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Working and caring for a dependent elderly parent
Comparative analysis of six European countries

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Stream 20: Family policy, gender and work-family reconciliation

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Introduction

The conciliation of family and professional life is the subject of research and a major political issue, at both a European level and in certain Member States of the Union, in the context of gender equality or supporting women at work. This issue of 'conciliation', to use the European terminology, is normally limited to working mothers looking after young children. However, this does not take into account the problem of another generation of women who have to take care of one or more dependent elderly parents while they are still in employment[1].

The terms 'sandwich generation' or 'middle generation' (50-65 year-olds) are often used to talk about those who experience this dual generational pressure. This generation have to support their children, who are sometimes young adults and who very often continue to live with them (or look after grand-children), and also need to support parents and parents-in-law, who, with advancing age, increasingly face chronic illness, disability and incapacity, becoming dependent and requiring help for a number of everyday actions. This generation can even be described as facing a 'triple front', when these tasks of support and care for many come in addition to professional activity. Changes in the labour market towards greater flexibility (status, pay and working hours) further increase the tensions and pressures suffered by these senior workers. In employment policy, the notion of 'aging or senior worker' is used to take into account the specific difficulties for people of this age group to remain on the labour market.

This research[2] aims to shed light on the situation of these senior workers (mainly women) and the role played by social policies, describing the condition of these 'main carer' women of an elderly parent, and on the way in which this role is or is not taken into account in the design and implementation of social policies currently under development in a number of European countries to meet this care demand. The main aim is to understand, through a purposive sample of households in six European Union countries with different Welfare State systems, how this coordination is 'managed' in different care arrangements and configurations.

This paper looks at the way in which new forms of flexibility at work - most particularly non-standard or atypical working hours - currently affect households with care responsibilities, whether they be households with young children or households providing care to an elderly person or persons.

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[1] The information available regarding all European countries shows that the main work of care whether formal or informal is provided by women: wives, daughters and daughters-in-law.

[2] This research entitled *Workers Under Pressure and Social Care* (WOUPS) was financed by the MIRE and by the French National Research Agency (ANR - - three-year programme, 2006 to 2009). This text is based on the six national reports written by the teams of all six countries (see bibliography), brought together in Le Bihan B., Martin C., dir., *Working and Caring for Elderly Parents in Six European countries National Reports (France, Germany, Italy, Netherlands, Portugal, Sweden)*, Report for the Drees/Mire, 2009. The members of the international research team on this project are: Barbara Da Roit, Trudie Knijn and Ellen Grootegoed for the Netherlands; Chiara Saraceno, Wolfgang Keck, Christina Klenner, Sabine Neukirch and Ute Klammerfor Germany; Ulla Björnberg, Sofia Engstrom, Hans Ekbrand for Sweden; Sanda Samitca and Karin Wall for Portugal; Manuela Naldini, Barbara Da Roit and Elisabetta Donati for Italy and Arnaud Campéon for France, in addition to the two coordinators and editors of this paper.

The **WOUPS** project has four components:

- an analysis of policies promoted by European institutions for gender equality (equal pay, equal opportunities, conciliation of work and family life, work/life balance), and their impact on the definition of national policies in the 6 countries studied;

- a retrospective analysis of policies applied in each of the countries studied in terms of the coordination of family/working life, childcare policies and policies for the dependent elderly;

- an analysis of care arrangements in dual-income couples or single-income households, working non-standard hours and having responsibility for young children in each country according to a range of criteria (sector of activity; types of working hours; level of qualification and pay; familial configuration; scale of informal support).

- an analysis of care arrangements for dual-income households or single-income households responsible for one or more dependent elderly parents.

The research that we present here only addresses the care of the elderly.

Part 1 therefore compares the care arrangements for the dependent elderly in each of the countries studied. We have aimed to describe the broad outline and main stages of policies in place. Despite their differences, these policies have the striking common point of promoting care at home, which is not without consequence on the role played by so-called 'familial solidarity', i.e. solidarity that relies on care provided by women in these households;

Part 2 of the study is a comparative empirical survey of the six countries of the WOUPS programme (Italy, the Netherlands, Portugal, France, Sweden, and Germany). The objective here is an in-depth study - and therefore of a restricted number of households in each country - of the coping strategies of households, their arbitration and the care arrangements set up to meet the two-fold constraint represented by the care of one or more dependent elderly parents (whether or not they are cohabitant) and the exercise of a professional activity. The configuration of these households (couples or single parent households), the range of relational resources (brothers and sisters, and neighbours) that may contribute to care, and the dependency level (physical and/or mental) represent essential variables that have been taken into consideration to select the cases studied. In this way, it becomes possible to appreciate the role and use of the various programmes and policies put in place in each country (at a local level), but also to access the arbitration of these households in the organisation of their care arrangements.

This study has given **four main results**.

Firstly, the analysis of long-term care policies or public policies relating to the dependent elderly present elements of convergence in the six countries studied, looking further than their distinct variations. In each of these countries, these policies have perceptibly developed towards mixed systems, combining financial benefits, homecare services, institutional care for the most severe cases, and a considerable call on the services of family members - daughters and daughters-in-law in particular. Even a country like Sweden, which until the beginning of the 1990's had a very wide range of services, has undergone a noticeable reorientation resulting in an increasingly significant contribution from families and relatives.

The most significant nuance regards the level of control of public authorities over the use of social benefits. Some of the countries studied give households total freedom of movement, allowing them to procure themselves whatever services they wish (Italy is the most emblematic case), while others countries control the use of benefits so that they are always converted into formal services in some way (for example France). Apart from this considerable difference, all the countries studied combine resources and care methods, despite

belonging to different welfare traditions. This convergence renders even more pertinent an examination of the conciliation that these practices of care and care management demand from the members of the family.

A second result relates specifically to care practices and the diversity of care arrangements. In all of the cases studied, this combination of resources is striking. In all countries, carers organise the mobilisation of a composite set of resources: formal and informal, professional and non-professional, paid and unpaid. However, these traditional categories of analysis of care practices show themselves to be insufficient, although here again combinations are observed: informal paid work, unpaid informal work, low-qualified professional work paid officially or on the black market, etc. This convolution appears necessary to adapt to the variability of the requirements of the cared-for person. However, it also shows the significant mobilisation of carers around the function of care manager, or organiser of the care arrangement.

The third significant result regards the importance of employment for these carers who, despite the tension provoked by this multiplicity of obligations and constraints, emphasise the necessity of maintaining their professional activity, not only for the financial resources that it provides, but also to be able to continue to provide their role of carer. In all countries, retaining professional employment is considered as a necessity in order not to be totally absorbed by the role of carer.

The final main result demonstrates the consequences of this coordination of the work of carer and professional work on personal, marital, and family life. All spheres of daily life (relationship with a partner, children, brothers, sisters and friends, leisure time, free time etc) is changed dramatically by this responsibility of carer. Care is therefore a responsibility that requires time and energy, and which unavoidably engenders multiple tensions, sometimes even pressure and stress which are felt acutely by carers, most often women.

In this presentation, these results are grouped together in two main parts: one regarding policies and schemes, and the other regarding care practices and their consequences in terms of conciliation.

I. Care policies

In all countries studied, the aging of the population is a major social and political issue (Martin, 2003). The increasing participation of women on the employment market and the resulting care deficit (Hochschild, 1995) pose the crucial question of care of the dependent elderly. Confronted by a wide range of obligations at a professional and familial level, families have more and more difficulty in taking care of their dependent elderly parents on their own. Geographical mobility resulting from social and economic transformation does not make things any easier. How is it possible to look after an elderly parent when you live many hundreds of kilometres away? And, when members of the family live close to each other, how is it possible to spend sufficient time with a parent when you need to be at work during the day?

To meet these difficulties, public schemes and programmes have been developed in all European countries since the end of the 1990s, including countries of South Europe such as Italy and Portugal, where the family traditionally plays a major role in the care of dependent

elderly parents. Resolution of these issues of conciliation of professional and care obligations does not only happen through the definition of a policy targeting the dependent elderly; it also involves employment and family policies. The examination of different types of leave available to carers provides the first elements of analysis in this direction (1). In terms of dependency, programmes and schemes rely on the development of personal care services (2) and/or the creation of financial benefits to help the elderly and their families pay for the required services, in a strategy of outsourcing care (3).

1. Specific measures for the conciliation of family and professional obligations

The countries studied therefore have 'conciliation' schemes, aiming to regulate working conditions in order to allow families to fulfil both professional and care obligations. The possibilities of professional leave are a first tool of conciliation (table 1). They may be specific, targeting the constraints related to the care of a dependent elderly parent, as in Italy or Portugal, or apply to family members in general. Whether or not this leave is paid is another major element; the three days per month available in Italy are paid, which is not the case of the 15 days per year available in Portugal.

Table 1:

	Type of leave
Germany	Leave to take care of a relative. One week / year. An advance from the employer subsequently reimbursed as part of social protection.
France	Familial solidarity leave to accompany a dying relative. Three months, renewable once. Unpaid *
Italy	3 days of paid leave/month for care of a severely disabled person.
Netherlands	Possibility of 10 days' leave/year to take care of a relative when the person is the main carer. Pay: 70% of salary. Long-term care leave: 12 unpaid weeks to take care of a very sick close relative (child, parent)
Portugal	15 days' unpaid leave to take care of an elderly parent
Sweden	Financial compensation (80% of income) to take care of a dying relative

* discussion in progress at the time of writing this report regarding the creation of paid leave fixed at €47/day for three weeks to care for a dying relative

Flexible working hours are the second tool of conciliation. If we refer to employment legislation, there are possibilities in all countries - more or less in the private sector - for working part-time; daily working hours can be organised according to certain time constraints, or a time-savings account can be used. The Netherlands are an excellent example of this (Da Roit, B. Grootegoed E., Knijn T., 2008). The Adjustment of Hours law, (2000) helps Dutch workers conciliate their professional activity and their familial and personal life. They have the right to increase or reduce their working hours, and thus have the possibility to work full-time at the beginning of their career, then to choose to work part-time when they have young children, or when they have dependent elderly parents. In 2001, more specific schemes for conciliation were implemented (Work and Care Act), providing different types of leave (table 1). Since January 2006, a Life Course Saving Scheme *(LCSS)* also helps workers save money in order to finance unpaid leave.

Although this type of measure is being developed to a greater or lesser degree in the countries studied, the issue is more the possibilities of flexible work time in practice, which we shall come back to in the second part of this text.

2. A policy based on the availability of care services for the elderly

Care of the dependent elderly mainly occurs through the development of services to accommodate the dependent elderly in institutions, or to allow them to continue to live at home. The objective is therefore the outsourcing of care, in order to relieve families of the responsibility of care tasks. Although this is not a priority in Italy, this service strategy constitutes the base of the current policy in place in the Netherlands and Sweden, and is a more recent objective in countries such as Portugal.

If we look at models of care developed by social policy analysts (Anttonen, Sipila, 1996), the Netherlands and Sweden belong to the Scandinavian model, characterised by universal access to institutionalised or home care for any dependent elderly person. The strategy is a defamilialisation of care, and the aid provided is above all public. In the Netherlands, institutional care of the elderly has been financed since the 1960s by a compulsory insurance plan, the AWZB (*Algemene Wet Bijzondere Ziektekosten*), which covers the cost of care of dependent and disabled persons. Initially reserved for people living in an institution, this insurance was extended to finance home care. Since the 1980's, a drive to reduce expenses means that institutions are reserved for the most dependent elderly, and home services have been developed to respond to the requirements of people living at home. Despite the recent transformations aiming to give more responsibility to families, and to introduce market strategies in social services to decentralise responsibilities, the social system of care remains very strong.

Since the 1980's, the development of services is also presented as a priority in Portugal, a country belonging to the familialistic model (Anttonen, Sipila, 1996), where the family traditionally takes care of dependent elderly parents. This has resulted in the financing of rural daycare centres, the creation of retirement homes and short, medium, and long-stay care services, as well as financing for home help services. Helping a person to live at home is considered as the best solution for the elderly who wish to remain at home for as long as possible, and also as the least expensive for public authorities, at least for low and moderate dependency levels. Access to services is universal, and financed according to the elderly person's level of income. The objective is to develop the most varied range of services possible, to respond to the diversity of families' needs.

In Germany, long-term care insurance - created in 1994 - offers care services for the dependent elderly, both at home and in institutions, depending on the level of requirement, assessed according to the number of hours of care required on a daily basis. Level I, the lowest, corresponds to a requirement of at least 90 minutes of help per day; level II to at least 3 hours of care per day; and level III to at least five hours of care per day and the need for permanent supervision.

Finally, France's policy for the dependent elderly is based on a financial benefit - the Personalised Independence Allowance - attributed to finance a range of specific services. Since the 1990's, this policy has been strictly linked to an employment policy aiming to develop the personal care service sector. This policy therefore accompanies schemes for the professionalisation of home help services.

In all the countries studied, priority is given to helping the elderly person continue living at home. Whatever the importance given to the development of services, in most countries

policies for the dependent elderly also offer financial benefits. The analysis therefore shows that the ‘ cash-for-care’ strategy is an element of convergence in care policies for the dependent elderly in Europe (Da Roit, Le Bihan, Osterle, 2007).

3. The creation of ‘ cash-for-care’ and the pivotal role of families

Financial benefits are available in five of the six countries studied[3] (table 2). Created between the end of the 1980’s and 2000, their management mobilises two territorial levels: the national level, in the context of which the service is defined, and a local level (municipality or Département), responsible for its implementation. Although they constitute an element of convergence of care policies for the dependent elderly in Europe, they follow different action strategies.

These benefits have not therefore been developed in the same context, and are based on varied approaches. Unlike other countries, in Italy the benefit was not initially designed for the dependent elderly. The *indennità di accompagnamento* was a benefit reserved for the severely disabled which was extended to the severely dependent elderly, similar to the case of France’s compensation benefit. In France, the Personalised Independence Allowance, which replaced the specific dependency benefit in 2002, was designed to respond to the requirements of the dependent elderly, and is the keystone of the scheme that was developed. In Germany, the Netherlands and Portugal, this service is one component of the response by public authorities, which combines aid in kind and financial aid. The schemes are in fact mixed, combining aid in the form of services and financial aid.

Table 2: financial services in France, Italy, Germany, and the Netherlands

	France	Italy	Germany	Netherlands	Portugal
Service	*Personalised independence allowance*	*Indennità di accompagnamento*	*Long-term care insurance*	*PGB* *Personal budget*	*Dependency benefit*
Amount	4 levels 2007: Gir 4: €509.91/m Gir3: €764.87 Gir2: €1,019.83 Gir 1: €1,189.80	€457.66/m	3 levels 2008: level I. €215/m level II. €420 level III. €675	Type of task (housework or personal care) and number of hours required Hourly rate per category Average amount in 2006: €11,500 /year	2 levels of dependency: Level I: difficulties in accomplishing basic everyday tasks alone 50% of non-contributive retirement pension (€90.96 in 2008) level 2: idem + medicalised bed + dementia 90% of minimum pension (€163.72)

[3]In Sweden, financial benefits remain highly marginal.

Attribution criteria	Dependency Requirements Income + 60 years	Incapacity (100% + continuous care)	Requirements insurance beneficiaries	Requirements Income	Dependency level
Assessment tools	Single grid (AGGIR) 6 levels of dependency	National criteria Implementation by a local commissions	Single grid Medical	Single national grid	Assessed by local medical team Implementation by Social Security
National – local	National framework Regional implementation Financing mainly local	National Law State financing	National legislation Social contribution (insurance)	National legislation Nat. financing	National legislation
Use of allowance	Allowance must help finance a precise care plan Control of use of allowance	Freedom of use of the allowance	Freedom of use of the allowance	Control of use of the allowance (1.5% free use)	Freedom of use of the allowance

In Germany (Keck, Saraceno, 2009) and the Netherlands, the strategy underlying these mixed systems is that of 'free choice'. The objective is to give the family the choice between recourse to services, or the use of a sum of money (*cash*) to finance care necessary for the daily life of the elderly person (*care*). These cash-for-care strategies therefore associate families to the definition of the most suitable method of care. They respond to the desire expressed by families to be more active in the organisation of the care arrangement, by letting them choose the carers - professional or non-professional - who participate in the care of their elderly parents. In the Netherlands, this benefit was introduced experimentally in 1995, then generalised in 2001, breaking away from the traditional 'public response' approach in the form of services. In Germany, long-term care insurance was created in 1994 and gives families the possibility to choose between two forms of aid.

Financing principles of allowances and benefits also differ from one country to another. In Germany, the system is based on long-term care insurance, financed by social contributions. Introduced in 1995, long-term care insurance is compulsory; all persons affiliated to a health insurance policy are obliged to take out long-term care insurance with the insurance company that provides their health cover. In France, Italy, and Portugal, services are mainly financed by income tax, at a national and/or local level[4].

Calculation of the amount of benefit is another variable element, and illustrates the different conceptions of cash-for-care policies. Two groups of countries may be identified. In the Netherlands and France, the amount of the benefit is adjusted to the range of services required, defined by social professionals according to the medical and social requirements of the elderly person. At identical levels of dependency, an isolated person does not have the same requirements as a person who lives with their partner or close to their family. Also, in

[4]Since the creation of the Caisse nationale de solidarité pour l'autonomie (CNSA) in 2004, a small part of financing of APA is based on a social contribution.

this first group of countries, income is taken into consideration in the calculation of the amount of benefit. The strategy is therefore specifically that of co-payment[5]. In Italy, Portugal and Germany, the amount of benefit corresponds to a fixed sum, which in Germany is determined by different levels of requirement; in Portugal the calculation is based on the minimum social pension. Only the dependency level is taken into account in the assessment, carried out by social and/or medical teams. But this does not necessarily signify that the user is not made to contribute. Indeed, the sums paid do not cover all the requirements of the elderly person, and the financial participation of users is therefore implicit in the provision of care.

There is another element that distinguishes these country groups: the use of the benefit received. In the Netherlands and in France, use of the benefit is controlled, and families must justify their expenses by submitting invoices for services they have used, or persons they have employed. Oppositely, in Italy, Germany and Portugal the benefit may be used freely. It is considered as a supplementary income for the family and is integrated into the budget. This is a determinant difference which explains in particular the development of a black market of care in countries like Germany, Italy[6]. This phenomenon is particularly significant in Italy, where families use the financial aid (€457.66) to pay half of the wage of a *badante*, an immigrant worker from central Europe, employed to look after an elderly parent 24 hours a day. The number of workers of this type is estimated at between 650,000 and 800,000 (Da Roit, Castegnaro, 2004) and the system is accessible not only to financially comfortable families but also to families with more modest incomes. This informal outsourcing of care of the dependent elderly is the linchpin of the long-term care policy in Italy. Accepted by all parties involved - families and the government alike - this system explains the difficulties encountered in developing professional services, the greater expense of which does not permit such a large number of hours and flexibility in home care.

Although regulation strategies of financial services are not the same, and although the analysis of these cash-for-care policies makes it possible to distinguish different groups of countries, we can nevertheless observe an element of convergence of all these systems: family involvement. Whatever the type of benefit - whether financed by tax or according to an insurance strategy, whether or not their use is controlled, whether or not they are associated to a specific range of services, if they vary according to the level of income or if they are attributed on the sole criterion of dependency - all have the common factor of associating the family to the care of the elderly person who receives it. This is firstly because, as we have seen, the amount of this benefit is insufficient to cover all dependency-related requirements, and also because they are associated to a policy of caring for the elderly at home, which makes family carers the main players in the care arrangement. At the end of the day, families are no longer the only care providers; they can rely on services or financial benefits to outsource some of the care tasks, according to differing conditions. However, families assert themselves as the main players of the coordination and arrangement of care.

Comparative and qualitative research carried out in these six countries reveals the significance of the mental pressure of this role of care manager, which we find in all countries, whatever the extent of the public schemes on offer. To this is added another common characteristic: the desire to develop mixed systems, combining services and financial aid, allowing families a certain degree of flexibility and offering a wide range of solutions to help them in their responsibility for a dependent elderly parent.

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[5]In France, co-payment comes into play above a certain level of income (€677)
[6]and Austria. See Da Roit, Le Bihan, Österle, 2007.

2 - The practice of care

1 - Presentation of the qualitative survey

The main objective of this research is to obtain the point of view of the main carers of the dependent elderly; to understand, in different national contexts, the way in which they provide and organise this care. It also aims to determine the way in which they coordinate care with their professional life, and its affect on their personal life, social relationships, everyday life and their family life.

The comparison of these care practices aims to understand what ‘caring and working’ involves for those who combine these activities; to understand how carers coordinate these different roles; why they do it, i.e the reasons they give to explain this involvement (concern for the person, sense of duty, 'it's only normal', etc.); the difficulties they face; how this coordination evolves over time; and how it forms part of a care trajectory.

An approach such as this may of course also help to identify discrepancies, and thus make clearer the contribution of schemes and policies from the carers' point of view. We have seen in the first part of this synthesis that, despite certain forms of convergence such as the combination of resources and cash-for-care for example, significant disparities remain. European citizens, in particular from those countries selected for this study, are therefore far from being equally supported when faced with caring for dependent parents at the same time as going to work. We can then legitimately ask ourselves which are the most suitable, efficient and innovative policies and systems. In sum, to what extent do these policies respond to the requirements and/or expectations of the cared-for person and their carer?

The method that we have decided to use is not designed to assess the role and impact of long-term care policies and schemes for the dependent elderly and their carers, which we have described in Part 1, but to understand the practices of care and the constraints in which they are performed. Long-term care policies and schemes are therefore one of the variables to be taken into consideration in the analysis of these care practices, but it is far from being the only variable.

The disparity of situations of dependency is such that it is difficult to claim to identify the impact of these schemes and programmes. However, taking this disparity into consideration is without doubt the best way to devise more suitable and more relevant policies and schemes.

The different research strategies possible for a subject such as this all have advantages and restrictions. Thus, for example, to examine the requirements of users, we could envisage an opinion poll of the expectations of carers in terms of measures, services and support in each country, asking those surveyed to assess the interest of a certain scheme to respond to their requirements and those of their dependent elderly parents. A survey such as this nevertheless presents a problem: how to take account of the incredible diversity of requirements and care configurations (variable according to the level and type of dependency, physical and/or mental, level of resources, accessibility of resources, etc.)? We remain in the domain of opinion, expectations, and demand.

We could also use methods that would control the comparability of the cases studied in each national configuration, to harmonise the levels of requirement and formal and informal resources, and to attempt an assessment of the strict effect of a public response or scheme. To attempt to ensure comparability, we can either construct test cases or case studies[7], or attempt to pair each case in each national situation, according to a series of precise criteria. These approaches both have their advantages, but also restrictions and difficulties. The case studies used in each country remain theoretical, even if they are based on real cases, and do not permit access to the actual care configurations or practices themselves. However, they do make it possible to compare the social and professional treatment of each of them, and thus to have a key for the comparison of needs assessment methods used, or the "ranges of services and care" (Le Bihan & Martin, 2003 and 2006).

Pairing is by definition imperfect, as it is limited to a few elementary variables: the level of dependency at a given time (assessed according to scales that differ between countries and sometimes even between professionals of the same country), the level of income (with methods of standardisation, but often without a correct valuing of assets), and the number of relatives likely to contribute to helping the dependent person (which implies knowledge of these persons, but which does not necessarily correspond to the number of actual carers). It can be seen that understanding of each criterion is highly delicate. However, too many criteria for pairing cannot be considered. It is necessary to choose, and thereby simplify the reality of situations, at the risk of losing dimensions that are nonetheless essential.

Another strategy could be to compile a large-scale quantitative survey in order to control - all else being equal - the weight of a certain variable through statistical methods and regression analysis. But this requires processing a great number of situations to make it possible to test a sufficient number of variables. These methods seek to ascertain that discrepancies observed in care practices are mainly due (all else being equal) to the existence of a certain measure or policy. But even in this comparison remains relative, insofar as these policies - and in particular accessibility to a certain measure or service - may vary greatly within each country, sometimes to the same extent as between countries. There is therefore nothing that says that the discrepancies observed in impact on carers' professional and family life in different countries may be explained by the existence of a certain measure or policy, nor that these impacts would be more significant in an intra-national comparison (between a number of cities of a single country) than in an international comparison. Finally, they do not take into account the sometimes rapid evolution of requirements and thus of care configurations (care trajectory). However, a major part of the efficiency of responses to dependency resides in their flexibility, their adaptability, and their reactivity. It is without doubt precisely for this reason that the support of relatives is often considered as irreplaceable. This informal care fills all the gaps left by formal care (Lesemann and Martin, 1993).

Our perspective is therefore voluntarily different: it is a qualitative comparative analysis, adopting the point of view of carers. What is lost in the capacity of control of variables is gained in the depth of the analysis. The complexity of the mechanisms at work and the diversity of the situations analysed are no longer considered as obstacles but as assets. Comparing qualitative material is also a means of taking consideration of

[7] We have tried this test case technique in a previous comparative study of the range of services and care for the dependent elderly in six countries of the European Union (Le Bihan & Martin, 2001).

the point of view of those involved, rather than undervaluing it in giving priority to objective data.

By studying care configurations in a number of national contexts and the accounts of the carers of dependent elderly parents regarding the coordination of their family and professional life, we have therefore wished to give priority to the care practices themselves, rather than the analysis of policies. What is their common point, regardless of the country? How do these workers/carers conciliate their professional, personal and family life with these tasks of day-to-day care and their role of care manager? Can we identify differences in these arrangements related to the context (responses of public authorities in particular, but also social norms in terms of intergenerational solidarity or gender roles)? Is it possible, and to what extent, to identify a shared issue around the conciliation of the stages of life? How is this issue characterised according to national contexts?

In this perspective, existing policies and measures are seen more as elements of context in which these practices are performed than as the main object of comparison. The most important element to understand in this qualitative comparison is the practices of care themselves, rather than simple differences of public intervention. Studying these behaviours in a number of national contexts therefore aims to test the weight of certain variables: different 'care cultures', according to country, social milieux, and gender (Kremer, 2008); the relative importance of the feeling of responsibility and/or obligation with regard to elderly parents; the terms of arbitration to meet the contradictions and constraints imposed by the difficult coordination of care tasks, the role of carer, personal and family life, and professional activities. The issue is therefore less to show that a certain national configuration provides better conciliation, than to identify what is common to this population, what these carers share or do not share in their experience, and thus to formulate new hypotheses on the strategies they follow and the main difficulties with which they are confronted and which need to be resolved.

However, it is important not to ignore the difficulties imposed by this type of research strategy. One of these is the linguistic issue. The people chosen to take part in the in-depth survey using a semi-directive interview grid express themselves in their own language, and it was not possible to fully translate the transcriptions of these interviews. A considerable budget was needed for this; we were obliged to develop a common strategy, not only in the selection of cases and the collection of information, but also in the processing of data, so that we could rely on analyses of our colleagues in each country. Of course, we have the possibility to go further for some of the idioms of the survey, and we plan to conduct more in-depth analyses upstream (comparison France - Portugal - Italy, in particular). However, this analysis using the entire corpus of interviews carried out in these three countries remains to be done.

In summary, by adopting this care practice perspective, we propose an alternative assessment of the impact of policies for the dependent elderly in different national contexts. The idea is less to assess these policies, than to appreciate the way in which they are used by family carers in practice. The questions we ask are therefore as follows:

- What resources or range of resources do carers turn to in the performance of their role of carer?
- What differences can be identified in the way in which care arrangements are organised in different countries?

- What is the impact of these care practices on the carer's daily life, and familial and social relationships?
- How is family and professional life coordinated?

2. Presentation of the sample and care arrangements

To compile our national samples, a series of selection criteria was defined: main criteria, and secondary criteria. The aim of this definition of criteria was to guarantee a minimum of comparability, while also helping to ensure sufficient diversity. In some countries, resources for this research were limited, and so national research projects with similar objectives had to be combined. We decided on a minimum of 15 exploitable cases per country, a minimum of 90 cases in total. The interviewees were all carers of a dependent elderly person, most often parents.

We selected the following main criteria:

- Interviewees were *main carers*, i.e. daughters, sons, daughters-in-law or sons-in-law with the main responsibility for the care of one or more dependent parents or parents-in-law. A main carer is not necessarily the only person involved in actual care tasks (this is rarely the case), but has the main responsibility for the organisation, monitoring and coordination of the care arrangement. Members of their family and professional network may also be involved. These tasks of care and coordination (*care management*) always demand time.
- These main carers may or may not live with the person(s) they care for. Cohabitation may be considered as one of the conditions for facilitating care or conciliation. It may also be a material constraint, or a choice that becomes problematic from the point of view of conciliation.
- Main carers are 40 years old or older.
- They have a full-time or part-time professional activity, with a minimum of 20 hours per week, the aim being to look at issues of conciliation of family, personal and professional life. The decision to include part-time work was particularly related to the inclusion of the Netherlands, a country in which the vast majority of women work part-time. We therefore voluntarily established a minimum of weekly working hours.
- The cared-for person is dependent, which means that they need help to accomplish a certain number of activities of daily life (getting up, getting washed, moving, going out, providing meals for themselves, shopping, housework). This dependency may be physical and/or mental (depression, problems of dementia, Alzheimer's disease). Although it is difficult to establish a standard level of dependency given the wide variety of dependency assessment grids in the different European countries studied, we had decided that the cases selected should require daily care in order to eliminate cases of slight dependency, so that only cases of average, average/high, high, or very high dependency were retained.

- The cared-for person may be cared for at their home, at the home of the carer or in an establishment. Selecting cases of institutionalised dependent elderly people seemed pertinent, both because the carer often has to manage coordination all the same (in addition to regular visits or accommodation during holidays, or some weekends), and because most of the time these cases of institutional care required a former care arrangement at home and arbitration to ensure the transition to the institution. Great attention is therefore paid to the evolution of the case in the collection of information.

To these main criteria were added the following secondary criteria:

- Main carers may be men or women. Given that carers are most often women, we suggested the selection of a few cases with male main carers (around three per country).
- The main carers surveyed may have recently ceased their professional activity (less than six months) but only and specifically because of their role as carer. By selecting these cases, we wished to include cases where conciliation of professional life and care tasks has imposed or has resulted in a withdrawal from professional life. In such cases, the interview must relate to the period where the carer was still on the job market.
- Those selected for the survey must have varied socio-educative, socio-economic and socio-professional profiles.
- The sample must also be diversified in terms of family situation: carers may or may not have brothers and sisters, may or may not be single, cohabit with a partner or be a single parent, have responsibility for minors or adults (double front families) and/or grandchildren. Given that these criteria cannot be known beforehand, we relied on the fact that these elements could show themselves to be diversified afterwards.
- Carers may or may not be paid for their care work.
- Interviewees may live in urban or rural areas. This criterion proved delicate to establish a priori given the diversity of national situations. For example, in the Netherlands, the notion of a rural area is very different in comparison with countries like France and Portugal.
- Finally, main carers may work according to non-standard or atypical hours.

On the basis of these criteria, we selected and surveyed a total of 129 cases. The interview grid used is given in the appendix, and addresses the following main themes: presentation of the interviewee, their professional activity, working conditions and family; the cared-for person, their requirements and care arrangement; the means of conciliation of the responsibility of carer with professional life; the coordination of the activity of carer with family life and personal life; the role of carer, the feeling of responsibility and/or obligation; the ideal care arrangement; and a completed stress scale[8].

[8] . A detailed presentation of these national samples is available in the synthesis report of this research, identifying for each case: the dependency level of the cared-for person (or persons) (very high level, high, average high, average, average/low or low); the level of income of the carer, the level of income of the cared-for person(s); and the care arrangement. We have not given many of the other variables collected during the survey (professional

Already we can observe the variability of dependency levels. From information held on each case (level of dependency with regard to current assessment grids in each country, and description of the requirements of the cared-for person), we have ranked each case on a 5-level scale: very high/high; medium/high; medium; medium/low; or low. Taking account of the highest level of dependency of persons cared for by one same carer, the spread per country is the following:

Table 3: dependency levels of the cared-for elderly

Level of dependency	High/Very high	Medium/ High	*Sub-total High*	Medium	Medium /low or low	*Sub-total medium and moderate*	*total*	*Ratio high lev / total*
France	7	7	*14*	3	/	*3*	*17*	*14/17*
Germany	11	6	*17*	9	/	*9*	*26*	*17/26*
Portugal	14	3	*17*	3	3	*6*	*23*	*17/23*
Netherlands	12	5	*17*	3	/	*3*	*20*	*17/20*
Sweden	4	/	*4*	4	9	*13*	*17*	*4/17*
Italy	18	4	*22*	3	1	*4*	*26*	*22/26*
Total	66	25	*91*	25	13	*38*	*129*	*91/129*

This table shows the relative homageneity of dependency levels of cared-for people in five of the six countries, as more than 7 out of every 10 cases at high or very high dependency levels. However, the Swedish sample does not follow this criterion, mainly because a secondary criteria was favoured which 'skewed' the selection: the fact that carers have a profession with non-standard hours. It will therefore be difficult to carry out comparisons of Swedish cases because of this bias.

Another interesting phenomenon that appeared *a posteriori*: the proportion of cases of cohabitation between the main carer and the cared-for person. To examine the care configurations *a posteriori*, we can look at the available project definition data. The *Share* survey, carried out in 2004 in six countries of which five are common to our survey, provides precious information about this point of view. As emphasised by R. Fontaine, A. Gramain and J. Wittwer (2007): "If we take into account the different forms of care, cohabitation or 'long-distance' care, the share of the dependent elderly supported by their entourage is large (83% on average) and remarkably similar in all countries (see table 4)" (Fontaine et al., 2007, p. 104) .

situation, working conditions, hours, etc.) in order not to overload the table, which is already very long (Le Bihan & Martin, 2009).

Table 4: proportion of dependent elderly supported by their entourage (Share survey, 200')

	Germany	Spain	France	Italy	Netherlands	Sweden
Dependent elderly cohabiting with another person	54	68	60	63	42	37
Dependent elderly living alone receiving long-distance care	29	16	26	24	37	42
Total of dependent elderly supported by their entourage	83	85	86	87	79	79

Reading: In Germany 83% of the dependent elderly are supported by their entourage, in one form or another; 54% live with somebody; 29% live alone receive long-distance care.

Field: elderly households over 65 years of age, suffering from severe, moderate or slight incapacity, couples with two dependents excluded, averaged data

In our sample, we have also taken into consideration cases of intergenerational cohabitation, i.e. cases where the elderly person lives with one of their children. Cases when a dependent elderly person lives with a non-dependent partner are therefore not included here, making a term-for-term comparison difficult. The distribution of these cases of intergenerational cohabitation of our sample is as follows.

Table 5: care configuration with intergenerational cohabitation

	Cohabitation	Rank
France	6 out of 17	3
Germany	11 out of 26	2
Portugal	11 out of 23	1
Netherlands	2 out of 20	5
Sweden	/	6
Italy	4 out of 26	4

This data was not part of our selection criteria; it is therefore possible that it is the expression of configurations that are more or less dominant depending on the country in question. However it is important to refrain from making hasty conclusions. This distribution is the result of coincidence over a too-small number of cases. We can simply note that it is above all high in Portugal (nearly one case in two), or even in Germany (around two cases in five), a little less in France (one case in three) and much lower in Italy and the Netherlands. No case of cohabitation was surveyed in Sweden, which could explain the overall low level of dependency of the cared-for elderly.

In sum, with regard to the trends observed in the Share enquiry, the situation in our purposive sample appears different in two countries. One is Germany, which may perhaps be explained partly by the number the cases selected where the carer is also a woman in a single-parent situation, which may lead to a larger number of cases of

cohabitation to reduce accommodation expenses. The other country that moves away from the observations of the Share enquiry is Italy. This time, it is possible that cases of intergenerational cohabitation are fewer due to the use of a *badante*, i.e. women, mainly immigrants, employed to live with the elderly person full-time, most often on the black market. But it should be remembered here that cohabitation is a care configuration or arrangement that is likely to have major consequences in terms of the flexibility of care, but also in terms of the pressure on the carer and their personal and family life.

In the general table of cases, we can also identify a certain number of the 'valencies' of our selection. Four countries appear to have certain specificities. In Italy, as already mentioned above, one care configuration stands out clearly: the employment of *badantes*. These women, foreigners who live with the elderly person and work five or six days a week, take responsibility for most of the care tasks, supervision and assistance of the elder person(s), and and are most often paid through a social benefit that is granted on the basis of an invalidity level of 100% (*indennità di accompagnamento*) with no income conditions. In the Italian sample, 14 out of 26 configurations use the services of a *badante*, which, as we have seen in the description of policies and measures, is an excellent illustration of the situation in this country. We can understand through this information that cases of cohabitation with the carer are rarer in Italy. A permanent presence is provided by the *badante*.

A second ‘valency’ can be identified if we analyse the number of cases that are the subject of either institutionalised care, or that use daycare centres in their care configuration. Table 6 below gives an idea of the distribution of our sample for these two components of the arrangement.

Table 6: care arrangements using a daycare centre or institutional care.

	Daycare centres	Institutions (retirement home, Healthcare centre)	Total of surveyed cases
France	1	4	17
Germany	12	/	26
Portugal	6	/	23
Netherlands	1	8	20
Italy	/	4	26
Sweden	1	3 (of which 2 on a waiting list)	17

Care arrangements relying on the use of daycare centres are decidedly more frequent in the German cases, with nearly one case in two. In the Netherlands, it seems also that one profile is more frequent than average for the situations studied; once again this profile conforms to what we know of this country's long-term care policy: the use of institutions. This applies to 8 out of the 20 cases analysed in this sample, which has no equivalent in the other samples.

An alternative identification of the diversity of these arrangements according to the samples is also possible. For France, an overall configuration stands out fairly clearly: the arrangement most often combines informal care provided by relatives - including the main carer - and a home help, facilitated in many cases by the payment of the autonomy

allowance. Nurses or paramedical personnel complement this main nucleus of the arrangement.

We find this combination in Germany, with the particuliarity of frequent use of daycare centres. The significance of this solution means that a number of care arrangements are composed solely of informal care and the daycare centre.

In the Portuguese sample, we can also observe that the arrangement relies solely on informal care in nearly 1/3 of cases. We can also note that these are mostly cases of cohabitation where it is not only the elderly person or an aged couple that live with the carer, but also a number of other members of the family (adult children, mother-in-law, a brother or sister). Each may then contribute to the support of the dependent person.

In the Netherlands, in parallel to the role played by institutional care, we can note the importance of the AWZB and the personal budget, which helps cover a large part of the costs of home care.

In Italy, besides the extent of the use of *badantes*, we find the combination of informal care and home care. Sweden, despite the specificity of its low-dependent sample, does not differ from the point of view of this main combination of informal care of relatives and home help.

It would of course be tempting to see typical configurations here, but we shall avoid making this type of assumption. Many of our colleagues encouraged us to do this, not only because of the small size of our samples, but also because this type of information does not necessarily teach us very much.

One of the main mistakes to avoid is that of hardening the boundary between informal care (by relatives, and therefore *a priori* most often unpaid) and formal care (*a priori* by professionals). In reality, this cut-off is for the most part clouded by the existence of forms of remuneration for the informal work of relatives (and not only in the form of payment of the amount of a social benefit, as may be the case in France with the APA), and also because paid work is itself often informal, as is the case for the Italian *badantes*, and for cleaning women in Portugal. Direct or indirect employment of non-professional helpers complicates considerably the portrait of these arrangements. Formal/informal, paid/unpaid, familial/non-familial oppositions are much too caricatural to convey the complexity of these arrangements.

One result of our survey is therefore to highlight the systematically composite nature of these arrangements. All resources available are therefore likely to be used and combined, whatever their character: formal or informal, paid or unpaid, familial or nonfamilial. As shown by the different situations studied, the boundaries between home and institution, professional and non-professional, formal and informal, familial and non-familial are increasingly blurred. The distinction between paid professional care and unpaid informal care is not enough to comprehend the reality of care arrangements, to understand that which certain analysts qualify for situations of home care as 'governance of home care' *(Burau et al., 2007).* This result supports our choice of method, favouring the level of care practices than the organisation of resources. Plurality of resources is the general rule. It remains to be seen to what extent these arrangements facilitate or do not facilitate the responsibility of care with all the other elements of life: family and personal life, and professional life, which we shall look at next.

3. The impact of the role of carer on professional life

The desire to maintain professional life

In all countries studied, the men and women interviewed all give significant importance to their professional activity. For many, maintaining a professional career is perceived as a priority. Many reasons for this are given in the interviews: financial reasons above all, as professional activity is an essential source of income for the day-to-day running of the household. In general, financial independence is presented as being important, but in the great majority of cases, it is not the only reason given to explain the importance of a professional activity. Many people emphasise the satisfaction that work gives them, whatever their socio-professional category.

"It's good to work, it's the only way to take a little bit of pleasure", says Sofia from Portugal.

"I couldn't stop working. It's real recreation for me", explains Tania (Portugal).

"I never take a day off! But for my morale it was better that I work, it helped me. Work helps too! But it was heavy!" (Josette, France)

Working helps carers to get away from their status as carer, and to invest themselves in an activity other than care, and to put to one side the problems related to the dependency of an elderly parent. As Dorothée from Germany explains:

"I have to do something other than look after my mother. Looking after my mother at home is only one aspect of my life. At work, I have other things to think about, I have to do different things.... you can't only be shut up in your own life. And it helps to know that there are other people who have problems".

Sofia is an IT technician, Tania and Josette teachers and Dorothée a nurse, but we find this same type of discourse among carers who are less culturally and socially advantaged. In the Netherlands, the case of a checkout assistant in a supermarket (NL20) emphasises the importance of her professional activity and explains that she would not leave her job for anything in the world, as it helps her to meet people. She appreciates contact with customers and with her colleagues.

Working gives carers social identity, and independence that goes well beyond the financial dimension. As explains NL16 in the Netherlands, professional activity constitutes a protection from the obligations of care. It is "another world", "a world apart", in which the carer can exist independently from their role of carer.

"I have to say that for me it is very important to work. At work, I concentrate on my job, it's my domain. There isn't any care, care isn't present at work. And for me, is very important to have something other than care. Work is something that I've got just for me" (Gesa, Germany)

"It's not always easy, but when I'm at work, I don't think too much. Working helps me to take distance, at least when I know that someone is looking after my father and that everything is okay. When there's a problem, I worry and I find it difficult to concentrate. But when everything's fine, I'm alright, I can work no problem" (Aurora, Portugal)

"I was happy to go to work because it helped me let off steam! My breath of fresh air...my work helped me! When I arrived in the morning, even if the worries were still there, at least I was in a different environment (...). My work's too crucial for my personal balance

to give it up; it really gives me space and time to breathe. I recharged the batteries at work so...it's what I said before, outside I was on my own, but at work, at least I had the feeling of being surrounded by people and having a real network" (Daniel, France)

Working helps to create a social and friendship network, to discuss with colleagues about subjects other than the problems of daily life, or to ask opinions and advice for people who have experienced the same type of situation. Fabienne in France emphasises the importance of this:

"And it's true that being at work helps to relax and you find yourself with people who have had the same problem. So you can get advice from here and there."

In the end, professional activity is even presented by many of the people interviewed as essential to meeting the obligations of the role of carer. It constitutes a point of balance, helping these men and women, who are sometimes very heavily involved in care tasks, to breathe and be able to carry on.

Luisa in Portugal lives with her husband, who suffers from cancer, and her increasingly dependent aunt, who needs help on a daily basis. She explains during the interview how she has first stopped working then started working again:

"Two or three times, coming back from the bakery, I found him lying on the floor. It was very difficult. I didn't dare go out any more. It was a very difficult period and my psychoanalyst told me "you can't go on like that, you can't stay like that in the house for hours. Go back to work and you'll see how it goes". So I went back to work, and he started to feel better, so we carried on like that...in fact, when I'm concentrating on what I need to do at work because I don't want to make a mistake, it helps me to take distance from my problems at home" (Luisa, Portugal).

But this attachment to work expressed by carers does not mean that care tasks and the time they require have no consequence on professional activity. Quite the opposite - daily life is often disturbed, and the pace of life imposed by the necessity to face various obligations leads to a certain number of difficulties.

Consequences on professional activity

In general, involvement as a carer in tasks such as the organisation of care requires time, and constitutes a significant mental weight which is added to other familial and professional obligations. But the situation is even more complex, and is not simply a accumulation of constraints. The organisation put in place by families to take care of a dependent elderly parent is not defined once and for all. It is unstable, subject to evolutions of the situation of the elderly person, and punctuated by periods of crisis following the decline of their state of health. A fall or stroke, for example, may lead to the hospitalisation of the elderly person, and most of the time requires a reorganisation of the care arrangement when they return home. Carers must therefore make a certain number of decisions very quickly, and take care of administrative tasks that take up a great deal of time and energy. These periods are difficult, during which carers have to manage everything at once, which increases stress and pressure experienced on an everyday basis. The concern of anticipating and managing these periods of crisis require carers to be alert and available at any moment, which is not always simple.

"Worried, yes of course! I'm never completely relaxed!" (Olga, Portugal)

"It's terrible, terrible, I'm always worried. I'm always frightened that something'll happen (...) Of course, you get used to the situation, but I never feel completely good, because you always feel a little bit powerless to resolve all the problems that might come up" (Ana-Maria, Portugal)

"I took a bit of distance because even when you're strong, it makes you fragile, and you're more fragile because it uses up your work time...I saw 02 97 on my mobile...I said to myself, "here we go again"! Since November it's been like a number of times per day! It's harassment..."(Edith, France)

"I think about her all the time. Is she alright? Has she had a fall? Is she doing something she shouldn't? Has she forgotten to turn off the gas? And then I've got problems, because she calls me at work, and my boss doesn't like that, of course" (Bettina, Germany)

For all these reasons, the activity of carer has a certain number of consequences on professional life. Taking distance from the problems of an elderly parent is not easy to do; the carer may encounter difficulties in concentration, because they must at the same time resolve problems related to the care of their parent, or because the difficulties of the moment prevent them from sleeping. Stress related to the accumulation of constraints makes the carer more fragile and therefore more likely to fall ill themselves. Fatigue and even exhaustion of the carer is frequent in situations of dependency:

"Last year, it was very, very difficult physically for me to recover, because while I was with them, I ran between my mother who was immobilised at the house, and my father who was in hospital...and at that time there was no home-help, the home-help started coming when my father had already gone back home from the hospital. I did things in my mother's house, I did a bit of cleaning, the shopping, I went to see my father in hospital and I did all the administrative stuff. I phoned places, and I discussed things with my brother by telephone. He took over at weekends so I could go home. I took over again afterwards because he absolutely couldn’t because we’re in September, school goes back, it’s the start of term, when you’re a headteacher it’s just not possible. So that's his weekend gone, and mine are here with the children. So I get my father settled, my mother, the home-help, and then I phoned every day saying (in a low voice), "Everything going alright?" Are you ok, Papa, Maman?"And with all that I was worn out! And afterwards I went every other weekend, I went back. As I said, it lasted a good while, it's important, because driving like that, it's three hours and I did it in the day because I didn't want to take too much...well, no, because I had my lessons to prepare and I didn't want to take too much time, so I did it in a day. In general, I tried to do Saturdays. I went four times in a row, and I went on a Saturday each time, just in case there would be things to do. For the shopping, which my brother didn't do. So you see, I was really very very tired. I finished the school year, I felt that I finished it tired out and on top of that I had a large class." (Alice, France)

"My health isn't so good. I'm more jumpy, I've got blood pressure problems and I've lost weight. I've much less time to relax than before, and I don't sleep very well" (Britta, Germany)

Even if a carer keeps their job, they may not always invest themselves professionally as they would like. Objectives of career development often have to be put on hold. Interviewees are not always able to work extra hours, and most have to give up hours of training offered by the company.

How do carers meet their many daily obligations? What happens when they have to deal with unexpected circumstances or even a medical or hospital appointment?

Flexible working hours

One of the questions at the beginning of this project was related to the flexibility of working hours to look after a dependent elderly parent. Not all countries are in the same situation. The Netherlands present a very particular configuration as part-time work is highly developed. Of the 20 interviewees, 8 work between 20 and 29 hours per week, 8 between 30 and 36 hours, and only 4 over 36 hours, and thus full-time.

In other countries, it appears firstly that working part-time is not considered as a solution. Daniel in France, an only child, looking after his Alzheimer-suffering mother alone, before accepting her institutionalisation. Noticing his exhaustion, his employer offered to place him on part-time work, giving him one free day per week, but Daniel did not wish to reduce his workload. In fact, in many situations, part-time work is initially chosen to look after children. Time thus liberated for the family is often used by carers to look after a dependent elderly parent, although this is not its original objective. Such is the case of Fabienne in France. Mother to two young children, she works at 80% to be available on Wednesdays, so that she can take the children to their clubs and activities, and spend time with them. However, she also uses this time to visit her mother, who is in a retirement home, and her father, who lives alone at home. This is also true for Frederike in Germany. Married and mother of a nine-year-old daughter, she decided to work part-time when her daughter was younger to be able to look after her. As an executive in a commercial company, she works betwen 24 and 34 hours per week, according to her constraints. As her mother has become progressively dependent, she also uses her free time to look after her.

Finally, it also happens that the carer decides to work part-time, but it is not always easy for this to be accepted by the company. This was the case for Valeria in Italy. She is a nurse, and prefers to manage her mother's dependency herself, who lives with her. Following the deterioration of her state of health, she decided to work part-time, but it was not easy to obtain the approval of her employer:

> "I ended up asking to work part-time. I thought I just had to ask, but they told me "It takes around six months", and I replied "but I need to be part-time now, maybe it won't be necessary in six months' time" I even thought about using annual leave in the meantime. But I ended up getting it. But it was complicated".

Esther is employed in the bank of Germany. She works part-time to be able to look after her father who needs help in all aspects of daily life. Although she chose to reduce her working hours, Esther recognises that it was not always simple, and not always approved of by employers: "It's not always a good thing to work part-time. You can say it's great, but the problem is moving up the ladder in the company you work in...you can see it in the job ads...its more full-time. And if an employer can choose, they're always going to prefer full-time, not part-time...so it's not always easy to work part-time."

Flexibility as a tool of conciliation

The question here is of actions developed in different countries to facilitate the conciliation of care tasks and professional constraints. These may be measures put in

place as part of policies in favour of the elderly, but also employment policy, health policy and familial policies. From a practical point of view, two problems arise for carers who work: freeing up time to accompany an elderly parent to the hospital or the doctor, and to be able to leave their place of work in the event of emergencies or unexpected circumstances.

We have seen in the first part of this document that many countries have systems of paid or unpaid leave, allowing carers to leave their place of work to look after a dependent elderly parent. In Italy, for example, carers may take 3 days' leave per month to look after a dependent elderly parent. The situations studied show that these days are very useful for carers to manage unexpected circumstances or to carry out various administrative or medical tasks for their dependent parent or parents; but it does not always resolve everything. In Portugal, the 15 days available are unpaid, and in general employers do not appreciate unexpected absences from one day to the next. Also, what happens in countries like France, where this type of measure does not exist, except to accompany a dying relative? Whatever the measures put in place, flexibility is essential to be able to meet care obligations. Informal negotiation with employers or colleagues is a tool of conciliation in all countries.

Alice, a primary teacher in France, takes care of her two parents who live 150 km away; she had no hesitation in taking 10 days off work when her father was hospitalised. She took sick leave, and made arrangements with her employer. In the same way, Bettina, who works in a small shop in Germany, organised her worktime with her manager to be able to be with her dependent mother. She starts at 9 in the morning, and finishes at 3 in the afternoon, to be able to give her time to her mother. However, the situation is not easy to manage, as her boss often wonders if she will be able to continue working under such circumstances.

This recourse to informal negotiation also exists in Portugal, where carers rarely take the 15 days of leave available to them. Some use one or two of these days, but it is sometimes difficult to take more, particularly in the private sector. They therefore prefer to negotiate directly with the employer, and work extra hours to make up their time of absence, or take one day of leave from their annual holiday leave.

"When my mother is ill, I take a certificate in. Every time there's a problem or when she has a bad night, even when it's not something serious, I take a day off, and that's it. When there's a problem, yes, I stay at home" (Maria-Teresa, Portugal)

Also, employees are not always aware of conciliation measures already in place. In Portugal, not everyone is aware of the possibility of unpaid leave. The same applies in Sweden, where, with the agreement of their employer, a carer may take paid days of leave to look after an elderly parent, and may request financial compensation from Social Security. In the German public sector, employees may take days off in the event of family problems, but are not actually informed of this possibility. The solution often consists of taking a day's leave when necessary:

"I take my days off. Last year, I organised my holidays to keep two days every month to be able to go to the doctor with my mother, because I can't do it with my full-time job" (Ute, Germany)

Executives, who often have a certain degree of autonomy in the organisation of their work, arrange their working hours to be able to conciliate their care obligations and their professional objectives.

Beatriz, an engineer in Portugal, explains that she organises her timetable alone, and that if she has to miss some hours, she takes a day's leave: "I've managed like that until now and nobody has ever said anything because I was absent". Luca, a police sergeant in a small town in Italy, explains how he organises himself to conciliate his professional and care obligations. He enjoys a certain degree of autonomy, but above all he has reconsidered his priorities and now gives time to his mother, who suffers from Alzheimer's before anything else: "I don't see my work in the same way. My job had been my priority for a long time, but now, I've got other priorities. Now the priority is my parents and nothing else... I mean... I let go of everything without a problem and I go to see them... it may seem paradoxical, but I'm much more flexible than my brothers who work freelance... no doubt because I work in the public sector... I can say "I'm off" and I can catch up my work time in a different way. I can say "I'm taking tomorrow off, I need it", and I don't have any problem in taking it".

As Luca emphasises, the sector of employment appears as a determinant factor. In all countries, conciliation appears easier in the public sector than in the private sector, where the nature of relations with colleagues and the employer is a determinant factor. However, when the work environment facilitates conciliation this is not necessarily detrimental to professional employment. In certain companies, the employer chooses to help employees conciliate their familial and professional obligations. Francesca, who is Italian, works full-time as a secretary in a multinational company. She is an only child, and therefore has sole responsibility for her increasingly dependent mother. Every month, she takes three days' leave, in accordance with the law, and has negotiated an extra day of annual leave to be able to meet her care obligations. With her employer's agreement, she is therefore absent two half days per week, Thursday and Friday afternoons. This understanding attitude by her colleagues and her employer is essential in allowing her to meet her various obligations. In the Netherlands, case NL04 has a 38-hour contract as a secretary in a financial public service. She emphasises the importance of the good relations that she has with her colleagues and her boss: "I'm a really good employee. So my boss told me: "Don't hesitate to rest if you need. I'll take over, or a colleague will". "I really discussed all that with him, even when my mother was very ill. And he told me, "We'll see how things go, do what you need to do and if you need to be absent, just send me an e-mail and go".

Even if it is a little exceptional, the case of Frederike in Germany is a good illustration of how some companies support the conciliation of the family and professional life of their employees. At 43, Frederike has just been promoted to the position of manager in the retail department in which she works; as we mentioned previously, she works part-time to look after her nine-year-old daughter and her mother-in-law.

When timetables are fixed and difficult to adjust to care obligations, carers negotiate directly with their colleagues to modify their hours. For example, Ada, a schoolteacher in Italy, looks after her dependent father and her disabled brother. She has three days' paid leave per month for each of them, and she cannot always take the time off as she has to fulfil her professional obligations. She works 24 hours per week, but her hours are fixed and she often has to work extra hours. She often makes arrangements with her colleagues, who easily agree to cover her teaching hours when she has a care obligation.

Through this example, we can see that even in Italy where three paid days are perfectly integrated by employees and employers, support and understanding from other people is essential for carers to be able to conciliate their different obligations.

Flexibility is therefore the main tool of conciliation used by carers in all the countries studied. As shown in the examples, this flexibility may take different forms. When carers wish to accompany a parent to a medical appointment, the solution is often a day's leave, taken from specific leave where this exists and is paid and accepted by employers, or where this is not the case, from holiday leave, a time-savings account or from days of compensatory time off. When it is necessary to manage unexpected circumstances that require an immediate departure from work, carers negotiate directly with their professional entourage. The sector of activity and relations maintained with colleagues and the employer are therefore determinant factors in the authorisation of a certain degree of flexibility in working hours. The main difference between countries lies in the degree of recognition of this flexibility as an instrument of regulation. In the Netherlands, it is integrated into the regulation of employment, and provides a general conciliation of family and professional life. Besides working part-time, carers have recourse to a variety of arrangements: extra hours to free up time slots for family obligations, working early in the morning to be able to leave earlier in the afternoon, or to free up a day during the week to carry out administrative or medical tasks with their elderly parents. We find the same operating principle in France with the 35-hour week and the possibility for employees to take compensatory time off (RTT).

5. The role of carer and relationships within the family

We can see that all carers describe the difficulties they encounter in conciliating their various professional and care obligations. Periods of crisis are more particularly a source of stress and problems. However, the objective is above all to cope on all fronts: familial, personal and professional. The impact of this role of carer on the life of carers needs to be appreciated differently, on the basis of pressure and accumulated fatigue in order to find the best possible compromise and in order not to abandon either professional activity or the role of carer. The analysis of the interviews carried out in the different countries shows that it is carers' familial and personal life that is most affected.

Alice's story in France is an example of this. Alice is 44 years old, a school teacher and mother of three children aged between 22 and 14. She lives 150 km from her parents' home, but she is very present when they have health problems. Her father, aged 87, is increasingly dependent and has to be aided every day. When he was hospitalised, Alice took 10 days' sick leave without hesitation - with the agreement of her employer - to go to look after him and to organise his return home. She then went back and forth every week to see him and make sure that there were no problems. She left on Fridays and only returned home on Sundays, thus sacrificing part of her time with her family:

> "Inevitably my husband and children suffered from it, that's for sure. I tried to make sure that this didn't happen professionally. I don't think so, because now I've got relatively good insurance now at a professional level for it not to make too many problems, but it's clear that when I've got to leave like that, I leave my husband to manage everything, I leave the children who are already worried about their grandparents."

The presence of other members of the family, whether a partner, children or brothers and sisters, is also a resource in the organisation of the care arrangement, and even in the facilitation of different familial and professional obligations. In Italy, Nadia shares the role of carer with her sister. They look after their very dependent father together; Nadia is the main carer, as it is she who has contact with the services and various

professionals who come to see her mother, but her sister provides precious support as she spends a great deal of time with their mother. Nadia can therefore go on holiday, or take time for herself. The same is true for NL12 in the Netherlands, who explains: "Looking after a parent is really a difficult job. But it's not so hard for me because I can share tasks with my family. But I know a lot of people who can't do that."

Knowing that it is possible to count on brothers and sisters to take over for a while, or to discuss a problem when necessary appears to be a resource that facilitates the various familial and professional obligations.

Four levels of analysis can be identified, ranging from the family in the widest sense, to the person interviewed themselves: relationships with brothers and sisters, family life and relations with children, marital relations and consequences on personal life. The impact of the role of carer may be negative and result in an absence or a lack of availability, disagreements and even conflict; but it may also be positive and reinforce family cohesion.

Impact on relations between brothers and sisters

The situation of only child is often difficult for the carer, who finds themself alone in facing the constraints of care. Francesca in Italy, Josette in France and G01 in the Netherlands are only children and are therefore the only support for their aged parent. Although there is no doubt that the presence of brothers and sisters may constitute an important resource for the main carer, this may also present a certain number of problems. The division of tasks is not necessarily simple, and the different points of view of members of the family regarding the situation of the elderly parent and what should be done is not always the same. The organisation of the care arrangement may therefore give rise to tensions and conflicts between brothers and sisters.

This is the case for Fabienne in France. She is one of a family of six children. Four of them live close to their parents, who moved to live near them a few years ago. Fabienne's mother is in sheltered accommodation; her father - whose health is deteriorating - wanted to stay at home, categorically refusing to go to live in an institution or even, until recently, to be helped by socio-medical professionals. This concerning situation required a family meeting in order to take stock. The decision was made to allow their father to live at home, to ask the help of professionals, and for everyone to take turns in looking after him at weekends. Their father's state of health is deteriorating, and looking after him for an entire weekend becomes an increasingly heavy responsibility. Disagreements between brothers and sisters have therefore appeared; some consider that the situation is no longer tenable and that much more systematic use should be made of professionals, and even that their father's removal to an institution should be considered as he refuses all outside help. Others give priority to their father's wish to remain at home, even if this involves certain risks for him in daily life.

In Portugal, Dolores explains that relations with her two brothers and sisters are not always easy. Both of her parents live with her, and neither ask her if she needs help: " I told them: "As you know, our parents have been living with me for three years now. And you have never asked if I needed help, if everything was all right. And now I can't face everything any more with my income and my husband's income (...) I manage everything and I find it too much. And I feel tired, it's become too much, and not only because of my health problem".

But how does this division of tasks take place? How is the main carer chosen? Geographical proximity is a determinant factor in the choice. The son or daughter who lives close to their parents is certainly more able to perform this function. Thus, in Fabienne's case, the four brothers and sisters who live close by are the only ones able to cover weekends. But this does not explain everything. Other elements play a part.

The gender variable appears to be an important element in the division of tasks. In the majority of cases, it is a daughter who is given the responsibility of care. Gender is in this sense a normative frame which automatically orientates the choice of the main carer from among brothers and sisters. Daughters are perceived and perceive themselves as being those who should provide care; Hedwig in Germany, Aurora in Portugal and Alice in France all explain that they were given the role of carer because they were the only daughters. Neither Hedwig's nor Aurora's brother, nor Alice's two brothers look after their parents regularly, which does not prevent them from paying visits or occasionally relieving their sister.

"It was totally normal! A son-in-law couldn't look after his mother-in-law or even my brother look after his mother! It was just normal that it should be me. Anyway, she's totally attached to me. She called me all the time even when I wasn't there. She really likes it when the others are there too, but I absolutely have to be there. Always!" (Hedwig).

"I was brought up like in Spain, that you don't put your parents in a home. The grandparents live with their children, and the daughters, it's their duty. I was brought up with that." (Alice)

"My brother doesn't go very often to see our parents, he calls nearly every day, but he doesn't go very often (...) I think that is a question of... well, I haven't thought about it too much because it's something that really annoys me... but maybe a mixture of selfishness and difficulty in managing the situation" (Aurora).

When brothers and sisters take care of their parents together, the division of tasks often reveals the impact of this gender variable. To return to the case of Fabienne in France, we can observe the very gender-oriented character of the division of roles between brothers and sisters, which has never been a subject of discussion. With her sister, she takes care of the shopping, the housework, the washing, contact with home help services or with health professionals, while her two brothers take care of the garden, DIY, and the accounts, which corresponds to traditional representations of so-called feminine and masculine activities. In Sweden, Hélène explains the division of tasks with her brother:

"My brother doesn't help very much... I take care of around 80% of tasks... he's certainly more... I mean, he's a carpenter so he occasionally takes care of certain things. He repairs the roof example. On a day-to-day basis, it's more me. It's sure he doesn't manage things in the same way as I do...I think about it all the time. I call her to ask her if she needs anything. I call her just to know if she's okay. I think that maybe, perhaps... its more daughters, isn't it? Daughters must do that more than sons. (...) I look after our mother on a day-to-day basis, and he does the parts I can't do".

Family history is another variable that explains the designation of the main carer. As explained by Finch and Mason (1993), when someone begins to look after their parent, they become the one to turn to the next time something is needed. The carer themselves perceives themselves as the one to turn to. The role of carer is therefore part of family history; it echoes the representation that the child has of their role towards their parents, and very often responds to the parents' request. The son or daughter therefore becomes

the main carer without there necessarily having been discussion and negotiation within the family to know who will take responsibility for care.

"My sister often goes to see them. Sometimes she takes them flowers, but that's all, she doesn't do anything else. But in fact, they [the parents] don't ask anything either. They know that it's me who looks after them" (Cecilia, Sweden).

The nature of ties between parents and children is an essential element in understanding why one child in particular becomes the main carer. To explain her involvement, Petra (Germany), who looks after her mother much more than her two sisters who also live close by, explains it in this way:

"I first thought that it would be my eldest sister, who is a doctor, who would look after all that and would have ideas on how to manage the situation. Ideas, yes that's for sure, but because of her job, she had very little time. She lives one hour away, she's the furthest. But it's surely also because I've always had the best relationship with my mother. So it was never the subject of debate or discussion. That's just how it was".

The case of Emmanuela in Italy also expresses this idea of a historical origin of this role and carer, built up over the years through relations created between members of the family. The eldest of two daughters, she looks after their mother, who suffers from Alzheimer's disease. She explains that this role was given to her firstly because her sister already had constraints as she has young children (Emmanuela is married but has no children), but also because she has always been more responsible than her sister; she is the one who can always be counted on in the family, and because she has always been closer to their mother.

Impact on relations with a partner and children

Taking care of a parent requires availability and involvement, which is then no longer available for other spheres of life. Relationships within the carer's own family may in some cases be disturbed by the constraints of care. The carer is no longer available for their own children in the same way. This is particularly a problem when carers have young children who require time and attention. The men and women that we interviewed rarely take time off their working hours to look after their elderly parents; it is therefore at the beginning or the end of the day that they will visit their father or mother to make sure that there is no problem, or to help in care tasks. These morning and evening time slots, traditionally for the children, therefore become those of the parents. In the same way, the weekend - family time *par excellence* - is often the time when the carer looks after their parents. The children are therefore caught between professional constraints of their parents and their obligations towards their grandparents. At the end of the day, they are the ones who suffer the most from the situation.

"We don't have so much time altogether as a family, and my daughter often says "we never go anywhere because of grandma". And she's right, it's always like that" (Hedwig, Germany)

"The children are fed up. They say, "You're always at your dad's, with granny or with grandpa"...Not always, but it must seem quite a lot to them. They express it like that. That's all. And so they're not happy to see me leave. This evening, they know that I'm not going to be home straight away, but I'm going to have to visit my father... my partner gets fed up from time to time as well. But he accepts it, I won't say because he has two, because he knows that I want to go to see him... and even if I don't want to, I've got to go

anyway... so for the moment that doesn't really cause any problems between us..." (Fabienne, France)

"With my parents' problems, all the attention goes to those who need it the most. I mean that all of a sudden, it's my son who suffers. I would like to give him more. He keeps saying, "Mum, mum", and I have to say to him, "Wait a minute, for the moment I've got to look after granny" (Dolores, Portugal)

The problems that this presents for children are of a varying degree of importance. Problems of time of course, because there comes a point where the addition of constraints becomes impossible to manage; but in some cases the consequences may be serious. In the German sample, two children have behavioural problems and need the attention of their parents, but they have great difficulty in being present on all fronts. Frederike relates how she has had to free up time to give to her daughter aged 9 1/2:

"The pressure has had consequences on my daughter. She has a tendency to self harm. She began by cutting off her hair, then there was a period where she didn't eat any more. Then she damaged my car with stones to attract attention. We hadn't realised that we were suddenly giving her much less time. "

The carer's partner also suffers the consequences of this involvement in care tasks. He may be a precious ally, an essential moral and practical support, as shown by the case of Josette in France. An only child, she is 250 km from her mother, who lives alone and is increasingly dependent. She therefore visits her regularly after her working week and her husband always goes with her. They also discuss the organisation of the care arrangement together, contact health professionals and carry out administrative tasks together. If the partner does not participate directly in the care arrangement, he may be a support and attentive ear. He may also understand and respect this commitment to the elderly parent:

"My husband is cooperative. He's been used to this situation ever since we've been married. We've always let the other be free to manage things in their own way. Sometimes he comes with me for a coffee [at my father's house] on Sundays, but not always". (NL07, the Netherlands). But the situation may also be a source of tension, or even conflict between a couple. Once again, the lack of time presents a problem and involvement with an elderly parent is not necessarily understood by the partner, who often has to take second place.

"I had to go to see my parents and it was a bit difficult. My husband said that I abandoned the house. In part it was true, but I couldn't abandon my parents. It was very difficult. And my husband started to yell because he thought that I spend too much money taking the car to see my parents" (Olga, Portugal)

Elisabeth in Sweden recently divorced. She considers that the time she spent looking after her mother was one of the points of tension with her partner and that it surely contributed to their separation. Silvia in Germany experienced the same problem; she relates how care of her mother was the subject of conflict with her partner: "Why do you do that? You shouldn't do that". He didn't understand at all. Instead of supporting me, he yelled. When he came home in the evening, he threw his things into a corner and watched television. And I couldn't stand this sort of behaviour. (…) yes, we separated in September."

Conciliation is particularly difficult when elderly parents live with the carer, their partner and the children, if there are any. It is difficult for the couple to preserve their intimacy or even simply moments of calm. Gwenn and her husband decided to accommodate Gwenn's mother; although both partners participate in her care, take turns on a daily basis so that she does not stay on her own for too long, and both consider that it is the best solution, they have had to adapt the situation. In the evening, after the day of work, they have to wait until after dinner to be on their own. Adjustments and adaptations of the different members of the family are frequent, even outside situations of cohabitation. The mother of Ute in Germany lives close by, which preserves the family environment, but this has not prevented the recomposition of daily life: "My husband had to get used to the situation, it's clear. This was the case for the whole family, until the situation stabilised. Of course, the partner and children have to make compromises. We talked about it before. We have very little time left to spend together".

Although the situations of Elisabeth in Sweden and Silvia remain extreme, and although partners in many case show themselves to be understanding, this does not prevent them from suffering from the situation. Edith in France explains that her husband started to have had enough because she had trouble sleeping and sometimes she woke up in the middle of the night to discuss her mother's problems: "He was fed up with talking about it all the time. It was obsessional...morning to night, even during the night", she says.

We can see that involvement in this role as carer of an elderly parent does not only concern the son or daughter involved; it affects all members of the family. Although this leads to a certain number of problems, there are also positive consequences. Ties may be formed between brothers and sisters, and solidarity reinforced within the family. Intergenerational solidarity is greatly called upon and is a linchpin in the care arrangement.

This is shown in Portugal, where there are many situations of cohabitation in the sample.

Impact on personal life

Of all the dimensions of daily life of the interviewees, personal life is the most affected. Relaxation, leisure, holidays, personal time, and even time spent with a partner are more and more reduced. The problem is certainly a problem of time, but not only. Carers who are heavily involved in care tasks are simply no longer able to relax; as fatigue and stress accumulate, they are no longer available to be able to dedicate themselves to other activities.

> "I haven't reduced my professional responsibilities, but I have reduced my other activities (...) I was a member of the music group, but I had to stop, it was too demanding (...) To play you need to be calm. You have to concentrate, you have to be calm, you have to be able to open yourself (...) and I started to feel bad" (Pedro, Portugal)

The organisation of holidays becomes complicated; brothers and sisters need to be contacted to ask them to take over, neighbours or friends need to be asked to help, it is important to be contactable, and not go away too far or for too long... an entire freedom of action and autonomy of life can be threatened.

"I haven't taken any holiday for a really long time. I stay at home because I'm always frightened that something might happen. I can't go away very far." (Ana-Maria, Portugal).

"It's possible to go away for a weekend, but not for a week. We haven't done that for nearly 3 years. In a way, I never get any respite" (Dorothy, Germany).

"During the weekend I'm on duty... in fact I have to sleep at my parents' house because the lady [who looks after them] doesn't work at the weekend. I stay on Saturday, I sleep over from Saturday to Sunday, I spent Sunday there and at the end of the day another lady comes and I can go (...) I haven't got any weekends to relax any more. I can't have projects any more" (Joao, Portugal).

Some carers choose to leave anyway and take their parents with them on holiday. This of course depends on the parent not being too dependent, and also means choosing destinations and is days that are suitable. Gwenn and her husband bought a camper van to be able to move around freely and comfortably taking Gwenn's mother with them.

Social relationships are also progressively reduced. All the interviewees emphasised the impossibility of maintaining a normal social life. This is due to a lack of time, and also because fatigue gains the upper hand; going out and leisure time soon have to take second place. In periods of crisis, situations are so difficult to manage that the carer can think about nothing other than their parent. The carer is not available for anything else.

"We went out quite a bit, but now we've stopped. Why? Because we are always... we finish the day of work and we have to go home. We have a lot of work, and then we have to look after my mother" (Sofia, Portugal).

"There's little free time. We can't really organise our free time because we have to be available all the time. If I go out I can't come back late because Mum is waiting for me. Because I have to change her. There isn't any free time, it's impossible" (Hedwig, Germany).

"All that had an impact on my own balance! I slept badly, I was seriously stressed...I was obsessional...my husband said "but your mum's the only thing you ever talk about". I had her in my head day and night! So it's the psychological condition that suffers! And so my relationships with others too...we cut down all our social relationships! Since November we haven't seen anyone, except for mum..." (Edith, France)

"Sometimes you're too tired to invite people round. But it can give you a boost as well!" (NL07, the Netherlands).

Carers who live alone and do not have any family are particularly exposed to the danger of total absorption by the tasks of care. Francesca is single and an only child. When her mother became dependent, she gradually dedicated all her energy outside of work to look after her. Her timetable was organised exclusively around her mother. She has been able to adjust things a little with the recruitment of a *badante* who supervises her mother during the day, but she always spends weekends with her: "I have completely given up holidays. I spend my holidays at home. And when I do go away, it's one week a year. And it's been like that for years now. Now I sometimes go out during the week, because there is the *badante*. Because I am with her on Saturdays and Sundays." Daniel in France, single and an only child, tells a similar story. He has looked after his mother, who has Alzheimer's, for years. He was so absorbed by his care tasks that he did not even realise that he was not well and that he had no personal life. It is only with hindsight, now that his mother is in a specialised institution, that he is able to realise what he has lived through: "After a while, I'd reached my limits. When you're

actually in the situation, you don't realise the concessions that you make, the stress, the fatigue, sometimes even the irritability, because you're in it up to the neck. But there comes a time when it's too much. (…) It was clear that I started to be desocialised and tired out. I felt like there was a lead weight on my shoulders...I had to hold on whatever the cost, to the point of forgetting about myself".

Conclusion

Many lessons can be taken from this comparative analysis conducted at two levels: at the macro level of care schemes, and the more micro level of the organisation of family care arrangements.

In all six countries studied, policies are being developed and measures are being put in place to help families cope with the dependency of their elderly parent(s). Targeting the care requirements of the elderly in day-to-day life, these measures mobilise an increasingly diverse range available resources. They combine aid in the form of services, and financial aid paid to the elderly person. This cash-for-care approach, and the control of the use of sums attributed which operates in France and the Netherlands, is a determinant element in the characterisation of the level of system regulation. In all cases, systems offering financial benefits demand a certain degree of availability from family carers, who become the main coordinators of the different professional and informal carers as part of the care arrangements. In all countries this coordination is a heavy workload, undertaken by family members.

Also, schemes and programmes have everywhere undergone a number of transformations, in Germany just recently. The development of services in Portugal, the introduction of cash-for-care in the Netherlands, the creation of a Solidarity Fund for Autonomy in France, and the revaluation of benefits allocated for home care in Germany all help to demonstrate that policies for the dependent elderly are not stabilised, and remain in development. The recent development of a profit-making service offer in Sweden, the Netherlands and in France, the difficulties in meeting care requirements in Sweden and the increasing cost of public programmes show that there are still more evolutions to come. The idea of implementing a 'cinquième risque' or dependency insurance in France is one of the developments announced. These progressive reforms make it possible to search for new sources of financing, to diversify and adjust schemes and programmes, and above all to complement the care provided by relatives.

The analysis of the qualitative interviews of families in six countries confirms this main observation. Whatever the country concerned and the policy put in place, the care arrangements studied appear as the combination of professional and informal solutions that families have to adjust over time, according to the evolution of the state of health of their elderly parents. Although the level of income, existing public schemes, the range of professional services, the level of dependency of the cared-for person and the extent of the social and familial network are important variables in the definition of the care arrangement, their instability, the concern of carers to ensure the best possible care of their dependent elderly parent(s) and the necessity to meet a wide range of familial and professional obligations, are factors that are common to all situations and all of the countries studied.

Care arrangements appear everywhere as the culmination of a variety of resources, both professional and informal, mobilising family carers who do their best to conciliate

their care obligations towards their elderly parents, their children and their partners while preserving their professional activity, which is presented by many as essential to be able to continue to fulfil these different tasks of carer.

To conclude, it also seems essential that these issues of conciliation and coordination of professional life and care responsibilities of dependent parents should be made a central objective in the definition of long-term care policies; the quality of care is strictly dependent on the way in which these carers are supported by public authorities in the future.

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