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Balancing elderly care and employment in Germany

January 2009

ISSN 1865-9683

Wissenschaftszentrum Berlin
für Sozialforschung (WZB)
Social Science Research Center Berlin

Research Area:

Education, Work, and Life Chances

Research Professorship:

Demographic Development, Social Change,
and Social Capital

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Order no.: SP I 2009-401

discussion paper

We thank Anita Fürstenberg, who arranged and conducted the interviews with the care givers and provided us with very helpful context information.

We also thank Hanneli Döhner, Josephine Heusinger, Susanne Kümpers and Hildegard Theobald, who gave us helpful comments and suggestions during a workshop we organized on this project in November 26, 2007, in Berlin.

Most of all we are indebted to the main protagonists of this study, the carers who, notwithstanding their multiple obligations and severe time pressures, found time to share their experiences with us. Thanks also to the social workers, who in many cases helped us to contact the carers.

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Introduction

In this report, we investigate the situation of workers who also care for an elderly parent in Germany. The study is based on qualitative, in depth interviews with care givers who are at least part time employed. The interviews aimed at detecting constrains and resources available to workers with caring responsibilities in the second half of their working life to deal with their multiple responsibilities and demands on their time and attention.

This report is one of a series of national reports on the same issue, which are all part of the project “Workers under pressure and social care” (WOUPS) supported by the French ministry of labour (MIRE) and by the French Agence Nationale de la Recherche (ANR), coordinated by the department of Ecole nationale de la santé publique at the University in Rennes. Towards this project, we also provided a report on the institutional framework of the German long-term care system, which we only synthetically summarize in the first part of this.

The outline of the report is as follows: The first section points to the relevance of balancing employment and informal elderly care in Germany and highlights the peculiarities of elderly care compared to child care. The second section, after a synthetic description of the key elements of the German long term care system, presents an overview, based on existing survey data, of the incidence and characteristics of workers having caring responsibilities towards an adult family member in Germany. The third section describes our sample of carers and evaluates its representativity and possible biases. In the fourth section, we discuss different patterns of work/care arrangements. In the fifth chapter, we analyse the tensions arising in these arrangements with regard both to caring and to gainful employment, paying attention to constrains, but also to the – human and emotional – resources carers are able to mobilize in the various situations. In the following two sections, the conciliation, or balancing, perspective is broadened to include family and friendship relationships as well as time for one’s own. In the concluding section, we highlight the most crucial aspects which put care givers in employment under pressure and we describe measures that might ease their situation.

1. Balancing work and elderly care

Work/family reconciliation policies have increasingly become part of employment-led social policy at both EU and Member State levels (European Commission 2007). The main concern, however, is on how parents and in particular mothers are able to balance child rearing and career prospects during the rush hour of life: the period in which achieving adequate qualifications, gaining ground in an employment career and forming a family are multiple processes which at best have to be managed in parallel (Gornick and Meyers 2003). Much less attention has been paid to caring responsibilities at the time parents or relatives become frail and need somebody to care for them (see Reichert 2003).

Policies and practices concerning the reconciliation of child care and employment may not be easily transferred to elderly care. Caring responsibilities for elderly parents usually occur at a different age and in a different phase of life – with regard to family and work responsibilities – than caring for children. Furthermore, elderly care is less predictable in timing, duration and intensity. Elderly care is often characterized by physical and psychical burdens and discomfort. In contrast to child rearing, which is directed to enable and empower individuals to become autonomous, elderly care mostly deals with a loss of autonomy and a preparation to death. In addition, the acknowledgement by society of child care and elderly care differs. There are, in most developed countries, child care policies which support a varied combination of family care (maternity and parental leaves) and publicly supported collective care. Public responsibility for elderly care developed much later, slower and in a much more fragmentary way. In this case, both carers and care dependent persons are little acknowledged in their needs. Family carers in particular, precisely because of being family members, for a long time have been denied any formal acknowledgement. Only in recent years, because of the dual phenomenon of population (therefore also kinship) aging and increasing women's labour market participation, frail elderly (not exclusively health) care has emerged as an issue and entered the policy agenda. Family carers' problems, particularly when they are also in employment, however, continue to be rarely considered and underestimated.

Population and work force projections however indicate that the issue of having caring responsibilities toward elderly people and being employed will be of growing prevalence. Population ageing has its strongest effect at the top tail of the age distribution. In Germany, for example, the share of people aged 80 years and over has more than doubled between 1970 and 2005, whereas in the same period the share of individuals aged 65 and over has increased only 1.4 times (European Data Service 2008). According to population projections, in 2040 more than 10 percent of the German population will be 80 years, compared to 4.3 percent in 2005.

The risk of care dependency increases disproportionately in old age. Among German recipients of long-term care insurance benefits, while only 1.4 percent of people aged 60 to 65 receive such benefits, in the 75 to 80 age bracket the share is 8.4 percent. And among individuals aged 85 to 90 years, more than a third receive subsidies because of their substantial im-

pairments. All experts assume a growing care demand in Germany in the future (Schulz, et al. 2001, Rothgang 2002), notwithstanding the increase of life time in good health.

While care demands increase, the pool of potential family care givers is likely to undergo contrasting trends, for demographic but also social reasons. On the one hand, there are good reasons to argue that the number of potential family givers will increase in the medium period. The improved health status of the elderly, in fact, in principle will allow partners to support their frail spouses more frequently and for a longer period than today. Currently more than 30 percent of the main carers who receive care allowances out of the German statutory long-term care insurance are partners, mostly women (Meyer 2007). Marriage instability, however, may reduce this availability of spouses. Also the number of adult children who might provide care for their elderly parents will probably increase up to 2030, when the numerous baby boomer cohorts will reach the age span between 40 and 65 years, which is often associated with caring responsibilities for elderly parents. Again, marriage instability both in the generation of parents and in that of children may however reduce this greater availability of children, particularly for frail elderly men. All research demonstrates that when parents divorce, the relationship with the father becomes weaker throughout the following years (Seltzer 1994, Lye 1996, Kalmijn 2008). And a (male) child's divorce reduces the potential availability of a daughter in law who, after a spouse and a daughter, is one of the main family carers. After 2030, in any case, there will be a sharp decline of potential care givers because the baby boomers will be replaced by the baby bust cohorts, born at the end of the 1960s up to now. This will happen just when the baby boomers themselves will reach the age in which the risk of being care dependent increases substantially, therefore causing a strong demographic unbalance between care dependent persons and potential family care givers.

The number of care givers – mostly wives, daughters and daughters-in-law – in the family is also affected by other developments than the demographic ones. More women will be (continuously) employed across the life span in the future. On the one hand, women in the younger cohorts are on average better educated and more employment oriented than the older ones. On the other hand, the transition of the baby boomer cohort into retirement will probably cause an additional job demand in the future, which may foster a greater overall labour market participation in the population of working age (Blinkert und Klie 2001, Häcker und Raffelhüschen 2007). Coupled with increasing age at retirement mandated by policies, this will certainly affect women's time organization and their availability to care. It might also affect values and preferences. According to research findings, in Germany a majority of people within all age groups still prefers to care for their parents rather than having recourse to residential care (Keck and Blome 2008). But the share of individuals who prefer home based family care has been declining between 1998 and 2003 (Blinkert and Klie 2004). Furthermore, an expanding market of formal and diversified care services for the elderly, which has been boosted by the introduction of the long-term care insurance, might improve the acceptance of such services and add to changing perceptions of the preferable care arrangements.

Whatever the development at the level of preferences and values, in the next two decades the expected overall growth of care dependent elderly people, coupled with demographic and family changes, will effect negatively the ratio between care givers and individuals in need of

care in Germany. In addition, the increasing women's labour market participation will affect negatively the availability of time to care by those who, up to now, have been the second main family carers after spouses (wives): daughters and daughters-in-law. This means also that more people in working age will face in the second half of life the dilemma of work and care conciliation. (Blinkert and Klie 2001, Häcker and Raffelhüschen 2007). Furthermore, most care givers in employment have more than just the two roles of carer for an elderly parent and worker. They often have also a family of their own, a partner and children, sometime also grandchildren. They have friends and are, or would like to be, engaged in other activities. These different obligations, relationships, interests, are often severely hampered by the caring demands of a very frail elderly parent (Stone and Short 1990, Murphy, et al. 1997). Focusing on the difficulties and constrains does not exclude, of course, that carers may experience enrichment and even empowerment in meeting all the obligations and challenges of their situation (Scharlach 1994, Moss, et al. 1989). It is necessary to understand the conditions under which this is possible and those which on the contrary render more difficult to cope with the different demands and challenges.

According to the literature, at least five aspects are important in considering the interference of caring obligations with being in employment (Brody, et al. 1987, Dallinger 1997, Neal, et al. 1997, Scharlach, et al. 2007):

- 1) How does care work interfere with the job?
- 2) How does employment affect care giving?
- 3) The impact of the dual demands of work and care on family relations and responsibilities, in particular towards the care dependent person, other (possible) family carers, relationship with spouse or partner and own children.
- 4) The impact of being both caring and being employed on the social life and free/leisure time
- 5) The impact of care and job obligations on the care givers' health.

It is therefore necessary to analyse different levels and directions of interference between caring and other relationships and activities in order to detect points of stress as well as possible resources. In this project, we describe the situation of balancing care and employment with the term 'challenges', to highlight that it is not the caring demands as such which univocally determine the degree to which carers experience over-stress, isolation, or other negative phenomena. It depends on a large degree on the one hand from the objective circumstances: the care arrangement and the resources available to develop the better balance, the situation in the workplace and its organisation, the demands, but also support, coming from other kin, friends, care services, as well as colleagues and supervisors at work. On the other hand, it depends on the way carers perceive their role and feel or not in control of the overall situation. Policies, with regard both to caring and to working time arrangements, play an important, possibly crucial, role in shaping the context and the resources in which these experiences develop.

2. The Institutional context and the incidence of family carers who are in employment

2.1 The German long-term care system

The German long-term care insurance, introduced in 1995, shoulders the basic care expenses for persons with substantial care needs and offers in principle the choice between care arrangements. Care allowances may be used either as cash payments or as benefits in kind in the form of domiciliary or stationary service provision. It is also possible to combine cash and in kind benefits. Care allowances are graded both on the basis of the degree of need and according to the type of care provision selected. Allowances for stationary care are highest, cash benefits are lowest. Allowances for domiciliary or semi-stationary care range in the middle. Since allowances in all cases do not cover the full cost of care, all additional provision by services must be paid, or substituted for by family members, or bought in the cheaper informal labour market. The care insurance mechanism itself, therefore, provides incentives for family (as well as informal paid) care, with or without some support by home based care services. Given the low level of cash payments, it also incentives recourse to irregular, cheap, mostly migrant, paid labour (Ostner 1998). Furthermore, the statutory long-term care insurance, while offering incentives for family care giving, so far hardly addresses the needs of family care givers themselves. Family carers do not have the right to claim the cash allowance. Monetary benefits are granted to the care dependent person, who may decide about its use. The main provision for family (and generally informal, unpaid) carers is social insurance coverage. Family care givers who have the main caring responsibility, care more than 14 hours a week according to the criteria used for service provision (which concern mainly body care)¹, and are not, or only part time, employed, may achieve the status of ‘caring person’ (Pflegeperson). This status entitles to contributions towards the old age pension paid by the long-term care insurance fund, as well as to insurance against accidents occurring while providing care. Main family carers may also ask for respite care (*Kurzzeitpflege*) and stationary care in case of emergency (*Verhinderungspflege*), each of both up to four weeks per year, if the care dependent person agrees. But until June 2008, the care insurance did not entitle workers with care responsibilities for a family member to take a leave, or some days off from their job in case of increased caring demands. This has been changed by an amendment to the law which came into effect in June 2008. The new *Pflegeweiterentwicklungsgesetz* entitles workers to two different kinds of leave: a maximum of ten days a year, without pay, to cater to different emergencies and a “caring leave” of maximum six months per person cared for, again without income compensation.

Before this amendment, provisions concerning some time allowance or leave existed only within some collective and company agreements (Klenner 2005, Dilger, et al. 2007, Klammer and Letablier 2007). In some cases, allowed leaves are longer (the maximum is 12 years for public servants), but often with no guarantee to return in the same job position. .

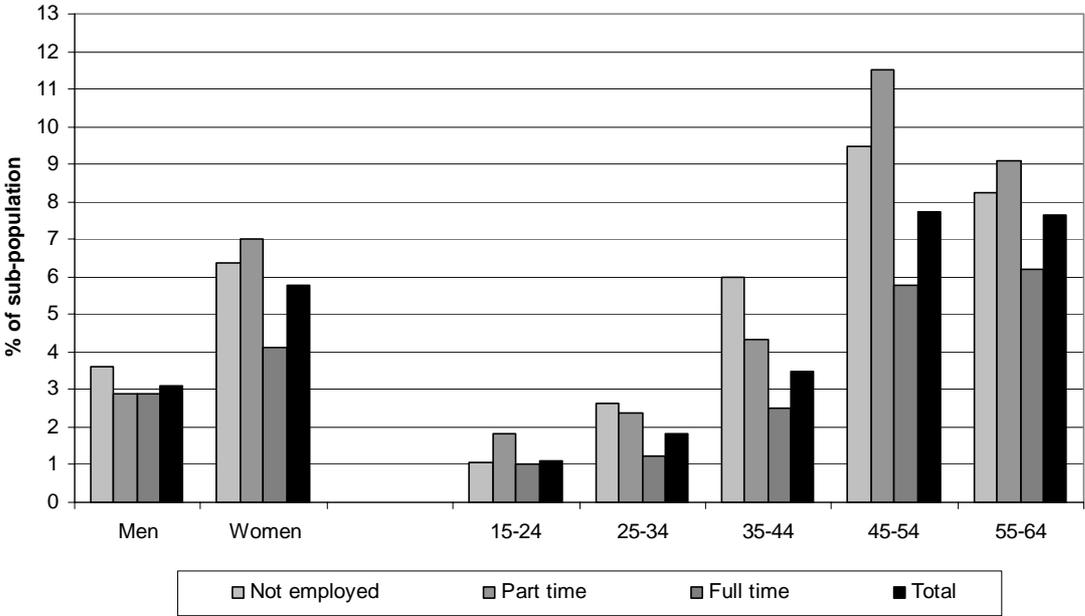
¹ The amount of care by services acknowledged for the different levels of need is the following:
level I = minimum 90 minutes daily nursing;
level II = minimum 3 hours daily nursing;
level III = minimum 5 hours daily nursing around the clock.

In sum, up to now there are only marginal rights and entitlements both in cash benefits as well as in work time adjustments for care givers in employment in Germany. Care dependent persons who receive long-term care allowances have the option to choose the best (affordable) option to meet the needs for both themselves and their care givers. But, irrespective of the care arrangement, the benefits from the care insurance cover only very partially the needs of the care dependent person. The family, therefore, has to allocate own time and/or money to guarantee adequate care. The resulting choices and care arrangements depend on the overall financial and caring resources available in a given situation. These in turn are strongly shaped not only by the financial status of the households and family networks involved, and not only by the numerical size of these networks, but also by their gender composition as well as by the individual biographies of their members – by their, often gender specific, “moral careers” (Finch and Mason 1993, Dallinger 1997, Heusinger und Klünder 2005).

2.2 Working for pay and caring for a non child family member: some statistical data

The 2005 German Mikrozensus survey allows an analysis of the incidence of caring for a frail elderly relative while being employed. A sub-sample of the 400,000 households in the sample has been asked whether they have caring responsibilities towards persons aged 15 years and over. *Figure 1* shows the incidence of such responsibilities for men and women and for different age groups with varying employment statuses.²

Figure 1: Caring responsibilities of 15 to 64 year old individual by employment status, sex and age



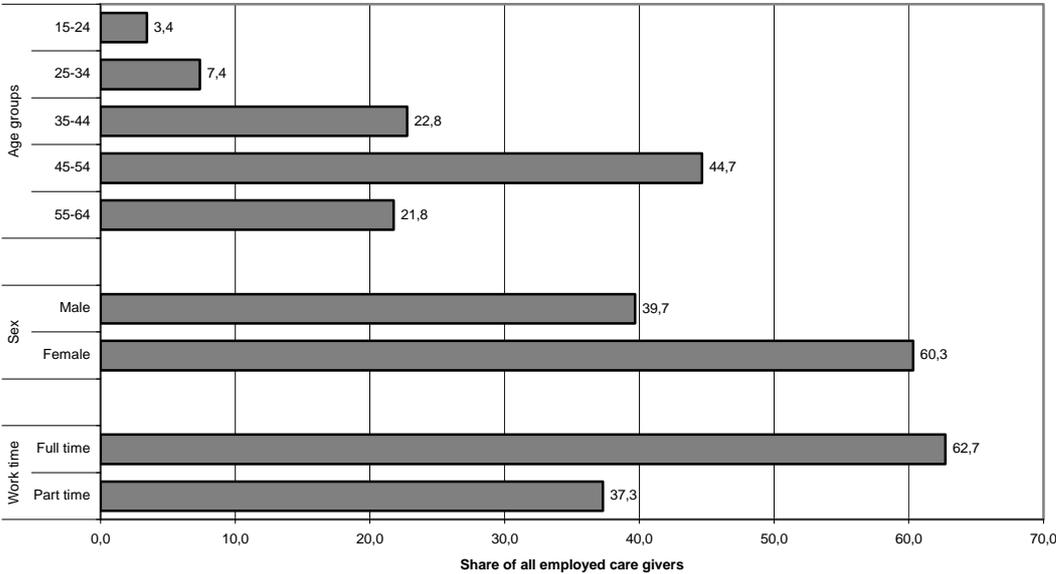
Source: Mikrozensus 2005

² Unfortunately, it is not possible to differentiate between regions because of too few cases to calculate robust statistics.

Around two times more women than men are engaged in caring for an adult relative or friend. Whereas men’s caring responsibilities are only weakly associated with their working time, women who provide care are clearly less likely to be full time employed than those who do not. This may indicate that women’s care activities are not only more frequent, but also more intense than those performed by men (Aliaga 2006) When an intense care need arises in the family, women are either already more available time-wise (e.g. because they already work part time), or are more willing (or more expected) than men to cut their working time in order to be able to care. For all age groups, caring obligations are less prevalent among the full-time employed than among those employed part-time or not in employment. This difference overlaps to a greater degree with the gender one. The vast majority of carers in employment, however, have a full-time job (see *figure 2*). It should, however, be considered that the Mikrozensus survey asked for any care provision, without distinguishing either level of need or amount of care provided. Thus an unknown proportion of respondents might provide a very limited amount of care.

The likelihood to provide care increases up to the 45-54 age bracket and then drops down again (*figure 2*). The higher incidence of working and caring tasks in the 45-54 years old group compared to the older one may be explained with the higher employment rate in the former. The share of people who provide care, in fact, is roughly the same in the two age groups, but employment rates are lower for the 55-64 year old, particularly for women.

Figure 2: Distribution of care givers in employment by age bracket, sex and working time



Source: Mikrozensus 2005

With regard to gender differences, two findings are relevant. As expected, working women have more often caring responsibilities than working men. But almost 40 percent of the family carers in employment are men. A 2003 representative study of the German population shows that among filial main carers 55 per cent are daughters, 14 per cent daughters in law, 31 % sons. There is no case of a son-in-law who provides care for his parents in law (Schneekloth 2005). Of course, many women carers are not in the labour force, often precisely because of their caring responsibilities in the past (with small children) and in the present. Thus, women are under-represented among carers in employment. Nonetheless, these data show that a large share of working men are engaged in some caring activity towards needy adults, a fact that should be acknowledged (Parker 1993, Schupp and Künemund 2004, Kramer and Thompson 2005)

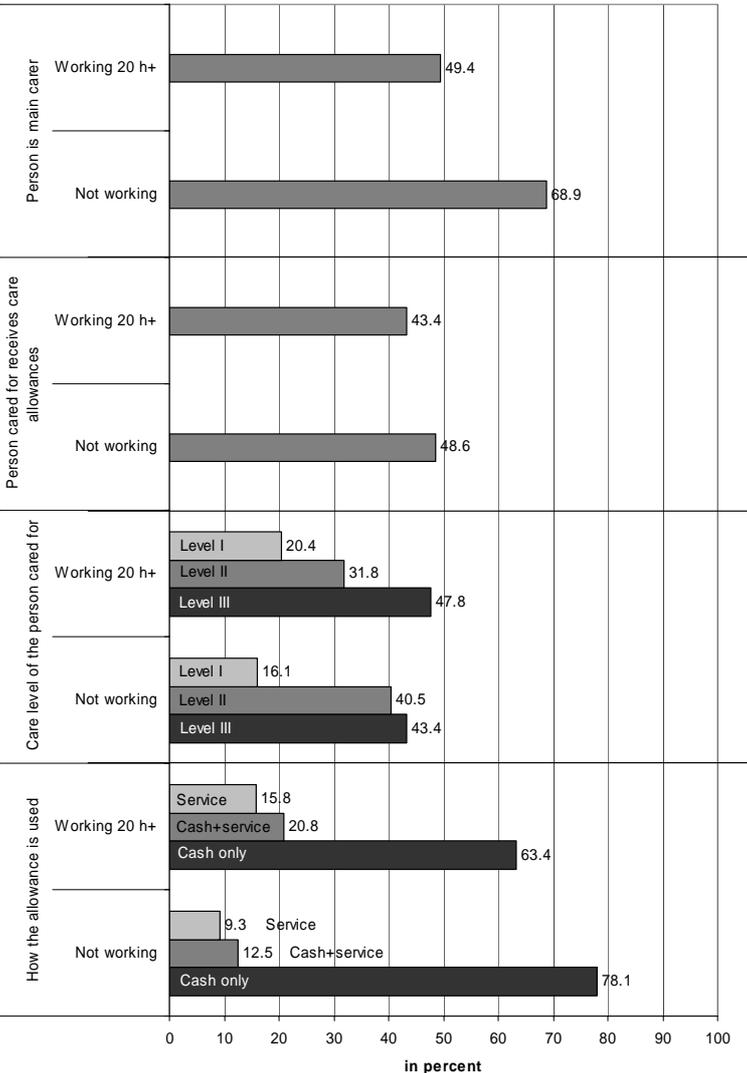
The 2002 German Alterssurvey offers better information than the Mikrozensus on the amount of care work performed and on the overall structure of care arrangements, although based on fewer observations. The Alterssurvey is a representative study of 40 and over years old residents living in private households. The overall sample size is slightly more than 3000 individuals. But only about 10 % of those in working age care for a relative. This small number does not allow any sophisticated analysis. But a comparison between employed and not employed carers is feasible.

Informal carers who are in paid work are less often the person with main caring responsibilities³ compared to non-employed carers of working age (*figure 3*)⁴. This not surprising finding indicates that care arrangements differ according to the labour market participation of the potential and actual carers. Carers who have a job are more likely to participate in a care arrangement in which the main contribution is provided either by another informal carer, or by services, or by a paid private carer. Moreover, even if they are the main carer in the family in so far they have the main responsibility for the care arrangement, their caring work involves more the organisation of the overall care arrangement than the direct provision of care (Rosenthal, et al. 2007). All this being said, almost half of carers in employment are also the main carer.

³ In this study the term main carer refers to those persons who provide most support compared to all other care providers within the care arrangement. In contrast, the main carer in our study refers to the persons who take most responsibility within the family, although care services or privately paid carers might provide more care work.

⁴ A small number of carers work less than 19 hours a week. On statistical grounds, it is not possible to calculate reliable indicators for this group. From a conceptual point of view, it is also not reasonable to integrate these short part-time workers in one of the other groups –either to those with substantial working hours or those not in paid work. This group is therefore not considered in the following section

Figure 3: Characteristics of carers of working age (40-64 years) by employment status



Source: Alterssurvey 2002, own calculation

Whether there are differences in the intensity of care required by the cared for person according to the carer’s employment status is not fully clear, although there seems to be a higher level of dependency among those cared for by the non-employed. The persons cared for by a non-employed carer, in fact, receive more often a statutory care benefit – thus have an acknowledged dependency status – than those cared for by a person in employment.⁵ Furthermore, those who are acknowledged the long term insurance benefit are more concentrated in the second and third level of dependency in the case of people cared for by the non-employed

⁵ It should be kept in mind that a person might be needing some kind of caring support without being acknowledged entitlement to a the long term care insurance benefit, either because his/her dependency is below the minimum established threshold or because for some reason the benefit has not been asked for. As we will see, below, the latter has been the case at least in one instance in our sample.

than by the employed. But carers in paid work seem to care at least as often as not employed carers for severely handicapped persons (care level 3).

Differences in the use of care allowances are much clearer. In the case of carers who are employed, at least some part of the care allowance is more often used in the form of benefits in kind (i.e. services) than in the case of non employed carers. It should, however, be pointed out that also in the case of the employed carers the allowance is mostly received in cash. Since the Alterssurvey includes both main and secondary carers, the caring needs not covered by services might, therefore, actually be covered by another family carer, not by the employed one. The small size of the sub-sample of employed carers does not allow comparing the caring arrangements of main and secondary employed carers. As we will see, in our sample, which includes only employed carers who take over main care responsibilities in the family, recourse to services is much higher and almost universal.

3. Sample Characteristics

The international research group of the WOUPS project agreed upon several sample criteria, some of them strictly required, others desirable. The required selection criterion was to interview 40 years old and over adults who were both in paid work (at least 20 hours a week) and the main carers in the family for their parent(s) or parent(s) in law. According to the sample criteria, the main carer had to be the person having the main responsibility for the overall caring arrangement, either providing the main bulk of care directly, or organising and supervising the caring package and dealing with emergencies and accidents in its delivery. This responsibility, therefore, should involve investment of time and energy, not only of money. The parent (in law) in need of care should need some help in (instrumental) activities of daily living (IADL, ADL) and/or to be supervised for several hours a day. The sample should also include diversity in education, income level and type of working hours (length, standard/non standard). It should also include at least three men. It was also suggested to diversify household and family situations: carers with and without children, with and without a partner, with and without siblings, living and not living with the cared for persons. To these requirements, for the German sample, we also added an urban/rural, as well as West/East diversification.

It should be kept in mind that these criteria exclude carers who have quitted their job because of the difficulties experienced in combining care and employment. In our sample, however, there are two care givers who had quitted their job very recently. Their experience offers an insight precisely on these dynamics.

Before presenting our sample we must point to two possible biases deriving from the way respondents were contacted. The first is linked to a common challenge facing investigators who study individuals who experience high time constraints and are therefore unavailable for, or unwilling to spend time being interviewed. In the US, surveys on family care givers in paid employment generally have quite low response rates, amounting to about 20 percent of all identified carers (see Scharlach, et al 2007: 754). This time constrain is even more decisive for qualitative interviews, which normally last longer than surveys based on a questionnaire

with predefined questions and answer categories⁶. The interviewer for our study reported that in several cases she had difficulties in scheduling an interview date, or had to postpone fixed dates because of the time constraints of the interviewee. In two cases, it took over two months before the interview was accomplished. Unfortunately, we do not know the number of care givers who were not willing to participate to the interview and the reason of their refusal, because many of the contacts to care givers were mediated by care services, particularly in Berlin. In the name of privacy rules, services did not grant us direct access to names and addresses of family carers. Hence, the interviewer contacted only those care givers who had beforehand communicated that they were willing to be interviewed. There is the risk that we might lack information on those care givers in employment who have the highest time pressures and therefore more difficulties in reconciling paid work and care. Consequently, the results might underestimate the pressures and offer a too optimistic picture. We are, however, confident that this selection bias is not too big, because one fourth of our respondents are in a situation with both high job and care demands.

The second possible bias concerns the specific way respondents have been found. In particular for the urban Berlin sample, 11 out of 18 contacts have been made with the help of day care centres, which have been particularly supportive in finding potential interviewees. They often have direct contact to the informal care givers who come to the day care centre regularly to take and pick up their care dependent relatives, developing over time a relationship of trust with day center workers. This relationship may have eased the acceptance of the interview. In contrast, home based care services forwarded our request to the service care giver who in turn contacted the family carer. This rendered the recruitment of potential respondents very complex. Moreover, our interviewer reported that home based care services were less willing to act as mediators between her and the potential interviewees. In synthesis, the specific pattern of access to potential respondents may account for two selectivity problems. First, care arrangements which include service provision seem to be overrepresented, particularly in Berlin, compared to the average situation. According to the 2002 Infratest study (Schneekloth 2005), in fact, more than half of the private care arrangements (55 %) in Germany do not receive support by care services. Second, within the sub-sample of care arrangements which include service provision, intensive care support by services might be more frequent than it is true on average, because respondents were contacted to a greater degree through day care centres (where individuals spend more hours) than through home based care services. We should not, therefore, read our Berlin findings, with their high presence of intensive recourse to services, as representative of the average. Rather, we should analyse them as a test case of the degree to which service use – more or less integrated and expanded with out of the pocket money – may or not help carers in employment in dealing with their conciliating problems.

Having said this, the overrepresentation of service provision in our sample may be not only the consequence of our sampling procedure, particularly in Berlin. It may indicate that when the main carer is in full time employment, use of services becomes more necessary in so far it

⁶ Our interviewer announced that the interview would last about 90 minutes. In fact most of the interviews took two to three hours. The longer duration, however, was not mainly caused by a miscalculation on the interviewer's (as well as our) part. Rather, once the carers had accepted the interview, they seemed to make use of it also to elaborate on their experience and to communicate it.

not only covers a substantial portion of daily time, but it also grants more stability than a complex package of time/care provided by different formal and informal providers. This is the reason why in all arrangements making a high use of services, day care centres play an important role. They cover, in fact, a larger proportion of time than home care services.

For the rural sample in Brandenburg we faced the opposite situation to that found in Berlin. In the official statistics on care facilities in Berlin and Brandenburg, there are almost no noteworthy differences in the availability as well as use of semi stationary care services (which include day care centres) between Berlin and Brandenburg. The substantial differences in the use of services between our rural and urban sample may therefore to a large degree be attributed to the sampling procedure itself. In Brandenburg, most of the contacts to care givers were mediated by private contacts of the interviewer, because the service channel did not work well. Services were not collaborative, often out of a feeling of having previously been exploited by researchers and students who collected information never bothering to give back anything. The Brandenburg sub-sample, therefore, might be skewed, and biased, in the opposite direction than the Berlin one. In any case, the Brandenburg sub-sample allows analysing care arrangements with no or low caring service support. But the different way in which the two sub-samples have been constructed accentuate urban/rural differences in the use of services versus cash allowance which probably appear greater in the sample than it is actually the case. We should rather consider these two different sub-samples as exemplary on the one hand of highly complex and structured care arrangements, on the other hand, of care arrangements which rely exclusively, or almost exclusively, on the care giver and her informal network, even if with some cash subsidy.

The analysis presented here concerns 26 interviews,⁷ including an interview with a grand-daughter caring for her grandmother, a responsibility the grand-daughter took up after her own mother died. In at least three cases, the female respondent shared at least equally the caring responsibilities respectively with a husband or a brother, but the men refused to be interviewed. *Table 1* shows the main characteristics of the sample in terms of geographical distribution, gender, relationship to the care dependent person, household composition, working time, level of education, level of dependency.

The sample is biased in favour of women if one compares it with the results of the TNS Infratest (Schneekloth 2005). If we include, however, the three identified male partners who contribute at least an equal amount of care work, but who have not been interviewed directly, the gender ratio of our sample corresponds quite perfectly (69% women and 31% men) to that found in the quantitative data. The daughter-mother relationship is prevalent, concerning half of all relationships. Also the majority of the cared for is constituted by women. This is not surprising, since, given the age difference between the spouses, particularly in the older cohorts, combined with women's higher life expectancy, frail older men are more likely to be cared for by a wife, while frail older women are more likely to be cared for by an adult child. All but one the care dependent persons in our sample had no longer a living spouse.

⁷ We have an overall higher number of interviews, but due to time constraints we limit our analysis to the number agreed for the overall project.

Our sample includes a fair range of diverse situations of dependency. There is both a number of very different types of dependency (dementia, Parkinson's disease, physical inability, etc.) and different statutory defined care levels (*Pflegestufen*). Except for two cases,⁸ all cared for persons are classified according to the three possible care levels. The ratio of persons with care level 3 in our sample (13 % in Berlin and 14 % in Brandenburg) is very close to the data from official statistics (see Statistisches Bundesamt 2007). There is, instead, an over-representation of care level 2. In more than half of all cases, the person in need of care is classified in care level 2 in our sample, whereas the rate in Berlin and Brandenburg ranges around 35-37 % (Statistisches Bundesamt 2007). This bias might be a result of the sampling procedure, since respondents were recruited mostly through care facilities. As there is a correlation between level of dependency and use of services, the sampling procedure might have resulted in an over-sampling of dependent persons with higher care needs.⁹

Twelve of the cared for persons live in the same household with the carer, and other three in the same building or very near. At the opposite, in one case the care dependent person lives in a different city. The households of the carers are quite diverse in composition. In particular, children – both young and adults – are present in twelve cases (in other five cases children are already living elsewhere); but in half of these cases there is no (longer) a partner. As a matter of fact, the proportion of carers without a partner is quite high: 16, five of whom live alone, five live with the cared for person, the others with their children with or without the cared for person. 11 of these unpartnered carers are divorced.

In 3 cases the main carer has also the responsibility for children 11 years old or younger (the youngest child is nine years old). In other eight cases, the carer lives together with children between 11 and 27 years old. One of these is not the carer's own child, but an 18 year old niece who moved with her aunt after the death of her own mother. This carer's household, therefore, seems to act as a caring resource for the family network at large. Overall, carers belonging to the so called sandwich generation (i.e. having caring responsibilities both towards the young and towards the frail elderly) are a substantial proportion in our sample. This is in partial contrast with the thesis of those who argue that the experience of being "sandwiched" is comparatively rare, since child care and elderly care needs emerge in different stages of the life cycle (e.g. Barkholdt and Lasch 2004, Künemund 2006). This contrast however is more apparent than real, since we do not focus generically on carers for the elderly, but on working age carers, who are likely to have still pre-adolescent and adolescent children in the household. Some of the children have been experiencing their parent(s)' caring for one or more grandparent since quite young.

⁸ In one case, the care giver has deliberately not applied for statutory care allowance because of his previous experience with his father, who had received professional full time care assistance with Pflegestufe 3. The main carer says that his father was "cared to death", since he did not have to move or to do anything on his own anymore, which made him become ever more dependent on care and feel "useless". In the second case, application for care allowance has been made for a second time at the end of 2007, but not yet decided on. "Pflegestufe 1" is expected.

⁹ Services have the complete list of those receiving the long term insurance benefit, not only of those who opt for services instead of receiving it cash. Yet, it is likely that services contacted mainly respondents with whom they have some kind of regular interaction.

Table 1: Overview of sample characteristics

Category	Number of interviews
Place of residence	
Berlin (urban)	18
Brandenburg (rural)	8
Gender	
Women	21
Men	5
Relationship to the care dependent person	
Daughter - father	4
Daughter - mother	13
Daughter-in-law - Mother-in-law	3
Son-father	-
Son-mother	5
Granddaughter-grandmother	1
Carer lives	
alone	5
Alone with care dependent person	5
With partner	2
With partner and care dependent person	2
With partner and child/ren	4
With partner,child/ren and care dependent person	2
With children no partner	1
With children, care dependent person, no partner	4
Working time of main carer	
High (full-time)	15
Intermediary (30-35 hours/week)	6
Low (<30 hours/week)	5
Sector of employment of main carer*	
Private	10
Public	10
Self-employed	5
Other (job creation measure)	1
Level of education of main carer (Number in brackets with apprenticeship)	
Tertiary education	12
Still completing tertiary education	1 (1)
Upper secondary education	3 (2)
Lower/medium secondary education	10 (10)
Care level of cared for person (Pflegestufe)	
No (Pflegestufe 0) *	2 (8 %)
Pflegestufe 1 – care demand min. 90 min a day	6 (23 %)
Pflegestufe 2 – care demand min. 3 hours a day	15 (58 %)
Pflegestufe 3 – care demand min. 5 hours a day	3 (12 %)
* In one case the cared for person is not classified in a “Pflegestufe” as the result of a deliberate decision by the main carer. According to the description of the need for care, the care level would most likely be “Pflegestufe 1”. In the second case, application for care allowance had been made for the second time at the end of 2007, but had not yet been decided on. Care level 1 is expected.	

The occupational status ranges from executive and/or managerial positions to skilled manual work, which only partly overlaps with diversity in level of education. Six care givers do not work in the field they are trained for; four of them – all women – accepted a position with a lower qualification level. One of them has recently given up her job, because of caring responsibilities. One respondent, again a woman, has a so called mini-job, or “1-Euro-Job”¹⁰ – a job creation measure addressed to the unemployed receiving social assistance. Five respondents are self-employed. There are two respondents who hold two jobs and two who are in training or studying on top of their working and caring responsibilities.

There is also a good diversity in terms of the sector of employment as well as of the occupational status. There is, however, a bias in favour of persons working in the public sector. Seven of the interviewees hold a job related to the care sector, either as nurses, professional care givers or in the administration of care services. Working in the care sector might result in a better knowledge about the availability and organization of specific care services and lead to a higher use of services (Jegermalm 2005).

Overall, the distribution of our sample with regard to working hours is quite close to that found in the Infratest survey in 2002 and in the Mikrozensus data of 2005 presented above. In both studies as well as in our sample, around 60 percent of (main) care givers work full-time and around 40 per cent part time. Hours range from 20 to 50-60 per week. Also with regard to the weekly distribution of working time, we have a wide diversity in our sample, ranging from fixed, regular working time to shift work, flex-time, and work on demand.

4. Patterns of care and work arrangements

4.1 Care packages

Caring for an elderly is almost always a combination and collaboration of different care givers, both informal and formal (Lewis 1998, Anttonen, et al. 2003). The composition of the care arrangements may differ with respect both to the number of involved persons and to the division of care work between informal and professional support. The structure of the care arrangement depends on the availability and willingness of other family carers, the financial opportunities to pay for care support and the amount of time the care dependent person needs for additional support apart from the main carer’s contribution. One decisive decision concerns how to use the statutory care allowance: in cash, in kind or as a combination of both. As we saw above, most of the care dependent persons and their carers in our sample opt for some service provision, sometimes in combination with cash benefits. In 11 cases, statutory service provision is topped up by an extensive use of a day care centre financed either by private means (usually the care dependent person’s pension) or, in the case of low income recipients, by social assistance. In no case the respondent is the only care provider; and in three cases out of four, the main carer is supported both by other family members or friends and by professional services.

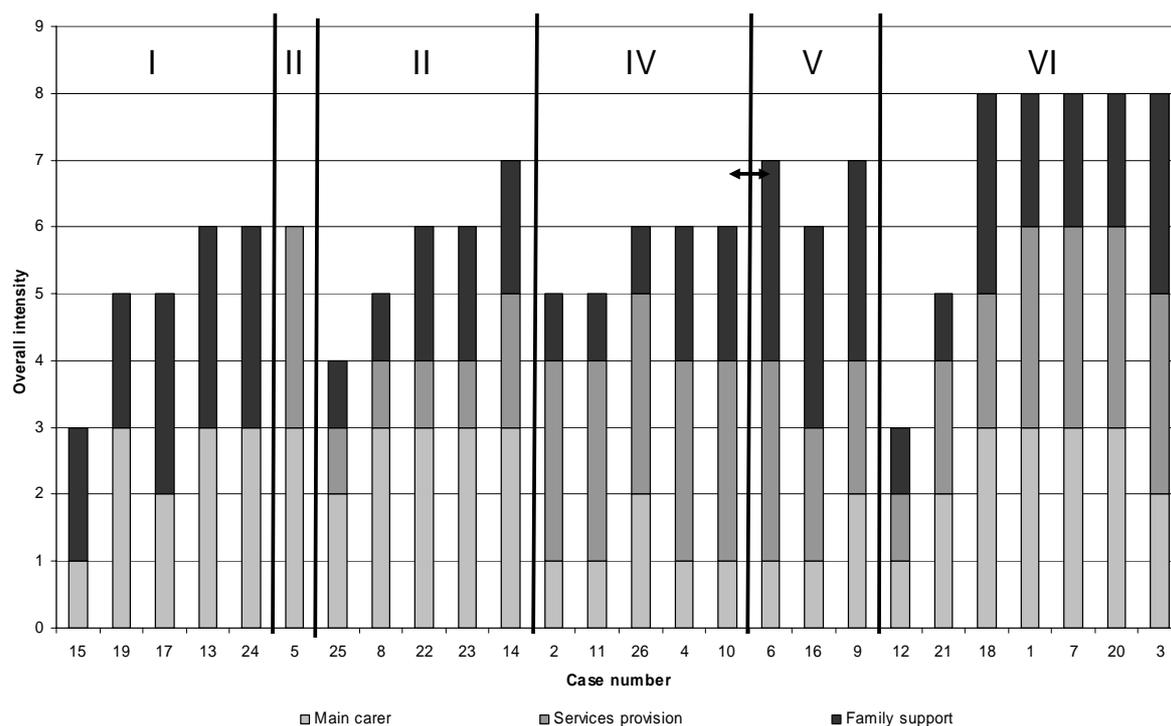
¹⁰ A “1-Euro-Job” is not based on an employment contract. Persons taking part in this measure receive social assistance and must perform some work which is paid one Euro per hour.

Six different patterns of combination of formal and informal support may be detected depending on the relative weight of one of the components (see *table 2*). But between and within these groups the care provided by each of the component of the overall package, including the main care giver, may be quite different, as shown in *figure 4*.

Table 2 Types of care arrangements

Type	Characteristics	N	%
I No service provision	Care is shared between main carer and other informal providers	5	19
II No informal care provision	Care work is only shared between main carer and care services	1	4
III Main carer dominates	Most of the support is given by the main carer, but informal and professional care is also used	5	19
IV Service provision dominates	Care services provide most of the support, but informal care is also given	5	19
V Other informal sources dominate	Family and other informal support is highest with lower support from main carer and services	3	12
VI Shared support	Substantial care contribution of main carer, informal support and service support, at least two agents provide same amount of support.	7	27
		26	100

Figure 4. Intensity of care by providers and by type of arrangement



Notes: Levels of intensity are defined as follows:

Main carer: High: 5 hours or more per day, intermediary: 3-5 hours a day, low: less than 3 hours a day

Informal support: Same time thresholds as for the main carer, but based on estimates, in particular when several family members or friends provide support. The availability of an emergency assistance or vacation replacement is considered in addition.

Service support: high: More than the standard service covered by the insurance, which includes domiciliary care two to three times a day for a maximum of two hours a day (*Pflegestufe 2*). This includes for example regular attendance to a day care centre; intermediate: the standard domiciliary care support; low: less than the standard domiciliary care support, e.g. only a home helper a few hours a week up to no service provision at all.

The pattern of shared support (sixth group) seems not only the better balanced among the different components, but also that which offers an overall larger coverage in terms of time. Only in one case falling in this group there is overall low time coverage. It is the case where no *Pflegestufe* has been yet assigned. Thus services must be fully paid out of the mother's pension. The carer, who is trying to re-enter the labour market and is involved in re-training and in a 1 euro job, feels that the caring burden has unjustly fallen over her and resists being too involved.

That I should take over the caring responsibilities is not considered from the beginning. I have to deal with my own job career and also my sister thought about, whether she could take my mother in her house, but finally decided that it does not work. She would be overburdened and would be buggered. And I won't do it, too. I would not dare to [spend] day and night with such a person who is very ill and centres around herself while talking. That would be terrible. (Monika)

Spouses and cohabiting children, when present, are the first persons to be directly involved in the caring arrangements, not only because they must share the carer's time with the care dependent person, but because usually they provide part of the care themselves, particularly if

the care dependent person lives in the same household. Given the gender composition of the sample (and of care givers in general), spouses are mainly husbands. We have both cases of husbands who do not help at all (and in one case even left the marriage because he did not approve of, or bear, his wife's intensive caring for her mother) and of husbands who share care equally with the "main" care giver. Symmetrically, men as main carers may count on the help of their wives, if they have one. In one case, this help continues even after the end of marriage. In another, instead, the wife handed over to her husband her caring role because of very tense conflicts with her mother in law whom she was caring for.

The main care givers often recruit their own children to help with care. In addition to the granddaughter interviewed as the main carer, in 12 of overall 19 interviews in which grandchildren are mentioned, at least one of them provides some assistance, particularly if the care dependent person lives in the same household, or very near. Grandchildren are usually not involved directly in physical care, but supervise and keep company to their frail grandparent during the absence of the main care giver; or do some housework for the care dependent person. Only the children of main carers seem however to be involved.

Siblings and siblings-in-law, if present, are the second important pillar of family support. Their different contribution depends on proximity, but also on the degree of siblings' solidarity. Contributions by different siblings may be unbalanced; yet, in many care arrangements all siblings are willing to provide at least some support. In two interviews, the main carer depicts that at the beginning the 'family council' met to discuss about the care arrangement and how the caring responsibilities should be distributed between the family members. Frederike, 43, who cares for her mother-in-law, explains how the care arrangement developed:

That is hard to say in our case, because we have decided on the care arrangement as a family. Basically five to six persons are caring. My brother-in-law, who lives in the house, did of course the support during the evening and night massively. Apart from that, we had arranged our fixed care days so that everyone could deal adequately with his or her private life and the child care responsibilities. I have mentioned that one brother-in-law has three children.

In other cases, however, siblings extricate themselves from the caring obligation either explicitly, as when they argue that they cannot provide care because of their high work load elsewhere, or silently, as when they just reduce the contacts and do not feel responsible any more. There are five cases in which quarrels with siblings about the division of care work are mentioned. In two of them, following these conflicts, there is no contact between the siblings any more. Peter, 59 years old, a master crafts man working full-time, who took over the care responsibility from his wife because she has quarrels with his mother, complains:

You could ask about my brother. He does not do anything. There is no response and I cannot consider his situation; he also does not consider mine. In fact, he is not available. Hence I have to rely on myself.

Other relatives, friends or neighbours do not play an important role in the care arrangements, although neighbours appear to be important for occasional help in case of emergency, or to check that the care arrangement runs smoothly: that the care worker comes when expected, the other daughter calls in and so forth. Their position is in the background of the care arrangement.

The amount of service support depends more on the income situation of the care dependent person and/or his/her carer than on the length of the carer's working hours. The statutory care allowance is sufficient to cover short daily visits from a domiciliary care service, typically in the morning to help a person to get up, get dressed, and have breakfast, at lunch time and sometime, depending on the care level, in the evening for supper and to put the person to bed. These short-time visits clearly do not cover the care demands of a person who is severely incapacitated, physically or mentally. Also when services are provided out of the insurance, they never cover the full day and every working day (and never nights and weekends). Further service support during the time the main care giver is at the work place – which can be “bought” from the services themselves or on the market – is quite expensive, particularly in the case of day care centres, which cost between 60-80 euros a day, or the employment of home helpers during the day and/or at night. In all cases, the additional amount – ranging between about 600 and 3000 euros a month in our sample – is primarily paid by the pension income of the person in need of care. In two cases, the service costs exceed the income of the frail elderly parent. In this case, a special social assistance scheme (*Hilfen zur Pflege*) covers the additional costs.

In the German system, care dependent persons with individual low income may in principle have access to higher than statutory service provision. If the income situation of the whole household and even extended family is poor, however, claiming social assistance in order to pay additional service provision, and even using basic services instead of claiming the cash benefit, is not always a viable alternative. Both the pension income of the person in need of care and the cash benefit of the statutory long-term care insurance are necessary to make ends meet. Thus all, or most, care must be provided by the family itself. This is not admitted frankly by the respondents, but rather indicated by the income composition of the household. In at least three of the five cases where there is no service provision, the income of the main care giver and her partner are close to subsistence level and the care dependent's pension and cash benefit improve the household income substantially. The “choice” in favour of cash benefit instead of services, or of taking less service time than allowed in order to have a quota of the insurance in cash, is inevitable.¹¹ The point is most clearly addressed by Hedwig, 56,

¹¹ We find precarious income situations more often in the interviews from rural Brandenburg than in Berlin. The economic conditions in that region are worse, because the ongoing social and economic transformation process after the fall of the wall is accompanied by high unemployment rates and low wages. Older employees, in particular, face a difficult situation once they have lost their job because they can hardly find a new job. But we should also keep in mind the different sample selection in the two areas we mentioned above. It is possible that because of that selection mechanism, which brought to a high incidence of people using cash, rather than service benefits in Brandenburg and a high incidence of users of day care services in Berlin, there is an over-representation of low income households in the former area and an over-representation of higher income households in the latter.

who is working as a teacher on a long part-time contract. Her husband is unemployed. She explained:

He [husband] should apply for Hartz IV [reformed social assistant measure]. But we did not do this, because we had saved quite a lot of money which we first have to spend [before he is entitled to benefits]. Then we have said “We care for mother, so we take from her pension to make a living and then get along somehow”.

In remaining two cases where care is divided between the main carer and other informal, mostly family, help, services are not used either because the care dependent person does not accept strangers, or because the carer does not evaluate the action of services positively. These are also cases where the level of dependency is relatively low (Pflegestufe 1). Nora, 42 years old, cares for her mother in her own household. She works long full-time hours and her husband also has a full-time job. The care work is concentrated on the nuclear family. Nora and her husband share the care work and their son also helps. There is no contact to Nora’s brother, who lives far away. Asked by the interviewer why she has not engaged any service, Nora reasons:

Because we are sufficient people and we could do that, and because we do not want to have a care service here. My mother does not want any stranger in the house.

In one case, both the dependency evaluation and the use of services is refused out of fear that it would accelerate the frail elderly’s dependency. Andreas, a former social worker, divorced, refused care service support because of a negative experience with his father. When his mother started to need care as well, because of physical impairment and a beginning of dementia, he took the deliberate decision to rely only on care provision by family and friends (whom are partly paid) and a private nurse:

She should keep grounded. She is not a case for nursing care. She should stand her ground (accentuate). She does the dishes and arranges the household, has her kind of work. It is important that she has something to do.

But in the meantime he has had to give up his job because of his caring responsibilities, lives with his mother and shares her pension.

Services, when used, do not seem to crowd out family care provision, but rather fill the care gaps. In the cases in which the main carer’s family network is reduced, they may be the only alternative either to the main carer’s own caring or to institutionalisation. It is, for instance, the case of Esther, who cares alone for her father. She has no partner and no siblings. She takes her father to a day care centre while she is working and engages some semi-professional help if she wants to go out. In all other cases with high service support, there are also other family members present who provide help. Ute (56) from Berlin, who works full-time as a secretary, provides such an example. Her mother is in a day care centre five times a week (for which she pays 600 euros a month, in addition to the statutory care allowance) and a domi-

ciliary care service visits her twice a day. But Ute may also rely on a broad family support network. Her husband, her sons, her aunt, the mother-in-law of her son, and the ex-daughter-in-law are available to support her.

In 10 cases, informally paid workers are included in the overall care package. Three of them provide personal care; the others are engaged as home helpers, but also have the responsibility to look after the care dependent person if nobody else is present. Their presence varies from a few hours once a week to a substantial number of hours every day. None of them seems to be living in, even in the two cases in which they come everyday during the main carer's absence.¹²

Together with degree of need, a decisive factor is proximity. If the person in need of care lives in the same household or building, the average care intensity is higher and also caring tasks are differently defined. Ten of the 12 carers who live in the same household with the person in need of care provide at least five hours of care per day, while only one, a woman, devotes to care relatively little time. In this case, however, the unemployed husband seems to be actually the main care giver, or at least is always present. In contrast, in seven out of 10 cases where carer and cared for do not live in the same household or building,¹³ care provision is less than three hours a day. The higher care intensity in case of cohabitation is the result of two interacting processes. Firstly, in many cases cohabitation has been prompted by the intensity of needs of the care dependent person. Cohabiting care dependent parents are therefore on average more care dependent than non cohabiting ones. Secondly, once a parent moves in with a child, the other children tend to feel less responsible for care, or to define themselves as secondary carers, thus leaving the main bulk of care, in addition to its overall organization, to the cohabiting child (Tomassini, et al 2003, Haberkern and Szydlik 2008).

Care arrangements, however, are no static packages. They develop over time and go through different phases, both because people have to adjust to other demands and the caring puzzle must be rearranged, and because caring needs evolve (and mostly increase). For instance, Quendoline's mother was frail but living by herself for some years, under the responsibility of another daughter. But then the mother suffered apoplexy and was in the hospital for some time. When she was dismissed, she could no longer live by herself and no other daughter was willing to host her, for various reasons. Quendoline and her husband took her to their own home and took care of her for almost two years, when both her and their own health conditions worsened and they had to send the mother to a nursing home.

In the majority of interviews (21), care givers evaluate the care arrangement as stable. But in five of these 21 cases, care givers make clear that the care arrangement, and in particular their contribution to it, is at the limit. They see difficulties to cope with further care demands and think that the whole care arrangement will have to be rearranged in that case. In other eight of these "stable" care arrangements, the equilibrium has been achieved through a reduction in labour market participation. Furthermore, eight respondents mention that although the care

¹² According to estimates, there are between 100.000 and 200.000 informal paid carers in Germany (Kondratowicz 2005) often hired with no social security. They are mostly women coming from Eastern European countries.

¹³ In the remaining the cases the person cared for lives next door in a separate dwelling.

arrangement is stable, the person in need of care does not receive the care support he/she needs. We will further develop this aspect below.

In sum, only six of the care arrangements are perceived by the main carer as both stable and good, meaning that care provision is well organised and regular and neither the care giver nor the person cared for seem to experience considerable disadvantages. In all of these care arrangements, in addition to the contribution of the main care giver, a high amount of care is provided by other family members and/or services.

Considering the future, all main care givers expect an increasing care demand, which will require some adaptation in the overall arrangement. Particularly those who feel “at the limit” anticipate a restructuring of the whole care arrangement, which might either result in reduced labour market participation by the main care giver or institutionalised care for the dependent person. Other respondents expect that they will have to change something, but do not foresee major re-arrangements. Only one (male) carer, on the contrary, thinks that the caring time required from him will actually decrease. The care needs seem to be rather stable at least in medium time terms, but his ability to cope with care tasks has increased. It is easier for him to provide care at present than at the beginning.

A care giver, whose frail mother in law died some months before the interview, described the “caring arrangement career” as U-curve shaped. She described the development starting with a crisis, when the mother-in-law started needing substantial care and everything had to be organised, followed by a phase of stable care provision with a well arranged division of care tasks between services and family members. Only in the last two months before her mother in law died, the care arrangement became fragile again, because of frequent crises and the mental burden in coping with the death of the mother-in-law.

4.2 Combining caring time with paid working time

In the sample, we find quite heterogeneous combinations of work and care loads, with a tendency of high demands in both areas (see *table 3*). Overall 23 interviewees (88 %) experience either high care intensity (more than five hours a day on average) or have full-time jobs. In five cases, they experience both – high care intensity and full time employment. Although we are aware that we might have not been able to include carers with the highest time pressures because they might not have been able to arrange an interview, we are confident that our sample includes a substantial quota of respondents for whom the reconciliation of job and care demands poses a substantial challenge.

Table 3: Care frequency and working time of main carers in the sample

Care intensity of main carer				
Working time of main carer	Low <3 hours a day	Intermediary 3-5 hours a day	High >5 hours a day	Total
Part time (20-30 h / week)	0 (0.0 %)	2 (8 %)	1 (4 %)	3 (12 %)
Long part-time (30-35 h / week)	3 (12 %)	3 (12 %)	4 (15 %)	10 (38 %)
Full-time (35 h/week and more)	5 (19 %)	3 (12 %)	5 (19 %)	13 (50 %)
Total	8 (31 %)	8 (31 %)	10 (38 %)	26 (100 %)

Atypical working hours are reported by 14 interviewees (54 %). Most of them have to work on weekends once or twice a month, or have long full-time working hours adding up to 50-60 hours per week. Two respondents work often late; but nobody takes over night shifts or periodically changing shift work. One self-employed carer works as an artist on demand and has to rearrange her working schedule almost weekly. Most of her performances are however in the evening hours, when her husband is at home and takes over care responsibilities. It should be noticed that non-standard working times are not experienced as a disadvantage. In contrast, starting work very early in the morning, working on weekends with the consequence of having one or two days off during the week, or working in the evening are welcomed and even have been agreed upon with the employer. In the first place, some caring tasks have to be done during the standard opening hours of offices, hospitals or medical practitioners. Having at least one morning off during the week, or coming back from work early in the afternoon eases the organisation of care work. Britta, 49 years, welfare worker in a youth centre, who works late shifts, for example said that her job has the advantage that it starts quite late, so she may do a lot of things for her mother during the morning. In the second place, in care arrangement with high involvement of other family members, care provision may be shared in a way that each family member takes over specific time slots for caring according to his/her working time. Such flexible arrangements may however put pressure on family relations, because there is less time for contact and common activities of the family members, particularly if this arrangement involves other household members, and not kin living apart. Spouses and parents and children may see very little of each other while taking their caring shifts and working or being in school.

Working time and arrangements may be considered a fixed, rigid, item in the caring arrangement, or on the contrary be adapted to the caring arrangement itself.¹⁴ This depends on the

¹⁴ According to a German survey in 1992, eight percent of men and 16 percent of women who became care givers had given up their job (Beck, et al. 1997).

negotiation resources and possibility of the worker, on his/her economic resources, on the work setting, on the options available, but also on the way the carer sets her/his priorities and own needs. Some reduce contractually their paid working time; others limit, or drastically eliminate, their availability to work overtime. Overall, 10 of the care givers in our sample have rearranged or reduced their working time, or were not able to increase it when this would have been good for their career or to pursue their professional interests. On the contrary, three carers state that they would have liked to reduce their working time in order to better face their caring obligations, but could not afford doing it on financial grounds.

In particular, six care givers state that they have reduced their working time in order to combine caring working and employment. Two of them report a rather marginal reduction of around five hours a week. For the other four the reduction was substantial. One male care giver, Ralf, who is caring for his mother and working as an unskilled worker in a carpentry, reduced his working time from full-time to 20 hours per week. Christina, 50 years, caring for her mother-in-law, changed her job arrangement totally. She gave up her full-time job as a physicist and became self-employed as an artist on a part time basis to be more flexible in organising job and care tasks, as a part of a caring arrangement where multiple formal and informal resources are balanced to offer a high coverage. Bettina, 46 years, who works as a shop assistant, has a university degree. She was a self-employed researcher before she started caring for her mother who has been allocated care level 2, is massively overweight, has serious problems of diabetes and incontinence, and lives with her (no services are present, but her siblings give her a hand with the mother).

Yes, I would prefer to work in the job I am trained for, [...] Of course, I miss it much. Not being able to work in the profession that I actually love. Also it is a great sacrifice that I have to work here [current job]. It is indeed nice, but it does not require the energy, I would have, to do something good.

At present her financial situation is not too bad because she combines her low wages with her mother's pension and long term insurance benefit. But she fears that if the caring responsibilities will last long she might be too old for a re-entry in her previous profession.

Andreas, who lives in East Berlin and until now has refused any institutional help for his mother, has lost his job also because of problems linked to his caring responsibilities (stress, lack of concentration and therefore making mistakes). He is now looking for a new job, but knows that it will have to accommodate his caring responsibilities. There is another unemployed man in our sample, the husband of a main carer, who is currently unemployed and justifies his not looking for a job because of the care needs of his mother in law. It is not clear, however, to what degree this caring role offers him a more valuable justification to being unemployed than the difficulties met by any low educated mature age male in finding a job in the Brandenburg labour market.

Three care givers would like to do more on their job, but cannot, because of caring obligations. In two of these cases, the carers would like to invest more time in their present job. In the third case, the inability to invest more time because of caring clearly limits her career prospects. She had to refuse a professionally and financially interesting job offer.

In the remaining 16 cases, respondents, including five who have long working hours, did not change their working time because of caring obligations, but keep a tight control on it. Johanna, 44 years, working full-time (with a caring arrangement dominated by informal paid and unpaid resources) explained:

Yes-no, I could work overtime, but I do not; because I would not cope with everything. I just get by with my tasks that I have a more or less balanced work time account at the end of the month. I would not manage to work more.

Esther, who works as a clerk on a part time contract four days a week, and can count only on herself and services to deal with caring responsibilities, rearranged her working time to fit the opening hours of the day care centre.

Only Frederike (43), who has a managerial position in a large company, said that she extended her working time during the caring period, because of a job promotion. It is an exceptional case, however, in so far it includes the highest use of services in the sample, together with a substantial presence of other family care providers (caring arrangements of the fifth type in fig 4). Her actual caring load is comparatively reduced, although she keeps the responsibility for the overall organization of the caring arrangement.

Job conditions, financial necessity, as well as preferences play a role on the degree to which carers perceive that they could accommodate their engagement in work to caring demands, if needed. Inflexible work arrangements, combined with the fear to lose the job and the need of income to maintain a living, limit the opportunities to provide more care although the care giver would like to do so. The fact that carers consider it as very difficult to find another job if they are fired, or once they drop out of the labour market at their age, is a very important reason. For Esther, temporarily leaving her job is just unthinkable:

My god, that [quitting the job] is suicide (laughs). I would never have the chance to re-enter into my job. It would mean to be knocked-off work for ever.

5. Tensions and resources in conciliating paid work and care

5.1 In the care arrangements

There are at least two aspects mentioned by the respondents which are relevant for the overall care arrangement: the smoothness and reliability of caring arrangements and the emotional climate of caring itself.

The arrangement must be seamless, all phases running smoothly one after another, with no accidents. This need concerns in particular frail elderly people suffering from dementia or having problems to move and who therefore are in danger of falling, but in general all those who must be left alone for some hours in between different forms of caring provision. Ute, 56 years, full-time employed as a secretary, caring for her mother with dementia and arthrosis, although she has one of the best balanced and longest caring arrangements, expresses her feeling of anxiety:

... it is more that I am anxious, if it is evening. She [mother] is brought back [from the day care centre] at around 6 pm and if I have pressure at the work place and realise that I am late today...I may leave her alone without bad conscience for one or two hours maximum. But if it is getting longer, then I become nervous, because I am afraid, because often something happens at home.

Accidents and unpredictability are the more or less conscious companions of all care arrangements: the cared for person turns ill, and cannot attend the day care centre, or needs extra presence by the care giver; the family care giver gets ill and cannot perform her daily routine; the day care centre closes down for a strike; the home carer for some reason does not show up – and so forth. In our sample, these accidents seem to be more a constant worry of the carers as an always open possibility than systematically recurrent events. But they require re-arrangement, a “plan 2” to fall back on: the possibility to take a day off from work at short notice, relatives or friends who are able and willing to fill in. Having a support network which provides not only general, but also emergency support and constitutes a reserve for various kinds of emergencies helps not only to lighten the everyday caring work, but also the psychological stress of constant worry and of difficult re-arrangements. In our sample, those who, irrespective of the care needs, can count less, or not at all, on such a network, while they experience continuous disruptions in their arrangement, are vulnerable to feelings of high pressure. It is the case of Bettina (46). The “normal” care arrangement is so frequently disrupted by various incidents that the carer feels that she cannot concentrate at work because of a constant worry that something might go wrong. Asked by the interviewer how often she thinks about her mother when she is at work, she said:

Well, the whole time. Is everything fine? Is she falling? Is she scalding? Is she doing something that she should not do or does she forget to turn the cooker off? I get into trouble, because she calls me at the work place, for example, because something happens. My supervisor does not like this, of course.

Dorothe, 44 years old, expresses the same feeling with regard to her mother who lives by herself, attends a day care center and is regularly visited by care workers:

.... I have to run after her all the time, so that everything is functioning well (accentuate). Currently I feel extremely pressured with this care arrangement, because I do not have some peace and quiet. Oh, has it worked out that she had dressed herself or did she walk around with the wrong clothes and does it work out as it should?

As we mentioned, there is no clear evidence of lack of necessary care in our sample. Instances of actually deficient care are never addressed explicitly in the interviews, but are hinted to in side notes. The only instance in which a possible danger might be detected concerns an arrangement which is not defined as stable, but as a provisional, forced one, while waiting that the care dependent person be assigned a care level, The care giver first told the interviewer that her sister had discovered that their mother, who lives alone, walks around during the night and risks therefore accidents. Then, later on, explaining how she defended herself from

the constant telephone calls of her mother who calls at all times just to chat, she said that she pulled out the telephone jack during the night, in order not to be disturbed.

In other 11 interviews, we find evidence that the person cared for spends a lot of time alone. They concern mostly cases of no or only basic use of services. In one case, the carer puts the dependent person – who is unable to move alone - back to bed after breakfast, leaving her there unattended until the early afternoon when she comes back from work. In other cases, care dependent persons who are physically mobile, but fragile, or with some kind of mental deficiency, are left alone for many hours, with the risk that they are found late if they hurt themselves, or get lost because they wander around. Tanja, 58 years old, who is self employed on a full-time basis as a commercial agent, describes such a situation:

I would say, it would be nice, if somebody would be always there, but that is simply not possible. It is too time demanding. You have always to organise things so that she [mother] has something to do. If nobody is around and she is alone at home and the sun is shining, then she would go outside, she would do this. Then something idiotic happens. She goes upstairs, falls down and so on ... In fact, somebody has to be with her.

The risk of accidents if the person in need of care stays alone is mentioned by five respondents. One example gives a good indication of how complex the situation could be. The mother of Petra is doing relatively well (care level 1). She is able to stay alone most time of the day, but she cannot manage the household any more. No service is used. Petra, 44 years old, reports:

She [mother] shocked me, because we said: We do not have the time to clean all windows before Easter, we will finish them before Pentecost. Then my mother calls me and says: "I have cleaned the windows." Well, I am entering a state of crisis because I know, she cannot stay safe on the ladder. And if she falls?

In other cases, the main carer is afraid that the care dependent person lacks enough stimuli and relationships, therefore further deteriorating. It is a concern expressed, for instance, by Johanna, caring together with her former husband for her mother in law, who also attends a day care center twice a week. The mother-in-law has Alzheimer and suffers from serious osteoporosis. Johanna worries that her mother in law sleeps too much during the day, just out of sheer boredom. Also Silvia, whose caring arrangement relies only on informal help, complains that she has no time to spend with her father after she has finished with the material caring. She can never take him outside:

When? We do not have the chance. We would be eager to take him outside with a wheelchair. Ok, the weather does not allow that at the moment. I ask myself, when summer comes, when might we do this? How and when?

Even working at home or being able to take the care dependent person at work may not fully solve the conflicting demands of work and care, as well as the conflicting loyalties experienced by the carers. Ines, 60 years old, self employed as an art teacher and artist, reports that she always feels guilty when she works at home and knows that her mother is next door unat-

tended. A somewhat dramatic example of what may happen is offered by Monika, who on Sundays works in the park and takes her mother with her there. Most of the time, her mother enjoys the change. But danger is always present:

On Sundays there are many visitors and I am happy that my mother keeps herself busy. It happens that she is sometimes unattended and there was a situation once when I misjudged what was going to happen. She [mother] misunderstood me and thought that I would go home in a moment although I am the last one who closes [the doors]. She did not understand it correctly. She has a sign language. I was upstairs, she downstairs, and somehow she understood that I would go and she should follow. And then she disappeared in the forest and I have searched for her several hours and informed the police and somebody had found her.

In sum, there are at least nine cases (35 %) in which the high work load from employment but also in managing other tasks, together with the insufficient support received from services or other family members, has a negative impact on the adequacy of the overall care provided. In three cases of difficulties experienced in balancing everything, carers considered the possibility to move the care dependent person to residential care or assisted living. In two of these cases, however, the person in need of care has strongly resisted, or is still resisting, this solution. This has caused severe conflicts between the carer and the person cared for and an overall deterioration of their relationship, thus possibly also deteriorating the quality of life of the care dependent person. The care giver who has already taken her mother into a nursing home has broken the relationship completely, because she cannot cope with her mother's reproaches.

Another aspect which may increase, or on the contrary lighten tensions in the caring arrangement is the quality of the relationship between the care giver and the care dependent person. Again, persons suffering from dementia are at risk of getting angry, insulting, anxious, and distrustful. But there may also be a long history of distrust and conflict, previous to the time when caring demands arose. In two care arrangements of our sample, this has led to a total break of the ties between the main carer and person in need of care. Peter (59), for example, who cares for his mother, had to take over the caring tasks from his wife because his mother distrusts the latter and has tried to break the marriage.

She [mother] does not get along with my wife. She has accused me to cheat with my partner. In written form she had informed my relatives about this. *Wife*: This happened already in our younger days. I was never ... the daughter in law; but now since dementia has started it is really bad. I went to the burial of my own mother; she [mother-in-law] has written a letter to my father and his present wife that her son cheats on me with another woman, when I am away from home. Because my father identified her handwriting they drew their own conclusion. But for me it was the point to say: "No, I will not care for her any more."

On the contrary, good relationships may offer a high motivation for care giving. In the sample, 14 interviewees – 13 women and one man – mention that they have a close relationship with the person in need of care and these strong bonds often account for the decision to be the

main carer. Most impressing is the opinion of a daughter-in-law, who divorced from her husband, but still shares with him the care work for her former mother-in-law. She explains:

Everything may be done, if the person who is in need of care accepts it and has a good relation with the carer. And she [ex-mother-in-law] is a lovely, tiny cutie, therefore it is a convenient task, beside all adversity and burdens, I have. But it is nice to do something for her and I recognize that she likes it and that she acknowledges the care work and appreciates all the things I do for her. That is in general very positive.

5.2. At the work place

Only a minority of care givers mentioned a negative impact on their regular job demands after having found a balance between paid work and care. The most often mentioned problems are difficulties to concentrate, because either the care giver feels responsible for the person in need of care even during the time he or she is at the work place, or because of a lack of sleep and rest. Nine of the 25 interviewees mentioned that they keep thinking of the person cared for during their job. Six said that this constant concern risks weakening their ability to perform well. Britta, 49 years, a welfare worker who cares for her mother, asked whether she has difficulties to concentrate because of the caring responsibilities, answered:

Yes, quite often. Yes [caring obligations] have an impact on my concentration when I must help with homework or do other things with the children. They ask me something and I listen to it, but I do not register [the content].

Problems in concentration at the work place are less frequent when the person in need of care does not stay alone while the main carer is at the work place. Several respondents whose care dependent person is in day care or otherwise supervised by somebody else have declared that they feel relatively relaxed. They know that the dependent person is not on her/his own and that somebody would call in case of an emergency. This makes it easier for them to separate care and job demands.

Stress from overburdening may result not only in lack of attention or worries. It can also emerge as a general weakening of an individual's capacity for resilience. A care giver, for instance, mentioned explicitly that she is not that resilient any more and this affects the number of sick days she has to take. There is evidence that this problem is more prevalent than actually mentioned by the respondents. Several care givers, in fact, state that they are exhausted and unable to do more, or that they experience a negative impact on their health, which in turn might increase the number of sick days they take.

Negotiation with employers and supervisors over working schedules are a widespread and sometime conflict-ridden experience. The supervisor of Bettina, a 46 years old woman who takes care of her mother and works in a shop, has accepted only reluctantly her rearrangement of working time following her care obligations. She also keeps hinting that Bettina might no longer be able to perform well in her job: "there is always the critique: »Well, are you still

good for this job here?«”. This hidden threat, of course, renders her insecure concerning her job tenure while de facto deterring her from asking any further allowance and understanding. Fear of losing her job because of her employer’s lack of acceptance of her caring responsibilities are so strong for Quendoline, who works full-time as a cleaner, that she has not informed her boss and her colleagues of her situation. Rather, she has organized the caring arrangements around her work schedule, counting on the fact that her unemployed partner is mostly at home with her care dependent mother.

Yet, in most cases, the agreement reached is perceived as relatively satisfactory. Fifteen of all care givers may make use of – either informal or formal – flexible work time regulations to organize and distribute their working time over the day or week, in a way that fits with their caring responsibilities. Carers with rigid working schedules complain more often than those with more flexible ones of conciliating problems, particularly if they do not have a support network to fall back on.

Working over-time is problematic, in particular if it is unpredictable in advance. Generally, services are not flexible enough to react to short-time demands. If a carer has to work over-time on a regular basis, she usually organizes informal care support to fill in her missing presence. But in at least two interviews, the respondent said that in case of over-time the person in need of care has to stay alone and there is the risk of accidents.

In case of emergency in the caring situation, carers apparently have no problem in taking time off if needed, although they handle such situations in quite different ways. In none of the cases we found a formal right to take some days off; or at least there seems to be no knowledge about employees’ rights.¹⁵ But employees often said that their supervisor is sympathetic, although sometimes reluctant, in such situations. If in the company there are working time accounts, or working tasks may be arranged flexibly, time out for caring may be made up later on. If working tasks and working time regulation are rather inflexible, the care giver has to take days off. In one case at least, the only flexibility available is that of making use of own annual vacation time. Ute, 56 years old, a full-time employed secretary, explains that in order to take her mother to the doctor:

Well, I take my leave days. Last year I have divided my annual leave so that I could take one or two days off each month to go with her [mother] to the doctor because I can’t arrange it within my full-time job.

As a consequence, she has no time for holidays left.

Self employed carers have sometimes more problems, because they work on their own account and have to deal with negative business impact in case they cancel appointments. Tanja (58), who works as a commercial agent for an insurance company on a self-employed basis, describes her job situation:

¹⁵ In the public sector, there should be the opportunity to take some days off every year if a close family member (not only a child) is in need of care. But none of the care givers hired in the public sector mentioned this possibility or had used it. We were surprised that none of the care givers had been informed about the possibilities which might be available at their workplace. Many answered that they had not even asked for what was available.

I reduce it [attending trainings on the job] and I do have problems in the company, because they do not accept it, that someone does not participate at their seminars. But it does not make any difference for me at all, whether they accept or not. That's my energy, which I have to arrange, so that some is left for everyone.

If the care giver has a job in which he or she is indispensable, she has always a fall-back solution, in which either services or another informal carer may step in and take over care responsibilities.

Carers experience a reduction of their further training and career possibilities because of their responsibilities overload and time shortage. This is particularly felt by workers with high education and holding higher status jobs or by self employed, as well as by those in insecure jobs, who feel they would need further training in order to improve their chances in the labour market. Also part time workers perceive that this puts them at a disadvantage, both in their company and in the labour market in general. Esther (50), a bank employee who is working reduced hours because of caring for her father, reports that, although de jure job offers do not exclude part-time workers, de facto applicants in her company who are willing to work full-time are always preferred compared to part-time job candidates.

There are, however, carers who combine education, job promotion and care work. In our sample, there are two care givers who participate to trainings, although to a reduced extent, and one who has been promoted during the caring period. Wiebke, 45 years old, who has been trained as a nurse and now is studying medicine, said that she does not attend lectures in the morning because she has to care for her mother and to work in one of her two jobs. She tries to catch up the lectures; but she has to admit that it is a disadvantage and she hardly may keep pace with the other students.

A positive example is Frederike, 43 years old, who cares for her mother-in-law. She has been promoted as head of the department while she cared for her mother-in-law and this even though she works part time. Her case is an exception for two reasons, however. She works in the only enterprise we found in our study which highly acknowledges child care and elderly care responsibilities of the employees. The firm is going to be formally certified as a family friendly one.¹⁶ Informally, there is a high sensibility for reconciliation issues at least for employees in managerial positions, who should be motivated to stay in the company. In the second place, this care arrangement involves the highest use both of services and other family members in our sample. So much so, that we suspect that Friederike is not actually the main carer. Her brother-in-law, in fact, lives together with his mother about 35 km away from Friederike and her family. From what Friederike says, he seems to spend most of the time at home and be in charge of practical arrangements as well as of filling in most of the care not provided by home care services and by the home helper.

¹⁶ The certification is provided by the institute "berufundfamily gGmbH" which is funded by the Herthie-Stiftung and supported by the Ministry of family affairs (see: <http://www.beruf-und-familie.de/index.php?c=21>, access date 28.05.2008).

One should be aware that, whatever the constraints are, holding a job might represent an important psychological and social resource for carers. Earning money and being financially independent is an obvious reason for all care givers to be in a job. But only one carer states that she works only because she needs the money, otherwise she would quit her job. All other respondents think that having a job is also important beyond making money. There are two different lines of argumentation. In one, the care giver perceives employment as a way to gain recognition and self-respect and to be independent. This involves more than being able to fend for oneself. It has to do with obtaining a social status. In the other line of argumentation, carers emphasise the positive impact of their job on their caring role. Having a job and being in the workplace offers the chance to distance one from caring and family obligations. This is seen as necessary in two ways. First, it compensates for the lack of social contact and the little acknowledgement which is given to care work by society, but in some cases also by the family. Being employed gives the chance for social contacts and exchange, to enrich personal life. Second, it is a kind of distraction from the often emotionally demanding caring situation. Dorothe, 44 years old, said:

Yes, I have to do something else. *Interviewer: "Why?" Respondent: "This is for compensation (accentuates). Caring for my mother at home, that is too one-sided. There [at the workplace] you have other things in mind, have to do something different and there are challenges, mentally. You cannot be immersed always with your own life. And you recognise that there are other people who are also not doing so well or so."*

This role of paid work and of its social and physical context, as at the same time a socializing and a buffering place, is of particular importance. Many care givers, in fact, state that they have less time to spend with friends, or that their social contacts deteriorated because of their caring responsibilities. Social contacts at the workplace, either with colleagues or with customers might partially substitute for the declining social network. They might also compensate a reduced private life. In cases in which the person in need of care lives together with the carer and her family, employment can even become a kind of place for privacy, as Gesa, 50, who works for a caring agency, argues:

... I have to say it frankly. For me, it is very important [to work]. At the workplace I focus on my job, that is my field and I have my private life. There is no [care], it is not present. And for me it is very important (accentuates) that I live out in this field and not to be involved there [caring responsibilities] in any way. I did not do this with my children at that time, because being at the workplace is mine that belongs to me. (laughing).

At least five care givers stressed the importance of having a job as a valuable experience in itself, which should not be questioned, nor put at any risk. Peter, who is working full-time and acts mainly as a care manager for his mother who suffers from Alzheimer disease, denies to have made any change in his work arrangements because of his mother's caring demands.

I have to negate, because I think, that domiciliary care service and the day care centre have to manage the care demand (accentuate). In this respect, I would be egoistic, I would prioritise my job.

The other four respondents who reported a high work orientation are women.

The positive impact of one's job could be less attractive for family care givers who are also employed as professional carers. They do have the chance and benefit of professional exchanges about their caring situation and the burden they face. But it may be hard to deal with the problems of care dependency at work, even witnessing all the possible deteriorations, and then go home and do the same for one's own mother or father. This is mentioned by Dorothé, a professional care nurse.

Well, let me explain it like this. It is always a bit difficult, if you have a job in the care sector because you have frequent contact to patients suffering from dementia, that is very prevalent, and if you also have to care for a relative. Because of having visited in the morning several care dependent people, then it is difficult to care for one's own mother (accentuates) in the afternoon, because sometime you are quite overstrained.

6. Impact of working and caring on family relations

Our carers do not only have the dual obligations to care for a parent and work for pay. They also often have, or would like to have, their own families to care about: partners and children, either living with them or living elsewhere. The high time and attention pressure under which most our carers seem to live everyday is also partly a consequence of these other relationships and engagements, which require the carer's presence and attention. But it also interferes to a greater or lesser degree with these same relationships and engagements. We have already seen that partners and children, together with siblings, are often recruited in the caring arrangement. But we are now interested in focusing on the relationships themselves and how the main carer perceives that they are affected by her/his caring obligations.

6.1 Children

Children of caring parents have to deal with two crucial relations. On the one hand, they experience the high work load of their parents and they have to cope with the fact that their mothers or fathers, or both, often have less time for them not only because of working demands, but also because of intensive caring obligations. On the other hand, children have to deal with the experience of witnessing the frailty of a grandmother or grandfather, of often severely deteriorating physical and psychical conditions and death. Furthermore, children in our society are usually sheltered from the exposure to intimacy with adult bodies. In the case of a frail grandparent, instead, they may become involved, although mostly indirectly, even with the most unpleasant aspects of bodily manifestations. This occurs especially when the care dependent grandparent lives in the same household with grandchildren

Of course, children's age makes a difference, both in terms of their own needs for care, attention, supervision, and of the psychological and cognitive resources they have to deal with the situation. The youngest child in our sample is nine years old and there are other two children younger than 11. Eight older children, ranging from 12 to over 20, live together with the main carer. Some of the older children have been experiencing the care dependency of their grandparents for a long time. Christina, 50 years, with two children now 13 and 15 years old, said:

The children have grown up with it [care dependency of grandparents]. They were quite young at that time and actually they do not know a different situation. There was always one of the grandparents not in good conditions. They [the grandparents] have to be chaperoned and you have to care for them. Hence they know it since they were young.

Exposure to one's own parents' care giving and direct involvement in care giving while growing up may promote a greater awareness of the possibility that such needs may arise, as well as a greater willingness to take responsibility for them. Or on the contrary it may cause the development of attitudes of refusal. We have not interviewed the children of the main carers, nor do we have longitudinal data. Interestingly, however, some respondent explicitly argue that not only what they do as carers is highly valuable, but they hope to become a role model for their children in doing this. Other respondents refer that, although they do not necessarily expect the same contribution from their children if they themselves become frail,¹⁷ taking over caring responsibilities is a sign of a strong and cohesive family which should also rub off on their children. In that sense, caring for frail parents is not only an outcome of tight family relations; it also promotes family solidarity in the next generation. The most straightforward expression of this has been made by a granddaughter herself. Wiebke, 45 years old, separated, with two children, who is caring for her grandmother, said:

It [family life] is becoming more intense. Grandma gives more family sense. I had once a love relationship which broke up; afterwards it was a bit not like a family anymore, in particular for the children. But since grandma is here, it is like a small, intact family circle. And the children enjoy it very much. Nina [17 year old daughter] is always complaining, when I say "Take the trash out!" or "Today you have to care for grandma!" But the bottom line is that she is doing it and she also likes it. And the eldest [daughter] anyway, she is even more attached to grandma.

Care givers also mention the importance of an intergenerational transmission of values and of teaching children life lessons. Ralf, 57 years old, who has an eleven year old daughter, mentions explicitly that:

¹⁷ In all value and opinion surveys there is a general agreement across generations on the positive value of intergenerational solidarity and caring for one's own frail elderly parents. Interestingly, however, the older respondent agree less often than the younger ones with the statement that one should provide care for one's own frail elderly parent. Probably, this difference is due to the fact that older respondents have experienced more often the burden of this obligation and want to spare their children from this experience (see Keck and Blome 2008).

It makes her (his daughter) concretely understand how it can be in the old age. These things are actually not necessarily always nice experiences. But they are experiences which are important.

Although caring obligations could weld together the family, they may also be a burden, in particular for younger children. Over half (9) care givers with own children report a negative, impact. In five cases, the impact is mild. The care giver would like to have more time and contact with her children (and grandchildren); or the carer refers that her children would like to perform more activities, but have to make compromises because of the time restrictions due to the high work load of the parents. Hedwig (56), who cares for her mother in her own home, says:

You don't have so much time for each other [in the family] and the daughter has then always said: "We may never make a trip because of grandma." And it is true, it happens always.

In other four cases, the consequences seem to be more serious. There are two children with behavioural problems who would need special support by their parents', but the latter are unable to provide it because of the time constraints they have. Frederike, notwithstanding her relatively privileged working and caring arrangements, faced such a situation with her daughter.

... it [high time pressure] had an effect on my daughter. She shows a tendency to self-destruction, because she is very sensible. She started to cut her hair; then there was a period when she did not eat anything. Then she damaged my car with a stone (laughs) to call attention on her, because we didn't realise that we had suddenly very little time for her. And she suffers from the illness of her grandma and the experience how she is decaying.

In this case, the parents responded to the child's demands and reserved more time for her, so that the situation improved.

Neither behavioural problems nor psychological suffering are apparent in the case of the 11 year old son of Ayse. But he has to watch over his grandfather most of the time when his mother, who is the main carer, is at work. She has a full-time job as care nurse and works regularly also on weekends. The mother assesses the situation of her son as positive and praises how responsible her son is at that age. She also mentioned that her son acknowledges what she is doing. But in the end, it seems that the son has to spend most of his non-school time in the afternoon – when the grandfather is taken back from the day care center, and also on the weekends his mother works – to watch over his grandfather.

In order to avoid negative consequences on their children because of lack of time, many parents – particularly mothers – give priority to their children above spouses, rest, and social life. They reserve all their free time to their children (and to a lesser degree to their partner, if present). As a consequence, the wider social network dwindles, but relationships within the nuclear family and to the care dependent person are stabilised and even intensified. This is how Ayse tries to balance the high care responsibility of her son.

Yes, yes in the past I have had several friends and at present I do not have time for them. They also do not visit me. We were often together and now not any more; too little time. If I have some time, then I spend it with my father [person cared for] and my son. Then I take my son out. He needs that, too.

6.2 *Spouses and Partners*

Caring responsibilities in addition to paid work affect partnership in two ways. First, it is a matter of time. Caring obligations of any kind reduce the time partners have for each other and together as a couple. If the person in need of care lives together with the couple, the required re-arrangements are of course much greater and involve also issues of privacy, intimacy, even habits.

These problems are only partly eased when the care dependent person and the carer with her family live in separate, but very close households. Although this solution allows for keeping one's own spaces and privacy, it also partly breaks down the boundaries between the two households, particularly when the care dependent person requires systematic monitoring and presence. Ute, whose mother lives next door, states:

My husband had to get accustomed [to the care situation], that's clear. This was a, how could I say, a learning task for the whole family till we reached the state that it smoothly suits. Of course, the partner and also the children have to make compromises. We talked about that before. There is only little spare time or time to spend together.

In other cases, couple's time is reduced because of the commuting time required for the carer to travel to her different duties: work, cared for person's house, her own. And, as we mentioned above, if there are young children, they come first.

Caring responsibilities may affect also the quality and "status" of the relationship. In the statement of Ute above, this second dimension is addressed at the background. Gesa expressed this more clearly. She lives together with her husband and her care dependent mother. Both partners work full-time. She mentioned the challenges her relationship has to undergo:

There are quite negative impacts. We have had relationship problems. They appeared clearly. It [the care arrangement] is virtually a marriage in a threesome. But now, we have climbed a high mountain and we grow along with this situation.

The example of Gesa and her husband shows that a relationship in the end might even benefit from the challenges due to caring responsibilities, because the couple learns and develops through them. Four of our respondents, all women, however, report that their care responsibilities were at least a component in the process which eventually led to separation or divorce. Silvia, from Brandenburg who formerly worked as an office clerk and now is unemployed because of her caring responsibilities, asked by the interviewer how her partner responded to the situation, answered mimicking his behaviour:

“Why are you doing this? You should not do this.” He did not understand it in any way. Instead of supporting me he only griped. When he got home in the evening, he threw his things in the corner and watched TV. And such things I could not bear. I don’t want this. *Interviewer*: „Did you split?“ *Silvia*: “Yes, that was in September [2007].”

Someone, however, feels that the (male) partner is the main victim of the situation. Tanja, who works in a long full-time job and cares for her mother without any service support, thinks:

Sometimes it takes a lot of energy and from time to time it is close to the limit. If you are engaged in your job and if everything went wrong. And the only one who suffers is my husband. He should be affected the least.

Two carers have started a relationship quite recently. Their partners seem to accept that they have caring responsibilities and the couple seems able to find some time to be together, but with great difficulties. It is the case of Bettina, for example, who lives together with her care dependent mother in a small town in Brandenburg.

Yes, I have started [a partnership] somehow, but it is just difficult. You cannot really be away and you also cannot take her [mother] along. It limits the private time with friends or with the partner a lot.

Ten care givers do not have a partner (any more). One of them addresses clearly the constraints that her situation puts on the possibility to find a companion. Wiebke, 45 years, who is caring for her mother and has a high work load because of working in two jobs and studying medicine considered:

Nevertheless, I reflect, Gosh, my prime years pass by. You could look for a man. But no time at all.

In other nine cases, the care givers mention that they hardly have time to meet friends or to pursue hobbies (e.g. dancing, doing sport), which would give them the chance to mingle with people and meet somebody suitable as a partner. Esther, who lives with her care dependent father and works on a long part-time contract, spends almost all her time on the job, caring, and doing housework. She feels lonely and misses a partner. Asked if she has a partner, she answered:

No. Of course, you can neither exchange views, talk about the things, nor that somebody comes by and you can sit together frequently. That is actually a burden.

Indirectly, Esther’s experience indicates that difficulties to find a partner or to live a good partnership are not only a matter of time, but also a matter of acceptance of the burdensome situation the care giver faces.

7. Impact on social life and free time

A carer's social life and her involvement in her social network are of course affected by time and energy constraints. There are risks of social isolation or of a restriction of the range of relationships one may engage in. But the caring context may also prompt an increased intensity of relationships. This may happen among siblings, who share both the concern and the care for a frail parent and might see more of each other because of this, therefore becoming also more involved with each other and the respective families. Also neighbours, whom once one only nodded to, may enter a closer circle of trusted acquaintances, in so far they provide some support. Other carers, met at the doctor's or in services, may offer the opportunity for an exchange of experiences. In sum, whether and how relationships are tightened, maintained, initiated, or weakened depend very much not only on the time constraints, but also on the structure of the care arrangement and on the willingness of friends and relatives to adapt to the situation.

Nineteen respondents report that contacts to friends had decreased or even had disappeared altogether. In three cases, the carers mention that they have fewer friends because the latter just vanished, not only for the carer's lack of time, but because of the friends' lack of flexibility. Hedwig highlights these problems. She cares with some help from family and services for her mother, who is bedridden and needs support over the whole day.

There is little free time. You can't arrange your free time according to your preferences because you have to be available all the time (accentuate). If I went out occasionally and met somebody, I could not stay long because she [mother] is waiting or you have to change nappies. No time to linger; that is not possible.

But there are also more positive instances. Nora cares with the help of her family for her mother who is living in the same household. She says that because of her difficulties in going out, friends and relatives come to her house.

You do not go out to a far place, you also do not go out so long, because you always have in mind that there is something at home; and you get home sooner [than planned]. Therefore, I like if everybody comes to our place. They know that I have a case of nursing care at home and they do not. Therefore they are more flexible.

How important it is that the circle of friends accepts and integrates the situation of the care giver is exemplarily described by Johanna. Asked by the interviewer if her relationship to friends and acquaintances, has worsened or reduced, she answers.

No, in contrast, it is even the case that they [the friends] can deal with this situation by all means. They accept that she [mother-in-law] is there and we take her with us. And on the contrary, it is disburdening for us, because all of them work in the care sector somehow. They know how to deal with care dependent persons and they just help her to go to the toilet or whatever has to be done, like bring her something to eat. All of them do this independently. We do not have to do anything and in such

situations we could even settle back and say: “Somebody will care for her.” It works out well.

Last but not least, the development of relationships to friends depends on the carer her/himself and her/his household’s needs. In some cases, it is a matter of what priorities the care giver has. How important are friends? Which life domain and relationships are pushed at the margin given the limited time? For main care givers with children and/or a partner it is likely that they concentrate on their family, therefore sacrificing friends.

Another crucial issue is how care givers manage to reserve some time for their own. Of course, this heavily depends on their work, care and family obligations. But it depends also on the degree to which a carer perceives that she/he needs and is entitled to time/space for her/himself in order to keep her/his integrity and psychological stability. Having no time/space for oneself may cause not only isolation, but also burn-out. While some carers seem to be totally absorbed in the triangle made by care, work and family, a minority clearly state that they must reserve some time for own activities to be able to meet all demands. Peter, who is working full time and takes care of his mother, described it as follows:

In my life I must keep respite periods. I have to allocate them, deliberately plan and take them because of the limited time. I must say to me: “You should rest now!” My wife also reminds me frequently: “Switch off!” And then I relax.

We inquired both about the availability of free time during a regular working week and about the possibility to take a vacation from both paid work and care. In principle, care givers with the responsibility for a care dependent person with an institutionally acknowledged care level – all but two our cases – may apply for benefits to pay for respite care for up to four weeks a year. If the care dependent person must be hosted in a nursing home during that period, however, the allowance does not cover the costs. One respondent moans that it is cheaper to take her care dependent mother on holidays than to pay for respite care. Financial restrictions as well as the unwillingness either of the carer or of the care dependent person to have recourse to a nursing home, therefore, greatly reduce the opportunity for care givers to have some vacation. Dorothe, who cares for her mother with Alzheimer disease, explained:

It may be possible to travel for a long weekend, but not to go away for a trip for one week. We have not done this the last three years. Well, I would have no peace in a sense.

And, of course, vacation time might be reduced because it is used, as in the case of Ute mentioned above, for meeting caring needs.

8. Gender differences in caring responsibilities

8.1 Daughters and sons: gender and moral careers

Why do daughters become their frail parents' main care givers more often than sons? And why is it easier to find daughters than sons in law caring for a parent in law? In the gender division of labour, women are usually allocated the main, if not the total, share of family work: housekeeping, caring, keeping in contact. Thus, when specific caring needs arise, women are perceived, and perceive themselves as responsible for meeting them. This, in turn, influences also to a large degree their decisions concerning paid work: whether to work and how much, particularly if they have family responsibilities.

Gender operates in this respect as a normative framework: caring obligations concern mainly daughters, not sons. Out of 21 female main carers in our sample, nine explicitly describe the development of how they became main care giver with terms such as "natural evolution", "role perceptions". One example is Hedwig. When the interviewer asked why she became the main carer, she answered: "I am the only daughter, quite simply." Later on she explained:

How do you mean this? That was somehow totally normal! It could not have been the son-in-law for his mother-in-law or my brother. It was just normal that I did it! She is anyway totally fixated on me. She always called me when I wasn't there. She is thankful when the others also help out, but it is important that I am always present. Always!

Rebecca, a 39 year old teacher, in addition to caring for her father, takes care also of her niece since when her sister-in-law died. Her brother, the father of the niece, lives one hour away. Asked whether the fact that she is a daughter and not a son has anything to do with her being the main carer, she answers:

Yes, sure, that is right, that has something to do with this old role perception, since I was present in the end and principally already was engaged in another care arrangement (she helped her mother care for her husband/father until the mother herself became care dependent). Yes, that is how it developed. Yes, right, role perception does play a role.

The gender logic explains also why studies find that there are generally more daughters in law than natural sons being the main carer (Haber Kern and Szydlik 2008). It seems as if sons provide most often through their wife's time and care, rather than performing the needed care themselves. Among children-in-law with the role of main provider, we find, in fact, only women.

When men are the main carers, they describe their situation more often in terms of lack of alternatives in the family, than as something which "naturally" befalls on them, as in the case of women. They just (have to) do it, because there is nobody else (see also Stoller 2005). Peter, 59 years old, who is more the care manager than the care giver of his mother, since the latter receives high support from social services, said for example:

As a son one did not care (about the mother's life). She lived her own life and then suddenly there's this medical condition and one has to arrange the things...!

Actually, at the beginning it was only "natural" that his wife took over the role as main carer. But the mother in law did not like her and was very offensive against her, so that the daughter in law finally refused caring and Peter had to step in. At the moment of the interview, they were considering moving the mother to a nursing home. For two other male care givers there is also no alternative family carer at hand.

"It happened just because of the situation that nobody else was there (laughing)[He has no siblings]." Later on he adds to this explanation: "But I have not done it under compulsion, it was a voluntary decision [to keep his mother in his home]." (Ralf)

This example makes clear that also men share with women the feeling that there is an obligation to care in the family. But men seem to perceive that this obligation falls first on women and only if these are not available, on themselves. This feeling of obligation is explicit in all five male main carers in our sample. Markus, 39 years, a lumberman living in a small town in Brandenburg, reacts strongly to the hypothesis that he might move his mother to a nursing home.

Why? My mother does not deserve that [residential care]. I put it like this: To be deported and neglected. This is how I have experienced it in a nursing home. That is not what she deserves.

The situation of Markus, however, clearly differs from that of the other men in the sample (and also of many women) with regard to how he anticipated the possibility that he might face caring demands from his parents. He considered very early in his life this possibility and decided to complete his civilian service at a nursing home. He remembers:

I completed the civilian service and at that time I realised what would come up to me in the future. So I went to a care service provider and therefore I understand a bit about caring. No, that I have considered in advance. The civilian service was the best opportunity. I worked really in a stationary care home for the elderly and have learned a lot. *Interviewer*: "When was it?" *Markus*: "At the age of 22."

At the time his father died, he decided to stay with his mother and not to move out as planned. His sister has moved 200 km away and supports him only in case of emergency. In a sense, he seems to replace his father as a spouse; hence – in contrast to the other male carers – he has neither children nor a partner.

Even if men take up main caring responsibilities less often than women, they do play often an important supporting role in the overall caring arrangement. 10 of the 21 female main care-givers are supported by a male partner or relative (mostly a brother). How crucial the support by a partner can be is clearly expressed by Quendoline, who cares for her severely impaired mother (care level 3) in her house:

But it does not work that one has a job and has also someone in need for care at home without having a partner at home to support one. It does not work, absolutely not.

Last but not least, the unequal division of care work within a couple is sometime balanced by a higher contribution to housework by the male spouse (see also Martin-Mathews and Campbell 1995). But this is not always the case and often the husband does not do more than before care responsibilities appeared. It is the case of Dorothe and her husband. She reports high time pressure and stress; but her husband is doing almost nothing.

My husband does actually nothing. He says: »someone has to care for mother.« In this respect it is not actually a problem. But my husband does nothing else (than accepting that she takes time to care). He does not even go to my mother for a visit.

An extreme instance of the gender division of labour in caring responsibilities is avoidance to be involved. In our sample, out of 13 cases where a male partner or brother would in principle be available to assist with the care work, 5 men are not at all engaged in the caregiving and another 3 are only helping very occasionally. One example is that of Tanja (58, married) who cares for her mother (Pflegerstufe 1). Even though she has four brothers, three of them living quite close, none of them provides any substantive support.

I would indeed once like to say: “On the weekends one of you takes her.” If one [the brother] would once say “We take mother to have coffee or dinner!” But that nobody ever does. Also those living in the same house [as the mother], yes, they pay some attention, but would they ever say: “Mother, we make this or that together with you or embrace you!” [Accentuated] That is exactly what she lacks. She wants to be included, she wants to be part. But the others do not see it like that.

Also Veronica, whose brother only visits the mother once a week, even though he lives in the same city, tells:

...my brother visits her [the mother] once a week and is present. *Interviewer*: “Does he have a good relationship to her?” *Respondent* “No, he is not even listening, he pretends, but he does not care what my mother says. He goes [to visit her], so that she can talk a bit, and that is also important. Or when I give him some instructions; for example to fix something. But in principle, he is no real help.”

The presence of siblings in the family network clearly evokes issues of fairness, in addition to gender specific considerations. It also prompts the question why a particular child became the main carer, instead of another. The interview posed this question indirectly, by asking the carer how she/he understood the process through which she/he assumed main (or exclusive) responsibility. Often the first reason was proximity or workload. Interestingly, these were offered more as an explanation for a sibling – regardless of gender – not taking responsibility than an explanation why the carer herself had taken it. And in many cases there was at least one sibling living as near and having a work and family load not very different from that of the main carer. For example Petra (44), who reports to work sometimes more than twelve

hours a day as a self employed financial consultant, excuses the almost complete lack of support by her older sisters (53 and 54 years old) with their own employment:

My first thought was that the older sister, since she is a doctor herself, could deal with this and would come up with ideas. Ideas were there, no question, but due to her employment, her possibilities were extremely limited. She lives one hour away (Petra also lives 40-50 minutes away from her mother) and has the longest distance. It's probably also that I always had the best relationship to my mother, so that it wasn't even raised as a family issue; much more, this was what one had to do and I am going to do it. Benevolent approval (laughing). It was like that.

Petra's words suggest that not only gender, but also other differences between siblings in the willingness to and availability for providing care for one's own parent may be based, objectively or as a post facto rationalisation, in the specific quality of the relationship between the main carer and the cared for parent. Overall, 14 respondents report that they always had tight or even the tightest relations to the person in need of care; 13 of them are women. It fits well into the general pattern that women in the family, in particular daughters and mothers, have the closest relation compared to others (Rossi and Rossi 1990, Szydlik 2000). The tightness of relationship is offered however as an explanation by women also when other sisters are present. In this case, the main carer declares that she was the one closest to her parent. But, as we know again from the literature (Finch and Mason 1993, Lüscher and Pillemer 1998), a good relationship with one's own parent, and even affection, may not be required to be available to care. Andreas has a very difficult relationship with his mother, who "treats him like a child", while being dependent from his care – a situation worsened by his becoming unemployed recently, with difficult prospects of finding a new job given his age and caring commitment. Also Peter, whose wife had to stop caring because of the hostility of the mother in law, does not have a good relationship with his mother. And Monika finds her mother an unsufferable self-centered person.

Finally, as Finch and Mason (1993) argue, also the moral career of the carer (as well as of the non carers) explains why a particular person is expected and/or expects from her-/himself to take the main responsibility for caring for a frail parent. Seven female care givers mention that they are either carrying high family responsibilities since they were young, or they have cared for another parent (in-law) before. A specific case of intentionally self-constructed moral career as carer is that of Markus, presented above. He consciously prepared himself to become his parents', and particularly his widow mother's, carer.

8.2 Gender difference in caring tasks

Gender matters not only in identifying who will care how much, but also, to some degree, in defining which caring tasks will be performed. A number of research findings suggest different patterns of assistance that are consistent with a gender-based division of labour (Finch and Groves 1983, Parker 1993, Kittay 1999). For example, most day-to-day, personal, and hands-on care is provided by women, whereas men are more likely to engage in arrangements for services or care management, transportation, home repair and maintenance tasks, or in intermittent assistance with occasional tasks. Another research finding, probably linked to this, is

that women experience greater negative consequences of care giving, typically referred to as “burden” or “stress” (Horowitz 1985).

In our sample, we also find clear gender differences in the caring tasks male and female main and secondary carers take up. The spectrum of care activities of women seems to be much broader than that of men, encompassing all personal and intimate care, emotional support, care management, home help and instrumental support. Male carers are more focussed on instrumental support and care management. The only aspect they mentioned more often than women concerns home repairs. Michael (51 years old), who helps his wife Christina caring for her mother, puts it thus:

In principle I am the concierge. I do the handyman work, if you want to put it like that. And that is also my part and desire, that I somehow help out and in general I try every evening to look after the things.

Men seem in particular to refuse intimate care, also when it is physically very demanding. Hedwig, for example, is caring for her mother who is not able to move any more and has to haul her onto the toilet seat. She, suffers from backache; but nonetheless:

Helping her (the mother) on the toilet, that neither my husband nor my brother would do. All this I have to do myself. These are things, the caregiving tasks, men would not do.

Similar problems are also mentioned in other two cases. Men seem to have problems in providing personal, physical care, particularly when the care dependent person is female. Female carers also acknowledge that this would present problems of intimacy and privacy in the case of male carers. Hence a son should not wash his mother. Peter reports that, especially with regard to personal hygiene, the son to mother relationship is surely not as optimal as the daughter to mother relationship.

...: mother-son-relationship is not as optimal as the mother-daughter-relationship. Thus washing would not be for me, or put her to bed her or something similar. If to change her diapers, I could not do it ...making food, cleaning the apartment; such things would not be a problem.

We do not have sons (in-law) caring for their father (in-law) in the sample. Thus we cannot know whether in this case male carers would have fewer problems in providing intimate, physical care. But in the opposite constellation, there are fewer reservations in the case of daughters caring for their fathers, as if the barriers of cross-sex and cross-generation intimacy were more easily crossed by women than by men carers.

9. Conclusion: tensions, resources and the role of policies

Unsurprisingly, the working and caring arrangements in our sample exhibit various degrees and types of underlying tensions. All our carers are under some kind of pressure on their time and on their loyalty. Yet, the points of pressure and of perceived difficulty may vary. For someone, the main point of concern is the job: how to deal with job demands, how to keep one's own job, how to find a job after having lost the previous one, given the caring demands. In our sample, we have a few "extreme" cases of this overriding concern: in addition to the two carers who had to leave their job because of caring responsibilities and cannot find a new one for the same reason, and the carer who had to take up a less skilled job, there is one carer who feels continuously under observation by her supervisor, and another that, for fear of this, instead of asking for some allowance due to her caring responsibilities, conceals them altogether. For other carers, the main point of concern is the (in-) adequacy of the caring arrangement. Particularly when the care dependent person has to remain alone for many hours a day, the constant concern that something wrong will happen seems never to abandon the main care giver. For still others, the main tensions concern neither the caring nor the work arrangements, rather the constraints having both obligations put on the carer's private life: on the relationship with and welfare of children, partners, and friends.

How these different concerns are distributed and experienced in the sample is not random, of course. Degree of dependency (or rather autonomy) of the cared for person is of course the first important divide. But the second divide concerns the perceived adequacy of the care arrangement. Having enough financial means to be able to buy adequate care – which in our sample mostly means attendance to a day care centre during weekdays plus some home help – reduces greatly not only own caring time, therefore liberating time for other important relationships. It also reduces radically the constant worry for the security and welfare of the care dependent person as well as the fear that caring obligations may be used by the employer as an excuse to fire or marginalize one. In this perspective, it should be pointed out that although the possibility to count on a mixed package of caregivers is essential for the smoothness of the arrangements, the stability of the arrangement is as important. Arrangements that have to be pieced together every day produce their own stress. Also being able to count on some kind of back up in case of an emergency - in the care arrangement or at work – is very important for the psychological balance and well being of the main carer. Feeling supported by one's own household and extended family may reduce the feeling of isolation and/or loyalty conflict.

Caring obligations themselves, which in some case may be perceived as an inescapable prison for lack of alternatives (if one is an only child with little resources, or if other siblings just don't do their part), might in other cases become part of "what means to be a family", strengthening bonds across households and across generations. And, of course, the care dependent person's behaviour and reaction play an important role in easing, or on the contrary further increasing, the tensions which are latent in all caring arrangements where carers have multiple responsibilities, loyalties, and interests. In this perspective, the cases involving mental disorder, like dementia, are the most difficult, because they often involve some kind of aggressiveness, which may feed on previous histories of difficult relationships.

Gender, personal and family biographies, conditions of work, financial means – all contribute to shape the balances or unbalances which characterize the daily life of family carers of frail elderly parents. In the German case, a large role is played also by care policies, with regard both to care dependent persons and care givers.

With regard to caring arrangements, the situations in our sample well exemplify the virtues, as well as the shortcomings, of the German long term care insurance. Once a person is acknowledged some kind of dependency, he/she, and indirectly his/her carers, may count on some form of support. All but two care dependent persons in our sample received a care allowance in some form, which means also that – in principle at least – their situation and that of their carers might be systematically monitored. But this support is (very) partial, therefore requiring, to be adequate, a large amount of integration by the family or by privately paid services. Thus, this policy de facto assumes as given the gender division of labour within families and specifically the availability of women to perform needed care, encouraging their total or partial economic dependence on someone else, even though this contradicts policies and goals put forth in employment or family policies. Furthermore, notwithstanding its universalistic framework, it reproduces also social inequalities. Since all carers in the sample work for pay, the inadequacy of the care provided by the long term care allowance implies that either they are working part time, or they must do a second (or a third, if they have an own family) shift. In any case, they must devote time and energy to arrange, coordinate and monitor more or less efficient caring puzzles. If they are not able to do so, because of lack of family and/or financial resources, they either risk being overburdened to the point of having to leave their job, or the care dependent person risks not receiving all the care he/she needs. In this perspective, one might argue that, notwithstanding its universality, the long term care insurance reproduces social inequalities not only among the care dependent persons, but also among the carers. This reproduction may be even supported by the “framework of choice” within which the care allowance is implemented, in so far income needs may suggest to take the allowance in the form of money rather than services, thus increasing the risk both of overburdening and undercaring.

It is worth noticing that in our sample the most efficient arrangements, and those which are more positively evaluated, are those which rely on a balanced use of day care services, or on a mixture of home care and day care, in addition to family provided care. They not only provide full time coverage, at least during the working time, but also professional coverage, stimulation and monitoring of the abilities and conditions of the care dependent person. But they are also very expensive and only care dependent persons with a relatively good pension can afford them. The same can be said for another service which would be very useful and in principle would be highly appreciated by carers: respite care. Entitlement, in fact, concerns access but not full financial coverage. The basic home care provided by the care allowance, on the contrary, does not seem very helpful not only for the carer with paid work obligations, but also for the care dependent person, because of the short caring visits and the exclusive focus on bodily care. Actually, here we can point to another kind of tension: between the narrow definition of care included in the policy framework and the wider concept of care as a relational and integrated activity. Finally, the care allowance is also largely skewed towards physical dependence. Individuals suffering from dementia or Alzheimer, if physically fit,

have more difficulty in being acknowledged as in need for care. They and their families get support later than it would happen if they had some kind of physical impairment.

Other limitations of the long term care allowance which emerged from our interviews concern the paradoxes created by the combination of level of care assigned and level of additional payments required in order to have something more than basic services. The higher the level of care, the higher the allowance, in fact, but also the higher the cost of additional services. As a consequence, it may not be convenient, financially, to obtain an adequate assessment of the care need. As Britta, 46, who cares for her severely dependent mother, explains:

No, before I thought so also. I also would tell someone that if a person could no longer be cared for at home, a higher care level would be better. But when a person enters a nursing home, or assisted living, it is much more expensive. We were considering care level 3, and then, thank God, I let myself be advised. "Let it be, otherwise your mom will have to pay much more."

Other limitations concern the lack of information on services and options available in addition to the basic care allowance. This concerns in particular emergency care and respite care as well as the possibility, in case the person needing care has a low income, to receive social assistance in order to be helped to pay for services. An even greater lack of information is apparent with regard to working place policies concerning care givers. In our sample, notwithstanding the variety of work settings and contracts, and the presence of carers working in the public sector, no carer seemed to be aware of the existence of specific rights to time off, even where they should have been available. Generally, negotiations are informal, based on personal relationships, rather than on some kind of entitlement. This, of course, weakens the position of the worker. In this perspective, the new law which came into effect in June 2008, should change substantially the situation, since it entitles carers in paid work to 10 days of unpaid leave a year and to a maximum of six months of "caring time" (Pflegezeit). It constitutes a clear improvement in terms of job security, partially assimilating adult/frail elderly care to care for very young children, but the income reduction is quite sensible.

For the employees, an important tool in arranging one's own multiple obligations and time demands is represented by work time account. Where they do not exist, and there is no specific allowance for workers with caring obligations other than those concerning a very young child, the only flexibility instrument is represented by one's own vacation time. But this means that workers who are already performing the dual task of working for pay and caring have no access to any time to rest and to spend leisurely with their children and/or a partner.

Overall, this study confirms that in the case of the frail elderly (but more generally of those who are no longer small children), even in Germany, notwithstanding the important shift represented by the introduction of the Long term insurance, both care receiving and care giving are still incomplete social rights (Leira and Saraceno 2002) and, while still largely premised, at least implicitly, on a male breadwinner model, they are largely absent from "work-family reconciliation" discourses.

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