Equalising Care in a Changing Society

1. Preface

The new Social Agenda emphasises the growing interest at European level in the causes and consequences of changes in family and household composition, and in how policy makers should respond to these changes. Some consequences of the changes are:

- **Growing demand for family care**: professional and unpaid care

- **Declining availability of family carers**: less people will be available for a growing number of elderly who depend on family care

- **Growing demand for possibilities to combine care responsibilities with employment**

In the framework of our project we explored results of scientific research, strategy development and the impact of different measures and legislation regarding care credits systems in diverse European countries on the income position of women and the redistribution of work and family responsibilities. From the joint insights and knowledge of experts in UK, Poland, Spain and the Netherlands and using the experience of the NGOs and Trade Unions participating in the Equalising Care Network we aimed at development of a new system for economic valuation and equalising all the necessary but unpaid care work in European Member States.

In this publication we like to present the results of our project 'Equalising Care in a Changing Society' and to exchange our findings with you.

Also we would like your cooperation to put new possibilities and strategies to implement a system to equalise care in European Memberstates on the agenda of policy makers, politicians, trade unions and civil society.

FNV Women's Union – Netherlands
Gabinet d'Estudis Socials (GES) – Spain
UK Coalition Against Poverty – United Kingdom
Women's Rights Centre – Poland

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2.1 Introduction

In the project 'Equalising Care in a Changing Society' we focus on the different patterns of care-giving and care-receiving combined with labour market participation of women and men and with the distribution of income.

In most European countries family responsibilities force women to reduce their employment temporally or even leave employment for a period of time. One of the effects is that the risk of poverty for women is larger than for men, because women have less time to regain income.

Especially older women are at risk because (the possibility) for pension accrual of people who spend part of their life caring (mostly women) is unequal to that of people who were employed all of their working life.

Table 2.1 Proportion of men and women at risk-of-poverty

The share of persons with an equivalised disposable income, before social transfers, below the risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income (after social transfers). Retirement and survivor's pensions are counted as income before transfers and not as social transfers.

2005									
Age	**All**	**16-24**		**25-49**		**50-64**		**> 65**	
		M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Poland	21	25	27	22	21	19	14	5	9
Spain	20	17	19	15	17	17	16	26	32
UK	18	19	19	14	12	16	16	24	29
Netherl.	11	15	17	10	10	8	8	5	6
EU 25	18	18	20	13	14	13	13	16	21

Soource: Eurostat

Looking at the figures in table 2.1 we see that the poverty rate for in the EU-25 is 18%. In the Netherlands the poverty risk for men and women in all age groups is below the EU-25 average. In UK the poverty risk for the younger age groups is approximately the EU-25 average, but from the age of 50 the poverty risk become higher and higher. Over 65 in UK nearly one third of the older women and a quarter of the older men

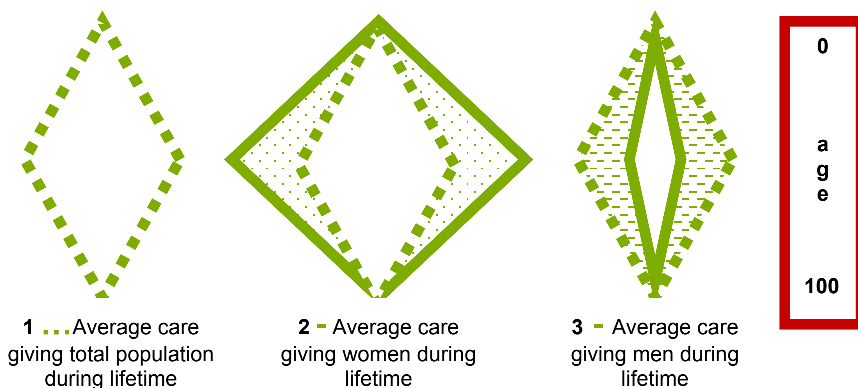
in live below the poverty rate, the same as in Spain. The youngest age group in Spain compares with the EU-25 average but growing age means that poverty risk grows as well.

Care giving and care receiving

In a society, based on equal opportunities, responsibilities for caring should be divided equally between men and women in specific age-groups.

However in all European countries unpaid care work, such as caring for children and dependent elderly, producing and preparing food for the family, protecting the environment and providing voluntary assistance to vulnerable and disadvantaged individuals and groups, is mainly performed by women.

Graphic 2.1: Average Caregiving by men and women during lifetime

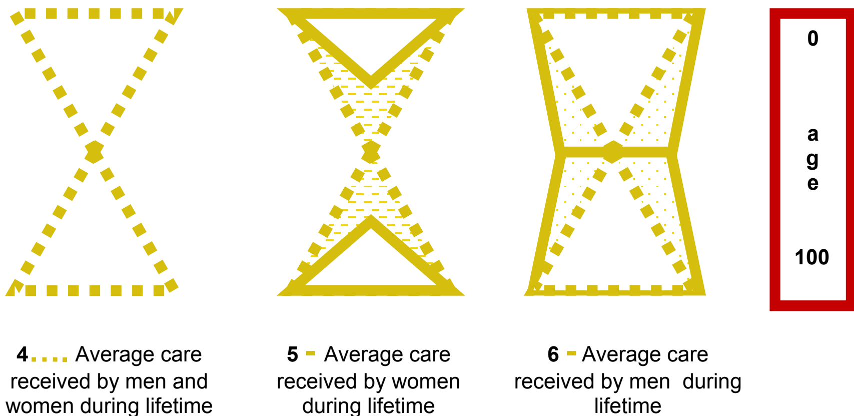


The dotted line in figures 1, 2 and 3 represents the average care giving needed. Figure 2 shows the difference between actual amount of care giving for women and figure 3 for men during life time related to the

average. Together he three figures show the difference during divers periods in life in care giving between men and women.

During lifetime the need to receive care from others is opposite to the need to give care to others as visualised in the figure 4 in Graphic 2.2:

Graphic 2.2: Average Care received by men and women during lifetime



4 .... Average care received by men and women during lifetime

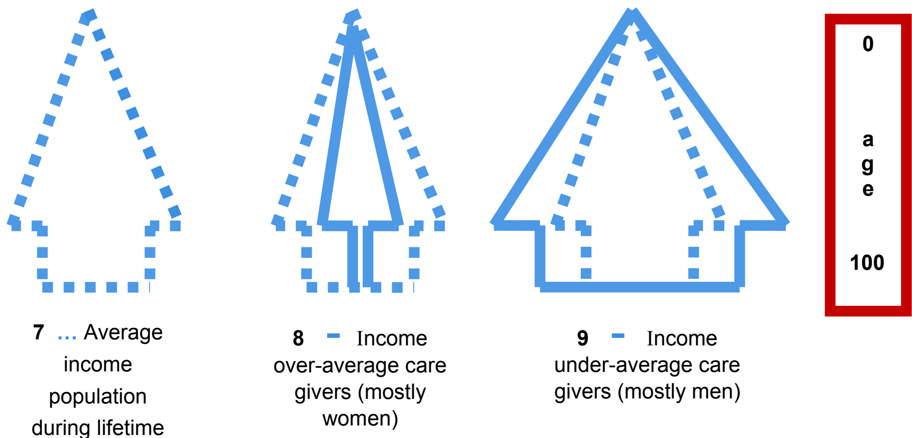
5 - Average care received by women during lifetime

6 - Average care received by men during lifetime

Figures 5 and 6 show that the average care received by men is also reversed to the care that women receive.

As most of the care work that is needed in society is unpaid care, this of course effects the income position of those who care. Graphic 3 shows the inequality in income distribution between over average carers and under average carers. As pointed out the over-carers mostly are women. The investment of women in care for others means that their income is lower then that of men and the risk of poverty is greater then that of men.

Graphic 2.3: Unequal income distribution between over-carers and under-carers



Macro-economic models that are used by governments or at European level for social policies, do not include instruments to relate poverty and social exclusion with the distribution of unpaid work.

In 2004 the High-level group chaired by Kok, argued that if Europe wants to hold the broad ambition of solidarity with the needy, now and in the future, it needs more growth and more people at work. (European Communities 2004: 12). The Lisbon objectives (2000) seek the solution in European Member States in enhancing women's labour market participation: in 2010 in each country 60% of the women must have a paid job. Only this way Europe is expected to become '*the most competitive and dynamic on knowledge based economy of the world*'. It is a condition for '*permanent, active and dynamic welfare states*' according to the Lisbon objectives.

As we know the progress of these objectives is not yet positive. The majority of the poor people living in the European Union are women: single parents or older women who did unpaid work most of their lives.

Employment practices only change when ideals and valuation of care change and new solutions are found for care in each country. (Kremer, 2005). In none of the European Member states an appropriate solution is found yet. At the same time the demographic trends show that the next decennia the need for care-giving will expand with the ageing of the population.

Three basic trends resulting in the current demographic changes are according to the Green Paper "Confronting demographic change: a new solidarity between the generations"[1]:

• **Continuing increases in life expectancy** as a result of considerable progress made in health care and quality of life in Europe: healthy life expectancy is still rising. This trend should continue, with the gap between male and female life expectancy closing.

Table 2.2 Life expectancy at age 65

	1995		**2000**		**2005**	
	males	fem	males	fem.	males	fem
Netherlands	14,74	19,2	-	-	16,44	20,13
Poland	-	-	13,58	17,74	14,29	18,49
Spain	16,15	20,17	16,69	20,79	17,25	21,3
UK	14,62	18,23	15,8	19,03	17,02	19,52
EU 25 2003					16,9 (2003)	19,6 (2003)
Source: Eurostat						

• **Continuing low birth rates**. From 1960 on - the baby-boomer generation – families have had fewer children than previous generations. Almost everywhere, fertility is below the population replacement level. In certain southern and eastern European countries, it is less than 1.3 children per woman"

Tabel 2.3 Fertility rate – number of children per women

The total fertility rate is also used to indicate the replacement level fertility; in more highly developed countries, a rate of 2.1 is considered to be replacement level.			
	1995	**2000**	**2005**
Netherlands	1,53	1,72	1.71
Poland	-	1,35	1,24*
Spain	1,17	1,23	1,35
UK	1,71	1,64	1,78
Source: Eurostat * 2005: Lowest Fertility rate in Europe			

• **Continuing growing number of workers over 60,** which will stop only around 2030, when the baby-boomer generation will become "elderly"

Tabel 2.4 Employment rate between 55 – 64 years of age

The employment rate is calculated by dividing the number of persons aged 15 to 64 in employment by the total population of the same age group. The indicator is based on the EU Labour Force Survey.			
	1995	**2000**	**2005**
Netherlands	28,9	38,2	47,7
Poland	-	28,4	28,1
Spain	32,3	37	44,1
UK	47,5	50,7	57,4
EU 25		36,9	43,5
Source: Eurostat			

Consequently in years to come there will be:

- a growing demand for family care: professional and unpaid care
- a declining availability of family carers: less people will be available for a growing number of elderly who depend on family care
- a growing demand for possibilities to combine care responsibilities with employment

2.2 Impact of the Lisbon strategies on unpaid care work?

With the growing demand for care in future decades in all European member states, the position of the people who provide unpaid care can not longer be neglected. From our research it obvious that In most European countries family responsibilities force women to reduce temporally their employment or even leave employment for a period of time. One of the effects is that the risk of poverty for women is larger than for men, because women have less time to regain income. The Lisbon objectives (2000) however seek the solution to decrease the poverty risk in European Member States by enhancing women's labour market participation: in 2010 in each country 60% of the women should have a paid job.

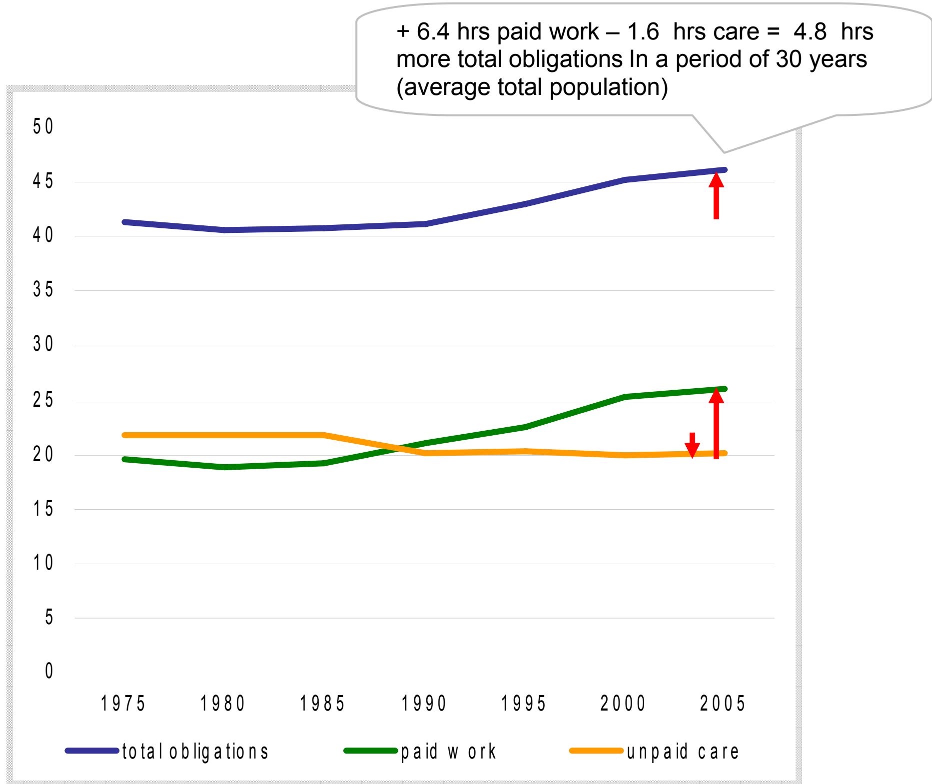
Increase of women's paid work
In the Netherlands women already did reach their part of the emancipation objectives: enhancement of the economical independency by increased participation in employment. Between 1975 and 2005 employment of women increased from 18% to 53%.

Next question is what the impact of the increase of women's paid work was on the volume of time spend at unpaid care ?

The past three decades Dutch economy became more and more monetarised: this means that on average the Dutch population spends more hours at paid work and less at unpaid care. The average time that people are spending at unpaid care reduced during that period with 1.6 hours, while the number of hours paid work increased with 6.4 hours a week. This means that women did not proportional decrease their unpaid care work and also that men did not take over a proportional part of the unpaid care work.

This is a disturbing development if we look at the total population: for each hour extra spend at paid work the time available for care work decreases with a quarter of an hour.

Graphic 2.4 Consequences of the rising number of hours spend at paid work 1975-2005, average time use total population 20-64 year

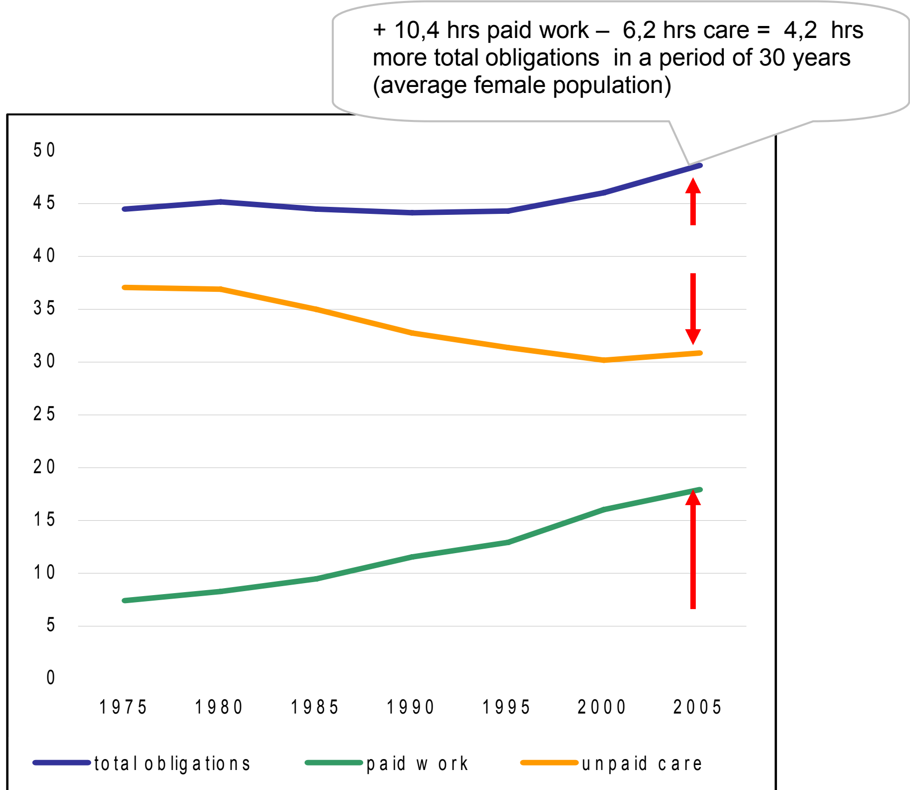


Source: SCP (TBO'75-05)

The government's objective – in line with the Lisbon agreement – is to stimulate more women to participate in the labour market. But increasing women's paid work has more effect on the unpaid care.

As shown in graphic 2.5 women worked 10.4 hours more outside the house, but reduced their care work with 6.2 hours. This means that every hour more paid work of women is related to a decrease of more than half an hour (36 minutes) unpaid care work.

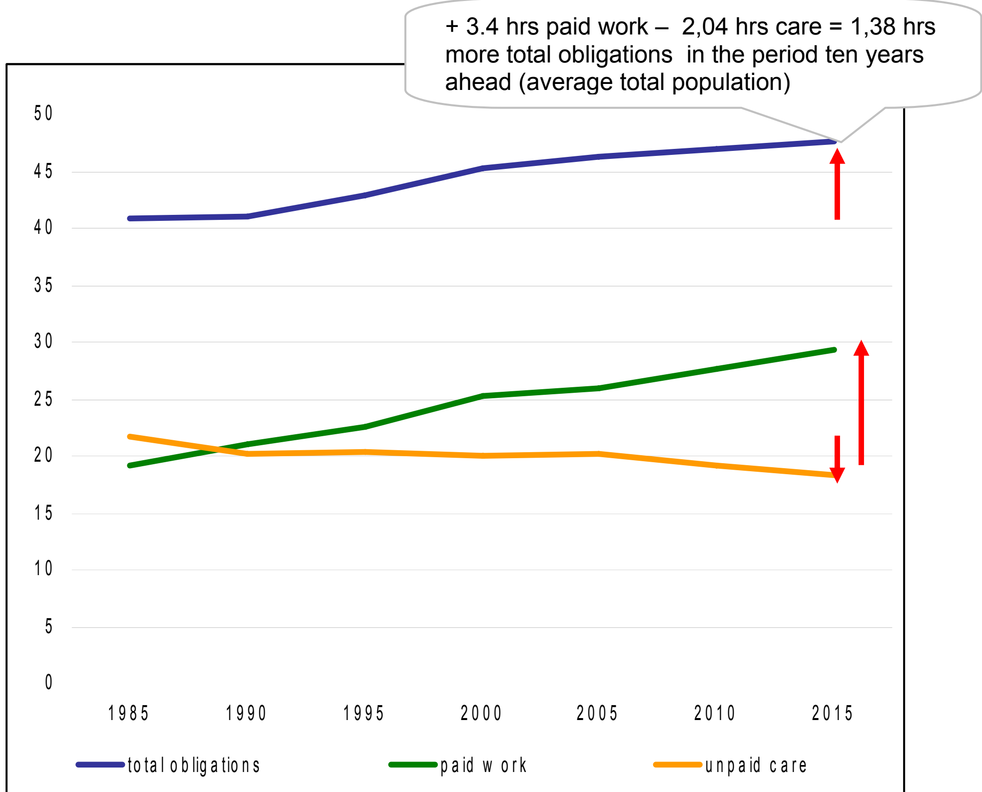
Graphic 2.5 Consequences of the rising number of hours spend at paid work 1975-2005, average time use women 20-64 year



Source: SCP (TBO'75-05)

In the following graphic 2.6 we draw the consequences of this policy ten years ahead: the hours paid work increase and the hours unpaid care decrease, but not proportional. Women increase their paid employment with another 3.4 hrs which implicates that unpaid care will decrease with 3.4 x 36 minutes. Consequently the total time necessary for all obligations (paid and unpaid) will increase with 1.36 hrs.

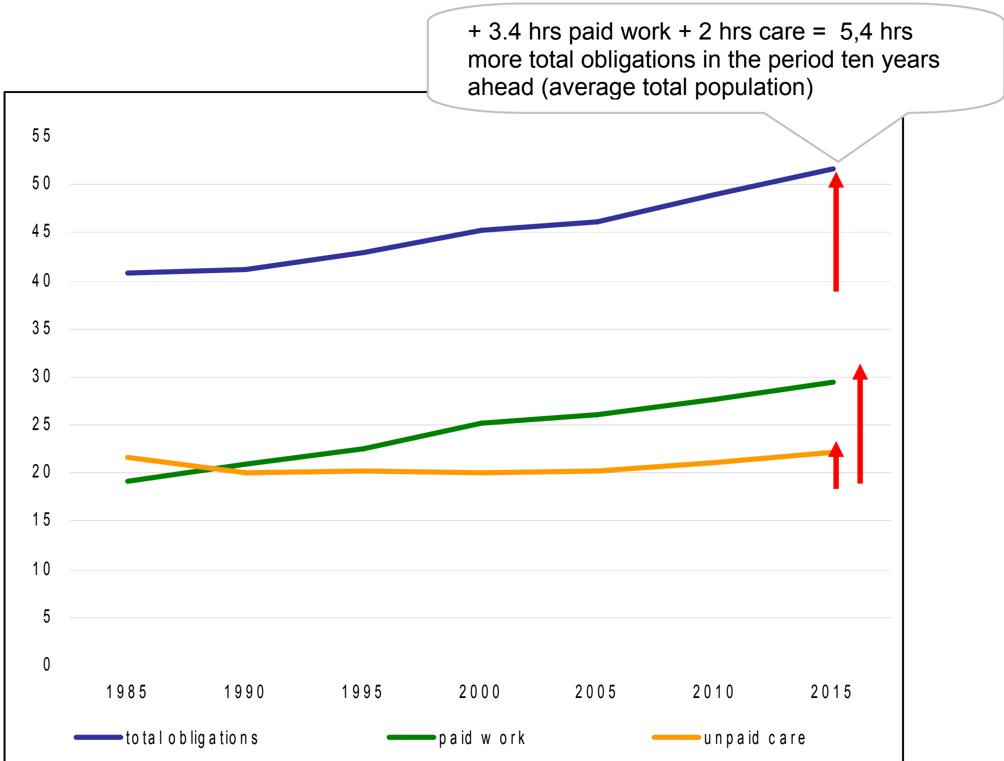
.Graphic 2.6 **Estimated consequences of the rising number of hours spend at paid work by women aged 20-64 in the next ten years, average time use total population**



Source: Estimation Equalising Care

But we also know that in the same period the demographic development will cause a growing demand for (unpaid) family care. In fact because of the growing demand for care the Dutch government tries to stimulate the population to enhance family care and care for dependent elderly people in your neighbourhood. This means in the years to come the average time spend on unpaid care should not be reduced but increased.

Graphic 2.7 Estimated consequences rising number of hours spend at paid work by women aged 20-64 + increase unpaid care for dependent elderly in the next ten years, average time use total population



Source: Estimation Equalising Care

Graphic 2.7 is our second estimation of the consequences now including two policies: the Lisbon agreement to enhance women's employment till 60% and the policy to ensure well- being of the growing group elderly by stimulating unpaid family- and informal care.

It will be obvious that an ongoing increase of the time necessary for all obligations (paid and unpaid) will not be possible in the future.

2.3 Objectives of the project Equalising Care in a Changing Society

In this project we investigated the unequal distribution of paid and unpaid work and its relation to the gendered system of intergenerational transfers.

Secondly we will investigate which systems and strategies exist and/or could be developed to equalise the difference between 'under-carers' and 'over-carers' and also if these systems are applicable in European countries.

Through transnational exchange of results of scientific research and strategy development as well as of the impact of different measures and legislation - for instance care credits systems - on the income position of unpaid carers and on the redistribution of work and family responsibilities

Although we expect a that such a system is important to redress gender inequalities and reduce poverty of (older) women, it has to be developed after careful assessment in order to promote employment of women who have to reconcile work and family responsibilities and at the same time give women and men a realistic choice concerning the way they arrange the balance between work and family life.

2.3.1 Central question

The central question of our transnational investigation is:

Which policies and strategies contribute effectively to an equal distribution of the costs and benefits of unpaid care work?

2.3.2 Hypotheses

In order to be able to answer the central question our investigation started from the following hypotheses:

1. There is a gender specific asymmetric relationship between care-receiving and care-giving. During their lifecycle, women give more care then they receive, whereas men receive more care then they give.

2. The individual income is inversely proportional to the individual volume of unpaid care work: When time spent to unpaid care work is above the social average of unpaid work, than income is below the social average income. The more time spent to unpaid care work, the less income is obtained.

3. The economic value of professional care per capita is inversely proportional to the volume of unpaid care services per capital. When the professional care per capita is high, the unpaid care work will be low. Unpaid care services bridge the gap between the social need for care and the supply of professional care by the government and the market.

4. A quota that indicates the relation between the volumes in time units of the paid and the unpaid work (PUW) is a policy instrument to equalise costs and benefits of unpaid work and to promote a balance between work and family life for men and women.

2.4 Comparison of the situation in four European countries

Partners from four European member states (Spain, Poland, United Kingdom and the Netherlands) did research regarding the four hypotheses. In this paragraph a sort summary of this research in the European member states mentioned and – based on the results – conclusions regarding the hypotheses.

The population of the four countries together is 157.5 million and represents one third of the total inhabitants of the EU-25 countries.
The key figures in table 2.5 illustrate the social economic situation in the four countries in 2005.

Table 2.5 Population, GDP, and social protection and minimum wages

Year	Figures regarding:	Poland	Spain	UK	Nether-lands.
2005	Total population (in millions)	38,2 million	43 million	60 million	16,3 million
2005	GDP (Gross Domestic Product) per capita	€ 11700	€ 23100	€ 27300	€ 28900
2005	Expenditure on social protection (as % of GDP)	21,6%	19,7%	26,1%	28,1%
2006	Minimum wages in euro	€ 234	€ 631	€ 1269	€ 1273
2005	Average percentage full-time employees earning minimum wage	4,5%	0,8%	1,8%	2,1%

In the 'youngest' EU member state Poland the GDP is half or less of that in the other three countries. Minimum wages in Poland are nearly 1/3 of those in Spain and 1/5 of the minimum wages in the UK and the Netherlands.

The expenditure on social protection is the lowest in Spain and the highest in the Netherlands

2.4.1 Total volume of time spend to paid and unpaid (care) work

The Human Development Report 1995 (UNDP,1995) indicated that on average in industrial countries the unpaid working time is comparable to the time spend at paid employment. For instance the Dutch population aged 12-65 year together spends 12185 million hours each year at domestic work and childcare in their own environment and 11762 million hours at paid work outside their home. So 51% of the total work volume is unpaid and 49% is paid.

Looking at the time-use surveys it seems that in the other three countries at stake the share of paid and unpaid work also is approximately equal. In Poland the share of unpaid work is the highest with 53% and of paid work the lowest with 47%. In UK and Spain the figures show a reverse situation: the percentage of paid work is higher. In UK 51% is paid and 49% unpaid and in Spain 52% of the total work volume is paid and 48% unpaid.

The conclusion of the Human Development Report 1995 that – on average – the unpaid working time is comparable with the time spend to paid work, is valid for the situation regarding time-use in Poland, Spain, UK and the Netherlands today.

2.4.2 The share of women and men of different age groups in the total volume of time spend at paid and unpaid (care) work?

In all four countries the share of men and women in paid and unpaid work differs. On average men do two-third of the paid work and one-third of the unpaid work. The time spend to paid and unpaid work by women is reverse to that of men.

In table 2.6 the figures for the four countries are specified.

The average time spent on various activities is calculated across the whole year including working days and weekends, as well as holiday periods. This

explains why, for example, the time spent on paid work is significantly less than a normal working day.[2]

Table 2.6: Time use paid work and care men and women aged 20-74

	Women	Men
Poland		
Paid work	2.29	4.15
Domestic and care work	4.45	2.22
Total	7hrs 14 min a day	6hrs 37 min a day
Spain		
Paid work	2.26	4.39
Domestic and care work	4.55	1.37
Total	7 hrs 21 min a day	6hrs 16 min a day
UK		
Paid work	2.33	4.18
Domestic and care work	4.15	2.18
Total	6 hrs 48 min a day	6 hrs 36 min a day
Netherlands*		
Paid work	2.25	4.01
Domestic and care work	4.04	2.31
Total	6 hrs 29 min a day	6 hrs 32 min a day

* the survey methods used in the Netherlands deviated from the European guidelines and results are not fully comparable with the results of the other three countries.

Source: Eurostat, Statistics in Focus, 4/2006

The figures in table 2.6 are the average for all persons aged 20 to 74. Looking at the different age-cohorts in this population, the hours spent on paid and unpaid work differ at lot.

In **Spain** for instance younger cohorts (people under 25 years of age) devote less daily time to paid work (1h29m) and to the household and the family (1h6m) and more time to studying (3 hours) and to social and recreational activities (1h51m). As age increases and up to a certain point, there is a reversion: people between 25 and 44 years old devote 4 hours and 15

minutes to paid work and 3 hours and 10 minutes to the household and the family, while only devote 17 minutes to studying and 1 hour and 22 minutes to social and recreational activities.
People between 45 and 64 years old show another pattern: the time devoted to working decreases (3h6m), while time devoted to the household and the family continues on the increase (3h42m). Both studying and social and recreational activities decrease (3 minutes and 1h15m). For people over 65 years old, both working and studying times are extremely reduced (0h7m and 0h1m respectively) while the time devoted to the household and the family remains constant (3h41m) and social and recreational activities turn increasing, (1h42m). So that middle-age and older cohorts are those spending more time in unpaid (care) work. It must be said that the Spanish Time Use Survey does not include a specific category called "unpaid care work" and that we have assumed that the most similar one is the one called "hogar y familia" (house and family).

Looking more specific at figures regarding unpaid care work in t**he Netherlands,** people of 20-34 of age spent 2h21m at care, aged 35-49: 3h17m care work a day, aged 50-64 care 2h55m and people over 65 care 3h21m each day of the week. The Dutch patron is comparable with the situation in Spain: the middle-age and oldest cohort spent the most time at unpaid care.[3]

Research in the **United Kingdom** indicated that 45 % of the carers were aged between 45 and 64.
Around 44,000 people (5%) aged 85 and over provided care, with around half of these (51%) spending 50 or more hours a week caring.
Remarkable is that in UK there are 114,000 children (just over 1 per cent) aged 5 to 15 years providing care in 2001. Of these children 9000 (8%) caring for 50 or more hours a week.
Of the 35-54 year olds 57% says they will provide care in the future. The 15-34 aged group in UK is less likely than older groups to say they will provide care in the future: just 49%.

In **Poland** 13% of the carers is between 18-33 years of age, 35% between 34-49 and the population of 50 years and older provide more than half (52%) of all the unpaid care work. Of these care givers in Poland 76% are women and 24% men.

2.4.3 Demand for professional care services of different cohorts of men and women

In the research done by B. Synak and co-workers (Synak, 2002) a "self-care index" based on the assessment of ADL (ADL – Activity of Daily Living) was used. Among people aged 65 or more in Poland 36.5 % felt a fair or severe impairment. This level of disability applied to 26 % of people aged 65-74 and 52.5 % of people over 75. Such an impairment was experienced by 31 % of elderly urban communities and 42 % of elderly in rural communities.
Błędowski and Pędich (2004) assume "that people with this level of disability need help in every-day activities, and this is performed almost entirely by family carers. It can be estimated, that in Poland 1,698.6 thousand people aged 65 or more need help from family carers because of their physical impairments. This is just an estimate and it can show considerable differences in various regions of
the country. It was confirmed by a research in six deliberately chosen country communities, representing different geographical, ethnical and cultural (customs) backgrounds, in which physical disability applied to 45 % to 80 % of elderly in various communities. This number does not include people who need help because of psychological or social problems."[4]

In UK there is a huge gap between need and provision of care. It is only partially income related. If everyone had sufficient money tomorrow to buy what they needed it would only partially solve the problem, because the supply does not currently exist. True, it would stimulate the market, that would be in the region of several £ billions the scale is difficult to estimate, investigations are ongoing by caring organisations. This can be related to the numbers currently in residential/professional care and the savings to Government by informal care, i.e. £57 billion, which is the same amount of money paid by the Government for the whole of the National Health Service.

2.4.4 Conclusions Hypothesis 1

From the figures presented in the country reports it is obvious that the first hypothesis is true:

There is a gender specific asymmetric relationship between care-receiving and care-giving.

Until the age of retirement women give more care then they receive, whereas men receive more care then they give. After 65 men provide more care, but older women – as long as they are able - are still the main caregivers in household.

2.4.5 Relation between income and unpaid care

In the second hypotheses we mentioned that the individual income is inversely proportional to the individual volume of unpaid care work.
As table 2.7 shows in **Spain** people with lower incomes are more frequently involved in tasks related to the household and to the family than those with higher incomes. In addition, the former usually devote more time to these activities than high-income groups. In all the cases, women are more commonly found to be charged with these tasks and also to devote more time to these activities as shown in table 2.7[5].

Table 2.7 Spain: Percentage of people who care and average duration related to Net average monthly income of the household

	All		Men		Women	
	% of the population	Average Daily hours	% of the population	Average Daily hours	% of the population	Average Daily hours
Net monthly income						
< 1.000 €	85,0	4:06	72,6	2:24	94,6	5:07
1.000 a 1.499,99 €	81,8	3:46	70,2	2:05	93,0	4:59
1.500 a 1.999,99 €	80,1	3:34	68,8	2:05	92,2	4:45
> 2.000 €	79,7	3:09	69,1	1:58	91,1	4:07

It is evident that for many carers combining paid work with caregiving is far from easy. In fact, according to a very important Spanish co-operative (Grupo EROSKI), around 50 % of carers in Spain had to renounce paid activities, or did reduced their working day, during the time they are responsible for a dependent elderly person. In addition, while earnings decrease expenditure is obviously increasing in order to cover the care-related needs.

So far, medium-classes have usually been those with more difficulties to have access to professional care services for the elderly, because they were neither poor enough to be entitled to a public facilities nor rich enough to afford paying a private care centre. But the new law regarding the care for dependent chronical ill people[6] ('Ley de Dependencia'), that has been recently passed by the Spanish Government should be expected to change this pattern. This Law introduces a subjective right which is based on the principles of universality, equity and accessibility and develops a model of comprehensive care. Dependence is therefore equaled from now on to education and health: a universal right to care for the dependent is recognised, so that all social classes will be entitled to public care, although according to their income level people will have to pay for part of its cost. But two points must be stressed. First, that this law will be gradually implemented until 2015 and that it will benefit, first, those people with greater levels of dependence, so that the least dependent will not see a change in provisions until the end of that period and will remain in the same position than now: mostly resorting to private centres, to family carers or to the informal economy. Second point, in Spain the concept of dependence is restricted to the disabled and to a segment of the elderly, but does not concern children before compulsory education.

Exact figures – as in Spain - about the income situation of carers were not found for **Poland**. But Poland was partner in the project EUROFAMCARE – funded by the European Commission for the years 2003-2005 - that provides a European review of the situation of family carers of older people aged 65 and over in relation to supporting services. In 2003-2004 six countries (Germany, Greece, Italy, Poland, Sweden and the United Kingdom) have

carried out a comparative study consisting of 1000 interviews per country with family carers who provided support for at least 4 hours a week. [7] From this study we learned that 60% of the caregivers in Poland has no paid employment. 62% is retired, 17% are full-time unpaid working and 14,5% is looking for a paid job to combine with the unpaid care.
One quarter of these carers indicate caregiving as cause of financial problems.
One third of the caregivers In Poland are daughter (37.1 %). In the second place caregivers are spouses (29.2 %) followed by sons (20.9 %) and grandchild (15.5 %).[8]

Table 2.8 shows how caring relates to employment and economic activity in the **United Kingdom**. Except among those looking after their home or family full-time, the likelihood of being a carer is always grater for women than for men. All over 1.4 million men and 1.7 million women do paid work and also provide unpaid care. Over 1.3 million men and 850.000 women work full-time and provide unpaid care. Men who look after their home or family full-time, and early-retired women, are the groups under state pension age which are most likely to be carers. The number of men looking after their home and family full-time is small (194,000) compared with 2.5 million women, but half these men (97,000) are also carers. Among those looking after home and family, 64,000 men and 225,000 women care for 50 or more hours each week.

Table 2.8 UK: People with caring responsibilities by economic activity category (people of working age)

	Men	**Women**
Economically Active	**9,9**	**13,4**
Self-employed PT	15,9	18,7
Employee PT	13,0	16,7
Self-employed FT	11,0	15,5
Employee FT	9,5	11,7
Unemployed	9,5	12,4
Full-time student	4,8	5,6

Economically Inactive	13,4	16,7
Retired early	21,5	27,2
Student	3,9	5,4
Looking after home or family	48,5	21,6
Permanently sick or disabled	12,6	15,4
Other	9,3	11,1
All	**10,5**	**14,4**
Source: 2001 Census Commissioned Tables, Crown Copyright 2004. These data refers to England and Wales only.		

Among the economically active:

- Self-employed people who work part-time are the most likely to be carers.
- 186,000 women and almost 32,000 men combine part-time employment with caring for 20 or more hours each week.
- 239,000 men and almost 158,000 women combine full-time employment with caring for 20 hours or more each week.
- 1 in 6 women working part-time and 1 in 8 women working full-time are also carers. The figures for men are just over 1 in 8 (PT) and just under 1 in 10 (FT).

The General Household Survey found that where the carer and the person cared for lived in the same household the amount of care provided increased. 63% of carers in the same household spent 20 or more hours a week caring and 31% spent at least 50 hours per week caring.

In UK the category of lower earners are less inclined to commit to providing care in the future: 48% of people earning £17,499 and under compared with 57% of people earning £30,000 and over.

In the **Netherlands** there seems to be a relation between educational level and the amount of caregiving. People with a lower education level care 21 hours a week, with middle education 18 hours and with higher education less than 18 hours a week. There also is a relation between paid work and care: people who are unemployed care nearly ten hours more per week than employees.

Table 2.9 Netherlands: Care work, population of 12 years and older, specified to education and employment, 2005 [9]

EDUCATION LEVEL	**(hours/week)**
lower	20,9
middle	18,1
high	17,8
EMPLOYMENT	
employee	17,3
no employment, not studying	26,5
student	5,8

No figures where found in the Netherlands regarding the relation between income and caregiving. But research was done among 343.000 men and women who should want to increase their employment, but could not because of care. Most mentioned reason by men and women is the fact that it is not possible to get more hours paid work. Next to that women also mentioned that the combination of a paid job with the care responsibilities should be too heavy and that childcare facilities are too expensive.

Table 2.10 Netherlands: Persons of 25-64 year without employment because of their care tasks, 2005

(x 1000)	**Total**	**Men**	**Women**
Wants (more hours) employment:	343	96	247
Reasons not to work(more) because of care:			
Can't get more hours paid work	153	50	103
Childcare of care is to expensive	18	1	17

Quality of available childcare is insufficient	2	0	2
Lack of childcare of care facilities	4	0	4
Partner does not agree	1	0	1
Combination care and employment is to heavy	30	1	28
Schooltimes don't match workingtimes	4	1	3
Other reasons	131	43	88

An indication of the relation between care responsibilities and income also can be the action of mother after childbirth and the period of parental leave. In the countries participating in our research 25% of the mothers in the Netherlands resumed work to the same extent as before the child was born, 58% asked for less working hours and only 1% did not go back to work at all. In Poland the percentage of mothers that leave their jobs after a child is born is the highest with 13%, in UK 10% quits her jobs and in Spain 5% of the young mothers. Part-time work is the solution of 40% of the mothers in UK and 30% in Spain and only 4% of the mothers in Poland ask for reduced working hours after parental leave. The percentage of women whom work the same hours is even 75%.

Table 2.11 Mother's action after parental leave

Action after parental leave	**UK**	**Spain**	**Nether lands**	**Poland**
Resume work to same extent	35%	53%	25%	73%
Ask for reduced working hours	40%	30%	58%	4%
Do not resume work at all	10%	5%	1%	13%
Don't know/no answer	15%	12%	17%	9%
Base: Establishments with employees on parental leave in the past three years (management interviews) *Source:* ESWT, 2004–2005				

A possible explanation for the high percentages of women who keep the same working hours is that grandmothers in Spain and Poland are the main childcare providers. In practice women remain to work the same extent after giving birth but quit their job as soon as a grandchild is born.

2.4.6 Conclusions Hypothesis 2

Based on the division of paid work and unpaid care in the four countries our second hypothesis is valid.

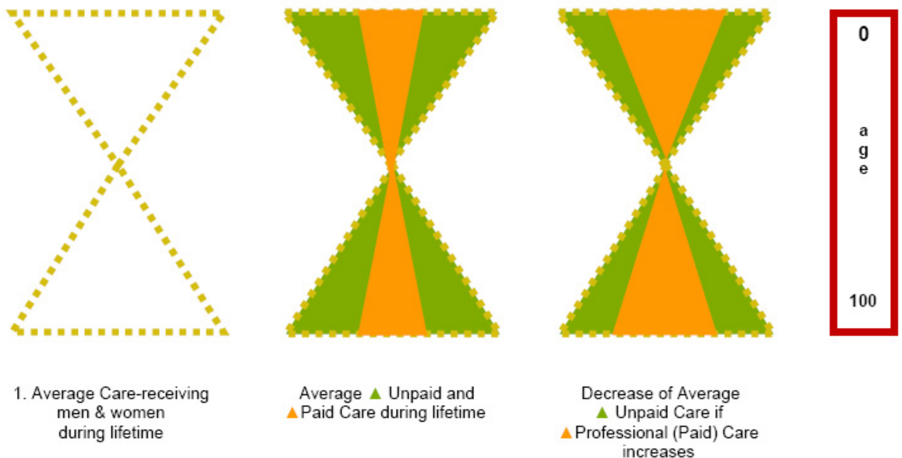
The individual income is inversely proportional to the individual volume of unpaid care work: When time spend at unpaid care work is above the social average of unpaid work, than income is below the social average income.

The more time spend to unpaid care work, the less income is obtained by men and women. As women care the most, their capacity to gain income is less than that of men **because** they care.

2.4.7 Inversely proportional volume of paid and unpaid care

Our third hypothesis stated that the economic value of professional care per capita is inversely proportional to the volume of unpaid care services per capital.

Graphic 2.8 Relation between professional care and unpaid care



When the paid professional care per capita is high, the unpaid care work will be low. Unpaid care services bridge the gap between the social need for care and the supply of professional care by the government and the market.

Our data collection in the four countries regarding this hypothesis included the following specific research questions:

- What is the average governmental inversion per capita in the different types of care? (health care, child care facilities, education etc.)
- How is the supply of care services distributed between the government and the free market?
- What kind of care facilities are available on micro, meso and macro level?
- What is the average volume of unpaid (care) work per capita?
- Which phenomena indicate that there is a gap between the need of care and the supply of care? Waiting lists? Professional care only accessible for high income groups? Etc.

The data available for our four countries were not sufficient to be able to conclude about the justification of the third hypothesis.

An indicator for the statement that formal care replaces informal care (and visa versa) is that in Sweden, where the expenditure on the care for elderly is high (2.74% GDP), women spend much more time at paid work and less time at informal care than in other European member states. And might professional care not be provided in Sweden, the care leave legislation entitles the caregiver to 80% of the previous wages (up to a maximum).

The expenditure on health care and more specific on care for elderly in the four countries participating in our research is (estimated) as shown in table 2.12

Table 2.12 Total expenditure on heath and on the care for the elderly		
	Total on health (as % GDP)	**Total on care for elderly 2005***
Poland	6.5 %	0.3 %
Spain	8.1 % e	0.3 %
UK	8.3 % e	1 %
Netherlands	9.2 % e	0.9 %

Source GDP and care elderly: Eurostat
* The indicator is defined as the percentage share of social protection expenditure devoted to old age care in GDP. These expenditures cover care allowance, accomodation, and assistance in carrying out daily tasks.
Source Health: European Commission Healthe & Consumer protection Directorate –General. e=estimated

Of the four countries the UK is spending the most (1%) at care for the elderly, directly followed by the Netherlands (0.9%). In Spain and Poland the share (0.3%) of the GDP on care for the elderly is nearly one third of this expenditure in the other two countries. Looking at the time use figures available we could not find a direct link between time spend at care and the difference in the total expenditure on the care for the elderly.

But, using data from the Survey of Health, Ageing and Retirement in Europe (SHARE), which was conducted among people aged over 50 in several European countries Bolin, Lindgren and Lundborg (2007) concluded that informal care (the care supplied by children or grandchildren) reduces the probability of utilisation of formal care provided in the household. At the same time however informal care increases the probability and the amount of utilisation of other types of health care.[10] Their analysis suggests that "informal and formal care provided in the household are substitutes, while informal care and formal care provided in hospitals or doctors' offices are complements."

notes

[1] Brussel, 16.3.2005, COM(2005) 94 definite

[2] Eurostat, Statistics in Focus, 4/2006

[3] Source: SCP (TBO 1975-2005), Breedveld,Koen en Andries van den Broek, TBO, SCP deze versie: 20061018:

[4]. Piotr Błędowski, Wojciech Pędich, Eurofam, National Background Report for Poland, 2004

[5] Instituto Nacional de Estadística, Encuesta de empleo del tiempo 2002-2003

[6] "Ley 39/2006 de Promoción de la Autonomía Personal y Atención a personas en situación de dependencia" (Law for the Promotion of Personal Autonomy and Care for People in a Dependent Situation), available at:
http://www.imsersomayores.csic.es/senileg/registro.jsp?id=3383

[7] Piotr Czekanowski, Brunon Synak, Giovanni Lamura Paper Research Network on Ageing in Europe for the 7th European Sociological Association Conference in Torun, Poland, September 9 -12, 2005.

[8] Synak B, editor. Polska starość. Gdańsk: Wydawnictwo Uniwersytetu Gdańskiego, 2002

[9] Source: Breedveld, Koen en Andries van den Broek, TBO, SCP deze versie: 20061018:
http://www.tijdsbesteding.nl/hoelangvaak/verplichtingen/zorgtaken/persoonskenmerken/20061018.html

[10] Bolin, K., Lindgren, B. and Lundborg, P. (2007), Informal and formal care among single-living elderly in Europe, Health Economics, published online in Wiley Interscience, www.interscience.wiley.com