



# WHO CARES ?

EXPERIENCES AND POSSIBILITIES  
TO RECONCILE WORK AND  
CARE RESPONSIBILITIES  
FOR DEPENDENT FAMILY MEMBERS





# WHO CARES ?

**FINAL REPORT**

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With the support of the European Commission



**ferpa**

**solidar**

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# WHO CARES?

## INTRODUCTION

# 1

### 1.1 AIMS AND OBJECTIVES OF THE PROJECT

In the context of **demographic, social and societal change** in Europe, it is likely that an ever increasing number of workers will have responsibilities to (help) look after an elderly or disabled relative at home. The main goal of the project was to **gather and assess policies and initiatives which have been taken by social partner organisations to influence and provide for a supportive legislative and policy framework** to assist workers to combine work with such (non-professional) caring responsibilities<sup>1</sup>. In doing so, the project looked more broadly at existing national support frameworks (e.g. through carers' leave, other leave provisions and flexible work arrangements etc.) as well as securing the offer of improved professional long-term care services was highlighted in order to avoid an over-reliance on informal carers. Such policies also have to be considered in relation to an active ageing agenda with an increasing expectation for workers to work up to (an increasing) statutory retirement age.

Data show that not only are women more represented among informal carers, but it is often women towards the end of their career who take on such caring responsibilities, rendering the combination of these dual responsibilities more challenging.

In its employment policy and skills strategy documents the European Commission has emphasised the **employment potential of the care sector** and the employment situation and conditions of care workers (including in the home care sector) is therefore also of particular significance for the development of this sector and the way in which it interacts with non-professional care provision at home. An exploration of a positive interaction between formal and informal care, as well as care provided by private, public and third sector providers is required to establish what might be an appropriate and effective mix at the national and local level.

Statistics clearly show that **demographic change is impacting countries to a different extent and at different times**, with some countries already experiencing a significant ageing process, while in others these trends are set to impact harder in the coming decades.

Unlike in relation to childcare, there is currently no universal leave requirement to care for adult relatives, meaning that workers often have to rely on individual workplace arrangements if they are seeking more flexible working solutions and time off to offer such care. A particular challenge is that

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<sup>1</sup> This project focusses wholly on initiatives to support employed (but also unemployed and inactive) individuals taking care of adult relatives at home. Henceforth the term 'informal carers' will be used to refer to such non-professional family carers.

such **care can often not be planned and its duration is difficult to predict** (and can often last many years). Even where carers' leave provision exists at national level it is therefore often not used as it tends to be either short and/or poorly remunerated. The project offered the opportunity to explore:

- ★ The surrounding policy framework which influences the context within which social partners and companies offer support to workers with reconciliation;
- ★ The policy framework which influences whether or not non-working carers are able to consider a return to work;
- ★ Existing examples of provisions to support family carers in collective agreements at sectoral or company level.

In order to explore the challenges and solutions which have been developed in different countries, two regional workshops were organized as part of this project in October (in Stockholm and Milan and Berlin<sup>2</sup>) to explore these issues. A survey was circulated to the member organisations of ETUC, FERPA, EPSU and Solidar to assess key concerns and gather information on existing collective agreement and company practices aimed at supporting working (as well as non-working) carers. Findings from this survey as well as evidence from a wider review of the literature and the proceedings of two regional workshops and two Round Table meetings are summarised in this final report.



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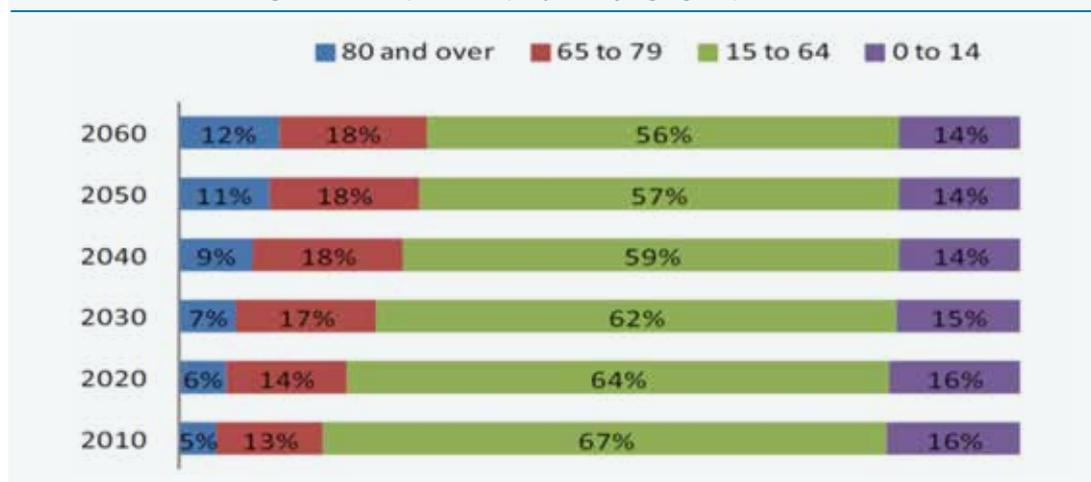
<sup>2</sup> A third meeting foreseen for Berlin in October 2014 did not take place for organisational reasons.

## IMPORTANCE OF CARE PROVISIONS AND SUPPORT FOR WORKING AND NON-WORKING CARERS

### 2.1 THE IMPERATIVES OF DEMOGRAPHIC CHANGE AND THE CURRENT MAKE-UP OF THE POPULATION OF ADULT CARERS

It is estimated that there are currently 21 million adults (12% of the population) in the European Union in need of regular care. This is set to increase as the population ages. As shown in Figure 2.1 below, 30% of the population of the EU will be aged 65 or above by 2060. In most countries, with growing life expectancy, healthy life expectancy has also increased, allowing older individuals to live more or less independent lives in the community (with some support from friends and relatives) for longer. At the same time, more severe health problems tend to cumulate in older age, making caring requirements ultimately more intensive and placing greater demands on long-term health and social care.

Figure 2.1 Population projects by age group (Eurostat)

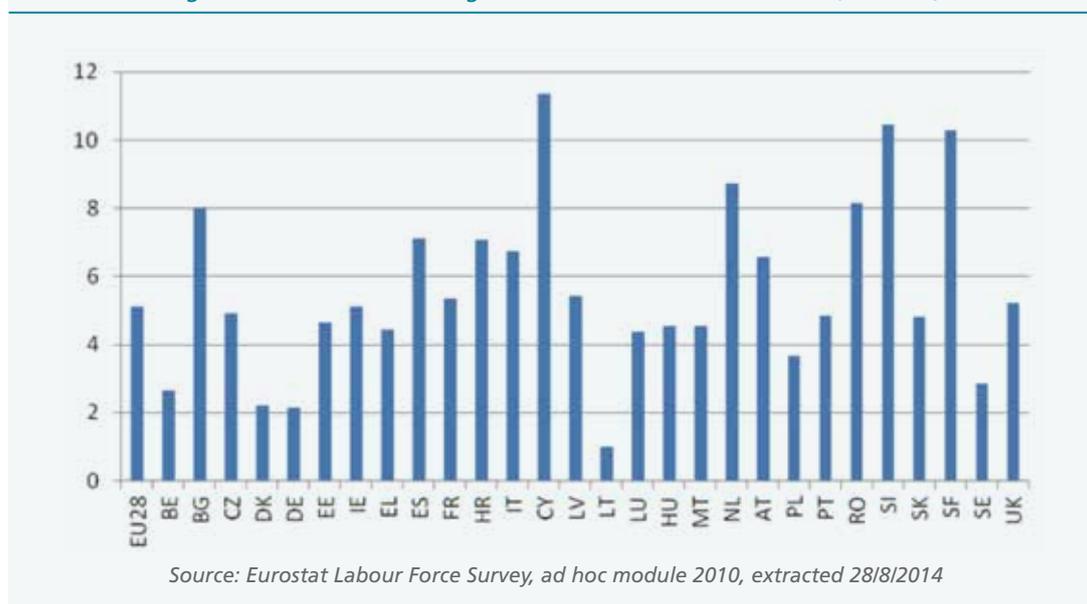


Eurostat data from an ad hoc module of the Labour Force survey gathered in 2010 (the last time such data were collected) shows that an **EU average 5.3% (over 17 million) of the population aged 15-64 regularly takes care of friends or relatives aged 15 or over** (generally disabled or older relatives). The same survey showed that 5% (approximately 11 million) employed individuals share working with caring responsibilities, but some estimates are significantly higher at more than twice this number. As demonstrated in Figure 2.2 below, **in some Member States these figures are significantly higher than in others**, with Cyprus topping the list at over 11% and the lowest rates being found in Lithuania at 1%.

Discussions during the project also clearly demonstrated that the challenge of caring is not just one for workers and those close to pension age, but also for pensioners themselves, as improvements in life expectancy mean that in the same family there can now be two generations of pensioners living and requiring support. Among the ‘younger pensioners’ in particular, many also play a significant role in assisting with childcare and behalf of working age mothers, but potentially placing a dual pressure on such individuals.

**Women are 1.6 times more likely to be carers than men**, although men are statistically also highly represented because of their greater share in the labour force. The ad hoc module of the labour force survey showed that caring for an adult relative numerically remains most prevalent among women aged 25-49, but statistically, the share of female adult carers is most significant among the 50-64 age group. There are gender differences in the type of care being performed with **women more likely to perform more intimate and intensive care tasks** (such as washing and feeding). Women also tend to spend more time caring on a weekly average.

Figure 2.2 Share of working carers in different EU countries (Eurostat)



Other data included in a study on care provision show that with the increase of the intensity of the care provided the typology on informal care needs among European countries also changes slightly. While in Denmark and Netherlands almost 80% of informal carers spend a lower number of hours on care, however once the need for care intensifies less informal care occurs (25% DK, 21% NL). In Poland on the other hand the situation of informal carers does not seem to change.<sup>3</sup>

Finally, another specific challenge identified relates to migration patterns. With the increasing migration of working age individuals to other Member States – particularly from Eastern and Southern Europe to Northern and Western Europe (in some cases to offer care services to individuals at home), this leaves gaps in family care provision and support in their home countries, which is increased when children remain in the home country to be looked after by grandparents.

<sup>3</sup> Bettio, F. Verashchagina, A. (2010), Long-term care for the elderly, provision and providers of 33 European countries, for the European Commission

## 2.2 IMPACT OF CARING ON EMPLOYMENT RATES

According to a study on informal carers (on the basis of a survey) employment rates in 2004 for such carers stood between 34% and 47% in Greece, Italy, the UK, Poland and Sweden<sup>4</sup>. The study further highlights that **between 7% and 21% of informal carers reduce their working hours and between 3% and 18% withdraw from the labour market**. National and EU studies on the relationship and employment of informal carers are rare and data is highly limited, making this a 'hidden challenge'. Nevertheless, certain trends can be observed: in Southern European countries, where informal care plays a predominant role the probability of participating in the labour market when providing intensive care drops significantly (between 4-42 percentage points); in the Northern and Western European countries where institutional and home care services are extensively present informal care does not impact negatively on employment if the care needs are not intensive, whereas in Central-Eastern and South-Eastern countries the majority of informal carers are not in employment, at least partly because formal care provision is poor. Data from Poland show that 32% of carers would like to work however the care activities limited the possibility to find employment. Information on the characteristics of family carers in employment is scarce. In Italy and Sweden most working informal carers work in the public sector (IT 46.8%, 61.4% SE) followed by those in the private sector (31.8% IT, 25.6% SE) and quite a significant number in self-employment (16.9% IT, 10.2% SE).<sup>5</sup> In Germany the situation is inverted, while in 2004 only 42.3% of informal carers were in employment, 51.8% worked in the private sector, 26.5% in the public sector and 12.1% in self-employment<sup>6</sup>. In the UK it is estimated that of the current 6 million carers, 2 million had to stop working and 3 million had to reduce their working hours to assist with caring tasks.

In contrast to the survey figures above, Eurostat data gathered as part of an ad hoc module carried out in 2005 found that the **employment rate of carers is around 4.3% below that of the average working population**, but it is important to note that most carers do not withdraw fully from the labour market, but seek to accommodate their care giving with their working life. This includes taking leave, reducing working hours or otherwise modifying working arrangements. This can be challenging if no entitlements exist to such flexibility and tends to have a significant impact on incomes, career progression and own pension prospects. Furthermore, the demands of caring and the stress of combining this with employment has been shown to lead to detrimental health and well-being effects for carers, including increasing their social isolation.

A Eurobarometer survey carried out in 2008 showed that **European citizens were less likely to be satisfied with support being available to individuals caring for dependent older relatives than was the case with childcare provision** (see Figure 2.3).

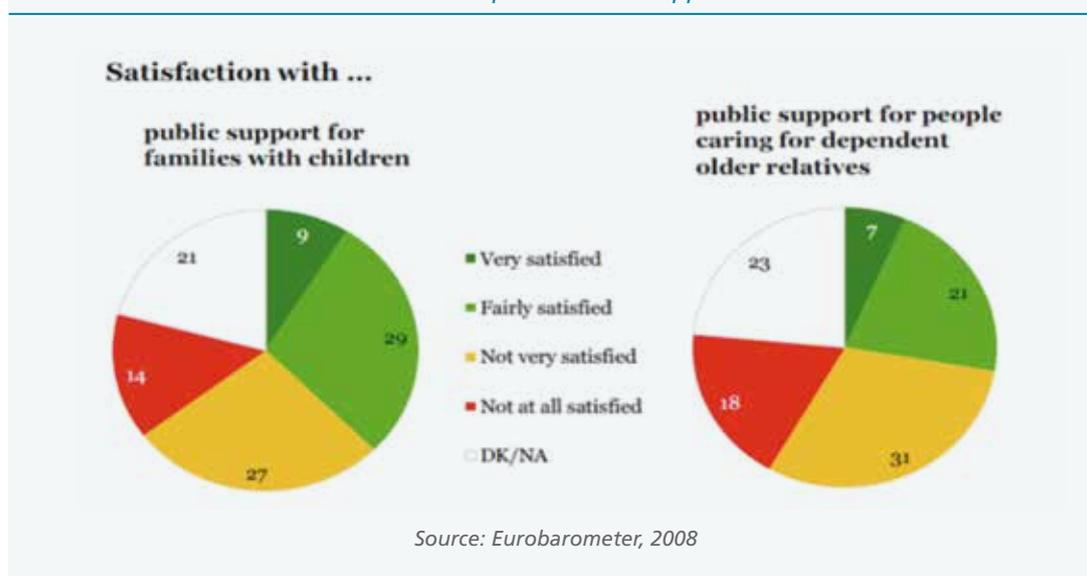
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<sup>4</sup> Bettio, F. Verashchagina, A. (2010), Long-term care for the elderly, provision and providers of 33 European countries, for the European Commission

<sup>5</sup> Quattrini, S. et al (2006) EUROFAMCARE, Rapport Italien, [http://www.uk.de/extern/eurofamcare/documents/deliverables/nasure\\_it.pdf](http://www.uk.de/extern/eurofamcare/documents/deliverables/nasure_it.pdf); Krevers, B. et al (2006) EUROFAMCARE Rapport Suédois, [http://www.uk.de/extern/eurofamcare/documents/deliverables/nasure\\_se.pdf](http://www.uk.de/extern/eurofamcare/documents/deliverables/nasure_se.pdf)

<sup>6</sup> Doehner, H. et al (2006) EUROFAMCARE, Rapport Allemand [http://www.uk.de/extern/eurofamcare/documents/deliverables/nasure\\_de.pdf](http://www.uk.de/extern/eurofamcare/documents/deliverables/nasure_de.pdf)

Figure 2.3 Levels of satisfaction with child and elder care provision and support



## 2.3 MAIN CHALLENGES FOR WORKING CARERS

A survey carried out among the project partners' member organisations pointed to three key areas in which challenges arise for working carers. These are the (lack of a supportive) legislative framework, shortcomings in public policy design and provision and challenges linked to employer policies and attitudes.

With regard to the **legal framework**, difficulties highlighted were primarily related to the **lack of, or inadequate provision for carers' leave**. As will be elaborated further below, there is currently no European minimum standard in relation to carers' leave, although this had been discussed in the context of a communication on work-life balance. As a result, existing provisions vary significantly in terms of leave being offered, its length, terms for eligibility and replacement rates paid. Existing leave provision is generally considered inadequate both in terms of its length, replacement rates and in relation to access to leave at short notice, even when variations to working hours are only needed over a short period of time.

Closely linked to this are **legal entitlements to request flexible working**. Again such entitlements are missing from the arsenal of EU level measures (e.g. the right to request to work flexibly and not to be reasonably refused). As a result, a significant diversity of legal provisions exist at the national level, with some countries lacking such provisions, while others offer them to specific groups and/or providing narrower or wider scope to employers' discretion whether or not to grant such request (and indeed the right to return to previous working arrangements when the period of caring ends).

The wider **public policy challenges** enumerated in the survey primarily relate to perceived **lack of public support services, both to assist individuals caring for adult relatives at home and their combination with respite and long-term care services**. Access to, affordability and quality care services in the community are often considered to be inadequate and linked to low levels of pay, availability of training and opportunity for progress for individuals working in such services. Non-professional home carers requiring additional support often have insufficient access to respite care, training and emotional support and many are considered to be forced into their caring role due to the lack of funding and investment in high quality, affordable and accessible long-term care services.

Finally, the level of **flexibility and support offered by individual employers is also generally seen to be insufficient**. Survey responses point to a lack of access to part-time work or flexible working options and an absence of wider psychological and practical support for those combining caring with work responsibilities.

### 2.3.1 Impact on working carers

The **main impacts of these challenges are financial, physical and emotional**. In addition, there is a wider **gender impact** for society as the majority of carers (particularly those providing more 'intensive' care services) are women.

These challenges arise not only from the physical and emotional impact of caring (which generally culminates in the loss of the loved one), but also from the stresses placed on carers resulting from their co-ordinating role where there is insufficient interaction – for instance – between the social and health care aspects of acute and long-term care. These are made more difficult by the fact that many carers find themselves fulfilling a role they were not expecting without any training or formal assistance.

For most carers' the lack of access to sufficient periods of carers' leave and low financial replacement rates brings with it the need to reduce working hours, **leading to a loss in income, pension entitlements and often career progression**. A minority of carers are driven to leave the workforce entirely, bringing with it much more severe financial penalties with long-term consequences leading to poverty and the loss of the social network which is generally offered by workforce participation.

Combining work with informal caring also leads to increases in stress, fatigue and ultimately depression and physical ill health resulting from a deterioration in work-life balance combined with the emotional impact of caring. This is particularly true because caring for an elderly relative (compared to a child) is generally physically and emotionally more demanding and more often than not culminates in the loss of the loved one.

For those carers who find themselves exiting the labour market altogether to fulfil a caring role, negotiating re-entry can be difficult, particularly if the period of caring was an extended one and regions and localities with generally difficult labour market situations.

### 2.3.2 Challenges for carers currently not in employment

The survey carried out for this project also gathered information on the specific challenges facing carers not in employment. In addition to those also common to working carers, the following can be enumerated:

- ★ Significant **financial pressures** affecting the carer's present situation as well as future pension provision. In some countries it was emphasised that cuts to welfare budgets resulting from the crisis have had a particularly detrimental impact on non-working carers, particularly as pressures to demonstrate availability to work increase in order to qualify for benefits. Such cuts have also affected the availability of respite care and long-term care alternatives.
- ★ **Difficulties in achieving labour market re-integration**. Worsening labour market situations resulting from the crisis make it even more challenging to compete with jobseekers only recently out of the labour market. Lack of part-time work opportunities and limitations in rights to request flexible working (for those already in employment for more than 6 months).
- ★ Potential for serious **social isolation** and consequent impact on mental health, especially for women who are caring for family members; they suffer the greatest impact with few possibilities for getting help with their daily duties.
- ★ The difficult labour market in the present economic crisis also means placing an increasing reliance on volunteers, mostly family members. While this makes the presence of active pensioners very important, it should not prevent the development of jobs regulated by union negotiations and agreements.



# WHO CARES?

## INTERNATIONAL AND NATIONAL POLICY CONTEXT

# 3

### 3.1 INTERNATIONAL POLICY CONTEXT AND INITIATIVES

The ILO's Workers with Family Responsibilities Convention, 1981 (No. 156) and Family Responsibilities Recommendation, 1981 (No. 165) applies to workers with dependent children, with responsibilities in relation to other members of their immediate family who clearly need their care or support and is the **main international instrument** addressing reconciliation of paid work and unpaid family responsibilities. Countries that ratify the Convention set out national policies defining the beneficiaries within a family and enable beneficiaries to exercise their right to family care and employment preventing discrimination. Countries should develop community services for child care and elderly care and provide broad public information on the principle of equal opportunities and provide guidance and vocational training to family carers to remain in employment.

Other relevant ILO conventions and policies to promote equality and protection of workers with family responsibilities and care workers are the Domestic Workers Convention, 2011 (No. 189) setting out standards of employment for domestic workers, the Maternity Protection Convention, 2000 (No. 183) which applies to all female workers without regard to their employment contract; the Discrimination (Employment and Occupation) Convention, (No. 111) 1958 and the Resolution concerning gender equality (ILC 2009) which promotes equality of opportunities over a live course and the ILO Decent Work Agenda that aims improve working conditions involving social integration and social protection of families.

The United Nations Convention on the Elimination of all forms of Discrimination against Women (1979) states in its Preamble, that States Parties are " *aware that a change in the traditional role of men as well as the role of women in society and in the family is needed to achieve full equality between men and women*" and reminds signatory States to reward the informal work of women in society and promote informal work of men to achieve equality between men and women.

The Framework Directives on parental leave (1996, 2010) as agreed by the European Social Partners set out minimum rights for all parents. The Framework Directive on Part-time work 97/81/EC outlaws discrimination between full-time and part-time workers. The European Directive 2000/78/EC for equal treatment in employment and occupation accompanied by the Racial Equality Directive 2000/43/EC and the Gender Equality 2006/54/EC set out a framework for equal opportunities for all notwithstanding age, belief, disability or sexual orientation. The European Social Partner Framework of Actions on gender equality places work-life balance as one of the four core objectives.

Within the European Union the **issue of long-term care is part of the open method of coordination on social policy leading to policy sharing and benchmarking of policy reforms**. One of the recent items was the issue of financing the long-term care sector sustainably, a peer review in Slovenia<sup>7</sup>, or the need to address staff shortages in the long-term care sector by ethical migration policy, a peer review in Germany.<sup>8</sup>

In June 2014 the European Council endorsed the report from the Social Protection Committee and the Commission on “adequate social protection for long-term care needs in an ageing society”<sup>9</sup>. The report recognises that long-term care should be defined as a risk in social protection schemes for equity and efficiency reasons. Social care is often not covered for under social protection schemes and remains a cost for individuals and living conditions of carees will depend on the willingness of the family to provide for it. The report further underlines the growing gap between the need for long-term care and the availability of care, and highlights that Member states need to take a proactive rather than reactive approach to prevent the loss of autonomy of elderly and provide for cost-efficient care solutions. Finally the report highlights that adequate protection against long-term care dependency is a major aspect for gender equality in old age as well as in working age.

The European Union has also financed a number of projects to gather insights on the provision of long-term care including the characteristics and needs of those that are in need of care, characteristics of caregivers and quality criteria for care provision. This includes the Daphne III project on the development on a European Charter of Rights and Responsibilities in need of long-term care and assistance.<sup>10</sup>

European States do recognise the need for improvement also with regard to the respect and rights of carees. Recently, the Committee of Ministers of the Council of Europe adopted a Recommendation on the promotion of human rights of older persons recommending to Member States to implemented measures, including preventive *measures, to promote, maintain and improve the health and well-being of older persons. They should also ensure that appropriate health care and long-term quality care is available and accessible.*<sup>11</sup>

In 2013 the Federation of European Retired Persons' Association (FERPA) aimed to launch a European Citizen Initiative for a right to quality long-term care accessible to all in the European Union and to protection for people with increasing care needs. This initiative has been however refused by the European Commission reasoning that it falls outside of the Unions competencies. FERPA is currently assessing the possibility to start a new initiative.

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<sup>7</sup> <http://ec.europa.eu/social/main.jsp?catId=1024&langId=en&newsId=2097&furtherNews=yes>

<sup>8</sup> <http://ec.europa.eu/social/main.jsp?catId=1024&langId=en&newsId=1889&furtherNews=yes>

<sup>9</sup> <http://ec.europa.eu/social/main.jsp?catId=758>

<sup>10</sup> [http://www.age-platform.eu/images/stories/22204\\_AGE\\_charte\\_europeenne\\_EN\\_v4.pdf](http://www.age-platform.eu/images/stories/22204_AGE_charte_europeenne_EN_v4.pdf)

<sup>11</sup> <https://wcd.coe.int/ViewDoc.jsp?id=2162283&Site=COE&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383>

## 3.2 NATIONAL POLICY CONTEXT

**European welfare regimes did not recognise “care” as a social risk** thus failing to provide social protection and leaving care as an individual activity or private obligation. Institutional long-term care policies emerged only since the 1990s when population ageing became a more widely recognised issue. **Receiving care services was not seen as a social right.** Thus long-term care was perceived as an informal activity, implicitly assumed to be a responsibility of women. In addition, caring for older relatives was and still is perceived to some extent as not something which opens access to the same rights to entitlements such as paid leave and income support as for maternity leave or parental leave. In recent years care policy has been characterised by the formalisation and standardisation of long-term care services, the setting of quality criteria, the determination of skills of professional care workers and the framing of care entitlements. A recent report published by the Social Protection Committee<sup>12</sup> concludes that Member States need to move to recognise long-term care needs a social risk to be addressed by the means appropriate to the management of social risks at the Member State level (see also section 3.2.3).

The **framework provision of care for the elderly is a rapidly developing policy area. The importance on national policy agendas differs however, to some extent relating to the specific impact of demographic change and bottlenecks and quality issues on the care supply side.** The issue of quality of care and framework of care provision was a priority topic in the past ten years in the UK and that resulted in a new Bill on Care in 2014. In Germany, the public debate about quality of care led to the introduction in 2009 of a classification of care providers which presents a tool for people in need of care to choose a good provider. On the other hand increasing need of care services and the preference of elderly to stay as long as possible in their home has led to the introduction of a carers' leave in 2011.

One factor that is often used to compare countries with regard to the engagement in long-term care reforms is public expenditure. This data however would need to be read with caution as data often focuses on the health care components of care only. Available data from the OECD show that public expenditure for the health and social components of care in 17 EU countries ranges from 3.7% of GDP in the Netherlands and 3.6% in Sweden to 0.2% in Portugal. Data from the European Commission show a similar trend (see figure below).

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<sup>12</sup> Adequate social protection for long-term care needs in an ageing society; Social Protection Committee; 2014

Figure 3.4 Public expenditure on Long-term care as % of GDP, by type of care in 2010

	Total	of which:		
		at home	in institutions	cash benefits
BE	2.35	0.60	1.30	0.45
BG	0.47	n.a.	0.17	0.30
CZ	0.81	0.06	0.23	0.53
DK	4.50	1.33	1.14	2.04
DE	1.43	0.40	0.58	0.45
EE	0.53	0.01	0.19	0.33
IE	1.11	0.19	0.92	n.a.
EL	1.36	0.88	0.13	0.35
ES	0.82	0.22	0.46	0.14
FR	2.16	0.44	1.38	0.34
IT	1.91	0.49	0.55	0.86
CY	0.10	n.a.	0.01	0.15
LV	0.67	0.05	0.51	0.12
LT	1.22	0.48	0.51	0.23
LU	0.98	0.33	0.56	0.09
HU	0.84	0.01	0.25	0.58
MT	0.65	0.09	0.56	0.00
NL	3.82	0.53	2.00	1.29
AT	1.63	0.47	0.34	0.83
PL	0.73	0.07	0.30	0.37
PT	0.31	0.23	0.06	0.00
RO	0.63	0.58	0.04	0.01
SI	1.43	0.20	0.70	0.53
SK	0.27	0.14	0.09	0.05
FI	2.51	0.70	1.50	0.31
SE	3.88	1.85	1.87	0.16
UK	1.97	0.86	0.56	0.56
EU-27	1.84	0.53	0.80	0.52

Source: DG ECFIN working paper on long-term care, 2012

### 3.2.1 Framework conditions for care provision

**Care models differ in EU Member states.** The definition of “long-term care” in public policy is often influenced by the different models of financing long term care and the target group (e.g. based on the ability to pay).

Care services are distinguished being informal or formal. Formal long-term care includes:

- ★ Institutional care which “stands for institutions and living arrangements where care and accommodation are provided jointly to a group of people residing in the same premises, or sharing common living areas, even if they have separate rooms. This does not include, however, temporary or short-term stays, such as respite care”<sup>13</sup>.
- ★ Home care: includes long-term care services provided to care recipients who live in their own houses or apartments. This also includes day care, respite care, and direct support to individuals who provide care, such as care allowances and care leaves. Care provided in home-like environments (sometimes referred to as assisted living), where it is only available for a certain period of time and individuals live in their own homes, not sharing living space with other beneficiaries with the exception of relatives or partners, is also considered home care.
- ★ Informal /family care: is defined as any care service that is not paid (despite the fact that a care allowance could be paid to the caregiver) and it is provided by a person having a family or social tie with the person cared for.

<sup>13</sup> Definition taken from the paper Rodrigues, R., Huber, M. & Lamura, G. (eds.) (2012). Facts and Figures on Healthy Ageing and Long-term Care. European Centre for Social Welfare Policy and Research: Vienna

There is a **clear correlation between formal and informal care in the framework of long-term care services provision in national policies**. The availability of formal services reduces the intensity of informal care provision. If formal care services are limited it often means that informal care provision becomes a full-time unpaid task for the family carer. Informal care can also be actively supported through a care allowance or by paying rather generous cash benefits to the person in need of care which can be used to replace the missing salary of the person providing for care.

Recent studies on patterns of long-term care provision in Europe show that the use of institutional care remained stable despite the growing number of elderly and that **an increase of home-care services occurred**. This highlights that policies on long-term care centre around “ageing at home”. Distinguishing different long-term care models between the Member States is complex as long-term care involves a number of different factors (social assistance to elderly, pension, care insurance, social security, public expenditure, family patterns, welfare models etc). However some trends were identified: while the Northern European countries (SE, DK, FI, NL, BE) have increasingly built up a model focussing on supply-oriented services with a strong state responsibility in providing for formal care, Western European countries place emphasis on social protection schemes, Mediterranean and Central-Eastern European countries are marked by limited availability of formal care and finally South-Eastern European countries where informal care is predominant but still presents a higher rate of availability of institutional care services which are currently however often in poor conditions<sup>14</sup>.

Long-term care is defined rarely from a holistic point of view setting out a vision of care of the elderly centred on their specific needs but also on the needs of informal caregivers that are the backbone of long-term care models. In fact, “long-term care” is defined according to a set national typology of the person needing care. It should be noted that long term care of elderly mainly focuses on the subsistence and health care components of care while in comparison to long-term care of young disabled emphasis lies much more on the social components and integration. Yet, compared to concepts of “day care” for very young children which entirely focusses on the development and social components of care, it seems that elderly care focuses too much on age and incapacity rather than based on needs of elderly with regard to enabling, rehabilitation or age-friendly environments..

Differences also exist in relation to the funding of care (public, private or insurance based). In term of public funding, the allocation of resources either to the health or social care budget can also have a role to play. Thus far, despite the increasing emphasis on home based provision, the majority of funding remains concentrated in the health care system (see p.15 of the SPC report on LTC). Data presented in the SPC report also provides an indication of the different sources of funding for LTC. This shows the differences in the role played by private household out of pocket expenditure compared to government, social insurance and private insurance funding.

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<sup>14</sup> Damiani et al.(2011), Patterns of Long Term Care in 29 European countries: evidence from an exploratory study BMC Health Services Research, 11:316; Bettio, F. Verashchagina, A. (2010), Long-term care for the elderly, provision and providers of 33 European countries, for the European Commission; Tedosi, F., Kraus, M. et al (2010), A typology of long-term care systems in Europe, ENERI Research Report No.91

THE THREE BASIC MODELS OF SOCIAL PROTECTION EXPLORED AS PART OF THIS PROJECT WERE REPRESENTED BY THE (PROSPECTIVE) HOST OF THE DIFFERENT REGIONAL WORKSHOPS:

Table 3.1 Long-term care expenditures by sources of funding, 2007

Country	General government (excl. social security)	Social security funds	Private insurance	Private households out-of-pocket exp.	Other	Non-profit institutions serving households	Corporations (other than health insurance)
Portugal	2.0	51.4	1.1	45.4		0.0	0.0
Germany	12.5	54.7	1.7	30.4	0.7	0.6	0.1
Spain	61.7	10.2	0.0	28.1		0.0	0.0
Slovenia	18.3	57.1	0.5	24.0		0.0	0.0
Austria	81.1	0.7	0.0	17.1	1.0	1.0	0.0
Finland	77.2	7.6	0.0	14.2	1.0	1.0	0.0
Estonia	48.2	39.3	0.1	12.4	0.0	0.0	0.0
Denmark	89.6	0.0	0.0	10.4		0.0	0.0
Hungary	60.1	30.2	0.9	2.4	6.4	6.4	0.0
Sweden	99.2	0.0	0.0	0.8		0.0	0.0
France	44.8	54.4	0.4	0.4		0.0	0.0
Poland	43.1	49.2	0.0	0.3	7.4	7.4	0.0
Belgium	31.4	58.7	9.8	0.2		0.0	0.0
Czech Republic	30.5	69.5	0.0	0.0		0.0	0.0
Netherlands	9.5	90.4	0.0	0.0	0.1	0.0	0.1

Source: OECD Health System Accounts 2010, cited in Help Wanted page 231

Note: countries ranked by decreasing share of out-of-pocket spending

### ★ A strong universal tax based model as found in Sweden;

The SPC report on LTC referenced above argued that *'the greatest involvement of formal care workers is found in those Member States where LTC is comprehensively financed from general tax revenue, organised as a public service and delivered by trained public sector workers. This then becomes an individual right, as in Denmark and Sweden'*. In Sweden, compared to other countries, a relatively good balance and co-operation is achieved between public long-term care provisions, both at home and within institutions and family assistance with care provisions. Assistance with home care provision and institutional care are universal (tax funded) and not means tested and therefore continue to enjoy a high level of public support. In surveys, citizens express their preference for publicly provided care (rather than private or family care). However, the system is not without its flaws and aspects of 'internal markets' and reduced budgets are seen by trade union representative as potential threats to public support for universal, tax based provisions. Thus, for instance, instead of being fully publicly provided, individuals are increasingly being given a choice to source their own home care support from a long catalogue of contracted providers. The main why in which such contracted providers can market their services as being superior to those of others is by cutting back on staffing and changing work organisation (e.g. no longer counting travel time between assignments as working time etc.). This has led to increasing pressure due to staff turnover, meaning that many of those being cared for at home do not enjoy continuity of service from a familiar provider. This can also lead to lapses in care provision which can contribute to repeat admissions to hospitals for care reasons.

The second key challenge identified in the Swedish system lies in the lack of co-ordination between the social care systems (which manages LTC at home) and which is run by the municipalities, and the health care system which is run by regional councils. Relatives complain that they spend a lot of time on organisational tasks seeking to co-ordinate service delivery between the health and social care system; with hospitals increasingly encouraged to shorten costly hospital stays, with community providers ill prepared and equipped to deal with the additional challenges imposed on them.

**★ An insurance based model which forms the backbone of the German system, for instance;**

In Germany, an insurance based model is in place which pays a care allowance to individuals requiring care based on the severity of their care needs. This allowance can be used to source either home based or institutional care (only individuals in more severe care categories are entitled to source institutional care and the level of financial support provided is usually insufficient to cover the cost of such care, with individuals (including family members) being responsible to cover the difference in cost. Providers for home based care are either private or third sector organisations which tend to orient their prices around the insurance rates available for support. Many suffer from high staff turnover and rates of pay and conditions can be low. There have been discussion around the level of training required for care providers both in homes and in the elderly care systems, which has partly reflected concerns about staff shortages. Use made of migrant workers from Eastern Europe to deliver home based care tends to be high, and in consequence a minimum wage for the care sector was introduced in 2010 to avoid a downward spiral of competition on wages. Overall, the insurance based systems does not provide for guarantees of quality or stability for carer and caree.

**★ A residual model significantly relying on family provision of care as represented by Italy and other Southern European countries.**

In Italy provision is not only highly localised and its quality strongly varies from region to region and locality to locality, but it also strongly relies on the family as prime care giver for elderly relatives. Low birth rates in this – and other Southern European countries place particular demographic pressure on family carers who tend to be women and who often find themselves if not permanently then at least partially excluded from the labour market. In Portugal, the responsibility of the family in this regard is enshrined in the country's constitution.

Recent new care initiatives<sup>15</sup> and the public debate show however that the restrictive vision of elderly care on subsistence and health care is not adapted to the needs of older people and other available options for provision of long-term care do not satisfy families that search for care solutions either. Designing long-term care policies is complex. It needs to take into account several factors: the needs of the elderly, needs of informal caregivers, changes of the structures of families and increased mobility of families moving for work and elderly wishing to travel or moving to countries with warm climate (here a new European legal field emerged on the access to care services in other EU countries).

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<sup>15</sup> Multi-generational homes, semi-residential care apartments available around the world stimulating travelling of elderly or yet the elderly flat sharing initiatives. In addition a number of specialised institutional care and home care services started to develop in particular for those with dementia.

The recent UK reform with regard to care provision<sup>16</sup> highlighted the fact that care services were too fragmented and ill-adapted to persons and caregivers needs. In its 2014 Care Bill, the law places at the heart of care provision the individual's "well-being" meaning: personal dignity; physical and mental health and emotional well-being; protection from abuse and neglect; control by the individual over 'day-to-day' life including over care support or support provided to the individual and the way it is provided; participation in work, education, training or recreation; social and economic well-being; domestic, family and personal relationships; suitability of living accommodation; individual's contribution to society. Local authorities will need to arrange for a holistic approach of health and social care of elderly including also the prevention of care. The UK reform is based on a broad variety of analytical papers and inventory of aging policies to reorganise the long-term care provision model<sup>17</sup>.

The recent issues around abuse and neglect of elderly in care and public debate will most likely lead to further reform activity in the European countries. The fact that some of the issues also arose due to exhaustion or lack of skills of family carers also shows that a care framework while depending on informal care should also focus on the needs of informal carers by providing advice services, adequate training and respite care solutions. There are some countries that have taken this into account (e.g. Sweden). Services such as training or advice for informal carers can be provided by public entities, NGOs, local communities, or networks of families and friends. A high number of Swedish municipalities offer 24h respite care services and public policies focus on good cooperation of institutional/health care services with informal carers. In a similar way Ireland had financed a programme called "caring for carers" that set up a comprehensive network of support institutions for carers which offer specific training courses on skills for home care. In some cases there might be a number of services already available but carers are simply not aware of them. The creation of one stop shops for carers could be a solution to co-ordinate services and provide comprehensive information and help. This has been done in France via the Local Centres of Information and Co-ordination (CLIC) which include also an individual service provided by social workers that assess care needs and the situation of the caregiver to determine care solutions. Helping caregivers to find the right balance between their personal needs and the needs of the care receiver can prevent conflict and health risks. As shown in the examples this kind of framework includes public and private partnerships in which also companies can play an important role.

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<sup>16</sup> [http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga\\_20140023\\_en.pdf](http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf)

<sup>17</sup> [http://www.cpa.org.uk/cpa/policies\\_on\\_ageing.html](http://www.cpa.org.uk/cpa/policies_on_ageing.html)

### 3.2.1.1 Working conditions for employees in the care sector

There are significant differences among Member States with regard to the definition of who is a care worker. A majority of health care related tasks or care provided in institutional care is carried out by professional nurses while many home care or social subsistence tasks are carried out by personal care workers. For the latter type of worker, definitions vary significantly. While in some Member State minimum number of years of training is required in other no standard training or minimum number of years of training are required. In many countries many personal care workers lack specific training on elderly care.

On the other hand the care sector expands continuously and is a promising sector for employment growth. In a number of European countries **personnel shortages for semi-qualified and highly qualified care professionals are expected. Migrant workers will play an important role in the care sector in the future.** In Italy for example more than 70%<sup>18</sup> of personal care workers are of foreign origin. The increasing need of employing migrants in elderly care will bring also cultural challenges as the understanding of “elderly” care is very different in countries outside in the EU. The question of inter-cultural training was also raised as a particular issues as an increasing number of care workers are recruited from within and outside EU countries.

The care sector also experiences **retention problems** due to uncompetitive salaries and poor working conditions. In fact the care sector is characterised by atypical employment contracts and shift work with a significant amount of night shifts and on-call work. Comparison of wage levels among the care workforce of EU countries is difficult due to a lack of clear and comparable definition of long-term care professionals. Nurses and social welfare workers, care professionals and home services belong to different employment categories but can all be found in long-term care.

Personal care professionals are generally less qualified than health care professionals, which is reflected in wage differentials. There is often also a difference in the qualifications expected from those working in institutional and in home care. With long-term care sector reforms the demand for high quality care services will increase thus the challenge for public policy and care providers is to build a sustainable and highly qualified care workforce.

Low wages is a problem for the retention of care workers however it is not the most important factor. Physical and psychosocial working conditions are much more impacting on working conditions for care professionals. The stress and hard physical work can lead to depression and exhaustion.

Care employment is typical female employment in European countries. In the Netherlands every seventh women in employment is working in the social and welfare sector.<sup>19</sup> The care sector in particular creates employment for women and older workers which is relevant for their integration into the labour market. However, due to the low quality of employment in this sector it creates a form of labour market segmentation by increasing the “gender gap”. Due to the limited resources available of public expenditure for the care sector (in particular after the economic crisis), demographic trends and the supply bottlenecks for care professionals it can be expected that employment conditions will not significantly improve.

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<sup>18</sup> OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing

<sup>19</sup> Leichsenring, K., Billing, J., Nies, H. eds. (2013) Long-term care in Europe, Improving policy and practice, Palgrave Macmillan

### 3.2.2 Carers' leave

As opposed to leave to look after children (maternity and parental leave) there are currently no EU-wide entitlements to carers' leave to look after adult relatives, although this has previously been discussed as part of a wider consultation on work-life balance issues. Similarly, carers of adults do not have the same entitlements to pension rights (for their time spent as carers).

The **majority of EU member states offer some form of carers' leave provision, but this differs significant in terms of length, level of payment and eligibility criteria**. Some of these leave provisions are rather general whereas others are specifically aimed to providing leave for 'end of life' care (palliative care leave).

At present 22 of the 27 EU Member States provide a form of statutory carers' leave (whether in the form of leave to look after ill relatives alone or in combination with leave for terminally ill relatives). Only two countries – Luxembourg and Sweden – provide palliative care leave only (without more generic provisions on carers' leave).

Table 3.2 EU countries with different forms of carers' leave provision

Member State	Leave to care for dependent relatives	Leave to care for terminally ill relatives
AT	★	★
BE	★	★
BG	★	
CY	★	
CZ	★	
DE	★	
DK	★	★
EE	★	
FI		
FR	★	★
GR	★	
IE	★	
IT	★	
HU	★	
LT	★	
LV		
LU		★
MT		
NL	★	
PL	★	
PT	★	
RO	★	
SI	★	
SK	★	
SP	★	
SE		★
UK		

Source: GHK (2011, unpublished)

Among the 5 countries that currently have no carers' leave provision, Finland offers the right to employees to request time off, but it is up to employers whether or not the leave is granted. The other countries only offer leave to look after children.

Leave granted differs in terms of length. In the majority of countries this ranges from 1-10 working days, but can be between 6 – 24 months as well (e.g. Belgium, Hungary, Ireland, Italy, Spain). Levels of compensation tend to be higher for shorter leaves but are only at 100% of salary in Austria and Italy. Six countries offer between 60-85% compensation, six countries between 5-60% and in a further six countries such leave is entirely unpaid. In most countries, eligibility is once per year, whereas six countries offer this only once per person cared for. Three countries offer carers leave once per case of illness. Relatively low levels of compensation mean that most carers prefer to take annual leave in a short-term emergency and modify their working arrangements for longer spells of care giving. As a result, take-up of carers' leave is generally low across all EU Members states. For men it averages around 0.7% and for women around 1.3%. Women are significantly more likely to access such forms of leave (77% of all take up).

Another issues raised during the project is that of the increasingly diverse structure of families which means that in future it will not be sufficient to focus carers' leave provisions on direct family members alone.

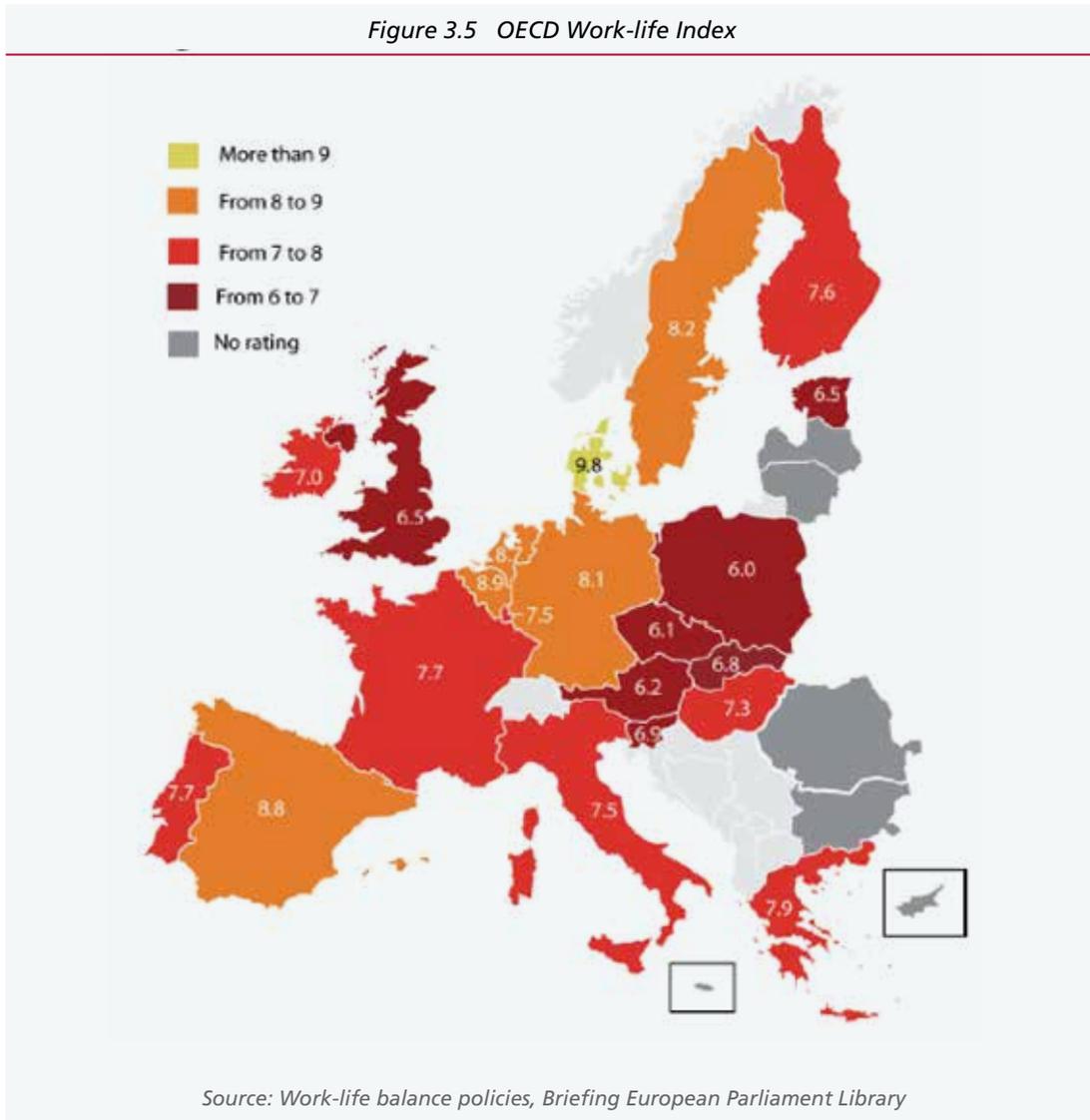
### 3.2.3 Work-life balance policies

Reconciling work and life/ family responsibilities is one of the current European Union policy priorities in particular in view to improve labour market integration of women, promote gender equality and ensure quality of care provision. The EU Parliament and the Council had foreseen to call the European year 2014 on work/life balance which has been postponed due to the European elections.

The OECD establishes a Work-life balance Index which is based on the number of hours worked, the time devoted to leisure and personal care and draws data from national statistics on working time and survey data on time spend by individuals on leisure and care.

The results show countries with the highest indicators for work-life balance are Denmark, Sweden, Germany, Belgium and the Netherlands while the countries that range on the other end include Poland, Czech Republic and Hungary.

Figure 3.5 OECD Work-life Index



Poor work-life balance increases the risk for workers of ill-health in particular stress, fatigue and emotional exhaustion, it lowers the work performance and decreases the quality of care given to children or elderly. Sources of conflict are working time patterns, long work hours, unpredictable workload or precarious employment conditions.

A number of different types of public policies can address these types of conflicts:

- ★ Family related policies: these include fiscal measures and social benefits, such as family allowance or child allowance and reduced taxes; leave arrangements such as maternity, parental or carers leave; formal care services for children and the elderly
- ★ Work organisation measures: including flexible working time rules with the possibility to adapt hours or request part-time work; flexibility with regard to the place of work – telework, life-course saving accounts allowing for workers to purchase time off

Also anti-discrimination laws and gender policies play an important role to change the role models of men and women in societies.

One factor that seems to have a very important effect for achieving good work-life balance as well as gender equality is the accessibility of formal care services (children and elderly). Long leave arrangements seem to have the opposite effect on gender equality as it is often women taking the leave<sup>20</sup>.

On the other side a number of policies imply that employers and social partners take actions at the sector or firm level including those on flexible working time schemes and telework. In addition, firms can also act in the field of health and safety by improving policies on psychosocial risks and stress to improve well-being at work and decrease ill-adapted work organisation leading to unforeseeable working time and tasks. It includes also training on the development of leadership skills for managers that include being sensitive to issues of work-life balance and workers needs and communication activities on healthy life styles.



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<sup>20</sup> Greve, B. (2012) Reconciliation of Work and Family life in four different welfare states, NEUJOBS, working paper No. 5.5

## 4.1 INTRODUCTION

**T**he activities of trade unions, and indeed social partners as a whole and collective and company level agreements can play an important role in enhancing and implementing the provision of leave and flexible working arrangements. In addition, they can provide access to other measures such as carer health and well-being measures, care related support and provision and awareness raising among employees, managers and co-workers.

However, existing studies<sup>21</sup> and the survey carried out for this project show that there are currently **only very few examples of collective agreements addressing relevant reconciliation measures**. Where such collective agreements exist, they primarily focus on offering enhanced leave of flexible working provisions rather than any other support measures for carers. In a number of countries, such agreements are primarily found in sectors dominated by relatively highly educated women. Prior to discussing measures introduced in sectoral or company level bargaining, the subsequent section provides an overview of the activities of trade unions and third sector organisations in seeking to influence national care policies. These reflect to some extent the nature of policy debate in different EU Member States.

### 4.1.1 Campaigning and policy initiatives of trade union and third sector organisations

As well as their critical role in national, sectoral and company level bargaining, trade union organisations (as well as third sector organisations) play an important part in influencing the policy agenda. The extent to which trade unions are involved in tripartite interest intermediation varies from country to country, so the level of influence exerted differs. Nonetheless, trade unions have played a key role in **lobbying for better care and carers' leave provisions**, as well as **providing training for negotiators and workplace representatives**. Additionally, trade unions and their associated organisations can play a role in **attracting funding for relevant initiatives** (including from European sources) and implanting relevant projects.

At the sectoral level, trade unions in the health and social care sector play a crucial role in lobbying for **better provision and improved working conditions, all of which contribute to better long-term care services** (whether offered at institutional level or in the community). Table 4.3. below summarises some of the initiatives taken by the project partner member organisations.

<sup>21</sup> E.g. Eurofound (2011); Company initiatives for workers with care responsibilities for disabled children or adults

*Table 4.3 Overview of trade union initiatives on policies to support working carers*

COUNTRY	RELEVANT POLICY INITIATIVES
<b>Belgium</b>	<p>The emphasis of campaigns and lobbying work with government is on the improvement of the quality, affordability and accessibility of support services and the provision of greater access to care leave and palliative care leave as well as the time credits system.</p> <p>Representative unions in the sector also focus on work to improve provision and working conditions of individuals providing home care services. Work is ongoing at national, regional and local level aiming to fight the commercialisation of such services.</p>
<b>Bulgaria</b>	<p>Trade unions in the health and social care sector participate in discussions of a new model of ‘domestic’ medical social care by creating health and social centres which would provide care for people in their home by nurses and social workers. The main challenge to be addressed is the lack of sustainable public funding.</p>
<b>Estonia</b>	<p>Trade unions participated in the development of the ‘Informal Care Development Plan of Estonia for 2013-2020’. This document intends to introduce a definition of ‘informal care’ into the Estonian legislation. The goal is to define such ‘informal care’ as state-paid service on a unified basis.</p>
<b>Germany</b>	<p>The national cross-industry trade union developed information material on combining work with care responsibilities and organised a number of training activities and workshops for members of works councils and employee board members.</p>
<b>Finland</b>	<p>Trade unions emphasised the need for legal reform, which – in 2011 – led to the passage of a law giving the right to carers’ leave. This did not go as far as had been desired by the trade unions as the employer specifically has to agree the leave request and the leave is unpaid. Social partners jointly have also developed guidelines for good practice in family friendly workplace arrangements.</p>
<b>Italy</b>	<p>In Italy, the trade union unit for retired workers is particularly engaged in working with partners in the sourcing of European funding. As an example a model was launched in the four convergence regions (Sicily-Calabria-Campania-Puglia). This provides specific funding (based on the resident population over 75 years) for each of the 200 districts, social health, and aimed at increasing the support of home care for dependent persons, in an integrated system. The programming of EU funds 2014-2020 offers further opportunities in this field.</p>

Table 4.3 Overview of trade union initiatives on policies to support working carers

COUNTRY	RELEVANT POLICY INITIATIVES
<b>Lithuania</b>	In 2014, a Tripartite Agreement was signed which aims to expand nursing competence, including the provision of nursing care at home.
<b>Poland</b>	<p>Trade unions have engaged in the following:</p> <ul style="list-style-type: none"> <li>• Training activities for the trade union leaders on negotiating proper measures of reconciliation of work and family life and support for workers with care responsibilities.</li> <li>• Research project on reconciliation of work and family life in co-operation with German and Lithuanian trade unions</li> <li>• Information for the carers put on the website</li> <li>• Political and legal initiatives to change the working time regulations. At the moment they allow the employer to change the work schedule even during the shift, for example to demand that the worker stays at work hours after the shift ends.</li> <li>• Political support for a lower pension age.</li> <li>• Support for the organizations of members of family who care for dependent relatives full-time.</li> </ul>
<b>Slovakia</b>	Sectoral trade union focus has been on campaigning for more equitable remuneration for care workers.
<b>Spain</b>	Social partners together with the government agreed a new law on care for people in a situation of dependency in 2007. Currently the law supports 730,000 individuals which is set to rise to 1.2 million.
<b>UK</b>	In the UK, the TUC campaign in 2013 on issues facing older women in the workplace. The majority of this work focused on issues relating to caring responsibilities. Events were held, guidance produced, a blog site and social media were used, and a final report set out policy recommendations. In the past the TUC has done a great deal of work on flexible working and allowing carers to reconcile family and working life.
<b>Switzerland</b>	The Swiss trade union congress addressed this issue at its congress in 2010 and is currently participating in a Parliamentary enquiry and round tables on the subject.

## 4.1.2 Enhanced leave provisions

Based on existing entitlements to carers' leave (see section 3.2.3 above), a number of collective agreements either enhance the length of statutory leave available, provide for longer periods of (partly) paid leave or enhance replacement rates during leave. The following examples can be identified:

- ★ In Austria, collective agreements exist in the public sector which provide for extended periods of paid carers' leave, unpaid care sabbaticals (followed by guaranteed re-employment) and individual (temporary) adjustment of working time.
- ★ In Belgium over 20 collective agreements provide a right to unpaid (or partly paid) leave to more than 10 days leave per annum for 'compelling reasons'.
- ★ In Finland it is possible to find some limited provisions in collective agreements on flexible working, enhanced leave and increased compensation during leave periods.
- ★ Additional leave is also offered for carers' of adult relatives in some agreements in Italy.
- ★ In Slovenia, some collective agreements offer additional days off to look after disabled relatives.
- ★ In Spain, enhanced carers' leave provision in collective agreements solely focusses on leave to look after children and disabled children. However, in the latter cases, such leave is available for a disabled dependent child into adulthood (depending on the nature of the disability).
- ★ A number of collective agreements in Sweden delivery enhanced access to palliative care leave (beyond that foreseen in the legislation).
- ★ In the Netherlands a limited number of collective agreements to offer additional leave to carers. This right is extended also to friends of a person in need of care and other distant family members.
- ★ A limited number of collective agreements in the UK also make enhanced provision for carers' leave.

Overall such enhanced provisions remains relatively limited and tends to focus more on offering additional days rather than improved replacement rates. Albeit helpful, this therefore does not overcome this issue of the 'financial penalty' associated with caring tasks. Long leave periods offered can not only have a detrimental effect on income, but also in career progression (and future pension benefits) and therefore remain problematic if offered on their own.

The relative **dearth of provisions enhancing financial compensation** thus serves to contribute to a situation in which many workers prefer to take other leave (such as annual leave) for short term caring tasks (or during periods of greater demand for assistance). This increases the stress on the individual as it further deprives them of much needed break periods.

### 4.1.3 Flexible working time

The offer of more flexible working arrangements can – in certain situations – be more helpful than enhanced leave periods but in principle should go beyond the offer solely of part-time working and is ideally combined with an offer to return to full-time hours should this be desired by the worker at any point. This also needs to be linked to a wider debate on the value of reduced or more flexible hours working and the tasks and roles which can be delivered on such flexible schedules, as reduced hours should not lead to reduced career opportunities.

As previously mentioned, a number of countries offer a right to workers to request to work flexibly, but in reality this is under rather different conditions, e.g. in relation to eligibility (qualification periods, open to individuals caring for children and/or adults, nature of contract etc), the grounds on which an employer can refuse (or whether such reasons indeed have to be provided). In the absence of a European entitlement linked to the right to request to work flexibly, collective agreements continue to play an even more important role in this area.

However, as indicated above, the level agreed provision at national or sectoral level in this field is rather limited with Portugal and Italy pointing to access to more flexible working through collective agreement. In Belgium, the right to reduce working hours (and to receive compensation higher than the number of reduced hours worked) is particularly available to specific age groups (see box below). In Germany, there are also examples of collective agreement with flexible working provisions, which in at least one case, combines this with a wider range of support and awareness raising measures specifically for carers of adult relatives and their employers (see box below).

*In Belgium, the so-called ‘tandem plan old timers’ negotiated in collective agreement pursues a specific two-pronged approach. It allows workers above the age of 55 to reduce their working hours while receiving more than part-time compensation. This measure receives governmental support and can be considered to be particularly helpful for individuals who wish to reduce their working hours to help look after an older relative without suffering a significant reduction in income. Whilst not devised as a policy for carers, it can therefore nonetheless provide a solution in such situations.*

*In the public sector, collective agreements provide for rights to career breaks. In public sector the time credit system is in place. In Flanders, if an individual reduces working time under this system to take care of a dependent relative, an additional allowance is paid by the ONEM. Local authorities can also pay a premium (premium Mantelzorg) to individuals taking care of dependents.*

*A collective agreement in the chemical industry in Germany explicitly covers support for carers of elderly relatives. The social partners also published a joint brochure on care of relatives and contributed case studies to a national initiative on the issue. The collective agreement asks employers to provide support in the following areas:*

- *Flexible working hours*
- *Flexible work organisation*
- *Support in providing care to relatives*
- *Keeping in touch during leave*
- *Access to training during leave*
- *Measures to raise awareness among supervisors*

In France, the social partners negotiated a wider national collective agreement on the quality of working life which takes account of the needs of working carers.

#### 4.1.4 Direct assistance with care

The agreement in the German chemical sectors highlights the possibility for employers to provide more direct assistance in sourcing care for individuals looking after adult relatives, for instance through partnerships with third sector providers.

#### 4.1.5 Other support for carers

Other support foreseen in collective agreements can include awareness raising activities for employees, employers and managers, as well as support for 'bottom up' carers' support groups at workplace level. Such initiatives are explicitly mentioned in the collective agreement in the German chemicals sector, but have to be implemented at workplace level. Similar agreements which further encourage activities at the workplace level exist in the Netherlands, where collective agreements in the insurance and local government sectors aim to stimulate negotiations on these issues at company level. In Portugal, collective agreements make provisions for an employee to request a transfer to a different workplace for health reasons (either their own or that of a dependent relative; see box in section 5.1.5 below).

### 5.1 INTRODUCTION

**A**t present, **initiatives at the workplace level support carers of adult relatives are significantly less widespread than initiatives aiming to support individuals seeking to reconcile work and childcare responsibilities.** Having said that, such initiatives are more likely to be found at the workplace level than in sectoral (or national cross industry) collective agreements. The 2011 Eurofound report provides a wide range of examples in this area, whereas the survey carried out for this study yielded more limited evidence of company practice as peak level and sectoral organisations are often not well informed about measures in individual organisations.

Company practices assessed for the Eurofound study also included enhanced leave provisions and access to flexible working. The most common form of workplace solution for working carers is flexible working time arrangements, part-time or individual ad-hoc extra leave days solutions.

Awareness raising measures range from staff surveys (to establish the needs of carers), over training provision for managers, the dissemination of information to the development of good practice toolkits.

Carers' health and well-being is at the focus on measures including providing for regular assessment of the health impact of caring on workers, access to confidential support and helplines, carers' support groups at company level and the delivery of health and well-being training modules for carers. Some companies go as far as providing practical support in sourcing or offering care for adult relatives.

*In the UK, the employers' initiative **Employers' for Carers** seeks to raise awareness of the business case for providing working arrangements sensitive to the needs carers (specifically adult carers). The organisation enables the exchange of good practice and provides training and consulting to employers wishing to develop more carer friendly policies. In its publication 'Who cares wins'<sup>22</sup>, it provides examples from three companies considered to have developed good practice in this area, focussing on the view not only of HR managers but also carers employed in the organisations.*

<sup>22</sup> <http://www.employersforcarers.org/business-case>

*In the Netherlands an association of carers and an HR advisory business have set up an organisation and website that provides advice to companies, works councils, workers and interest groups on how to help carers to combine work with care tasks. The website provides access to a best practice database. It also includes examples of companies that have concluded collective agreements, on how to establish an overall employee-friendly business, introduce carer friendly policies and how to raise awareness among workers and management.*<sup>23</sup>

### 5.1.1 Enhanced leave provisions

As an example of common measures at company level providing enhanced leave provisions, in a Dutch cosmetics company workers with care responsibilities are entitled to extra 5 days of care days on top of those provided under the legal national framework. In order to be beneficiary the worker should have less than 10 days of sick leave of that calendar year.<sup>24</sup>

### 5.1.2 Flexible working time

In one example in Germany, working time can be reduced with salaries also reduced, but not in proportion with the working time reduction. Such reduced salaries would then be retained for a relevant period of time after return to full time work. This measure is intended to give access to reduced hours working while cushioning the overall impact on wages.

Another example from the pharmaceutical industry in Germany provides a programme for “family part-time” work which allows workers to receive 65% of their salary while working only 50%.<sup>25</sup>

The example from a German metal working company proves of high flexibility for its workers by setting up of life-time working accounts. Workers can save on the working time account additional work time or non-taken holidays.<sup>26</sup>

An Irish manufacturing company provides in addition to legal carers leave, extra leave arrangements which can be negotiated to the individuals situation.

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<sup>23</sup> <http://www.werkenmantelzorg.nl/praktijk/praktijkverhalen>

<sup>24</sup> <http://www.eurofound.europa.eu/areas/populationandsociety/workingcaring/cases/nl004.htm>

<sup>25</sup> German Federal Ministry for Family, Elderly, Youth and Women (2011) Reconciling work with elderly care

<sup>26</sup> Beruf und Familie Label (2009) Brochure on elderly care

### 5.1.3 Occupational health services and programmes for carers

In examples provided in a Eurofound report, a Dutch transport company organises for psychological support if requested.<sup>27</sup> In an Austrian bank workshops on work-life balance and well-being are offered to prevent stress and burn out.<sup>28</sup> A German manufacturer provides psychosocial assistance to its workers during the phase of care. It also helps determining the best possible care provision and selection of providers.

### 5.1.4 Direct assistance with care

In most of the Dutch company examples provided in the Eurofound report financial support can be provided in very urgent cases, e.g. paying the Christmas bonus in advance, housing loans or loans under specific conditions arranged with the company.

A software company in Germany rents out transport material to its caregiving workers such as wheel chairs. This way workers do not have to go in addition to specific service providers to rent such material<sup>29</sup>.

In France “service cheques” can be acquired to get home care assistance A French pharmaceutical company provides to its caregiving workers “service cheques” of up to a value of 900 Euros to assist with care costs. The company has furthermore created intranet services such as the “virtual house” which assists in how to re-organise the home for care purposes.<sup>30</sup>

### 5.1.5 Other support for carers

In Austria a telecommunication provider signed a framework contract with a provider for counselling services. The counselling can be used by all employees to receive advice over issues on work-life balance or family conflicts. In addition to that the company employs a person that represents those that are on care leave (children or elderly) and is responsible for all issues with regard to care-leave and reintegration after leave.<sup>31</sup>

At a German car manufacturer a group of employees concerned about work and care provide extensive help to working caregivers in form of advice services. They have also published a leaflet for employees seeking assistance to set up care arrangements in the early days. The brochure was published in Turkish and German.<sup>32</sup> A similar initiative was created in a UK telecommunication company where an employee group on “work and care” was created to provide each other support and advice on care provision. The company gives members of the group a certain number of working hours to assist their meetings. The group organises each year a “Carers Week” to raise awareness of the issue at company level.<sup>33</sup>

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<sup>27</sup> <http://www.eurofound.europa.eu/areas/populationandsociety/workingcaring/cases/nl002.htm>

<sup>28</sup> <http://www.eurofound.europa.eu/areas/populationandsociety/workingcaring/cases/at003.htm>

<sup>29</sup> German Federal Ministry for Family, Elderly, Youth and Women (2011) Reconciling work with elderly care

<sup>30</sup> <http://www.eurofound.europa.eu/areas/populationandsociety/workingcaring/cases/fr002.htm>

<sup>31</sup> <http://www.eurofound.europa.eu/areas/populationandsociety/workingcaring/cases/at001.htm>

<sup>32</sup> <http://www.eurofound.europa.eu/areas/populationandsociety/workingcaring/cases/de001.htm>

<sup>33</sup> <http://www.eurofound.europa.eu/areas/populationandsociety/workingcaring/cases/uk003.htm>

In a German manufacturer specific training was initiated by the employee working group on elder care. It included training on dementia helping caregivers understanding of the sickness better.<sup>34</sup>

In Portugal, collective agreements make provisions for employees to request transfers from their workplace on the grounds of illness – either their own or that of a family member. An example of the Collective agreement between Banco Comercial Português and FEBASE - Financial Sector Federation. The agreement contains the following key provisions:

*Mobility between workplaces*

*Clause 31*

*Transfer to another workplace at employee's request*

*1 - In the workplace transfers at employee's request, provided that the qualification requirements for the performance of the activity are met, it will be given priority to the following hierarchy of factors:*

- a) Health reasons for the worker or any member of their household, properly supported and benefiting from the transfer;*
- b) Merit demonstrated during the counseling and evaluation process;*
- c) Household of the household or employee;*
- d) If the spouse is working in the local in question, with no possibility to be transferred;*
- e) Proved family care need;*
- f) Proved continuing education requirement;*

*2 - Should the preference factor mentioned in a) not be attended, the employee may request a Medical Board to review this decision, under clause 77.*

*3 - An employee who meets certain preference factor cannot be overridden by another worker who fulfills several subsequent factors.*

*4 - If, for more than a worker in the preceding paragraphs, the same factors are met, priority shall be given to the oldest request for transfer.*

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34 Beruf und Familie Label (2009) Brochure on elderly care

# WHO CARES?

## CONCLUSIONS

# 6

- ★ The fact that the impact of demographic change on societies, labour markets, health and care policies and public budgets will be significant is now clearly understood.

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- ★ There is a high level of agreement on the challenges facing working carers of adult relatives. These are primarily practical (the ability to negotiate enough flexibility to combine work and caring tasks), financial (mainly resulting from many carers' being required to reduce working hours or having to leave the labour market entirely), organisational (having to spend time to co-ordinate between service providers) physical and emotional. Beyond this there is also a wider gender impact, cementing even further the unequal gender distribution of caring roles in society and resulting employment and pay and pension gaps.

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- ★ Having said this, data on the number of working carers is lacking meaning that this can remain a 'hidden problem' in the policy debate.

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- ★ For those carers who find themselves exiting the labour market altogether to fulfil a caring role, negotiating re-entry can be difficult, particularly if the period of caring was an extended one and regions and localities with generally difficult labour market situations. For them the financial, physical and emotional pressures, as well as the social isolation experienced by many working carers can be even more significant.

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- ★ Despite this increasing awareness, the level of measures taken by governments, social partner and individual employers focussing specifically on informal carers of adults remain limited.

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- ★ Long-term care strategies tend to pay insufficient attention to the precise requirements of those being cared for themselves and their specific wishes and too little attention is paid to innovative solutions for inter-generational or age conscious living arrangements. Not enough attention is also paid to creating a more successful interaction between home care, support for formal home carers and relative formal institutional care and health care. This could significantly reduce pressure on working carers and improve care provision.

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- ★ Support services for home care remain under-developed and face issues of quality and affordability and availability (in terms of geographical distribution urban and rural areas, but also underdevelopment in a number of countries). Respite care and practical and psychological support services are also under-developed. In recent years, budgetary cuts for health and social care as well as for municipalities and regional authorities has significantly undermined the funding base for high quality service provision.

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- ★ Insufficient attention is being placed on quality standards in care provisions (both within institutions and at home). This goes hand in hand with a lack of standardisation of training requirements.

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- ★ Carers' leave provision remains patchy and insufficient, most particularly with regard to replacement rates and take up is low as a result. Adult carers lack the same protections and rights as carers of children in terms of leave and pension entitlements.

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- ★ Legal rights to flexible working are also not ensured at the EU level and different levels of access therefore exist at Member State, sectoral and company level.

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- ★ There are limited examples of collective agreements making specific provisions to support adult carers and those that do tend to limit this to (slightly) enhancing access to carers' leave (even in these cases often unpaid).

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- ★ Company level practices also tend to emphasise leave – and in some cases flexible working provision. Here, additional leave also often remains unpaid and access to flexible working is often not an outright entitlement (and reduced working hours are linked to commensurate reductions in salary).

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- ★ There are few examples of practices offering direct practical or emotional support or broader flexible working options.

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- ★ Stronger rights based solutions are required in relation to leave and flexible working which ensure adequate compensation.

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- ★ Similarly, efforts are needed to avoid further widening gender gaps in any such policy approaches.

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- ★ Collective agreements could provide a more solid basis for company level provisions and entitlements, but currently appear to be under-utilised as a tool.

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