

Lise Lien

Care responsibility and work participation

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ISSN 0804-5135

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Preface

This study was initiated by AbbVie Norway, a branch of the global medical firm AbbVie. AbbVie is concerned by the sustainability of the healthcare system across Europe and thus helped to support the creation of a European Steering Group in 2014. Their primary goal was “to foster an exchange between academia, healthcare providers, patients' groups and industry”. The group’s work, led by the former Health Minister of Ireland, Mary Harney, was launched in a pan-European White Paper and Call to Action in Brussel in March 2015 under the name: Acting Together. A Roadmap for Sustainable Healthcare. The objective of the group was to “stimulate pan-European multi-stakeholder partnerships that will drive healthcare transformation by identifying practical, tangible actions and providing innovative solutions to the sustainability challenges facing healthcare systems”. This small pilot study is a result of this initiative.

The aim of this small-scale study has been to make some preliminary investigations into excessive care burden and how it may have an impact on employees’ working situation, and how employees in the best possible way can cater for employees who experience an excessive care burden, for a shorter or longer period of time.

A web-survey was sent to AbbVie Norway, and an omnibus survey was carried out by a contracted company, Norstat. My colleague, Anne Hege Strand (Fafø), contributed with the statistical analysis. Lien carried out qualitative interviews with both employers and employees in private sector and municipal care sectors. I am very grateful to them all for sharing their stories with me, and their experiences illustrate the importance of “care for carers”. I would especially like to thank Hanne Børke Fykse, Strategic Health Initiatives Manager, External Affairs, AbbVie Norway, for being very constructive and helpful during this exciting process.

Oslo March 2015,
Lise Lien

1 The aim of the study

Some projection studies show that 25 per cent of the youth have to choose studies in health and social care to cover the need for health care personnel in Norway in 2025 and this is seen as unrealistic (Meld. St. 13 (2011-2012)). This calls for changes in the sector, and it is suggested that relatives have to cooperate more than before with the public elderly care system (Meld. St.13 (2011-2012)). While most caregivers are in paid work this may call for more flexibility at work and sometimes in a combination with (more) help from the public care system.

In this small-scale study we examine employees with additional care responsibilities, e.g. for children with disabilities and/or for elderly, and how this responsibility may affect their work and their work participation¹. The aim is to map out what measures employers can implement to secure that caregivers stay in work and preferably in full time work, and therein securing a better work-life balance. It is not necessarily the role as caregiver in itself, which may cause strains for these carers, but rather the intersection between work and caregiving. How employees handle, experience and balance these roles will vary and may be understood as individual adaptations to different factors at the community, work place and family level.

We will begin this paper by giving a short description of the Norwegian context both in terms of the challenges of the future welfare state, the Norwegian work-life and our formal and informal care system before presenting some important findings in this pilot study. The concluding remarks with a shortlist of workplace measures are to be found in the last chapter.

¹ We should emphasise that extra care responsibility do not necessarily involve extra strain for the carer, and therefore some will not need particularly solutions at work.

2 Background

2.1 Demographical changes

In Norway publicly financed care play a substantial role, and have done so for several decades. But Norway, like other European countries, is facing many of the same challenges in providing a sustainable care system in the future. Sustainability is not only connected to finances, but also to manpower.

First of all our welfare state will face some challenges due to *demographical changes*, such as an aging population and fewer workers behind each senior citizen. Demographic projections scenarios show that the working age of the population (15-64 years) as percentage of total population in Norway will be reduced by 8, 2 percentage points, from 66, 2 per cent in 2010 to 57, 9 per cent in 2060, and at the same time elderly (65 years and over) as percentage of the population will rise with 10 percentage points in the same period from 15 per cent in 2010 to 25 per cent in 2060. The rise in very elderly (80 years and older) as percentage of the population will rise with 5, 1 percentage points from 4, 4 per cent in 2010 to 9,6 per cent in 2060. The very elderly population as percentage of working age population will rise with 9, 8 percentage points from 6,8 percent in 2010 to 16,6 percent in 2060 (European economy 2011:301). It is in 10 years' time Norway will experience a growth in the very elderly population.

This means that there will be more employees in the age group 50-64 years old who in the future may experience the possible strain between work and care, not only for their own parents but also their (grand) children and/or in-laws (St.meld. nr.25 (2005-2006)). Along with this development, Norway has experienced big changes in the family structure. The families are getting smaller with fewer family members to share the caregiving tasks. About half of the marriages end in divorce, and now Norway are experiencing the first generation of elderly divorcees. We experience a growing urbanisation, and geographical distance between caregiver and elderly parent play an important role for the help given (Gautun 1999). At the more positive side we are registering that men contribute more in caregiving tasks – both for children and other relatives – and that grandchildren also do their share (NOU 2011:17/11 p. 26).

The public finances in Norway are healthy and will probably stay so for decades, but some of our future problems will not be solved by money alone.

2.2 Scarcity of human resources

Norway is already facing *recruitment challenges* in our health care sector. Calculations done by Statistics Norway, show that the sector may experience a huge lack of healthcare personnel of up to 38 000 man-year in 2030 (Texmon & Stølen 2009). If the on going tendency of fewer young people choosing this form of education continues, we might experience even bigger challenges in the elderly care sector in the future. The consequence may be more emphasis on family care.

In the future the composition of the population and the supply of manpower will be more challenging in some geographical areas than in others. Many rural municipalities in Norway have been facing recruitment challenges for decades – especially in the northern parts of Norway. Here health personnel from other Nordic countries and Russia have been crucial in upholding the local health and elderly care services for years (Moland & Lien 2013). Many countries in the world are facing the same recruitment challenges, and Norway has committed itself not to actively recruit health personnel from countries with such challenges (Meld. St. 11 (2011-2012)). Nevertheless, in 2010 over 25 000 employees with foreign origin worked in health and social care sector in Norway and about 9 000 of those originated from countries with health personnel recruitment challenges² (Meld. St. 13 (2011-2012)).

2.3 But what if...? Health improvements, medical discoveries and welfare technology

It is difficult to predict the future but it is worth noting that health improvements, medical discoveries and innovation in welfare technology play an important role in several scenarios. If researchers solve the Alzheimer's riddle and if we will have a treatment of it from 2020, Norwegian calculations show e.g. that one may experience a 25 per cent reduction in man-year needed in the sector in 2050 (St.meld. nr. 25 (2005-2006) p. 53), and that will of course also lessen the burden for family members with relatives with such diagnosis.

Health improvements among the elderly may also reduce the need for health care personnel in the future. Many health-trend studies are supporting the hypothesis of dynamic balance – the occurrence of long-term illnesses will increase, but the need for formal health care will be postponed, and it will be needed for a shorter period of time (Daatland & Veenstra 2012:7). But this does not necessarily imply cost reductions for society. Health improvements most often comes at a cost, while such improvements often are a result of money spent on available, and often expensive medicine, and different prevention measures. The world is also witnessing a growing discipline in Anti-ageing Medicine and not at least innovations in welfare technology. Despite a growing number of technological innovations, the use of technology in the elderly care sector in Norway is not widespread. The reasons why may be multifaceted and can be linked to poor technology and/or lack of ICT-knowledge in the sector, organisational resistance and economy (NOU 2011:11 p.109).

Even though we have observed great health improvements in the population we also observe class differences in health. Socio-economical background has an impact on health status and we also observe differences in health and life expectancy between different regions, municipalities and neighbourhoods in Norway (Krokstad & Skjei Knudtsen 2011)). People with higher education and high income have experienced a higher degree of health improvements than those with low education and low income. There are a growing number of people struggling with obesity that have resulted in an augmentation in diseases such as diabetes. We also observe an augmentation of young people reporting health problems, and especially mental health problems.

² These are not necessarily being actively recruited, but have come to Norway by their own initiative.

2.4 The Working Environment Act and the Agreement on a More Inclusive Work Life

Both the Working Environment Act and the Agreement on a More Inclusive Work Life (IA-agreement) in Norway is meant to secure and enhance the safety, health and well being of workers. They both deal with risk prevention, but also with health promotion.

The Norwegian authorities are aware of the strain some employees with extra care responsibilities faces. An amendment to the Working Environment Act July 1st 2010 was meant to give employees better opportunities to combine work and care for relatives. From then on employees' in Norway, who nurse close relatives and/or other close persons in the home during the terminal stage, are entitled to 60 days leave of absence to take care of the patient. You are not entitled to an economic compensation for these days, but in some workplaces they have provisions in their collective agreement securing an economic compensation. Employees are also entitled to a maximum of 10 days leave of absence, without economic compensation per calendar year to care for parents, spouse, cohabitant or registered partner. According to the Working Environment Act employees with care responsibility for children with a chronic or long-term illness or disability and where there is: "(...) a markedly greater risk of the employee being absent from work, the employee is entitled to a maximum of 20 days leave of absence (...)" (Working Environment Act 2012:38). Our data suggests that some employees i) are in need of more days off, ii) are in a situation where full time work may be difficult or iii) that neither the employer nor the employee know and/or utilize the regulations well enough.

Another important agreement in Norwegian working life is the Agreement on a More Inclusive Work Life (IA-agreement). This agreement has three main goals; i) reducing the sick leave rate among employees, ii) including people with disabilities in working life and iii) increase labour market participation for the 50+ years population.

These goals are meant to underpin the strong activation policies in Norway. Employees in organisations with an IA-agreement are entitled to 24 days of sick leave during one year (with certain restrictions). These days may only be used in connection with own sickness. The IA regime has strict rules the employer have to follow when an employee get sick. If possible, the employer shall facilitate the work – either to prevent sick leave or to get the employee back to work as soon as possible. It is the employer who is financing the first 16 days of sick leave (and the employee is fully compensated), and therefore better facilitation of work and prevention measurements may affect the organisation both economically and with regard to productivity.

Increased labour market participation for the 50 + years population (goal number 3 in the IA-Agreement), is meant to secure a sustainable pension system in the future. Different political parties have stated that it is important that employees – both men and women – work full time as long as possible. In Norway, 40 per cent of women work part-time for a shorter or longer period of time and app. 70 per cent of women in elderly care sector are working part time. Calculations show that a few years with part-time work due to caring for children will not affect your pension much, but a long period of part-time work will have a financial consequence – obviously in a short-term perspective but also in a more long-term perspective. After the Norwegian pension reform in 2010, women's work participation is of more importance than before, as future pension income will be based on individual income and work-participation to a greater degree than before. So labour market -participation is important, not only in a gender equality perspective, but also for the standard of living in senior years.

2.5 Formal care

How a society organise its (health) care services depends on political choices and ideology, economy and general norms and values. But it is also affected by the aging of the population, the composition of the work force and changes in family patterns. Our health care/elderly care services are predominately public and financed through general taxpaying.

Women entering the labour market in the 1970'ies are one reason for a well-developed formal care sector in Norway. Caring for the elderly in nursing homes were, and still are quite common, but more in some municipalities than in others. There has also been a shift in how we look at people with disabilities, mentally ill persons and elderly. Instead of institutionalizing these groups of people the aim is rather giving them the possibility to more independent lives and enhanced life quality outside institutions - in short let all people experience a life as normal as possible. This ideology of normalisation has changed not only the way we look at elderly care and the way we organise the care, but also how we understand the concept of caring. The normalization ideology has also affected other groups in society such as children with different kind of disabilities and mentally ill persons. The ideology of normalization has changed the policy of care towards a de-institutionalisation policy. The closure of psychiatric institutions and discontinuation of treatment facilities have e.g. meant that mentally ill patients to a greater degree are living at home and are receiving outpatient treatment. Nursing homes have changed from a place where quite healthy elderly lived their lives for many years, to a place where only the sickest and weakest elderly live. Another important reason for this de-institutionalisation has been economically motivated. Care in institution is expensive.

In recent years the policy of elderly living at home as long as possible has become more pronounced. Less pronounced is what this may imply for relatives. Between the years 1995-2005 it has been a reduction of app. 3000 beds in elderly institutions and from 1992 to 2010 the proportion of elderly receiving practical help from the home services has declined from app. 50 per cent to one fourth of those receiving help from the home services (Otnes in Daatland & Veenstra 2012:63, 64). Changes like these and the pronounced policy that relatives have to contribute more, may possibly reinforce the pressure on family members as care providers, especially if they at the same time are expected to work full time in paid work.

Today we have a relatively well functioning division of labour between formal and informal care in Norway. At the same time some relatives are reporting lack of much needed help, the wrong kind of help and too many bureaucratic hurdles. Carers for children with disabilities are e.g. reporting that the bureaucracy is perceived as a great psychological and time-consuming burden (Haugen et.al. 2012). Studies of carers' for elderly parents also find that relatives are of the opinion that particularly their mothers do not get enough help from the public care system (Gautun 2003 in Gautun 2008). We often read in the newspaper stories about insufficient care. Still – elderly care in Norway is functioning quite well, and in general people in need get the help they are entitled to.

In Norway the state is expected to help and compensate families with additional care responsibilities. The development from institutional care to more informal care at home has since the mid-1960'ies been followed by a development in different monetary compensations to secure people with extra care responsibilities the opportunity to combine care and work. Often this compensation does not match the carers' loss of wage, and therefore comes at an economic cost for the employee. There has been several NOU's (Official Norwegian Reports) and Reports to the Storting (White papers) where caregiving has been addressed. In NOU 2011:17 it was e.g.

recommended to: i) expand the monetary compensation to caregivers for children under the age of 18 who suffers from serious and long term diseases and ii) legislate the caregivers rights to support. The stipulated costs for such changes for the Norwegian municipalities are between 87 MNOK to 1075 MNOK, but the size of these figures is uncertain (KS/PricewaterhouseCoopers 2012).

2.6 Informal care

Knowledge about informal care is important for many reasons. Informal care plays a substantial and necessary role of the total care provided in any society, and more in some countries than in others. And as pointed out above, it will probably need to play an even more important role in the future. The formal care system is expensive – especially care in nursing homes – and it is not dimensioned to fill all care needs in society. Nor is it probably desirable that formal care should fill all care tasks needed in a society. Therefore informal care is crucial – also in a welfare state perspective. But if relatives have to take more responsibility for the care of the elderly in the future at the same time as it is a strong pressure on full time work, more employees may experience role stress as carer and employee. Finding sustainable solutions at the work place and/or in collaboration with the public care system may ease this possible role stress – probably not only for employees with extra care responsibilities but also for employees with “normal” care responsibilities.

The amount of formal and informal elderly care in Europe varies to a great degree. In some European countries women have the main responsibility for the informal care in the family. This may seem to have a more negative effect on their employment, and number of hours worked, than for women in countries with a strong formal care sector, such as Norway. In countries characterized by a high degree of informal care, women experience to a greater degree than men, the social pressure from others to take on the caregiving tasks. Comparative studies of Norway, Great Britain, Germany and Israel find that the expectation of adult children caring for their parents is lowest in Norway. This is being explained by the strong standing of formal care in Norway (Daatland & Herlofson in Kotsadam & Jakobsson 2012:98).

Countries characterized by a high degree of formal care give women greater opportunities to enter paid work. Different social and monetary compensation also contributes to this. Kotsadam and Jakobsson (2012) find that care responsibilities, *in general*, does not contribute to reduced wages, number of hours worked or the probability of being in work in Norway³. That said – our data is indicating that some employees experience this.

It has been a substantial shift in money spent on nursing homes towards help given in the private home of the elderly or in residential care with health care personnel present 24/7 or less. In the 1990'ies two thirds of the resources spent on elderly care was spent on institutional care, and one third on home care services. Now half of the resources are spent on home care services and other measures outside institutions (Brevik in NOU 2011:11 p. 23).

³ This *may* change in the future due the pension reform. If women (or men) continue to work part time as a result of caregiving tasks over a long period of time this will affect their pension income in the end.

2.7 Monetary compensating system⁴

The compensating monetary system in Norway is well developed. If caring for a sick child or attending to persons to whom you have close ties to in the final stages of life you may be eligible for *attendance allowance*. Generally this implies to close family members, but close friends and neighbours may also be entitled to such allowance. To receive this kind of allowance as e.g. a parent for a child with extra care needs, the child must be in need of constant supervision and care for at least seven subsequent days. Nav will pay attendance allowance from the 8th day with some exceptions. If you have a chronic sick child you are generally not entitled to an attendance allowance. If the child is in need of constant care and supervision, and if it the care is being conducted by others than its parents for most of the day, you may not be entitled to an attendance allowance. You may also be entitled to a graduated allowance. The attendance allowance is calculated on the same basis as sick pay - that is to say that you are fully compensated for the loss of income. This will not have any implications for the employer, while there is no employer liability period. As a general rule you may receive attendance allowance for a restricted period of time⁵.

Care benefit is another monetary compensation for carers with sick children. Carers may receive care benefit until, and including the year of, the child's 12th birthday. If the child has a chronic disease or a disability this right may be extended until the calendar year the child turns 18. If the child's sickness causes the carer to be absent from work, the carer is entitled to care benefit, and also if e.g. you have to escort the child to a doctors' appointment. Depending on number of children and marital status - in general a carer may receive care benefits for 10 to 30 days per calendar year, and the benefit is equivalent to full work income. Parents with disabled children or children with a chronic disease may apply for additional care benefit days. The employer are obliged to make advance payments of care benefits - in addition to the ten days they are obliged to cover - and the care benefit days exceeding these ten days the employer may seek reimbursed by Nav⁶. You may also be entitled to some monetary compensation from the municipality. According to the Basic Agreement in KS, chapter 1 § 14.1. 2, an employee may be entitled to 12 (14) workdays with care benefit or up to 24 (28) workdays with 50 per cent wage.

What may cause problems for carers are when e.g. your child are having a diagnosis which the system is not covering or if there is a discrepancy of the caregiver's perceived need of help and what the care system is offering. The child's diagnosis or behavioural problem may nevertheless make it difficult for a parent being in full time work.

⁴ This is not an exhaustive review of the Norwegian system.

⁵ <https://www.nav.no/en/Home/Benefits+and+services/Relatert+informasjon/Attendance+allowance.291819.cms>

⁶ <https://www.nav.no/en/Home/Benefits+and+services/Relatert+informasjon/Care+benefit.291818.cms>

2.8 Gender

In contrast to many other countries, most women in Norway are in paid work. But the Norwegian labour market is very gender divided, and women's and men's work have different characteristics. Men have generally higher salaries, are experiencing higher degree of empowerment and have positions with a higher degree of flexibility. Statistics Norway (SSB) conducted a survey on the combination of work and care responsibilities using data from 2005 (Lohne 2007). In this survey they looked at "ordinary" care for children. They found that the proportion of parents having the possibility to come later at work or leave work earlier due to domestic reasons, almost 80 per cent of men in public sector had that possibility, compared to 60 per cent of women. In private sector slightly more men have that possibility, but for women that possibility rises up to 80 per cent. They found the same tendencies when looking at the possibilities for parents to organise their work time in ways that allow them to take time off due to family matters. Despite the fact that women still are more responsible for the informal care in the family than men, men do participate in a larger degree than before (NOU 2011:17 p. 26, Levekårsundersøkelsen, SSB). But there seem to be differences between how men and women cope with such a responsibility. Sons, as caregivers for older parents with a chronically illness, report less burden than daughters (Faison et.al. 1999). Research conducted in Norway, are indicating that women to a greater degree than men reduce their work participation when experiencing extra care responsibilities for children with disabilities (NOU 2011:17, Haugen et.al. 2012).

Even though many women work part time, the reasons why is not always straight forward. Health and family, but also work place issues are common reasons, such as the organisation of work and norms and values (Nicolaisen & Bråthen 2012:81). Another Norwegian study aiming at explaining the reasons why employee in municipal sector are working part time approximately one of four employees in part time work answer that their reason for this is care responsibility. In the age group 35-44 years 18 per cent answer that the reason for working part time is care responsibility for children and five per cent answer that the reason is care for other relatives. One of ten in the age group over 62 years old are working part time because of care responsibility for a persons who is sick and in need of care (Moland 2009:40-41).

Even though Norway is being seen as a gender equal country there are lot of research claiming that this is a truth with certain modifications, by pointing at the gender divided labour market, the fact that women still have the main responsibility for the family and that part-time work is more common amongst women than men (Hansen & Slagsvold 2012). Generally women seem to a larger degree than men to adjust their work life to their family life (Lien & Gjernes 2009, Hansen & Slagsvold 2012). Research show that many women, with care for disabled children, have reduced their occupational activity, but at the same time work participation seem strongly connected to socio-economical background, educational level, the level of the child's care needs and the subjective notion of health (Finnvold 2011 in NOU 2011:17 p. 22).

Even though extensive caregiving tasks, in some ways, may seem to affect women more than men, this does not suggest that men do not contribute to caregiving tasks, and that they too may be affected in different ways. The typical caregiver with additional care responsibility is not necessarily a family-oriented, part time working woman with a low degree of education. Caregiving is rather something that concern us all – women or men, some time or another and to a higher or lesser degree.

2.9 Care burden and role stress

There exists a lot of research on care burden, especially from the USA and UK, but less from Norway. This lack of interest may e.g. be explained by Norway's well-developed formal care system, monetary compensation system and quite flexible work arrangements. These kinds of support systems may lessen possible care burden for employees.

Caregiver burden is often being referred to as the effect of stressors on caregivers for a physically or mentally ill person. Such stressors may be psychological, physical or social. The term "care burden" may have a negative sound to it. Having an extra care responsibility does not necessarily have negative implications for the carer. Some researchers therefore talk about family caregiving *consequences*. Others focus on life course role-identity. This is a theoretical approach suggesting that: "(...) caregiving be viewed as a role in the life course that one is likely to enter and exit once or several times during adulthood" (Marks 1999:952). The sum of multiple roles with its demands and expectations may cause role overload or role conflict. Escorting your parent to the doctor at the same time as you are expected to be in a morning meeting at work may create such conflicts (Marks 1999). Still, research shows that persons with extended caregiving roles in general are experiencing poorer mental health, and some times poorer physical health than others (Marks 1998, Ostwald et.al 1999, Faison et.al. 1999). This may be a consequence of the combination of the persons' impairment and kind of tasks performed by the caregiver, the workload of the tasks and time invested in performing these tasks - often referred to as objective burden. The subjective burden on the other hand, may be defined as the caregivers' "attitude toward or emotional reactions to the caregiving experience" (Montgomery et.al. 1985:21) and has to do with the caregivers' perceived notion of burden. Similarly caring tasks may therefore, be perceived differently by different individuals. We may add that the emotional strain can be of such a character that it is emotional exhausting more objectively speaking.

Role stress theory used in work-family research has been dominated by focus on the negative effects of the work-family interaction, but as Rantanen et.al. (2011) point out, this research has become more concerned with the positive outcomes of the interaction between the work role and the family role. In our study it is quite obvious that the interaction between the roles as a caregiver and employee may have several positive effects and that paid work is perceived as important per se. But at the same time being able to balancing these roles in a satisfying way on an individual level, may depend on type of occupation and different work arrangements. So, caregivers in paid work do not necessarily experience role stress, but for those who do, measures at the workplace (and or governmental measures) may lessen this kind of stress. It is not necessarily work per se which causes the perception of role stress, but the intersection of work and care.

All employees, women and men alike, may experience work related stress at one point or another, and this kind of stress may develop because an employee is being unable to cope with the demands being put on him or her. A demanding home situation may add to this stress. Often it is possible to make some arrangements to lessen this kind of stress and this kind of arrangements does not even have to cost money. While work related stress can be a cause of illness and linked to sickness absence, stress reduction measures may be a good investment.

3 Methods for data collection and research question

This project is a small-scale study where the main aim has been to make some preliminary investigations into a topic which is thought to increase in importance over the next decades, namely how an excessive care burden may have an impact on employees' working situation, and how employees in the best possible way can cater for employees who experience an excessive care burden, for a shorter or longer period of time.

In this project we carried out qualitative interviews with both employers and employees in private and municipal care sectors. We have talked to employees with an additional care responsibility, and how this impacts on their work situation and work-life balance. We have also conducted a small web-omnibus survey among employees, asking about how work-life balance issues implicate on employees.

3.1 Web-omnibus survey

An omnibus survey was carried out in June 2014, by a contracted company, Norstat. The questionnaire used in the web-survey was a shorter version of a piloted survey used in AbbVie Norway.

A total of 600 Norwegian employees were surveyed, out of which 139 persons (23 percent) answered that they had additional care responsibilities. The survey used a quota-sampling strategy, and is thus not a random sample. The survey results show that the sample consists of approximately equal shares of women and men, and approximately the same number of publicly and privately employed. This reflects the Norwegian labour market well. However, a majority of the respondents have higher education, have a reasonable high household income and live in urban areas in Norway. The survey therefore reflects the answers of what are likely to be middle-class and upper-middle class employees in Norway.

3.2 Interviews

Our data also includes interviews with one employer and seven employees in both private and public sector, who have or have had additional care responsibilities. Some were recruited by AbbVie Norway, and some through contacting two Norwegian municipalities. Fafo prepared a Power Point presentation with facts about the project and the presentation were held by the local managers. Fafo also prepared an information sheet, which was handed out to the employees by the local managers. Employees who wanted to participate could contact their managers or Fafo. To secure anonymity our quotes are not connected to sector. We used some of the interviewees' reflections when constructing some of the questions in the web-omnibus

survey, and we are also using quotes from these interviews to illustrate some points from the web-omnibus survey.

Initially we also interviewed four patient organizations about extra care responsibilities and work participation. For most of them work and extra care responsibilities were not something they had thought much about. What seemed to matter was more, and partly different, help than offered today from the state. Even though the collaboration between the public care system and work measure is important we are concentrating on possible workplace measures in this study.

4 Findings and discussion

Of the 600 respondents in the web-omnibus survey, approximately one quarter (139 persons) stated that they have an extra care responsibility. Of these 53 per cent are women, and 47 per cent are men. Slightly more are working in public sector (54 per cent) than in private sector (46 per cent) and 86 per cent are working full time.

Table 1. Employees with additional care responsibility.

Have additional care responsibility	No.	Percent
Yes	139	23
No	461	77
Total	600	100

Table 2. Key characteristics of employees with additional care responsibility.

Have additional care responsibility	Yes
Work full time	86
Women	53
Private sector employee	46
Married/cohabiting with children in the household	44

The sample we are reporting from in this study is therefore not in any way reflecting the stereotypical image presented of carers, namely that this will be a woman, employed in the public sector and working part time. What our survey suggests is that employees from varying backgrounds may find themselves in a caring situation during their life course where they, for a shorter or longer period of time, have an additional caring responsibility for someone. This is an important point, and illustrates the need for measures in all types of working places, not just in female dominated work-places.

4.1 Care responsibility and age

The combination of more employees working full-time than before – particularly women, and the expected growth in the need of informal care for the elderly may increasingly tighten the potential conflict between paid work and unpaid care work. Older workers in the age group between 50 and 64 years may find themselves in a particular squeeze – where care responsibilities may include both own children, grandchildren *and* own parents at the same time. This is perhaps the exception, but nevertheless a scenario, which may face more people in the future.

At the same time there is a political ambition to retain people in work for as long as possible and increase work participation rates among senior employees. Increasing the care responsibility of this age group may represent a factor that pushes senior workers out of employment or into part time work.

Female employees may face a particular risk here. Not only do women aged 50 + have a higher risk of sick leave, many women in this age group in Norway are also employed in the health and care sector, in jobs characterized by shift work and a low degree of flexibility. This is not to suggest that older, female employees have a higher likelihood of having an additional care responsibility, compared to other employees. However, the possibility of this group combining extensive care needs with paid work may prove more difficult for some groups of employees than others. Women may here be at particular risk, where experiencing additional care needs may be a factor pushing women out of the labour market, cutting short both their working careers and pension incomes.

The findings from our survey suggest that a majority of those with additional care responsibilities are in the 50 + age group (table 3), underscoring that this age group is of particular importance when discussing combining employment and additional care responsibilities. Our web omnibus-survey do not, however, indicate that women more frequently than men are having additional care responsibilities, rather the opposite, our survey found that additional care responsibility were relatively equally distributed between women and men (table 4). Yet, the consequences of this may still differ for women and men, as suggested earlier.

Table 3. Employees with additional care responsibility by age. (Numbers in per cent).

Has additional care responsibility	Yes
Less than 30 years	1
30-39 years	21
40-49 years	19
50+ years	58
Total	100

Table 4. Employees with additional care responsibility by sex. (Numbers in per cent).

Has additional care responsibility	Yes
Men	47
Women	53
Total	100

4.2 Caring for children or caring for the elderly?

Having care responsibilities for a child is quite different than having care responsibilities for a spouse/partner or for parents. Caring for a spouse, partner or parent may change the roles in the family and adding to the carers total work load as well as it may be perceived as a mental toll.

While most of the respondents with extra care responsibilities in our sample are in the age group 50+ years, it is not surprising that most of the caregivers in our study report having care responsibilities for parents or in-laws. Of the total sample, about 14 per cent are reporting having such responsibilities, while four per cent care for other family members. Five per cent have extra care responsibility for children under the age of 18, and three per cent for children over the age of 18. Two per cent have extra care responsibilities for spouse/partner, and only one per cent is reporting having care responsibilities for friends. These are not particularly high numbers, but behind these figures there are many employees who are struggling every day to avoid role stress.

Families caring for children with disabilities have special rights stipulated by law and regulations in Norway. Small children will e.g. have rights regarding participating in pre-school or other forms of day care and when they grow older they have the right to attend school. Parents will also have the right to different kinds of financial support (e.g. attendance allowance and care benefit), depending on type of care responsibility. They are for instance entitled to some additional days off work depending on their child's health condition. These laws, regulations and economically compensatory measures may be interpreted as the state admitting a responsibility for caregivers. Norwegian law also allows parents with small children the right to work part time.

Elderly care is not regulated to the same extent, and that may generate other types of challenges for these caregivers. In the last 20 years in Norway there has been a reduction in residential care for the elderly, and at the same time the growth of care homes have not been sufficient to compensate for this reduction. The use of public home care has increased, and the help offered to the elderly living at home is often characterised by advanced nursing (Gautun & Hermansen 2011:98), and to a lesser degree help with practical matters. It is mostly users under the age of 67 that have benefited from the growth in home care in the period from 1992-2006. Relatively speaking the group 80+ years old who received home care were reduced from 41 per cent in 1992 to 37 per cent in 2006 (Gautun & Hermansen 2011:98).

The reduction in residential care is not per se a problem, but when relatives experience a lack of formal care for their loved ones it may cause problems - both for the elderly but also for the caregivers. Caring for parents with extensive needs e.g. elderly living at home with dementia/Alzheimers and with no partner to look after them may put caregivers in full time work in stressful situations - particularly if one is facing a lack of (enough) help from the formal care system. But this period of extensive care may be more challenging for some employees, than for others. One of our interviewees illustrates the unpredictability having an older parent with dementia may cause, and that flexibility at work was essential in the caregiving period:

My parent, funny enough, remembered my phone number and started to call me up at work every hour. After a while I could get ten calls a day during work. Sometimes I had to rush out of work in the middle of the day to search for X, who had left the house and didn't find the way home. I had to intervene all the time regardless my whereabouts and work situation. (Employee)

The employee continues saying:

This is the only place that I've ever worked where living with such a strain has been possible. We don't have fixed working hours, but are instead rated by a set of goals. There are a lot of mothers with small children here, and it is never questioned if they need to stay at home because of a sick child, or if you have extra care responsibility and need to stay home because of unforeseen happenings. The freedom is built into the system. We are very privileged, because we can do the work from home. (Employee)

One manager in the same company confirms this flexibility:

We provide a lot of flexibility and that's perhaps what employees' value most. Some people wonder whether employees exploit the freedom, but that's something we hardly ever see. On the contrary, it's perhaps more the case that people work more than they should: Because they are given the freedom, they feel an obligation to give something back. (Manager)

In this statement we can observe that the company has a policy of empowering employees. In this kind of regime a high degree of trust between employer and employees is essential and it is also a regime where self-management is important:

You have of course a responsibility yourself. Your employer may facilitate, but it is up to me to use the tools my workplace offers to me. (...) I do not experience a lot of stress, because I have a very good dialogue with my boss and that helps. That said – I'm awfully good at logistics and that is one method to reduce stress. It's a consequence of how my life has been. (Employee)

Control in such systems is achieved through goal achievements and not necessarily by work presence. Not always being forced to go to work to perform your work tasks, but being able to combine work tasks from home with both planned and unforeseen happenings in private life makes it easier to combine work and family. It will probably reduce the level of stress too.

4.3 Work and family

Amount of time used on care

The experience of care burden or role stress may be a consequence of time spent on caregiving tasks, the intensity and type of care, the caregivers' type of paid work and work hours. One characteristic of the respondents in our sample is that most of the informal caregivers are working full time (86 percent). Approximately half of the respondents with additional care responsibilities use 1-10 hours per month on caregiving tasks. Considering the hours used, one might think that this should not in itself cause problems for the caregiver, but if the hours used is during working hours it may still become stressful. It may also be stressful if the caregiver lives in another city than the person in need and have to use hours to get there. The caregiver might also experience these relatively few hours spent on caregiving tasks as psychological/emotional demanding (subjective burden). If the person with care needs e.g. is a parent with Alzheimers

disease the "loss" of the parent may be experienced as a huge mental burden, or if the adult child and the elderly parent never have had a good relation this may also be felt as a stressful task.

About 21 per cent of the respondents have what may be defined as an extensive care responsibility. They are using from 16 hours up to more than 21 hours per month on caregiving. This is likely to be a group of employees who might need or benefit from measures at work to better cope with the work-care role.

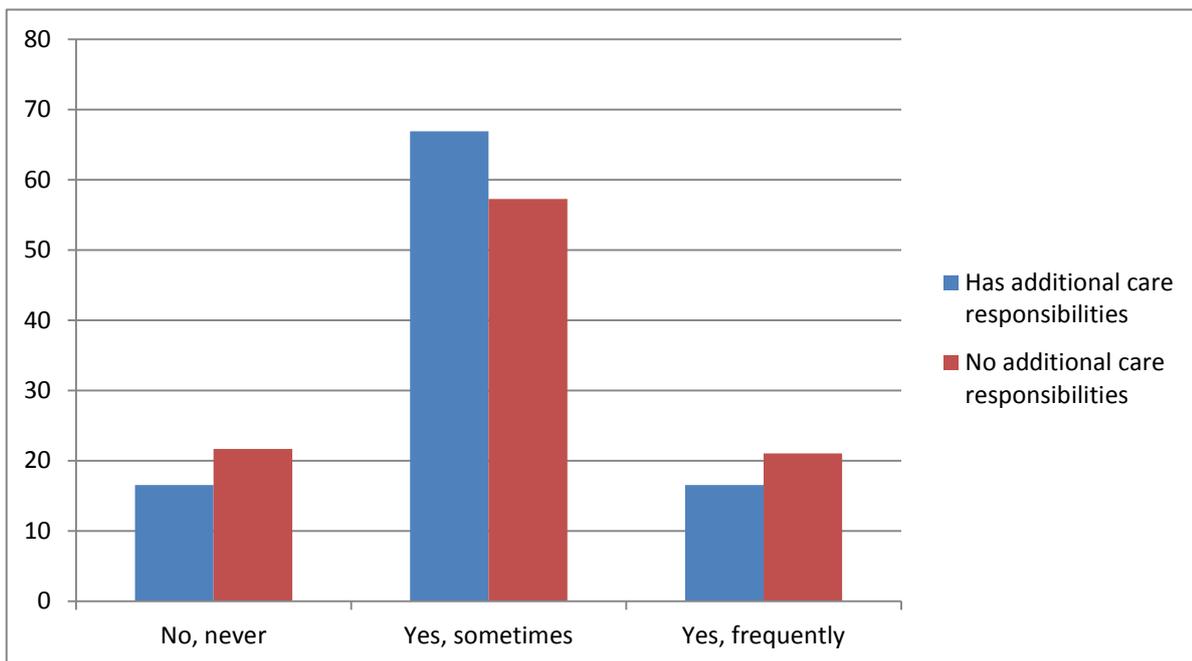
Some of those interviewed have children with a substantial need for care living at home. Not surprisingly they never use the phrase "care burden" in the interviews, but several clearly feel exhausted, they have many worries and are carrying a deep sorrow. The "battle against the system" is often felt to be the most exhausting task of being a caregiver. Their paid work is, on the other hand, mainly presented as an energizing and important source for experiencing a good balance in life.

Work intensity and stress

The experience of work intensity and stress may be related. Stress may have a negative impact on health, but mostly so if employees are experiencing the work intensity as negative. EU-OSHA's (2014) report on psychosocial risks in Europe shows that stress at work is one of the most common health problems in European work places. Many workers today are required to work at a high pace and face high demands for efficiency and quality. This frequently creates stressful situations for individual employees and/or for whole group of employees. Some stress at the workplace is normal, but excessive stress during long periods of time may interfere not only with the employees' productivity, but also employees' physical and mental/emotional health. Managing work-related stress may therefore be a good investment for employers.

On our question if "you during an ordinary working week have to work more than your contracted hours to handle all your work commitments", a high degree of our respondents answer positively to that. Of employees with additional care responsibilities 67 per cent are experiencing this, compared to 57 per cent of employees with no additional care responsibilities. We do not know how many times a month they experience this, and how many extra hours they have to work to handle all their work tasks, but the answers may indicate a demanding working life for quite a few employees, and more so for employees with additional care responsibilities.

Figure 1 Work intensity - During an ordinary working week, do you have to work more than your contracted hours to handle all your work commitments?



N= 600

Both the Norwegian Working Environment Act and the IA-Agreement are meant to secure the employees' physical and psychosocial work environment. Measures at work may be directed toward the single individual and/or a group of employees. Chronic job strain in combination with extensive care responsibility may wear some employees out, but measures at work may ease this possible situation of role stress, which in turn may reduce the sick leave rates.

If work related stress is understood as an organisational issue, and not only single employees' individual faults, one could probably create a more manageable working place for *all* employees, not only for those with an extra stressful home situation. Stress often is a combination of single individuals' ability to tackle stress, their home situation *and* factors at the work place, such as leadership and the organisation of work. Being in a caregiving role may be very stressful singlehandedly and in a combination with a stressful work situation it could get too much. Emotional stress over time may not only affect employees' work-capacity - in terms of impaired memory - but also their health situation. Workplace measures aiming at reducing work related stress should therefore be part of any organisation's ordinary health, safety and environmental work (HSE), and all employees will profit from it.

The work-family balance

Having a good balance between work and family is not surprisingly appreciated by most employees, and in our sample 94 per cent of employees with additional care responsibilities answer that they "agree" or "strongly agree" on the statement that it is important for them to have a good balance between work and pleasure, compared to 89 per cent of employees without such additional care responsibilities. A good balance of work and family give employees the opportunity to both be a high goal achiever at work and at the same time a present and good

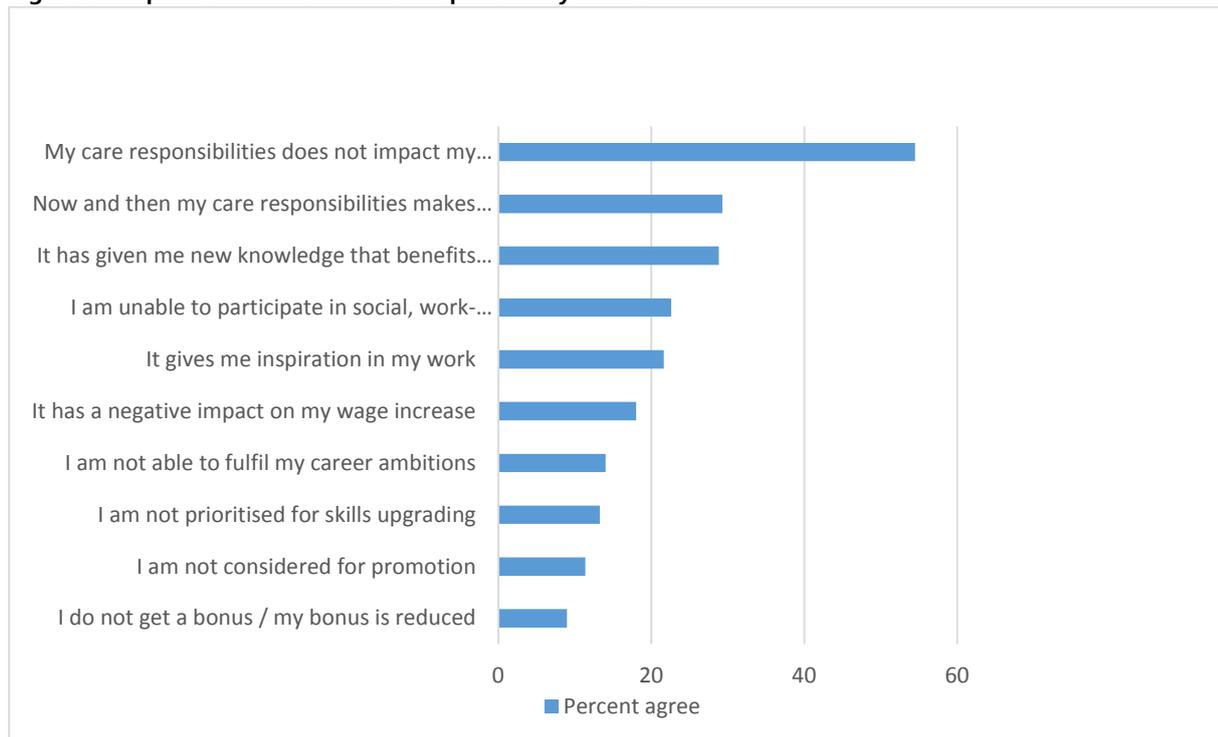
family carer. A good balance of those two roles would probably also ease individual role stress issues.

To get more knowledge about the impact extra care responsibility may have on employees, we put forward some suggestions of such possible impact in our survey (Figure 2). Some of these statements were inspired by our qualitative interviews, and some by previous research.

Impact of additional care responsibility on work

The survey findings imply that many employees with additional care responsibility have a relatively good work-life balance. Over half of the respondents (54 per cent) answer that their care responsibilities does not impact on their work. This is linked to the type of care responsibility the employees have, who they care for, the intensity and type of the care provided and the medical diagnosis of the person in need of care. But it may also be explained by the presence of good workplace measures as well as the nature of the work. Office work may have more possibilities for flexible work arrangements than work in service and health- and elderly care. The more flexibility, the more opportunity an employee has to lay the work-family jigsaw.

Figure 2. Impact of additional care responsibility on work.



N= 139

Although over half of our respondents report that their care responsibilities does not have an impact on their work, about 30 per cent of the respondents are reporting that their additional care responsibilities sometimes makes them unfocused at work. As previously mentioned, research on caregiver burden show that such kind of responsibility put an extra toll on many caregivers, and that the role of caregivers are linked to a higher risk for e.g. both physical and

mental health problems, social isolation and family stress (Ostwald et.al. 1999:299). Our interviews support this research, that additional care responsibilities can be tough on the caregiver:

I get awfully tired because of sleep deprivation. I also carry a big sorrow within me all the time because of my home situation. I kind of play a role at work – putting on a happy face even though I’m sad. (...) Sometimes I snap at my colleagues, but that is a consequence of me being tired, or me having had a tough start at home. (Employee)

As a parent I worry a lot, and I have had it like this for years. I am worried for my child’s future. I hope we get really old so that we can take care of our child as long as possible. (Employee)

- *What do you feel about the policy that elderly should stay in one’s own home as long as possible?*

- As far as I’m concerned, it’s rubbish. I’ve rarely been as worn out as at that time. I wouldn’t have been able to keep up caring for X while working full-time much longer. *But* it depends on the diagnosis. (Employee)

These carers are living under a lot of pressure, but they are going to work every day because work is perceived as very important to them. With some important measures present at the work place the burden these employees carry may be less heavy.

Having a social life is important for general well being for most of us, and both work and private life are important arenas for experiencing social belonging. In our study 37 per cent “strongly disagree” that their care responsibility makes them unable to participate in social, work-related activities, but almost one of four “agree” or “strongly agree” to that.

Two of those interviewed, who had a typically strong work orientation, stressed that it is their private life that is suffering, and not their paid work:

It is all about prioritizing and what you often out-prioritize is your social life. (...) It is not my work, which has been out-prioritized. I have been out-prioritized my life. (Employee)

It is not my work, which is suffering, but my recreation time. I choose my work before friends. (...) My recreation time is gone, but there is many social activities at work so much of my social needs are covered at work. (Employee)

These quotes are illustrating a high degree of work-orientation, but they also illustrate the work place as an important social arena. Worth thinking about is that work arrangements after working hours or in weekends may exclude some employees with additional care responsibilities from attending, and those who probably are most affected are those with a particularly excessive care burden.

Career and additional caring responsibilities

In the survey 14 per cent of employees with additional care responsibilities report that their care responsibility have a negative impact on their wage increase, 11 per cent answer that it has a

negative impact on career ambitions, 9 per cent feel that they are not prioritised for skills upgrading, 7 per cent say they are not being considered for promotion and five per cent do not get a bonus or get their bonus reduced. With so much data suggesting that this group of employees are highly work-orientated, employers are risking to get less out of this group of employees than there is a potential for. That said – we do not know if it is their care responsibilities, which is causing this or if it is other factors.

For an employer it is also worth noting that employees with additional caregiving tasks may perceive this role as something positive for the work carried out. App. 30 per cent of the respondents state that it has given them new insights that benefit the work being carried out, and that it has given them more inspiration in their work (app. 20 per cent).

Attitudes toward work

We wanted to find out if caregivers have other attitudes towards work than other employees. On the question “my work is foremost a means to an income and my main focus in life is family and recreation” (table 5), there is no major differences between employees with additional care responsibility and those with no such responsibilities. It seems rather to be the case that employees with additional care responsibility values work somewhat more than those without such responsibilities.

Table 5. My work is foremost a means to an income, my main focus in life is family and recreation

	Has additional care responsibility		Total
	Yes	No	
Strongly disagree (1)	22	54	76
	15,83	11,71	12,67
(2)	40	128	168
	22,78	27,77	28
(3)	29	96	125
	20,86	20,82	20,83
(4)	30	117	147
	21,58	25,38	24,5
Strongly agree (5)	17	65	82
	12,23	14,1	13,67
Don't know	1	1	2
	0,72	0,22	0,33
Total	139	461	600
	100	100	100

On our question if work is perceived as an arena for personal development and *not* foremost a means to an income (table 6), employees with additional care responsibility answer to a slightly larger degree (79 per cent) than employees without such care responsibilities (75 per cent) that they “strongly agree” with this statement. The importance of work is generally very strong in

Norway and these figures are probably just mirroring that fact. For employees with a demanding home situation work may fill some social as well as intellectual needs. All of our interviewees stressed the importance of work to them, and two of them said:

I go to work no matter what. My work is my haven. There I can think about other things.
(Employee)

It is important being at work because at home it is always a lot of focus on problems.
(Employee)

Table 6. My work is not foremost a means to an income, but an arena for personal development

	Has additional care responsibility		
	Yes	No	Total
Stongly disagree (1)	4	13	17
	2,88	2,82	2,83
(2)	5	34	39
	3,6	7,38	6,5
(3)	19	66	85
	13,67	14,32	14,17
(4)	57	192	249
	41,01	41,65	41,5
Strongly agree (5)	53	154	207
	38,13	33,41	34,5
Don't know	1	2	3
	0,72	0,43	0,5
Total	139	461	600
	100	100	100

4.4 Care responsibility and time off work

Estimated costs of sick leave

The cost of sick leave is not fixed but will vary according to which calculation model used, sector, the wage level in the organisation, the importance of the work tasks of the absent employee, if colleagues have to work over time to compensate, or if the employer have to use expensive temporary help to get the job done (Hem 2011:25). The Norwegian Association of Local and Regional Authorities (KS) - the employers' association and interest organisation for municipalities in Norway – use a model which includes e.g.: pension costs, employment tax and paid holiday (Hem 2011:8). Estimations done in private sector have found that the costs of sick leave varies quite a lot, but in 2011 the average cost was estimated to about 13 000 NOK (€ 1417⁷) for one week of sick leave, or 2 600 NOK (€ 283,4) for one work day (Hem 2011:24).

Other and more non-economically factors may also be of great importance when calculating the costs of sick leave. One study of elderly care institutions points out factors such as: administrative costs, physical and mental wear on colleagues, implications for the psychosocial and physical work environment, reduced level of quality and possible raise in sick leave among colleagues (Bordi & Rønningsen 2004 in Hem 2011:6).

There are factors that may keep the costs of sick leave low: e.g if the employee work part-time and if the temporary help costs less than the absent employee (Hem 2011:26) or if the person in sick leave is not being replaced. But the costs may also be kept low if the employer finds compensatory measures. These measures may be connected to general flexibility in the organisation e.g. by some rearranging in the staff.

Absence from work

Extra care responsibility in combination with work may put a great deal of strain on the employee depending on the intensity, duration and kind of responsibility, but it also depends on what kind of work the individual employee has.

Part-time work combined with monetary compensation is one solution for caregivers who are entitled to such kind of economic support. These employees will suffer less economically than employees not being entitled to such support, but who will still find themselves in a so challenging position that they choose part-time as a coping strategy. These are the employees that suffer a personal economical loss (but they may obviously gain other things by spending more time with the person with care needs).

Our interviews are indicating that working part-time is the only solution for some caregivers due to their extensive care responsibilities. This gives them much needed flexibility. One of our interviewees in a non-flexible working situation, and who do not receive any form of monetary compensation says:

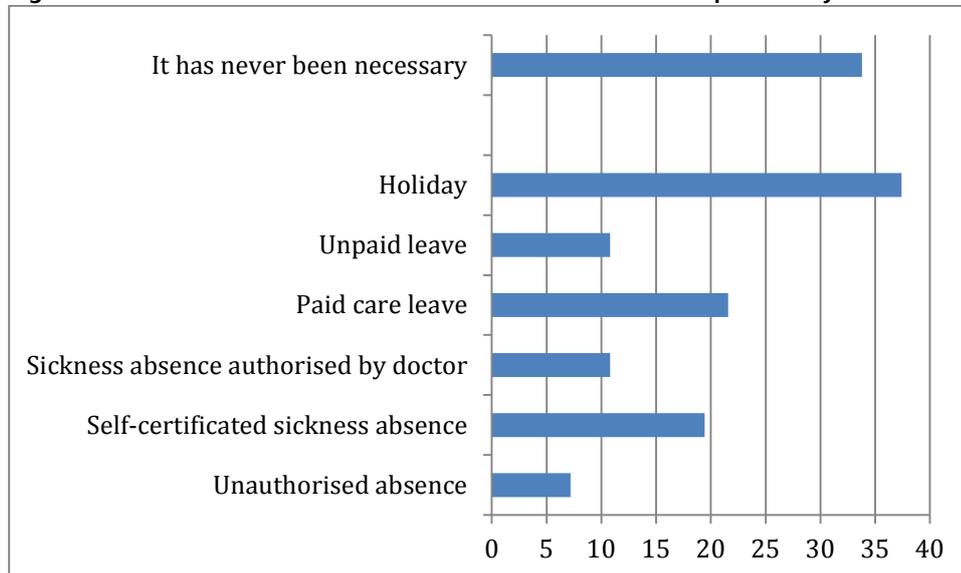
⁷ Euros per 14.12.2014. Since the numbers in NOK are old this is not quite correct but it gives a notion of the costs.

Personally I cannot see how we shall live in accordance with the political ideal of full time work. It is simply not possible. We both work part-time to get the flexibility we need. (Employee)

For some care responsibility involves many meetings with the care system and the care system has opening hours when most employees are at work themselves. Working part-time gives those employees the possibility to arrange such meetings on non-working days. But sometimes even employees in part-time need time off due to unforeseen happenings or fixed meetings. In such situations employees are entitled to time off work. Despite that, one of our interviewees told us that this are not always being respected by employers – either because they do not know the rules, or they know about it but want the employees to use their non-working days for such meetings.

In our web bus survey we asked what kind of time off the respondents had used to carry out care tasks (figure 3). The answers show that app. 35 per cent with extra care responsibilities never has had to take time off work due to their care responsibilities. The second most used solution among caregivers is the use of holidays (37 per cent). The use of holidays has no economical implication for the employee, for the employer or society. 11 per cent of the respondents have used unpaid leave to carry out care tasks. Unpaid leave will foremost affect the employee economically, but the employer may experience some productivity loss depending on the employees work tasks and position.

Figure 3 Reasons for time off work due to additional care responsibility



N= 139

Other kinds of sick leave comes at an economical cost either for society or for the employer - both in terms of a loss in productivity and/or economically. It may also affect the quality of the work. In Norway we have different arrangements entitling parents extra sick leave days in case of a childs sickness, and some parents are entitled to even more days depending on their child's medical diagnosis. We also have arrangements entitling employees the right to sick leave by own sickness and with no reduction in pay. IA-organisations (see chapter 2.4) are entitling

employees 24 days of sick leave during one year and a maximum of 8 successive days (with some regulations). These sick leave days can only be used for an employee's own sickness. This kind of sick leave does not have to be authorised by a doctor and are fully compensated economically.

11 per cent of our respondents report having used sickness absence authorised by doctor due to additional care responsibility and 19 per cent have used self-certificated sickness absence. We do not know if this absence is associated to the sickness of the person in need of care or of the carers' own sickness - caused directly or indirectly by the person in need of care. E.g. some persons in need of care may get physically violent, and the caregiver may get physical harmed by the person they have a care responsibility for. In such situations sick leave may be one option. Another Norwegian study supports these findings. When asking employees on sick leave the reasons behind their absence from work 26 per cent admitted that their sick leave was caused by private matters, such as seriously sick parents or spouse or seriously or chronically sick children (Ose & Slettebak 2013:29).

We do not know how many days the respondents have been taken time off work or how many days in a row they have been off work. An employee's sick leave of up to 16 days is fully compensated by the employer, sick leave exceeding 16 days are covered by Nav.

One interesting finding is that 7 per cent are reporting that they have used unauthorised absence to cope with their care responsibilities. Unauthorised sickness absence, self-certificated absence and un-authorized time off work gives a contribution to explaining some of the sick leave rates in Norway - suggesting that some of the sick leave may be a response to insufficient help from the formal health care system and possibly a lack of flexibility at work.

Some employees with extra care responsibilities are not legally entitled to paid leave and in some cases it is the employer who decides if the employee will get paid leave or not. Many work places have a collective agreement entitling the employees the right to paid leave. The municipalities have attendance allowance schemes for relatives, but in some cases also friends and neighbours can get it. The allowance is quite low and will not replace a normal income. This may explain the reason why using sick leave as a solution rather than paid leave.

4.5 Measures at the workplace

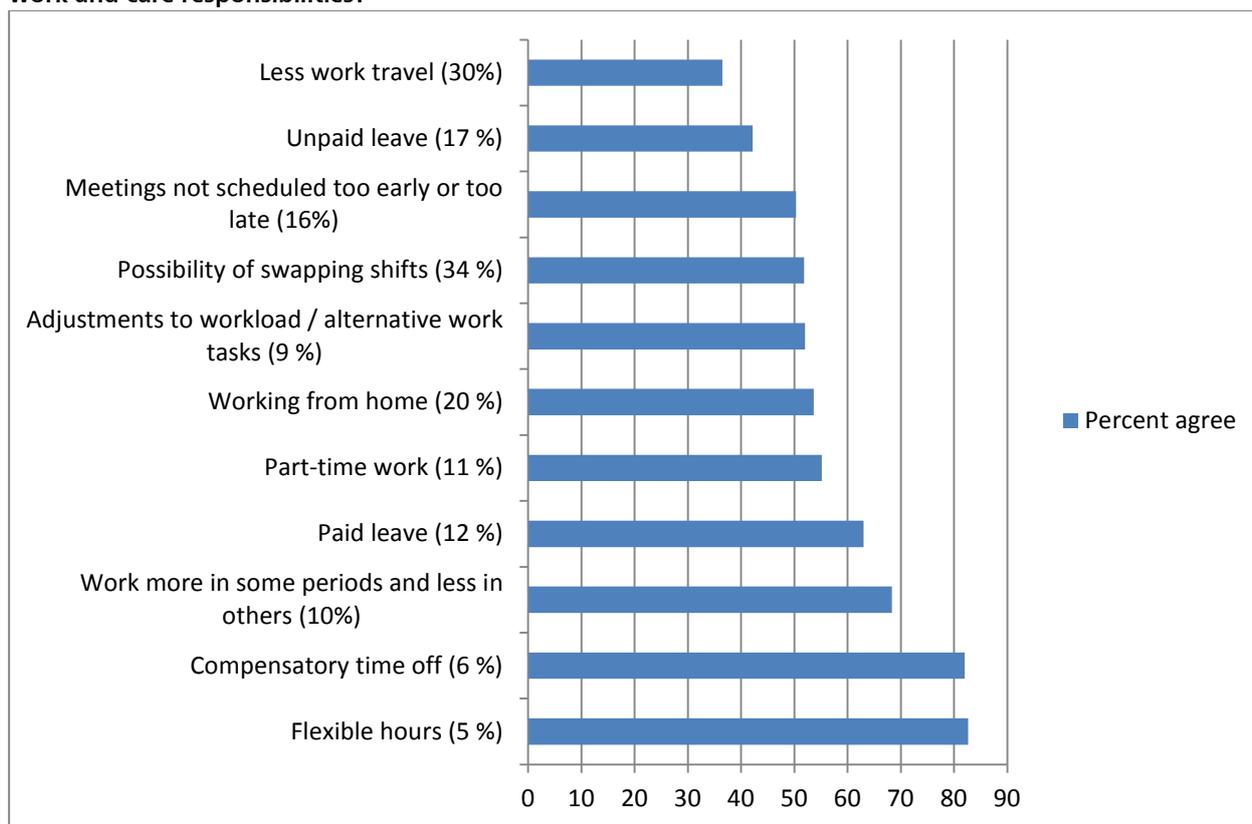
The political ambition of increasing the retirement age, which is echoed in the IA-agreement, have lead many Norwegian enterprises to introduce different work place measures such as: bonuses to postpone retirement, reduced work load, reduced working hours without loss of payment, lifelong learning initiatives and longer vacation/more days off work. Few of these measures have been aimed at alleviating the intergenerational squeeze; senior workers responsible for caring for their parents and/or own (grand-) children (Ennals & Hilsen 2011:5, 1). Some Norwegian research indicate that care obligations do not motivate early retirement (Gautun & Hagen (2010) in Ennals & Hilsen2011) nevertheless they also find that 57 per cent of senior workers have experienced situations where they have found it difficult to combine work and care responsibilities (ibid.).

About one third in our survey sample is reporting additional care responsibility and only a few of those are reporting difficulties of coping with work-family balance. Yet, the amount of employees experiencing such difficulties should be put on the agenda. Due to changes in elderly

care sector, and because more employees will most likely have to cope with this in the future – especially senior workers who is expected to stay in working life longer than before.

We wanted to map out which kind of measures seemed most important for employees in order to combine work and care responsibility. In our web bus-survey we gave the respondents eleven predefined measures to choose from. Some of these measures are not relevant for some employees, and that is shown in the brackets.

Figure 4 Measures: Which of the following measures do you think are most important in order to combine work and care responsibilities?



Numbers in brackets refers to percentage of sample who answered that this measure was not relevant for his or her workplace

N= 139

The measures thought of being most important is flexible hours and compensatory time off. Over 80 per cent of the respondents are of that opinion. Those two measures are also being perceived as relevant for most of the respondents. Almost 70 per cent think that working more in some periods and less in other is an important measure.

Over half of the respondents think working from home, adjustments to workload/alternative work tasks, possibility of swapping shifts and scheduling meetings not to early or late in the afternoon is important. In Norway, ICT and broadband is highly developed, and working from other places than one’s workplace is common, desirable and achievable for many employees. These findings are in keeping with what we have written earlier.

App. 35 per cent of the respondents think that less work travel is an important measure. Work travel is more common in some jobs than others and that may explain that 30 per cent of the respondents find this measure irrelevant. Many workplaces today have e.g. the possibility of

telephone- or videoconferences and presumably many work travels could have been cut down on. First of all it would have economical savings for employers, it would make life easier for many employees and even the environment would benefit from it. But it is no necessarily the nature of work that will be of importance when talking about flexibility at work but also work place cultures. The first two quotes are from an interview with an employee who has different experiences from different work places:

- *Did your former employer have the opportunities to better facilitate the work for you?*

- Yes, I believe so, but it was not a culture for it. It was never discussed or ever on the agenda at meetings. We simply didn't talk about it. (Employee)

Later the employee says this about the culture in the current work place:

(...) The freedom needed for caretaking has been systematized. (...) We shall of course earn money and achieve our work goals, but it is many different ways to achieve those goals. E.g. in some periods you may work more and in other periods less. (...) Not having fixed working hours has given me huge flexibility. If I had to drive my family member to the doctor during the day, I could catch up my work in the evening. (...) My employer knows that I deliver and therefore they give me the freedom to decide the best way to reach my working goals. (Employee)

In our survey 57 per cent of those with additional care responsibilities have told their employer about their circumstances at home, and 18 per cent state that their employer has initiated measures to ease the employees work load (see annex). Relations at work and trust, is key factors when addressing these issues, and that could be easier to address for some employers than more flexible arrangements. All of those interviewed, regardless of workplace, are pointing out the need for a good and open dialogue with their leader and being met with understanding both from manager and from colleagues. This requires an open dialogue at the workplace, and has no economic implications:

- *Does your employer know about your care responsibilities?*

- Yes, and when I've asked about help, I've always been met with: "Of, course" and "Is there anything we can do for you"? That is very important. This is the attitude at my workplace. But you have a responsibility of informing your employer. It will make it easier for the employer if you are informing them that you are having a tough period at home. It works both ways. My employer knows that I'm doing my work, and that I always deliver. (Employee)

These quotes indirectly show an employer with great trust in their employees and employees appreciating this trust. And better still – both the employer and employee seem to benefit from it.

The discrepancy between those in an extra care situation and employers who have initiated measures is huge. The reason why may be explained by some employers not taking their responsibility to seriously, but it may also be explained by the nature of the work. Nevertheless we have also seen that some more "relational" measures are possible for every work place to implement.

In the care sector working from home is obviously not possible. Among the employees we interviewed the common factor to achieve flexibility was part-time work. Other reasons for working part-time were the medical diagnosis of the person in need of care, and lack of (enough) help from the formal care system. These caregivers report that both their employer and colleagues know about their caregiving situation. Still, some of the interviewees are of that opinion that their employer could have done more to facilitate for them. The factors mentioned are linked to the organisation of work, to leadership and relations at work:

- Working-time – a bit more flexibility in the mornings
- More flexible systems for swapping shifts between colleagues
- More flexibility around time off work – e.g. when meetings with the care system, doctors' appointments etc.
- Predictability at work
- Relations at work

The first three arrangements may cause a dilemma for the employer. In the elderly care sector employers have become more aware of the value and importance of more fairness and equality between employees, such as sharing awkward working hours and alternating demanding patients. The aim is to contribute to a good working environment for all and reducing the sick leave rates in the sector. Alternating work on holidays is another arrangement. Facilitating for one employee may, however, generate problems and feelings of unfairness among colleagues. Introducing special measures directed at employees with additional caring needs will require openness from the caregiver towards colleagues explaining why such arrangements are necessary, as we mentioned above.

Another important factor for caregivers with additional care responsibilities is that managers and colleagues are showing understanding. But for others to understand what some of these caregivers have to struggle with every day is demanding and to a certain degree impossible. Some caregivers even tell that they themselves lack the proper words to describe their situation, and this will of course make it even harder for others to understand.

My colleagues think that I'm exaggerating when I'm trying to tell them about my situation. But actually it is more demanding... I understand that it is hard to imagine. (...) It is very emotional so it is difficult to talk about it. (Employee)

I often don't find the words describing our situation at home, so I don't talk much about it. (Employee)

What is most disappointing when having this kind of responsibility, is not being met by understanding. That is of great importance. At this workplace both managers and colleagues is meeting me with understanding. (Employee)

As mentioned earlier those interviewed, and our survey data, suggest that work is of great importance for many caregivers. For some predictability at work, structure and order at the work place is important for the work-family balance. As one put it:

Because my private life is chaotic, I need my work to be predictable to get some order in my life. (Employee)

Predictability may be understood in terms of getting information about which colleagues you are going to work with on the next shift and knowing your work schedule well in advance. It has simply to do with how the workplace is organising its work. Some uncertainty at work we all have to cope with, but it is possible to organise away some uncertainty quite easily.

5 Summary and concluding remarks

Our findings suggest that employees with additional care responsibilities, in general, do not differ significantly from other workers. It is a heterogeneous group, and the typical caregiver is not necessarily a family-oriented woman with a low level of education who work-part time. It is rather a group anyone of us will be a part of sooner or later regardless of gender, socio-economic status or type of work. But the outcome of this responsibility on work participation and the perception of work-family balance may differ.

The opportunities for balancing work and family must be understood in terms of the nature of an employee's work - often linked with an employee's level of education. Since it will concern most of us during our lifetime for a longer or shorter period of time, measures at the work place must be understood in that perspective. Caregivers with extra care tasks are at any time a marginal group in numbers in most workplaces (at least in Norway), but all employees might find themselves in this group one time or another and a workplace should therefore be prepared and have some routines for these kind of situations.

Even though men in Norway steadily is using more of their time on caregiving tasks and domestic work, the main responsibility still seem to rest on women. Women's work participation is important, not only for the economic independency of women but also for the national economy and the upholding of our welfare state, while app. 86 per cent of employees in e.g. the elderly care sector are women. Combining care and work may be challenging but what kind of work you have (in combination with help from the formal care system) may decide one individual's possibility for balancing work and family. Jobs in the (health) care sector are characterized, to a great degree, by a lack of flexibility. Women with additional care responsibility in part-time work may therefore be explained by a lack of flexibility at work, and in some cases in combination with a lack of (enough) help from the formal care system - and not necessarily a particularly strong family-oriented view. Our findings actually indicate that this is a group of employees who is highly motivated for work.

Our main goal was mapping out some workplace measures important for employees with additional care responsibilities. We gave the respondents 11 predefined measures to choose from – some inspired by those interviewed and some inspired by previous research. These were the most important measures:

- Flexible hours
- Compensatory time off
- Work more in some periods and less in others
- Paid leave
- Part time work
- Working from home
- Adjustments to workload/alternative work tasks
- Possibility of swapping shifts
- Meetings not scheduled to early in the morning or too late in the afternoon.
- Unpaid leave
- Less work travel

The employee's profession and position will vary considerably, and work related measures have to take that into consideration. That is to say that some measures will work well in some workplaces but not in others, but each workplace should work out local routines.

Even though part-time work is not politically desirable this may be the sole opportunity for some employees, especially for those with extensive care responsibilities with no or little claim on formal care. Another possibility than part time work, might be to give these employees access to more formal care. Slightly more flexibility at work is probably possible also in the (health) care sector by doing some organisational changes, but as an employer you may face the dilemma that facilitating for one employee may get undesirable outcomes for other colleagues.

In our interviews some other measures was mentioned that would make the workday better for some employees with additional care responsibility. Those measures have more to do with management, organisation of work and relational issues:

- Structure and order at the work place to get more predictability
- Open dialogue – both between the manager and the caregiver and between the caregiver and colleagues
- Showing understanding and compassion, but not pity

When having a chaotic private life the need for predictability, structure and order may be of great importance for some. Knowing what colleagues you are going to work with at your shifts may be important, likewise knowing your work schedule well in advance. Others just need being understood and being met by compassion. Openness at the work place also opens up the opportunity of talking about problems and needs, and this is a prerequisite for the employers' ability to facilitate work. Such openness also requires trust between the employer and the employee at the work place.

Even though we are facing a strong political ambition of all employees working full time, this may not always seem as the best solution at the individual level. For employees with additional care responsibilities it may sometimes be impossible to work full time because of the nature of their work. And it may also be linked to individual values. The economic consequences of working part time may be regarded less important than caring for your loved ones.

An interesting calculation would be to cost calculate the amount of unpaid care work of these employees. If they stopped doing this work, what economic consequences would this have for the formal care sector? Maybe the public help and monetary compensation should take differences in possibility for combining work and care into more consideration when deciding help measures? There is probably a "breaking point" regarding how much employees with full-time work and care responsibilities can cope with, before choosing part-time work, early retirement or sickness absence as coping strategies. This small study shows that it is important with political joined-up thinking. Obtaining the best solutions in the future forces the politicians to look at the labour policy, senior citizen policy and care policy as different sides of the same coin.

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Care responsibility and work participation



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Fafo-paper 2015:04
ISSN 0804-5135