

Summary and conclusions

Competition between informal care and paid work

5.1 Background, design and definitions

Several million people in the Netherlands provide help to their elderly parents or to loved ones with impairments. This help can include doing shopping, helping in the household or providing personal care. We refer to this form of help as ‘informal care’. The Dutch government wants citizens to provide more of this kind of help in order to curtail the growth in the costs of care. At the same time, the government wants to increase the labour participation rate, again in order to improve the public finances. As part of this aim, the state retirement age has been raised and part-time workers are being urged to increase their working hours. As a result of these measures, informal care and paid work are likely to be combined more often in the future.

Although the government has taken steps to facilitate this combination, there is still a question about how far the goals of ‘more informal care’ and ‘more employment’ can be reconciled. Those who are asked to work longer – older people and women with part-time jobs – are precisely the people who often provide informal care. Earlier publications by the Netherlands Institute for Social Research|scP have drawn attention to the often problematic combination of work and care (De Boer & Keuzenkamp 2009; Sadiraj et al. 2009). Those studies described how much help working people provide and how many of them felt they were under heavy burden.

Research questions

This report provides additional insights into the degree to which work and informal care stand in each other’s way. It reveals whether the percentage of workers providing informal care is growing, and also whether the decision to begin providing informal care depends on the number of hours that people work. Finally, the report explores the question of whether working people who take on informal care tasks reduce their working hours or experience poorer health.

Data sources

The data used in this report were drawn from a biannual panel study of around 4,800 workers and non-workers in the Netherlands aged 16-65 years (the Labour Supply Panel compiled by scP). The participants are monitored over time; in each wave of the study they complete a questionnaire which includes questions on work and care. New respondents are also recruited for each wave (refreshment sample) in order to compensate for panel attrition and to ensure that young people are also represented. This ensures that the group size is maintained and the respondents remain sufficiently representative for the population of working age.

The share of informal carers among the employed in the Netherlands can be described using this data set for the years 1996-2012. The relationship between informal care on the one hand and working hours and health status on the other was studied only for the most recent period, namely 2004-2012. In the latter analyses, the different years were combined (pooled) to ensure that there were sufficient observations of people who began providing informal care between two measurement points. The respondents were asked about their working hours and health status at the time of the first survey, in other words in advance, and whether either had reduced at the time of the second survey.

The data set had a number of limitations for our purposes. To start with, while it is known whether someone provides help and for how many hours per week, it is not known to whom they give it. Probably, most working informal carers provide care to their partner, child or parents, but for the effects on working hours and health it could make a difference who the care recipient is. That could not be tested using our data.

We also know little about why the recipient needed help. We know that recipients were suffering from illness, disability or age-related problems, but not what the exact problem was. Earlier Dutch and international research (De Boer et al. 2010; Sherwood et al. 2008) noted that informal care was more intensive for some disorders than others. For example, providing informal care is more burdensome when the recipient has behavioural problems or is a cancer patient with severe physical impairments. This distinction could also not be made with our data.

Finally, workers involved in very intensive care situations, for example caring for a terminally ill person, may be underrepresented in the dataset. It seems plausible that these people will often have neither the time nor the energy to fill in a questionnaire.

Definitions

Informal carers are defined in this report as people who provide help to relatives, friends, acquaintances or neighbours who need that help. The recipients may live with the carer or elsewhere. The questionnaire stated explicitly that care provided to healthy children did not count. Respondents were asked only about – unpaid – help with household tasks and personal care. These are tasks for which professional carers can also be brought in. Informal care paid for from a personal budget (pbg) did not count, nor did help doing odd jobs, supervising tasks or helping with administration. The extent of the total help provided – in terms of both hours and persons – will consequently have been underestimated somewhat compared with a situation where a broader definition of informal care is used.

Policy documents not infrequently set a minimum threshold for the intensity of help, with those providing care for no more than eight hours per week not being classed as informal carers. The idea behind this is that it is mainly those providing a lot of care who are vulnerable and who may need support. The flipside is that those providing less intensive care are left almost completely out of the picture.

No lower limit was set in this report for the extent of help provided: both intensive and lighter forms of care are included. We analysed, however, whether the effects of more and less intensive care differed. Intensive care was defined as care for more than four hours per

week, which means that we chose a lower threshold than the government usually does. The reason for this was that the number of workers providing more than eight hours care per week was too small in our dataset, at just 1.5% of all workers in 2012. Workers only rarely provide such extensive help, because it is often difficult to fit in alongside their job. Everyone in paid work, regardless of the number of hours worked, was counted as working in this report. The total was subdivided into people with short and long working hours (0-27 hours versus 28-40 hours per week). The analyses of the number of informal carers were limited to persons aged 23-65 years who were not primarily pupils/students. The analyses of the impact of providing help covered people aged 23-58 years, in order to exclude reductions in working hours due to older workers' schemes and pre-pension arrangements.

S.2 Views on informal care and work

Do informal care and paid work compete with each other?

There are two conflicting viewpoints about combining paid work and informal care. According to one view, they compete with each other, because both impose a claim on people's available – and limited – time. Starting and continuing to provide informal care increases the burden on workers according to this view, and can lead to them experiencing more health complaints. Informal carers may also cut their working hours in order to reduce the burden they experience. This could particularly affect women, because they provide help to others much more often than men.

According to the other view, there is an untapped potential of capacity in society which could be exploited. In this view, a committed social life, in which people help each other, goes hand in hand with greater labour participation. Combining work and care is good for social cohesion between citizens. It is also desirable because informal care and paid work can (as stated) improve the affordability of government provisions.

Given the main thrust of current government policy – more participation universally and more own responsibility instead of government responsibility for sick loved ones (Van Noije et al. 2012) - it is plain that the policy is based mainly on the second of these two views, though there is also attention for the potential negative effects of combining work and informal care; for example, the government wishes to extend the leave arrangements for working carers, thereby hopefully reducing their burden.

S.3 Trend in the number of working informal carers

More participation

Some of the figures from our study support the participation viewpoint, because more and more workers are providing help. While the percentage of working informal carers remained unchanged in the period 1996-2002, it grew between 2004 and 2012 from 13% to almost 18%. Half these workers were providing help for up to two hours per week in 2012;

around a quarter were providing help for between two and four hours, and another quarter were helping for more than four hours per week.

The number of workers providing a maximum of two hours help per week has risen in particular. The share of workers providing non-intensive care has thus increased. It may be that they cannot always be the main carer but are able to relieve other carers so that they do not become overburdened.

The growth in the number of working informal carers was greatest among women aged 45 years and over and people working for less than 28 hours per week. In 2012, roughly a third and a quarter, respectively, of these groups were providing care. These two groups were also the main providers of informal care in 2004.

The increase in the share of informal carers among the employed is due partly to the changed profile of the working population, which now includes more older persons and women than in the past – precisely the groups which have traditionally often provided informal care. The strong growth in community-based as opposed to institutional care is likely to have played a role as well, as more and more people with a large, complex care need continue living at home. Another possible cause is shrinking family size, which means that there are fewer other family members who could in principle help provide care to a loved one. Finally, the increase is probably also related to the growing emphasis placed by the government on more civic participation and on citizens taking more responsibility for their immediate social setting (e.g. introducing guidelines on providing ‘usual care’ to fellow household members, and the introduction of the Social Support Act (Wmo)). Our study thus produces indications that this policy has resulted in workers more often providing informal care to loved ones.

S.4 Informal care and working hours

People with longer working hours less often start providing informal care than people with shorter hours and non-workers

Situations were also observed in our study in which paid work and informal care got in each other’s way. It is known from earlier research that people working longer hours less often provide help than others. It is generally assumed that this is because they less often begin providing informal care, and that a reduction in working hours by informal carers does not play a very important role. This assumption is found to hold good. After correcting for differences in background characteristics between people with longer and shorter working hours (such as sex and age), 9% of non-carers with longer working hours had begun providing informal care when the following wave of the study was carried out two years later. The figure was higher among people with smaller jobs and non-workers of the same age (11-12%). Evidently, a long working week sometimes deters people from taking on care tasks. In this sense, informal care and paid work do compete with each other. This finding also suggests that the decision not to provide informal care has consequences for others. Our data did not allow us to determine whether someone else steps in in such cases, for example another loved one or professional carers, or whether the person need-

ing help receives less care than they would like. American research by Scharlach et al. (2007) among full-time working informal carers of older persons found that all these effects occur in practice.

No reduction in working hours when starting to provide help...

Generally, taking on informal care tasks does not lead to an adjustment of the carer's working hours. Longitudinal analyses showed that workers who had begun providing help had not reduced their working hours or expressed a wish to do so any more often than those not providing informal care. 9% of them had reduced their weekly contract hours by at least four hours, and 4% had given up work. These percentages were virtually the same among non-carers (9% and 3%, respectively). In addition, 10% of workers who had begun providing help wanted to reduce their working hours by at least four hours per week but had not (yet) done so. Virtually the same proportion (9%) of non-carers expressed this wish. Workers who were still providing help when the next (third) wave took place two years later also did not have a greater propensity to cut their working hours. There were no differences between men and women on this point.

... unless the help was intensive and the previous working hours long

Only workers who had begun providing intensive informal care (for more than four hours per week) and who previously worked long hours were more likely to have cut their working hours: 17% of them had reduced their working week by at least four hours, and 7% had given up work. The corresponding figures among non-carers with long working hours were 9% and 3%. Overall, thus, even those providing intensive informal care in combination with a longer working week mostly continued to work as many hours as before.

Providing help mainly means a reduction in free time

Evidently, most working informal carers are able to perform their care tasks in such a way that they do not deviate from the average worker as regards reductions in hours of work (De Boer et al. 2010). They are evidently more likely to give up their own free time than to adjust their working hours. The fact that most informal carers in our dataset (76%) provided help for a maximum of four hours per week will have made this easier. Some of them will also not have taken any measures because they expected in advance that the care provision would be (relatively) temporary. But even when providing intensive care, carers may be inclined to defer a radical decision such as reducing their working hours for as long as possible because of the impact on their income and career. It has also been suggested in earlier research (Cuelenaere et al. 2009) that informal carers are reticent in asking their employer for an adjustment in their working hours. They often do not find it easy to talk about their care tasks at work (De Klerk et al. 2014).

5.5 Informal care and health

Sharp increase in sickness absenteeism when providing long-term help

Subjective health status and sick leave from work were adversely affected more than working hours by taking on informal care tasks. Although the number of health complaints did not rise generally when taking on care tasks, it did where the care was intensive. The length of working week made no difference. Of those who began providing intensive informal care, 15% took a more negative view of their own health afterwards than before. Over the same period, only 8% of non-carers reported a deterioration in subjective health status. Long-lasting sick leave, for two or more consecutive weeks in a calendar year, also rose sharply. 10% of carers were off sick for such a long period before they began providing care; afterwards, this rose to 18%. Sickness absenteeism also increased among people providing non-intensive care. The biggest increase occurred among workers who had taken on long-term care tasks (i.e. were still caring for someone two years later). Almost a quarter of them had been off work sick for at least two weeks after starting to provide informal care. The negative impact of intensive and long-term informal care on subjective health and sickness absenteeism may be caused both by the care situation – which can be burdensome in itself – and by the combination of informal care and work. In reality, both factors probably play a role.

5.6 Informal care and gender differences

Working men provide less informal care than working women. In 2012, 13% of them helped loved ones with personal care or household tasks, compared with 23% of women. This gender gap would probably have been smaller if supervision, help with administration or odd jobs had been included under our definition of informal care, but we know from other studies (e.g. De Boer et al. 2015) that a difference remains even then.

Once men and women began providing informal care, the effects were generally the same. For example, they reduced their working hours to the same extent. There was, however, one difference: men developed more health complaints after taking on informal care whilst women did not, except when providing intensive care. This may have been because the care situation itself was different: working men more often care for their partner, while women more often care for parents or parents-in-law (De Boer et al. 2015); the former may be more burdensome. The fact that men have to combine informal care with a longer working week than women did not appear to be the cause of their greater health complaints.

5.7 Conclusion

Informal care and paid work partly stand in each other's way

This report shows that workers performing care tasks are a mixed group. Between the two opposing views on combining work and informal care lies a whole gamut of circumstances

and consequences, all of which occurred in this study. A high proportion of workers are well able to combine their work with care tasks and are spared adverse effects such as having to reduce their working hours or seeing their health deteriorate. A smaller group, mainly among those providing intensive or long-term help, are however confronted with a deterioration in health or lengthy sick leave from work. For this group, therefore, providing informal care to loved ones and doing paid work do stand in each other's way. In addition, people with long working hours less often took on informal care tasks than people working shorter hours or not in work, again suggesting some competition between the two tasks.

Policy implications

The share of workers providing lighter forms of informal care has grown in recent years. Based on our dataset, providing this type of care can often be fitted in reasonably well alongside paid work. The government wants to see a further increase both in the amount of informal care and in the labour participation rate. This policy carries two risks. First, people working longer hours are less inclined to begin providing informal care. This can potentially increase the burden on others. Second, more problems will arise if the intention is to drive up not just lighter forms of informal care, but also the amount of intensive or long-term care. Our study shows that providing this care can have a negative impact on informal carers themselves (poorer health) but also on their employers (higher sickness absenteeism). It is therefore important to guard against asking too much of people.

To the extent that policy on combining work and informal care is desirable, it can best focus on workers providing long-term or intensive care, whatever their working hours. Although providing informal care in most cases did not lead to a deterioration in health, providing intensive care did, while providing long-term care greatly increased sickness absenteeism. These effects remained after correcting for the greater age of the informal carers.

The impact of informal care on sickness absenteeism probably lies partly in the care situation itself and partly in combining that care with work. Any savings made on professional care by calling on members of the social network may therefore have a price in the form of working informal carers reporting sick. That price is paid by the employee themselves and their employer. A recent study showed that measures such as creating an informal care-friendly organisation and acceptance of combining work and care by colleagues and superiors can contribute to a better work-care balance (Plaisier et al. 2014). However, this demands extra efforts on the part of employers. To some extent this is unavoidable – the increasing number of older workers means that employers are in any event more often being confronted with people combining work with informal care – but it is important to avoid the demand for informal care becoming so great that too much is asked of the informal carers.

Informal care and participation in society

The participation society has many facets. On the one hand, we see that citizens are having to continue working for longer, and on the other that people are expected to devote more

time to caring for loved ones. There are already many people active in both these areas, and their number is growing steadily. Often this is problem-free, especially in the case of non-intensive and short-term care. Most workers appear to be able to fit providing this help into their work and private life. Yet more social participation does not happen by itself: sometimes people start doing so much that they exceed their own capacities. In the future, more help will be needed from people's social networks and more and more will be asked of the participating citizen. This study begs the question of where the boundary lies and who pays the price for the changing demands. With effect from 2015, the assessment by local authorities of the capacities of citizens will play a greater role in determining the help that is asked of them. It is therefore very important to continue monitoring developments in this area. As this study shows, there is already a group of working informal carers who are reducing their working hours, giving up work altogether or long term absent because of the pressure of combining these tasks.