break from caring and has clear mental health benefits (Glendinning 1990; Hirst 2003).

2.4 Welfare states, care and work

Both the opportunity to combine work and care and the adverse impacts of care on labour market participation and earnings can be mitigated by formal care provision (Arksey and Glendinning 2008). Policy analysts identify distinctive welfare state models that broadly reflect different arrangements for long-term care. These be conceptualised as a defamilialisation-familialisation continuum (Bouget et al 2016) – the extent to which family care is prescribed through legal obligations and/or is wholly unsupported, partially supported, or to a greater or lesser extent replaced by formal, publicly and collectively funded support services.

Thus Eastern European and new member states exemplify 'familistic' models, in which any formal service support is only provided, if at all, to the person needing care. There is also frequently a legal obligation on families to provide financial or other support to dependent members (Bouget et al 2016). There is extensive dependence on family care-giving and carers face major barriers to undertaking paid work, including an absence of leave entitlements, benefits in kind or domiciliary support services. Countries' overall labour market structures creates additional barriers (Bouget et al 2016). Thus in southern European countries, care responsibilities have a noticeably larger impact on carers' labour market participation and on the numbers of hours worked, compared to northern Europe (Columbo et al 2011).

In contrast, Nordic and central continental European countries have relatively comprehensive, universal programmes in which the provision of support to disabled and older people is assumed to be a collective, public responsibility; there are also no legal obligations to support relatives. Domiciliary services (or cash payments to be used to purchase care) are well-established, relatively comprehensive and targeted at the person needing support and/or family care-givers, so the provision of care does not depend wholly on unsupported family effort.[2] In Belgium, for example, family

[2] A modified variation of this model is illustrated by UK and Ireland, in which access to services for people needing care and/or carers is rationed through strict eligibility criteria.

carers are supported through home care services, service vouchers, day and respite care services (De Wispelaere and Pacolet 2017). In contrast, in England adults with assessed support and care needs are unlikely to receive formal care services if a family member is 'willing and able' to meet those needs.

A variant of this model might be termed 'supported familialism', in which services or cash payments (for either the carer or person receiving care) are intended at least in part to support family care. The German Long-Term Care Insurance cash benefit option is an excellent example of this, as are earnings replacement benefits such as the UK Carers Allowance (Arksey et al 2005).

The importance of welfare services in supporting carers' continued employment and as the precondition for a good work-life balance cannot be understated (Eurocarers n.d. a). A recent international review (Brimblecombe et al 2018) found the vast majority of research showed a positive relationship between use of formal services by a person needing care and carer employment outcomes. It is illustrated by recent English research showing that, in the absence of at least one 'key service', carers were more likely to leave work. This longitudinal study clearly established causality – ie the absence of services was a cause rather than a consequence of carers leaving work (Pickard et al 2018). Home care services, day care, personal assistance and mobile meals service, all provided during the working day, appear most effective in supporting carers' employment (Pickard et al 2015). Raising government expenditure on formal services for older people to the EU average in countries currently below that average has been estimated to increase labour force participation by 9% - 13% among women aged 45-59 (Viitanen 2007).

2.5 EU policies

The EU has long been concerned about work-life balance policies, not least because of their central role in promoting gender equality. The principle of reconciling family and working life is enshrined in primary EU law and reinforced through secondary legislation such as the Directives on Equal Treatment and Parental Leave (Bouget et al 2017). The principle (but not the legislation) has been now been extended to other care responsibilities. In 2007 the European Ministers of Employment and Social Affairs endorsed support for family care as a top priority for the EU; in the same year a EU-wide organisation representing carers – Eurocarers (www.eurocarers.org) and a family care special interest group of the European Parliament was launched (Glendinning et al 2009). Concerns with an expanded range of family care-giving situations received further impetus from the 2015 Juncker Commission and the 2016 European Commission work programme, which proposed both legislative and non-legislative measures to increase the labour market participation of family carers. Consultation between November 2015 and July 2016 on possible amendments to EU legislation, including new measures relating to carers leave, met with opposition from employers' organisations, though the proposals received strong trades unions support. In April 2017, the European Commission proposed a new directive on work-life balance (COM (2017) 253) which aimed to strengthen existing rights and create new rights for family carers, including: rights to five days a year care-giving leave, paid at least at the same level as sick pay; the right to request reduced working hours; and flexible working arrangements. These measures are considered important elements in the European Pillar of Social Rights and the further promotion of gender equality (European Parliament 2018).

There has also emerged a growing body of evidence on the business and economic benefits of supporting carers to remain in the labour market. If highly trained or experienced carers have to take lower skilled positions in order to obtain greater flexibility or a more convenient workplace, this involves a loss of human capital and workplace productivity. Carers forced to leave the labour market altogether incur new employer recruitment and training costs, particularly as the modal age for care-giving (for older people, at least) is 50-64 – precisely when employees have acquired

optimum skills. Employee turnover also affects the quality of customer service and retention, and hence overall economic output. High rates of absenteeism as a result of clashing work-care responsibilities are other significant consequences and burdens for employers (Eurocarers n.d. a).

As well as costs for individual businesses, a lack of adequate support measures for working carers also incurs costs for the economy as a whole. Carers who have to leave work will pay less taxes, will not be able to contribute to pension funds and will incur additional public expenditure in the form of welfare benefits and healthcare costs. English research estimates that between 2009/10 and 2015/2016 the numbers of carers who left employment because of caring increased from approximately 315,000 to 345,000. The public expenditure costs were estimated to be £2.9 billion a year: £1.7 billion in social security benefits paid to people who left their jobs because of unpaid caring, plus £1.2 billion in taxes forgone from lost earnings (Pickard et al 2017).

3 National approaches

Two groups of measures that can help workers with family care responsibilities to remain in the workforce are: rights to a period of full or part-time leave from work (with guaranteed return); and more flexible arrangements within the workplace. These are discussed below, followed by a discussion of the potential of technological developments in reconciling work and care.

3.1 Leave from paid work

Although there is as yet no EU legislation on leave for care of disabled children, adults or older people, nevertheless many Member States have at least some provisions, albeit often piecemeal and rarely comprehensive. Entitlements to short-term periods of leave are relatively widespread; these are often intended primarily for the parents of (sick) young children and range from five to 36 days per worker each year. Some countries only offer entitlement to short-term leave (eg CZ, EE, LV).

Among countries offering longer-term leave, there is considerable diversity in their duration, eligibility criteria and levels of remuneration (if any) (Schmidt et al 2016; Hoyer and Reich 2016). Almost all EU member states have legislative provisions on leave for the care of disabled children (usually up to age 18). A few countries (eg SK) do not offer leave options of any kind for carers of disabled adults and older people. Within those countries with longer-term leave provision, there are variations in eligibility and arrangements, depending on the age of the person needing care. For example, France and Italy each have more than one different long-term leave schemes. Only a few countries (AT, DE, IE, SE, UK) have carer leave legislation that disregards the age of the person needing care.

The duration of longer-term care-related leave entitlements varies, from several months to over a year (AT, BE, BG, DK, DE, IE, IT, FI, FR, NL, IS, NO, DK, SE). Eligibility for longer-term leave can be restricted by the relationship of the carer to the person needing care (eg tp close family members only); the intensity and type of care needed (eg medically certified terminal illness); the carer's social insurance record and current employment contract; whether employment is in the public or private sector; and the size of the employer (DE). Paid leave entitlements may exclude (eg IT, NL) or include (HR, LU, SI) self-employed people. In Liechtenstein and Malta, eligibility for care leave is at the employer's discretion (Bouget et al 2016). Leave entitlements also vary in their flexibility, another factor affecting their attractiveness; for example, in Austria carers can choose between part-time or full-time leave.

In a representative survey of European companies, just over a third reported that long-term leave was available for the care of a sick relative. Higher proportions of companies in Scandinavian countries and Poland reported offering care leave to employees, compared with southern Europe. Long-term care leave was much more

likely in the public and service sectors, in larger companies and in those with high proportions of female and skilled workers (Columbo et al 2011). It is common, however, for leave entitlements to include protection of employment-based social security benefits such as pensions and health insurance, although even this may depend on whether leave is paid or unpaid and its duration (Bouget et al 2016).

The relative generosity of different care leave models can be analysed according to four dimensions (Schmidt et al 2016):

- The nature and level of earnings replacement or other financial compensation during periods of leave, for example whether it is a payment or loan, flat-rate or earnings-related.
- The type and level of the care given by carers on a regular basis. Some countries use standard disability assessments (eg ES, HR, FR, IT, LU, NO, RO, SK, SL, LT, TR); others require medical certification of the need for care (EE, HU).
- The relationship between a person needing care and the carer and whether these include care for a non-relative and/or someone in a different household (DK, IE, IS, NO, SE).
- The duration of the leave entitlement. In many countries entitlements are restricted just to short periods of end-of life-care (AT, BE, DE, DK, FI, FR, LU, NO and Canada) (Bouget et al 2016).

Analysis of country arrangements along these dimensions shows that in Austria both payment and duration are relatively generous; Germany and Italy offer relatively long-term leave options; while in Netherlands and Canada a large circle of potential carers is entitled to leave[3]. Leave from work in Canada is intended primarily for the last few weeks of terminal illness, whereas in the Netherlands it can be granted for routine daily care (Schmidt et al 2016).

These variations have implications for the perceived attractiveness to carers of taking leave from work, given the opportunity and other costs of doing so. Care leave can have a positive effect on employment in some circumstances, particularly when combined with flexible working practices (Brimblecombe et al 2018). Care leave entitlements for part-time as well as full-time workers and the availability of earnings-related replacement income during periods of leave from paid work will significantly affect the willingness of men as well as women to withdraw temporarily from the labour market to provide care and therefore have major implications for gender equality. Conversely, some benefit regulations actually create major barriers preventing carers from remaining in paid work; the UK's Carer's Allowance, for example, cannot be claimed if carers have any more than minimal earnings and thus acts as a disincentive to maintaining contact with the labour market (Arksey et al 2005). Other factors likely to affect the attractiveness of leave options to men as well as women include whether it is accompanied by a right to return to the same (or similar) job; and the protection of career opportunities and promotion prospects.

In almost all European countries (except Lichtenstein) carers taking leave from work have their contracts of employment protected (Bouget et al 2016).

Take-up of care leave options is difficult to compare across countries, as it depends on estimates of the number of potentially eligible employees; however, overall it appears to be relatively low (Bouget et al 2016). For short-term leave, take up rates are available for Italy (5%-16%), the Netherlands (8%-15%) and Germany (1%, where leave is allowed only for arranging, not providing, care). For longer-term leave, take-up has been estimated as 2.7% in Italy, 2.5% in Austria and 2% in France and Germany. In some countries (DE, FR, Canada) complex application procedures are

[3] However, while income replacement in Canada is relatively high and earnings-related, in Netherlands it is unpaid (where not covered by a collective agreement).

cited as barriers to take-up; in France and Canada, workplace stigma is reported as an additional barrier (Schmidt et al 2016). In the Netherlands, of all family care-givers (including those outside the immediate family circle) only 5% take unpaid leave and 7% take paid leave, with low take-up being attributed to the ready availability of part-time work in that country (Bouget et al 2016). However possibly the most decisive factor affecting both overall take-up and gender equality is the availability of adequate financial compensation during care leave[4]. It should be noted that none of these assessments take into account the availability and levels of collectively funded and provided formal services available to support children, adults or older people with long-term care needs; as noted earlier, these will also have a major impact on whether carers need to take leave from work in the first place.

3.2 Workplace flexibility and other measures to support carers' labour market participation

Care leave arrangements vary in their flexibility. Piecemeal schemes (IT, RO, NO, TR) allow carers to spread leave, and thus maintain contact with work, over an extended period. In other countries, care leave entitlements can be shared between two or more carers (DK, NO and Canada). Rights to request part-time work are widespread (AT, BE, DE, DK, HR, IT, LT, MK, NO, NL, PL, RO, SE, SI, TR, UK), although these are still more common for parents (of non-disabled children) than for carers of disabled adults or older people; restrictions on employers refusing a request to work part-time are also often stricter for parental leave than other types of care leave (Columbo et al. 2011). In some countries (IE, LI, MT) switching to part-time work in order to care is only allowed at the employer's discretion (Bouget et al 2016). Even in countries guaranteeing rights to part-time work for care-related reasons, less than half allow carers an automatic right to revert to full-time hours. However, few countries impose a limit on the duration of a period of part-time working (Columbo et al 2011).

In many countries, carers can request flexible working hours (AT, BE, DE, DK, HR, IT, FR, RO, NL, MK, LT, NO, PS, SE, SI, TR, UK). In the UK, the right to request flexible working was extended in 2002 from parents of (disabled and non-disabled) children to carers of working age and older people; requests can cover the hours, times and/or place of work and almost all requests are approved (Courtin et al 2014). In a few countries (LI, MT – private sector) flexible working hours are only allowed at the employer's discretion. Overall across the EU, around 30% of employees consider they have some flexibility in their working hours and the majority consider this fits 'well' or 'very well' with other, family responsibilities (Eurofound 2016b). If carers cannot afford to take unpaid leave, workplace flexibility can be vitally important in enabling them to fit in appointments or deal with small emergencies. In-depth research with English carers (Arksey et al 2005) found that flexible starting and finishing times were highly valued by carers; for example, they could build up their hours in order to leave early or start work late when the person they supported had medical appointments. Other dimensions of flexibility that carers reported helpful included: being able to arrange workloads to include some weekend or evening work; rearrange shifts informally with colleagues without needing approval from managers; annualised hours; and working from home. Even small matters like car parking and access to a telephone to make/receive care-related calls were reported to be helpful.

Flexible working arrangements alone may not be sufficient to enable carers to work. The ability to work flexibly also depends on household income, local labour market structures and the amount of care needed (Brimblecombe et al 2018). Other

[4] The range of care allowances and cash benefits for carers has not been included in this paper as their rationales and types – paid to the person needing care or the carer, compensating for extra costs or lost earnings, incentivising family care – are diverse and extend well beyond simply replacing lost earnings (Keefe et al 2008).

workplace-based measures may also be helpful, particularly where intensive personal care is required. A long-standing UK charitable initiative, Employers for Carers (www.employersforcarers.org), has extensive experience of working with government and large UK employers on developing and implementing carer-friendly policies and practice in the workplace, including:

- Reviewing HR policies and practice
- Helping employers identify and engage with carers in their workforce
- Developing and supporting networks of carers among staff
- Signposting carers to both internal and external sources of support
- Measuring and monitoring outcomes.

English research confirms the importance of the overall workplace ethos. Employers who publicised their support for carer employees could avoid restrictions imposed by middle managers and resentment from colleagues if carers regularly took time off or were perceived to seek other 'privileged' treatment (Arksey et al 2005). Both Canada and Australia have schemes to certify workplaces as 'carer-friendly'; in Manitoba for example, CareAware certification requires workplaces to have a positive culture, flexible work programmes, access to information for carers and give general attention to employee health and wellbeing (Courtin et al 2014).

Some carers take on intensive care responsibilities precisely because they are already out of the labour market – for example because of their own poor health, recent redundancy or unemployment (Arksey et al 2005). Support to return to work at the end of a period of care-giving is therefore also important, particularly for carers seeking to re-enter the labour market in their 50s after an extended absence. Poland, for example, has measures targeted at the labour market reintegration of family carers (Bouget et al 2016). While caring for relatives, carers acquire a wide range of specialised personal care, medical, nursing and communication skills (Eurocarers nd b). If formally recognised, these skills can be major assets for labour market (re-)entry. In Norway, the labour market service helps all job seekers lacking formal training to obtain relevant qualifications, including former family carers who now aspire to become healthcare professionals. Slovenia and Cyprus also have training programmes for carers to help them acquire formal care and nursing qualifications (Spasova et al 2018). Such initiatives of course have the additional benefit of increasing the skilled formal care workforce.

Finally, given that substantial care-giving responsibilities most commonly arise for people in late middle age, policies to support paid work and care intersect with those relating to extending working lives through flexible retirement. In particular, partial retirement can encourage older workers to remain in the workforce for longer than they would otherwise have done, with partial access to pension income at least partly replacing foregone earnings (Eurofound 2016a).

3.3 The potential for technology to improve reconciliation of work and care

Many commentators note the potential for new digital information and communication technologies (ITC) to impact on reconciliation of work, family and care. However, there is relatively little empirical evidence on their acceptability or effectiveness. Relevant ITC technologies can be grouped into two broad clusters.

3.3.1 Technologies to reduce needs for help and/or support care-giving

These are variously termed 'assistive technologies' and include tele-health (information and advice systems, remote diagnosis and monitoring of health symptoms) and tele-care (eg virtual visiting, reminder systems, home security and

alarms). Available research appears to focus predominantly on people with dementia and their carers.

However, systematic reviews (AKTIVE Consortium 2013; Davies et al 2013; Godwin et al 2013; McKechnie et al 2014; Pu et al 2018) have so far found few high quality studies of their effectiveness. Studies have involved small populations, lacked control groups and/or relied on data collected by service providers, thus risking bias and limiting robustness and wider generalisability. There is some evidence of benefits to carer morale, stress, strain and anxiety. However, there is little evidence of reductions in the physical demands of caring or improvements to carers' quality of life.

For example, one review (AKTIVE Consortium 2013) concluded that tele-care provided security and confidence for older people, particularly those with dementia, and carers. Reported benefits for dementia sufferers included improvements in independence, peace of mind and health and well-being. Carers were reported to experience reduced pressure and better relationships with the older person. One carefully evaluated Swedish project (Magnusson et al. 2005) piloted the use of video phones and televisions to connect frail older people and their carers to local call centres that offered information, advice and support. The intervention was found acceptable to frail older people and helpful to some carers; however, carers who were in crisis, already overburdened or ambivalent about their caring role found it less helpful. It also helped some carers to develop new informal support networks, thus reducing social isolation; however, it was found to be relatively ineffective in reducing the perceived stresses of the caring situation.

Moreover, there is evidence of psycho-social barriers among older people and of variability in individual capabilities and familiarity with technology. One review found that stigma associated with 'gerontechnologies' created barriers to acceptance (Yusif et al 2016). Some studies report that practical constraints in using tele-care are significant, including the costs of developing and implementing programmes of tele-care support (AKTIVE Consortium 2013; Yusif et al 2016).

3.3.2 Technologies to support carers in paid employment

Teleworking involves the use of ICT such as smartphones, tablets, laptops and other devices that enable work to be conducted outside of traditional office workspaces (Eurofound and ILO 2017). Currently over 80% of the German workforce uses digital information and communication technologies; moreover, companies that have embraced the latest digital developments are also reported to be more 'family friendly' and supportive of employees' care responsibilities (Stüben 2017).

A cross-national evidence synthesis (Eurofound and ILO 2017) found wide variations in the routine use of ICT, ranging from 2% to 40% of employees, depending on the economic structure and work culture of individual countries, occupations and sectors. The reported benefits of ICT for workers were reductions in time spent commuting; more time spent working; greater autonomy and flexibility; better overall work–life balance; and higher productivity. Benefits for companies included increased motivation, reduced turnover, enhanced productivity and reduced space-related costs. However, other reported impacts are less likely to be of benefit carers, especially the tendency for ICT to lead to longer working hours and increased difficulties in maintaining boundaries between paid work and home life.

4 Discussion and learning

4.1 Policy complexity

Improving the reconciliation of paid work and family care-giving involves the intersection of several policy domains that are usually considered separately:

- Labour market policies and, within these, gender-related differences in patterns of work; contract and income differences (Schmidt et al, 2016); differences

between public and private sectors, professional and manual, secure and flexible employment; and (early) retirement and pensions policies. All these affect the perceived opportunities for combing paid work and care, and the opportunity costs of care-giving.

- National welfare state models and, in particular, degrees of universalism and defamilialisation – the extent to which formal long-term care policies substantially rely on, or aim to support or (partially) replace, the care provided by families. In welfare states with extensive formal long-term care services that substitute for family care, carers are more likely to remain in paid work and experience fewer pressures and stresses in doing so. Similarly, access to and levels of cash payments for care that can (partially) replace earnings will be important in shaping carers' choices about remaining in or withdrawing from paid work.
- Family policies and, in particular, beliefs about the roles of women within families; these are sometimes enshrined in civil law (Bouget et al 2017).

Thus 'whether dual work and adult care commitments affect productivity at the workplace, absenteeism or job change intentions is co-determined by characteristics of the work and care arrangements' (Schneider et al, 2016: 220; my emphasis). In summary, long-term care policies (including access to formal services and/or cash support for family care-giving), labour market policies and, within the workplace, human resources practices all shape both care-related and work-related outcomes. Consequently evaluating the appropriateness, acceptability and adequacy of measures aimed at 'reconciling' care and work is a complex task.

4.2 Diversity of carers and care-giving situations

Policies need to cover a wide range of care-giving situations and carer characteristics. Many carers of disabled adults and older people do not live in the same household as those they care for; indeed, some live countries and even continents away (Neal et al 2008). The support needed by disabled, sick or older people is frequently subject to considerable fluctuation, crises and deterioration over time (Arksey et al 2005). The trajectory of care-giving is also often uncertain, making it difficult to predict either future changes in the intensity of care-giving or its overall duration. This makes devising work-care reconciliation measures considerably more challenging than those appropriate for the relatively predictable milestones towards independence of (non-disabled) children.

Medical and technological developments are enabling increasing numbers of children to survive extreme prematurity, albeit with complex disabilities (Glendinning et al 2001). More children and working age adults are also surviving what would previously have been life-threatening illnesses or accidents, again with complex long-term support needs. Meanwhile, 'lifestyle'-related illnesses and mental health problems are creating new support and care needs among working age adults. Supporting a severely disabled or chronically ill dependent child starts at an early stage in a parent's working life and may continue for decades. In contrast, supporting an adult child or partner who develops support needs in adulthood will affect mid-career plans and promotion opportunities. Adults caring for a frail elderly relative may find that decisions about early retirement are particularly affected (Arksey et al 2005).

Thus, depending on the ages of both the person needing care and the carer, carers will have invested different (often gender-related) levels of human capital in their previous careers; these differences will in turn impact on the work-related choices and opportunities available to them (Schmidt et al 2016). These variations will have different implications for the constraints and opportunities that carers face in making decisions about paid work; for their current and future earnings; and for their eventual pension entitlements. They need to be reflected in nuanced and flexible policy responses, in order to avoid inadvertent discrimination against certain groups of carers

or workers, whether male or female, higher or lower paid, professional or unskilled, or at particular stages in a working career.

4.3 Leave from work

Leave from work as an effective means of reconciling work and care-giving depends on three factors:

- The remuneration available during care leave to replace lost earnings: its level, eligibility conditions and associated social protection (protection of work-based insurance and pension entitlements). Remuneration may come from reduced earnings (eg at sick pay levels for short periods), repayable loans (eg Germany) or social security payments (eg UK).
- The anticipated duration of care-giving. This will vary according to the characteristics of the person needing care. According to UK population survey data, over half of those caring for an adult disabled child have done so for more than ten years. This is about double the proportion of carers supporting a disabled spouse and about three times the proportion caring for a parent (-in law) for at least 10 years (Maher and Green 2002). The median duration of caring for a partner is four years, but only two years for a father (Henz 2004). Short periods of leave entitlement (eg up to 6 months) are likely to be unhelpful other than in cases of terminal illness.
- The extent of workplace 'carer friendliness' where carers are identified and offered information and support will help to overcome any stigma and reluctance of carers to identify themselves. Guarantees of return to the same or similar job at the same salary level will also be significant.

4.4 Changing labour markets and patterns of work

Future policy developments will need to take into account the growth in temporary and non-traditional forms of work. Between 2001 and 2012, temporary employment grew by 25% in the EU27. It accounted for almost a third of the 14.5m net increase in the number of employees, with marked increases in temporary contracts in Poland, Germany, Italy, France and Netherlands. Temporary employment is more likely among people with lower educational qualifications, migrant workers, part-time workers and in some service sectors, and is associated with an average 19% reduction in wages (Eurofound 2015). Within the long-term care sector, Austria, Germany and Italy rely extensively on migrant care workers (Colombo and Muir 2016). In the UK almost 2 million people are employed on zero-hours contracts – ie without a minimum number of guaranteed hours (ONS 2018). It will be extremely difficult for carers employed on temporary or precarious contracts to reconcile work and care responsibilities; nor are they likely to be entitled to periods of leave from work. Other measures will be needed.

5 Conclusions and Recommendations

There is an urgent need for robust evidence on the impacts of carer support policies on carers' labour market participation and economic outcomes. Evidence on the effectiveness and cost-effectiveness of measures is still in short supply. Economic evaluations are particularly lacking, as is evidence on the short and longer-term impacts of carer support measures on carers' financial wellbeing and employment opportunities (Schneider et al 2016). The lack of evidence has been attributed to the predominant focus of much evaluation on outcomes for people needing care, with carer outcomes receiving far less attention (Bouget et al 2016).

There is a particularly acute need for robust, well-designed research into the acceptability, effectiveness and cost-effectiveness of technologies to support care-giving. Research so far has focused on the potential for assistive tele-care and tele-health to support older people with dementia and often includes outcomes for carers. However, the quality of the evidence is widely considered poor; outcome measures

rarely include benefits for carers' paid work; and little is known about whether workplace-based ICT helps carers in reconciling paid work and care-giving.

Secondly, policy formation and review needs to take a holistic approach; workplace-based measures to support carers are unlikely to be effective on their own. Instead of the hitherto piecemeal approaches, a 'suite' of measures is needed to support working age carers:

- The availability of formal welfare services to support working carers will affect the extent to which they can continue labour market participation without difficulties or stresses that impair their health or eventually precipitate decisions about changing work patterns or stopping work altogether. The acceptability and quality of services to both carers and the person needing support will be as important as their accessibility.
- Labour market structures and trends will also affect opportunities to combine care-giving with paid work. In particular, the availability of part-time work opportunities for both women and men, and the levels of pay and other conditions associated with part-time work may be decisive. Policy formation will also need to take into account changing work patterns and the emergence of self-employment, temporary and non-standard contracts. For non-statutory workplace measures, peer networks of employers can promote good practice within and between countries to avoid stigmatising carers (see https://www.employersforcarers.org).
- Eligibility criteria and levels of replacement incomes, whether from employers or social welfare payments, will be critical in incentivising carers to sacrifice (some) earnings by reducing hours or taking care leave – in particular encouraging men as well as women to assume or continue substantial care responsibilities. Otherwise, 'an unequal distribution of caring work contributes to income inequality, inequalities in retirement incomes and in participation in social life' (Jenson and Jacobzone 2000: 34).
- Finally, support is needed for carers who do stop work or dramatically alter their working lives and who wish to return to paid work after care-giving has ended. For some carers, the skills acquired in providing care are valuable human resources that could be transferred to future paid care work and ease a transition back to work.

Finally – and most important – policy development and evaluation should involve carers and the organisations representing them. These are extensive across all EU countries; some are linked to specific conditions (eg carers of people with dementia); some are linked to specific age groups (eg carers of frail elderly people); many have a broad, general remit (see http://www.eurocarers.org/membership_lists). Carers' organisations can advise on the appropriateness and acceptability of work-care reconciliation measures; they may also be in an excellent position to engage employers' organisations and trade unions in dialogue about how to reduce the work-related penalties of family care.

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