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Combining work and care for the elderly: An overview of the issues

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Introduction

There are number of indications that more and more workers will be confronted with the problems of caring for frail elderly family members. The ageing of the population structure, the dramatic growth in the population of the very old (over-80s) and the growing labour force participation of women are only some of the most obvious.

While there is general consensus that severe pressures are building up as a result of increasing conflict between work and family responsibilities in this area, the fact remains that, as yet, there are insufficient data or information to evaluate the gravity of the situation adequately. Who helps these frail elderly? How is such help financed? How much comes from the family, the neighbours, the community, the State? How does the need to provide such help affect the lives of other family members? Specifically, does it inhibit the labour force participation of workers, particularly women workers who most often provide home help to the elderly? What are the effects of eldercare responsibilities on the workers? What policy approaches have been formulated that alleviate the caregiving burden on the workers? And, finally, what is the proper mix of help to the frail elderly person who can no longer cope alone?

Although societies have been concerned for many decades about how the burden of child-raising affects worker participation and mobility, to date, these same societies have paid relatively little attention to the burden of eldercare. While legislators and policy-makers have been concerned with reconciling work and childcaring responsibilities, the issue of workers and eldercare responsibilities has only recently begun to attract more attention.

At the international level, the seemingly conflicting objectives of promoting the advancement of women through equal opportunities in the workplace while, at the same time, supporting the family as the basic unit of support for its individual members, including the frail elderly, are to be

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found in several international action plans and documents. An example is the Vienna International Plan of Action on Aging, adopted by the United Nations in 1982, which states that while the family is the "fundamental unit of society, ... many (women) who have completed their child-rearing roles become caught between the desire and need to work and earn income and the responsibility of caring for elderly parents or grandparents" (United Nations, 1982, para. 66).

The 1990 Kitakyushu City Declaration of the United Nations International Conference on Aging Populations in the Context of the Family also recognizes that family care for the elderly is primarily provided by women and addresses directly the issue of equality and social responsibility: "Policies should be developed to ensure that family care for the aged does not hamper gains in women's status or the range of opportunities open to them". Further, the Declaration warns that family care "does not absolve society of its responsibility for high-quality care."

The ILO's Workers with Family Responsibilities Convention, 1981 (No. 156), and the associated Recommendation No. 165 provide an international standard-setting framework for national legislations and the implementation of policies to support workers, both women and men, with family responsibilities. The provisions of the Convention are phrased in terms which include those workers with responsibilities for the care of the frail and dependent elderly although such workers are not specifically mentioned.

Given the paucity of information on this complex subject, it is not surprising that in a recent strategy document on the implementation and development of measures to improve the reconciliation between work and family responsibilities for women and men issued in January 1992, the Commission of the European Communities pointed out: "While serious gaps in information have been identified in relation to childcare across the Community, information about adult care as an equality issue appears to be even more sparse. An essential first step will therefore be to collate and assess relevant information and statistical data" (Commission of the European Communities, 1992).

The present article will provide an overview of the issues affecting workers with eldercare responsibilities and highlight associated policy initiatives in the public and private sectors.

The ageing of populations: Present and future trends

According to the United Nations' report on *The world ageing situation 1991*, significant demographic transitions are taking place throughout the world and the ageing of populations is truly a global phenomenon. In 1950, 8 per cent of the global population was aged 60 and over. By 2025, the total number of the elderly will have increased sixfold, representing about 14 per cent of the world's total population (United Nations, 1991b).

The same report points out that the shift in the distribution of the majority of the elderly population from industrialized to developing countries is particularly significant (see figure 1). It is estimated that by 2025, 72 per cent of the elderly population will be living in developing countries. While the industrialized countries have already undergone the transition from high to low fertility and mortality, the developing countries, and particularly those in Asia and Latin America, are in the midst of this demographic transition. However, this transition is occurring at a much faster pace than that previously experienced by the industrialized countries. Only in sub-Saharan Africa are countries still in the early stages of the transition from a predominantly young to an older population structure. Projections indicate, however, that by the second decade of the next century, population ageing will be a significant issue in these countries as well.

But mere percentages of the elderly within the total population do not tell the whole story. In many developing countries, the rates of survival from birth to old age have increased while relatively high birth rates persist. Although the proportions of the elderly in some countries will increase only gradually, their absolute numbers will nevertheless grow significantly over time (US Bureau of the Census, 1987).

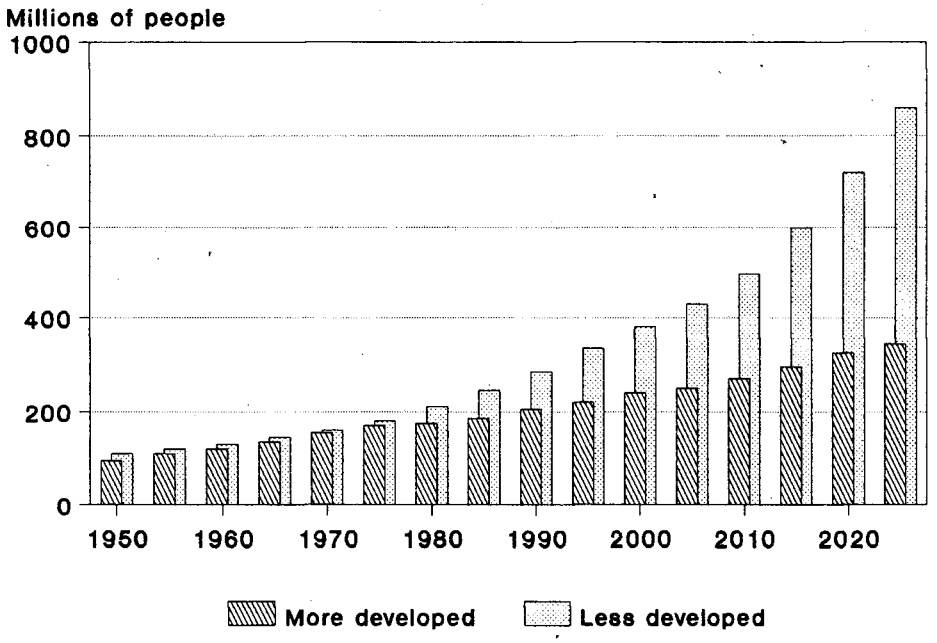
Two other factors in population ageing have important implications for policy-makers and planners: the substantial growth in the number of the over-80s and differences in longevity according to sex.

According to United Nations projections, during the period 1950 to 2025 the 80+ age group will grow twice as fast as the 60+ in both developed and developing regions (United Nations, 1991b). By 2025, the world's very old will number about 137 million, of whom 79 million will live in developing countries. In 1990, eight countries (India, China and six industrialized countries) counted over one million octogenarians among their citizens, (see table 1). By 2025, this number is expected to include 13 additional countries (see table 2).

In most countries women survive to older ages than men. According to the United Nations projections mentioned above, over the period 1985 to 2025, the expected increases in the number of persons aged 80+ are 8 million for males and 14 million for females in the developed regions; and 24 million for males and 35 million for females in the developing regions.

Considering that they are the group most often in need of support and care, the rapid increase in the world's very old obviously has implications for policies intended to assist family caregivers, the vast majority of whom are women. Further, since women most often outlive men and tend to marry men older than themselves, more older men than older women can count on the support of their spouses when they become frail. By contrast, older women are far more likely than their male counterparts to be widowed by the time they reach older ages and are thus obliged to depend on their own resources, their children or public sector support when they need care. For example, the US Bureau of the Census reported in 1987 that among

Figure 1. Population aged 60 and over in more developed and less developed regions, 1950-2025



Source: United Nations: *World population prospects 1988* cited in *The world ageing situation 1991* (New York, 1991).

countries with data on marital status, 75 per cent of women aged 80 and older were widows with the highest rates occurring in China – 92 per cent, Japan – 87 per cent, and Singapore – 83 per cent (US Bureau of the Census, 1987, op. cit.). Finally, family caregivers (who are most likely to be women) need to plan for their own old age throughout their life course. In other words, in view of women's longevity and the frequent interruptions in their working lives (hence in pension contribution records), the provision of family care is often achieved at the detriment of the female caregiver's own financial security and good health in later life.

Trends at macro level in developing and industrialized countries

Eldercare in developing countries

While this article focuses primarily on workers with eldercare responsibilities in the industrialized world, attention should also be given to

Table 1. Countries with over 1 million octogenarians in 1990 ('000s)

Country	Population aged 80+	Country	Population aged 80+
China	8 748	Japan	2 902
United States	6 982	France	2 298
India	3 444	United Kingdom	2 118
Germany	2 985	Italy	1 835

Source: US Bureau of the Census: *An aging world II* (Washington, DC, US Government Printing Office, 1992), p. 100.

Table 2. Countries projected to have over 1 million octogenarians in 2025 ('000s)

Country	Population aged 80+	Country	Population aged 80+
China	40 443	Turkey	2 065
India	15 750	Poland	1 935
United States	14 330	Canada	1 824
Japan	11 609	Thailand	1 801
Germany	6 340	Pakistan	1 603
Indonesia	4 652	Korea, Rep. of	1 484
Italy	4 301	Argentina	1 276
Brazil	4 009	Philippines	1 145
France	3 874	Australia	1 079
United Kingdom	3 751	Colombia	1 033
Mexico	2 866		

Source: Op. cit., p. 101.

the situation of such workers in the developing world, particularly in view of the increasing longevity among the elderly previously indicated.

In recent years, gerontological research has focused more frequently on patterns of family support for the elderly in developing countries. No doubt, this is in response to the concern expressed in many parts of the developing world that traditional forms of family support are beginning to break down due to a variety of factors, such as rural-urban migration by the younger family members, changing family patterns, and the shift from an agriculture-dominated economy to an increasingly industrialized one. In the absence of the social security and social assistance supports that exist in the industrialized countries, the frail elderly in developing countries are a population subject to considerable risk. For the time being, however, most research evidence suggest that the vast majority of the elderly in the developing world continue to rely on their families or their own work as

their only form of security at advanced ages. While there are disturbing indications from all Third World countries that the traditional system of family support is under increasing strain, the fact remains that most older persons in these countries continue to work until they are no longer physically able to do so and then are obliged to rely on children and relatives for their basic needs. Furthermore, the sharp breaks between work and retirement encountered in many industrialized countries are much less common in the developing world; retirement is for most older workers in these countries a very theoretical concept. One can only speculate that the need to care for the frail elderly develops over time, as the older family member gradually becomes incapable of making his or her contribution to farming and household duties.

As far as the situation of workers with family responsibilities is concerned, a surprising research gap exists in these countries. Why? A number of reasons suggest themselves. First of all, it is commonly assumed that (with some cultural variations) the majority of the caregivers of the frail elderly in developing countries are women, many of whom work in agriculture and the informal sector. Very little is known about the kind of arrangements they make in their lives to combine work with caregiving responsibilities. Also, research suggests that the majority of the elderly in developing countries continue to work in subsistence farming, in the informal sector or by providing care for grandchildren. In this regard, older women in particular often make a significant contribution by continuing to engage in small-scale agriculture and artisan undertakings. These older women may also play an important indirect role by facilitating the labour force participation of younger women whose children they care for at home (Rix, 1991). Research in Africa has shown that when the older woman becomes frail and needs care, it is often the grandchildren who provide support (Apt, 1991).

In many Asian countries, support for the elderly is by tradition the son's responsibility, but evidence shows that the actual care is usually provided by the daughter-in-law. The lack of information on how workers cope with eldercare responsibilities is of particular concern in newly industrialized countries where increasing percentages of women are working in the formal sector of the economy, particularly in textile manufacturing, electronics, and various industries requiring large numbers of workers for assembling products. For example, Singapore and Korea actively try to encourage families to care for their elderly members through "moral education" or "filial piety" programmes (United Nations, 1991b; Gibson, 1990). As these countries also have high levels of female labour force participation, the pressures on women to play both their economic roles and fulfil their families' expectations must be considerable.

Female labour force participation rates

One crucial factor in the issue of eldercare is female labour force participation rates. At the global level, women's share in the labour force increased markedly between 1970 and 1990, with the exception of the former USSR and sub-Saharan Africa where it declined slightly (United Nations, 1991c). The highest rates of economic activity for women aged 15 and over can be found in eastern Asia (59 per cent) and the former USSR (60 per cent). All other developed regions as well as Southeast Asia and sub-Saharan Africa also show relatively high rates (45-50 per cent). The lowest rates are to be found in North Africa (16 per cent) followed by Western and Southern Asia (21 and 24 per cent). Latin America and the Caribbean report that women comprise approximately 32 per cent of the labour force.

When reporting women's labour force participation rates, particularly those referring to the developing world, one must treat statistics of this type with caution. In spite of substantial work by the ILO in this area, methodological problems and ambiguities still make it difficult to provide an accurate picture of women's labour force participation. Women's work is still often undercounted, particularly in developing countries, where women are frequently engaged in subsistence agriculture and small-scale, household-based self-employment. This is important to keep in mind when trying to assess the double burden of women, i.e. work and family caregiving responsibilities, including eldercare.

In the industrialized countries, assuming that eldercare responsibilities are more likely to become an issue for women over age 45, it is useful to look at labour force participation rates according to age. Data compiled by the US Bureau of the Census on economically active women in the population by age reveal that, in industrialized countries, labour-force participation rate declines significantly during the ten-year span in women's lives between the ages of 45-49 and 55-59 (see table 3). While these rapid declines are striking, it must be kept in mind that, in the absence of appropriate longitudinal data, no definitive conclusions can be drawn on why the percentages of women in the labour force drop so sharply in most industrialized countries after the age of 55. One question remains especially pertinent, namely whether family caregiving responsibilities are one of the principal reasons preventing more women in the 55-59 age category from being in the labour force.

In the United Kingdom, for example, Laczko and Noden cite evidence from the 1986 Labour Force Survey that 15 per cent of women aged 50 to 59 years who had left employment in the previous three years had done so in order to care for a family member (Laczko and Noden, 1992). Similarly, the United Kingdom National Carers Survey conducted in 1990 found that, of non-employed carers, 81 per cent had a paid job before taking up caring, and 68 per cent said that they would be in paid work if they had not been caring for someone at home (Eurolink Age, 1992). In their discussion of eldercare

Table 3. Female labour force participation rates by ages 45-49 and 55-59, selected industrialized countries, different years

Country/year	Ages 45-49	Ages 55-59
Australia		
1986	58.2	30.9
Austria		
1988	50.4	24.6
Canada		
1986	67.1	44.7
Denmark		
1986	81.9	60.5
France		
1990	71.8	46.8
Germany (Fed. Rep. of)		
1988	60.9	41.1
United Kingdom		
1986	69.9	51.5
United States		
1991	75.4	55.7

Source: Op. cit., pp. 131-134.

issues in the United Kingdom, Laczko and Noden point out that this issue has been ignored in the recent literature on older workers' employment, which has "concentrated almost exclusively on the problems of men facing redundancy and early retirement".

One measure for assessing the magnitude of eldercare issues in both industrialized and developing countries, is women's generational support ratios, (for example, the number of women aged 45 to 49 per 100 persons aged 65 to 79). Such ratios are considered to be useful (though rather crude) measures of the availability of female generations to care for the elderly population. This approach consists of evaluating the size of the generations as a proxy for true support relationships, in the same way as dependency ratios are used to represent support by the working population for the inactive population. On the occasion of the United Nations International Conference on Aging Populations in the Context of the Family held in 1990, the Population Division of the United Nations provided generational support ratios to assess the possible support from women among the younger cohorts (ages 45-49) for the older cohort of both sexes (ages 65-79) (United Nations, 1991a). The figures show that by the beginning of the next century, all the regions show a decline in the ratio of potential younger female caregivers to the older generation. While Africa remained the most stable, Europe and North America achieved the lowest rates, with only one potential female caregiver for every seven older persons. In Asia, the number is expected to decline to one middle-aged caregiver to every three older persons.

Evaluating the availability of caregivers into the next century is problematic, to say the least, particularly for countries undergoing rapid demographic and social changes, which are largely the developing countries. Demographers have pointed out that when fertility decreases the availability of family support for the elderly also decreases (Gonnot, 1991). However, this decrease can be significantly attenuated if there is also a rapid fall in child mortality, with the result that more children survive and live longer, thereby increasing the pool of potential caregivers. A second major influence on the number of potential caregivers is rural-to-urban migration, which has been recorded in practically all developing countries. Country studies have shown that the elderly tend to be left behind in the villages as their children and younger relatives migrate to the cities. Therefore, even in developing societies where population ageing is still relatively modest, migration can substantially modify the availability of family support. Mexico and Zaire show steadily increasing ratios of elderly persons to adult women in non-urban areas, which suggests a growing eldercare burden in the rural areas of these countries.

The interaction of a number of profound social and economic trends arising from the modernization of societies – ageing of the population, differential longevity of men and women, increased labour force participation of women, rural-to-urban migration, etc. – will inevitably lead to increasing numbers of persons experiencing a conflict between the demands made on them for eldercare and their work. Furthermore, in industrialized countries, this conflict often becomes more acute at a time in the family life cycle when childcare responsibilities are no longer an immediate concern and when many women have returned to the labour force to work full-time. However, statistics also reveal that children remain in the family longer than in the past because of higher education. Thus, many working women may still be caring for teenage children in the household at the same time as assuming eldercare responsibilities for parents and other older family members. This has led to the coining of the term "sandwich generation" to describe the situation of middle-aged individuals caught between their obligations to both older and younger generations (Brody, 1985).

Who are the caregivers?

Before discussing selected policies and practices aimed at addressing caregiving issues, an attempt will be made to construct a profile of the person providing care for the elderly and, thus, to gain a better understanding of the incidence and magnitude of the problem for the working population. Because of the data limitations described above, this means predominantly the industrialized countries.

In the United Kingdom, the 1985 General Household Survey described carers as "people who were looking after, or providing services for, a sick,

handicapped or elderly person living on their own or in another household" (Laczko and Noden, 1992, op. cit.). Attempts to evaluate the caregivers in the United States have used different criteria, such as the number or type of activities for which the elderly persons need assistance or the number of hours of care provided by the caregiver per week. In most surveys a caregiver is defined as a person, male or female, who provides unpaid help to another person with one or more activities of daily living (ADL), such as bathing, dressing or feeding, or other activities, such as shopping, transport, manageing finances, etc. Definitions therefore vary and include persons taking care of elderly persons suffering from mild to very severe impairments.

Clearly, for the construction of a caregiver profile, a number of standard factors should be taken into account, including sex, age, employment status, socio-economic status, living arrangements and state of health. In the United States, the National Long-Term Care Survey conducted in 1982 yielded interesting data on the characteristics of caregivers (NLTCS, cited in Select Committee on Aging, 1987). It revealed, for example, that more than seven out ten caregivers were women; 33 per cent were wives and another 40 per cent were daughters or daughters-in-law of the elderly. While two-thirds of caregivers were under the age of 65, the average age was 57. Twenty per cent of the caregivers had children under age 18 living with them. One-third of the caregivers were classified as poor or nearly poor, according to standards established for 1982 household incomes. Significantly, a majority shared living quarters with the dependent elderly. Most importantly, for the purposes of this review, more than 33 per cent of the caregivers were actively employed, 70 per cent of them working full time. Unfortunately, the published results of the national survey do not provide cross-tabulations, such as how employment of the caregiver relates to age, income or health status.

Another national survey of employed caregivers conducted by the American Association of Retired Persons (AARP) in 1989 showed that 55 per cent of caregiving households included a working caregiver (compared with only 33 per cent in the above-mentioned survey) (AARP, 1989). The AARP survey also found that employed caregivers were more likely than non-employed caregivers to be younger (36 per cent of full-time workers providing care were aged under 35; 37 per cent were in the 35-49 age group). Although employed caregivers were predominantly female (64 per cent), a remarkable proportion was male (36 per cent). The working caregivers proved to have achieved a high level of education (50 per cent had undertaken some university-level or even graduate studies). Almost half fell in the professional "white-collar" category, so not surprisingly their incomes were also higher: the 1986 median annual household income for employed caregivers was US$29,800, compared with only US$20,400 for the non-employed caregiver.

Laczko and Noden report that in the United Kingdom the peak age spread when caregiving occurs lies between 45 and 64 years, with women

bearing a heavier burden of care than men. Indeed, the evidence even suggests that male carers may receive more informal and service support than their female counterparts (Laczko and Noden, 1992, op. cit.).

What we still need to know

Private or public sectors strategies to support caregivers may not prove effective if they fail to target the specific needs of each group. The importance of filling the gaps in existing data and analysis regarding the actual living circumstances of working and non-working caregivers cannot be overemphasized.

In the context of industrialized countries, what is for example the average age at which the worker first assumes eldercare responsibilities? In the 45-54 age group? Or in the 55-64 age group? ILO data on labour force participation rates for women show that there is a sharp drop in female employment in the 55-64 age group (ILO, 1988). Could this mean that by the time eldercare responsibilities become burdensome, most women have already withdrawn from the labour force? Or is their departure from the labour market the result of increasing responsibilities in this respect? Further, do women receive fewer services and support than their male counterparts?

Some countries, for example the United States, may be more preoccupied about family support for the elderly where public sector approaches to health and the long-term care of the elderly are less generous and not universally available. This is not the case in most west European countries; the Danish National Institute of Social Research, for example, states that in Denmark there is a broad consensus concerning the elderly person's right to aid from the public sector when the need arises. According to the Institute, "The Danish system of service provision enables the elderly and their relatives to be independent of each other, as help with activities of daily living tends to be obtained as formal care through the public services." (Plovsing, 1992a).[1]

There is no doubt that factors such as availability of community-based services for the elderly, housing policies, rates of institutionalization, policies to promote equal opportunities for men and women, as well as cultural preferences, combine to produce a very complex picture. This makes it difficult to assess precisely the needs of family caregivers in the industrialized world.

[1] With regard to women's roles in society, the Danish National Institute of Social Research states that "the homeworking housewife is disappearing in Denmark, which is one of the greatest social changes in the latest years . . . Younger women are today in the labour market to almost the same extent as men, and there is no difference between married and unmarried women's attachment to the labour force" (Plovsing, 1992b).

Who is receiving care?

The other set of data and information critical for the development of support strategies for employed caregivers is, of course, the profile of the recipient of care, i.e. an assessment of the level of impairment of the elderly persons receiving care, their economic circumstances, living arrangements, etc. According to US data, employed caregivers were far less likely to care for severely impaired individuals (Mutschler, 1991, op. cit.). Co-residence with the impaired elderly person was also somewhat less likely than for the non-working caregiver, although 62 per cent of the employed caregivers resided with the elderly relative, compared with 80 per cent of the non-working caregivers.

As mentioned above, the type of care needed by the recipient can generally be classified in one or two principal groups: (1) assistance with activities of daily living (ADL), including dressing, bathing, feeding, toileting, help with walking around inside; or (2) instrumental activities of daily living (IADL), including meal preparation, housework, shopping, transportation, managing finances, etc. US data show that employed caregivers tend to provide more help with IADL tasks than with ADL tasks (AARP, 1989, op. cit). A chronic physical disability was listed by most full-time workers as the reason the older person needed care. Only 3 per cent of the full-time workers examined cared for a mentally disabled older person.

It has also been pointed out that there is an essential difference between childcare and eldercare, namely the child will eventually progress towards independence while the older person will most likely become increasingly impaired and dependent as time goes on. Eldercare is therefore often considered to contain a much higher level of stress for the caregiver than childcare.

Finally, the AARP survey also showed that more full-time workers cared for their mothers (31 per cent), than for their fathers (14 per cent), grandparents (19 per cent), or parents-in-law (14 per cent): other relatives or non-relatives accounted for the remainder.

Review of existing policies to assist employed caregivers

This section reviews current policies and practices according to three principal categories: statutory programmes; community-based services; and programmes sponsored by employers.

A. Statutory provisions

Leave policies

The amount of leave (annual holiday or personal leave) mandated by law can make a crucial difference to how well a worker copes with caregiving

responsibilities even though family care is not the stated purpose of such leave policies.[2] Once annual or personal leave has been used up, however, the worker may resort to taking unplanned leave without permission or to feigning illness in order to respond to caregiving pressures. Needless to say, in the long run, such "unauthorized" leave will have negative consequences for productivity, increase stress for the worker and eventually even lead to dismissal.

Comparisons between statutory annual leave policies in industrialized countries reveal that European countries are far more generous than is the case in industrialized countries in other parts of the world. In the United States, for example, there is not even a national legal requirement that employees be given any vacation time, although after one year of employment most Americans average nine days of vacation and after ten years of employment 16 days; by contrast, Denmark and France each provide 30 days of statutorily mandated annual leave (Ferber, O'Farrell and Allen, 1991). No European country grants fewer than 15 days. In addition, collective bargaining agreements often extend vacation time beyond the statutory requirements.

Leave policies specifically designed to allow the worker to take care of family emergencies are obviously one of the most appropriate responses to workers' caregiving needs. While most European countries provide extended leave policies in the event of maternity and/or care for a sick child, leave policies in the event of the illness of an older family member are still relatively rare. It should be noted in this context that the ILO's Workers with Family Responsibilities Recommendation, 1981 (No. 165), specifies in article 23 (2) that, "It should be possible for a worker with family responsibilities to obtain leave of absence in the case of illness of another member of the worker's immediate family who needs that worker's care or support."

Paid leave of up to one week a year is already available for employees in Austria for the care of a sick relative, if no one else is available to provide such care. Similarly, employees in Belgium have the right to unpaid leave of up to ten days a year for contingencies such as sickness or hospitalization of a family member living at the same address or for the care of the employee's parents, regardless of whether or not they reside with the employee. Similarly, civil servants in Belgium are entitled to unpaid family leave up to a maximum of two months per year (ISSA, 1993).

In the United States, legislation introduced and adopted by Congress in 1991 requires employers with 50 or more employees to provide up to 12 weeks of unpaid leave for family caregiving. The Act provides unpaid leave for the birth or adoption of a child (currently there is no federal provision for maternity leave in the United States), or for the serious illness of the

[2] With regard to annual holidays with pay, ILO Convention 132 explicitly states that opportunities for rest and relaxation should be taken into account when fixing the time at which the holiday is to be taken.

employee or his or her child, spouse or parent. While the Bill was supported by the trade union movement and, among others, advocacy groups for the elderly, President Bush vetoed this initiative twice, citing the need for the private sector to remain competitive. The Bill was reintroduced and finally approved by President Clinton in 1993.

Social security allowances and credits

Social security, particularly in the form of old-age pensions, has contributed to older persons' financial security and autonomy more than any other income transfer programme. Such programmes have, at least in the developed world, brought about a profound change in family relations by largely freeing adult children from financial responsibility for elderly parents. Adequate health care, which is often an integral part of social security protection, has also functioned to relieve children from many caregiving responsibilities. Yet, for actively employed persons also providing eldercare, there remain many areas of concern. Specific social security policies aimed at assisting the employed caregiver to alleviate his/her eldercare responsibilities remain rare.

The few examples of such social security legislation actually in force recognize that family members who leave the labour force to care for elderly relatives not only sacrifice wages, but also jeopardize their own security in old age if they do not continue contributing to their social security pension scheme (Gibson, 1991, op. cit.). Such schemes address the problem by granting caregivers pension credits for those periods when they are obliged to take time off from work to assume either child- or eldercare responsibilities.

In Germany and Italy the provision for old-age insurance takes account of the periods devoted to the education of children or to the care of dependants, (including the elderly), up to a specified maximum. In the United Kingdom, the qualifying period for pension purposes is reduced for women who need to stay at home to look after a child or another member of the household who is sick or elderly. Luxembourg is proposing to allow periods spent caring for elderly or disabled persons to be credited as contribution periods for old-age and complementary pensions. Norway has enacted a new provision which provides complementary pension protection to persons who have chosen to stay at home to take care of children or sick, elderly and disabled relatives, rather than to take up paid employment (ISSA, 1993, op. cit.).

Social security can also provide direct cash benefits or carers' allowances. In Sweden, a relative, close friend or neighbour is now entitled to a cash benefit when taking care of a sick person during the final stages of their life. The rate of payment is the equivalent of a sickness benefit and is payable for a maximum of 30 days. Similarly, in Norway employees are entitled to a daily cash benefit from the sickness insurance fund when caring for relatives who are terminally ill. Other countries (e.g. Australia, Ireland, Israel, the United

Kingdom) provide cash benefits to carers in recognition of the fact that they are not able to undertake full-time employment because of their caregiving responsibilities. In the case of Ireland, the rate of the allowance is set at a rate similar to unemployment benefit (ISSA, 1993, op. cit.).

The important question is now whether or not these types of programmes will spread to other countries in the future and whether new and more generous measures will be introduced to alleviate the burden on working caregivers. Given the current slow economic growth worldwide and the financial strains on most national social security systems, the debate regarding benefits for family caregivers will inevitably be greatly influenced by cost considerations.

In spite of the current budgetary constraints on social security, in 1991 the Committee of Ministers of the Council of Europe formally adopted Recommendation R(91)2 on social security for workers without occupational status (Eurolink Age, 1992). This recommendation is intended to cover family workers and persons at home with family responsibilities and is particularly important for countries where social security protection is normally secured through employment. The recommendation includes guidelines to be followed by governments when providing protection for persons who interrupt or delay their economic activity, or who refrain from engaging therein in order to provide family care for a certain period.

Fiscal policies

Tax credits for caregivers have also been widely discussed in industrialized countries as another mechanism to support the caregiver. Both Japan and the United States provide such tax credits. Eligibility requirements are quite stringent, however, and the amount of the tax deduction allowed is often significantly below the actual expenses incurred. Assessing the true value of caregiving and translating this into a tax deduction or credit is, indeed, an extremely complex exercise. Proponents of this approach argue that it merits greater consideration, since it allows the maximum degree of individual choice by the caregiver on how to use this financial assistance. Providing this freedom of choice, it is argued, guarantees a far more efficient use of the money than if the State actually paid a cash benefit. As in all such fiscal policies, the principal criticism is that such tax exemptions tend to benefit middle- and upper-income taxpayers rather than the most needy.

B. Community-based services

General trends

In recent years, many industrialized countries have moved away from policies to build more institutions to accommodate the growing numbers of

the elderly and focused rather on community-based care which allows the elderly to remain in their own homes for as long as possible. This trend has been motivated both by cost concerns (the growing cost of institutional care), and by a respect for the wishes of most older persons to remain autonomous and independent.

When considering institutional care, it is important to understand at the outset that only small numbers of the elderly are institutionalized at any point in time. Taking the United States as an example, approximately one quarter of the aged are in need of some type of long-term care at any given time. Of this subpopulation, only 1,4 million persons live in nursing homes. The remainder – between 4,6 and 5,1 million older persons depending upon the definition of disability – are functionally impaired but do not live in an institution and continue to live in the community (Select Committee on Aging, 1987). These older persons require both community-based services and family support for their daily existence.

Another example is the Netherlands, which currently has a higher proportion of elderly persons living in institutional settings than any other country in Europe. However, over the past few years a fundamental reconsideration of policies for the elderly has been undertaken (Knipscheer, 1992). By expanding home-care programmes and encouraging family support, it is planned to reduce institutionalization for older persons from over 11 per cent of the elderly population in 1980 to 6 per cent by the year 2000. Moreover it is interesting to note in this context that the labour force participation rate for women in the 45-65 age category is extremely low in the Netherlands (about 20 per cent in 1987). This seeming paradox should therefore be a caution against making quick assumptions about the relationship between labour force participation and institutionalization of the elderly.

In Japan, where institutionalization rates for the elderly have traditionally been low, with the family assuming most of the caregiving burden, the Ministry of Health and Welfare is developing a "Ten-Year Gold Plan" to promote home and community-based care for the elderly (Gibson, 1990, op. cit.; Chambers Associates, Inc., 1991). The plan seeks to lighten the caregiving load on families by providing support services and respite care (see below). However, while public opinion polls in Japan indicate that there is continued strong support for co-residence of the frail elderly with their children, there appears to be a widening gap between attitude and actual behaviour. According to a national survey by the Ministry of Health and Welfare, more than 90 per cent of middle-aged Japanese believe that the care of bedridden parents is the responsibility of families. However, in fact, almost half of the bedridden elderly are hospitalized or institutionalized (Maeda and Shimizu, 1992). Part of the explanation for this contradiction may be found in the higher career aspirations and greater labour force participation of Japanese women.

In Denmark, where institutionalization rates have traditionally been high compared with other west European countries, major policy changes

now actively encourage home care for the elderly. Since 1987 only independent dwellings for the elderly are being built: an actual legal ban has been placed on the construction of new institutional care facilities. Expenditure on home care as well as rent subsidies for the elderly have increased rapidly, while expenditure on institutional care is declining. At the same time, Danish women continue to participate in the labour force in greater proportion than in other EC countries (Plovsing, 1992, op. cit.).

Similarly, Australia, France, New Zealand and the United Kingdom have taken measures to promote community care. Some expert observers have, however, suggested that these measures have also had some unexpected consequences. According to Clare Wenger in a report on family support for the elderly in English-speaking countries, "Paradoxically, while paying lip service to care in the community, the competing policy trend in Australia, New Zealand, and the United Kingdom has been to encourage the growing commercial provision of residential care. Large government subsidies have thus supported a growth in institutional care, while community care has remained under-resourced" (Wenger, 1992). The implications for the employed caregiver, relying on community-based services to supplement care is that when these services are scarce, the only viable alternative may be to pay for assistance provided by expanding private sector services.

Examples of community-based services

What are the community-based services most often requested by family caregivers? Studies in the United States have identified four basic kinds of services that caregivers need: (1) education about the changes that occur with age and related training in caregiving skills; (2) information about services available for those providing as well as those requiring care; (3) emotional support; and (4) occasional breaks from caregiving duties (Mutschler, 1991, op. cit.).

Information for caregivers at the community level is often provided in pamphlets, workshops or meetings organized by community-based service providers. For the employed caregiver, it may be particularly important that these meetings do not conflict with work schedules.

Emotional support may be provided by counselling services within the community as well as the formation of self-help groups. These groups may be particularly important for caregivers of the elderly suffering from mental impairments, such as Alzheimer's disease or other dementias.

Finally, high on the list of services for many caregivers – whether employed or not – is the provision of respite care (the chance for caregivers themselves to rest and recuperate), either at an institution and at home. In France, Germany and the United Kingdom, rooms are reserved in geriatric hospitals and nursing homes for short-term stays, allowing caregivers to take time off from caregiving. In Germany, legislation came into effect in 1989

covering respite stays in nursing homes for up to four weeks so that caregivers may take a holiday. In Israel there has been a notable expansion of respite care over the past ten years, with particular emphasis on day-care facilities for the elderly. Adult day care, another form of respite care, has also expanded rapidly in Canada, the United States, Japan, and the Scandinavian countries in recent years (Gibson, 1992).

Community-based services are also emerging in urban settings in some developing countries. Examples are to be found in Hong Kong, Singapore and the Republic of Korea for the Asian region and in Argentina, Jamaica, Mexico and Uruguay for the American region. Researchers have observed that even in a highly industrialized country, such as the United States, that community-based services tend to be concentrated in urban areas. This leads to the inevitable conclusion that family caregivers in the rural areas are a group particularly in need of services.

C. Assistance for caregivers from the employers

Research conducted in the United States and the United Kingdom shows that the implication for the employer when workers have no access to caregiving support are: impaired efficiency through stress, decrease in productivity and the quality of work, physical complaints, and absenteeism (IPM, 1990; and Mutschler, 1991, op. cit.). A 1986 survey of 96 companies in the United States revealed that managers observed the following problems among employees with caregiving responsibilities for the impaired elderly: lateness (73 per cent), unscheduled days off (75 per cent), absenteeism (67 per cent), excessive use of the telephone (64 per cent), and emergency hours off (58 per cent). Yet according to the same survey, very few companies were seriously considering ways in which to address caregiver issues. Of those that provided services to help caregivers, most were large companies with more than US$10 million in gross earnings per year (Mutschler, 1991, op. cit.). On the more positive side, a recent report by the research body of The Conference Board revealed that managers' understanding of work/family issues has markedly improved over the past three years. These findings were based on interviews with The Conference Board's Work-Family Research and Advisory Panel consisting of individuals from the United States, Canada, Europe and Australia (The Conference Board, 1992).

While employer-based policies that assist employed caregivers of the elderly are still relatively rare, in some countries, such as the United States and Japan, the number of examples is slowly growing.

The range of policies provided by employers addressing caregiver concerns includes the following: (1) direct services, such as counselling, adult day-care, and information; (2) personnel practices and policies, such as flexible work arrangements (flexitime, part-time work with benefits, job-sharing), leaves (personal, family and medical leaves – paid and unpaid but retaining benefits such as pension contributions and health insurance);

and (3) employee benefits, such as subsidies for caregiving services, and, if health insurance is provided by the employer (primarily in the United States), health benefits for elderly dependants or long-term care insurance policies.

Direct services for employees with eldercare responsibilities

A growing number of US companies now provide information and referral services for employees with these responsibilities. Examples include a Caregiver Fair, organized by The Travelers Companies (insurance company), at which representatives of community-based services provide information for employees with eldercare responsibilities.

The American Association of Retired Persons has developed kits on how to organize such fairs or hold special meetings or seminars on eldercare to be used by companies having more limited funds for such activities.

Such information can also be provided through corporate coalitions with community-based service providers. IBM established such a coalition and initiated a nationwide programme called Elder Care Referral Services (ECRS). During the first five months of their operation, 56,000 employees and retirees made use of these services (Heath, 1990).

Adult day care is offered by a few US companies. One of the most impressive examples is that of the Stride Rite company (a manufacturer of children's shoes) which provided an intergenerational day-care centre at the company's corporate headquarters. The facility encourages informal opportunities for the children and the elderly to meet while also providing each group with its own activities (Heath, 1990, op. cit.).

Personnel policies

Flexible leave time is probably the most extensively used personnel policy which addresses eldercare concerns for workers. While a study in the United Kingdom uncovered little evidence of eldercare provision by employers, it did find many examples of compassionate leave for family reasons. This leave was granted mostly during periods of crisis only (IPM, 1990, op. cit.). Evidence of longer-term leave for eldercare was reported only by the British Broadcasting Corporation (BBC), which recognizes eldercare responsibilities as a valid reason for a career break. In fact, the National Carers Survey conducted among 500 employers in the United Kingdom revealed that, with the exception of the BBC, no private employer offered any special conditions of employment to assist employees with eldercare and only five public sector employers offered or were considering offering eldercare initiatives (Eurolink Age, 1992, op. cit.).

By contrast, the Japanese Ministry of Labour indicated in 1990 that approximately 14 per cent of companies employing more than 30 persons now offer long-term leave of absence to employees to care for their elderly

relatives. The leave is unpaid, but the employer continues to provide health insurance. For example, since 1978 Kikkoman Corporation has offered the possibility of taking leave for up to six months; this was extended to one year as from 1989 (ISSA, 1993).

In the United States, unpaid leave is the benefit most frequently provided for family caregivers. A groundbreaking leave policy introduced by IBM in 1989 allows employees up to three years of personal unpaid leave, with the continuation of full benefits and the assurance of a comparable position upon return.

Flexible work schedules are another policy to accommodate caregivers' needs which is gaining ground. As a policy approach, it is clearly preferable to have formal written rules for flexitime rather than having leave decisions made on a discretionary basis by work supervisors (Mutschler, 1991, op. cit.). Flexible work schedules permit workers to adjust their work and care responsibilities more easily, without depending on the personal goodwill of the immediate supervisor.

Employer-provided benefits for eldercare

In the United States, employee benefits relating to eldercare are very recent innovations in benefit packages and are at present available primarily in large corporations. Dependant Care Assistance Plans (DCAP) are intended to provide financial relief to the caregivers of the young and the old. If the dependent older person meets the eligibility criteria, the plan allows the employee to place up to US$5,000 of pretax income into a special account held by the employer. The account can then be used to pay for caregiving expenses while the employee continues to work. The main attraction of DCAP is the fact that funds placed by the employee in such accounts are tax-exempt, provided the caregiver can prove that he or she is the principal source of financial help of the recipient. Roughly 1,000 US employers currently offer this benefit (Heath, 1990, op. cit.; Mutschler 1991, op. cit.).

A limited number of US employers also offer long-term care insurance as a benefit. This benefit is usually offered both to the company's retirees and to the spouses and parents of current employees. Advocates of private long-term care insurance hope such private insurance will help reduce public outlays for nursing home care. It should be kept in mind, however, that the outcome of the continuing debate on health care reform in the United States will inevitably have an impact on the future growth of private long-term care insurance. At present, the number of persons protected by such insurance is very low mainly because of the high cost of the premiums, as well as the relatively limited medical and long-term care protection provided by these schemes.

Final remarks

Until more reliable data and information are available about the circumstances of both caregivers and recipients, it will be difficult to assess which policy approaches work most efficiently and effectively in different settings. What is already clear is that national strategies to help relieve the burden of eldercare on workers will be composed of many different approaches, ranging from statutory family leave policies and social security provision to voluntary, community and employer-sponsored measures. The critical issue is which policies mix works best and at least cost to society.

In their search for the most effective mix, policy-makers should perhaps draw a lesson from the experience gained in promoting childcare provision for employed persons, though clearly child- and eldercare responsibilities differ in many important ways. It is critical to stress from the outset that such measures are intended for both men and women. They should therefore take into account the issue of the proper sharing of responsibilities between men and women in the family. Furthermore, as it is also risky to assume that measures aimed at alleviating eldercare responsibilities will automatically result in a higher and sustained female labour force participation, such measures should not be designed primarily as means of promoting equal opportunities for women in the workplace.

Although much attention has been given over recent decades to the complex issue of promoting equal opportunities for women and men in the labour market, there has been relatively little systematic effort to assess the impact of family caregiving responsibilities on the employment opportunities of either sex or, for that matter, of workers in general. What is missing from the debate is a greater understanding of the consequences for employment of the choices made by both men and women regarding their family caregiving obligations. A positive step forward rectifying this situation would be greater support for longitudinal studies tracking over time the consequences for labour force participation of decisions made by family members to care for their young children as well as their sick and elderly family members.

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