

Briefing Paper:
Balancing Work and Care: International Challenges and Irish Perspectives

November 2017



CONTENTS:

1. Balancing Work and Care: a Social and Economic Challenge	3
2. Ireland: The Situation and Some Figures	5
2.1 Carer's Leave	6
2.2 Carer's Benefit	6
2.3 Low/moderate take-up: figures	7
3. A Knowledge and Research Gap	8
3.1 Fear of negative career consequences or negative perception of employers	8
3.2 Weighing the opportunity costs	9
3.3 Carer's Allowance preference	10
3.4 Employers' non-accommodation or discouragement of leave?	11
3.5 Employers' facilitation of preferred alternatives to full leave?	11
3.6 Lack of awareness of entitlements	11
3.7 A knowledge and research gap	12
4. Equality Challenges: Gender, Socioeconomic and Health Inequalities	12
4.1 Gender disparities in caring	13
4.2 Socioeconomic disparities in caring	15
4.3 The social and health costs of caring	15
5. Developments	19
5.1 Proposed EU Directive on Work-Life Balance	19
5.2 Proposed Family Leave Bill	20
5.3 HRB Project on Work-Life Balance and Supporting Working Carers	21
6. Conclusion	21
References	23



1. Balancing Work and Care: a Social and Economic Challenge

We hear a lot about time-bombs these days in discussions of ageing populations: pension and welfare time-bombs, 'grey tsunamis', dementia time-bombs, or the pressure exerted by disproportionate amounts of countries' fixed and liquid assets being bottlenecked in the hands and funds of an ageing, mainly retired baby-boomer cohort. One need not resort to such alarming metaphors, but the increased demands for informal care which longer and healthier lives will bring represent a challenge to all countries with constrictive population pyramids. Demographic changes across Europe and a shifting dependency ratio, allied with cutbacks in formal supports and shorter hospital stays, all will contribute to the expanding demand for informal care. Changes in societies and family structures mean that the capacity to meet the demand for informal care will decline, and it is projected that an unpaid care gap will grow rapidly (Triantafillou et al. 2010: 19–24; Pickard 2015; European Commission/Social Protection Committee 2014: 30–38). It is especially likely that older workers, as mandatory retirement ages rise or full retirement is put off for financial reasons, will end up having to balance work with caring obligations (Eurofound 2015: 7). The increased prevalence of care obligations will fuel demand for supportive work environments, for example through the embrace of flexible working arrangements.

This is an issue with repercussions for the sustainability of the workforce. An English study, using data from the English Longitudinal Study on Ageing (conducted in 'waves' two years apart), shows that just ten hours of care provision by people aged between fifty and retirement age (65 for men, 60 for women) significantly increased the chances of an individual's having left employment by the next wave (King and Pickard 2013). The data suggest that employment is negatively affected by a care burden far lower than the threshold at which much current literature assumes the burden to begin negatively to impact on work. Employers for Carers UK has identified caring obligations as accounting for a surprisingly large proportion of exits of skilled personnel, the training of whose replacements may be an expensive proposition. Interestingly, and against traditional distribution of caring responsibilities in the general population, it is, increasingly, the reason for an especially disproportionate number of men leaving their job, especially in skilled



professions.¹ Caring obligations are only going to become a more common dilemma for workers, given the demographic profile in Western Europe. As has been emphasised for a couple of decades now, the increase in population mobility and greater participation of women in the workforce also means the traditional models of family care – generally a burden taken up by women as mothers, daughters, daughters-in-law or siblings – can no longer be relied upon.

The move toward a supportive work environment for informal carers has benefits for families, businesses and the overall economy (Employers for Carers 2017; Carers UK/Employers for Carers 2013; Grayson 2017: 53–66). Carers who are supported are less likely to exit the workforce, whether at once or in increments as the burden of care increases, allowing employers to retain talented employees in roles for which they are suited (Bittman et al. 2007; Glendinning et al. 2009; Carers UK 2015). In addition, literature on work and care suggests that carers who retain a working identity often respond better to the demands of caring, and are not as exposed to some of the risks associated with the caring role, such as social exclusion or isolation, or negative impacts on psychological and physical wellbeing as well as on financial circumstances (Stiell et al. 2006).² This is emphatically captured in a paper on carers and employment by Rob Anderson (2016: 272), drawing on data from the 2012 European Quality of Life Survey (EQLS):

Empirical data from the EQLS show somewhat worse physical and mental health among carers than among non-carers. However, the differences are significant only for carers of working age who are not in employment, among whom for example 16% rated their health as ‘bad’ or ‘very bad’, compared with 4% of working carers; and 14% said they felt depressed ‘most of the time’ compared with 6% of working carers, and 5% of the working age population who were non-carers. The same pattern is evident in relation to social exclusion: among people of working age who were not carers, 10% agreed or strongly agreed that they felt ‘left out of society’ compared with 11% of working carers, but 16% of working age carers who were not in employment; and 26% of the non-employed carers agreed with the statement that ‘people look down on me’ compared with 16% of working carers and 17% of non-carers. Clearly the working carers and other carers are different in many respects and may have, to some extent, different starting points in relation to employment, health

¹ This was discussed in the introductory address by Employers for Carers Chairman Ian Peters at the Eurocarers In-Country Research Meeting on Working Carers, 3rd March 2016 (see [agenda](#))

² Grayson (2017: 32) reminds that ‘many carers describe their job as a form of respite from caring – a welcome opportunity to be absorbed in other things than the needs of the person cared for’.



and social inclusion, but the argument that employment may be supportive of the health and well-being of carers is persuasive.

There is consensus that all health and social care systems in Europe assume and depend upon a supply of informal care, and that even in those countries where it has not traditionally been as significant (the Nordic countries and the Netherlands, for example), its importance is growing. It is important therefore to ensure that family carers are adequately supported in their caring role and secured as far as possible from exposure to the negative professional and personal consequences which are commonly acknowledged to result from assuming the role. Measures to support the balancing of work with informal care must be part of a suite of measures by which the state supports family care, including those who choose to care full time. Those who do leave the workforce to care should be supported to re-enter it through appropriate reactivation initiatives when their caring role comes to an end, and offered adequate social security to ensure they do not fall into poverty through caring. As an OECD report puts the matter:

[Supporting] family carers effectively is a win-win-win solution. It is beneficial for carers. Without support, high-intensity care-giving is associated with a reduction in labour supply for paid work, a higher risk of poverty, and a 20% higher prevalence of mental health problems among family carers than for non-carers. It is beneficial for care recipients, because they generally prefer to be looked after by family and friends. And it is beneficial for public finances, because it involves far less public expenditure for a given amount of care than if it was provided in the formal sector (Colombo et al. 2011: 4).

2. Ireland: The Situation and Some Figures

The majority of Irish carers are working carers: in Census 2011, 59.1% of self-identified carers over the age of 15 were in employment (CSO 2012). Ireland has legislation aimed at supporting carers, and it is, when compared with other European jurisdictions, progressive in its intent, as well as (again, comparatively) generous in its provisions (for comparisons in leave and benefits entitlements, see Reinschmidt 2014; Bouget et al. 2016; Hoyer and Reich 2016 (which relies on Bouget et al.); Schmidt 2016; Reinschmidt and Pieper 2017). Carer's Leave and Carer's Benefit legislation was brought into effect in 2001. Take-up of the leave appears, however, quite moderate, even low – although this would be in line with European trends (Bouget et al. 2016: 28). Here we will look at legislation and available benefits for



those who must leave work to care in Ireland, and in the next section suggest some reasons for the low take-up and discuss the knowledge gaps in the area.

2.1 Carer's Leave

The Carer's Leave legislation allows a person to leave their work in order to care for someone who requires full-time care. It allows employees temporarily to leave employment for between 13 and 104 weeks to provide full-time care. Carers may be entitled to Carer's Benefit and are permitted to work for a maximum of 15 hours per week while on leave. To qualify for carer's leave an employee will need a medical assessment that the person for whom he/she will be caring is in need of a full time carer. The employee's entitlements in employment will not be affected apart from those relating to remuneration, holidays, and pensions. Generally, the employee is entitled to return to the same position that they left. If this is not feasible, then they should be no worse off in terms of their terms and conditions of employment. Carer's Leave entitlement is not affected by one's eligibility for Carer's Benefit.

2.2 Carer's Benefit

Usually but not necessarily tied to Carer's Leave, Carer's Benefit a short-term payment paid for up to 24 months to people who give up employment to care on a full-time basis for someone who requires full-time care and attention. Employees who have at least one year's service may take unpaid Carer's Leave of up to 2 years from their work in order to provide full-time care for someone who needs it; Carer's Benefit may be paid during this time. Additional payments are made if the carer is looking after more than one person. A person in receipt of Carer's Benefit must be aged 16 or over and under 66. They must have been in employment for at least 8 weeks in the previous 26 weeks before becoming a carer. They must have worked for a minimum of 16 hours per week or 32 hours per fortnight. Finally, they must be able to show that they have given up work in order to be a full-time carer. Carer's Benefit can be claimed for a total period of 104 weeks for each person being cared for. This may be claimed as a single continuous period or in any number of separate periods up to a total of 104 weeks. If Carer's Benefit is claimed for less than six consecutive weeks in any given period, however, a person must wait for a further six weeks before they can claim



Carer's Benefit to care for the same person again. If caring for more than one person, the Benefit can be received for each care recipient for 104 weeks. This may result in the care periods overlapping or running concurrently. Carer's Benefit is €210 weekly.³ Unlike Carer's Allowance, Carer's Benefit is not means-tested; but, it does not include a travel pass or Household Benefits Package, which Carer's Allowance may. The maximum amount of time a recipient of Carer's Benefit is allowed to engage in work and training is fifteen hours a week. In addition, the maximum one is permitted to earn from this work and remain eligible is €332.50 – this is *net* income, after all deductions, e.g. PRSI, union dues, superannuation dues, etc.⁴

2.3 Low/moderate take-up: figures

Despite the comparatively generous and progressive entitlements to carer's leave in Ireland, the figures suggest that take-up is rather low. Those for 2013 show that there was a 2.4% decline in recipients of Carer's Benefit from 2012. This represented a drop of only 40 people, from 1,638 to 1,598 people. Spending on Carer's Allowance in the same one-year period by contrast increased by €45m; this represented a 9.4% rise in recipients, from over 52,000 to over 57,000. The entire spend on Carer's Benefit was almost exactly half that increase, at just under €22.5m. Granted that a relatively high percentage of full-time carers may be retired from full-time work, the figures still suggest a general reluctance to leave full-time work to care, and suggest Carer's Allowance is taken up by those without well-paid work. At the end of 2015, Carer's Allowance recipients stood at 63,003. Figures for Carer's Benefit are not available publicly beyond 2014 at the end of which year there were 1,769 – a significant 10% increase, but still a low absolute figure. Take-up has risen, however: at end

³ To rise to €215 in March 2018.

⁴ The figure appears to have been based on an equivalence with the after-tax weekly income of a 40hr week on the minimum wage that held until January 2016. The €332.50 one can earn that is disregarded from means on Carer's Allowance is a gross rather than net figure. That Carer's Benefit is not means tested should mean that income unrelated to that from the job the person has left in order to care should not count toward the €332.50 – so rental income, for example, should not affect what one is permitted to earn from the fifteen hours of work. Likewise, a spouse or civil partner's income is not taken into account. This changes if, after the allowed period claiming Carer's Benefit elapses, a person moves on to Carer's Allowance.



of Jan. 2017, there were 2,771 recipients of Carer's Benefit, caring for 3,117 people.⁵ The average duration of Carer's Benefit claims from the commencement of the scheme in 2001 to the end of the 2015 was 65 weeks. The average duration from 2010 to the end of 2015 was just marginally shorter, at 63 weeks.⁶

3. A Knowledge and Research Gap

The balancing of work and care in the Irish population, the situation of working carers in different types of employment and in different sectors of the economy, and the attitudes of employers toward Carer's Leave, all are under-researched in Ireland. Knowledge and research gaps in the area generally are manifold; the figures available do not 'speak for themselves' in any significant or informative way, and without further research one cannot be overly confident in drawing any conclusions. Though it must be stressed that, in the light of this knowledge gap, explanations are conjectural, there are a number of factors which may go some way toward explaining the relatively low numbers availing themselves of Carer's Leave. These are a typical combination of economic and psychosocial factors.

3.1 Fear of negative career consequences or negative perception of employers

It is likely that a factor in the relatively low take-up is the fear – not at all assuming that employers are discriminating against those who take long-term leave – that the negative effects on a person's career will be inevitable. One can draw a comparison with fully accepted and promoted forms of leave, such as maternity leave or unpaid parental leave: it was reported in August 2015 that in Britain an estimated 54,000 women a year left work soon after returning from maternity leave (Equality and Human Rights Commission 2015). In addition, long-term, full-time carers can face the knock-on effects on earning potential which come with a prolonged period out of the professional workforce. Long-term carers, whose return to the workforce after the transition from the caring role often comes after a long absence, face inevitable difficulties and disadvantages (enhanced age coupled with lack of experience) regarding employment prospects. With those who take up Carer's Leave, it

⁵ Dept. of Social Protection private communication with Family Carers Ireland 23rd Feb. 2017

⁶ Dept. of Social Protection private communication with Family Carers Ireland 12th Jan. 2017



may be the case that their absence, though only medium-term, costs them in terms of opportunities for continuing professional development.

3.2 Weighing the opportunity costs

The choice to apply for Carer's Leave or to remain in employment is usually a matter of weighing opportunity costs, economic social and psychological. The first and most important factor is the economic disadvantages to which carers are exposed. Europe-wide, longer-term carers report themselves in surveys to face the anxiety of falling into a poverty trap, and research uniformly demonstrates the higher risk of poverty to which carers are exposed. In Ireland, if the carer takes a period of leave from a secure and well-paid job, the amount received in Carer's Benefit may be substantially lower than what they would earn by remaining in employment. In addition, extra income may potentially be offset by increased costs associated with providing care which are not all covered by benefits or relief. The amount of hours permitted also affects what kind of work can be taken up. An arrangement whereby a worker only works fifteen hours a week is far less likely to be accommodated in higher-paid, skilled professions. Thus the only available work tends to be in low-paid, part-time jobs. It must also be noted that those carers who belong to the 'sandwich generation', and who must care for their own children as well as elderly parents, cannot always afford to give up employment.

There are further psychological factors to consider in understanding the low take-up of Carer's Leave. For those who temporarily leave a profession, the adjustment may be difficult and their sense of identity affected. This consciousness of the social status that comes with membership of a professional class is something which affects not only the carer but also the care recipient. While many people report that they would prefer if possible to be cared for by a family member, this desire may not override a care recipient's desire to see family members, particularly their own adult children, secure in a job and earning a good living. There is a sincere wish on the part of a care recipient not to hold back or burden their children, and they may in many cases derive greater consolation from the success and security of their inheritors than from being cared for primarily by a family member who would be forced for a time to give up work and attendant social standing. For this reason, they may accept outside care and actively dissuade a family member from taking up Leave



to provide care. The esteem and sense of social inclusion that comes with a profession points to another psychological barrier to taking up Carer's Leave and receiving Carer's Benefit. Carers often feel their role is undervalued, particularly from an economic standpoint. It is widely felt that the genuine economic contribution of carers is often unacknowledged or underappreciated; and for some, the category to which they are assigned by the caring role does not wholly escape the various stigmas attached to being a welfare recipient (Carer's Benefit is an income replacement, but Carer's Allowance, the better-known and more discussed payment, is classed a social welfare payment). This can affect self-esteem, especially in an economy which tends to measure economic participation or contribution in terms of productivity and output – those who feel they are involved not in a strictly 'productive' sector of society but in managing decline feel relegated to its margins. In addition, the low income which leads to anxieties about budgeting for domestic and social life can have a major impact on quality of life and mental health.

While the primary determining factor in whether or not an employee decides to avail of Carer's Leave remains consideration of the economic implications of doing so, the influence of social and psychological issues on the decision should not be underestimated.

3.3 Carer's Allowance preference

A person who has been on Carer's Leave for over 104 weeks – this is rare, however, as figures indicate – would after that period transition to Carer's Allowance. It is likely however that those on lower incomes or in unskilled jobs would immediately apply for the latter payment. Carer's Benefit is not means-tested, but those on low incomes would receive a full Carer's Allowance after the means test. The Carer's Allowance payment is €1 less weekly than Carer's Benefit, but it entitles a carer who is living with the person they care for to a Household Benefits Package, which includes an electricity or gas allowance of €35 monthly and a free TV licence, and in some circumstances can entitle recipients to a small travel allowance. Thus it would make more economic sense for those in lower-skilled jobs to go straight on to Carer's Allowance.



3.4 Employers' non-accommodation or discouragement of leave?

There is the possibility, of course, that employees are discouraged by employers or supervisors, openly or subtly, from taking extended periods of Carer's Leave. One must entertain this possibility; but on available evidence it is by no means conclusively demonstrable that this is happening, and it would naturally be very difficult to register or to monitor if it were. There is no real evidence that there is active dissuasion from taking leave of this kind occurring.

3.5 Employers' facilitation of preferred alternatives to full leave?

Alternatively, it may of course be the case that large numbers of skilled workers are being sufficiently accommodated by employers with flexible working hours or other measures that many do not need to take Carer's Leave. If lower-paid or unskilled workers tend to move on to Carer's Allowance, and higher-skilled workers are being accommodated, the low take-up might be expected. Again, this is something we just don't know – though one report would cast doubt on it (Citrix Ireland 2013) – and much greater engagement with employers and employees is necessary to get an accurate picture of how the legislation is working.

3.6 Lack of awareness of entitlements

It is further possible that there is still relatively poor awareness of these entitlements among the working population, on the parts of both employees and employers. This is confirmed in informal surveys, and acknowledged by the Government of Ireland. In 2012 the Government agreed to sign up to a National Carers' Strategy, comprising forty-two actions. One of the simpler actions was actively to promote awareness of Carer's Leave entitlements both within government departments and among the wider public.⁷ This may lead to greater awareness; but it is not certain that greater awareness will lead to wider take-up of the leave.

⁷ Efforts of the Department of Employment Affairs and Social Protection to do so were acknowledged in the 'Family Carers Scorecard' – which assesses the annual Government progress reports on the Strategy – of the National Carers' Strategy Monitoring Group in 2017. These represented the final progress report and scorecard due in the lifetime of the current National Carers' Strategy.



3.7 A knowledge and research gap

These explanations may all partially account for the low take-up of carer's leave, but are all conjectural: the fact is that we just don't know why the take-up is so relatively low, and this means that the area represents a significant knowledge and research gap. Greater knowledge of how Carer's Leave legislation is working, or is perceived by employees, would be of benefit in several regards. The data in themselves are of interest, and may contribute to how economists conceptualise the problem of reconciling work and care in the future; further, one must know whether the scheme is working, or whether a restructured scheme – which for example offered shorter (currently the shortest in Ireland is 13 weeks) leave but greater pay, related to one's income level and social insurance contributions, as in Germany – would better serve those who require Carer's Leave (particularly as lower-income individuals may opt to apply directly for Carer's Allowance).⁸

4. Equality Challenges: Gender, Socioeconomic and Health Inequalities

The extrapolation mentioned above which estimated that 54,000 women in the UK left work soon after returning from maternity leave (Equality and Human Rights Commission 2015) is a reminder of how raising children can impact negatively on women's careers. The task of caring for elderly, disabled or infirm relatives tends more commonly to fall to women than to men, and this is reflected in figures and must have consequences for women's labour force participation. It is also observable that those on lower incomes may be more inclined to leave their work in order to care full time, or to reduce hours where possible in order to devote more time to caring for dependent relatives. Such a choice is consonant with what we would assume about a person's weighing of the opportunity costs involved in caring. Given what is understood about carers' burdens, however, and what has been outlined above regarding the negative health outcomes for carers who leave the workforce, and the correlation between employment balanced with care and higher self-reported happiness or self-esteem, to imagine the choice ought to be reducible to a strictly economic consideration is misguided. Greater support for carers, allowing them to stay in the workforce (even part-time) can have a hugely beneficial effect on their wellbeing; and,

⁸ Carer's and unemployment benefits in Germany are not at flat rates, but initially pegged to one's net former income, and paid as a (fairly high) percentage of it, reducing over time to a flat rate.



though moving on to Carer's Allowance may still make sense for many on lower incomes or who are already working part-time, it should not be the assumption that this should be the option for lower skilled or lower earning workers while skilled professionals with caring obligations have better chances of remaining in full employment. Measures to facilitate the balancing of work and care, be they governmental or employers' initiatives, can help to address these two markers of inequality in the workforce. Keeping a carer in the workforce can also help offset the financial costs of caring, and counter the loneliness and social isolation which is often the consequence of full-time care, and which represents another form of inequality, preventing a carer from participating fully in their society, as a citizen and as an individual.

4.1 Gender disparities in caring

Figures for the take-up of Carer's Leave – measurable through recipients of Carer's Benefit – show the typical gender imbalance in caring responsibilities. The last available figures which break down recipients by gender are for 2014, and show that, proportionately, women are far more likely to avail themselves of Carer's Leave, being four times more likely (1,054 Female vs. 265 Male) to be recipients of Carer's Benefit (Dept. of Social Protection 2015: 98). The Census statistics support this expected skew. In Census 2011, across all age groups, there were 72,999 male and 114,113 female carers; the latter represents 61% of carers (CSO 2012). In the 2016 Census, a moderate rise in carers was almost evenly distributed between genders. There were 77,112 male and 118,151 female carers, the latter again representing 61% of the total (CSO 2017).

In what is perhaps the earliest piece of research dedicated to family caring in Ireland – which doubled as a lobbying document (Noonan 1983) – it was noted that responsibilities for family caring fell disproportionately on the young women in a family, and often impacted negatively on their progress in other areas of life. At the time, the Prescribed Relative Allowance (a forerunner of Carer's Allowance) was generally the only option for income as a carer (unless one was a single woman between 58 and 65), but figures showed that men were far more likely to be accepted as a Prescribed Relative (i.e. carer) by the scheme. Records were patchy, and the only data available were on prescribed relatives of widows and of old-age contributory pensions, representing about a fifth of total applications



between 1980 and 1982. The available figures showed that, in that period, 232 men had applied to be accepted as prescribed relatives, and 64 (27.5%) were rejected. 387 women had applied, and 210 (54.3%) were rejected (Noonan 1983: 11).⁹ The allowance was payable only to people meeting certain criteria, including that they not be a married person wholly or mainly maintained by a spouse; it was also paid not to the prescribed relative but to the person receiving care – an unsavoury situation which made the carer financially dependent on their dependent relative, and which was rectified by the later introduction of Carer’s Allowance. Regarding the (often young) women to whom caring obligations tended to fall, the study notes: ‘Many returned to rural areas from Dublin or England. All appeared to have had jobs they liked and an active social life. This is a generalisation, but it was noticeable that those women who never had a job tended to feel “cheated of life” in a way that those who had had a job did not’ (Noonan 1983: 3). Conditions have changed, but Noonan’s paper is remarkable for how the complaints of those forced into a caring role are echoed today in almost the same language; emblematic is the report’s emphasising ‘the unreasonableness of the State’s expectation that when people do give up jobs to care for elderly/infirm relatives, they should do so without any recompense or recognition’ (ibid.: 12). Replace ‘any’ with ‘adequate’ and this could have been written today. The disparity in the numbers of female as against male carers is perhaps expected, and is even more pronounced in other European countries. A recent French report on family care published by the Caisse nationale de solidarité pour l’autonomie insists the general figures speak to ‘disturbing realities’, namely, that ‘caregiving is in large part an involuntary role’, and that ‘Women are much in the majority of those assuming the role, and making the attendant sacrifice of personal ambition – the work of caring is perhaps the most implacable bastion of gender inequality’ (CSNA 2014: 12).

⁹ The disparity may come from the fact that applying men were more likely to be leaving insurable employment. It was originally a condition of receipt of the allowance – which at its inception in 1969 was only available to the daughter of a pensioner – that the daughter be leaving insurable employment to look after their parent. Interestingly, the effect of this was that ‘possibly as the result of the original stipulation that the daughter be insurably employed (which no longer applies) the Prescribed Relative Allowance has one very important corollary. This is that the prescribed relative (carer) is credited with social insurance contributions for all of the period spent as such. The State thereby recognised that the carer is doing an insurable job on its behalf, even though it pays the person who received the service rather than the person who gives it’ (Noonan 1983: 7–8).



4.2 Socioeconomic disparities in caring

As much as it is a gender equality issue, the question of adequate state recognition and support of informal care is also a socioeconomic one. It is significant that studies from the Netherlands, where the world's first system of compulsory long-term care insurance was introduced in 1968, and where, consequently, care has traditionally been seen as the state's responsibility, indicate that the expectation that family provide care, even at the expense of their own career progression, is more prevalent among lower-income households and communities, and that this expectation extends to societal and governmental level, where it is expected lower-income families should incur the opportunity costs associated with adoption of the caring role (Van den Broek et al. 2015; Da Roit 2012). Scottish studies which examined correlation between deprivation measures and the prevalence and intensity of caring meanwhile found no significant difference in the prevalence of caring across five income-related quintiles, but that intensity of caring increased significantly among those in the lowest two (Scottish Government 2015). Similar correlations between deprivation levels and intensity of caring were indicated in the Irish Health Survey 2015 (CSO 2016). The earlier OECD report on balancing work and care noted that carers in the 28 surveyed countries were over 50% more likely to be homemakers (Colombo et al. 2011: 8). It has often been noted that the measures which facilitate work and informal caring apply in the main to those in higher-skilled, higher-income professions. An element of truly supporting the balancing of work and care is to ensure that informal care provision does not become the assumed recourse for lower-income families, while better off families can remain in the workforce, sharpening the income divide and making care a barrier to social advancement among the working classes.

4.3 The social and health costs of caring

As mentioned above, the opportunity costs associated with caring are, for many, primarily economic; but there are also social costs, in particular the common tendency for carers to become more socially isolated as a care burden increases. Many are unable, due to the supervision required for the care recipient, to leave their house for extended periods or even at all. This kind of limitation of social life, coupled with the stresses associated with



caring, can have detrimental effects on carers' health. This was very clearly brought out in discussions with a steering group of carers and former carers convened as part of a project to develop an online Palliative Care Hub for the public in Ireland: 'Particularly noted was the importance, in any project promoting the awareness of a caring process, of drawing emphatic attention to the issue of carer burnout – it is almost inevitable where no supports or respite help is sought, and can lead to decline in mental health, social isolation, fatigue and depression' (O'Sullivan and O'Mahoney 2014: 7).

International studies suggest loneliness and isolation can increase the risk of heart disease and stroke (Valtorta et al. 2016), of general cardiovascular disease (Holt-Lunstand and Smith, 2013) and of dementia (Holwerda et al. 2012), and can lead to higher mortality (Holt-Lunstad et al. 2015). Isolation can compound or worsen depression or psychological distress which may have its roots in caring. A number of Irish studies show that sample populations of carers struggle with psychological problems such as stress or depression more than the general population. Among a sample of spousal carers of people with dementia, anxiety and depression were common, with '37% of carers [reporting] clinically significant depressive symptoms, and a further 40% [reporting] levels of depressive symptoms that were not clinically significant'. Further: 'About 35% reported anxiety symptoms indicating borderline (15%) or probable (20.6%) mood disorders' (Brennan et al. 2017: 9). In a study of 247 full-time family carers of children with an intellectual disability, 'two fifths of respondents scored above the threshold for poor psychological distress (40.8%), which is a much higher proportion than that found among the general population (12%)' (Lafferty et al. 2016: 15). In a large survey of stress and coping skills in carers of older people (2,311 respondents, ranging in age from 19 to 92), it was found that 44% were at risk of developing clinical depression (Lafferty et al. 2014: 28–9). The chronic stress associated with caregiving has been shown to have a negative impact on the immune system, making carers more vulnerable to infection: carer burden is correlated with low production of immunoglobulin A (Gallagher et al. 2008), and parents of children with significant developmental difficulties when monitored showed poor antibody responses to pneumococcal vaccination (Gallagher et al. 2009). This echoes the findings of a previous study of carers of people with dementia, which also showed elevated salivary cortisol levels indicating emotional distress, as well as a poor antibody response to influenza vaccination (Vedhara et al. 1999).



As noted above, an earlier OECD study (Colombo et al. 2011: 4, 8) suggests that the prevalence of mental health problems among carers is about 20% higher than for non-carers. Family carers were also 50% more likely than non-carers to be homemakers (ibid.: 8), a rude enough datum by which to draw any conclusions but which nevertheless does suggest a relationship between remaining active in the workplace and maintaining one's psychological health. The report of the 'carers@work' programme, which examined work and care reconciliation trends in Germany, Italy, Poland and the UK, identifies the need to remain in the workforce as a financial necessity for some carers, but also a matter of attitude and esteem: 'A number of people were very explicit about their reliance on the income from work for being able to cope financially. Some stressed that continuing to work gave them more control over their lives, that is, some degree of independence'. There were some differences here: concerns about identity were more commonly expressed by study participants from Germany and the UK: 'Quite a few working carers expressed the importance of continuing to have an identity as "workers" rather than being reduced to being caregivers only. These views were particularly often expressed by British and German working carers' (Hoff et al. 2014). It is reasonable to assume this difference is reflective of the comparatively developed systems of supports in these two countries, and especially of the existence of strong lobbying and advocacy groups. Such groups make the moral and economic cases for supporting carers, drawing attention to their contributions to their society, and their campaigns can establish supporting carers as an important issue at government level.¹⁰ The effect of such advocacy is to make caring a public health issue, and in some cases to destigmatize it. A discussion paper originally developed for members of the UK Parliament (Cass, Fast and Yeandle 2014) identifies four requirements for sustainable family caring in a society, and the first and most basic, before reconciliation measures for work and care, income security or even supports, is societal recognition and

¹⁰ Since the study, there have been rapid improvements in Italy, which have been driven by the lobbying of regional legislators and national senators by advocacy groups such as Anziani e non solo and C'entro. In June 2016, the Senate passed the 'Dopo di Noi' legislation, which is intended to secure the future of disabled children when their parents or other carers die or can no longer provide the required level of care. In March 2014, the Emilia Romagna region passed legislation to establish the recognition and support of family carers (Norme per il riconoscimento ed il sostegno del caregiver familiare). The Senate announced in October 2017 its intention to examine legislation to address the needs of informal carers in Italy.



acknowledgement of the caring role (the four are: Carer Recognition and Rights; Services for Users and Carers; Work-Care Reconciliation; and Financial Support).¹¹ The importance of this is brought out in the ‘carers@work’ report, which asserts that, rather than being a public health issue, caring in Poland and Italy was perceived as a private matter – likely not a subject to be discussed outside of the family. ‘Whereas Italian and Polish working carers regarded their caregiving obligations as an entirely private matter and thus avoided telling anyone in the workplace, British and German working carers made sure that at least their line managers were aware of their situation and invested substantially in building or maintaining a relationship of trust (“bank of trust”) with their line managers’ (Hoff et al. 2014). The perception that caring is a private matter is patently an obstacle to reconciling work and care, as it acts to dissuade people from revealing their caring role and so making cooperative arrangements to accommodate it as far as possible, rather than, say, taking unpaid leave. The Canadian Human Rights Commission’s paper on balancing work and care recognises that it is necessary for a carer to bring their caring obligations to the attention of employers if they are to be accommodated, and encourages openness about the matter while respecting an employee’s privacy (Canadian Human Rights Commission 2014: 5–6).¹² The European Commission’s report into adequacy of social protection in ageing societies identifies work and care reconciliation as an essential component of future work environments, and notes (2014: 61): ‘The first prerequisite for implementation of carers-related measures is that employers are aware of and recognise the difficulties of reconciling work and LTC duties and that initiatives also bring tangible benefits for them’. Grayson (2017: 56–63, 81–3) similarly recommends appropriate openness in the workplace, and that employers be proactive, through employee engagement, in creating an environment and corporate culture that recognises caring obligations as a common source of stress in workers’ lives. These measures may ease the burden on carers at crucial times, allowing them to arrange to provide care without dropping out of the workforce or drastically

¹¹ Fast later represented these as a ‘pyramid of carer needs’, reproduced in Grayson 2017: 189.

¹² The Canadian Human Rights Act affords protections from discrimination on eleven grounds, ‘such as race, age, sexual orientation or family status’. Canadian courts ‘have determined that providing care to a family member is covered under the protected ground of family status. This means that people who need to provide care to family members also have a right to participate fully in the labour force. Employers have an obligation to remove barriers that prevent people from doing so (Canadian Human Rights Commission 2014: 3).



reducing hours, or, conversely, putting off care arrangements out of consideration for household finances only for a resulting health crisis to necessitate an extended period of leave that might have been avoided. All such measures serve to address and mitigate the disadvantages to which a caring role can expose a person, and lessen the health and social costs for carers.

5. Developments

It is reasonable to believe that temporary leave or flexible working arrangements necessary to provide or to organise care for a loved one will increasingly be sought by workers both in skilled and unskilled positions, and may become a mainstay of corporate policies. The EU has recently held a major consultation on work-life balance, and some advocacy groups have used this as a platform to call for an EU Directive on Carer's Leave. On these matters, Ireland ought, given its relatively generous terms of Carer's Leave with regard to job security guarantees and length of leave, to serve as something of a model to aspire to: but the low take-up of the leave and the knowledge gaps regarding and lack of research into the subject mean that we cannot in fact be sure the legislation is optimally efficient in Ireland, never mind transferable to different legal, cultural and economic contexts. Some recent developments provide opportunities to address the current knowledge gaps.

5.1 Proposed EU Directive on Work-Life Balance

A noteworthy development at EU level is the recent proposal of a Directive on work-life balance.¹³ Its intent is not only to serve the ends of fairness and equality but also better to secure the economic future not only of employees but also of employers, whether corporations and smaller businesses or the public sector. A carer-related Directive would signal the formal EU-level recognition in legislation of informal or family care both as a barrier to workforce participation and career advancement generally – therefore an area

¹³ A Directive is one of the regulatory instruments of the European Union. They direct Member States to achieve a particular result, usually within a specified timeline. Directives are binding – the Commission can take legal action against a state which fails to accomplish the directed result, or whose legislation is incompatible with it – but they do not prescribe how Member States should achieve the result. This is distinct from a Regulation, which is binding and contains instruction on how to achieve a particular end, and from a Recommendation, which is given to all Member States but which is not binding and has no legal force.



where legal protections against potential discrimination must be in place – and as something which, when undertaken, must be supported by Member States so that family carers can provide safe and adequate care for their loved ones while remaining full participants in their society. Even the proposal of a Directive may signal the beginning of greater recognition of informal carers by Member States. Two elements of the proposed Directive are a right of workers to call for flexible working time, and a proposed Union-wide entitlement to five days of leave at sick-pay rates to care for or make arrangements for the care of ill relatives. The right to call for flexible working time, and its encouragement as a way of facilitating employees' balancing of work with care obligations, signals awareness of this as a social and economic problem and willingness to address it. Marian Harkin MEP, who has for years chaired the European Parliament's Carers Interest Group, wrote in a press release of April 26th 2017 of the proposed measures: 'This Commission proposal is a first indication that Social Europe is now firmly on the agenda and that the interests of carers, in particular family carers, are central to Commission thinking'.¹⁴

5.2 Proposed Family Leave Bill

The Carer's Leave legislation has not been reviewed since its inception in 2001. In 2012, the impending transfer of responsibility for the legislation to the Department of Justice was announced. It is part of the current Government's legislative programme to produce a Family Leave Bill, which, according to a statement by David Stanton TD on 10th October 2017, 'will consolidate all existing family leave legislation such as parental leave, carer's leave, maternity leave and adoptive leave into one Act while making necessary amendments and improvements'.¹⁵ This statement that the consolidation of legislation may entail amendments and improvements suggests the progress of this Bill might afford an opportunity to revise the Carer's Leave Act if this is required. This, of course, would require researching the effectiveness of the current legislation, but no large-scale study of such has yet been undertaken.

¹⁴ M. Harkin MEP, '[EU paid leave proposal for family carers warmly welcomed](#)' 26/04/17

¹⁵ <https://www.kildarestreet.com/wrans/?id=2017-10-10a.552&s=%22family+leave+bill%22#g554.r>



5.3 Health Research Board Project on Work-Life Balance and Supporting Working Carers

Family Carers Ireland was recently a co-applicant for a Health Research Board Emerging Investigator Award granted to Dr Attracta Lafferty of University College Dublin. The project, titled 'Development of a workplace-based programme to promote health and self-care behaviours among working family carers' will involve a major, four-year study focusing on self-care behaviours of working carers. It will investigate how better to support carers in maintaining their health and wellbeing, creating a programme to help working family carers to improve their physical and mental health. If the new programme is successful, it may be applicable on a larger scale in different work settings throughout the country. The research project, with a grant budget of almost €800,000, will commence in autumn of 2018. Early stages of the project will entail a review of European and international literature on balancing work and care, and its scope will include data-gathering on different methods of supporting working carers, and examine what is working and what is lacking in Ireland. Current data suggest that Ireland lags in terms of measures for facilitating those balancing work with care – for example in the reluctance among employers to embrace flexible working time (Citrix Ireland 2013), a trend which ignores the benefits flexible work can have for an economy (Citrix 2014). (The Canadian Human Rights Commission notes: 'Flexible work arrangements have been shown to reduce absenteeism, foster employee loyalty, improve morale and retention, and increase productivity' (2014: 7)) Some EU countries, for example France, Luxembourg and the Netherlands, 'incentivise carers to reduce their working time rather than leave employment. In the Netherlands, part of the income forgone by reducing working hours may be paid by the state' (European Commission 2013: 12).

6. Conclusion

The project is timely: the increased attention over the past decades to demographic trends and the health and financial implications for ageing western societies has focused attention on countries' long-term care needs. It has been recognised that, with ageing populations and an imminent 'care gap', the indirect costs of the increased demand for informal care, if those of working age cannot reconcile work with care, will be significant for public finances, with lower social security contributions and tax revenue, and higher transfer payments



(Rechel et al. 2009; European Commission/Social Protection Committee 2014; Geyer et al. 2017). The subject of work and care reconciliation could be said currently to be ‘in the ether’; and it will inevitably become more and more a focus of employers’ policies and of the attention of employers’ representative groups, as well as of carer advocacy groups and of government.

The public, private and third sectors all have important roles in promoting actions which enable the reconciliation of work and care. As is emphasised by Grayson (2017: 201–28), there are roles for a wide range of stakeholders in creating a greater awareness of family caring in society, and – acknowledging that anyone can become a carer – of the needs of carers who must balance their caring with employment commitments. Design or promotion of initiatives which support work and care reconciliation could fall (for example) to national or regional governments, or governmental agencies; NGOs and voluntary organisations; private employers or (sectoral or national) employers’ representative groups; trade unions; or professional associations for human resource management. There has long been a push by advocates for caring to be recognised as a public health priority; but it is necessary for ageing societies fully to appreciate it as a pressing economic issue, which, if supports are truly to be proactive, must be addressed by numerous actors, and on the most macro scale the market and society as a whole. We have detailed some of the knowledge and research gaps in Ireland, which gaps sharpen the challenges Ireland shares with other western societies. It may be hoped that the collaborative efforts of governmental agencies and departments, academia, private enterprise and voluntary associations can begin to address these knowledge gaps, and use findings to identify effective and achievable measures facilitating work and care reconciliation in Ireland.



References

- Anderson, R. (2016) 'Carers and Employment in the EU' in *Teilhabe im Alter gestalten: Aktuelle Themen der Sozialen Gerontologie* Eds. G. Naegele et al. (Springer)
- Bittman, M., Hill, T. and Thompson, C. (2007) 'The impact of caring on informal carers' employment, income and earnings: a longitudinal approach' *Australian Journal of Social Issues*, 42.2, 255–272.
- Bouget, D., Spasova, S., Vanhercke B. (2016) *Work-life balance measures for persons of working age with dependent relatives in Europe: a study of national policies* Brussels: European Commission
- Brennan, S. et al. (2017) [De-stress: A study to assess the health and wellbeing of spousal carers of people with dementia in Ireland](#) Dublin: Alzheimer Society of Ireland
- Caisse nationale de solidarité pour l'autonomie (2014) [Être proche aidant aujourd'hui](#) Paris: CSNA
- Canadian Human Rights Commission (2014) [A Guide to Balancing Work and Caregiving Obligations: Collaborative approaches for a supportive and well-performing workplace](#)
- Carers UK (2015) [State of caring 2015](#) London: Carers UK
- Carers UK for Employers for Carers (2013) [Supporting working carers: The benefits to families, business and the economy – Final report of the Carers in Employment Task and Finish Group](#) London: Carers UK.
- Cass, B., Fast., J., Yeandle, S. (2014) '[The challenge of caring, now and in the future: learning from across the world](#)' Discussion Paper for Westminster Seminar, Leeds: University of Leeds
- Central Statistics Office (2012) [Census 2011 Profile 8: Our Bill of Health – Health, Disability and Carers in Ireland](#)
- Central Statistics Office (2016) [Irish Health Survey 2015](#)
- Central Statistics Office (2017) [Census 2016 Summary Results Vol. 2](#)
- Citrix Ireland (2013) *Flexible Working in Ireland?*



Citrix (2014) *The productive value of the untapped workforce: A study into the potential economic impacts of a flexible working culture* London: Centre for Economics and Business Research

Colombo, F., Llena-Nozal, A., Mercier, J. and Tjadens, F. (2011) [Help Wanted? Providing and paying for long-term care](#) OECD Health Policy Studies, OECD Publishing

Da Roit B. (2012) 'The Netherlands: the struggle between universalism and cost containment' *Health and Social Care in the Community*, 20.3, 228-237.

Department of Social Protection (2015) [Statistical Information on Social Welfare Payments 2014, Section E: Illness, Disability and Caring](#) (p. 98)

Employers for Carers (2017) *The Business Case for Supporting Working Carers* EFC Briefing

Eurofound (2015) [Working and caring: Reconciliation measures in times of demographic change](#) Luxembourg: Publications Office of the European Union.

European Commission (2013) *The indirect costs of long-term care* Research Note for DG Employment, Social Affairs and Inclusion

European Commission/Social Protection Committee [Adequate social protection for long-term care needs in an ageing society](#) (2014) Luxembourg: Publications Office of the European Union

Equality and Human Rights Commission (2015) *Pregnancy and Maternity-Related Discrimination and Disadvantage* (London: Equality and Human Rights Commission)

Gallagher, S., Phillips, A.C., Evans, P., Der, G., Hunt, K., Carroll, D. (2008) 'Caregiving is associated with low secretion rates of immunoglobulin A in saliva' *Brain, Behavior, and Immunity* 22, 565–72

Gallagher, S., Phillips, A.C., Drayson, M., Carroll, D. (2009). 'Parental caregivers of children with developmental disabilities mount a poor antibody response to pneumococcal vaccination' *Brain, Behavior & Immunity* 23, 338–46

Geyer, J., Haan, P., Korfabe, T. (2017) 'Indirect Fiscal Effects of Long-Term Care Insurance' *Fiscal Studies* 38.3, 393–415

Glendinning, C., Arksey, H., Tjadens, F., Moree, M., Moran, N., and Nies, H. (2009) [Care provision within families and its socio-economic impact on care providers across the](#)



[European Union](#) (Research Works, No. 2009-05) York: Social Policy Research Unit, University of York

Grayson, D. (2017) *Take Care: How to be a Great Employer for Working Carers* Bingley: Emerald Publishing

Hoff, A. et al. (2014) '[Informal and formal reconciliation strategies of older peoples' working carers: the European carers@work project](#)' *Vulnerable Groups and Inclusion* 5.1

Holt-Lunstad, J. et al. (2015) 'Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review' *Perspectives on Psychological Science* 10.2, 227–37

Holt-Lunstad, J., Smith, T. (2013) 'Loneliness and social isolation as risk factors for CVD: implications for evidence-based patient care and scientific inquiry' *Heart* 102.13, 987–9

Holwerda, T.J. et al. (2012) 'Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL)' *Journal of Neurology, Neurosurgery & Psychiatry* 85.2, 135–42

Hoyer, S., Reich, N. (2016) [Leave and financial support for family caregivers in EU member states](#) Frankfurt: Observatory for Sociopolitical Developments in Europe

King, D., Pickard, L. (2013) 'When is a carer's employment at risk? Longitudinal analysis of unpaid care and employment in midlife in England Health and Social Care in the Community' 21.3, 303–314

Lafferty, A., Fealy, G., Downes, C., Drennan, J. (2014) [Family Carers of Older People: Results of a National Survey of Stress, Conflict and Coping](#) Dublin: National Centre for the Protection of Older People/UCD

Lafferty, A., O'Sullivan, D., O'Mahoney, P., Van Bavel, B. (2016) [Resilience in Family Carers of Adults with an Intellectual Disability](#) Dublin: National Disability Authority

Noonan, M. (1983) "Who Cares about the Carers?" A study of the single woman in her role as carer of elderly or infirm relatives' Dublin: Council for the Status of Women

O'Sullivan, D., and O'Mahoney, P. (2014) [Palliative Care Community Learning Project](#) Dublin: All Ireland Institute of Hospice and Palliative Care

Pickard, L. (2015) 'A growing care gap? The supply of unpaid care for older people by their adult children in England to 2032' *Ageing and Society* 35, 96–123



Rechel, B., Doyle, Y., Grundy, E., McKee, M. (2009) [How can health systems respond to population ageing?](#) Copenhagen: World Health Organisation

Reinschmidt, L (2014) [Caregiver Leave Models in Europe: Comparison of caregiver leave models for reconciling care and work in Germany, Austria, Belgium and Sweden](#) Frankfurt: Observatory for Sociopolitical Developments in Europe

Reinschmidt, L., Pieper, J. (2017) [How do European countries support family carers? A look at work-life balance policies in Germany, Austria and Belgium](#) Frankfurt: Observatory for Sociopolitical Developments in Europe

Schmidt, A., Fuchs, M., Rodrigues, R. (2016) [Juggling family and work – Leaves from work to care informally for frail or sick family members: an international perspective](#) Vienna: European Centre for Social Welfare Policy and Research

Stiell, B., Shipton, L. and Yeandle, S. (2006) [Caring for Sick or Disabled Children: Parents' experiences of combining work and care](#) London: Carers UK

Triantafillou, J. et al. (2010) [Informal care in the long-term care system: European Overview Paper](#) Athens/Vienna: European Commission

Van den Broek, T. et al. (2015) 'Care Ideals in the Netherlands: Shifts between 2002 and 2011' *Canadian Journal on Aging/La Revue canadienne du vieillissement* 34.3, 268–81

Scottish Government (2015) [Scotland's Carers](#)

Valtorta, N.K. et al. (2016) 'Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies' *Heart* 102.13, 1009–16

Vedhara, K., Cox, N., Wilcock, G., Perks, P., Hunt, M., Anderson, S., Lightman, S., Shanks, N. (1999) 'Chronic stress in elderly carers of dementia patients and antibody response to influenza vaccination' *The Lancet* 353.9153, 627–31