

# **SOCCARE PROJECT**

**NEW KINDS OF FAMILIES, NEW KINDS OF SOCIAL CARE**

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## **Workpackage 6: Final Report**

# **Families, Work and Social Care in Europe**

**A qualitative study of care arrangements  
in Finland, France, Italy, Portugal and the UK**

## **SOCCARE Project Report 6**

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## Abstract

The SOCCARE Project studied social care arrangements of European families in five different socio-economic and cultural environments that represent the variety of European welfare states (Finland, France, Italy, Portugal and the UK). It focused on four key family types that all are heavily affected by the ongoing demographic, socio-economic and structural changes within European societies: 1) lone parent families, 2) dual-career families, 3) immigrant families and, 4) “double front carer” families (that have young children and, at the same time, elderly family members in need of care).

The project interviewed almost 400 European families in detail about their opportunities and difficulties to make flexible and responsive care arrangements and to combine these with participation in paid employment. These interviews were made in national languages by five national research teams. The interview data was analysed mostly at the national level and reported in national workpackage reports. Moreover, on the basis of the information available in these national reports (and in synopses of interviews), care arrangements and their in/flexibilities in that particular family type were compared in the five European countries. Results of these qualitative comparisons were reported in four comparative workpackage reports of the project. In addition, the SOCCARE Project produced a state-of-the-art report on comparative social care research and finally, a final report. All reports of the SOCCARE Project are freely available at its web site (<http://www.uta.fi/laitokset/sospol/soccare/>).

The findings of the project have been thoroughly disseminated and discussed with policy experts at the local, national and European levels. The final aim of the project has been to provide a major contribution towards shaping a functioning framework for future policies on social care in Europe. Accordingly, the SOCCARE Project gave a number of policy recommendations. A part of these recommendations were based on particular findings from the workpackages but the main recommendations were based on the evidence from the whole project. Recommendations were given for policies on formal care, policies on informal care, labour market policies and other social policies (including housing policies, immigration policies, social security policies and social work).

According to the final and most general recommendation of the SOCCARE Project, it is highly necessary that policies do away with strict dichotomies. Citizens of Europe are not either workers or carers. They are both at the same time. As well, children, disabled people and older people are not in need of either informal or formal care. Both are essential and practically always, there is a need to integrate both at the level of everyday family life. To face the challenges of the future, an integrated policy perspective on work and care is required in Europe.

The SOCCARE Project was funded by the European Commission, 5<sup>th</sup> Framework Programme, Key Action for Socio-Economic Research. It started March 1, 2000 and ended August 31, 2003. It was co-ordinated by the Department of Social Policy and Social Work, University of Tampere, Finland. Its main partners were: Jorma Sipilä & Teppo Kröger (Finland), Claude Martin (France), Rossana Trifiletti (Italy), Karin Wall (Portugal) and John Baldock (United Kingdom).

## **1. Executive summary**

### **The SOCCARE Project: background, objectives, methodology**

Social care is a universal and familiar phenomenon but its flexible organisation as well as co-operation between informal communities and formal organisations has been problematic in all European welfare states. Traditional policies have often been one-dimensional, emphasising only certain providers and services while excluding or marginalising others. Due to the ongoing profound changes in European family and population structures, working patterns and welfare systems, the problems of providing social care in a flexible and responsive way are becoming even more urgent, forming one of the major policy questions of Europe in the 21<sup>st</sup> century: how can policies support European families so that these will continue to be able to cope with the social care needs of their members while participating at the same time in paid employment? For European socio-economic research the question is how to support the shaping of such policies.

This project studies social care arrangements of European families in five different socio-economic and cultural environments that represent the variety of European welfare states (Finland, France, Italy, Portugal and the UK). It focuses on four key family types that have all been heavily affected by the ongoing demographic, socio-economic and structural changes within European societies. The overarching objective of the research project is to discover how public policies and social services could more efficiently and responsively help families to cope with their care responsibilities and to combine these with employment.

In this project, we have studied four family types facing particular forms of pressure and stress. These family categories are (1) lone parent families, (2) dual-career families, (3) immigrant families and (4) “double front carer” families. In these families, skilled intersectoral and interorganisational co-operation is required to reach satisfactory care arrangements. The findings were analysed comparatively in close co-operation between five national research teams.

Social care has often been analysed by dividing the concept into dichotomies between public and private, professional and non-professional, paid and unpaid care. However, the everyday reality of care often transcends these dichotomies. Therefore, this project has been based on an integrated concept of social care. Social care is defined here as the assistance and surveillance that is provided in order to help children or adults with the activities of their daily lives. Social care can be paid or unpaid work provided by professionals or non-professionals, and it can take place within the public as well as the private sphere. Formal service provision from public, commercial and voluntary organisations as well as informal care from family members, relatives and others, such as neighbours and friends, are here included within social care. This broad definition of social care has been the point of departure for this project.

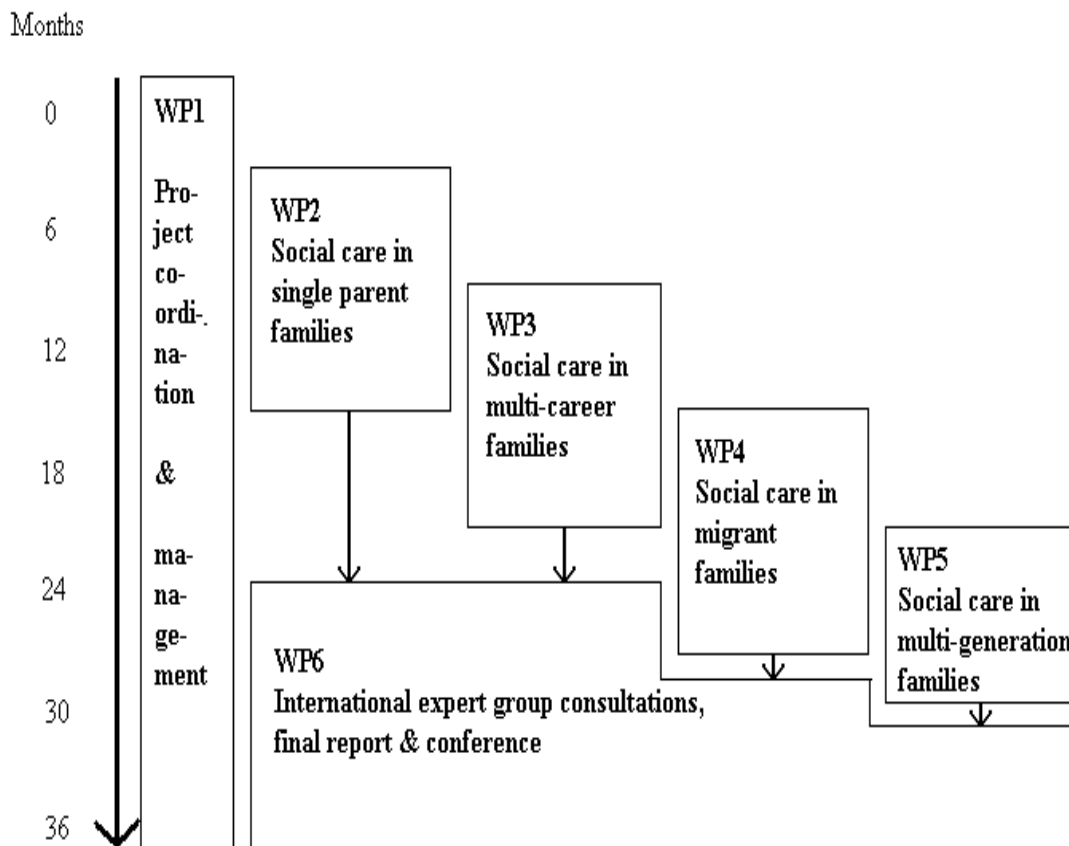
By its methodology, the SOCCARE Project has been comparatively oriented but it has also deeply adhered to national contexts. Data have been gathered according to common interview guides and analysed according to common frames but both of these phases of research work have been open to necessary national adaptations. Due to their limited size, national samples of this project could not be made identical or representative. However, this is not even the idea in qualitative research. The main idea has been to study the

interaction of individual social policies and individual families in their national and local social contexts. Consequently, it has been more important that the samples represent necessary variation than that all the samples from different countries are identical.

Co-operation has been a very essential characteristic of the SOCCARE Project. Interview and analysis guides were not ready and waiting at the start of the project but, instead, they are results from collective processes including thorough mutual discussions and cross-cultural learning within the multi-national project group. Biannual project meetings have been the major forums for these discussions.

The co-operative character of the project has been reflected also in its division of responsibilities. The co-ordinating partner of the project has been responsible for project co-ordination and management and for the final workpackage but each of the other four partners has also been responsible for a workpackage. Thus, each partner has on its turn been co-ordinating the research work of all five partners (Figure 1).

Figure 1. The original structure of the SOCCARE Project



Altogether, almost 400 European families were interviewed in detail about their opportunities and difficulties to make flexible and responsive care arrangements and to combine these with participation in paid employment. These interviews were made in national languages by the five national research teams. Common interview guides for each family type were applied in order to ensure that each national team received the same information. These guides included background questions about the situation of the family, questions about the practicalities of their work and care arrangements and not the least, questions about their subjective evaluations of the care arrangements.

In all workpackages except WP5, the analysis of the interview data was done in two phases. In the first phase, the data were analysed locally. Each national team analysed the interviews that they had made themselves. However, this was done according to commonly agreed frames of analysis. Furthermore, every national team presented their results in national workpackage reports written in English. In the second phase, the project partner that was responsible for co-ordinating the workpackage in question used all the information available in the national workpackage reports to compare care arrangements and their in/flexibilities in that particular family type in the five European countries. As well, the workpackage co-ordinator had access to synopses of each interview done in the five countries. However, in Workpackage 5, the comparative analysis was made on the basis of the primary data, transcriptions of original interviews.

A literature review of the-state-of-the-art of previous comparative social care research was included in Workpackage 1. The review found significant gaps in existing knowledge. Previous comparative studies had focused primarily on publicly provided care services, much disregarding both privately provided services and informal care. Methodologically, earlier studies had often been limited to statistical descriptions of national service systems connected with some conceptual thinking. Developed quantitative research methods had been rarely used and comparative qualitative studies on social care had been almost non-existent. The voices of local policy-makers, care workers and, above all, care users and their family members had been nearly absent from comparative social care research.

For its part, the SOCCARE Project has tried to fill some of these knowledge gaps. The project has had two interconnected focuses. First, to study what kind of implications do public social policies have for private family life in different European welfare states and, second, to study the agency of citizens within the constraints and opportunities provided by changing family and labour market structures. Findings from these qualitative studies have been compared between countries, disseminated and discussed with experts and professionals of social care. SOCCARE has been a project of interdependent equal partners doing qualitative research together on the everyday care arrangements of European families.

### **Welfare state contexts in the SOCCARE Project countries**

Formal care service provisions and labour markets have many variable characteristics in the five project countries. In the discussions of the project team, based on national literature and knowledge, several significant differences became highlighted. For example, there are considerable variations in levels of female part-time vs. full-time work, employer flexibility, access to childcare services, paternal involvement in childcare, availability of care services for older people and scope of family support (Table 1).

### **Care arrangements in lone parent families (Workpackage 2)**

This workpackage of the SOCCARE Project studied work and care arrangements of 127 lone parent families from Finland, France, Italy, Portugal and the UK.

By focusing on childcare arrangements, main trends can be seen in the way people manage to combine employment and care. Every care arrangement is actually applied to individually specific conditions within the constraints of existing general labour market and childcare service structures. These structures may be reinforced by individual strategies or they may be challenged by the expression of new demands.

Table 1. Special characteristics of work and care contexts in Finland, France, Italy, Portugal and the UK

	<b>Finland</b>	<b>France</b>	<b>Italy</b>	<b>Portugal</b>	<b>UK</b>
<b>Levels of female full-time and part-time work</b>	Full-time work: high	Full-time work: high	Full-time work: medium	Full-time work: very high	Full-time work: medium
	Part-time work: very low	Part-time work: low	Part-time work: low	Part-time work: very low	Part-time work: high
<b>Employer flexibility</b>	Medium	Medium or high	Variation between public and private employers	Low	Low
<b>Availability of childcare services</b>	For under-school-age children: universal	For under-school-age children: universal	For under-school-age children: huge regional variation	For under-school-age children: medium	For under-school-age children: low (high cost)
	For school children: limited	For school children: high	For school children: huge regional variation	For school children: limited	For school children: low
<b>Paternal participation in childcare</b>	Likely	Varied	Low	Low	Varied
<b>Availability of care services for older people</b>	Limited (by needs-testing)	Standardised but limited (by needs- and means-testing)	Low (high cost)	Low	Limited (by needs-testing and high cost)
<b>Scope of family support</b>	Limited	Limited	Very high (“the long family”)	High (not always available)	Limited

In all countries, most of the lone parents would like to balance work, formal care and intimate informal care, whatever the organisation of this informal care (individual, in the family, including or excluding ex-partners, etc.). However, there can not really be seen a continuing convergence towards a common European model. It seems that decisive differences remain between the national contexts. The collectivisation and externalisation of childcare is still higher in Finland and France, whereas community arrangements are more likely to be structured in Italy, while Portugal seems to be at a turning point. Beyond the convergence, the British cases have unique characteristics, such as common experiences of multiple couple life and impoverishment by incurring debts.

Of course, when we speak of national variations with small samples (27 families from Portugal, 25 from each of the other four countries) having no statistical representativeness and bringing no real comparability, we only wish to focus on the main issues emerging from the national samples.

Where (mostly in Finland, France and Portugal) full-day work is the norm, it brings long days in external care for children and often feelings of guilt for lone parents. For these parents, flexibility of work may be by its character as well family-unfriendly as family-friendly. The higher the qualifications and incomes, the more family-friendly the flexibility of work seems to become. When low-paid jobs are concerned, flexibility has most often a family-unfriendly character. In these cases, flexibility meant unsocial and atypical working hours and it actually acted as a hindrance to lone parents' access to work. In these situations, the equation often makes lone parents to reduce their working hours in order to avoid high service fees. This was a very common observation in our data.

Thus, for all lone parents whose qualifications and incomes are lower than the average, formal support at a low price and/or informal support are decisive resources for accessing work. The fact that none of the Finnish lone parents interviewed had real part-time jobs is very significant, and deeply contrasts with the British situation. The importance of formal resources emerges out of many care arrangements.

The significant involvement of close family members in daily childcare arrangements has its advantages and disadvantages. The advantages are linked to the fact that these arrangements are generally stable and inexpensive. In addition to the major contribution from grandparents, many lone parents see advantages also in having their ex-partners to take part in daily childcare arrangements, both in emotional terms for the children and in practical terms for themselves. The disadvantages raise from the resulting dependence that makes the lone parents feel obliged to "justify their lives" to the support providers. For the same reason, there are some feelings of a lack of privacy. These feelings are stronger for young lone mothers who still live in their family home.

The main element of convergence in the national samples is the numeric importance of varied arrangements. This means that the majority of working lone parents balance work and care by combining several sources of formal and informal care. Within this varied type, we observed that income differences heavily influence the form of the arrangements. For the majority of lone parents, filling gaps in the work schedules means combining extensive formal support with segments of informal support. In addition to this, we may observe that this form of care arrangement is marked by considerable variations concerning the involvement of ex-partners.

When we compare family support, we find large contrasts between the Southern and the Northern samples. In Portugal and Italy, family solidarity tends to allow lone mothers to obtain work, even though this often means low-qualified and low-paid jobs. Also in the other three countries, geographical proximity brings increased family support but, however, it seems to be considerably more limited than in Portugal and Italy. In Finland, France and the UK, other family members, most often maternal grandparents, may collect the children at the end of day-care or school or extra-school activities in order to fill a gap between the end time of the formal provision and the return time of the lone parent. However, they seem not to be involved in the kind of family routines that are characteristic of Italian families. Thus, people from the Southern countries seem less likely to be isolated from family networks. On the other hand, they often feel indebted to their family. Conversely, in countries where formal support is high, feelings of debt are not so usual but contacts with family members may be sparse.

In terms of causality, it is hard to say whether family support is higher in the Southern countries because of the lack of formal support, or vice versa. Nevertheless, there were some lone mothers in the Italian sample that had moved closer to their family members, due to the lack of formal support. In these cases, family care was not so much a preference but the only real alternative.

### Care arrangements in dual-career families (Workpackage 3)

This workpackage of the SOCCARE Project studied work and care arrangements of dual-career families in Finland, France, Italy, Portugal and the UK. The sample of this workpackage includes 124 families where both partners are in paid work or studying full-time and are responsible for the care of children aged 12 or less and/or older people needing regular assistance. Full-time employment and study is defined here as 30 hours a week or more. In this research, we concentrated on couples where both partners work full-time in positions that require particular commitment and time-use, as it is these families that are especially posed to the challenge of combining their care and work responsibilities.

This was a quota sample, not a representative random cross section. It was designed to capture a range of particular care + work arrangements. In all cases these families consisted of a man and woman couple where both partners were pursuing careers.

These families have exceptionally busy, and often complex, work-plus-care schedules. Many are in the middle of high skill careers and at the same time they are major producers of childcare and care for older people.

Our interviews did not reveal people who had a quality of life they were particularly content with. They did not complain greatly but they presented themselves as people who were getting by, doing the best they can, and often looking forward to when this difficult stage in their lives would end.

The work-plus-care strategies of these families are rarely static but in transition as children grow older and older people grow frailer.

The key factor that allows the combination of paid work and care responsibilities is some flexibility in employment timetables or care timetables or both. This may come from flexible working hours, an employer tolerant of caring responsibilities, care services that operate beyond working hours or wider family and support networks that are flexible.

There is a key distinction between those families where the flexibility comes from one source (for example, from time-flexible care provided by a grandmother *or* by a public service such as a nursery, school or home care service) and those where the flexibility comes from a wider range of sources (for example, from working hours *and* paid helpers *and* friends). We have defined single source flexibility as “uniflex solutions” and multi source flexibility as “multiflex solutions”.

Uniflex solutions are generally more robust than multiflex solutions but not always so, as the single key source can be withdrawn.

Families in similar circumstances (in terms of work and care responsibilities) may respond with very different care-plus-work strategies. There is no majority response.

The social policy and social service environment provided by a particular country and locality appear less important than the preferences, values and ideologies of the families themselves.

The gender balance in terms of care organisation and care tasks between the dual career couple is critical to the kind of work-plus-care strategy that can be followed.

Access to public and private transport is also a critical factor in determining work-plus-care strategies. Use of non-family care services very often requires transporting children or travelling to older people’s homes.

The single most important constraint faced by the families are limited opening hours by nurseries and schools and limited service hours from home-care services and day-centres.

Except amongst the poorest families, issues of cost of services is rarely a core issue. These are couples who have chosen dual-careers and income rather than time.

EU directives on working hours and leave for caring responsibilities are often not used by respondents. Many worked more than 48 hours a week.

The most effective way of assisting these families would be an infrastructure of childcare services and care services for older people that could be used flexibly in terms of hours and forms of assistance. It appears inefficient that these, often highly skilled, workers have to adjust their labour market participation, or even leave the labour market, because of the inflexibility of routine public services.

#### **Care arrangements in immigrant families (Workpackage 4)**

The main aim of this workpackage of the SOCCARE Project was to analyse how immigrant families organise care for young children and elderly persons and also to identify the specific constraints and problems they face when combining their work with caring responsibilities.

The findings of the workpackage show a great diversity of caring strategies. We can divide them into five main types: (1) extensive delegation, (2) mother-centredness, (3) negotiation inside the family, (4) father-centredness and (5) leaving children alone. The two first types were predominant in our sample while the other ones emerged in certain types of immigrant families.

Results from the five countries also allow us to distinguish several migration patterns: (1) mixed marriage migration, (2) student and/or qualified professional migration, (3) asylum seeker migration, (4) labour migration and (5) returning migration. An important finding is that certain types of migration patterns seem to be associated with certain types of caring strategies.

In the unskilled labour migration pattern, the work/family life balance and caring strategies are based either on low cost extensive delegation and leaving children alone or on individual solutions and mother-centredness (the mother cutting her working hours). On the other hand, the work/family life balance in skilled professional migration puts the emphasis on medium/high cost extensive delegation (formal services and live-in helpers) and mother support (centred on the mother but she does not cut her working hours). In the student migration pattern (in which both members of the couple are currently studying/working and belong to the same ethnic group), the balance between work and family life is achieved through extensive formal delegation and in some cases through shared parental and familial care. Instead, the mother-centredness strategy is predominant in mixed marriage migration. Finally, the work/family life balance in asylum seeker migration is rather similar to unskilled labour migration.

In summary, like other families, immigrant families who care for young children and/or elderly family members face constraints in terms of financial resources, availability of care services, work timetables, marital negotiation of gender roles and support networks. Our previous workpackages have shown that all families have to deal with these factors but for immigrant families, the migration pattern and the experience of immigration, as well as the family and societal context in which it takes place, have a strong impact on caring responsibilities and solutions.

Another issue is to discuss how policies might alleviate the pressures that immigrant families experience when they try to manage work and family simultaneously. As foreign people continue to immigrate into the European countries, policy-makers often ask whether

existing policies are successful in “integrating” migrant families. However, they rarely question whether policies are successfully supporting the duality of work/family obligations of immigrant families and whether more could be done in this respect. The effects of work/family problems on the lives of second generation immigrant families are also rarely questioned.

The qualitative study of this workpackage allows us to understand some of the problems and dissatisfactions experienced by immigrant families. The following problems were found essential: (1) the absence of sufficient collective structures (even if the coverage of care provision varies significantly between the countries, our interviews showed that in all five countries the most vulnerable immigrant families — unskilled labour migrant families, lone parent families and refugee families — experience the most significant problems); (2) the absence of accessible information on care provisions in the receiving country; and (3) social and cultural integration difficulties of immigrant families, in particular of unskilled labour migrant and asylum seeker families, especially during the first years after arrival in the host country (language barriers, housing problems, low paid and atypical working hours, social isolation, discrimination in the labour and housing markets and in school).

### **Care arrangements in “double front carer” families (Workpackage 5)**

This workpackage of the SOCCARE Project is mainly based on an analysis of interviews conducted in the preceding three workpackages of the SOCCARE Project. These interviews have been supplemented, however, by additional interviews aimed specifically at collecting information on the special challenges that some families face in confronting care responsibilities on “two fronts”: the care of children, and the care of elderly relatives.

The project originally planned this workpackage to be a targeted study on the situations of four-generation families. In the beginning of the research project, we had identified this family type as being at the forefront of the new transformations in family structures. Our research interests evolved with each wave of the study, however. It was clear already from the first wave of interviews with lone parent families that the mere existence of four generations — whether they live together or not — proved to provide little basis for predicting the form of support that is actually exchanged among family members. Furthermore, in all five project countries the most problematic situations for double-burdened caregivers were seen in families with three generations, rather than in families with four or five generations. Due to these findings of earlier workpackages, this workpackage was redirected to focus on “double front” care situations, particularly in three-generation families.

The first main result of this workpackage was that in “double front carer” families, the emphasis is on the elder care whereas the care of children is generally described as less problematic and more “natural”. Not only does this latter one seem to involve less fatigue and stress but also, it was presented as a resource to recover from the main burden of eldercare.

There were two main types of care networks found in our sample. (1) Those composed of “weak ties”, where the network is minimal or even absent and care-giving falls on one person. More than half of our sample (56 cases) is included in this first type. (2) The second main type, instead, has relatively rich and polycentric networks that share care responsibilities. A third of our sample (32 cases) is included in this latter type. (3) There is also a third type with a specialised sub-division of tasks between at least two caregivers, but this type was rarer within our sample.

All the three types of networks exhibit connections with professional and non-professional services. The range of professionally provided services is vast, ranging from less intensive health related services and home services to “total assistance”, such as nursing homes or assisted living centres, where the elderly person has around-the-clock access to help.

Families in Finland, France and the UK use most often combinations of informal care and publicly provided formal care. Only Portuguese and Italian families use mostly third sector and private care facilities. On the other hand, the informal non-professional paid sector is wide and varied in Italy, France and Portugal, offering a range of types of assistance. Some types of this non-professional care are light and temporary but others entail daily or weekly assistance with housework, bathing and personal hygiene. In some occasions carers of the latter type even live with the elderly person, providing around-the-clock services in exchange for room, board, and a small amount of money. These workers are usually women, and in Italy and Portugal they are typically immigrants coming from outside of the European Union. Their working conditions are often inadequate. However, for the Italian and Portuguese families, this solution is less expensive than an intensive formal home care service or a residential home.

In any case, there are marked differences between Italy, Portugal and France in the relationship between families and paid services. In the former two countries, private assistance, especially for the elderly, is used to substitute for public services. In France, it is used only to complement public services. In contrast to these countries, in Finland and Britain where access to formal services is easier and care provisions are more generous, non-professional extra-family care work is mainly provided by volunteers, usually free of charge. However, its coverage is limited.

Concerning the general organisation and control of the care arrangement, the family and, in particular, the main caregiver remains everywhere the most important resource. It is s/he who, even in the richer and more co-operative networks, assures the co-ordination of the various activities. However, if too scarce help — or none at all — is available to her/him from the outside, this fundamental resource tends to become quickly exhausted. From this point of view, formal and informal services need to be combined in a complementary way.

In conclusion, the need to think in terms of an integrated system or network of care, compatible with paid employment, emerges ever more clearly from the words of our participants. By thinking about the networks between families and services as an integrated network of care, we are able to depart from a logic that envisages either total delegation of care or the myth of specialisation. In the first case, the asymmetry of the relations is in favour of services that have the power to “govern” the network. In the second case, according to the model of health services, services deal with only small components of the user’s needs without examining how they affect the bigger picture. Indeed, the growing use of non-professional services in many countries, whether paid or voluntary, can be interpreted not only as a strategy to meet an unsatisfied need but also as an effort to find more flexible and personalised solutions. Such solutions, above all, leave the “government” of the care for family members to the family itself.

## Main policy recommendations of the SOCCARE Project

### *Main recommendations for formal care policies*

- Availability of formal care services to all families who need them must be the number one policy aim for social care policies in Europe. As universal availability of informal care cannot be taken-for-granted in any European nation, formal care is unavoidably needed. However, without public co-funding, the most part of people will not be able to use these services. If the access to formal care services is limited to certain segments of the population, social inequality will emerge and gender equality will become endangered.
- In all of the project countries, the study identified considerable gaps in childcare service provisions. Such gaps probably exist in all EU Member States. Today, childcare is not adequately organised during parents' atypical working hours (evenings, nights, weekends), when the children or their parent/s is/are ill, during afternoons after school hours and during school holidays. These gaps need to be addressed as they bring severe difficulties particularly to those families who do not have strong informal support networks. Children must be guaranteed necessary adult care also in these situations.
- Flexibility in opening times and content of services leaves a lot to hope for. Currently, existing services are not flexible enough to suit individual needs and cultural values of families in most of the countries. Often, small changes in institutional practices would bring significant improvement in this respect.
- Care provisions for older people must in particular go through a thorough self-examination. Why do so many European families see these services as "last resort" and do not wish to use them? The quality of these services and their responsiveness to needs and values of families are in distinctive need of a major improvement all over Europe.
- A fundamental change in the orientation of formal care services is necessary: service provisions must not any more be seen and planned as a system of their own. Instead, service providers must recognise that they form only one part in the whole sphere of care arrangements of families. Consequently, informal carers need to be accepted as equal partners with formal care providers. For formal care, this brings the need for close co-operation and integration with informal care.

### *Main recommendations for informal care policies*

- If a huge increase in future demand for publicly subsidised formal care services is to be avoided, families must become better able to combine informal care-giving and participation in paid employment. It is no more appropriate to expect women to end their paid work when care needs emerge in their families.
- The full sphere of social policies needs to be evaluated and reformed from this perspective: do they really support — or instead, hinder — the combination of worker and carer roles?
- Carers need to be able to combine working and caring both simultaneously and sequentially. To make a *simultaneous combination* of these roles possible, carers need to be able to adapt the hours and places of their work. Families also need access to

support services like domiciliary care but these must be adjusted to the needs and preferences of both, the care-givers and the care-receivers.

- In order to make a *sequential combination* of work and care possible, care leaves need to be available to employees. In practice, only a small minority can use an unpaid care leave. As a consequence, financial compensation schemes for the loss of income are necessary. In this respect, family members of older people are in all EU Member States clearly disadvantaged compared with parents of young children. Carers of older and disabled people are in most need of policy extensions in this respect but in several Member States, parental leave and benefit schemes are not adequately developed, either.

### ***Main recommendations for labour market policies***

- Recent increase of atypical working times has brought considerable cost to the well-being of families and increasing financial cost to local authorities. A fundamental discussion between the social partners is required: as the employers do get the profit out of the increase of atypical working hours, how will they participate in bearing the costs of this trend?
- “The flexible labour market” has been understood as a method to boost both the revival of national economies and the autonomy of workers. However, the kind of flexibility that our research found in many low-paid jobs could rather be characterised as “flexible exploitation of labour”. In particular, many lone parents and immigrants worked under strict and, from their perspective, fully inflexible working conditions that made the combination of work with care responsibilities very difficult. The emphasis of flexible labour market policies needs to change. Policies must focus primarily on promoting opportunities of choice to employees in order to make it possible for them to conciliate work and care. In the case of lone parents and immigrants, our results show that the need for this policy change is urgent.
- As argued above, workers need to be given opportunities for care leaves and part-time work. After such a leave or a period of part-time work, it must be secured that employees can without problems return to their own work positions.

### ***Main recommendations for other social policies***

- The lack of proper housing is a major barrier to well-functioning care arrangements. Housing policies need to promote affordable housing where the demands of care have been taken into account. There must be room enough for care. Furthermore, if the apartment or the environment is constrained by physical barriers, caring for older and disabled people becomes very difficult and consumes a lot of resources. Instead, by inclusive planning, independence of disabled and older people can be promoted and needs for care prevented. In order to make informal care possible, housing policies should also provide opportunities for different generations and family members to live close to each other.
- If people cannot afford to use social care services, they and their informal carers are left in a very precarious situation. Thus, social security policies are significant in providing families the financial means to use formal care services. In particular, policies on pensions and child benefits should be considered in connection to policies on formal care. The affordability of care services to all parts of the population must be

ensured. As well, in order to achieve a better gender balance in caring, the participation of men needs increasingly to be supported by social security policies.

- In our study we saw that general immigration policies have significant consequences for care arrangements of families in Europe. Families become very vulnerable when they are isolated from their original social networks. Consequently, immigration policies should support these networks, not negate them. In particular, family reunification should include elderly and disabled family members. General integration problems make the everyday lives of many immigrant families difficult and these problems need to be addressed with determined policies. Immigrant families can not properly organise care for their members if they are continuously discriminated against in labour markets and public services.
- Social work has traditionally been concerned with the material conditions of families, domestic violence, mental and substance abuse problems. However, it should be noted that the lack of care is a social problem as serious as the lack of income. As a consequence, social work should develop its professional practices and increasingly focus on supporting families in forging well-functioning care arrangements. On the other hand, health care tends to medicalise and individualise older and disabled people's problems. The contribution of social work is needed to balance the situation and bring forward the everyday life level and the care networks of these people.

Finally, we want to emphasise that it is highly necessary that policies do away with strict dichotomies. Citizens of Europe are *not either* workers *or* carers. They are *both* at the same time. As well, children, disabled people and older people are *not* in need of *either* informal *or* formal care. *Both* are essential and practically always, there is a need to integrate both at the level of everyday family life. To face the challenges of the future, an integrated policy perspective on work and care is required in Europe.

## 2. Background and objectives of the project

Social care is a universal and familiar phenomenon but its flexible organisation as well as co-operation between informal communities and formal organisations has been problematic in all European welfare states. Traditional policies have often been one-dimensional, emphasising only certain providers and services while excluding or marginalising others. Due to the ongoing profound changes in European family and population structures, working patterns and welfare systems, the problems of providing social care in a flexible and responsive way are becoming even more urgent, forming one of the major policy questions of Europe in the 21<sup>st</sup> century: how can policies support European families so that these will continue to be able to cope with the social care needs of their members while participating at the same time in paid employment? For European socio-economic research the question is how to support the shaping of such policies.

This project studies social care arrangements of European families in five different socio-economic and cultural environments. It focuses on four key family types that have all been heavily affected by the ongoing demographic, socio-economic and structural changes within European societies. The overarching objective of the research project is to discover how public policies and social services could more efficiently and responsively help families to cope with their care responsibilities and to combine these with employment.

More detailed objectives of the project are:

- to describe and explain social care arrangements used by four key family types most affected by demographic, economic and labour market changes,
- to identify innovative methods for combining family and formal care provision for young children and older people,
- to identify the challenges to existing welfare arrangements as they are perceived by users, providers, professionals, managers and policy makers from the local to the European level,
- to identify and analyse the most sustainable and flexible arrangements for social care in the context of labour market needs and the competitive challenges faced by European nations,
- to add to existing statistical data on social change and social care in Europe by providing a more qualitative account of social processes,
- to create a sound basis for the further exploitation of the findings through both continuing research and direct inputs into policy design and social care practice.

In this project, we have studied four family types facing particular forms of pressure and stress. These family categories are (1) lone parent families, (2) dual-career families, (3) immigrant families and (4) “double front carer” families. In these families, skilled intersectoral and interorganisational co-operation is required to reach satisfactory care arrangements. This study took place in five different environments that represent the variety of European welfare states (Finland, France, Italy, Portugal and the UK). The findings were analysed comparatively in close co-operation between five national research teams.

Securing social care for all citizens and under all conditions is inherent in the social objectives and cultural values specific to Europe. Ways need to be found to sustain this

European commitment in the face of international economic competition. This research project aimed at finding ways in which such policy-making that combines needs, resources and motivations in new and more adequate ways could take place. The changes of social care in Europe have implications that are local, regional, national and international. We have focused on how European families and their formal environments may co-operate and combine their resources in order to construct social care in innovative and flexible ways. The barriers that prevent successful solutions have also been examined.

We have analysed these issues primarily from the perspective of the families. However, research results of this project have been thoroughly discussed with end-users, first with social care experts at the local level, and then with an International Expert Group that represented different user groups from all the current 15 EU Member States. Furthermore, the findings have been discussed in two Dialogue Workshops organised by the European Commission and in the Final Dissemination Conference, organised by the SOCCARE Project. Thus, a constant dialogue with experts from the different levels has been embedded in the work of the project. The final aim of the project is to provide a major contribution towards shaping a functioning framework for future policies on social care in Europe.

### **3. Scientific description of the project results and methodology**

#### ***3.1. Research methods and research process of the SOCCARE Project***

Social care has often been analysed by dividing the concept into dichotomies between public and private, professional and non-professional, paid and unpaid care. However, the everyday reality of care often transcends these dichotomies (Daly & Lewis 1998 & 2000). Therefore, this project has been based on an integrated concept of social care. Social care is defined here as the assistance and surveillance that is provided in order to help children or adults with the activities of their daily lives. Social care can be paid or unpaid work provided by professionals or non-professionals, and it can take place within the public as well as the private sphere (Kröger 2001, 4). Formal service provision from public, commercial and voluntary organisations as well as informal care from family members, relatives and others, such as neighbours and friends, are here included within social care. This broad definition of social care has been the point of departure for this project.

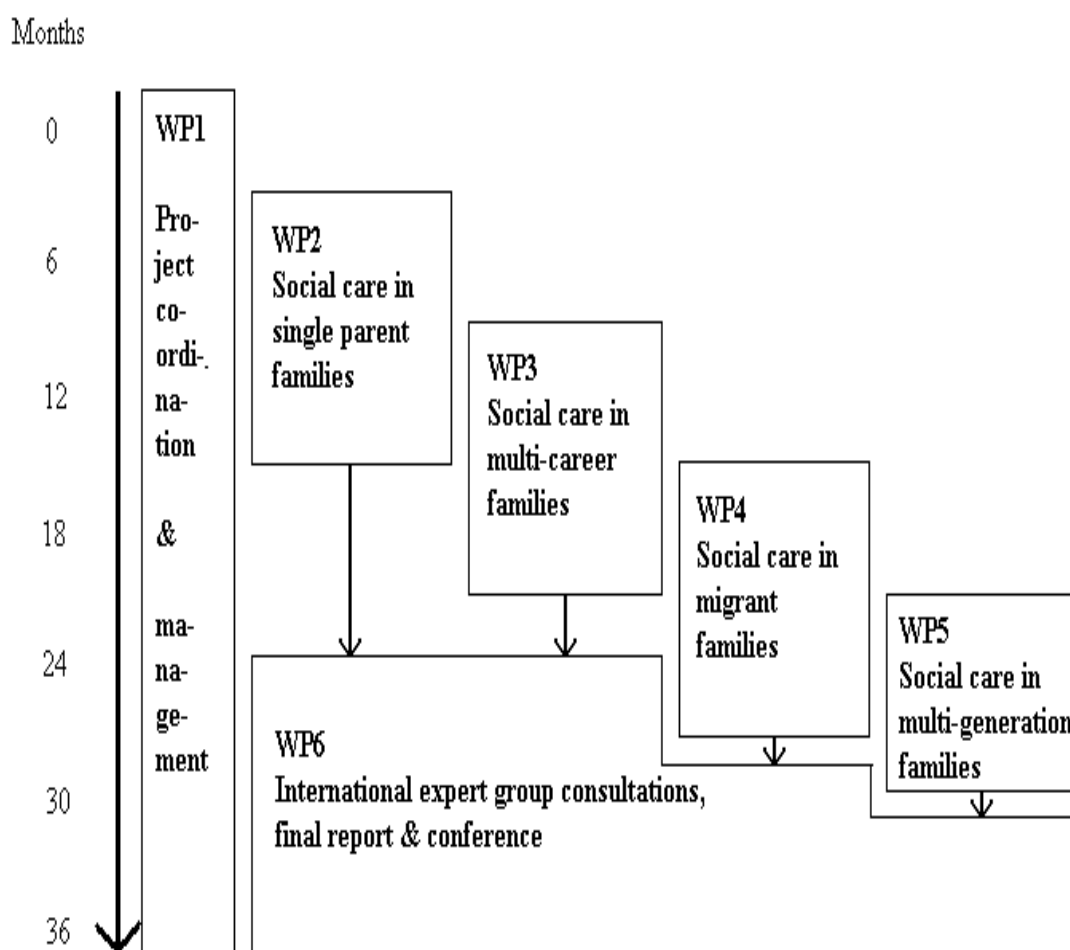
Like Evers (1994, 18), our project looks forward to “policies and processes which aim at a better interaction of a plurality of different sectors and actors”. The SOCCARE Project has been looking at all kinds of informal and formal care that are used by families in the five project countries. The aim has expressly been to study the opportunities and difficulties of family members to combine support from different sectors in a responsive and flexible way. Such a research task requires a detailed analysis of the situation of individual families in different European welfare state contexts. Qualitative methods were weighed to be best suited for this purpose ? instead of using aggregate data detached from cultural meanings. The desire of earlier qualitative comparisons has precisely been to try to understand welfare regimes “from the bottom up”, to study how private lives interact with public issues and policies (Ungerson 1996; Freeman et al. 1999). For example, the SOSTRIS Project from the TSER programme emphasised that individualised methods of comparative study are needed if the causal processes and individual implications of social exclusion are to be explored in European social research (Chamberlayne & Rustin 1999).

Björnberg (1992, 2) has made a difference between “comparative research” and “co-operative research”. According to her, “comparative research” aims at presenting strict comparisons on parameters of a research problem whereas “co-operative research” aims primarily to provide opportunities for exchange of research experiences. On the other hand, Millar and Warman (1996, 51-52) have presented two extreme alternatives for comparative data collection. At the one end is “questionnaire approach” where all national contributors are expected to find answers to the exactly same detailed questions. The other extreme is setting only the topic, and perhaps a broad framework, to be studied freely by national contributors. The first option aims at full comparability whereas in the second option any direct comparability is almost accidental. However, the first approach, unlike the second one, risks losing the national context.

The methodology of the SOCCARE Project has been situated between the extreme alternatives of these both dichotomies. By its basic character, the project has been comparatively oriented but it has also deeply adhered to national contexts. Data have been gathered according to common interview guides and analysed according to common frames but both of these phases of research work have been open to necessary national adaptations. Due to their limited size, national samples of this project could not be made identical or representative. However, this is not even the idea in qualitative research. The

main idea has been to study the interaction of individual social policies and individual families in their national and local social contexts. Consequently, it has been more important that the samples represent necessary variation than that all the samples from different countries are identical.

Figure 1. The original structure of the SOCCARE Project



Co-operation has been a very essential characteristic of the SOCCARE Project. Interview and analysis guides were not ready and waiting at the start of the project but, instead, they are results from collective processes including thorough mutual discussions and cross-cultural learning within the multi-national project group. Biannual project meetings have been the major forums for these discussions and ? occasionally ? debates.

The co-operative character of the project has been reflected also in its division of responsibilities. The co-ordinating partner of the project has been responsible for project co-ordination and management and for the final workpackage but each of the other four partners has also been responsible for a workpackage. Thus, each partner has on its turn been co-ordinating the research work of all five partners (Figure 1).

In practice, the national samples of lone parent families, dual-career families, immigrant families and “double front carer” families were gathered according to specific criteria, proposed by the partner responsible for the workpackage and discussed together. The interviewed families were found using several different sources in order to increase the

variation of situations. The first three samples are separate, each including (about) 25 families from each country. Instead, the fourth one (of “double front carer” families) was mostly found within the other three samples. Altogether, almost 400 European families were interviewed in detail about their opportunities and difficulties to make flexible and responsive care arrangements and to combine these with participation in paid employment. These interviews were made in national languages by the five national research teams. Common interview guides for each family type were applied in order to ensure that each national team received the same information. These guides included background questions about the situation of the family, questions about the practicalities of their work and care arrangements and not the least, questions about their subjective evaluations of the care arrangements.

The analysis of the interview data was done workpackage by workpackage in two phases (except in WP5, see below). In the first phase, interview data were analysed locally. Each national team analysed the interviews that they had made themselves. However, this was done according to commonly agreed frames of analysis. Furthermore, every national team presented their results in national workpackage reports written in English. In addition to results of the qualitative analysis of the interviews, national reports included quantitative and other basic information about the national characteristics and situation of the family type under study. This information provided a context for the comparative interpretation of the national interview data.

In the second phase, the project partner that was responsible for co-ordinating the workpackage in question used all the information available in the national workpackage reports to compare care arrangements and their in/flexibilities in that particular family type in the five European countries. As well, the workpackage co-ordinator had access to synopses of each interview done in the five countries. These synopses, 1-2 pages each, were written in English. After that, the responsible national team presented their comparative findings to the whole project group to be discussed and commented. Taking into account the comments from the other partners, the responsible partner then wrote the comparative workpackage report.

The research project has been realised according to the original research plan written in 1999, with two exceptions. The first exception concerns the timetable of the project. It proved out that it was not possible to conclude all the planned workpackages at the planned analytical level in the planned timetable. Therefore, we applied an extension period of 6 months to complement the 36 original project months. The Commission granted this extension.

The second exception concerns Workpackage 5. In our original research plan, we identified four emerging family types that probably face an overload of caring problems and general difficulties in organising daily life. Along with lone-parent families, multi-career families and families who had recently emigrated from another country, we thought that four-generation families that are increasing due to the ageing of the population would face the same kinds of pressures. With four-generation families we understood families who have four generations alive but who do not necessarily live together.

However, following cross-country comparisons within the first three empirical workpackages, we came to the conclusion that four-generation families do not pose a particular care problem. On the contrary, the richer informal resources that are included in the larger number of generations seemed to act as a kind of a buffer against particular strain in organising care. Instead, we found out that many three-generation families were in a very difficult situation when the middle-generation was expected to provide care to their young children and to their old parents at the same time.

To get more information and a better understanding of this phenomenon, the project decided to refocus its last empirical workpackage. Project partners decided, after a consultation with the responsible Scientific Officer of the Commission, to concentrate the main part of empirical work in this workpackage on these “double front carer” families. This reorientation process is described in more detail in chapter 3.7. of this report. In this last empirical workpackage, we also wished to take in use an analytical strategy different from the previous workpackages. Whereas the most part of the empirical analysis in the other workpackages was done at the national level in a decentralised way, here we wished to do the analysis of the data in a centralised way. In this case, the national team responsible for the workpackage had access to the primary interview data, not only to secondary sources like synopses and national reports.

In all, the SOCCARE Project has had two interconnected focuses. First, to study what kind of implications do public social policies have for private family life in different European welfare states and, second, to study the agency of citizens within the constraints and opportunities provided by changing family and labour market structures. Findings from these qualitative studies have been compared between countries, disseminated and discussed with experts and professionals of social care. All this has been done in a co-operative manner so that each national partner has needed the contribution of all the others in order to accomplish its own responsibilities. SOCCARE has thus been a project of interdependent equal partners doing qualitative research together on the everyday care arrangements of European families.

### ***3.2. State of the art in earlier comparative care research (Workpackage 1)***

A review of the existing state of knowledge in comparative social care research was included within this workpackage. The literature review covered comparative studies of two major areas of social care, childcare and care for older people. Additionally, comparative research on issues of family, gender and work were looked into as these have direct connections with social care.

Concerning comparative research on childcare, basic information about provision levels is now available even though the comparability and the coverage of the data are partly insufficient. However, the main features of national childcare systems in Europe are well known. Comparisons have found clear differences between models focusing either on early education or on social care for children. On the other hand, several reports show a general convergence towards universal provisions for over-3-year-old children in Europe. At the same time, in many European countries there is a constant and remarkable shortage of services for under-3-year-old children.

Care services for older people have been compared intensively especially during the 1990s. Deinstitutionalisation and community care are commonly adopted policy preferences all over Europe but individual countries still have very distinctive provisions. Many Northern European countries are decreasing their provision of institutional care, whereas several Southern European countries are still constructing the required basic network of residential services. Also domiciliary care provisions differ largely between European nations. Support to informal care has become an important policy issue everywhere. In all, despite the lack of fully reliable detailed data, it has been observed that even though European nations are facing similar pressures in care for older people (population ageing, funding limitations, excessive reliance on informal family care etc.), their responses are dissimilar, reflecting national institutional and cultural traditions.

Also family structures are partly converging but still very diverse in different European countries. Concerning the cultural assumptions about the obligations of families, especially Scandinavia and Southern European countries are apart from each other. A European consensus on family policies has been difficult to find due to significant differences between national approaches to family policy. For example, France has had a very explicit family policy whereas Britain has applied a non-interventionist approach.

It was feminist social policy scholarship that finally brought social care policies into comparative welfare state research on equal standing with social security policies. Gender-sensitive research has shown the inadequacy of the previous mainstream comparisons that ignored the unequal relationships of women and men with European welfare states. Findings from comparative care research have remodelled previous welfare state typologies.

Recently, it has become widely recognised that social care policies affect considerably the opportunities of women and men to participate in paid work. Where they exist, flexible care services are a major support for the reconciliation of work and family responsibilities. In order to promote participation in paid labour, these services need to be generally available and affordable. The connection between childcare and mothers' employment has been known for a longer time but now also the effects of social care services to the position of working fathers as well as to the position of working carers of older and disabled people have been placed under comparative study.

Nevertheless, there still remain significant gaps in comparative social care research. Previous comparative studies have focused primarily on publicly provided care services, much disregarding both privately provided services and informal care. Methodologically, earlier studies have often been limited to statistical descriptions of national service systems connected with some conceptual thinking. Developed quantitative research methods have been rarely used and comparative qualitative studies on social care have been almost non-existent. The voices of local policy-makers, care workers and, above all, care users and their family members have been nearly absent from comparative social care research.

For more details of the state-of-the-art review, see [SOCCARE Project Report 1](#).

### ***3.3. Welfare state contexts of care arrangements in the SOCCARE Project countries***

Formal care service provisions and labour markets have many variable characteristics in the five project countries. In the discussions of the project team, based on national literature and knowledge, several significant differences have become highlighted. For example, there are considerable variations in levels of female part-time vs. full-time work, employer flexibility, access to childcare services, paternal involvement in childcare, availability of care services and cash benefits for older people and scope of family support (Table 1). In this chapter, some of these country-specific issues are discussed.

However, we want to emphasise that the SOCCARE Project does not actually study these variations between countries. Instead, the project analyses the care arrangements of families in the five countries. For example, we have found that specific kinds of families from different countries may have more in common with each other than with their next door neighbours. On the other hand, families facing apparently similar problems and constraints nonetheless often choose very different strategies to deal with them. In any case, care arrangements of families are not constructed in a social void but they are instead

deeply influenced by their labour market and welfare state contexts. This is the reason why also here, few pages are used to brief descriptions of these national contexts. A care arrangement of a family cannot be fully understood without knowing the social context where it raises from.

Table 1. Special characteristics of work and care contexts in Finland, France, Italy, Portugal and the UK

	<b>Finland</b>	<b>France</b>	<b>Italy</b>	<b>Portugal</b>	<b>UK</b>
<b>Levels of female full-time and part-time work</b>	Full-time work: high	Full-time work: high	Full-time work: medium	Full-time work: very high	Full-time work: medium
	Part-time work: very low	Part-time work: low	Part-time work: low	Part-time work: very low	Part-time work: high
<b>Employer flexibility</b>	Medium	Medium or high	Variation between public and private employers	Low	Low
<b>Availability of childcare services</b>	For under-school-age children: universal	For under-school-age children: universal	For under-school-age children: huge regional variation	For under-school-age children: medium	For under-school-age children: low (high cost)
	For school children: limited	For school children: high	For school children: huge regional variation	For school children: limited	For school children: low
<b>Paternal participation in childcare</b>	Likely	Varied	Low	Low	Varied
<b>Availability of care services for older people</b>	Limited (by needs-testing)	Standardised but limited (by needs- and means-testing)	Low (high cost)	Low	Limited (by needs-testing and high cost)
<b>Scope of family support</b>	Limited	Limited	Very high (“the long family”)	High (not always available)	Limited

### 3.3.1. Childcare services and economic benefits in Finland, France, Italy, Portugal and the UK

Access to non-family childcare varies tremendously between the five countries.

In Finland, local authority day-care services have been a universal social right for all under-school age children from 1996. However, if the parents wish instead to use private childcare services, they are supported by an economic benefit from the social security authorities (and, in several cities, by a supplement from the local authority). Furthermore — after the earnings-related maternal and parental care benefits for the first 10 months of a child's life — parents have a right to a flat-rate childcare benefit together with a right for a leave from work until the child becomes 3 years old. However, this Child Home Care Allowance is now, after severe cuts implemented in 1996, so low that many parents, lone parents in particular, can not afford to stay at home for the whole 3 years.

Local authority day care services are operated under social welfare administration and they have two main forms: day-care centres and municipal childminding. Day-care centres are focused on early education for 3-6-year-olds but many of them take in as young as one-year-old children. Municipal childminding is a service where local authorities employ a childminder who works at her — 99 % of municipal child-minders are women — home, caring for 4-5 under-school-age children, sometimes including her own children. Children cared by municipal childminders are often younger than those cared in day-care centres. Day-care centres are usually open from 7.00 to 17.00 but some are open until 19.00 and there are even a few 24-hour facilities. Privately organised day care services are still rather limited in Finland.

Despite of the universal right to day-care, three quarters of Finnish children under the age of 3 were cared at home in 1998. Furthermore, a third of 3-6-year-old children were not cared in day-care centres or by local authority childminders (Kröger & Anttonen & Sipilä 2003). However, the situation of 6-year-olds changed in 2000 when they were offered universal free-of-charge half-day pre-school. It can be organised either in a day-care centre or in a school. This pre-school service is now used by over 90% of the 6-year-olds.

School is started at the age of 7 in Finland. Children aged 7–9 years usually spend only four hours a day at school (from 8/9 to 12/13 o'clock). School and pre-school services including warm meals are free of charge but for local authority day care services, families are obliged to pay a fee that is related to their incomes. Many low-income families are exempted from the fee but parents with high incomes must pay the maximum fee that in 2003 is 200 € per child per month.

The high labour market participation rate of mothers in France is usually explained by the extensive public services devoted to young children. All parents have access to the quasi-free of charge pre-elementary school (*école maternelle*), even for two-year-old children. Families are expected to pay an income-related fee only for the lunches. In 1998, 100% of 3- to 5-year-old children and as many as 35% of two-year-olds were in this pre-elementary school. The French situation is good in that sense, compared to other European countries, even if many needs are still not covered, particularly during atypical working hours. French children under three may be looked after at their home by a babysitter, in a crèche or at a childminders' home (Martin, Math & Renaudet 1998). Most day-care facilities for children are open 8.00–17.00. Schools are usually open 8.00–16.30 but for a small fee, after-school care is generally available until 18.30.

The provision of care for very young children is more limited in Italy, Portugal and the UK. In Britain, public provision by local authorities is limited to pre-school education for 4-year-olds and selected nursery provision by social services for families with special needs – usually social rather than financial. Children start primary school in the UK during

the year in which they turn 5. For the most part of families with small children, there is a lack of accessible and affordable childcare of acceptable quality. Only 60% of 3-5-year-olds attend some sort of nursery care (mostly only part-time) and only 5% of those under 3 years. In the UK, public and private day nurseries are usually open 7.30–18.00, whereas nursery schools are usually open 9.00–15.00 and play schools only between 9.00 and 12.00.

British governments have followed a market-based approach to the provision of childcare services. State intervention, where it has taken place at all, has mainly been aimed at providing incentives to suppliers or subsidising the purchase of private provision. As a result, access to formal childcare is largely income dependent in the UK. Most formal pre-school and out-of-school-hours childcare services are provided by the private sector or, to a more limited extent, by the voluntary sector. Childcare is therefore expensive and particularly unavailable to families with low incomes. According to a study by the Daycare Trust, the average cost of a nursery place (five days a week 8am-6pm) in 2001 was £395 (about 590 €) a month in the Northeast of the UK and £586 (about 870 €) in inner London. Childminders cost about 590 € per month (720 € in London).

Since 1998 the Labour government has designed and implemented several “New Deal” policies like the Working Families Tax Credit to reduce disincentives to enter the labour market but these may not be sufficient unless access to childcare is improved. However, the introduction of the Child Care Tax Credits for Working Families (CCTC) in April 2000 may have partly helped low income families. It is available to parents who work at least 16 hours a week and have incomes below set thresholds that are rather low. The money can be used to pay for registered childminders, nurseries and play schemes, but not for non-registered childcare by relatives and neighbours. The maximum value is 105 € a week for one child and 158 € per week for two children. CCTC pays at the maximum 70% of actual childcare costs.

Nevertheless, due mainly to economic reasons, parents in the UK still tend to rely more on relatives and informal childminding than do French or Finnish families. In particular, working lone parents mostly either fit work timetables round available (unpaid or unofficially paid) informal care from family members, friends and neighbours.

It is inappropriate to talk about childcare policies at a national level in Italy. The variations are so significant between the regions and localities that it is necessary to look only at the localities in which the inquiry was realised. The Italian national samples have been mostly gathered from the regions of Florence and Bologna but some of WP3 and WP4 interviews were made in the Veneto region, as well. Even though all of these three regions belong to the Northern Italy, they show a profound disparity in their development of their social and educational services. The differences would still be drastically larger between the North and the South of Italy.

Bologna, city of education par excellence, is equipped with crèches and other flexible services for early infancy that reach 24 percent of under-3-year-olds, while in Florence the figure is less than 10 percent and the quality of the services is inferior. The national average is only 6%. Concerning nursery schools for 3-to-6-year-olds, while their coverage is similar (over 90%) in the two cities, they are however more community- rather than state-managed in Bologna, a fact that usually indicates both a greater care and a greater integration of the system of services for infancy. There is also the same kind of difference in the availability of full-time school classes. Between the two cities, there is thus a major difference in their capacities to take into account the problems of families with children in non-traditional terms. Also the third region where part of the Italian data has been gathered, the Veneto region, has its unique characteristics. As a result, the Italian data is influenced by these regional variations.

Italian public nursery schools for children 3–6 years are usually open 8.30–16.30. Crèches for 0–3-year-old children are, in principle, open 7.30–17.00/18.00 hours but, as said, local variation is huge and the services available often bear no relation to national policy. Italian schooldays often end at 12.30 or 13.30 and in any case many children go home for lunch.

In Portugal, the levels of formal childcare provision have grown steadily over the last fifteen years and this has brought the country somewhat closer to other European countries. In 1994/95, 55% of the three-to-five age group were in pre-school education (compared to 29% in 1985/86), and by 1998/99 this had risen to 65%.

Formal childcare policies have in Portugal mostly focused on pre-school education for the over-three-year-olds. Particularly in the 1970s and the 1980s, childcare was primarily seen from the point of view of the child's educational career rather than from the point of promoting the reconciliation of work and family life. However, during the 1990s there was considerable development in the “social component” of childcare in Portugal.

The responsibility for providing services for children below age three is mainly in the hands of licensed and unlicensed childminders and of the third sector that receives state support from the Ministry of Labour and Solidarity (in particular, non-profit social solidarity institutions and establishments belonging to the *Misericórdias*). Public day-care centres in Portugal are open 9.00–15.30, but they are usually closed for 2 hours during the lunchtime. Private and voluntary day-care centres are open 10–12 hours a day.

Six is the official age for starting full-time education and in the late 1980s the universal and free compulsory schooling was extended from six to nine years. It includes three “cycles”. During the first four years, school hours are usually from 8.30 or 9 am to 15.30 — but many children may have school either in the morning or in the afternoon due to the fact that schools may have two separate shifts in order to fit in more pupils. In the second and the third cycle, timetables may vary, with classes starting at different times in the morning and with some gaps in classes during the day. This is a frequent problem for families with children and in this respect, private schools are advantaged, providing children a regular school timetable and other activities after school.

One solution for families is to use publicly supported leisure time centres (*ATL*) that are provided by local authorities or non-profit social organisations and that charge a means-tested fee. Some of them even provide transport facilities to fetch the children from school. However, even though the provision of *ATLs* is expanding, it is still insufficient. Many children do not have access to this type of facility nor informal care but are left by themselves for many hours.

In practice, after-school and school holiday facilities are limited in all of the five countries. More details about childcare services and family benefits in these countries are available in the national WP2 reports on lone parent families.

### 3.3.2. Long-term care and economic benefits in Finland, France, Italy, Portugal and the UK

The provision of benefits and services that support care for older people varies widely across the five countries, as well. However, the main policy goal everywhere is that older people should be able stay in their own home for as long as possible. Another similarity is that according to a recent survey, despite differences in national welfare policy and provision, the level of informal care across the European countries was found to be similar. Around 6% of citizens seem to carry out daily care for older people in most EU Member States (European Commission 2000). Women are likely to be informal carers of both

groups, children and elderly people, but men are more likely to be involved in childcare than in care for older family members.

It is not our task here to provide a detailed description of the generosity, coverage, and actual implementation of social policies for the elderly in Europe as there are already studies that provide this kind of information (for example, Rostgaard & Fridberg 1998; Bettio et al. 1998; European Commission 2000; Rostgaard 2002). However, there are some important variations in our interview data that do appear to be connected to variations in welfare regimes. These differences came to light notwithstanding the particular research approach that we chose to follow: a study of the similarities in the daily lives of our participants, cutting across all five countries.

What surprised us most, initially, was that families were generally rather satisfied — though not with everything — with the way assistance was organised, no matter what level of quality or generosity was provided. In other words, it appears that families reason within a national standard of viable alternatives and measure their own unsatisfied needs with respect to what their own welfare system can cover. Our participants only rarely viewed their own situations through a comparative lens, criticising the national standards of their own countries with respect to those reported in other countries. For this reason we found their reflections on how to improve public services to be feasible and just as interesting to discuss as the common challenges they recounted. Indeed, interesting convergence seems to emerge on certain fundamental problems regardless of the relative generosity of each welfare regime.

Nevertheless, it is clear that in terms of the elder care resources provided by the public sector, our five countries fall along a very long continuum of generosity. Finland and France are nearly equal at the most generous extreme. Finland, in addition to granting a pensioners' care allowance based on a sliding scale of dependence, provides home-help services to frail old people living at their home. Carers of older people may apply for a Home Care Allowance and for respite care services. In addition, institutional care is socially acceptable and within the reach of many families, though its quality varies.

In France, that the number of hours awarded for each type of arrangement is determined by the elderly person's position on a "dependency scale", which is calculated using transparent and objective criteria. Such transparency implies that the criteria are rather uniformly applied (Le Bihan et al. 2000), even if services are granted according to a means-test.

Unlike Finland and France, the UK is located at an intermediate point on the continuum, offering a series of non-contributory benefits on a smaller scale that resemble those found in Southern European countries (attendance, disability living and invalid care allowances). Home care services are generally good, and based on a "care package" that is determined by local authorities. The hours of assistance provided, however, are rather limited, and the authorities also assess the share of the costs that must be contributed by the users. Even so, at least some of our participants find the in-home assistance program to be timely and efficient.

Finally, Italy and Portugal are at the least generous extreme of generosity, and elderly people in these two countries are at the greatest risk of finding themselves unable to afford the care they need. Access to publicly provided domiciliary care services in these two countries is much more difficult, as is the access to long-term institutional care. In Italy, the proportion of expenses that families must pay for nursing home care is calculated on the total employment income of all of the children. There is no cap on family co-payments, and families thus have no possibility to estimate the amount of expenses they may become burdened with. It is the unpredictable level of expenses that is most upsetting to families. However, in Portugal user fees are calculated on the basis of the elderly person's income.

A difference that we noticed in the accounts of our Southern European respondents seems to concern the general attitude that supplementing an elderly person's pension benefits to pay for nursing care, in addition to other expenses, is "obviously" the responsibility of the family. In contrast, a respondent from Northern Europe may notice even small expenses that come out of her/his own pocket.

Most of the care for sick or disabled adults and older people is provided informally in all five countries. In Finland, for example, it has been estimated that seventy percent of all care for older people is informal care. Concerning the informal care of sick, disabled and older people, it is people who themselves are 50–59 years old or over that are the most likely providers of care. A Eurostat survey also indicated that it is people with poor rather than good health who devote most time to caring for other adults (European Commission 2000, 82). Women are more likely than men to participate in caring activities even though many of them work full-time.

Informal care within households of adults and older people in Southern Member States and Ireland is much higher than in the rest of Europe (European Commission 2000). It is close to the EU-average in the UK, France and Finland. In France, Portugal, Finland and the UK, entitlements to care payments and benefits in kind like subsidised care services for an older person depend primarily on their needs and incomes. In Italy this is not the case; disability benefits vary on a local basis following regional laws or regulations. The number of family members also has an influence on the availability of benefits supporting care.

The availability of caring services varies significantly across the five countries and within each country from locality to locality. More services are generally available in urban than in rural settings. In France, Finland and the UK there are varying combinations of public, voluntary and private organisations providing care while in Italy and Portugal the state, where involved, is more likely to contract or subsidise care services of the voluntary sector. In these two countries it is to a greater extent the responsibility of the family to take care of older relatives. This is due to that there are relatively low volumes of home help facilities and institutional care available compared with the other countries.

In France a dependent older person may receive means-tested financial help from the state to employ either a family member or a third person to care for her/him. In Portugal such help is available only to relatively poor older people. In Finland the primary responsibility for providing caring services is municipal and the services are needs-tested. In the UK there is a mix of private, public and voluntary care, which is means-tested. In France dependent older people can receive maximum of 48 hours of care per week if they are a couple and 30 hours per week if they are single. A means-test is in use also in France. In Finland and the UK there is no formal limit to the hours of care provided and organised by the state. In Portugal long hours of care are available only in the private sector. More details of old age services and benefits in each of the five countries are available in the national WP3 reports on multi-career families.

Nevertheless, in all the five countries informal carers are the major providers of care for frail or disabled adults. The public and independent (third sector and for-profit) welfare services augment rather than replace family care. It is differences in support for family care for older people at country, regional and local levels, which are most likely to impact on how families combine employment and caring obligations.

### 3.4. Care arrangements in lone parent families (Workpackage 2)

This workpackage of the SOCCARE Project studied work and care arrangements of lone parent families in Finland, France, Italy, Portugal and the UK. Research work in the workpackage was co-ordinated by the French project partner. First, this chapter presents some basic information about the situation of lone parents in these five countries and then it reports the main findings of the workpackage.

To begin with, it is necessary to underline the diversity of lone parent families, which are too often considered as a homogenous group. It must also be remembered that lone parenthood is only one of the characteristics of these individuals and their situations. Moreover, lone parenthood may last a longer or a shorter time.

#### 3.4.1. Lone parent families in Finland, France, Italy, Portugal and the UK

The number of lone parent families has increased regularly in all European countries during the past decades. These families are particularly vulnerable in terms of care arrangements. They have to face a simultaneous pressure from both family responsibilities and work life. The force of the pressure depends on the contributions of the ex-partner and on the parental and social networks as well as on the accessibility of service provisions.

Lone parent families represented in 1996 12% of all European families with children under 25 years of age (Table 2). This proportion was small in Italy (7%) and Portugal (8%) compared with France (13%) and especially, Finland (19%) and the UK (22%).

Table 2. Households with children aged under 25 in the EU in 1996

	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	UK	UE-14
Couples with one child	31	35	36	28	25	<b>32</b>	18	<b>30</b>	30	27	30	<b>30</b>	<b>30</b>	<b>29</b>	31
Couples with 2 children	32	35	33	40	34	<b>33</b>	26	<b>35</b>	34	41	36	<b>32</b>	<b>32</b>	<b>31</b>	34
Couples with 3 children or more	17	13	12	9	14	<b>18</b>	32	<b>10</b>	16	19	10	<b>11</b>	<b>17</b>	<b>13</b>	14
Couples with children, one or more being over 25	3	0	2	4	9	<b>2</b>	4	<b>8</b>	4	2	3	<b>5</b>	<b>1</b>	<b>1</b>	4
Other types of households	2	1	3	9	10	<b>2</b>	4	<b>6</b>	8	0	9	<b>10</b>	<b>1</b>	<b>2</b>	4
Independent lone parent families	15	14	13	7	5	<b>13</b>	12	<b>7</b>	7	10	10	<b>8</b>	<b>19</b>	<b>22</b>	12
“Included” lone parent families	1	0	1	2	4	<b>1</b>	3	<b>3</b>	2	0	2	<b>3</b>	<b>0</b>	<b>1</b>	2
All Lone parent families	16	14	14	10	9	<b>14</b>	15	<b>10</b>	9	10	13	<b>12</b>	<b>19</b>	<b>23</b>	14
Proportion of “included”	8	1	4	25	43	<b>7</b>	21	<b>29</b>	21	3	17	<b>28</b>	<b>3</b>	<b>5</b>	12

Source: Chambaz 2001, 660.

In addition to these independently living lone parents, it is necessary to take into account those lone parent families that are included in other households. In 1996 2% of all European households included a lone parent family without being one. This increases the proportion of households linked with lone parenthood to 14%.

Women are heavily over-represented amongst lone parents, especially in Portugal (94%). On the other hand, from the five countries Finland had the highest proportion of lone fathers (20%). On average, within the EU 21% of lone parents were single, 22% were widowed and 57% were divorced or separated (Table 3). In France, Finland and the UK a quarter of lone parents has never been married but in Italy (10%) and Portugal (12%) it is rare for a lone parent to be single. Instead, in these two Southern European countries widows are still a significant group within lone parents (43% and 38%). However, in each of the five countries divorced or separated people are nowadays the largest group of lone parents.

Table 3. Marital status and labour market activity of lone parents in the EU, all lone parent families (independently living or included) in 1996

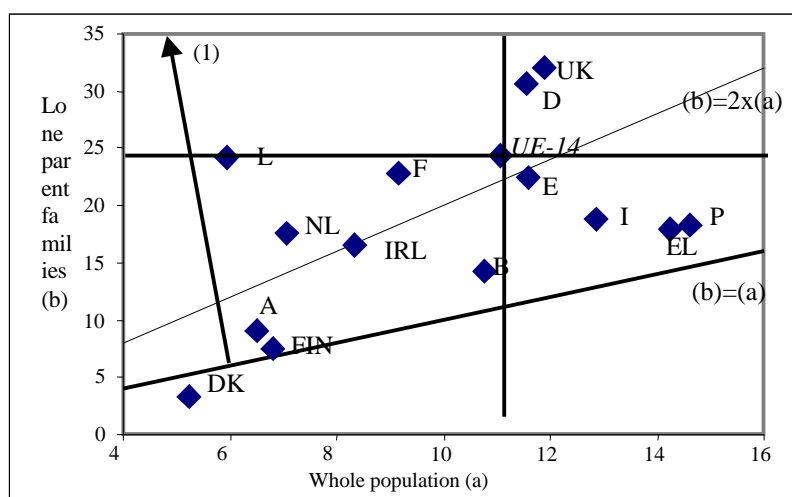
	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	UK	UE-14
Single, never married	12	34	27	2	14	26	29	10	18	14	26	12	27	25	21
Married, divorced, separated	69	63	58	52	39	55	42	47	59	69	55	50	62	67	57
Widowed	19	3	15	46	47	19	29	43	23	17	19	38	11	8	22
Employed	61	75	71	59	47	76	38	51	63	50	74	75	63	45	59
Unemployed	10	5	10	12	16	11	7	7	12	10	5	2	15	9	10
Inactive	29	20	19	29	37	13	55	42	25	40	25	23	22	46	31

Source: Chambaz 2001, 662.

On average, in 1996 59% of lone parents within the EU Member States were employed, 10% were unemployed and almost a third were inactive in the labour market (Table 3). The employment rate remained lower than the average in the United Kingdom (47%) and in Italy (51%). In these two countries, over 40 per cent of lone parents were inactive in the labour market. On the other hand, the employment rate was high in France (76%), Portugal (75%) and Finland (63%).

The high majority of working lone parents had a full-time job; only 20% of them were working part-time but this varied significantly between the countries. The share of lone parents who work part-time was high in countries where part-time work is also otherwise generally widespread like in the UK (39%). On the other hand, part-time work for lone parents was significantly less frequent in Finland (5%), Portugal (8%) and Italy (8%).

Figure 2. Poverty of European lone parent families



(1) The arrow shows the way of an increasing weight of lone parent families amongst the poor.  
Source: Chambaz 2001, 666.

When the poverty threshold is defined as half of the median national standard of living, one European lone parent family out of four (24%) is poor (Figure 2). The poverty rate is thus twice as high as for all households (11%). But, once again, this varies widely from country to country. In the United Kingdom, a third of lone parent families live under the poverty threshold but, on the other hand, the poverty rate of lone parent families is under 10% in Finland. In France, Italy and Portugal about a fifth of lone parents are in poverty.

### 3.4.2. National samples of lone parent families

The Finnish sample of lone parent families includes 25 families most of whom live in Tampere, which is the 3rd biggest city in Finland with its 200.000 inhabitants (Table 4). The sample was gathered by using several different sources and methods: snowballing within social networks (9), local lone parent association (5), social and health care services (5), workplaces (4) and ads in the library and on the Internet (2). Almost all lone parents of the sample are divorced or separated. Within the sample, also three lone fathers are included.

Table 4. The Finnish sample of lone parent families by income, marital status and age of youngest child

(N)

	Divorced/ Separated*				Single				Total
	Age of Youngest Child			Sub-total	Age of Youngest Child			Sub-total	
	Up to 3	4 to 6	7 to 11		Up to 3	4 to 6	7 to 11		
Low-Income	1	0	0	<b>1</b>	0	1	0	<b>1</b>	<b>2</b>
Average-Income	4	5	5	<b>14</b>	1	1	0	<b>2</b>	<b>16</b>
High-Income	1	4	2	<b>7</b>	0	0	0	<b>0</b>	<b>7</b>
<b>Total</b>	<b>6</b>	<b>9</b>	<b>7</b>	<b>22</b>	<b>1</b>	<b>2</b>	<b>0</b>	<b>3</b>	<b>25</b>

\* Including one widow from cohabitation.

Low income is here under 1500 €/per month, average income 1500-2500 €/per month and high income over 2500 €/per month.

The French sample of lone parent families includes 25 families most of whom live in Rennes, which is the biggest city with its 200.000 inhabitants in Brittany, the Western Region of France (Table 5). Also this sample was gathered by using several sources. Contacting users of day care services (5) and social services (3) followed snowballing within social networks (17).

Table 5. The French sample of lone parent families by income, marital status and age of youngest child

(N)

	Divorced/ Separated				Single				Total
	Age of Youngest Child			Sub-total	Age of Youngest Child			Sub-total	
	Up to 3	4 to 6	7 to 11		Up to 3	4 to 6	7 to 11		
Low-Income	3	2	1	<b>6</b>	2	0	0	<b>2</b>	<b>8</b>
Average-Income	5	3	3	<b>11</b>	1	0	0	<b>1</b>	<b>12</b>
High-Income	1	0	2	<b>3</b>	2	0	0	<b>2</b>	<b>5</b>
<b>Total</b>	<b>9</b>	<b>5</b>	<b>6</b>	<b>20</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>25</b>

The French team easily found lone mothers with young children who were active in the labour market and who had had their child after entering professional life, often with high qualification. However, many young single mothers with low income and low level of qualification do not work but live on state allowances. The conscious exclusion of non-working people from the sample led to exclude this large category of lone mothers.

The Italian sample of lone parent families includes 25 families living mostly in Florence and Bologna (Table 6). The sample was gathered mainly by snowballing. As in the other national contexts, also the Italian team used their professional networks in the field of

social care services. One Italian specificity concerns the presence of widows (5 cases), which refers to the national trend that was underlined earlier.

Table 6. The Italian sample of lone parent families by income, marital status and age of youngest child  
(N)

	Widows/ Widowers*				Divorced/ Separated***				Single****				Sub- total	Total
	Age of Youngest Child**			Sub- total	Age of Youngest Child			Sub- total	Age of Youngest Child			Sub- total		
	<3	4-6	7-11		<3	4-6	7-11		<3	4-6	7-11			
Low-Income	0	1	0	<b>1</b>	1	1	1	<b>3</b>	3	1	0	<b>4</b>	<b>8</b>	
Average-Income	0	0	1	<b>1</b>	0	3	3	<b>6</b>	1	2	0	<b>3</b>	<b>10</b>	
High-Income	0	0	3	<b>3</b>	1	0	2	<b>3</b>	0	0	1	<b>1</b>	<b>7</b>	
<b>Total</b>	<b>0</b>	<b>1</b>	<b>4</b>	<b>5</b>	<b>2</b>	<b>4</b>	<b>6</b>	<b>12</b>	<b>4</b>	<b>3</b>	<b>1</b>	<b>8</b>	<b>25</b>	

\* One interviewee was first separated and then widowed, another is a widow from a long period of cohabitation.

\*\* One interviewee has children under 24 since it is a case with a pressing care duty for an elderly parent.

\*\*\* Including 2 who were separated after cohabitation.

\*\*\*\* One interviewee is single as concerns the youngest child but had been married and separated earlier.

Low income is here under 1000 €/per month, average income 1000-1500 €/per month and high income over 1500 €/per month.

The Portuguese sample of lone parent families includes 27 families living in Lisbon or in its suburbs (Table 7). The sample was gathered by using several different sources and methods, mainly snowballing and direct contacts with day care and social services. 13 of the interviewed lone parent families were four-generation families. Out of the 9 single mothers, 6 had other people living with her and her children.

Table 7. The Portuguese sample of lone parent families by income, marital status and age of youngest child  
(N)

	Divorced/ Separated				Single				Sub- total	Total
	Age of Youngest Child			Sub- total	Age of Youngest Child			Sub- total		
	Up to 3	4 to 6	7 to 11		Up to 3	4 to 6	7 to 11			
Low-Income	2	3	1	<b>6</b>	2	1	1	<b>4</b>	<b>10</b>	
Average-Income	0	2	4	<b>6</b>	2	1	0	<b>3</b>	<b>9</b>	
High-Income	0	3	3	<b>6</b>	1	0	1	<b>2</b>	<b>8</b>	
<b>Total</b>	<b>2</b>	<b>8</b>	<b>8</b>	<b>18</b>	<b>5</b>	<b>2</b>	<b>2</b>	<b>9</b>	<b>27</b>	

The UK sample of lone parent families includes 25 families living in Canterbury (Table 8). The sample was gathered mainly by using contacts and information from the social services. The British team used snowballing, as well.

The presentation of the sample differs slightly because of the British particularities of these families. The main difficulty was due to the fact that lone parent families, particularly lone mothers, are mainly out of the labour market. As a result, the age of lone mothers of our sample is higher than the mean age of lone mothers in the UK. The sample is presented with two new columns for children between 12 and 18 and above 18. The presence of young adults is partly linked to the precedent phenomenon.

Table 8. The UK sample of lone parent families by income, marital status and age of children (N)

	Divorced/Separated							Single								
	Children's age							Children's age								
	Up to 3	4 to 6	7 to 11	12 to 18	19+	Sub-total (children)	Sub-total (families)	Up to 3	4 to 6	7 to 11	12 to 18	19+	Sub-total (children)	Sub-total (families)	Total (children)	Total (families)
Low Income	3	4	2	0	5	14	3	5	1	1	3	4	14	5	28	8
Average Income	0	1	8	8	2	19	6	0	4	3	0	0	7	4	26	10
High Income	1	2	4	4	7	18	5	1	1	0	0	1	3	1	21	6
Income unknown	0	1	0	0	0	1	1	0	0	0	0	0	0	0	1	1
<b>Total</b>	<b>4</b>	<b>8</b>	<b>14</b>	<b>12</b>	<b>14</b>	<b>52</b>	<b>15</b>	<b>6</b>	<b>6</b>	<b>4</b>	<b>3</b>	<b>5</b>	<b>24</b>	<b>10</b>	<b>76</b>	<b>25</b>

Low income is here under £200 (about 300 €) per week, average income £200-350 (about 300-525 €) per week and high income over £350 (about 525 €) per week.

### 3.4.3. Main findings of the workpackage

#### **The impact of social institutions and networks on care arrangements**

First, the way day care and school are conceived in the different countries strongly impacts the structure of the care arrangements — even though opening hours actually differ largely from one locality to another and even from one service to another.

In a large majority of cases, we found that childcare is assumed by a combination of formal and informal arrangements. Informal care allows lone parents to fill the gaps and ease the inflexibilities of formal care. This means that the better the access to formal care, the more improbable it is that the use of alternatives is about forming the basis of the everyday care arrangement. Rather, when formal services are available, informal care is used only to fill remaining gaps and to allow lone parents some free time. This leads us to the conclusion that such "comfortable" care arrangements are more probable in countries where the provision of formal day care covers a large range of needs (in Finland and France). However, we found out that even in these countries, childcare services are not adapted to the atypical work timetables of many of the lone parents.

Second, the conceptions of family life differ largely from one case to another. It is evident that in many care arrangements, the grandparents — especially the child's maternal grandparents — are very present. This observation was made in all the countries, though in Italy it is the most regular and somehow spectacular arrangement.

The different modes of insertion of all the social institutions and networks, structured by both national and local rules as well as by individual experiences and preferences, make the samples very variable. Beyond the singularity of each configuration, one should pay attention to the level of predictability of the childcare arrangement in everyday life. For lone parents, the most satisfactory care arrangements, whatever their form, are those which exclude feelings of uncertainty and emergency.

This means that the more structured the day care is, the more predictable it is and, thus, the better it seems to be for most lone parents. However, the qualitative analysis indicated that the same level of predictability does not always mean the same level of satisfaction.

Each type of arrangement induces specific roles, values and identities. As well, each care arrangement is the result of experiences that mobilise different constraints and resources and take place in an individual context.

### Constraints and resources of care arrangements

The resources and constraints that seem to be most significant in structuring daily childcare arrangements are, on the one hand, those of a financial nature and, on the other hand, those relating to the degree of availability of the various types of both formal and informal support. It seems to us that the way childcare arrangements are organised is mainly determined by the combined effect of these resources/constraints.

Our analysis of the interviews indicates that, to some extent, family income influences the way childcare arrangements are organised. Low-income families usually face the largest practical problems in reconciling their working lives with childcare arrangements and therefore also have greater emotional stress. Nevertheless, these problems are not originally just financial: they derive from the combination of financial and other types of constraints, in particular the degree of availability of practical forms of formal and informal support. For example, lone parents who are much supported by their families do not have to face as many practical problems, even though they may suffer from a fair degree of monetary restrictions.

Table 9. The national samples of lone parent families by working hours and childcare during work

	Typical working hours			Sub-total	Atypical working hours			Sub-total	Total
	Childcare during work				Childcare during work				
	Day-care/ school	Day-care/ school and/or family care	Day-care/ school and/ or extra- family care		Day-care/ School	Day-care/ school and/or family care	Day-care/ school and/ or extra- family care		
Finnish sample	11	2	3	<b>16</b>	3	6	0	<b>9</b>	<b>25</b>
French sample	7	5	2	<b>14</b>	2	3	6	<b>11</b>	<b>25</b>
Italian sample	4	9	0	<b>13</b>	0	10	2	<b>12</b>	<b>25</b>
Portuguese sample	5	7	3	<b>15</b>	1	9	2	<b>12</b>	<b>27</b>
UK sample	9	4	1	<b>14</b>	0	8	3	<b>11</b>	<b>25</b>
<b>Total</b>	<b>36</b>	<b>27</b>	<b>9</b>	<b>72</b>	<b>6</b>	<b>36</b>	<b>13</b>	<b>55</b>	<b>127</b>

If we look more closely at the working hours of lone parents within our sample, we can see that as many as 55 of them have atypical working hours and work partly in the evenings, nights and/or during weekends (Table 9). Within this group, there is large variation ranging from some English lone parents who work only few hours to some lone parents who work 50-60 hours per week.

Working hours seem to influence distinctively the childcare arrangements of lone parent families as the care patterns differ largely between lone parents working typical and atypical hours. The most usual arrangement for those families where the lone parent works regularly on weekdays is standard formal provision, that is, day care centre care and school, particularly in the Finnish and UK samples. However, as many as every second lone parent family with typical working hours of the total sample need additional work-related childcare, usually from family members.

Instead, within the group with atypical timetables, only 6 families receive their childcare solely from day care centres and schools. Actually, a part of even these families (especially, FINSP24 and PSP27) have remarkable gaps in their care arrangements and

thus, the fact that they do not use any other but formal care simply reflects the unavailability of such care. 13 families supplement formal provision with additional extra-family care, mostly from nannies (especially in France) and after-school clubs. However, the absolute majority of lone parents with atypical working hours receive additional care from other family members of their children, primarily from maternal grandparents and absent parents. Support from family members is usual everywhere but in Italy and Portugal and also in the UK it is of fundamental importance. Furthermore, there are several families in Portugal that do not receive any formal services. In all, the extent of the needed additional childcare shows clearly that standard forms of formal provision do not cover the needs of those lone parents who have atypical and irregular working hours.

We have observed that several other kinds of constraints have a strong impact on the care arrangements, as well. Children's age is the most evident one: the growing autonomy of children makes a big difference between lone parents caring for babies and lone parents caring for preadolescents. The number of children and the age gaps between them also structure specific constraints. Besides, children's health problems may have dramatic effects on the care arrangement even if the lone parent has high income. Health problems may also affect the carer her-/himself. Particularly, the Italian and French (and partly, Finnish) analysis stress the impact of nervous breakdowns of lone mothers. These parents have to reorganise their work, using therapeutic leaves and social assistance. They hardly manage to organise their everyday lives and suffer from a strong feeling of guilt in relation to their children.

Moreover, the study of actual arrangements leads us to point out that geographical constraints are also a major key to inter-individual differences. Residential mobility that has been provoked by changes in conjugal and professional lives has strong effects on the structure of social networks that can be mobilised for informal care. Long distances to work and to social networks are a real difficulty in the organisation of the care arrangement. This difficulty becomes even more acute when the lone parent lives in an environment where formal care is poorly provided and/or where there is no convenient public transport and/or when she/he has no driving licence or car.

All these constraints are at least as important as the financial ones and they are not automatically linked to the family economy. However, they are not only constraints, the same issues function as fundamental resources for the care arrangement. Flexible working hours make flexible care arrangements possible. Older children may become a source for additional care. Good transport connections give opportunities to individualised participation in care.

As previously said, the family support appears to be the major source of help. As well, even though they may have a psychological cost, all other informal sources of help may also be considered as additional resources for the care arrangement. One should bear in mind the essentially relational nature of these resources.

### **Typology of care arrangements of lone parents**

On the basis of all these elements in our qualitative comparison, a common typology of care arrangements has been constructed (Table 10).

This typology emerged out of long discussions that were led at different steps of the collective work of the project team. This typology encompasses national typologies that were made by national project teams. Cases have been placed in this typology on the basis of the link between the structures of needs and resources, the types of roles assumed by the carers and their subjective evaluation of the arrangement. Rather than making comparisons

between national contexts, this typology aims at comparing and finding variations between and within common patterns of care.

Table 10. Distribution of the national samples of lone parent families according to the typology of the care arrangements\*

Type	Subtype	Italy	Portugal	France	UK	Finland
<b>1. FAMILIAL ARRANGEMENTS</b>	<i>Family support to single young lone mothers</i>	4, 11	9, 12, 19	14	9	none
	<i>Family support to adult lone mothers</i>	3, 5, 9, 12, 15, 16, 21, 22, 24	1, 3, 6, 7, 10, 11	9, 15, 19	1, 3, 6, 22	2, 12, 17
	<i>Post-break shared care</i>	2, 6	4, 16	11, 17, 22	2, 17, 23	9, 14, 16, 19
<b>2. VARIED ARRANGEMENTS</b>	<i>Formal/ Informal</i>	13, 14, 19, 20, 25	2, 5, 8, 17, 18, 20, 25	1, 3, 4, 23, 24, 25	7, 12, 13, 21, 24	3, 4, 10, 18, 25, 26
	<i>Strong basis of domestic services</i>	17, 23	15, 23, 26	2, 6, 13, 18, 20, 21	14, 20	1, 8, 13, 27
<b>3. "ISOLATED" LONE PARENTS</b>	<i>Lone-lone</i>	10	14, 22, 27	16	16, 18, 19	23
	<i>Formally assisted</i>	7	None	5, 7, 12	8, 11	5, 22, 24
	<i>Self-sufficient</i>	18	13, 21, 24	8, 10	4, 5, 10, 15, 25	7, 15, 20, 28

\* Numbers in the table refer to the numbers of the interviews.

### ***Type 1: Familial arrangements***

Definition: Familial arrangements are all organised among the family and in them, the use of formal services is limited to day care and school. These arrangements may be intergenerational or based on the ex-partner's involvement.

#### ***Type 1/Subtype 1: Family support to young lone single mothers***

The first subtype of family arrangements is a model of care arrangement based on family support to young lone single mothers. This kind of care arrangement is the one which is most embedded in intergenerational relations.

#### Common characteristics

- The mother is a young woman (mainly with low income and low educational level);
- The arrangement is exclusively based on family support (except day care), which may even turn to a model of "double mothering" by the lone mother and her mother;
- There is a strong proximity between the mother and her family, maybe cohabitation;

- The father is fully absent or does not play a regular role in the care arrangement;
- The carer has little financial independence.

Cases: Italy (4, 11); Portugal (9, 12, 19); France (14); UK (9).

In terms of trajectories, the single mothers who are involved in this type of arrangement are young women (all of our 7 subjects are under 26 years old), who often have had a baby before stabilising an independent couple and/or before leaving their family home. Pregnancy is unplanned, but generally the family members have reacted positively to it and have made themselves available to provide the support required. The maternal grandmother plays indeed a major role in this type of arrangement and the care arrangement may turn into a “double mothering” model. Thus, the financial impoverishment of these young women, which does exist, is reduced by a sort of tacit acceptance of a pact between generations. Such a pact may often be a reproduction of the family experience of the previous generations.

#### *Type 1/Subtype 2: Family support to adult lone mothers*

Common characteristics

- The arrangement is based on family support;
- There is a strong proximity between the mother and her family;
- The father is absent or does not play a regular role in the child day care;
- The extra-family support is weak but it exists.

Cases: Italy (3, 5, 9, 12, 15, 16, 21, 22, 24); Portugal (1, 3, 6, 7, 10, 11); France (9, 15, 19); UK (1, 3, 6, 22); Finland (2, 12, 17).

This subtype has common characteristics with the first one, having family support as the main basis of the arrangement. Yet, in terms of trajectories, these lone mothers are generally older and they have usually experienced couple life independently from their family homes. Many of them have got separated or divorced and still live separately from their family home, even though close by. In terms of roles, in contrast with many situations of the first subtype, family support in this subtype never means “double mothering”. The role of the family members, especially of the maternal grandmother, is here more supportive than substitutive. Furthermore, these women are independent or at least wish to be so. However, they can count on their parents’ support with childcare and have thus a “safety net”.

#### *Type 1/Subtype 3: Post-break shared care*

Common characteristics

- The parents aim at keeping the arrangement as close as possible to the period when they lived together;
- There is a strong proximity between the mother and the father;
- Both the parents work and may have free time;
- Work timetables may be flexible but fit together;
- The care arrangement may be formalised by a judicial decision;
- In most cases, the children already go to school;
- Grandparents may support the carer but play a very subsidiary role.

Cases: Italy (2, 6); Portugal (4, 16); France (11, 17, 22); UK (2, 17, 23); Finland (9, 14, 16, 19).

In terms of trajectories, the lone parents who are involved in this type of arrangement are most often people between 35 and 50 and they have experienced much more stable and longer couple way of life — many had been married for several years — than lone mothers

in the previous two subtypes. Many of them have more than one child and pregnancies were planned by the couple. When the couple split, the children were most often already at school.

The major difference between this subtype and the two previous ones is the predominant role of the ex-partner in the care of the children. Grandparents play only a subsidiary role. Thus, the lone parents who are organising such care arrangements do not feel in debt towards their own parents about childcare. They feel much more linked to their ex-partners.

### ***Type 2: Varied arrangements***

Definition: This category covers all the kinds of individualised arrangements that mix family support, services and extra-family support (friends, neighbours).

#### *Type 2/Subtype 1: Strong basis of formal care within extra support*

Common characteristics

- The use of formal services goes beyond the day care or school timetable but is strongly limited by financial constraints;
- Qualification and income are usually average or lower than average;
- Supporters like ex-partners, grandparents of the children, friends and neighbours offer some occasional support but are not regularly available.

Cases: Italy (13, 14, 19, 20, 25); Portugal (2, 5, 8, 17, 18, 20, 25); France (1, 3, 4, 23, 24, 25); UK (7, 12, 13, 21, 24); Finland (3, 4, 10, 18, 25, 26).

In terms of resources, the particularity of these arrangements actually lays in the fact that they mix a high demand for formal support on the one hand and help from secondary supporters on the other hand. These people often spend much time at work, sometimes even on irregular schedules, and they are most often users of the day care services. In addition to regular day care, they also use other formal services (extra-school activities, libraries, playgroups, etc.). Furthermore, if even this is not sufficient, they may call for baby-sitters or activities. However, they try not to spend much money, as their financial resources are not very extensive. Thus, most of them prefer to use informal support.

One characteristic feature of this subtype of care arrangements is that many of the lone parents worry about the length of the daily day care of their children.

#### *Type 2/Subtype 2: Strong basis of domestic services within extra support*

Common characteristics

- The use of services is high and goes beyond the day care or school timetable;
- Qualification and income are most often higher than average;
- The use of domestic services aims at dealing with the flexibility of the work schedules or at allowing the main carer free time;
- Informal supporters like ex-partners, grandparents of the children, friends and neighbours regularly care for the children.

Cases: Italy (17, 23); Portugal (15, 23, 26); France (2, 6, 13, 18, 20, 21); UK (14, 20); Finland (1, 8, 13, 27).

When looking at the trajectories of these lone parents, we observed that they have always given a great importance to their work in order to attain a satisfactory professional status. Most of them have had a (long) period of living as a couple. As they usually had a good

job even before moving together, they have aimed at the preservation of their professional status also after the break.

As a result, these people, who spend much time at work, often on irregular schedules, can afford and call for services such as domestic employees, baby-sitters and municipal childminders besides school, day care and other activities like sport clubs or artistic classes. Ex-partners and grandparents are supporters who fill some gaps in the lone parents' schedules when needed. However, it is primarily the access to domestic services (and friends) that allows these lone parents to assert independence from their family of origin.

### ***Type 3: "Isolated" lone parents***

#### *Type 3/Subtype 1: "Lone-lone" parents*

Common characteristics

- The arrangement is most of the time assumed by the lone parent;
- Qualification and income are often lower than average;
- The family resources and the availability of informal support are weak or non-existing;
- The balance between work and caring is very difficult to achieve. As a consequence, some children are left without adequate care;

Cases: Italy (10); Portugal (14, 22, 27); France (16); UK (16, 18, 19); Finland (23).

The trajectories of these women — no lone fathers were included in this group — combine highly difficult starting points like a low qualification, a low-paid job, a conflict in the family, constrained mobility. They have experienced processes of deep impoverishment and slipping into situations of chronic and entrapping hardship. The general lack of informal help limits their possibilities. Consequently, the necessary and exclusive use of formal services (public or private) constitutes almost a special form of poverty trap, consuming a disproportionate part of their scant revenues.

The situation of these families is made even more difficult by the atypical working hours of several of these lone mothers. Crèches and schools, even with extra-curricular activities, do not cover their working hours. This has led to a situation where some of the children in these families are left without adequate adult care, being responsible for themselves and/or their siblings at a very young age.

#### *Type 3/Subtype 2: Formally assisted lone parents*

Common characteristics

- The arrangement is most of the time assumed by the lone parent;
- Qualification and income are often lower than average;
- The family resources and the availability of informal support are weak;
- The balance between work and caring is highly difficult to achieve;
- Only high formal support permits to maintain access to work and limit the time when children are left without care.

Cases: Italy (7); France (5, 7, 12); UK (8, 11); Finland (5, 22, 24).

This subtype corresponds much more to the hard management of incompatible constraints than to the care arrangement itself. Hard conditions of work, such as changing shifts or high irregularity or great mobility, put maximal pressure on the lone parent who suffers from a lack of every kind of informal support (family, involvement of the ex-partner, friends, neighbours, etc.). However, the formal support cannot be as regular and

intense what these lone parents would need. Formal services may even threaten to deprive them of the custody of their child. Such dependence on the support of formal care is the main characteristic of this subtype. The balance between work and care is so hard to achieve that the carer could not do it at all without this extensive support. None of the interviewees experienced this dependence positively. All of them were nervous and critical towards the quality of formal support. The interviewers ended these interviews with a strong feeling that they had approached dramatic and in some cases almost hopeless situations.

*Type 3/Subtype 3: Self-sufficient lone parents*

Common characteristics

- The family resources and informal support may be available but are usually not called for;
- The tension between work and caring limits the free time of the carer;
- The use of formal services is the major basis of the arrangement and takes a big part of the family budget.

Cases: Italy (18); Portugal (13, 21, 24); France (8, 10); UK (4, 5, 10, 15, 25); Finland (7, 15, 20, 28).

This subtype seems not to be very far from the subtype “lone-lone”. In these cases, professional and residential mobility has loosened or interrupted the role of informal networks. Nevertheless, these lone parents, though they are in a situation of strong constraint and sometimes deprivation, proudly state their claim of “having made it”. Let us notice that they have succeeded in this because their income is generally higher than in the subtype lone-lone or because the flexibility of their work is of a more family-friendly character. Independence is the main objective for these lone parents, even when their resources are limited.

#### 3.4.4. Summary of main results

By focusing on childcare arrangements, main trends can be seen in the way people manage to combine employment and care. The common typology helps to observe variations within comparable care arrangements. This permits us to go beyond the simple hypothesis that national policies fully determine the care arrangements. Every care arrangement is actually applied to individually specific conditions within the constraints of existing general labour market and childcare service structures. These structures may be reinforced by individual strategies or they may be challenged by the expression of new demands.

In all countries, most of the lone parents would like to balance work, formal care and intimate informal care, whatever the organisation of this informal care (individual, in the family, including or excluding ex-partners, etc.). However, there can not really be seen a continuing convergence towards a common European model. It seems that decisive differences remain between the national contexts. The collectivisation and externalisation of childcare is still higher in Finland and France, whereas community arrangements are more likely to be structured in Italy, while Portugal seems to be at a turning point. Beyond the convergence, the British cases have unique characteristics, such as common experiences of multiple couple life and fatherhood — which may be due to the young age of lone mothers — and a pattern of impoverishment by incurring debts.

Of course, when we speak of national variations with small samples having no statistical representativeness and bringing no real comparability, we only wish to focus on the main issues emerging from the national samples.

Where (mostly in Finland, France and Portugal) full-day work is the norm, it brings long days in external care for children and often feelings of guilt for lone parents (see, “varied arrangements”). For these parents, flexibility of work may be by its character as well family-unfriendly as family-friendly. The higher the qualifications and incomes, the more family-friendly the flexibility of work seems to become. When low-paid jobs are concerned, flexibility has most often a family-unfriendly character. In these cases, flexibility means unsocial and atypical working hours and it actually acts as a hindrance to lone parents’ access to work. In these situations, the equation often makes lone parents to reduce their working hours in order to avoid high service fees. This was a very common observation in the “formal/informal”, “lone-lone” and “lone assisted” subtypes.

Thus, for all lone parents whose qualifications and incomes are lower than the average, formal support at a low price and/or informal support are decisive resources for accessing work. The fact that none of the Finnish lone parents interviewed had real part-time jobs is very significant, and deeply contrasts with the British situation. The importance of formal resources emerges out of many care arrangements.

The significant involvement of close family members in daily childcare arrangements has its advantages and disadvantages. The advantages are linked to the fact that these arrangements are generally stable and inexpensive. In addition to the major contribution from grandparents, many lone parents see advantages also in having their ex-partners to take part in daily childcare arrangements, both in emotional terms for the children and in practical terms for themselves. The disadvantages raise from the resulting dependence that makes the lone parents feel obliged to “justify their lives” to the support providers. For the same reason, there are some feelings of a lack of privacy. These feelings are stronger for young lone mothers who still live in their family home.

The main element of convergence in the national samples is the numeric importance of varied arrangements. This means that the majority of working lone parents balance work and care by combining several sources of formal and informal care. Within this varied type, we observed that income differences heavily influence the form of the arrangements. For the majority of lone parents, filling gaps in the work schedules means combining extensive formal support with segments of informal support. In addition to this, we may observe that this form of care arrangement is marked by considerable variations concerning the involvement of ex-partners.

When comparing the Southern and the Northern samples, we understand that patterns of solidarity are very different.

When we compare family support, we find large contrasts. In Portugal and Italy, family solidarity tends to allow lone mothers to obtain work, even though this means often low-qualified and low-paid jobs. Also in the other three countries, geographical proximity brings increased family support but, however, it seems to be considerably more limited than in Portugal and Italy. In Finland, France and the UK, other family members, most often maternal grandparents, may collect the children at the end of day care or school or extra-school activities in order to fill a gap between the end time of the formal provision and the return time of the lone parent. In addition, they may also look after the children when the mother wants to go out with friends. However, they seem not to be involved in the kind of family routines that are characteristic of Italian families. Thus, people from the Southern countries seem less likely to be isolated from family networks. On the other hand, they often feel indebted to their family. Conversely, in countries where formal support is high, feelings of debt are not so usual but contacts with family members may be sparse.

In terms of causality, it is hard to say whether family support is higher in the Southern countries because of the lack of formal support, or vice versa. Nevertheless, there were some lone mothers in the Italian sample that, due to the lack of formal support, had moved closer to their family members. In these cases, family care was not so much a preference but the only real alternative.

For more details of the workpackage on the care arrangements of lone parent families, see [SOCCARE Project Report 2](#) and the national reports on [Finland](#), [France](#), [Italy](#), [Portugal](#) and [the UK](#).

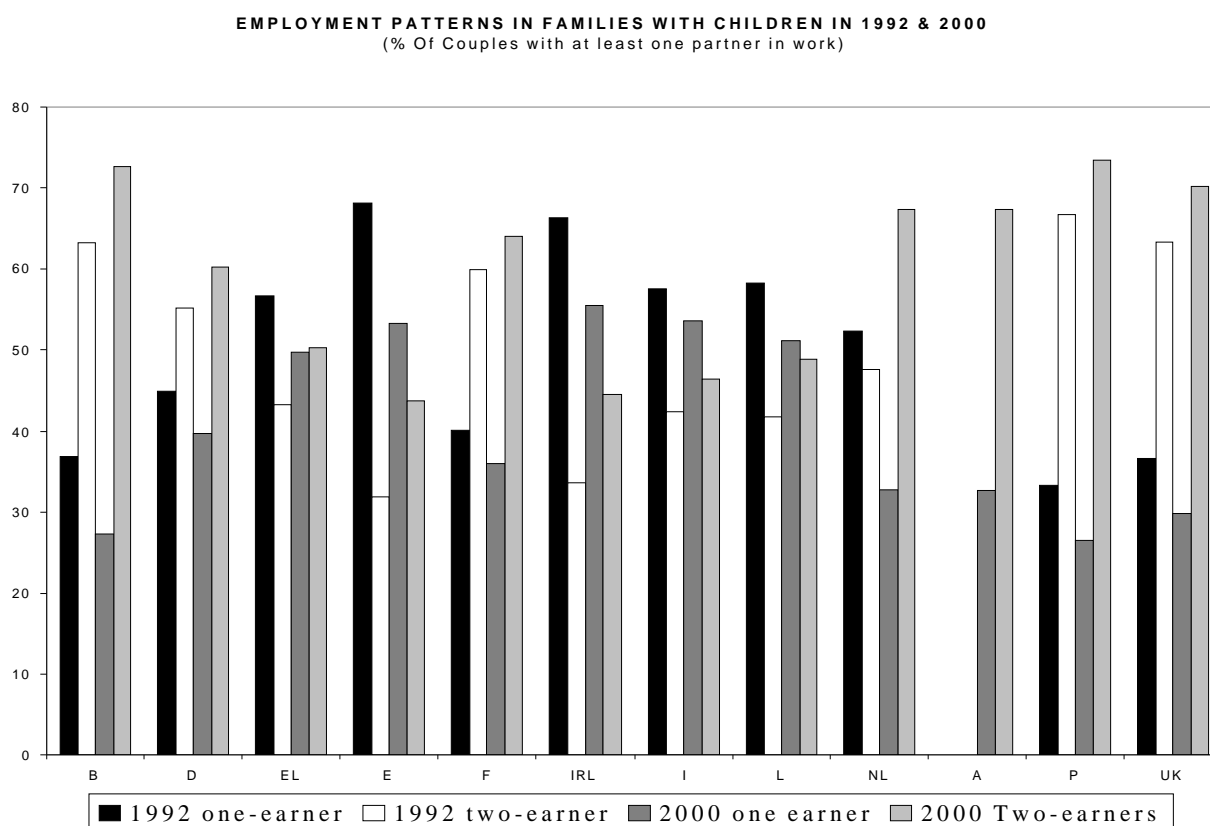
### 3.5. Care arrangements in dual-career families (Workpackage 3)

This workpackage of the SOCCARE Project studied work and care arrangements of dual-career families in Finland, France, Italy, Portugal and the UK. Research work in the workpackage was co-ordinated by the British project partner. First, this chapter presents some basic information about the situation of this family type in these five countries and then it reports the main findings of the workpackage.

#### 3.5.1. Employment patterns of European working families

During the 1990s employment patterns of European families experienced a distinctive change. EU statistics show a clear trend away from one-earner couples towards two-earner families in all Member States covered by the data (Figure 3). Concerning couples with children under the age of 15, the proportion of dual-earner families increased from 1992 to 2000 by 4% in France and Italy and by 7% in Portugal and the UK.

Figure 3. Employment patterns in families with children in 1992 and 2000.  
Percentage of couples at least one partner in paid work.



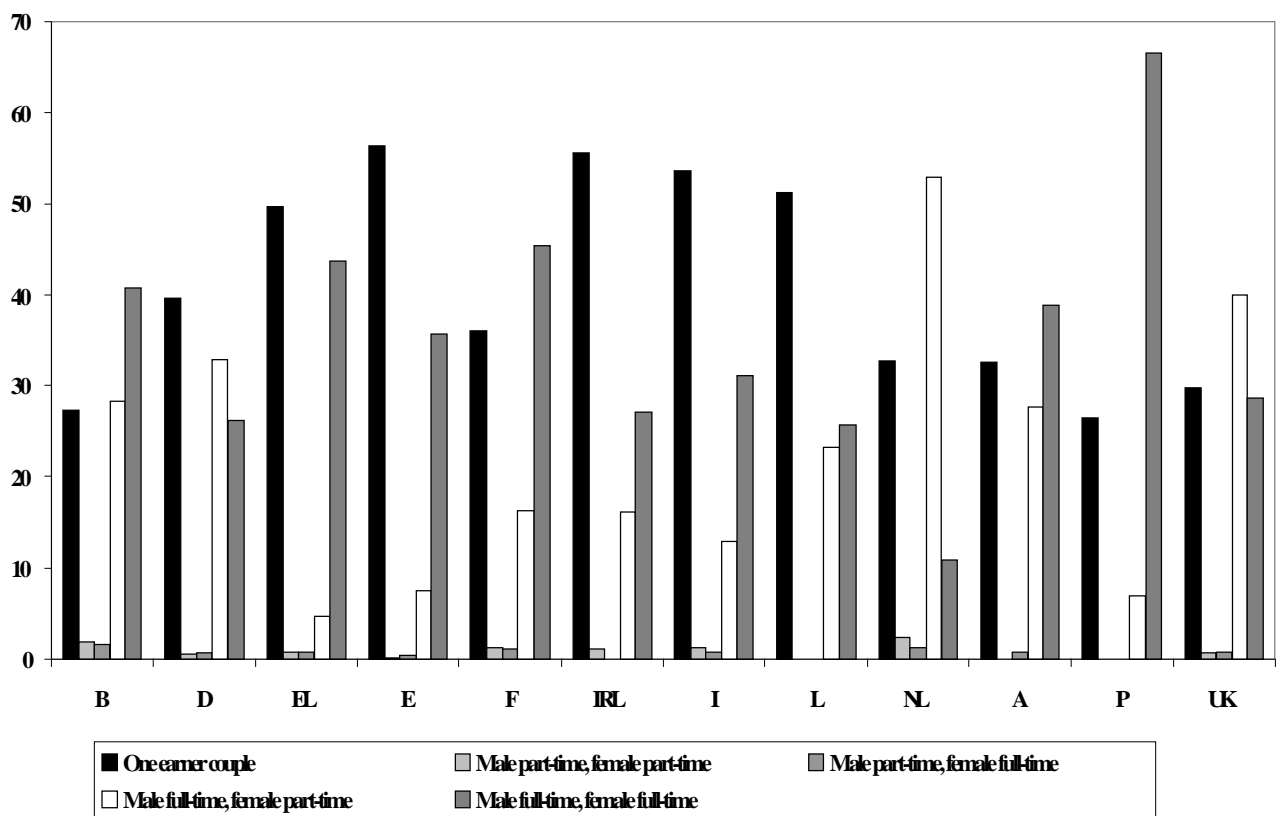
Source: Eurostat (60/2000/21/5–2002): 1997 data for Ireland, 1999 data for Luxembourg and UK.

However, the proportion of dual-earner and one-earner families still varies within Europe. As many as three quarters of couples are dual-earners in Portugal and the figures for the UK and France are almost at the same level. However, only 46% of couples were dual-earners in Italy in 2000. Finland is not included in Figure 3 but dual-earner families have been the dominant mode there for three decades. Thus, the traditional family pattern

having the male as the sole breadwinner has become considerably less common in Europe during the last decade. From the five countries included in this project, one-earner families form the majority only in Italy.

On the other hand, there are several different kinds of dual-earner couples. Both partners may be working full-time or either of them may work part-time. In principle, both could be working part-time, as well. When the share of dual-earner couples was discussed above, Portugal, the UK and France were seen to be close to each other. However, when the composition of their dual-earner families is concerned, particularly Portugal and the UK are very far from each other (Figure 4). In Portuguese dual-earner couples, practically all women and men work full-time but in the UK, it is most usual that a full-time working man lives together with a woman who works part-time, not full-time.

Figure 4. Forms of labour market participation by couples in 2000.



Source: Eurostat (60/2000/21/5–2002): 1997 data for Ireland, 1999 data for Luxembourg and UK.

In all European countries covered by the data, male part-time work is extremely rare, irrespective whether the female spouse works full-time or part-time. In Portugal (and in Finland) also female part-time work is very rare. Instead, in Britain it is very usual. France and Italy are situated between these two extremes, having a larger group of female part-time/male full-time working couples than Portugal and Finland but, at the same time, having this group outnumbered by dual-full-time-working families.

The working patterns of our sample seem to follow the general characteristics of European employees as a recent survey found out that around 50% of European employees work during evenings, 50% working on Saturdays and 25% on Sundays (Kauppinen 2001,

3). In particular, many Italians (63%) work on Saturdays, and many Finns (39%) work on Sundays. Portugal (18%) and Italy (22%) have the lowest percentages when it comes to working on Sundays. The survey also found that 76% of European employees have fixed working time schedules but that 41% do not work the same number of hours every day.

However, the increase in dual worker households has not had a substantial impact on the traditional pattern of women as main carers and primarily responsible for household tasks. Here there is a distinctive gap between values and gender roles. The European Value Study (1999/2000) found that most people see an equal sharing of household tasks as contributing to a successful partnership. The study also showed that in the countries represented in our sample most people judge fathers to be equally good at caring for their children as mothers (80% in France, 86% in Finland, 71% in Britain, 69% in Italy and 68% in Portugal). In the case of caring for older people, the European Value Study indicated that many people still see caring for their parents as a moral obligation (67% in Portugal, 67% Italian, 63% in France, 47% in Britain and 43% in Finland). Most couples also agreed that care should be shared.

### 3.5.2. The sample of dual-career families from Finland, France, Italy, Portugal and the UK

The sample of this workpackage includes 124 families where both partners are in paid work or studying full-time and are responsible for the care of children aged 12 or less and/or older people needing regular assistance. Full-time employment and study is defined here as 30 hours a week or more. In this research, we concentrate on couples where both partners work full-time in positions that require particular commitment and time-use, as it is these families that are especially posed to the challenge of combining their care and work responsibilities.

This was a quota sample, not a representative random cross section. It was designed to capture a range of particular care + work arrangements. In all cases these families consisted of a man and woman couple where both partners were pursuing careers.

- Sixty-seven (67) of the families cared for at least one child 12 or under;
- Thirty-two (32) families cared for at least one older person who needed assistance;
- Twenty-five (25) of the families cared for at least one child and one older person.

The sample was obtained through service providers, employers and by snowballing. Twenty-five families were sought and found in all of the five nations, with only one exception (24 families from one country). These families were interviewed in detail about their family, paid work, the people they cared for, the ways in which their work-plus-care responsibilities were organised (detailed timetables), how they responded to emergencies, the support they received from other family members, friends and social care services. Furthermore, interviewees were also asked about their finances, the problems they encountered and their views on their situations.

The interviews were open to both partners but only 15 men participated, other respondents were women alone. This uneven gender representation emphasises the perspective of women and allows no more than a glimpse of men's views on these care arrangements. The interviews were recorded. Synopses of each interview were produced in English. Some interviews were transcribed and translated (the project budget did not allow full transcription and translation).

Research in this workpackage was based on a detailed review of the work-plus-care strategies of the families and was designed to indicate the patterns that emerged and their

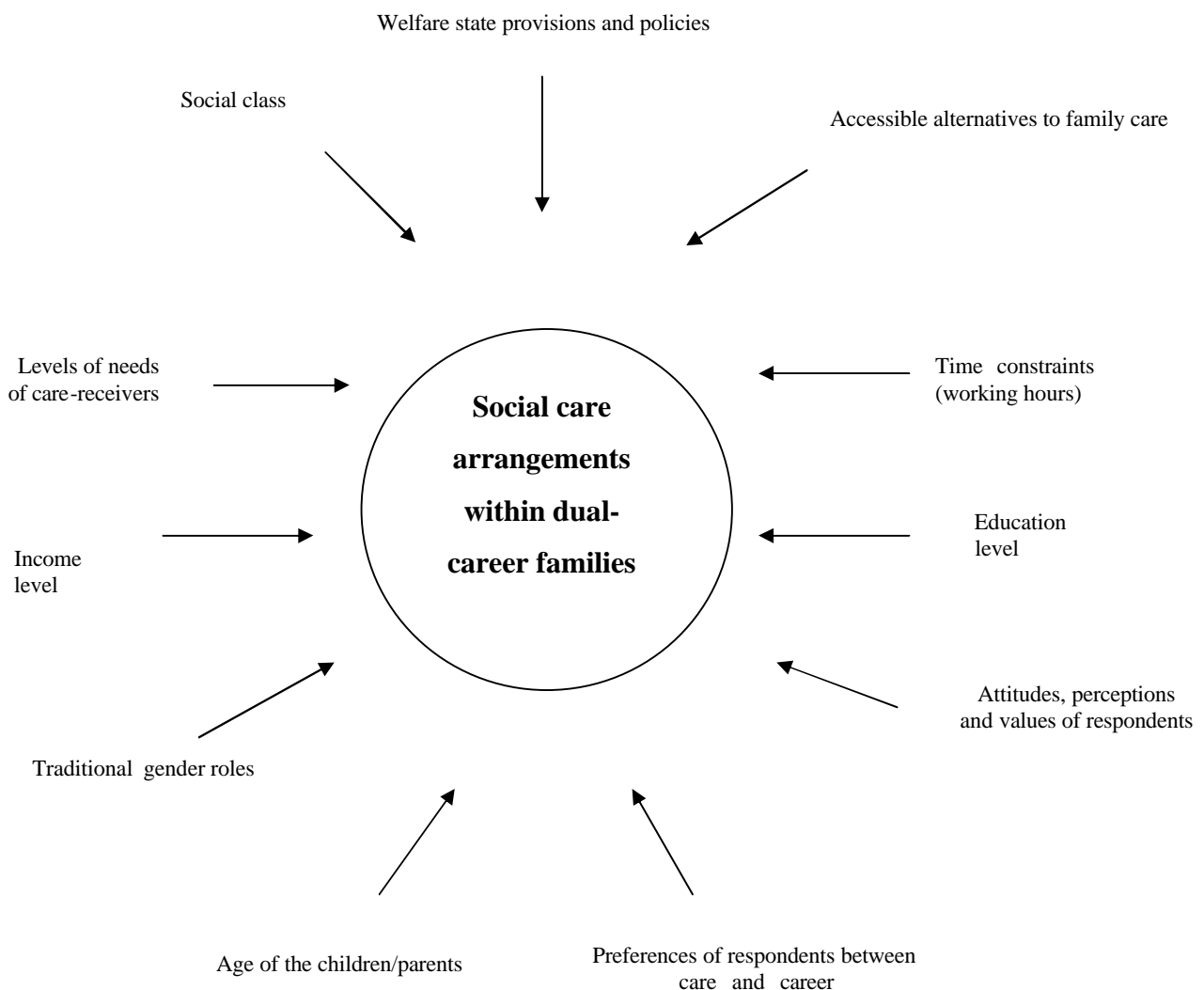
implications for national and EU social policies. The qualitative data generated from our interviews was where possible compared to more quantitative sources, data on attitudes towards gender roles, and material on national and EU policies and provision.

### 3.5.3. Main findings of the workpackage

The specific task of this workpackage was to address the question:

*How do multi-career families combine full-time employment with their caring responsibilities for young children and/or older people?*

Figure 5. Factors likely to affect care arrangements within dual-career families



According to our theoretical perspective, the way families organise their care arrangements can be affected by many several factors: welfare state provisions and policies, education level, social class, traditional gender roles, levels of needs, accessible

alternatives to family care, time constraints, income level, age of children (and parents) and individual preferences and values (Figure 5). Many of these factors are closely interrelated with each other.

### **Care + Work Strategies in Multi-Career Families**

The descriptions of how multi-career families arrange the care of their children, older relatives or both show how the parents and/or carers combine full-time work and long working hours with their caring responsibilities. The interviews also illustrate how work schedules impact on daily care arrangements and how families respond to care emergencies.

#### *Childcare*

It is clear from the data that parents construct a considerable variety of care arrangements for their children while they are at work. At one extreme, the public provision of school and nursery care can be the sole alternative to parental care. At the other, family members are seen as the only alternative source for childcare. In between these two extremes, there are various but distinct combinations of family care, public care and private provision.

Within our data of 67 dual-career families caring solely for children, Finnish families (15 out of 17) tended to rely on public care facilities. In contrast, Italian (11 out of 17) and Portuguese (9 out of 11) families used primarily third sector and other private care facilities and/or their family and social network. British (15) and French (7) families could not be said to rely on any particular caring pattern but used instead a range of combinations of care. National and local welfare policies and public provision of childcare are likely to influence how care arrangements are constructed outside of nuclear and extended family and social networks. However, it is clear that families who face broadly the same needs and policy environments may still respond very differently.

The descriptions of childcare arrangements show the consequences of long working hours. The availability of care facilities, the quality of social and family networks as well as commuting times to and from work are key determining factors. However, these factors are not the only ones that create families' care arrangements, cultural differences also play a role. For example, when children begin school at the age of seven in Finland, they often return home alone or go to their friends as their parents are usually working the whole day. Also in some Portuguese families young children walk to or from school alone but in the other three countries, the need to bring and fetch children almost always disrupts the working day.

Another dimension along which the dual-career households differ from each other is the degree to which the parents share childcare and household tasks. Very equal sharing is rare, but when it does occur, it is quite deliberate. It is more common to have a certain degree of sharing of tasks but, at the same time, it is usual that one of the parents, usually the mother, still is the dominant carer and the organiser of care in these families. Some mothers receive little help from their partners and this appears to be associated with a richer range of non-family provision.

Amongst the childcare-only sample, nine Finnish families (out of 17) share care equally along with six British (out of 15), three Portuguese (out of 11), five Italian (out of 17), and one French family (out of 7). One partner is the main carer in six British and five Italian, four Finnish, two Portuguese and one French family. Only in one French family and in one Italian family, it is the father who is the main carer. While the data does not lend itself to

direct comparison as the samples were not randomly selected or matched, there appear to be some national differences in care sharing patterns.

The preferences of the respondents seem to play a significant role in choosing the care services they prefer to use. Some of the families see that being cared for by the extended family is good for the child and for the family. However, several respondents did not like the idea of depending too heavily on relatives as it can result in debts of gratitude. Such views were particularly heard in the Finnish families, but were also observed in some French, Portuguese, Italian and British families. Reciprocal care arrangements with friends or relatives were often seen as time consuming and likely to cause additional demands in the long run as such arrangements have to be paid back, often in the form of caring for friends'/relatives' children. Some families had chosen to employ a nanny rather than to delegate the caring of their children to neighbours, friends and/or relatives.

A great many factors influenced the care strategies but the factors that parents spoke mostly of were work schedules, modes of transport, travelling time to and from work and to and from care facilities such as schools and nurseries, and opening times of these care facilities.

Income level, age of parents, age and number of children played a more limited role. The issue of children being left without adult care was age-related but it was always uncommon in our sample of under 12-year-old children. Some Finnish children walked alone or with friends to and from school or spent some time at home alone after school. In some Portuguese families quite young children were left alone. Caring arrangements were influenced by as well men's as women's attitudes towards gender roles. The age of the parents was relevant to these gender roles in caring. Stress-levels within some of the families were high and most parents regretted that their caring arrangements meant that the time spent together as a family was limited.

Most parents sought to strike a balance or to find a compromise between work and childcare demands. Only in a small minority of cases could we find couples who either gave absolute priority to the job (and even then, in most cases, only one of the parents did this) or absolute priority to the children.

Age and wanting to achieve career goals were not the only reasons why some families adopted a strategy that prioritised career demands over parenting. Financial necessity could also be a determining factor. For example, an Italian mother said she would love to be able to stay at home with her children for their first five years but due to economic pressure, this was not possible (ITMC18). A British mother reported that her job allowed her to meet the material needs of her family (UKMC2). In addition, the need for a separate identity beyond motherhood was important to most of the women in our sample.

The French and Finnish parents were able to depend mainly on publicly provided childcare facilities and appeared satisfied with both the costs and services, although gaps in services were identified mainly in terms of opening times. The British, the Portuguese and the Italian respondents complained about scarce and highly expensive childcare provision. Many parents worked more than 48 hours a week despite the EU Working Time Directive and some reported difficulties in getting time off from work in emergencies. Our evidence indicates that the Directive on Parental Leave does not always work as employees are reluctant to ask for time off, as they fear it could harm their relationship with their employer and their career.

Co-ordinating caring of children with the parents' work timetables is essential for multi-career families. The interviews showed that to co-ordinate work schedules with the taking and the collecting of children to and from school/care facilities is a particular challenge for

these families. In many families it is the woman who has to adapt her work arrangements when there is a clash between her and her husband's schedules.

*"Someone has to take the responsibility ... I feel like a sort of co-ordinator, who tries to hold all pieces together and who tries to think about the whole system for example the care arrangements. If my husband knows that I have two meetings, it does not necessarily cross his mind that there is also the care of the children that has to be arranged."* (FINMC22)

Work-related travel, which requires that at least one parent is away from home for a few days either during the week or the weekend, also heavily influences the care arrangements. Fourteen families in our sample have jobs that include work travel. Frequent work-related travel is most present in the Finnish sample (13 out of 17). Most of the families in our sample work during evenings and weekends, as well.

The way parents handle emergency situations is also interesting. If parents can not rely on their family network, they tend to share caring when their children are ill. However, if the children are ill for a longer period, it is more often the woman who cares for them.

A recent survey found that 81% of employees in Europe, especially the women, are satisfied with their current combination of employment and caring obligations (Kauppinen 2001, 5). This is not reflected in our sample where a significant part of the families find it difficult to reconcile employment and family obligations. A Finnish respondent reports:

*"It has been really difficult [combining work and family]. I mean REALLY difficult. If I say it straight, it is stupid even to try [to combine them]."* (FINMC6)

Furthermore, many parents (particularly from Portugal but also from other countries) said that they are extremely tired due to the pressures on them. Some of them report feeling guilty about not spending enough time with their families. For example a Portuguese mother stated:

*"I end up feeling very guilty because I don't spend much time with them, and the little time I do have with them, I'm always getting cross with them because I want them to hurry up... and because I want to get things done myself... so I can have a bit of a rest..."* (PMC15)

One Italian mother decided to take a part-time job because when the nanny was the main carer, her child used to shout at her when she arrived back from work:

*"Why do you come here? Go back to work!"* (ITMC9)

### ***Care for older relatives***

The families with young children have a constant responsibility to care for them. In contrast, where families are caring for an older relative, the responsibility varies from a daily involvement to a weekly or even, a monthly commitment. Most of the older relatives receiving care are parents of one partner of the couple, usually of the woman, who is also regularly the main carer. The accounts given by our sample show that care is more likely to be shared for a husband's parent. As well, men are more likely to be involved in caring for their children than for an older relative. The double front descriptions in particular show how women are more likely to be main carers on both fronts and how their partners are usually more involved in care of children than of older relatives. This corresponds with the Eurostat survey finding that men are often involved only in the care of their blood relatives and, furthermore, that they are generally less likely to be involved in the caring of older relatives than of children (European Commission 2000).

The care arrangements of older relatives are primarily structured, on the one hand, by the health and self-care abilities of the older person and, on the other hand, by working

schedules of family members. A combination of long working hours and short interval/high level care needs resulting from the poor health of the older person generally produces nursing home care.

Our elder-care-only sample of 32 families does reflect the national patterns of access to institutional care. It was only within the French (5 out of 11) and the Finnish (2 out of 7) samples where older relatives were found living in nursing homes. In the other national samples old people were living at home, even with extremely short interval/high care needs. Older people lived alone in the 2 British families (out of 2). In all the Portuguese families (8), in most of the Italian (3 out of 4) families and in one French family, the older person lived with the family. The Portuguese and Italian families in our sample tended to perceive nursing homes as the last resort for the care of their older relatives and they also saw caring for an older family member as a duty of their own.

Publicly provided home help services were part of the care arrangements for the older people in Finland and France, and a few Portuguese families relied on adult day-care centres. Most of the families in Italy, Portugal and Britain cared for their older relatives without help from the public or private sectors. The Finnish and the French families were, on the other hand, generally satisfied with public services. However, a fairly frequent complaint from the couples caring for older people also in these two countries was that they did not enjoy the same public support as families caring for children concerning, for example, financial support and opportunities to have care leave from work without getting their jobs threatened.

Home care arrangements are vulnerable to changes in the health of the older person. Care arrangements were more stressful in those families where they supported older people with short interval/high care needs. Long lasting care commitments had a negative impact on the health of the carers, on the stability of the couples' relationships and on the relationships within the extended family.

Attitudes and preferences of the older person, the respondents and other relatives constrain the range of possible care arrangements. Work schedules and travelling times to and from work are dominant determinants of care timetables. The flexibility of the workplace can make it possible to adjust work to care provision for older people. For example, a Portuguese respondent reported:

*"I don't come in at 9.30 like other people, I come in at 10.30/11.00. I asked for permission to do this, because I leave my grandmother dressed and ready. Then I don't take any lunch hour, or restrict it to half an hour. I don't take more than half an hour, which is enough to go round the corner to get something to eat and get back here (to the workplace)." (PMC3)*

However, generally the attitudes of work colleagues and employers are less accepting of responsibilities for older people. Our interviews show it is easier to get time off from work to care for an ill child than to care for an ill older relative. Furthermore, a Finnish respondent believes it is not only the culture of the workplace but the society in general that pays more attention to families with childcare obligations than to families with caring responsibilities for older people (FINMC24). To balance the needs of their older relatives with their work schedules, some respondents had accepted that their older family member moves into a nursing home while others had them moving into the family home.

In caring for an older person, it was usually only one person, the respondent, who was involved in the care tasks. Often, other family members did not participate in the caring activities. Sometimes the older relative preferred to have just one carer. As well, some respondents found it difficult to delegate caring responsibility to other relatives or to home care services. Traditional attitudes towards gender roles seemed an important factor in

explaining the division of caring. Male partners rarely participated in the caring arrangement of their “in-laws”, a pattern that was not evident in female respondents.

The couples in families caring for children were generally in their thirties or forties, some were younger, and many shared care tasks. In families caring for older relatives, the couples were generally in their late fifties and sometimes older and rarely shared tasks. Across all five countries, when the older relative had short interval/high care needs, it was the woman who was the main carer even if she worked longer hours than her spouse.

### ***“Double front care”***

The descriptions of these 25 families indicate that most organise their daily lives entirely around the needs of their children and their older relatives, the opening hours of support facilities and their work schedules. Seventeen of the older people live in their own homes (mainly French and British), and seven, primarily Portuguese couples have their older relative living with them and their children. Just ten of the twenty-five families receive home help for the older person and often this was not on a daily basis even where the older person had short interval/high care needs. The “double front” families in Finland, France and the UK use combinations of informal and formal care. Only Portuguese and Italian families use private care facilities.

Generally, caring for both children and older relatives while maintaining two careers means that the families face, at the same time, all the above-identified difficulties related as well to childcare as to caring for older relatives. Many of these families thought that their situations could be improved by additional provision of good quality services, by employers’ recognition of their particular difficulties and by financial assistance. Leave from work or a right to move temporarily to part-time work, yet being later able to return to full-time work and having their original positions protected, was a solution mentioned by some carers. Financial support to compensate for the loss of earnings, caused by having to take leave from work for caring or by having to pay for extra care for their older relatives, was also mentioned.

Again, double front caring and two jobs add up to a need for two cars. However, not all of these families have two cars at their use. For example, in one of the families, the husband has to take the children to school and his wife to work, return home to help his mother and cousin before finally driving himself to work (PMC1).

### **Conclusions on the effects of work schedules and service provisions on care arrangements**

The working schedules of the couples and whether they have flexible, regular or irregular working hours are critical in determining their care arrangements. Most of the couples work between 38–48 hours per week, the average working hours in the EU found by the Labour Force Survey. However, some work more than 48 hours a week. Our sample confirms earlier findings that the ratified EU directive limiting work to 48-hour week is often ignored. On the other hand, our sample had more workers with flexible and irregular working hours than indicated by the above-mentioned European survey. This difference may be due to the particular characteristics of multi-career families who also care.

Some couples work the same number of hours a week and in other couples the female works longer hours than her spouse. To some extent we have found evidence to support the argument that caring tasks in families are divided depending on who is the main earner. Equally we have found some support for the influence of traditional attitudes to gender roles on family life (Brines 1994; Blossfeld & Drobnic 2001; Drobnic & Blossfeld 2001).

However, there are equally significant contrary cases. Some double front families have adopted completely different approaches to balancing work and care responsibilities. In two families the husbands work longer hours than their partners and share childcare equally while their partners are the main carers for older relatives. In another family, the man is the main carer for two older relatives while his partner is the main carer of their children. Our data seems to indicate that the number of working hours has limited effects in influencing the gender structure of caring arrangements.

Access to care facilities appears to be particularly constrained in Portugal and Italy for both groups, children and older people. Childcare was most often described as unsatisfactory in Britain due either to the high prices or badly scheduled and scarce care facilities. The most positive accounts of provision for both children and older people were given in France and Finland. Access to and timing of care services are critical to care strategies of families.

However, the availability of alternative care sources seems to have only limited effects on the gender balance of caring in these families. Indeed, access to services may sometimes appear to legitimise rather than to moderate women's larger care responsibilities and roles.

#### 3.5.4. Summary of main results

These families have exceptionally busy, and often complex, work-plus-care schedules. Many are in the middle of high skill careers and at the same time they are major producers of childcare and care for older people.

Our interviews did not reveal people who had a quality of life they were particularly content with. They did not complain greatly but they presented themselves as people who were getting by, doing the best they can, and often looking forward to when this difficult stage in their lives would end.

The work-plus-care strategies of these families are rarely static but in transition as children grow older and older people grow frailer.

The key factor that allows the combination of paid work and care responsibilities is some *flexibility* in employment timetables or care timetables or both. This may come from flexible working hours, an employer tolerant of caring responsibilities, care services that operate beyond working hours or wider family and support networks that are flexible.

There is a key distinction between those families where the flexibility comes from one source (for example, from time-flexible care provided by a grandmother *or* by a public service such as a nursery, school or home care service) and those where the flexibility comes from a wider range of sources (for example, from working hours *and* paid helpers *and* friends). We have defined single source flexibility as "*uniflex solutions*" and multi source flexibility as "*multiflex solutions*".

Uniflex solutions are generally more robust than multiflex solutions but not always so, as the single key source can be withdrawn.

Families in similar circumstances (in terms of work and care responsibilities) may respond with very different care-plus-work strategies. There is no majority response.

The social policy and social service environment provided by a particular country and locality appear less important than the preferences, values and ideologies of the families themselves.

The gender balance in terms of care organisation and care tasks between the dual career couple is critical to the kind of work-plus-care strategy that can be followed.

Better public provision may paradoxically allow families to adopt a more traditional allocation of tasks within the home. Some men will contribute to care only when there is no alternative. The state may provide that alternative through services, care payments or credits, or employment protection that allows women to exit the labour market temporarily.

Access to public and private transport is a critical factor in determining work-plus-care strategies. Use of non-family care services very often requires transporting children or travelling to older people's homes.

The single most important constraint faced by the families is limited opening hours by nurseries and schools and limited service hours from home-care services and day-centres.

Except amongst the poorest families, the issue of cost of services is rarely a core issue. These are couples who have chosen dual-careers and income rather than time.

EU directives on working hours and leave for caring responsibilities are often not used by respondents. Many worked more than 48 hours a week.

The most effective way of assisting these families would be an infrastructure of childcare services and care services for older people that could be used flexibly in terms of hours and forms of assistance. It appears inefficient that these, often highly skilled, workers have to adjust their labour market participation, or even leave the labour market, because of the inflexibility of routine public services.

For more details of the workpackage on the care arrangements of multi-career families, see [SOCCARE Project Report 3](#) and the national reports on [Finland](#), [France](#), [Italy](#), [Portugal](#) and [the UK](#).

### **3.6. Care arrangements in immigrant families (Workpackage 4)**

The main aim of this workpackage was to analyse how immigrant families organise care for young children and elderly persons and also to identify the specific constraints and problems they face when combining their work with caring responsibilities. Research work in the workpackage was co-ordinated by the Portuguese project partner.

Our primary interest in this family type lies with the fact that these families have to face strong pressures and specific difficulties when organising care for children or elderly persons: (1) pressure from work (long working hours, atypical timetables); (2) economic difficulties (specially in the case of unskilled labour migrants and refugees); (3) pressure arising from different cultural values related to caring (specially in the case of migrants coming from societies with contrasting cultural and religious values); (4) pressure arising from the absence of family and social networks (mainly in the case of first generation migrants); (5) pressure related to territorial, racial and social discrimination (as it may hinder accessibility to services provided by the host society and integration in the labour market). Consideration of these different sources of “vulnerability” that immigrant families may experience led us to suppose that they might develop specific strategies to cope with care arrangements and to tackle the constraints and difficulties in balancing work and family life.

In order to understand the care arrangements in immigrant families we have to pay attention to the social contexts in which they are embedded. It is important to bear in mind the national policy contexts in the host country as well as the type of migration flows between the sending and receiving countries.

In our previous workpackages on care arrangements in lone parent families and dual-earner couples we underlined the influence of familial trajectories, type of family household, social networks, caring values and family/gender obligations, and the constraints (or resources) associated with the family’s social position and living conditions (level of income, occupation, atypical vs. typical working hours, living in a privileged vs. a socially deprived area of residence). From the point of view of immigrant families, these variables have to be considered in the context of migration — a factor which implies not only a “before” (country of origin) and an “after” (host country) but also a comparison between “us” (immigrant population) and “them” (general population in the host country).

With regard to the “before” and “after”, it is essential to consider the migration pattern of immigrant families. This concept refers to at least three main dimensions of the migration process: (1) the nature of the migration trajectory (individual/familial); (2) the nature of the migration project (reasons to leave the country of origin), and (3) the duration of migration (the more permanent or temporary nature of the stay in the host country).

With regard to the “us” versus “them” dimension of migration, or, put in sociological terms, analysing the cohabitation of different ethnic groups in the host society (interethnic dimension), our approach is centred on the concept of ethnicity. This concept focuses on the contrasts and similarities/connections between the migrant populations and the majority population group.

Thus, rather than to discuss whether the interviewed migrant families from a particular country of origin are “assimilated” or “integrated” in the host society, our approach in this workpackage is to identify the different dimensions of ethnicity and to examine how these contrasts influence the work/family balance and the care arrangements of immigrant families.

### 3.6.1. Immigration in Europe: brief overview

The theme of immigration in Europe has deserved growing attention both from governments and social researchers due to the increase and diversification of in-flows over the last few decades. First of all, in order to understand immigration in Europe, we have to take into account that there are countries with a long tradition in immigration (like France and the UK) and others that only recently have started to receive immigrants in a larger scale (like Finland, Italy and Portugal), having themselves been emigration countries until the 1970s.

It is after World War II that immigration in Europe has acquired a considerable importance. Four different phases can be distinguished: (1) a period of post-war adjustment and de-colonisation, (2) a period of labour migration, (3) a period of restrictions in migration flows and, finally, (4) the period of dissolution of socialism and afterwards.

Table 11. Foreign population in selected European countries, 1980-2001 (thousands).

	1980	1985	1990	1995	1998	2001 or latest available	Variation 1980-2001 %
<i>EU</i>							
Austria	282,7	304,4	456,1	723,0	737,3	761,2	169,3
Belgium		846,5	904,5	909,7	892,0	861,7	
Denmark	101,6	117,0	160,6	222,7	256,3	258,6	154,5
<b>Finland</b>	<b>12,8</b>	<b>17,0</b>	<b>26,3</b>	<b>68,6</b>	<b>85,1</b>	<b>91,1</b>	<b>611,7</b>
<b>France</b>		<b>3752,2</b>	<b>3607,6</b>				
Germany	4453,3	4378,9	5241,8	7173,9	7319,6		
Greece	213,0	233,2	229,1	153,0			
Ireland			80,8	96,1	111,0	126,5	
<b>Italy</b>	<b>298,7</b>	<b>423,0</b>	<b>781,1</b>	<b>991,4</b>	<b>1250,2</b>	<b>1270,6</b>	<b>325,4</b>
Luxembourg	94,3	98,0	110,0	132,5	147,7	164,7	74,7
Netherlands	520,9	552,5	692,4	725,4	662,4	651,5	25,1
<b>Portugal</b>	<b>49,3</b>	<b>80,0</b>	<b>107,8</b>	<b>157,0</b>	<b>178,1</b>	<b>190,9</b>	<b>287,2</b>
Spain	182,0	241,9	407,7	499,8	719,6	895,7	392,1
Sweden	421,7	388,6	483,7	531,8	499,9	477,3	13,2
<b>United Kingdom</b>		<b>1731,0</b>	<b>1875,0</b>	<b>1948,0</b>	<b>2207,0</b>	<b>2450,0</b>	
<i>non-EU</i>							
Czech Republic			34,9	158,7	219,8	201,0	
Hungary				140,0	150,2	110,0	
Norway	82,6	101,5	143,3	160,8	165,1	184,3	123,1
Switzerland	892,8	939,7	1100,3	1363,6	1347,9	1424,4	59,5

Note: The countries with the largest foreign population and the highest growth are highlighted.

Source: Table based on Salt 2000 and Council of Europe 2001 and presented by João Peixoto in the SOCCARE Workshop "Care arrangements in immigrant families", Institute of Social Sciences, Lisbon, May 2002. When analysing the statistical data, it should be borne in mind that the comparability between countries is not easy to establish, due to the diversity of sources, lack of common definitions and the different compilation methods used.

(1) The first period elapsed between 1945 and the 1960s. During these years the UK and France, for example, received many returnees from the colonies and workers from former overseas territories. This was the period of post-war adjustment and de-colonisation. (2) In the second half of the 1950s, some European countries whose national economies were developing very quickly began to attract labour migrants from other regions. Some of these countries even established active recruitment policies in order to satisfy their labour market

needs. It was a period of intense labour migration in which most European countries opened their borders to the entrance of foreign labour migrants. (3) However, the active recruitment of migrants came to a halt after the first oil price shock in 1973. The recruitment of new migrants became more restrictive but, nevertheless, all the European countries continued to register the entrance of migrants. (4) These flows rose through the 1980s and reached a peak in the 1990s. Since the early 1990s the flows of migrants have included an increasing number of asylum seekers and refugees (due to the fall of the “iron curtain” as well as several wars and ethnic conflicts) and illegal migrants (due largely to restrictive immigration policies) (Bauer et al. 2001; Coppel et al. 2001).

Reflecting the increase in migrant inflows during the 1980s and 1990s, (legal) foreign population in Europe rose strongly. Between 1980 and 2001 the foreign population increased in almost all European countries, with Finland, Italy and Portugal registering some of the largest relative increases (Table 11). However, the countries that show the largest growth in immigrant population belong to the group of countries with the lowest percentages of immigrants (Table 12). In 1998 about 5% of the European population was composed of foreigners.

Table 12. Foreign population as a percentage of total population in selected European countries, 1980-2001 (%)

	1980	1985	1990	1995	1998	2001 or latest available
<i>EU</i>						
Austria	3,7	4,0	5,9	9,0	9,1	9,4
Belgium		8,6	9,1	9,0	8,7	8,4
Denmark	2,0	2,3	3,1	4,2	4,8	4,8
<b>Finland</b>	<b>0,3</b>	<b>0,3</b>	<b>0,5</b>	<b>1,3</b>	<b>1,6</b>	<b>1,8</b>
<b>France</b>		<b>6,8</b>	<b>6,3</b>			
Germany	7,2	7,2	8,2	8,8	8,9	8,9
Greece	2,2	2,3	2,3	1,5	1,5	1,5
Ireland			0,8	2,7	3,0	3,3
<b>Italy</b>	<b>0,5</b>	<b>0,7</b>	<b>1,4</b>	<b>1,7</b>	<b>2,2</b>	<b>2,2</b>
Luxembourg	25,8	26,7	28,6	32,6	34,9	37,3
Netherlands	3,7	3,8	4,6	5,0	4,2	4,1
<b>Portugal</b>	<b>0,5</b>	<b>0,8</b>	<b>1,1</b>	<b>1,6</b>	<b>1,8</b>	<b>1,9</b>
Spain	0,5	0,6	1,0	1,2	1,5	2,2
Sweden	5,1	4,6	5,6	6,0	5,9	5,4
<b>United Kingdom</b>		<b>3,0</b>	<b>3,3</b>	<b>3,6</b>	<b>3,8</b>	<b>4,1</b>
<i>non-EU</i>						
Czech Republic			0,3	1,5	2,1	2,0
Hungary				1,4	1,5	1,1
Norway	2,0	2,4	3,4	3,7	3,7	4,1
<b>Switzerland</b>	14,1	14,5	16,3	19,3	19,0	19,9

Note: The countries with the highest percentages are highlighted.

Source: Table based on Salt 2000 and Council of Europe 2001 and presented by João Peixoto in the SOCCARE Workshop “Care arrangements in immigrant families”, Institute of Social Sciences, Lisbon, May 2002.

Some European countries register high numbers of asylum seekers (for example, Switzerland, Luxembourg, Belgium and the Netherlands) but particularly the Southern European countries have extremely low percentages of asylum seekers. Moreover, illegal

or clandestine immigration is nowadays one of the main concerns of the European countries but its exact scope is difficult to estimate. Another recent trend in European migration flows is the growing diversification of the migrants' countries of origin.

In summary, we can consider that in general terms the European countries roughly fall into two main groups with regard to the characteristics of migration flows. (1) The first group is made up of countries with a long tradition in immigration. From the project countries, France and the UK are included in this group. Immigration to them has continued from the end of World War II until the present moment. These countries have had high amounts of immigrants but recently, they have had the lowest growth rates of foreign population. On the other hand, these countries have received many asylum seekers and refugees.

(2) New immigration countries that started to receive considerable amounts of immigrants only later form the second group. Italy, Finland and Portugal are included in this group. These countries still have low percentages of immigrants, but they have recently been the ones to register the highest increases in the immigrant population. On the other hand, the numbers of asylum seekers have been rather low in these countries, even if some of them like Finland have over the last decade registered an increase in numbers of refugees. Finally, there are two trends that may be observed in both groups of countries: greater diversity in the countries of origin and the increase in illegal immigration.

It is important to notice that there are persistent contrasts between the social profile of immigrants and the social profile of nationals. For example, immigrants continue to have considerably lower levels of education than nationals and they are over-represented in certain sectors of employment, mainly in the industrial and service sectors where qualifications and average wages are low. This partly reflects past and present demands for low-skilled workers in some sectors of the economy. Many studies have also pointed out that although immigrants' levels of integration vary widely, most of them experience a wage disadvantage for a considerable part of their working lives.

In relation to integration, significant proportions of immigrants live in geographically disadvantaged areas, have high unemployment rates and live in more poverty-prone families when compared with the averages of the host countries. In other words, there are pockets of poverty which are difficult for immigrants to exit from. Many of these problems are not linked directly with immigration per se but they reflect, at least in part, the fragility of national social policies, which are magnified by the existence of high proportions of immigrants.

There is a growing decline and ageing of the European population that is leading to a decrease in the working-age population. As well, in some economic sectors there is also an increasing shortage of skilled as well as non-skilled labour. In this context and as many non-European nations show demographic vitality, immigration flows to Europe are expected to continue.

### 3.6.2. National samples of immigrant families

The Portuguese sample is composed of 25 Cape Verdean families. Portugal has received its largest immigrant group from its former African colonies, from the so-called PALOP (*Países Africanos de Língua Oficial Portuguesa*) countries Angola, Cape Verde, Guinea-Bissau, Mozambique and São Tomé. Together they count for almost half of all foreign population in Portugal and a half of all PALOP immigrants have come from Cape Verde. Thus, Cape Verdeans form the largest ethnic immigrant group in Portugal with 47.216 people legally resident in 2000.

The sample was collected in the city of Lisbon, where the majority of Cape Verdean immigrants are concentrated. All of these families care for young children (under 12 years) and three of them also provide care to an elderly person. In terms of family structure, the Cape Verdean families fall in two main types: couples with children and lone parents with children. About half of the interviewees are first generation migrants and the other half are second generation. In the majority of the cases, these immigrants have lived in Portugal for more than 10 years. Except for two cases, we are talking about unskilled labour migrants. The majority have low qualified jobs, mainly in the building and public works sector (the men) and in the cleaning sector (the women). All lone parents work full-time and in couples the predominant model is the dual-earner model with both partners working full-time.

The Italian sample of immigrant families was collected in three different regions of Italy (Veneto, Emilia-Romagna and Tuscany) and it includes 26 Moroccan families. The Moroccan community is the largest foreign ethnic group in Italy with its 170.905 residents in 2000. However, Moroccans are highly dispersed all over Italy. In the studied three regions, they have had a considerable presence for a longer time. Even though originally Moroccan immigration to Italy was masculine and “pendular” by its character, it has recently transformed to a settling pattern whereby entire families come to stay. On the other hand, the term “marocchino” has become generally used in Italy as a highly stigmatising and negative synonym for all immigrants.

Like the Cape Verdean families, all the Moroccan families care for children (under 12) and three of them also provide care to an elderly person. Nevertheless, while in terms of family structure the Cape Verdean families were distributed between two main types of families, all the Moroccan families were couples with children. This sample includes no lone parents. Moreover, while the Cape Verdean interviewees were both first and second generation migrants, the Moroccan interviewees belong all, except for one case, to the first generation. With regard to the duration of stay in the host country, the Moroccans are more recent migrants than the Cape Verdeans. Most Moroccan people of the sample have been in Italy for 5 to 10 years.

The French sample was collected in Rennes and includes 22 families. Contrary to the former samples, there is some diversity in terms of geographical origin. This reflects recent trends in immigration to France. Traditionally, Portugal, Italy and Spain together with Algeria have been the major countries of origin but in the 1980s and 1990s many more immigrants have started to move from Morocco and Turkey to France. Also more generally, there has been a diversification of source countries. One part of this development has been the rapid increase of immigration from sub-Saharan African countries like Senegal, Côte D’Ivoire, Congo and Mali in the 1990s.

The majority (18) of the sample families are couples with children and the remaining four are lone parents. All care for children below age twelve and none for elderly dependent relatives. Although all of them may be considered first generation migrants, time of permanence in France varies from less than five to more than ten years. Also the

reasons for migration are varied, including family reunion, unskilled worker migration, asylum seeking and student migration.

Six couples within the sample are mixed Franco-African couples and the African partners (all women) come from Tunisia, Mali, Burkina Faso and Senegal. The other couples are composed of immigrants from three regions of Africa: (1) the Mahgreb, (2) West Africa (Mauritania, Senegal, Burkina Faso and Mali) and (3) Central Africa (The Republic of Congo and the Democratic Republic of Congo – former Zaire).

The Finnish national sample was collected in the regions of Tampere and Helsinki (the latter including three major towns: Helsinki, Espoo and Vantaa). It includes immigrants from two main countries of origin: 13 from China and 14 from Estonia. After Russians, Estonians are the second largest immigrant group in Finland with around 10.000 residents. Instead, there are only 1.700 Chinese people living in Finland. As in the French sample, there are some cases of “mixed couples” (a Chinese or an Estonian woman married to a Finnish man) and time of permanence in the host country is not very long. All immigrants are first generation migrants and nearly all of them have been in Finland for less than ten years. Several Chinese families have been in Finland only for a couple of years whereas the Estonian families, having arrived in the 1990s, have lived in Finland for 5 to 10 years.

The migration patterns of the Chinese and Estonian immigrant families are rather different. The majority of Estonian immigrants are what the Finnish immigration authorities consider as “returnees” (immigrants with Finnish origins). Their social and occupational profile is not very qualified. Most of them are either medium or low qualified employees in the service sector or industrial workers, thus suggesting that some “returnee” migrants might have emigrated as a response to labour demands in the unskilled sectors of the Finnish economy.

In contrast with the above-mentioned profile, the Chinese immigrant families have a “skilled worker” profile in terms of the migration project and their socio-professional position. Many of them migrated in response to training opportunities (student migration) or employment opportunities in highly skilled sectors of the labour market (highly qualified professional migration), a few came as unskilled immigrant workers and a few to join other family members. Consequently, the socio-professional status of the Chinese families is linked to medium or highly qualified professions and there are no industrial workers or unskilled workers in the service sector. Finally, the dual-earner model (both working full-time) prevails in these families.

The UK national sample was collected in the Southeast of England and includes 25 families. The majority of the families live in East Kent but seven families live in more urban settings further north and nearer to London. As in the Finnish and French samples, also this sample includes some cases of “mixed couples” where British nationals are married to migrants from different countries (Hungary, Spain, Italy, Canada, EUA). However, most of the immigrant families are Asian (from Malaya, Uzbekistan, India, Hong Kong) or Asian with partners from other countries (Mexico, Colombia). There are also a few families from European countries (Eire, Holland).

In terms of migration patterns, the UK sample has no asylum seeking families but is otherwise quite varied. Most are first generation migrants that have been in the UK for over ten years and a few cases (3) concern British nationals born abroad who returned to the UK as young adults. Reasons for migration include family reunion and (skilled as well as unskilled) worker migration, student migration and the “returnee” migration of British nationals born abroad. Consequently, the socio-professional status of these families spans a large spectrum of positions.

### 3.6.3. Main findings of the workpackage

#### **Labour migrant families and care arrangements in Italy and Portugal**

First we try to uncover similarities and differences in the strategies used by the Cape Verdean families in Portugal and the Moroccan families in Italy to reconcile their work with the care of children and dependent elderly persons. Both of these groups can be understood as labour immigrants, they have migrated in order to work. We emphasise the meanings which the actors attribute to their practices, the evaluations they make and the problems and tensions they face.

Within Cape Verdean immigrants in Portugal, the majority have full-time jobs, with unsocial hours. This makes it difficult if not impossible for them to reconcile work and care arrangements through the use of standard formal care services.

Second, most of the men are construction workers and the women do unskilled cleaning work. As a result, they have low salaries, which makes it difficult if not impossible for them to afford paid services, whether formal or informal.

Third, most households cannot rely on informal support networks, because they either simply do not exist or are severely limited. For example, almost half of the families had neither maternal nor paternal grandparents living in Portugal. Many of those interviewed stated: *“I don’t have anybody here.”* The lack of informal support mechanisms is most noticeable in the households of first generation immigrants. By contrast, they are more available in households made up of Cape Verdeans who came to Portugal as children or were born in Portugal. In these cases it is mainly the grandparents who provide the informal support.

If we turn to the family structure of the Cape Verdeans, we find couples with children, extended families and lone parent families. As far as the types of conjugal relationship are concerned, cohabiting couples are, for the selected group of Cape Verdeans, more frequent than marriage (10 couples currently live outside of marriage and 7 are married). Cohabitation is said to be widely accepted and tolerated in Cape Verdean society. In fact, the Cape Verdean women we interviewed seemed to give cohabitation the same value as marriage.

The average number of children is two. Only three of the families had three under-12-year-old children. Only three other families had an elderly family member in need of care. Values concerning care tend mainly towards giving the family (in practice, the woman) a prominent role.

Turning now to selected Moroccan immigrants in Italy, we can see that except in a few cases, they have all followed classic family migration trajectories. The Moroccan man emigrated first, sometimes while he was still unmarried and childless, then he later married (nearly always in Morocco). However, the marriages were in most cases arranged by their families. While roughly half of the Cape Verdeans interviewed in Portugal were second-generation immigrants, the Moroccans interviewed in Italy were all, except one case, first-generation immigrants. Moroccans have on average higher educational attainment levels than the Cape Verdeans.

Most of the Moroccan women have a tenuous relationship with the labour market: some are maids, others work a few hours a week or on an irregular basis, while others work on a half-day basis. Only few Moroccan women have unsocial working hours. Most men, by contrast, have regular full-time jobs. The prevailing labour market model for couples is therefore “the man working full-time and the woman working part-time, for just a few hours or on an irregular basis.” We may call this model the “attenuated male-breadwinner” model.

Moroccan women are therefore clearly in a different situation to Cape Verdean women as the majority of the latter group work full-time, for 7 to 8 hours a day, with unsocial working hours. Working on a casual basis, for only a few hours a week or on a half-day basis, reflects the priority which Moroccan women give to family and household responsibilities. Both in childcare and the care of the elderly, Moroccan immigrants grant the family a central role. Looking after a child is a responsibility that should fall on the family, and mainly on the mother. But the mother's role in education is also stressed. In educating their children the Moroccans interviewed wish to pass down their cultural and linguistic heritage in accordance with Islamic principles and to instil values such as obedience, discipline, respect for their parents and older people. They see that these values are not being passed down in the crèches and schools of Italy.

Thus, Moroccan immigrants are somewhat resistant to using formal support services, mainly when the children are very young. The parents have less difficulty with using formal support services if it is for a relatively short time. However, leaving a child in an institution all day long is not acceptable, and is often seen as “*abandonment*”.

When it comes to care for the elderly, the Moroccan immigrants interviewed share the notion that “*children should take care of their parents*”. Taking an elderly person out of his family environment is actually regarded as immoral:

*“Yes, I think a child has to take care of his parents. Excuse me if I say something that, I saw a difference between Morocco, between a foreign country, let's say, and here: even if your papa or mamma is 120 years old, if he can't see, if he can't move, he always stays with his daughter or son, at home. Until they die. But that's everywhere – you never see somebody's parent left in a rest home, not when there are children [...] But here you even see people that aren't that old who go and stay in a rest home, even if they have children.”* (ITMF7)

The role of the family in caring for the elderly is therefore crucial as the possibility to use support mechanisms outside the scope of the family is clearly rejected.

If we look at the availability of informal support networks, we can see that the Moroccan immigrants' situation is similar to that of the Cape Verdean immigrants: most do not have access to them.

*“Here? No one. Really! I'm alone, do you understand? I take the bigger one, and he takes the baby. No one. I feel alone here, I find myself alone. If I were in Morocco, it would be different...”* (ITMF9)

*“Oh, in Morocco you have everyone around, really. It makes me want to cry when I think about it. In Morocco if you knock on one door, ten open for you: ‘Don't worry about it, I'll take care of it.’ Here, can I tell you the truth? Here, if you need somebody, there isn't anyone.”* (ITMF10)

Except in a few cases, the Moroccans do not have their parents in Italy. In addition, most of those who do have parents living in Italy cannot count on them to provide support for various reasons (the parents are physically dependent on them, live far away etc.). Furthermore, even though some Moroccans have other relatives like brothers and uncles living in Italy, nor are these perceived as being potentially available to provide support (because they work, have children, do not have time, and some of them need assistance themselves).

Both Moroccan and Cape Verdean immigrants state that in their respective home countries the situation would be different, because “there would always be someone” to take care of the children and the elderly.

There are no great contrasts with the surrounding society in values of Cape Verdean immigrants regarding the provision of care. In the Portuguese society, the family, especially the wife, is the main source of care for children and the elderly. The generally adopted ideal is that a child should remain the first years of life at home with parents (Wall et al. 2001 and 2002). On the other hand, formal support services are valued as well by the Cape Verdeans as the Portuguese, in so far as they are seen as providing enriching experiences for the psychic and affective development of the children. Formal support for small children is therefore not rejected, and for some families it is a primary choice.

There is a slight difference between the Cape Verdean immigrants and the Portuguese people when it comes to looking after the elderly. In both groups there is a belief that the elderly should be cared for within the family for as long as possible. A nursing home is contemplated only if there are no alternatives (Wall et al. 2001 and 2002). However, while the Portuguese see a nursing home “the last resort,” the Cape Verdeans we interviewed were very reluctant or even refused outright to use one. This shows that they are less open to the use of formal services, especially institutional care.

Turning to the average profiles of the Moroccan immigrants selected in Italy, one of the clearest social differences between them and the Italian population lies in the woman’s situation in relation to work: Moroccan women work part-time, for a few hours per week, or casually. Although there is still a fair number of Italian women who stay at home, this has been in decline. Moreover, when Italian women work they are, like Italian men, in full-time jobs. Part-time work is of little significance for the Italian population. In Italy the dual-earner model has nowadays been normalised and legitimated to a degree that even surpasses the actual numbers (Trifiletti et al. 2001, 2).

Most employed Moroccan women work as cleaners or maids and Moroccan men are mostly factory workers. Working conditions for Moroccan immigrants differ from those of the majority: they have unsocial working hours and their salaries are low. The Moroccan working population is generally younger than the Italian, and their accommodation is of a lower standard. However, there are fewer if any differences in terms of average educational attainment levels. The prevailing model for the conjugal division of labour among Moroccan immigrant families is the “attenuated male-breadwinner” model, which is not the prevailing model in Italy generally. The status of the Moroccan woman is correspondingly more subordinate to the husband and to the family than in Italy in general.

There is some common cultural ground between the Moroccan immigrants and the Italian society: the prevailing family organisation is the “couple with children,” based on marriage. Lone-parent families, blended families, and cohabiting couples are not very significant in the Italian society (Sabbadini 1999). On values regarding the provision of care, the Moroccans we interviewed and the Italians generally agree on the core role of the family, especially the wife, in the care of children and the elderly.

However, the Moroccan immigrants seem to grant the family a greater responsibility in children’s education than most Italians do. For them, looking after and educating a child, especially in the early years, are primarily family responsibilities, placed mostly on the mother, in accordance with the ideal of “*the mother always present*” (beside her children). Accordingly, Moroccan immigrants value the educational role of formal services for young children less than Italians do in general.

As well the selected group of Moroccans as the Italians generally see the family (mainly the adult children) as being important in the care of the elderly. For the former, however, a nursing home is never justified. This flat refusal is not found among the Italians generally, as they do not totally rule out a nursing home, even though they consider using it only when there is no alternative.

Both the Cape Verdeans and the Moroccans have a strong ethnic identity. In overall terms they are both very different from their host societies. The Cape Verdean immigrants are different in social and racial terms, while the Moroccan immigrants are different in social and cultural terms.

The woman plays a key role in the provision of care for children and the elderly in both immigrant groups. It is them who are mainly responsible for providing the care. Except in a few cases, the men take no regular part in care arrangements, either for practical reasons (unsocial working hours) or for cultural reasons. However, the Cape Verdean woman is very different from the Moroccan woman. The former is at the same time a mother/carer as well as a worker and a breadwinner, while the latter is mainly a mother/carer, a housewife and an educator, in a subordinate position to her husband who is “the head of the family” and “the breadwinner”.

Table 13. Care arrangements in the samples of Cape Verdean and Moroccan immigrant families

Care arrangements of Cape Verdean families	Care arrangements of Moroccan families
<i>In childcare</i>	<i>In childcare</i>
<i>Family care arrangements</i> <ul style="list-style-type: none"> <li>• Grand-parental care (6 cases)</li> <li>• Older child care + formal care/childminder (1 case)</li> </ul>	<i>Family care arrangements</i> <ul style="list-style-type: none"> <li>• Mother-centred care (15 cases)</li> <li>• Grand-parental care (3 cases)</li> <li>• Shared parental care (3 cases)</li> <li>• Older child care (2 cases)</li> </ul>
<i>Formal care arrangements</i> <ul style="list-style-type: none"> <li>• Extensive formal care (4 cases)</li> </ul>	<i>Formal care arrangements</i> <ul style="list-style-type: none"> <li>• Extensive formal care (1 case)</li> </ul>
<i>Informal care arrangements</i> <ul style="list-style-type: none"> <li>• Paid childminders (3 cases)</li> <li>• Unpaid neighbour support (1 case)</li> </ul>	<i>Informal care arrangements</i> <ul style="list-style-type: none"> <li>• Restricted formal care + paid/unpaid informal care (2 cases)</li> </ul>
<i>Care arrangements with leaving children alone</i> <ul style="list-style-type: none"> <li>• Restricted formal care + older child care + leaving children alone (5 cases)</li> <li>• Restricted formal care + work-place care + leaving children alone (2 cases)</li> <li>• Restricted formal care + leaving children alone (1 case)</li> </ul>	-
<i>In care of the elderly</i>	<i>In care of the elderly</i>
<i>Family care arrangements</i> <ul style="list-style-type: none"> <li>• “Hands-on” family care (1 case)</li> <li>• “Hands-on” family care + paid neighbour supervision (1 case)</li> <li>• Family supervision (1 case)</li> </ul>	<i>Family care arrangements</i> <ul style="list-style-type: none"> <li>• “Hands-on” family care (2 cases)</li> </ul>
-	<i>Care arrangements with self-care</i> <ul style="list-style-type: none"> <li>• “Hands-on” family care + part-time domiciliary services + self-care (1 case)</li> </ul>

The care arrangements of the Moroccan immigrants show that the women adjust their work patterns to the requirements of their care obligations (Table 13). This is particularly evident in the “mother-centred care” arrangement. By contrast, most of the care arrangements of the Cape Verdean immigrants reflect a strategy in which caring has been adjusted to the women’s occupations. There are two opposing care arrangement strategies here and this reflects the different ethnicity profiles of these two groups of immigrants.

Most Cape Verdean women, especially those of the first generation, find it more difficult to reconcile work and caring than do most of the Moroccan women. This has partly to do with the amount of time allocated to the job. In terms of average profiles, Cape Verdean women are full-time workers, while Moroccan women are part-time workers or “less than part-time workers.”

However, Cape Verdean women suffer from more severe stress than Moroccan women, even if only full-time workers are compared. The difference is mainly a result from the types of their working hours: Moroccan women who work full-time have usually normal working hours, whereas full-time working Cape Verdean women have unsocial or very unsocial working hours. In this context it is worth recalling that there are no cases of leaving children alone among our sample of Moroccan immigrants whereas there were eight such cases among the Cape Verdean immigrants.

Nevertheless, as we have seen, there are some pressures and problems that affect both the Cape Verdean and the Moroccan women. However, these problems do not derive directly from their care arrangements and the reconciliation of work and caring but rather from their situation as immigrants (racial discrimination, being passed over in social and occupational terms, difficulties with the host country language, etc.). In particular, bad or poor housing is a recurrent topic in the interviews of both groups of immigrants. This is an area where immigration policies should put more emphasis in.

Our analysis of the care arrangements of Cape Verdean immigrants showed that the formal state sector and the so-called “third sector” do not satisfactorily cater for the needs of those parents who work unsocial hours. Bearing in mind the results of various studies which have indicated that the number of this type of jobs in the European Union labour market is continuously increasing, state intervention can no longer continue to avoid these facts. If it does so, reconciling work and family life will depend exclusively on private means, which are not distributed in an egalitarian manner.

In relation to Moroccan immigrants, we would like to emphasise that Moroccan women’s relative lack of involvement in the labour market makes it difficult for them to integrate into the Italian society. They have major difficulties in communicating in Italian and these difficulties form a barrier to their full integration in the labour market and other areas of social life. This is another aspect which immigration policies should definitely look more closely at.

## **Immigrant families and childcare arrangements in France, Finland and the UK**

### ***France***

The French national sample comprises diversity with regard to countries of origin, types of immigration and social class of immigrant families. All of the couples have at least one member of African origin: some have come from the Mahgreb, others from West Africa and the rest from Central Africa. Differentiation of the sample is strongest, however, concerning the migratory pattern: some came seeking political asylum, many arrived as students, some came to join a French husband or other members of their family, only a few came as labour migrants. This diversity makes it difficult to consider these families as

belonging to a specific “immigrant community” (comparable to the Moroccan or Cape Verdean unskilled labour migrant families in Italy and Portugal).

The most common care arrangement in this group of immigrants is what we have called the “mother-centred” pattern (Table 14). Included are families who combine work and care for young children by cutting back, completely or partially, on the mother’s employment.

“Shared parental care” is a family arrangement which relies on sequencing care provided by both members of the couple (taking and fetching, being with the child after school or on Wednesdays). Another type of shared parental care is combined with care from an older child. It has a slightly more complex sequencing involving three carers. In the only case of this arrangement, the couple lives with three children of their own (aged 8 years, 3 years and 9 months) and a step-daughter aged 15 years who sometimes cares for the younger children.

Table 14. Childcare arrangements in immigrant families of the French sample

<b>Care arrangements of immigrant families in Rennes</b>
<p><i>Family care arrangements</i> (may be combined with standard formal care)</p> <ul style="list-style-type: none"> <li>• Mother-centred care (10 cases)</li> <li>• Shared parental care (2 cases)</li> <li>• Shared parental and older child care (1 case)</li> <li>• Live-in family member care (1 case)</li> </ul>
<p><i>Formal care arrangements</i></p> <ul style="list-style-type: none"> <li>• Standard formal care (no extras) (3 cases)</li> <li>• Extensive formal care (2 cases)</li> </ul>
<p><i>Care arrangements with leaving children alone</i></p> <ul style="list-style-type: none"> <li>• Formal care + leaving children alone (1 case)</li> <li>• Extensive formal care + leaving children alone (1 case)</li> </ul>

In “formal care arrangements”, the parents rely essentially on services provided by day care centres, schools or after-school care or activity centres as their main care strategy while working. In the French sample, the use of standard formal services (without “extras” such as “homework help” after school or activity centres on Wednesdays) usually concerns families with adolescent or pre-adolescent children.

The third and last caring pattern “Care arrangements with leaving children alone” concerns situations where formal care and family care are not sufficient to cover the caring needs of young children. “Leaving children alone” refers here to situations where young children (usually below age ten) are left on their own for certain periods of time because the parents find it difficult or impossible to find other solutions while recognising that the children are not really old enough to look after themselves.

Like other families, immigrant families that care for young children in Rennes face constraints in terms of financial resources, availability of services, working timetables, and support networks. All families have to deal with these factors but for immigrant families, the experience of immigration and the context in which it takes place (type of immigration, type of family and family/gender values, employment opportunities in the receiving society, etc.) shape the meanings and the forms of caring in specific ways.

Those who immigrated to marry (a French national) and to build a family give high priority to caring for young children, are more “family-orientated” and adopt a social care

pattern which stresses the role of the mother as the main carer. This is related to the immigrant mother's marginal position in relation to the labour market of the receiving society. These women are more protected from economic difficulties, from the total absence of kin networks (which exist on the husband's side) and the downward mobility of many labour migrant or refugee couples. However, they are constrained to a certain gender role inside the family, reinforcing a traditional gender socialisation. However, as the children get older, many of these women seek to alter their position and adopt new ways in combining employment and mothering.

Migration situations where one or both members of the couple have immigrated as students shape different patterns of work/family/caring lives. In couples where both have studied in France, the members of the couple are not only fairly well integrated culturally and socially but also have more similar positions/qualifications with regard to the labour market and the breadwinner role. The meaning and forms of social care thus shift toward a more varied combination of approaches to balancing work and social care, much closer to the prevailing "reconciliation models" of the receiving society. In some situations these are combined with strategies used by women in the country of origin – a family member, such as a sister or a cousin, who lives in the household and helps in caring and household tasks.

Asylum seeker families have more problems in organising their care arrangements. During the first years after immigration, there are strong economic constraints due to long periods of waiting for legalisation, followed by entry into low paid, unqualified jobs. Those who had previous qualifications may have to struggle to train and work at the same time, a problem that puts extra strain on the amount of time available for caring. Women will sometimes be obliged to stay at home unemployed either because they are not legalised or because priority is given to the husband's employment or training. If they are lone parents, they may have to juggle training, work and caring at the same time. Legalisation, housing, work and training to get a better job — in other words the elementary steps toward establishing a "normal" life in a new society — will be family priorities. In such a situation, care arrangements have to adapt to these priorities rather than the other way round. Children may have to contribute to this effort by becoming autonomous, helping out as soon as they can or staying alone with no one to care for them.

### ***Finland***

The Finnish national sample includes two main countries of origin: China (13 families) and Estonia (14 families). As in the French sample, however, there is considerable diversity with regard to types of families and migration patterns. In some families both members of the couple are immigrants, in others only the wife (mixed couples). Some immigrants came as labour migrants, others came to study or to take up highly qualified jobs, and many Estonians label themselves as "returning migrants". This diversity makes it difficult to look at immigrant families in Finland as a whole or to compare caring strategies between Chinese and Estonian immigrant families.

The most common work pattern adopted by the Chinese immigrant families of the sample is full-time work for both parents. Their most usual caring strategies combine standard formal care with support from one of the parents in terms of fetching, taking and being with the child in the afternoon when day care/school finishes (Table 15). Day care or school combined with "support from the father" takes place when the father has more time either because he is temporarily unemployed or waiting for a job or because his timetable is more adjusted to the day-care/school timetable.

Table 15. Childcare arrangements in Chinese immigrant families of the Finnish sample

<b>Care arrangements of Chinese immigrant families*</b>
<p><i>Family care arrangements</i> (may be combined with standard formal care)</p> <ul style="list-style-type: none"> <li>• Mother-centred care (1 case)</li> <li>• Father support + standard formal care (3 cases)</li> <li>• Mother support + standard formal care (3 cases)</li> </ul>
<p><i>Formal care arrangements</i></p> <ul style="list-style-type: none"> <li>• Standard formal care (no extras) (1 case)</li> <li>• Extensive formal care (2 cases)</li> </ul>
<p><i>Informal care arrangements</i></p> <ul style="list-style-type: none"> <li>• Childminder (1 case)</li> </ul>
<p><i>Care arrangements with leaving children alone</i></p> <ul style="list-style-type: none"> <li>• Standard formal care + care by an older child + leaving children alone (1 case)</li> </ul>
<p>* Interview n° 3 is not included in the table because the interviewee's wife and child live in China.</p>

Leaving a young child with a childminder is another solution. There is only one case in the Finnish sample but some other interviewees underlined their preference for such solutions. Many of the Chinese families actually have had difficulties in obtaining information on existing services (because there has been little information available in English).

The last caring pattern “care arrangements with leaving children alone” concerns situations in which formal care and family care are not sufficient to cover the caring needs of young children (defined here as children aged ten or under). In Finland, however, there seems to be some social acceptance of this practice. Although day care centres for children under seven are open until five in the afternoon, schools have short hours for 7-8-year-olds, from eight or nine to twelve o'clock or one pm. Afternoon clubs may or may not be available and may or may not be used by families. In practice, this means that some children over age seven spend the afternoon on their own.

In summary, we have a small number of Chinese immigrant families but strong diversity in terms of immigration and how it shapes family/work life and care arrangements. Apart from the only mixed marriage migration case, we can identify three other migration patterns.

Short-term professional family migration concerns families with high educational qualifications (both members of the couple, often engineers) who came to work or to work and study at post-graduate courses at the same time. Their needs for care services are multiple due to the couple's strong involvement in professional life. These families were very keen to learn more about existing services (afternoon clubs, babysitting services, etc.).

A second profile seems to be closely associated with the professional migration of single persons followed by, some years later, marriage with Finns. These two Chinese women (one a physicist, the other a biologist) are now in Finland to stay and they are integrated in the Finnish society. They speak Finnish, have highly qualified jobs, use Finnish day care or childminder services and are less isolated in terms of social networks.

With regard to labour migration, we only have three cases and their family trajectories are rather different (two interviewees emigrated as single persons and the third one came to

join her husband who had found work in Finland). Nevertheless, all three cases seem to portray some common vulnerabilities and constraints that contrast sharply with the highly qualified Chinese immigrant families already described.

Table 16. Childcare arrangements in Estonian immigrant families of the Finnish sample

<b>Care arrangements of Estonian immigrant families</b>
<p><i>Family care arrangements</i> (may be combined with standard formal care)</p> <ul style="list-style-type: none"> <li>• Mother-centred care (2 cases)</li> <li>• Shared parental care + standard formal care (1 case)</li> <li>• Mother support + standard formal care (2 cases)</li> <li>• Older child care + standard formal care (2 cases)</li> </ul>
<p><i>Formal care arrangements</i></p> <ul style="list-style-type: none"> <li>• Standard formal care (no extras) (2 cases)</li> </ul>
<p><i>Care arrangements with leaving children alone</i></p> <ul style="list-style-type: none"> <li>• Childminder + shared parental care + leaving children alone (1 case)</li> </ul>

When we take a closer look at the Estonian immigrant families, we find that many of the immigration trajectories of the so-called “returning migrants” are linked to economic migration. Living and working conditions in Estonia, prior to emigration in the late 1980s and early 1990s, were bad. Run-down, overcrowded houses, lack of basic amenities such as running water, families living in “rooming houses” provided by the factory, low-paid jobs and unemployment, these are the images that make up the family and work background of many interviews. The late 1980s and early 1990s introduced new opportunities like the fact that immigrants with Finnish roots became considered as “returning migrants” and given a more privileged access to Finland. Although many label themselves as “returning migrants”, none of them had ever lived in Finland before the immigration. Thus, in practice, they are first generation migrants and usually have few or no other family members living in Finland.

Specific types of care arrangements for small children are difficult to construct as within the Estonian family sample, we have only eight interviews of families with children below age 12. In these families, childcare is organised mostly around family care. The two further cases (with standard formal care) included adolescent children.

Once again, the mixed marriage migration pattern stands out quite distinctly in the case of two families. It is clearly associated with the “mother-centred” care arrangement that tends to develop into a combination of formal care and “mother support” when the child approaches school age. Furthermore, the sample includes some cases of lone mother economic migration. By immigrating, they wanted to “get a fresh start” but that is not always easy. Some have remarried with a Finnish man.

We can see that the experience of immigration and the family trajectory in the receiving country have a considerable impact on the way immigrant families organise their care arrangements. As “returning migrants”, these Estonians have had some advantages over other economic immigrants who move in order to work in a foreign country (such as the Moroccan or Cape Verdean immigrants). From the point of view of ethnicity, the cultural (namely the language) and racial contrasts are not very strong. The Finnish immigration authorities also provide “Ingrian Finns” with considerable support regarding social

housing, social benefits and training courses followed by subsidised employment. These measures act as a buffer even if these people do not always avoid difficulties in accessing the labour market and its low qualified sectors of employment. Marriage to a Finnish national, on the other hand, also serves as a kind of buffer. The Estonian women in “mixed couple” families tend to take up the long parental leaves and part-time work more frequently than, for example, the Chinese economic migrant families or mixed couples.

Overall, the most vulnerable situation in the sample of Estonian immigrant families was the one that brought together low qualified migration and lone parenthood. Resources (networks, time, money) were low and pressures to work in order to set up a better life and to keep a job were strong, meaning that childcare had to be adapted to work needs.

### ***United Kingdom***

The UK national sample reflects the multi-cultural mix of immigrants who came to the Southeast of England in the 1980s and 1990s as labour migrants, students, highly qualified professionals or as a certain type of “returning” migrants (British citizens born abroad returning to the UK as young adults). Many of the couples or lone parents are Asian, some are mixed Asian and other non-European countries (one mixed Asian and a European country), others are European and the remaining ones are mixed British and other countries.

As in France or in Finland, this diversity makes it difficult to consider these immigrant families as belonging to a specific immigrant community, but it allows us to carry out an exploratory analysis based on the different types of immigrant families.

One of the most common caring solutions is the “mother-centred” arrangement (Table 17). Included are families who combine work and care for young children by cutting back partially on the mother’s employment/study hours. “Shared parental care” is another family arrangement that relies on the sequencing of care provided by both members of the couple. As in many other countries, it is mainly nurses and other workers of the health sector who use this solution. Second generation immigrants are more likely to have a family support network (primarily “grandparent support”) and this has an important influence on the care arrangement.

Table 17. Childcare arrangements in immigrant families of the UK sample

<b>Care arrangements of immigrant families in Kent/UK</b>
<p><i>Family care arrangements</i> (may be combined with standard formal care)</p> <ul style="list-style-type: none"> <li>• Mother-centred care (6 cases)</li> <li>• Shared parental care + standard formal care (2 cases)</li> <li>• Mother support + standard formal care (2 cases)</li> <li>• Grandparent support + standard formal care (1 case)</li> <li>• Workplace family care (1 case)</li> </ul>
<p><i>Formal care arrangements</i></p> <ul style="list-style-type: none"> <li>• Extensive formal care (7 cases)</li> </ul>
<p><i>Informal care arrangements</i></p> <ul style="list-style-type: none"> <li>• Live-in domestic helper + formal care (2 cases)</li> </ul>

In “formal care arrangements”, parents rely essentially on services provided by nurseries, schools, pre-school and after-school facilities. In the French and Finnish immigrant families, we found many families with children over ten (sometimes younger) using standard formal services (with no extras) who allowed children to go independently to and be alone after school. In the UK, on the contrary, there seems to be concern about letting children come and go alone, mainly because it is not considered safe and also due to disapproval of “latch-key” children. Moreover, in the UK it is formally illegal to leave a child under age 12 alone at home. Parents’ and grandparents’ support in taking and fetching the children is thus considered necessary. This may in part explain why we have no cases in the UK sample of “standard formal care” with no family support before and after school hours.

Therefore, the most common pattern of formal care is “extensive formal care” whereby families combine the use of standard formal services with other services — such as breakfast clubs and after school clubs — or use private facilities that have longer opening hours. The immigrant families who have this kind of “extensive formal care arrangements” have an average or high income level and are linked to immigration trajectories of highly qualified professional migrants or migrants who have acquired training and graduate/post-graduate qualifications in the UK.

The third and last caring pattern “live-in domestic helper” concerns two middle class families (a Malaysian couple and a mixed Malaysian/Mexican couple) who both have a live-in domestic aid from Malaya. In both families, the domestic helper fills the caring gaps in the middle of the day as well as before and after school/play-school.

In summary, there is some diversity in the caring patterns of these families and they are shaped to a great extent by the migration situation, the level of resources (economic as well as family support networks), the family’s division of paid labour and existing school and care facilities.

### **Immigrant families and care arrangements for elderly persons in Finland, France and the UK**

In the Finnish, French and British samples there were some immigrant families with caring responsibilities for elderly relatives. An example of possible difficulties in this kind of a situation is provided by an Estonian lone mother who has an aged mother living in Estonia. She goes to help her mother at least once a month and also supports her financially. She has been trying to bring her mother into Finland for six years without success, without getting permission from the Finnish immigration authorities. This type of situation creates tensions for many immigrant families, as in many European countries the right to family reunion does not include elderly parents. When these elderly people need care on a regular basis, family networks find it very difficult to respond to their needs due to the impossibility of bringing them to the host country.

In those immigrant families that had the elderly relatives living in the host country, the organisation of care arrangements depended on combinations of the following factors: working hours, family income, geographical nearness between home and workplace and availability of informal support, particularly from other family members. As in Moroccan and Cape Verdean families, family obligations to care for elderly parents were strong and in these families it was mainly the women (daughters) who took on the responsibility for caring. Family care was the main solution adopted and it was strongly valued. This led to some reluctance, in particular in some Mauritian families living in France, to consider placing the elderly person in a nursing home.

However, in contrast with the negative combination of the above mentioned factors in the Cape Verdean families (unsocial working hours, very low income levels and lack of unpaid informal support), the Estonian and the Mauritian families had a more positive combination of factors, making the reconciliation of work and caring easier to implement. Their working hours were usually typical or flexible, some extra informal support was often available (from sisters, cousins, daughters) and medium incomes allowed the occasional use of some form of paid care (for example, hospital care for two weeks so that the main carer can have a holiday).

#### 3.6.4. Summary of main results

Our main research question in this workpackage was “how do immigrant families balance paid work and family care responsibilities, primarily for young children?” In this respect the findings show a great diversity of caring strategies. We can divide them into five main types: (1) extensive delegation, (2) mother-centredness, (3) negotiation inside the family, (4) father-centredness and (5) leaving children alone. The two first types were predominant in our sample while the other ones emerged in certain types of immigrant families.

Results from the five countries also allow us to distinguish several migration patterns: (1) mixed marriage migration, (2) student and/or qualified professional migration, (3) asylum seeker migration, (4) labour migration and (5) returning migration. An important finding is that certain types of migration patterns seem to be associated with certain types of caring strategies.

In the unskilled labour migration pattern, the work/family life balance and caring strategies are based either on low cost extensive delegation and leaving children alone or on individual solutions and mother-centredness (the mother cutting her working hours). On the other hand, the work/family life balance in skilled professional migration puts the emphasis on medium/high cost extensive delegation (formal services and live-in helpers) and mother support (centred on the mother but she does not cut her working hours). In the student migration pattern (in which both members of the couple are currently studying/working and belong to the same ethnic group), the balance between work and family life is achieved through extensive formal delegation and in some cases through shared parental and familial care. Instead, the mother-centredness strategy is predominant in mixed marriage migration. Finally, the work/family life balance in asylum seeker migration is rather similar to unskilled labour migration.

In summary, like other families, immigrant families who care for young children face constraints in terms of financial resources, availability of care services, work timetables, marital negotiation of gender roles and support networks. Our previous workpackages have shown that all families have to deal with these factors but for immigrant families, the migration pattern and the experience of immigration, as well as the family and societal context in which it takes place, have a strong impact on caring responsibilities and solutions.

Another issue is to discuss how policies might alleviate the pressures that immigrant families experience when they try to manage work and family simultaneously. As immigrant families continue to flow into the European countries, policy-makers often ask whether existing policies are successful in “integrating” migrant families. However, they rarely question whether policies are successfully supporting the duality of work/family obligations of immigrant families and whether more could be done in this respect. The effects of work/family problems on the lives of second generation immigrant families are also rarely questioned.

The qualitative study of this workpackage allows us to understand some of the problems and dissatisfactions experienced by immigrant families. It is important to mention the following problems: (1) the absence of sufficient collective structures (even if the coverage of care provision varies significantly between the countries, our interviews showed that in all five countries the most vulnerable immigrant families — unskilled labour migrant families, lone parent families and refugee families — experience the most significant problems); (2) the absence of accessible information on care provisions in the receiving country; and (3) social and cultural integration difficulties of immigrant families, in particular of unskilled labour migrant and asylum seeker families, especially during the first years after arrival in the host country (language barriers, housing problems, low paid and atypical working hours, social isolation, discrimination in the labour and housing markets and in school).

For more details of the workpackage on the care arrangements of immigrant families, see [SOCCARE Project Report 4](#) and the national reports on [Finland](#), [France](#), [Italy](#), [Portugal](#) and [the UK](#).

### **3.7. Care arrangements in “double front carer” families (Workpackage 5)**

This workpackage is mainly based on an analysis of interviews conducted in the preceding three workpackages of the SOCCARE Project. These interviews have been supplemented, however, by additional interviews aimed specifically at collecting information on the special challenges some families face in confronting care responsibilities on “two fronts”: the care of children, and the care of elderly relatives. Research work in the workpackage was co-ordinated by the Italian project partner.

The project originally planned this workpackage to be a targeted study on the situations of those 4-generation families that we had already interviewed in the earlier workpackages. In the beginning of the research project, we had identified this family type as being at the forefront of the new transformations in family structures. Our research interests evolved with each wave of the study, however. Due to this reorientation process that is described in the following, the workpackage was redirected to study “double front” care situations that are seen actually to be more usual in three-generation than in four-generation families.

#### **3.7.1. Multi-generation and “double front carer” families in Europe**

Because of longer average life spans, four-generation families have become a statistically more frequent phenomenon throughout Europe. However, what this trend might mean for the future, especially in terms of intergenerational equity, has been puzzling researchers for nearly twenty years (Laslett & Fiskin 1992). These researchers, worried about the possible social ramifications of this transformation, also acknowledge that knowledge in this field is still far too limited (Rossi 1993).

Despite the relative lack of specific information on these transformations, it seemed that one would be able to trace, merely from the increased number of years in which more generations of the same family co-exist before being separated by death, a necessary redefinition of the expectations concerning the “normal” life course of family members. Such a shift would in turn alter the relations among them (Hagestadt 1982; Facchini 1992; Attias-Donfut & Renaut 1994). In addition, we would expect that the co-existence of many generations would also affect the timing of the transfer of resources between generations. Furthermore, the older generations’ expectations of support might change. Indeed, the image of old age itself might alter (Bengtson 1993, 5, 21).

However, it was already clear from Workpackage 2 and the first wave of interviews with lone parent families that the mere existence of four generations — whether they live together or not — does not by itself necessarily produce discernible patterns of behaviour in daily life. Above all, the mere existence of four generations proved to provide little basis for predicting the form of support that is actually exchanged among family members.

Instead, the demographic features driving the phenomenon were confirmed in our data. The growth of four-generation (and five-generation) families is highly correlated with the average age of women at the birth of their first child. In Portugal, where the average age of mothers at first childbirth is the lowest in the EU, less than 25 years, 15 cases of four- or five-generation families were identified in the national samples of the three previous workpackages. These types of families exist not only in countries where it is common for diverse generations to live together or near each other, as in Portugal, but also in countries such as Finland, where, in contrast, it is very rare for elderly parents and their married children to live together. In Finland household exit and autonomy from the family usually happen at a young age: only 8% of Finns between the ages of 25 and 29 still live with their families of origin, compared to 17% of their peers in the UK and 18% in France. In

Portugal and Italy, young people demonstrate an opposite tendency, with 52% and 59% of the age group still living with their parents. However, though we had expected to find a fair number of multi-generation families in Italy where residential proximity is the rule and extended families are common, in reality they were rare within our samples. Nevertheless, in Italy where women have fewer children and at an older age than in Finland, there are overall fewer four- and five-generation families.

It was a challenge for all national project teams to include, as was requested, a certain quota of four-generation families in each workpackage. However, we found it to be no coincidence that this was especially difficult to achieve in Italy and France. At the same time, it was very clear to us that the many families of four and even five generations in Portugal (15 cases) and Finland (12 cases) had little in common. While the Portuguese families usually could be characterised by a certain amount of residential proximity, the various generations of Finnish families were instead so spatially dispersed that their relations were often sporadic at best.

In only two cases of the 12 Finnish families the oldest generation was regularly assisted by the middle generation. Even then, this care was not necessarily provided by the same person who cared for the youngest generation. In one case it was the great-grandmother herself, along with the grandmother, who took care of the great-granddaughter from the last generation. In other cases, we saw irregular care provided by the older generations (who often lived hundreds of kilometres away) or no substantial exchange of care at all. This naturally reflects the patterns of residential autonomy exhibited by the very old in Finland, which on the basis of the Europanel is the highest in Europe (42% of men and 80% of women above the age of 75 years live alone), as well as the relative generosity of its welfare system. Portugal, the other extreme of our five countries, reflects the second lowest level of elderly autonomy in Europe: only 16% of men and 33% of women over the age of 75 live alone. In Italy 22% of men and 69% of women, in France 22% of men and 59% of women and in the UK 30% of men and 58% of women over 75 live alone (Eurostat 1999).

Though the relatively lower number of years between each generation is a feature that favours multi-generation relations of care, it may be counter-balanced by the younger average age of elderly people in Portugal, who may be less needy than their generational counter-parts in other countries.

As a result, neither the residential proximity nor the smaller age gaps between generations necessarily produce a high concentration of caring demands on the middle generation. For example, most of the 15 Portuguese four-/five-generation families did not see any appreciable exchanges of assistance — except when the help, mainly of an economic nature, flowed from the oldest generation directly to the lone mothers whom we interviewed. In these cases, the support provided by great-grandparents substituted for the support that had been withdrawn by the mothers' own parents because of disagreements or conflicts.

Contrary to our expectations, an overload of caring demands on one specific generation did instead emerge in the UK, where we usually assume relatively weaker networks of family solidarity. Importantly, however, it was not the “sandwich generation” between the oldest generation and the parents of small children that was the most heavily burdened in four-generation families. Instead, it was the lone mothers themselves who had to provide care on two fronts at the same time: on the one hand, to their own children and on the other, to their grandparents. These mothers tended to “skip” a generation in a way that is probably characteristic of their situation. In three of the seven four-/five-generation families in the British sample, the lone mother had broken off relations with her own parents while sustaining a more or less demanding care relationship (in one case

cohabiting) with her maternal grandmother, with whom she had never broken off. We saw at least three similar cases in Portugal, as well as one or two among the five Italian four-generation families but in these latter cases, care flowed in the opposite direction.

These observations led us to believe that, compared to earlier studies on intergenerational solidarity made predominantly in Anglo-Saxon countries, the family networks in the Mediterranean countries may have a greater capacity to redistribute the burden of care. As a result, the generation responsible for small children is spared from the obligation towards the oldest generation, and vice versa.

In recent years a series of studies conducted in various European countries both in and outside of the Mediterranean area have clearly demonstrated the new centrality and generosity of elderly grandparents who are still in good health (“the young-old”) (Attias-Donfut & Segalen 1998).

Moreover, in the mean time, the results of Workpackage 3 on dual-career families demonstrated that there is a much greater likelihood of finding extremely old, physically dependent individuals in three-generation families with post-adolescent or adult children than in four generation families. Only Portugal was a partial exception from this rule. There, because of narrower age gaps between the generations, very young children can also be found in multi-generation families with dependent elderly members.

Indeed, in all five of our project countries the most problematic situations for double-burdened caregivers were seen most frequently in families with three generations, rather than in families with four or five generations. In fact, the mere effect of the verticalisation of the kinship network often means that the four-/five-generation families are richer in personal resources (Laslett et al. 1993).

### 3.7.2. The sample of families with dual care responsibilities

In this workpackage, we used two samples. (1) First, we gathered all “double front carer” families from our original samples from the three previous workpackages. This reconstructed sample has altogether 100 cases (24 from Finland, 12 from France, 27 from Italy, 8 from Portugal and 29 from the UK). In practice, the data from this sample includes English-language synopses (1-2 pages each) from each of these 100 interviews.

The “double carer” was in a subordinate worker position in two thirds of these 100 cases (Table 18). Only 10 were in a professional position and 8 were free-lancers or in a semiautonomous position. Thus, in the light of our sample, it is rare that people can combine dual caring responsibilities with a professional career. Part-time workers (34 cases) are almost as numerous as full-time workers (43 cases). Furthermore, it is even more distinctive that there are only 15 people with irregular working hours against 62 persons with regular working hours. This situation is in stark contrast with other families in our samples. For example, irregular work schedules were much more usual for lone parents. The absolute majority of “double front carers” of our data work (full-timely or part-timely) in a subordinate position with regular working hours.

(2) From this larger sample we chose 66 families where both “care fronts” were in a very active phase to be studied in more detail. From these interviews, full transcriptions were made. This primary data was analysed in a co-ordinated way by the Italian project team that was responsible for the work in this workpackage. The English (5), French (12), Italian (22) and Portuguese (8) transcriptions were written and analysed in their original languages but the Finnish (19) transcriptions were first translated into English.

Table 18. Work arrangements of all “double front carers” of the total sample

Work	Regular working hours				Irregular working hours				Weekly working hours not available/ not possible to define		TOTAL	
	Full-time		Part-time		Full-time		Part-time		Men	Women	Men	Women
	Men	Women	Men	Women	Men	Women	Men	Women				
Employees/ Subordinate Workers	1	32	-	23	-	2	-	3	-	5	1	65
Semiauto- nomous collabora- tors/ Free- lancers	-	-	-	-	1	-	-	6	-	2	1	8
Profes- sional Workers	1	3	-	1	-	2	-	-	-	5	1	11
Seasonal/ Occasional Workers	-	-	-	1	-	1	-	-	-	-	0	2
<b>Sub total</b>	<b>37</b>		<b>25</b>		<b>6</b>		<b>9</b>		<b>12</b>		<b>89</b>	
Not working at the moment of the interview	Men								Women		<b>11</b>	
	-								11			
<b>TOTAL</b>												<b>100</b>

### 3.7.3. Main findings of the workpackage

#### *Types of double front care arrangements*

We distinguished five main types of caring patterns in double front carer families:

1. Light care involvement on two fronts;
2. Care involvement of the classical “sandwich generation”;
3. Medium or heavy double front of care;
4. Periodical or organisationally difficult double front of care;
5. Very heavy double burden of care.

These five patterns were identified on the basis of the following two main criteria:

- the position of the family in the phase of the life course
- the organisational constraints deriving from the type of needs children and elderly present (age, health status) or from geographical distance/difficult transportation

conditions. In a sense this dimension is intended to measure how much the two fronts of care present simultaneous requests.

Both of these two dimensions were intended to be independent from 1) subjective interpretations of the care burden and 2) the different formal and informal care resources available to share the task. Next, each of these five types is described and explained.

### ***1. Light care involvement on two fronts***

This type of care arrangement is characterised by a weak level of involvement of the main caregiver in the daily care of the elderly person(s). S/he is usually much more involved in the care of her/his small children. Even if s/he calls the older person(s) every day for emotional support, s/he usually does not visit more than once or twice a week. Elderly members of the family still live independently either alone or as a couple, even if one partner of the elderly couple is already dependent on care. However, the elderly household needs external support for mobility outside the home (e.g., for medical controls). The caregivers are usually aged from 35 to 45, except when the main caregiver is a grandchild. The whole sample includes 24 cases of this type of care arrangement but as these are not specifically demanding situations, only 4 interviews of this type have been transcribed and analysed more closely (Tables 19 and 20).

Table 19. Types of double front care arrangements, whole sample

	<b>France</b>	<b>Finland</b>	<b>Italy</b>	<b>Portugal</b>	<b>United Kingdom</b>	<b>Total</b>
<b>Light care on two fronts</b>	3	4	5	1	11	<b>24</b>
<b>Sandwich generation</b>	4	6	3	-	4	<b>17</b>
<b>Medium or heavy double front</b>	-	4	6	3	3	<b>16</b>
<b>Periodical or difficult burden</b>	2	5	4	1	7	<b>19</b>
<b>Very heavy double burden of care</b>	3	5	9	3	4	<b>24</b>
<b>Total</b>	<b>12</b>	<b>24</b>	<b>27</b>	<b>8</b>	<b>29</b>	<b>100</b>

### ***2. Care involvement of the classical “sandwich generation”***

In this care arrangement type, the main caregivers (aged over 48) take care of a dependent elderly relative or a very dependent spouse and of grandchildren, even if this is not on a strictly daily base. Their adult children may sometimes help and support through a form of partial reciprocity. In Southern Europe, this type has a subtype where the care of an adult family member (usually elderly parent or disabled spouse) is combined with

responsibilities towards own grown-up but not yet autonomous children. The whole sample includes 17 such cases and almost all of them (14) have been transcribed.

### **3. Medium or heavy double front of care**

In this type of care arrangement, the elderly member of the family needing care does not (any more) have a partner. S/he needs more help in everyday life and either lives alone, cohabits with her/his daughter or son's family or lives in a sheltered home, still requiring an almost daily supervision by the main caregiver. Age of the caregiver is a bit higher than in Type 1 (37 to 54 years).

A subtype can be seen in migrant families coming from cultures where older people commonly cohabit with their sons. The main caregiver, usually a daughter-in-law, is therefore younger (24–41 years) than in other families belonging to this type. Some caregivers are young because they are grandchildren of the elderly people. Within the sample, there are 16 families in this kind of a situation and 12 interviews have been transcribed.

### **4. Periodical or organisationally difficult double front of care**

In this care arrangement type, difficulties in organising mobility are a characteristic feature. A dependent elderly person or couple may need care on either on a daily basis, requiring tiresome daily journeys of several miles, or requiring periodical long-distance journeys. The latter case involves the absence of the main caregiver (aged 42 to 63) from her/his own family for several days. In this case, children are not any more very young and may actually sometimes help. This type of care arrangement also includes some families where a dependent elderly person spends short periods at the home of the caregiver, sometimes sequencing her/his care and dividing it among several children. The sample includes 19 families belonging to this type. 12 interviews have been transcribed for further analysis.

Table 20. Types of double front care arrangements, transcribed sample

	<b>France</b>	<b>Finland</b>	<b>Italy</b>	<b>Portugal</b>	<b>United Kingdom</b>	<b>Total</b>
<b>Light care on two fronts</b>	-	-	3	1	-	<b>4</b>
<b>Sandwich generation</b>	4	5	3	-	2	<b>14</b>
<b>Medium or heavy double front</b>	-	4	4	3	1	<b>12</b>
<b>Periodical or difficult burden</b>	2	5	4	1	-	<b>12</b>
<b>Very heavy double burden of care</b>	6	5	8	3	2	<b>24</b>
<b>Total</b>	<b>12</b>	<b>19</b>	<b>22</b>	<b>8</b>	<b>5</b>	<b>66</b>

### ***5. Very heavy double burden of care***

In this final type of care arrangement, young children, often from late births, have to be cared for at the same time with a very frail elderly person needing daily and often continuous supervision and care. This elderly person is usually cohabiting with the family or living next door. Ages of these caregivers were in our sample from 37 to 47, only in Portugal and in migrant families we could find younger carers. Younger ages of the main caregiver may be observed also in a subtype where the person needing care is a severely ill or disabled spouse. Together with Type 1, this care arrangement type is the most usual within our sample. All of these 24 interviews have been transcribed and analysed.

#### **Trajectories towards the double front of care**

Independently of the level of care demanded by the “double front”, four distinct patterns emerge in how caregivers have come to be responsible for their role.

##### ***1. Caregiver by default: “chosen” by the circumstances***

In these cases, speaking about a lack of alternatives does not mean that no alternatives actually exist. However, the existing alternatives are either not seen or they are found unacceptable by the caregiver. As a result, the caregiver (possibly together with her/his family) accepts, endures, and even perceives the care-giving situation as it is but never really makes a decision about it. It is instead the circumstances that decide. These circumstances might include physical or geographical proximity, whereby it is taken for granted that an occasional caregiver becomes the main caregiver. Families do not question this trajectory.

*“Because we live the closest. Whenever they have to go to the hospital, I always take care of it because my sisters live in Rennes, and since they both have jobs, they are not very available.” (FMC08DB)*

Accepting the role of an exclusive caregiver as the only possible alternative is an especially common situation for immigrants and only children as in these situations other family resources are often unavailable.

##### ***2. The “chosen” caregiver: caring on two fronts at the request of the elderly person***

In these cases it is the preference of the elderly family member that is decisive, despite other possible alternatives. An elderly person’s refusal to compromise and accept alternative care-giving arrangements is often connected to the image of involving strangers in her/his care. This reaction can be seen as a defence of what little autonomy the elderly person has left.

*“It is difficult to bring someone in whom she doesn’t know.” (FDB01)*

More explicitly, family members recognise the right of the old person to refuse institutionalisation in nursing homes and hospitals. However, if in addition to physical health problems, the elderly person suffers also from psychological disturbances, her/his demands to the carer may grow quite severe and unbearable.

##### ***3. The negotiated caregiver: caring on two fronts at the wish of others***

In this case, the main caregiver is “chosen” by other relatives who, though being present, are not involved or are only minimally involved in caring for the elderly relative. Unlike

with the first caregiver type who assumes her/his role for the lack of other alternatives, here it is understood that in this case the main caregiver is designated only after a certain amount of implicit or explicit negotiations with other family members.

Sometimes the final outcome of such negotiations is a smooth and peaceful transition based on “objective” circumstances such as personal affinity with one family member or personal conflicts with another, the ease with which the caregiver can reconcile the caregiving with her/his job, or particular family arrangements. In other cases, the agreement is made only after much discussion and compromise.

*“There are also my brother and my sister, but they aren’t involved. My brother lives in the Chianti and my sister is in Florence, but she works all day and doesn’t have much time to take care of mother. I work, too, but three days a week I work only in the mornings, and my mother lives alone and I call her to make sure everything is fine.”* (ITMC25DB)

#### **4. Choosing to care on two fronts: the voluntary caregiver**

Finally, some of the main caregivers we interviewed explained that they had freely (and sometimes happily) chosen to assume exclusive responsibility for their caring obligations. In these cases, the element of individual choice prevailed over all other factors.

*“I wouldn’t like to include any outsider in this, stirring things up. Since this has started to, this system of ours works well, so that, so that it feels that an outsider wouldn’t fit into this. As long as I’m healthy and my condition is this good.”* (FINSP13ADB)

In some extreme cases these caregivers end up leaving their paid jobs so that they can care better, for example, for terminally ill family members. In every case, the inevitability of caring for elderly family members, along with the specific negative connotations of formal “elder care”, restrict the range of options caregivers have in deciding how to meet the double front of care. These restrictions are not just logistical but above all highly symbolic. Here the difference between elder care and childcare is stark. With childcare, the support network is much richer in alternatives and back-ups, and care arrangements can shift without causing too much disruption to the family. In contrast, in care for an elderly relative the possible solutions seem to be reduced to two: *“I’ll take care of him/her myself”* vs. *“Someone else must take care of him/her”*.

In the case of care for an elderly person, to take on a care responsibility has often greater consequences for the individual autonomy of the carer. The situation often produces serious problems of reconciliation between paid employment and unpaid care work. In some cases it leads the caregiver to sacrifice a significant part of her/his personal and professional life. Furthermore, the extent and the duration of the caregiver’s obligation are not well defined beforehand but are instead wound up with the carer’s own sense of obligation and duty.

*“For her, I think it is the best solution but for us, it is the worst. But we also take into consideration that we still have many years to live, and no one knows how many she has. So we chose the best solution for her, thinking of her, not of us.”* (PMC01DB)

#### **Being a double front carer**

All of the families we interviewed had children and that is why we cannot observe the well-known carer role of unmarried daughters in our data. However, otherwise the classic hierarchy of care obligations that has been said to regulate “who does what for whom” in the care of elderly relatives (see, Qureshi & Simons 1987; Ungerson 1987) was regularly confirmed by our participants. In particular, the importance of the spouse and the adult

children (especially when they are living together with the older person) became highlighted. In addition, gender imbalances in care are also evident in our data, perhaps most clearly in the Portuguese cases, where sons tended to delegate the care of their own elderly parents to their wives. In several cases the caregiver had little choice but to understand the “legitimate excuses” of all the others (c.f., Finch & Mason 1993).

The quality of relationships among family members is of great importance because they heavily influence how the caregiver sees her/his role. Even if the caregiver cannot count on concrete help from other relatives, the stress and depression to which caregivers are subject seems notably reduced if they feel themselves surrounded by positive symbolic exchange. It is a major support to be embedded in a flexible kinship network where, if necessary, roles might change with the evolution of the disease.

*“I mean, my brother and sisters are up there, they are really good. My brother spends a lot of time with Mum and Dad, he keeps me informed of the true story. You get a made up one from Mum and Dad because they don’t want to worry you.” (UKMC08FU)*

The past and present relationship between the caregiver and the person being cared for is even more decisive. When the caregiver perceives that the difference between the needs and requests of the dependent family member and the resources available to meet those needs is too great, she/he may fall victim to a growing and unbearable sense of impotence. Such exhaustion manifests itself in various ways: physical reactions (chronic tiredness and insomnia), psychosomatic illnesses (allergies, eczema skin conditions, lowered immunity to illness), psychological difficulties (senses of guilt or inadequacy, low self-esteem, irritability), and behavioural problems (defensive attitudes towards others, detachment from relationships). Often, the caregiver is not able to see when the stress has become too great and that she should take a break.

*“It has been very exhausting, it’s been totally. I noticed it was so tightly scheduled already when, and especially, last summer when Mom was in one hospital and Dad in another, and mother’s affairs were so wrong as can be, and we couldn’t, we couldn’t make any sense of it and then it was actually so that I drove between the two hospitals, went home in between and dropped in at work, sometimes here and sometimes there. So that last spring and summer and fall, it was all such a big hassle [...] The work was waiting here, it didn’t go away and you couldn’t take days off for something like this or anything. So that everything was extremely tight [...] It was a feeling of huge hurry, hopelessly huge hurry and anxiety, they were the topmost feelings.” (FINMC21DB)*

Even the most motivated caregivers, when abandoned to themselves, eventually run out of energy. However, with the burn-out of the main caregiver a precious resource is lost. The amount of strain associated with caring obligations appears to be directly connected to the length of time (months, years) as with time, a caregiver is easily left with the impression that there is no light at the end of the tunnel.

The risk of burn-out or break-down becomes even higher when, in addition to genuine physical exhaustion, the caregiver is aware of the irreversibility of the degenerative illness like in the case of the Alzheimer’s disease. The inability of elderly persons to recognise their family members and their incomprehension of their own actions are two other major sources of mental strain that caregivers often describe.

Being a caregiver for a parent or a spouse radically changes the interpretation of the relationship. For couples, the relationship between the partners is transformed not only by the symbolic and material weight of finding oneself having to care for someone who up to then was completely autonomous and self-sufficient, but also by the required effort to learn new skills. These individuals discover that they have to invent a new role for themselves in relation to their own partner.

When a relationship between an adult child and his/her parent transforms into a care relationship, the change of roles may be even more challenging because it often takes the shape of an inversion of roles. Becoming “the mother/the father of your own father or mother” and being forced to watch the progressive deterioration of an ill parent requires adjustment and redefinition that can be extremely painful and exhausting. If most of the care burden falls on one person alone, the problems are amplified and the weight can become unbearable.

In these situations, the original quality of the relationship can be decisive. If the relationship has always been positive, it is more likely that the adult child’s sense of gratitude lightens the perceived weight of the care-giving responsibility. If, vice versa, the memories of the past are negative and remind of a relationship full of conflicts and difficulties, it becomes more problematic to take on the care-giving burden and it is lived with greater stress and displeasure. The relationship between the caregiver and the cared-for becomes tenser, and the probability of episodes of crisis and breakdowns becomes higher.

*“Yes, I’ve always had that sort of caring role but I do still find it difficult being in that role with my father. Because our background, our personalities and we’ve never got on particularly well. But at least I can detach myself emotionally from it more.”* (UKSP02FU)

From a social policy point of view, these accounts highlight the importance of recognising that, in addition to individuals with no family to care for them, there are also people with a family who nevertheless will not be helped by it. Some family members can not and others will not be available as main caregivers.

In conclusion, the importance of not being left alone as a caregiver should be highlighted. From an institutional point of view, this does not necessarily mean that the best response is economic support whereby taking care of family members becomes considered as a remunerated job. Rather, policies need to favour the conditions under which this care-giving work can be carried out in the best possible way. In other words, a positive balance needs to be constructed between costs and benefits for both the caregiver and the cared-for.

The type of external support most lacking seems to be support that helps the carer to withstand the stress associated with care and to understand when it is appropriate to help but also when it is needed to stand aside and share the responsibility with someone else. This last aspect is particularly difficult in those cultural contexts where the task of providing care represents a traditional family value and is experienced as an act of love and intimate duty. Cases of intensive caring whereby the sole caregiver provides around-the-clock attention are not unknown in our data. However, in the interest of the psychological and physical health of both the carer and the person being cared-for, this kind of situations should be avoided.

### **Networks of care**

In our sample, family care networks were composed of members from the family of origin, from the family by marriage and from the extended family. These are complemented by informal networks that are made up of friends, neighbours, volunteers, and domestic aids providing either public or privately paid services.

Table 21. Network types of double front carer families, whole sample

<b>NETWORK TYPES*</b>					
<b>NETWORK STRUCTURE</b>	<b>Family-based</b>	<b>Informal family + others</b>	<b>Mix: services + family</b>	<b>Mix: informal + services</b>	<b>TOTAL</b>
<b>Relatively extensive, rich, and polycentric</b>	5	6	8	13	<b>32</b>
<b>Specialised, centred on two caregivers</b>	2	3	2	5	<b>12</b>
<b>Minimal or absent network, loose couplings, strongly centred on one main caregiver</b>	15	10	17	14	<b>56</b>
<b>TOTAL</b>	<b>22</b>	<b>19</b>	<b>27</b>	<b>32</b>	<b>100</b>

\*Rich = more than the couple and at least 1 person out of the family.

Specialised = 2 main carers with others on the periphery of the arrangement. An example: 1 carer for everyday life, 1 carer for different tasks.

Minimum = 1 carer doing most of the care arrangement (more or less helped by the other adult or children) – usually a heavy burden.

Informal = family and neighbours and volunteers.

Services = public and private.

Above is a synthetic distribution of the network structures and network types we identified in our sample (Table 21). The first main type of networks in our sample is formed by those composed of “weak ties”, where the network is minimal or even absent and where care-giving falls on one person. This category includes more than half of our whole sample (56 families). Instead, the second main type has relatively rich and polycentric networks and it covers one third of our sample (32 families). In this case, the main caregiver, if there even is a one-and-only main caregiver, knows that she/he can count on other family members for practical assistance and second opinions. The number of cases where there is a specialised sub-division of tasks between at least two caregivers, with or without the support of services, was considerably smaller.

Of the family-based networks, 5 could be characterised as having relatively large, rich, and polycentric structures, while in contrast, 15 of them appeared quite weak, with loose couplings among members and care falling mainly on the shoulders of one, isolated caregiver. Among the mixed networks, composed of family members and aides either hired privately or provided through social services, 8 demonstrated relatively strong and polycentric structures, 2 demonstrated more specialised networks with care-giving centred on two members of the network with separate tasks, and in 17, the network could be characterised by its relative weakness and loose couplings, and by the overwhelming dependence on one main caregiver. Finally, the care-giving networks that depended on a

mixture of family members with non-professional assistance, or non-professional and professional assistance, were characterised either by centring on one or two primary caregivers (14 cases) or by having a richer network (13 cases).

### **Balancing the two fronts of care: children and the elderly and their possible relationships**

In all five countries included in the research, parents of small children did not find the need to provide care on two fronts to be an excessively demanding burden if the physical and emotional needs of their elderly family members remained within certain objective and subjective limits. In these situations, it was taken for granted that families would direct the most of their attention to caring for their children. It is only when the care demands of the elderly became more frequent and time-consuming, when they were in need of daily visits or even around-the-clock care that parents with small children began to feel unhappy with the care arrangement. In this kind of a situation, parents often experienced feelings of guilt for the time lost with their own children. However, in this respect, differences emerged among the five countries. Parents in the Southern Europe, and sometimes in France, seem much more likely to express feelings of regret and sadness about not being able to guarantee as much time to their children as they would like.

*“Well, there was a period when I was very busy taking care of my mother, and I really wasn’t there for them, and they saw her as an enemy: ‘You’re always at her house, you’re always with Grandma!’ They didn’t handle it very well, and then they don’t see her the way children usually see their grandparents [...] They don’t feel a lot of affection for her. To them, she’s just a very needy person, someone who takes me away from them and that’s all.” (ITDB04)*

*“What do I miss the most? Time. Time to stay with them without having to nag, without having to say ‘put your sweater on, take your sweater off, go wash up, hurry up, go get your backpack ready, make sure you have your swimsuit, make sure you have your gym clothes’. To have time to relax with them, to watch a movie or to go out for an ice cream, or to talk about a book with them.” (PMC01DB)*

In other words, what really leads to feelings of being over-burdened is when the time necessary for caring for elderly family members interferes with the time needed to manage the daily lives of children. In these cases, children are often asked to take too much responsibility for themselves in a way that is forced by the circumstances and not appropriate for the development of the child. A minority of interviewees emphasised the limitations imposed on their own families by the need to stay close to a dependent parent or grandparent: they cannot go away for a vacation or take a day off. Paradoxically, however, this problem is one of the most easily recognised and solutions are often found via social services or the broader kinship network. In contrast, the damage done to everyday family life is more insidious and, moreover, there seem to be no good solutions to this problem.

While families in the Southern Europe seem to sacrifice time with their children to care for elderly relatives, despite of their associated feelings of guilt and regret, families with small children in the UK and Finland (and sometimes in France) are instead more likely to use their own family responsibilities as a justification for *not* becoming the principle caregivers for elderly family members. Indeed, in these countries, having child rearing responsibilities is usually accepted as a reasonable excuse in family negotiations on care. From Finland, the most “secularised” country in this respect, we have a case where even becoming a grandmother led the participant to suspend a strong and burdensome commitment that she had previously made to her own parents. Thus, those who do take on

the double front carer role in these countries probably do so out of rather uncommon ideas about family obligations and relations.

Nevertheless, the same discomfort with competing caring needs that we saw among Southern European interviewees also emerged among some of the Finnish double front carers, expressed in nearly identical terms. However, unlike in Finland, in the Mediterranean countries the conflict between the two fronts of care is felt most strongly when the children reach school age and even beyond. Missing out on these “formative years” seems to produce more feelings of guilt than losing time with very small children and babies.

Though it seems counter-intuitive, we found that in all countries caring for an elderly person and for a very small child was less difficult than caring for an elderly person and an older child, at least when the level of dependency of the elderly person was not very significant. In several cases the caregivers saw similarities between the needs of the very old and the very young. Furthermore, many expressed the potential that the old and the young can have as resources for each other.

*“Then, watching the children play, their smiles, they give her hugs, these are things that an old person [...] She is coming to the end of her life, and so it is important to give her these things [...] Children are like medicine for the elderly, and vice versa, grandparents have an incredible wealth of affection to give.” (ITDB07)*

*“Jani [the grand-grandson] is so very important to her. In other words, if you think of people in her age, many of them are in an old people’s home and pretty demented. But she doesn’t have time to get demented or sick in the middle of all this. I’ve noticed about her that, you see, earlier she lived alone. A home helper came a couple of times a week and did the grocery shopping. The bags were too heavy for Martta [the great-grandmother] to carry. Jani was born and when he weighed ten kilograms, she was carrying him around like he wouldn’t weigh much anything. Even when I had told her that there’s no need to carry him.” (FINSPI2ADB)*

In addition, the dependence of the elderly is more easily accepted by grandchildren who, having always seen their grandparents in such a condition, see it as natural. In several interviews, parents recognised that by exposing their children to the elderly and infirm grandparents, the children learn to accept illness and death as a normal part of the human existence. For the adult children, however, it was often more difficult to construct such an image of their own parents, whom they remembered as being omnipotent.

Some of our participants even mentioned that the grandparent/grandchild relationship seems able to withstand the deep disorientation brought by the Alzheimer’s disease. This bond appears to remain a durable and important reference point for the elderly person’s own sense of self-identity.

*“Well, it’s that she doesn’t recognise. Except for the youngest one, she always recognises him when he visits her. ‘The little one, where is he?’ She always remembers him as ‘the little one’, but she does recognise him. Maybe he is the only one whom she really recognises.” (ITDB08)*

#### 3.7.4. Summary of main results

The first main result of this workpackage is that in double front carer families, the emphasis is on the elder care whereas the care of children is in general described as less problematic and more “natural”. Not only does this latter one seem to involve less fatigue and stress but also, it has been presented as a resource to recover from the main burden of

eldercare. These results are grounded in our data. They do not derive from a bias in the interviews but do really express the views of the carers.

It may appear that such an imbalance could derive from a different definition of family obligations towards elderly members, which is a field where several countries of our sample have no legal enforcement comparable to parents' responsibilities for their children. However, the greater attention given to elderly care can be recognised in the words of our respondents in all countries. One reason for this imbalance can, rather, be that such care arrangements involve complex and often disappointing negotiations among the members of the extended family of the elderly person. Even if the existence of viable alternatives in residential services of higher quality (in France or Finland) may alleviate the sense of guilt of adult children when institutionalising a parent, in any circumstance, this is a difficult decision to take. Usually family members recognise the right of the old person to refuse institutionalisation.

In fact, the main part of the care for elderly people is carried out in all countries by informal carers. This was testified by the many stories of long years of family care involvement told by our respondents. The real problem, then, is how such bulk of informal care can or cannot be complemented by other resources.

It is absolutely necessary to go beyond the simple hypothesis that national policies fully determine the care arrangements. In fact, even if negotiations among siblings are performed everywhere, this does not mean that networks of help are always formed. This affects the quality of life of our sample families deeply.

The two main types of care networks in our sample are those composed of "weak ties", where the network is minimal or even absent and care-giving falls on one person. More than half of our sample (56 cases) is included in this first type. The second main type, instead, has relatively rich and polycentric networks that share care responsibilities. A third of our sample (32 cases) is included in this latter type. There is also a third type with a specialised sub-division of tasks between at least two caregivers, but it was rarer within our sample.

All the three types of networks exhibit connections with professional and non-professional services. The range of professionally provided services is vast, ranging from less intensive health related services and home services to "total assistance", such as nursing homes or assisted living centres, where the elderly person has around-the-clock access to help. There the institutional mandate covers both health and social needs. Families in Finland, France and the UK use most often combinations of informal care and publicly provided formal care. Only Portuguese and Italian families use mostly third sector and private care facilities.

In Italy, France and Portugal, the informal, non-professional paid sector is wide and varied, offering a range of types of assistance. In France it is framed by the *Prestation spécifique dépendance*, becoming thus semi-public. Some types of this non-professional care are "light" and temporary, limited by their nature. Others entail assistance delivered daily or several times a week, including housework and help with bathing and personal hygiene. In some occasions carers of the latter type even live with the elderly person, often providing around-the-clock services in exchange for room, board, and a small amount of money. These workers are usually women, and in Italy and Portugal they are typically immigrants coming from outside of the European Union. Their working conditions are often inadequate. However, for the Italian and Portuguese families, this solution is less expensive than an intensive formal home care service or a residential home.

In any case, there are marked differences between Italy, Portugal, and France in the relationship between families and paid services. In the former two countries, private

assistance, especially for the elderly, is hired to substitute for public services. In France, it is used only to complement public services. In contrast to these countries, in Finland and Britain where access to formal services is easier and care provisions are more generous, non-professional extra-family care work is mainly provided by volunteers, usually free of charge. However, its coverage is limited.

Concerning the general organisation and control of the care arrangement, the family and, in particular, the main caregiver remains everywhere the most important resource. It is s/he who, even in the richer and more co-operative networks, assures the “synergy” and co-ordination of the various activities. However, if too scarce help — or none at all — is available to her/him from the outside, this fundamental resource tends to become quickly exhausted. From this point of view, formal and informal services need to be combined in a complementary way. Often both of them are necessary.

In conclusion, the need to think in terms of a system of care, compatible with paid employment, emerges ever more clearly from the words of our participants. By thinking about the networks between families and services as an integrated system of care, we are able to depart from a logic that envisages either total delegation of care or the myth of specialisation. In the first case, the asymmetry of the relations is in favour of services that have the power to “govern” the network. In the second case, according to the model of health services, services deal with only small components of user’s needs without examining how they affect the bigger picture. Indeed, the growing use of non-professional services in many countries, whether paid or voluntary, can be interpreted not only as a strategy to meet an unsatisfied need but also as an effort to find more flexible and personalised solutions. Such solutions, above all, leave the “government” of the care for family members to the family itself.

For more details of the workpackage on the care arrangements of double front carer families, see [SOCCARE Project Report 5](#).

## 4. Conclusions and policy implications

### 4.1. Conclusions and policy implications from Workpackage 2

Each individual care arrangement of our sample has been applied to specific conditions within the constraints of existing labour market and childcare service structures. Lone parents have to be innovative in using all the existing opportunities to overcome the gaps in service provision and the inflexibility of their work conditions. Their everyday life innovations include, for example, moving to an environment where formal and informal childcare services are close and available; changing to a one with standard or flexible timetables; minimising work trips; working at home; arranging most intensive work periods to coincide with the grandmother's holidays. All these practical ways to adapt the arrangement to the social context also have impacts on structures, as they may cause a concentration of requests for services or, on the contrary, consolidate family communities. Structures may be reinforced by individual choices or influenced by the expression of new demands.

In countries like Finland and France where formal childcare it is largely provided, it is the dominant source of care for working lone parents. Traditionally, formal care has provided standard and rather inflexible services. However, several lone parents of the sample have received responsive formal childcare services that could be seen as innovations within the public care system. The most flexible example was the Finnish 24-hour day-and-night care centre that was open each day (and night) of the year. In particular, there are some lone parents who are doing 3-shift work, including weekends, who are in clear need of such an extensive service. Several day care centres also have extended opening hours (6-22 o'clock on weekdays) and this serves the day care needs of most lone parent families. Providing extended or around-the-clock services does not however mean that the amount of external childcare will necessarily increase. It only coincides better with the actual atypical working hours of the lone parents.

Nevertheless, extended opening hours do not solve all the practical problems in day care. The criticism of lone parents at day care deals most often with the practical difficulties linked to the refusal of entry in the case of a sickness of the child.

The expansion of the voluntary sector is an important development. A good example is the Finnish MLCW (*Mannerheim League for Child Welfare*) childcare service. MLCW is a voluntary organisation instructing young and other adult women in childcare and providing their flexible services to families with children. The service is an innovative form of "paid volunteering". From the perspective of lone parents, however, this service is problematical due to its cost.

The experiment of the French ADMR ("*Aide à domicile en milieu rural*") with atypical schedules is also a good illustration of this recent change. ADMR is a traditional voluntary organisation involved in various kinds of home help. Despite the instability of the work offered and the recruiting difficulties deriving from it, all users appreciate the service. However, ADMR also illustrates the major dilemma that voluntary sector organisations have to face: whether they have to depend on the state in order to receive (co-)funding for their innovative and accessible services or, they are obliged to offer their services at a higher price, which means that many lone parents will not have access to them.

In most of the countries, local lone parent associations have developed organised forms of mutual exchange ("care circles") which are significant innovations. Unfortunately, lone

parents' associations have a very short life cycle, as their founding members often stop their active participation as soon as their family situation changes or when their children start school. In Italy, the state does not categorise lone parents as “one-parent families” that require specific attention and support. This policy inaction is reflected also in the mobilisation of lone parents as we observed a serious lack of mutual solidarity among our lone parent sample from Italy.

Because low-paid jobs usually have flexible hours in a family-unfriendly way, many lone parents feel that they are not properly fulfilling their role as parents, leading to feelings of guilt. Instead, lone parents in independent professions and lone parents who work at home have the opportunity to organise their working timetables more freely. This flexibility is far more family-friendly as it allows time for childcare and, in some cases, time for oneself, as well.

As a conclusion from Workpackage 2, we wish to underline two main challenges for the future.

- (1) The intensified pressure that is due to the change of the labour market in the direction of more frequent atypical hours and uncertain employment status. The absence of employers when facing the consequences of this development is a major issue. Up until now, employers have not been sufficiently concerned with the problems caused by the increase in unsocial working hours. So far, the problems raising from employer action have been transferred to local authorities and families.
- (2) The other major challenge concerns gender inequalities in terms of caring pressure. In most of the European countries, caring is still overwhelmingly on the responsibility of women. A wider sharing of caring tasks between men and women is certainly one of the main challenges for the coming years. In order to reach this goal, it needs to be supported by strong collective incentives.

#### ***4.2. Conclusions and policy implications from Workpackage 3***

The general trend in Europe is towards dual-earner couples regardless of whether they have children or not. In families with children, dual-career families are now as common as one-earner families or families where one partner (usually the male) works full-time and the other partner works part-time. In some European countries like Portugal and Finland, dual-career families already dominate the labour market.

Surveys report unanimously that the majority of men and women in the EU Member States think that families should share both household chores and paid work equally. However, in practice, both the literature and our sample show that women still do the most of informal care, concerning caring for older relatives as well as childcare. Men are more involved in childcare than in care for older relatives and both men and women spend less time on eldercare than on childcare. Despite the differences in national welfare provisions both the research literature and our sample demonstrate that in each European country, there are fewer people involved in caring for an older person than in childcare.

Dual-career couples tend to work long hours and have limited time to spend together as a family. Combining work and family obligations can vary from simple to complex and from robust to fragile arrangements. Our data show how for some families it is demanding and stressful to combine work and care. This is particularly so in the admittedly rare families with “double front” caring responsibilities. While families often do combine informal and formal care sources, overall the family is the main provider of care. Variations in work and

care strategies are mainly explained by personal preferences, the care services available, work schedules and transport constraints.

In spite of the EU Working Time Directive, about half of our respondents and their partners work more than 48 hours a week. Work schedules have a critical impact on how dual-career families manage care plus work. Daily and emergency care needs have to fit in with work demands. Care arrangements most often depend on one partner having a more flexible working schedule and/or working fewer hours than the other. Getting children and/or older relatives ready in the morning, taking them to school/nursery/adult care centre and collecting them to take home is structured around the start and finishing times of work. The partner who starts work later and who finishes earlier usually undertakes these tasks; sometimes the same person, sometimes not. In “double front care” families, it is absolutely critical that at least one of the partners has some flexibility in her/his working hours. The flexibility of working schedules also plays a significant role in emergency and unusual situations: a child or an older relative becoming ill, having hospital or medical appointments.

Workplace culture and the attitudes of employers and colleagues seem to be more understanding when time off is needed to care for a sick child rather than to care for an older relative. While the EU Directive on Care Leave allows parents and carers to ask for time off in emergencies, some respondents are reluctant to do so as they wish to avoid being seen in a bad light by their employers and colleagues.

Social and extended family networks seemed to be a critical element in explaining many care arrangements, particularly the arrangements of families caring for an older person. Where families were isolated from social and family networks, that is, where relatives and friends were not involved in caring, tasks were often left to one person only. However, the influence of attitudes and values of respondents and other family members was significant. Some families preferred not to rely on their family or social network because such care arrangements often incur reciprocal or emotional costs and were felt to add to the demands on the couples. As well, the preference of the older person her-/himself to be cared for at home by one carer and not wanting to go into a nursing home was also influential.

Caring arrangements for older relatives are vulnerable to any changes in the level and the frequency of care needs. While parents can look forward to children becoming more independent over time, couples anticipated that their older relatives would make increasing demands for care over time and worried whether or how they could manage to meet increased demands. Many of the families were involved in caring for an older relative who had only long interval needs and continued to live independently. The care that the respondents provided was predictable and the most frequent form was daily visits. In contrast, the older relatives of some respondents had short interval and wide-ranging care needs. Here a choice of two solutions was apparent: entry into a nursing home or having the older relative to move in with the family.

There is evidence that the EU directives on parental care and working time exert some influence on the lives of dual-career families. While some respondents and their partners in our sample worked more than 48 hours a week, most worked less and two respondents were on maternity and parental leave respectively indicating some positive effects of social policy.

National differences in welfare provisions were expected to have a substantial impact on care arrangements. The effects were seen in the details of family life. Our respondents organised their care arrangements according to the availability, location and the opening hours of care facilities, the proximity of their workplace, the hours they worked and their personal preferences. The respondents described compromises. Many couples regretted that often they had only limited opportunity to spend time together as a family unit.

Leaving the children without adult care after school was of particular concern in some Portuguese and Finnish families. Service opening times added to the difficulty of arranging care, particularly in rural areas, across all the five countries.

While the Finnish and the French families had access to more comprehensive systems of support for caring and parenting from publicly provided services, gaps in services were still apparent. Examples of such gaps include the lack of after-school care in Finland and waiting lists for home-help care for older people in France. Access to public care services was very limited for the Portuguese and the Italian families and they were more likely to use third sector and informal care. There was a similar picture in Britain although there was available very limited financial support for carers and currently, policies to provide more state subsidised childcare are being developed as part of the National Childcare Strategy. In general, the Finnish and the French families were more satisfied with the welfare provision available to them than were the British, the Portuguese and the Italian families. The latter ones often complained of insufficient and scarce public services as well as of limited and highly expensive private services. Concern about the quality of care provided by public services for older people was voiced by the Italian, the Portuguese and the Finnish respondents. It is likely that this concern contributed to seeing residential care for older people as a last resort.

Across the five countries, families were asking for more after-school care, summer care and care facilities that could help them with their care needs in emergencies. An on-call home care service for children as well as older relatives that could respond quickly and that could provide care for a few days at a time was seen as an ideal solution by many respondents. In Finland, the Mannerheim League does provide such a service but some of the Finnish respondents who had used it had been disappointed (to, for example, not having influence over the person of the child carer). Respondents also requested for more publicity and better information about local care facilities for children and older people.

Some respondents suggested that the difficulties they faced in combining employment and care would be eased by more flexible opening hours of day-care facilities. Often all that was required was to extend the opening hours by an hour or two. In many cases this would have profoundly changed the balance between work and care schedules. In Italy, Portugal and Britain, high day-care prices and the shortage of free public services caused requests from families for financial help towards the caring costs of children and older people. Necessarily, reforms of this kind have to be implemented at the national level. However, the EU has the ability to influence national debates and policy developments.

The European Union could intervene through an initiative similar to the Directive on Parental Leave but this time concerning the care of older people. The debate that would be generated by such a proposal might also open up discussion about the discrimination experienced by some of our respondents who had needed to take time off from work to care for their older relative. Compared to parents with sick children, the carers of older people had significantly more difficulties in getting time off from work. An opportunity for carers to take paid leave to look after their older relatives would ease the existing shortfalls in service provision and reduce the increasing pressure caused by the ageing of the population. However, this would need to happen in tandem with increased service provision so that such a reform would not reduce families' ability to choose between different modes of care.

Some respondents suggested information centres that could be a "one stop shop" where people could find out about parents' and carers' legal rights and care facilities and where they could be receive advice on care-giving. We learnt that parents often have to rely on "word of mouth" information to find out about services. Many service providers do not advertise, as they may be over-subscribed or do not operate waiting lists.

Our interviews did not reveal people having a high quality of life. Most of the dual-career families were not particularly content with their everyday lives. While most of our respondents did not complain greatly, they presented themselves as people who were getting by, doing the best they can, and often looking forward to when this difficult stage in their lives would end. This is not a particularly upbeat picture of people who constitute the core of Europe's producers of economic value and much of its caring. There must be ways to make these people's lives more than just tolerable.

Many researchers into the work-life balance insist that simple policy solutions will not work; that the complexity of the problem must be reflected in a complexity of policy and service responses; that what is needed is a substantial pluralism of potential solutions. We do not entirely agree with this. While we accept that the main finding of our research is the variety in families' responses to unique combinations of needs and constraints, a number of basic social policy remedies do suggest themselves. These are best captured by the term "support infrastructure". Just as complex modern cities cannot work efficiently without an appropriate infrastructure of roads, communications and drains, so families combining employment and care need an appropriate infrastructure of services and entitlements that they can rely on. Pursuing the analogy with town planning, what is surprising is how reluctant and partial governments have been in recognising the infrastructural supports that families require if they are to operate effectively and efficiently.

Two parts are essential to this infrastructure:

- (1) Specific entitlements to flexible employment arrangements that take account of care responsibilities for children, elderly and other family members. These exist in part in various ways but they are rarely comprehensive and complete. Included in these would be distinctive rights to emergency leave when a child or other dependent is ill or a care crisis occurs. We see no evidence in the way our sample talked about their commitments to career that they would abuse or over-use such entitlements.
- (2) Childcare and social care services that routinely operate outside normal working hours so that care can be fitted round employment schedules. Services also need to transcend the reasons why some people do not or will not use them. In our interviews, people often said that existing services were of insufficient quality, too inaccessible or too rationed.

In short, dual-career families (and others who combine work and care) need entitlements and services that they can control and use as reliable elements of their work + care arrangements.

### ***4.3. Conclusions and policy implications from Workpackage 4***

Workpackage 4 was concerned with how public and private policies might alleviate pressures that immigrant families experience when managing work and care responsibilities at the same time. As foreign people continue to immigrate into European countries, policy-makers often question whether policies at work are "integrating" migrant families. However, they rarely ask whether policies are successful in supporting the duality of work/family obligations of immigrant families and whether more could be done in this respect. The effects of work/family problems on the lives of second generation children are also rarely questioned.

The qualitative study of this workpackage allows us to understand some of the problems and dissatisfactions experienced by immigrant families. It is important to mention the following.

- (1) A major problem is the absence of sufficient collective structures. Even if the coverage of care provision varies significantly between the countries, interviews show that the most vulnerable immigrant families (unskilled labour migrant families, lone parent families and refugee families) experience problems in all five countries. Lack of care provision means that there is, above all, a shortage of low cost, universally available, care provision. We are referring, here, to low cost facilities that cover not only the typical working hours of parents but also take into consideration a certain period of time before and after standard working hours and the starting and finishing times of schools. In some countries, such as the UK, there is a general lack of universal care provision. In other countries, such as Finland, the problem emerges for certain parts of the day/week or for a particular age group (for example, for young school children who finish school at noon). In Portugal, the high concentration of African immigrant families in areas of social deprivation causes that the existing third sector collective structures in these areas do not cover the extensive needs for care provision for young children.
- (2) A second major problem is the absence of information on care provisions in the receiving country. Easy access to information, not only on work life and social security issues but also on existing provisions (schools, after school care, nurseries, transportation of children, childminders, school holiday care), preferably in native languages (or, at least, in English), was wished by different kinds of immigrant families, the highly qualified professional families as well as the low qualified labour migrant families.
- (3) A third general problem concerns the social and cultural integration of immigrant families, in particular of unskilled labour migrant and asylum seeker families and especially during the first years after their arrival in the host country. The social isolation problems of some women in other migration patterns, like in the mixed marriage migration, should not be forgotten, either. Social and cultural integration problems that affect the well-being of these families include low paid and atypical working hours, housing problems, language barriers, social isolation, discrimination on the labour and housing market and in schools, and not being able to work due to delays or difficulties in legalisation. This last-mentioned problem affects not only asylum seekers and labour migrants but also, in some countries, the wives of legal working migrants who are entitled to family reunion but not to a work permit. Interviews show that difficulties in integrating the labour market (or in keeping a full-time job) are a major problem as they considerably reduce the family's level of income. On the other hand, atypical or long working hours are frequently a characteristic of the type of jobs that immigrant workers, especially first generation migrants, have access to. Such unsocial work schedules affect strongly and directly caring arrangements. If we consider that this kind of pressure from work is not likely to diminish, given the general trend of the labour market, then policies have not been sufficiently concerned with the consequences on family life. In this respect, public policies as well as employer policy (with work site care provision?) need to be reconsidered.

To end the discussion on policy implications of Workpackage 4, we present here a short synthesis of the different policy measures suggested by the national reports on the basis of interviews with local professionals working in the field of migration/social care combined with suggestions emerging from the interviews with immigrant families.

***Policy measures suggested in the Finnish national report:***

- Language courses for immigrants,
- Those who move to Finland to work or marry need to get the same type of support that refugees and returning migrants receive,
- Centres for information about services and social benefits in English,
- More care provision (afternoon clubs) for primary-school children.

***Policy measures suggested in the British national report:***

- Centres for information about services and social benefits in English,
- To increase the care provision and to extend the opening hours of formal care services,
- More affordable formal care services,
- To create a Central Agency from which immigrants can get information and access to care services,
- “One Stop Shops” for information about the entitlements and the services that are available.

***Policy measures suggested in the Portuguese national report:***

- To develop a childminders’ net (properly trained) to support immigrants who have atypical working hours,
- To extend the opening hours of the formal care services (for young children and dependent elderly people),
- More affordable formal care services (for children below age six as well as for primary school children: especially pre- and after-school care provision),
- Public support for housing,
- To develop policies against social exclusion, in particular for labour immigrant families.
- To develop policies against social exclusion, in particular for labour immigrant families.

***Policy measures suggested in the Italian national report:***

- Public support for housing,
- Decrease the bureaucracy of public migration offices,
- Language courses for immigrants,
- To extend the opening hours of the formal care services (for young children and dependent elderly people).
- To develop policies against social exclusion, in particular for labour immigrant families.

**4.4. Conclusions and policy implications from Workpackage 5**

In all the five countries we studied, we found a broad agreement that it is inexcusable to leave elderly people who have worked their entire lives to be economically dependent on their own adult children for even the most basic services.

The academic literature on the “double front care” issue has previously concentrated on the “sandwich generation” of women between the ages of 50 and 60 years who find themselves with responsibilities both towards their elderly family members and their very young grandchildren. However, our study instead brings to light the challenges faced by a

slightly younger cohort of women who up to now have been almost invisible in debates on family care. These women, who have delayed childbearing by several years and who are often the last born of their own mothers, must sometimes meet the caring needs of their own parents or elderly dependent family members (or sometimes a seriously ill husband) while they still have quite young children of their own. In these situations, the customary timing of the life course is confused and caregivers must deal with an “unnatural” coincidence of needs that usually occupy different stages of life.

These situations arise not from a diminishing age gap between generations but rather from its widening. It is thus most frequently found in those countries where population ageing is accompanied by trends in which young people delay marriage and stable cohabitation, that is, in Southern European countries like Italy. In the Finnish sample, instead, we found four-generation families and the “sandwich generation” of slightly older women with care on two fronts to be more commonplace.

During the research, our interviewees presented many policy-relevant suggestions. The ideas of these “double front carers” are grounded in their own profound experiences of providing care to elderly family members and in their sensitive management of intergenerational relationships. These suggestions are rich in practical solutions and provide many lessons for social policy. Many of them seem valid for all countries facing population ageing. Below, we attempt to present these ideas systematically.

***1. In making their needs-assessments, social support services should consider all the fronts of care that families have to face.***

None of our five countries can be said to be generally capable of offering care services that encompass the extraordinary burdens associated with caring for both dependent elderly relatives and children/grandchildren — or even, in addition, a disabled or dependent relative or foster children. Such a variety of “care fronts” occurred even within our very small sample. Instead, the services and forms of assistance are usually always aimed only at one problem at a time, incapable of comprehending double (or triple) simultaneous sources of need, the various commitments they demand, and the consequences of such burdens on family life. What these policies amount to is a mix of various forms of formal care, delivered often according to strict rules, with a fully arbitrary blend of whatever forms of informal care happen to be available.

***2. Assessment of the total personal resources that make a family ‘care-rich’ or ‘care-poor’ should be systematically formulated so that it can be inserted into the access criteria of various support programs and services.***

At present, family caring resources are counted only when social protection systems use them punitively, as demerits against an individual’s right to assistance. We saw this phenomenon often in Southern Europe where informal family resources are measured in order to take the formal support away. Instead, the focus should be on how the informal resources could be combined with formal services, taking their specific qualities into account. The objective should be both to activate these resources, and to provide them with a protective frame of reference. In fact, this is the most general recommendation that we can derive from our research. Formal social recognition and consistent support to family caregivers could prevent their exhaustion and burn-out and thus, help to save an essential resource.

In suggesting potential access criteria for social support that takes family caring resources into account, we find the transparent criteria used in France for access to the *Prestation Dépendance* especially useful. This program allocates a certain number of hours

of assistance, of one kind or another, based on demonstrated need. A family's need is calculated by taking into consideration each front of care on which they are occupied, including childcare, elder care, and care for other disabled or dependent family members. Furthermore, while the nuclear family is the first unit of analysis, the extended kinship network also enters into the equation. This system is also important for those who lack relational resources, or do not have family members to help with small daily chores. The recognition, compilation, and valorisation of small and even occasional forms of assistance or companionship from the family network and the community should become a part of the shared culture, preventing the exhaustion of any single source of support.

This approach could accommodate the range of generosity found across the different welfare regimes as each country could continue to distribute a level services and assistance that is proportional to its resources. On the other hand, this approach would provide a new foundation for convergence of the criteria used to evaluate need. Finally, the functioning of services could also become more similar, because, though embedded in different institutional structures and offering differing levels and types of coverage, to reach the objective of high quality service, the means are often the same (Eliasson-Lappalainen and Szebehely 1999).

### ***3. Assistance and services should be timely and global.***

When families first encounter a care crisis for an elderly relative and are pressed to quickly develop new care arrangements, they above all require assistance in constructing the new setting and orienting themselves in these radically changed circumstances. The moment in which an elderly person is dismissed from a hospital into the care of his/her family is extremely critical. These families need to know to whom they can turn to in order to get a full and straight answer not only on the forms of assistance available to them but also on the meaning and potential duration of the crisis. Unfortunately, such integrated information has not been available for the most part of our sample families.

Some of our participants emphasise the heavy strain that assuming the care for one or more elderly relatives places on the personal relationships of couples and young families. It is not simply a matter of sacrificing time that could be spent with one's own children. Couples, too, feel the stress — even to the point of separation. Sometimes, the undeniable evidence of the *weight* of care-giving that women who care on a “double front” must bear even gets more traditionally inclined men to accept a part of the burden.

Also in this sense, “first aid” care services could resolve certain fundamental problems precisely because their provision would be configured according to a comprehensive overview of the resources available and the expected course of care. Usually services, especially health services, simply and hurriedly delegate care to whichever unlucky relative happens to be closest to the events.

### ***4. Clarify both the intra-familial solidarity pacts and the gender contract on which the care arrangement will hinge in the future.***

We have seen the tacit and taken-for-granted ways in which main caregivers are designated. However, if public assistance were conditional on a sort of explicit and contractual stipulation of *who*, among siblings or within couples, is responsible for which caring tasks, an enlarged sense of collaboration could take root. The idea that other people are also involved in the care-giving would relieve a complaint expressed by several main caregivers who receive no assistance from their family or social networks. The development of explicit shared agreements could also prevent situations in which the

designated caregiver suffers from extreme social exclusion as a result of her/his caregiving burdens.

These agreements need to be adjusted and made compatible with the scope of family obligations that are understood and accepted within the specific cultural framework of each country (Miller and Warman 1996). However, the awareness of the greater disadvantage suffered by Southern European caregivers facing care on two fronts should discourage the services from making misguided normative evaluations about the complex balancing between needs and resources.

It is crucial that public services attain a deep understanding of the complicated ethical motivations behind caregivers' willingness to care for their elders. Service operators need to learn to act within a framework of altruism. In a certain sense, formal services need to learn to speak the language of families.

***5. Help in accepting the decline and the death of a family member needs to be provided.***

There is no doubt that the greatest strain for caregivers is the daily sight of the deterioration of their close family members. Often, caregivers even lose their ability to distinguish their own physical problems from the distress caused by their impatience and feelings of guilt. Taking care of an elderly person also means confronting the experience of death, having to overcome an extremely powerful social taboo.

A counselling service could considerably ease these problems. As experiences from self-help groups of caregivers illustrate, it is not necessary that these counsellors have specialist training in formal psychology. It is enough that they are able to listen to feelings that are hard to express. This type of service could also lower the probability that some siblings withdraw themselves completely from the care of their declining parents. Currently, many of the withdrawing siblings are incapable of managing the emotional difficulties associated with seeing their parents in decline.

A certain amount of information about decline and death, and about how to prepare for it, could be developed and incorporated into service programs. It would be very useful if such an information resource, grounded in the accumulated experience of caregivers, was widely circulated and accessible. The capacity to interpret the situation from the point of view of the elderly person, to perceive their small needs and to maximise whatever resources of self-sufficiency they retain, greatly helps. Thus, family members still would have the opportunity to respect and cherish the signs and traces of the "old self" that remain. This kind of a gradual approach, though, completely contradicts the "threshold logic" behind the most part of existing service provision for the elderly.

The history of the personal relationship with the elderly person remains the crucial starting point in the willingness to provide assistance with intimate tasks such as personal hygiene. It is not surprising that the more generous and developed welfare state regimes are clearly more capable of taking these kinds of needs into account. In contrast, welfare states in Southern Europe appear to exhibit a particularly brutal incomprehension of the meanings embedded in such extremely intimate tasks. Instead, such care tasks are often taken-for-granted as part of the family's obligation.

***6. Support for relationships between grandparents and grandchildren is needed.***

The presumed and commonly discussed decrease of potential caregivers for the elderly is based on imaginary hypotheses, not on an understanding of the real rules of family reciprocity (Godbout 1998). In particular, the very special relationship between

grandparents and grandchildren is still relatively unexplored (for an exception that confirms this impression, see Attias-Donfut & Segalen 1998). This relationship may provide a wealth of security for children: it is their chance to skip over a generation and spend time with calm and self-assured adults who, free of the strains and responsibilities of parenting, can afford to always be “on their side”.

Furthermore, reciprocities may emerge when the relationship is transformed and the dependencies are reversed. Once more, skipping a generation, the grandchild is situated in a more symmetrical role where, though not being directly responsible for care-giving, s/he is permitted to provide care gratuitously. Of course, the history and quality of the individual grandparent-grandchild relationship shapes the grandchild’s involvement when the elderly person starts to need care.

Among our five countries, only Finland has attempted to compensate family members for this type of caring, instituting a care allowance that can be claimed by an adult caregiver, even if s/he is a relative of the person being cared for. However, we can ask whether placing a monetary value on the relationship may undermine the altruistic ethic that usually characterises the grandparent-grandchild relationship. A more appropriate solution to reward the care provided by a grandchild might be awarding a longer-than-average parental leave, when the grandchild has need of it or, alternatively, the accumulation of credits in a “time bank” that the grandchild could later use for the care of his/her own children. These types of retribution seem to be in better accordance with the long-term balance of the intergenerational give-and-take that characterises the grandchild-grandparent relationship.

We can also ask if services like occasional companionship could be seen as strategies capable of compensating for demographic imbalances that threaten to dry up intra-familial care-giving resources (Laslett et al. 1993). Such a change in perspective would be specially needed in Southern Europe.

We can thus conclude that the efforts to define a more sustainable social justice must first address a new social contract that articulates more evolved forms of the gender contract and inter- and intra-generational solidarity (Esping-Andersen 2002). Inter- and intra-generational solidarity must be based on a joint consideration of what forms of informal and formal assistance can be mobilised in light of the public and private social costs of an ageing society (Attias-Donfut et al. 2002; Myles 2002).

#### **4.5. Main policy recommendations of the SOCCARE Project**

##### ***Main recommendations for formal care policies***

- Availability of formal care services to all families who need them must be the number one policy aim for social care policies in Europe. As universal availability of informal care cannot be taken-for-granted in any European nation, formal care is unavoidably needed. However, without public co-funding, the most part of people will not be able to use these services. If the access to formal care services is limited to certain segments of the population, social inequality will emerge and gender equality will become endangered.
- In all of the project countries, the study identified considerable gaps in childcare service provisions. Such gaps probably exist in all EU Member States. Today, childcare is not adequately organised during parents' atypical working hours (evenings, nights, weekends), when the children or their parent/s is/are ill, during afternoons after school hours and during school holidays. These gaps need to be addressed as they bring severe difficulties particularly to those families who do not have strong informal support networks. Children must be guaranteed necessary adult care also in these situations.
- Flexibility in opening times and content of services leaves a lot to hope for. Currently, existing services are not flexible enough to suit individual needs and cultural values of families in most of the countries. Often, small changes in institutional practices would bring significant improvement in this respect.
- Care provisions for older people must in particular go through a thorough self-examination. Why do so many European families see these services as "last resort" and do not wish to use them? The quality of these services and their responsiveness to needs and values of families are in distinctive need of a major improvement all over Europe.
- A fundamental change in the orientation of formal care services is necessary: service provisions must not any more be seen and planned as a system of their own. Instead, service providers must recognise that they form only one part in the whole sphere of care arrangements of families. Consequently, informal carers need to be accepted as equal partners with formal care providers. For formal care, this brings the need for close co-operation and integration with informal care.

##### **Main recommendations for informal care policies**

- If a huge increase in future demand for publicly subsidised formal care services is to be avoided, families must become better able to combine informal care-giving and participation in paid employment. It is no more appropriate to expect women to end their paid work when care needs emerge in their families.
- The full sphere of social policies needs to be evaluated and reformed from this perspective: do they really support — or instead, hinder — the combination of worker and carer roles?
- Carers need to be able to combine working and caring both simultaneously and sequentially. To make a *simultaneous combination* of these roles possible, carers need to be able to adapt the hours and places of their work. Families also need access to

support services like domiciliary care but these must be adjusted to the needs and preferences of both, the care-givers and the care-receivers.

- In order to make a *sequential combination* of work and care possible, care leaves need to be available to employees. In practice, only a small minority can use an unpaid care leave. As a consequence, financial compensation schemes for the loss of income are necessary. In this respect, family members of older people are in all EU Member States clearly disadvantaged compared with parents of young children. Carers of older and disabled people are in most need of policy extensions in this respect but in several Member States, parental leave and benefit schemes are not adequately developed, either.

### **Main recommendations for labour market policies**

- Recent increase of atypical working times has brought considerable cost to the well-being of families and increasing financial cost to local authorities. A fundamental discussion between the social partners is required: as the employers do get the profit out of the increase of atypical working times, how will they participate in bearing the costs of this trend?
- “The flexible labour market” has been understood as a method to boost both the revival of national economies and the autonomy of workers. However, the kind of flexibility that our research found in many low-paid jobs could rather be characterised as “flexible exploitation of labour”. In particular, many lone parents and immigrants worked under strict and, from their perspective, fully inflexible working conditions that made the combination of work with care responsibilities very difficult. The emphasis of flexible labour market policies needs to change. Policies must focus primarily on promoting opportunities of choice to employees in order to make it possible for them to conciliate work and care. In the case of lone parents and immigrants, our results show that the need for this policy change is urgent.
- As argued above, workers need to be given opportunities for care leaves and part-time work. After such a leave or a period of part-time work, it must be secured that employees can without problems return to their own work positions.

### **Main recommendations for other social policies**

- The lack of proper housing is a major barrier to well-functioning care arrangements. Housing policies need to promote affordable housing where the demands of care have been taken into account. There must be room enough for care. Furthermore, if the apartment or the environment is constrained by physical barriers, caring for older and disabled people becomes very difficult and consumes a lot of resources. Instead, by inclusive planning, independence of disabled and older people can be promoted and needs for care prevented. In order to make informal care possible, housing policies should also provide opportunities for different generations and family members to live close to each other.
- If people cannot afford to use social care services, they and their informal carers are left in a very precarious situation. Thus, social security policies are significant in providing families the financial means to use formal care services. In particular, policies on pensions and child benefits should be considered in connection to policies on formal care. The affordability of care services to all parts of the population must be

ensured. As well, in order to achieve a better gender balance in caring, the participation of men needs increasingly to be supported by social security policies.

- In our study we saw that also general immigration policies have significant consequences for care arrangements of families in Europe. Families become very vulnerable when they are isolated from their original social networks. Consequently, immigration policies should support these networks, not negate them. In particular, family reunification should include elderly and disabled family members. General integration problems make the everyday lives of many immigrant families difficult and these problems need to be addressed with determined policies. Immigrant families can not properly organise care for their members if they are continuously discriminated against in labour markets and public services.
- Social work has traditionally been concerned with the material conditions of families, domestic violence, mental and substance abuse problems. However, it should be noted that the lack of care is a social problem as serious as the lack of income. As a consequence, social work should develop its professional practices and increasingly focus on supporting families in forging well-functioning care arrangements. On the other hand, health care tends to medicalise and individualise older and disabled people's problems. The contribution of social work is needed to balance the situation and bring forward the everyday life level and the care networks of these people.

As a final word, we want to emphasise that it is highly necessary that policies do away with strict dichotomies. Citizens of Europe are *not either* workers *or* carers. They are *both* at the same time. As well, children, disabled people and older people are *not* in need of *either* informal *or* formal care. *Both* are essential and practically always, there is a need to integrate both at the level of everyday family life. To face the challenges of the future, an integrated policy perspective on work and care is required in Europe.

## 5. Dissemination and exploitation of results (Workpackage 6)

### 5.1. Dissemination activities of the project

The SOCCARE Project included continuous interaction with policy-makers at different levels. At the local level, local professionals and policy-makers were interviewed by project teams. Findings were also presented in local workshops. Through local media, results were disseminated to the local population.

At the national level, members of the national research teams participated in many national seminars and conferences, highlighting the project results and their practical implications for policy-making. In addition, national teams organised national workshops where the perspectives and findings of the research project were discussed with academic and policy experts of that country. Teams have publicised their findings also in national languages, not just in English, in order to reach end-users at the national level.

At the EU level, the project gathered an International Expert Group that included a policy expert from each of the current 15 EU Member States. Findings and policy recommendations of the project were disseminated to and discussed with this group in a specific seminar in Brussels, organised by the SOCCARE Project. Furthermore, the project participated in two Dialogue Workshops in Brussels, organised by the European Commission. In particular, during these two workshops as well as in other communications, the SOCCARE Project has actively informed the Officials of the DG for Employment and Social Affairs of the European Commission about the results of the research project.

Also otherwise, at the international level, project members have participated in numerous social scientific and other conferences, presenting papers on project findings. Reports of the research project have been advertised also on several international e-mail lists, reaching hundreds of European social scientists, practitioners and policy-makers. All reports of the SOCCARE Project are freely available from the web site of the project (<http://www.uta.fi/laitokset/sospol/soccare/>). Finally, the SOCCARE Project organised a Final Dissemination Conference in Brussels in May 2003.

#### Local dissemination seminars organised by the SOCCARE Project

Local dissemination seminar and discussion panel for local policy-makers and professionals, Tampere, 23 January 2002.

- Minna Zechner: “Experiences of families about care for older people in Tampere” [in Finnish].
- Teppo Kröger: “Experiences of families about childcare in Tampere” [in Finnish].

Local dissemination seminar with local and regional policy-makers of immigration issues, Florence, 5 December 2002.

- Rossana Trifiletti, Simonetta Simoni and Alessandro Pratesi: “New families, new models of care: the voice of Moroccan women in Florence and Veneto region” [in Italian].

Local dissemination seminar with local social workers and researchers, Florence, 19 March 2003.

- Rossana Trifiletti & Simonetta Simoni: “Care in immigrant families” [in Italian].

### **Other dissemination at the local level**

- Claude Martin: “Solidarités publiques, solidarités privées: proches, bénévoles et professionnels. L'exemple de la dépendance des personnes âgées”. Conférence dans le cadre des Rencontres organisées par le Collège coopératif de Bretagne de l'université de Rennes 2 sur le thème «Professionnels et bénévoles: professionnalisation, formation, co-gestion. L'exemple du tertiaire relationnel non lucratif ». Rennes, Le 28 avril 1999, publiée dans les actes.
- Teppo Kröger & Katja Repo: “SOCCARE: A European research project on care arrangements of children and older people” [in Finnish]. Conference on Research on Europe, University of Tampere, Tampere, 19-20 April 2001.
- Empirical results of the SOCCARE Project have been reported in the main newspaper of the Tampere region (“Aamulehti”) on several occasions, 2001 and 2002.
- Minna Zechner: Interview on a local radio channel about the SOCCARE Project and its results, 2002.
- Katja Repo: “Tensions within the family economy”. Seminar “Perspectives to Critical Family Research”, University of Tampere, Tampere, 18 November 2002.
- Teppo Kröger: “Childcare arrangements in families in Europe” [in Finnish]. Seminar on social scientific issues, University of Tampere, Tampere, 22 January 2003.
- Minna Zechner: “Comparative qualitative research” [in Finnish]. Seminar “Research in Process”, University of Tampere, Tampere, February 2003.
- Minna Zechner: “Dual caring commitments in Finland and Italy” [in Finnish]. Seminar on methodological issues in childhood and family research, University of Tampere, Tampere, 11 February 2003.
- Minna Zechner: “Comparative research in the European context (SOCCARE)” [in Finnish]. Course on research process, University of Tampere, Tampere, 24 February 2003.
- Katja Repo: “Service experiences of career families”. Seminar “Expertise and Customership in Culture and Welfare Services”, University of Tampere, Tampere, 31 October 2003.

### **National dissemination seminars organised by the SOCCARE Project**

National research seminar “Family, Care, Work, Services”, University of Tampere, Tampere 21 January 2002.

- Minna Zechner: “Experiences of lone parent families from combining work and family life” [in Finnish].
- Teppo Kröger: “Dual-career families and care arrangements” [in Finnish].
- Minna Zechner: “Working migrant families in the Finnish care world” [in Finnish].

National dissemination seminar “One generation at work, where are the two others?”, Helsinki, 14 November 2002.

- Jorma Sipilä: “Why is this issue being studied?” [in Finnish].
- Katja Repo: “A continuous balancing act: conciliation of two careers and care arrangements” [in Finnish].
- Teppo Kröger: “Not fully alone: care arrangements of lone parents” [in Finnish].
- Minna Zechner: “Two worlds of care: care of children and older family members in immigrant families” [in Finnish].

National dissemination seminar “Servizi formali ed informali per anziani: un confronto europeo”, Milan, 15 October 2003.

- Rossana Trifiletti & Simonetta Simoni: “Care arrangements in double front carer families” [in Italian].

### **Other dissemination at the national level**

- Claude Martin: “Comparer les politiques familiales en Europe”. Communication au séminaire de recherche en sociologie des politiques sociales, Faculté des sciences sociales Sorbonne, Paris V, Le 31 mai 1999.
- Claude Martin: “La prestation spécifique dépendance et ses effets sur les *carers*”. Communication aux journées d’études du MAGE (GDR CNRS, Marché du travail et genre), Le 19 novembre 1999, à l’IRESCO-CNRS (publiée dans Les documents de travail du MAGE).
- Claude Martin: “De quoi dépend la dépendance ? La prise en compte des changements démographiques dans la définition d’une politique sociale”. Communication avec Alain Jourdain au colloque organisé par l’INED et la SIDESME à Paris le 7 décembre 1999 sur le thème « Changements démographiques et systèmes de santé », publié dans la revue Cahiers de sociologie et de démographie médicales, 39<sup>ème</sup> année, n°2-3, avril-sept 1999.
- Claude Martin & Blanche Le Bihan: “La PSD : stratégies des acteurs “. Communication au séminaire DRASS – DREES organisé à Orléans les 5 et 6 octobre 2000 sur le thème « Handicap et dépendance ».
- Teppo Kröger: “Third and fourth sector in childcare arrangements of lone parents” [in Finnish]. Conference on Social Work Research, Rovaniemi, 23-24 February 2001
- Claude Martin: Interview dans une émission sur les familles monoparentales en Europe de la chaîne ARTE, « Album de famille ». Juin 2001
- Claude Martin: Interview dans une émission sur la prise en charge des personnes âgées dépendantes en Europe de la chaîne ARTE, « Album de famille ». Novembre 2001.
- Karin Wall & José São José: “Families and eldercare” [in Portuguese]. Congress on Family and Ageing, Institute of Social Service, Lisbon, January 2002.
- Teppo Kröger: “Locality, policy-making and welfare mix in care services for older people” [in Finnish]. Conference on Social Work Research, Kuopio, 14-15 February 2002.
- Minna Zechner: Interview on the national radio Channel 1 about the SOCCARE Project and its results, 2002.
- Minna Zechner: “Two parents in paid work: how is childcare shared?” [in Finnish] Conference on Family Research, University of Jyväskylä, Jyväskylä, 11-12 April 2002.
- Teppo Kröger: “Combining work and childcare in European lone parent and dual-career families” [in Finnish]. Conference on Family Research, University of Jyväskylä, Jyväskylä, 11-12 April 2002.
- Minna Zechner: “Combining working life and family life” [in Finnish]. Seminar for teachers and educators on facing parents, Summer University of Tampere, Tampere, 23 April 2002.

- Rossana Trifiletti: “Social care in immigrant families and double front carer families” [in Italian]. Seminar “Social policies for frail elderly: perspectives towards privatization and marketisation”, University of Florence, Florence, 3 May 2002.
- Claude Martin: “Articulation des temps de vie. Conciliation vie professionnelle / vie familiale : un enjeu européen”. Conférence au colloque « Egalité professionnelle entre les femmes et les hommes : enjeux et perspectives », organisé par la délégation régionale des droits des femmes et la direction régionale du travail, de l’emploi et de la formation professionnelle, Université de Rennes 1, INFED, Rennes, le 18 juin 2002.
- The Portuguese team published two scientific articles about the project results in two Portuguese social scientific journals (see publication list), 2002.
- Claude Martin: “Conciliation entre la vie familiale et la vie professionnelle dans l’espace social européen”, Conférence aux Rencontres de la Délégation interministérielle à la ville et au développement social urbain sur le thème « Les arrangements quotidiens dans la ville : vie familiale et vie professionnelle », Paris, ministère de l’Emploi et de la Solidarité, 27 juin 2002.
- Minna Zechner: “Caring on two fronts” [in Finnish]. National graduate school of family research, Jyväskylä, 10 October 2002.
- Teppo Kröger: “Childcare arrangements of lone parent families in five European countries” [in Finnish]. National Social Policy Conference, Kuopio, 25–26 October 2002.
- Teppo Kröger: “SOCCARE: Qualitative comparison in Europe” [in Finnish]. Seminar on methodological issues in childhood and family research, University of Tampere, Tampere, 12 November 2002.
- Teppo Kröger: “Care arrangements of children in lone parent families and dual-career families in Europe” [in Finnish]. National Conference on Social Work Research, Turku, 13–14 February 2003.
- Claude Martin: Discutant dans le cadre du séminaire “Comparaisons européennes” de l’INED sur les politiques d’aide à l’enfance dans les pays nordiques, séance autour de Guony Björk Eydal (Université d’Islande), “Childcare Policies in the Nordic Countries”, 5 May 2003, INED, Paris.
- Teppo Kröger: “Not fully alone: care arrangements of lone parents” [in Finnish]. Article in the newsletter of the National Association of Lone Parents, June 2003.
- Katja Repo: “Conciliation of work life and family” [in Finnish]. National Conference on Social and Health Care, 6-8 August 2003.
- Claude Martin: Participation à la soirée thématique d’ARTE sur les politiques de prise en charge de la petite enfance en Europe. 9 Septembre 2003.
- Claude Martin: Participation à la soirée thématique de FR3 sur la place des personnes âgées dans la société. 23 Septembre 2003.
- Simonetta Simoni: “Significati della cura di anziani e bambini tra le famiglie marocchine immigrate in Italia: una ricerca”. Seminar “Le culture del corpo in Maghreb: rappresentazioni, pratiche terapeutiche e società” for social workers and cultural mediators, Prato, 28 September 2003.
- Blanche Le Bihan & Claude Martin: “Comparer les paniers de service pour prendre en charge la dépendance des personnes âgées dans 6 localités européennes”. Séminaire international de l’INED, le 6 octobre 2003.

### **European dissemination seminars organised by the SOCCARE Project**

International seminar “Lone parent families and social care”, Université de Rennes 1, Rennes, 23 March 2001

- Rossana Trifiletti & Simonetta Simoni: “Lone parent families and social care: the Italian case”.
- Antoine Vion: “Lone parent families and social care: the French case”.
- José São José & Karin Wall: “Lone parent families and social care: the Portuguese case”.
- John Baldock: “Lone parent families and social care: the British case”.
- Teppo Kröger: “Lone parent families and social care: the Finnish case”.

International seminar “Multi-career families and social care”, University of Kent, Canterbury, 11 November 2001

- Rossana Trifiletti & Simonetta Simoni: “Multi-career families and social care: the Italian case”.
- Claude Martin & Armelle Debroise: “Multi-career families and social care: the French case”.
- José São José & Karin Wall: “Multi-career families and social care: the Portuguese case”.
- John Baldock: “Multi-career families and social care: the British case”.
- Teppo Kröger: “Multi-career families and social care: the Finnish case”.

Meeting of the International Expert Group, European Commission, Brussels, 22 April 2002

- Claude Martin: “Care arrangements in lone parent families in Europe”
- José São José: “Care arrangements in immigrant families in Europe”.
- John Baldock: “Care arrangements in dual-career families in Europe”.
- Rossana Trifiletti: “Care arrangements in four-generation families in Europe”.

International seminar “Immigrant families and social care”, University of Lisbon, Lisbon, 31 May 2002

- Rossana Trifiletti: “Immigrant families and social care: the Italian case”.
- José São José: “Immigrant families and social care: the Portuguese case”.
- Claude Martin & Armelle Debroise & Blanche Le Bihan: “Immigrant families and social care: the French case”.
- Minna Zechner: “Immigrant families and social care: the Finnish case”.
- Jan Hadlow: “Immigrant families and social care: the British case”.

Final Dissemination Conference “The Findings and Policy Recommendations of the SOCCARE Project”, Brussels, 19 May 2003

- Claude Martin: “Care and work in lone parent families”.
- John Baldock: “Care and work in dual-career families”.
- Karin Wall: “Care and work in immigrant families”.
- Rossana Trifiletti & Simonetta Simoni: “Mix of informal and formal care in ‘dual-front’ families”.
- Teppo Kröger: “Main findings and recommendations of the SOCCARE Project”.

### Other dissemination at the European and international level

- Claude Martin: “Les répercussions pour les femmes soignantes et aidantes des politiques de prise en charge des personnes âgées et des enfants. L'exemple français et perspectives de comparaison européenne”. Conférence au colloque international organisé les 25 et 26 janvier 2001 à Montréal par la faculté de science politique et de droit de l'Université du Québec à Montréal et le centre de sociologie du Travail, de l'Emploi et de la Formation de l'Université Libre de Bruxelles sur le thème : « Cohésion sociale et protection sociale : nouvelles convergences ou espoirs nostalgiques ? ».
- Teppo Kröger: “Studying care strategies of European families: methods and practices of the SOCCARE project”. Family and Welfare: DG Research, Dialogue Workshop, European Commission, Brussels, 14-15 June 2001.
- Teppo Kröger: “Working carers and caring workers: European welfare states promoting the combination of work and care”. 5th European Conference of Sociology, Helsinki, 28 August - 1 September 2001.
- Claude Martin: Discussant at the seminar of the European Observatory on the Social Situation, Demography and Family on “Immigration and Family”, Helsinki, Finland, 8-10 June 2002.
- José São José: “Famílias e Cuidados aos Idosos”. Seminário Famílias e Envelhecimento [Workshop Family and Ageing in Portugal], ISSSL, Lisboa, 2002.
- Minna Zechner: “Sandwiched two-front carers”. Nordic Sociology Congress, Reykjavik, 15-17 August 2002.
- Jorma Sipilä: “The last bastion of undifferentiated social care”. Nordic Sociology Congress, Reykjavik, 15-17 August 2002.
- Teppo Kröger: “Work and childcare in lone parent families: a study from Finland, France, Italy, Portugal and the UK (SOCCARE)”. Nordic Social Policy Research Seminar, Espoo, 22-24 August 2002.
- Teppo Kröger & Minna Zechner & Rossana Trifiletti & Simonetta Simoni: Dissemination and discussion, Qualitative Methods Workshop, DG Research, Family and Welfare Cluster, European Commission, Brussels, 30-31 January 2003.
- Teppo Kröger: “Care strategies of European families: Results from the SOCCARE Project”. Family and Welfare: Policy-relevant Findings. DG Research, Second Family and Welfare Cluster Dialogue Workshop, Brussels, 31 January 2003.
- Claude Martin: “Payment for care for dependent elderly people: policy issue in France”. Communication in the International Conference on “The Direct Employment of Domiciliary Care by Older People”, Policy Studies Institute, London, 13 May 2003.
- Claude Martin: Discussant in the session “Family as a health provider”, in the international seminar of the European Observatory on the Social Situation, Demography and the Family, “Family and health”, Tutzing, 20-22 June 2003.
- José São José: “Trabalhar e Cuidar de um Idoso Dependente: problemas e soluções”. Semana Europeia para a Conciliação Trabalho/Vida Familiar e Social [European Week for the reconciliation of Work and Family Life], Fundação Dr. António Cupertino Miranda, Porto, 2003.
- Karin Wall: “Work and Family in Portugal”. Workshop on Work and Employment, City University, London, 2003.

- Teppo Kröger: “Having an influence, after all? Experiences from a policy-relevant EU research project”. 20:e Nordiska Socialhögskolekonferensen, Helsinki, 16-18 August 2003
- Claude Martin: “La politica francese sull’assistenza all’anziano nel lungo termine: una soluzione intermedia fra le assicurazioni e l’assistenza pubblica”. Communication nel seminario internazionale, “L’anziano nella Rete dei servizi. Le riposte possibili”, Fondazione Don Carlo Gnocchi, 22 settembre 2003.
- José São José: “Caring for a dependent elderly relative: ambivalence and conflicts”. 6th European Conference of Sociology, Murcia, 25-28 September 2003.
- Karin Wall: “Balancing work and childcare in lone parent families”. 6th European Conference of Sociology, Murcia, 25-28 September 2003.
- Minna Zechner: “How to become a dual carer”. 6th European Conference of Sociology, Murcia, 25-28 September 2003.

## **5.2. Exploitation of results**

The research results of the SOCCARE Project can be broadly exploited in two fields: policy-making and research.

Within policy-making, the project has been active in disseminating its results to different levels of decision-makers. *At the local level*, findings have been discussed with the representatives of local authorities, voluntary organisations, different professions and service users. Local mass media has delivered the results to the wider public. The results have direct applicability and use as they point out gaps and inflexibility in public, voluntary and private service provisions at the local level.

*At the national level*, the project has disseminated its results in co-operation with different kinds of national players. In Finland, for example, the project organised a workshop together with the Finnish Federation for Social Welfare and Health which is a national organisation, mostly for voluntary providers of social and health care. The research results have particular applicability at the national level in the five project countries, that is, in Finland, France, Italy, Portugal and the UK. However, the recommendations of the project are written at such a general level that they can be used also in other countries. For those national policy-makers who wish to make it possible for their citizens to combine participation in paid employment and care responsibilities, the results and the recommendations of the SOCCARE Project provide a framework for policy evaluation and reform.

The same applies to policy-making *at the European level*. This study has been realised in five different national welfare state contexts. Variation in these contexts brings out some particular issues. However, the general needs of families are the same all over Europe. Everywhere, family members need flexible working conditions and access to formal support services. If labour market and social policies do not take into account employees’ care responsibilities, these policies are not based on a realistic and firm ground. Also at the European level, policy-making must remember that citizens are workers and carers at the same time. Efficient policy must address simultaneously both of these two spheres of life. The recommendations of this project provide a framework for sketching such integrated policies at the European level.

Within research, previous comparative studies on social care have mainly focused on descriptions of national service systems, based mostly on statistical sources (see, Kröger 2001). Qualitative comparisons have been rare and the voices of service users have remained absent. The SOCCARE Project has tried to develop a new methodological perspective to comparative care research. We have concentrated on the everyday life experiences of families in different European countries. We have asked about the difficulties as well as about the innovative solutions that family members have faced when trying to combine care and work responsibilities. Instead of comparing different countries we have aimed at comparing different social situations in different kinds of welfare state contexts.

Members of the SOCCARE Project Team see that there remains a lot to do with this new methodological perspective. In this project, we have only sketched the approach. The methodology of qualitative comparative care research needs to be developed further. Comparative theoretical concepts and perspectives need to be made deeper and more diversified. The methodology could be applied to several new research themes as well as to other national and local contexts.

Members of the project group will certainly continue their work with these questions even after the official end of the SOCCARE Project. However, it is important that also more generally, comparative care research will in the future focus on the everyday life level of citizens and not just on the system level of formal provisions.

## 6. Acknowledgements and references

### Acknowledgements

First of all, we are deeply grateful to all those families in Finland, France, Italy, Portugal and the UK who have opened their everyday lives to us. We sincerely hope that this report and our other reports make justice to their struggles and innovations in combining work and family lives.

Second, we wish to thank Virginia Vitorino, the Scientific Officer responsible for this project in the European Commission. Her learned guidance and interest in our project have been a major source of support for the realisation of the project. Furthermore, the Commission organised a very useful workshop on comparative qualitative research methods in January 2003 in Brussels. We are also grateful for “the flexible working hours” that the Commission provided us when it granted our project a 6-month extension to our original project period.

Third, the SOCCARE Project has had the privilege of having esteemed commentators during its research process. Our International Expert Group provided us with many valuable comments and perspectives. This group included the following persons: Christine Petioky (Austria), Wilfried Dumon (Belgium), Claus Jensen (Denmark), Riitta Särkelä (Finland), Julien Damon (France), Katherine Bird (Germany), Laura Alipranti (Greece), Anna Lynch (Ireland), Marina Merana (Italy), Monique Borsenberger (Luxembourg), Marja Pijl (Netherlands), Cesarina Marques (Portugal), Juan Antonio Fernandez Cordon (Spain), Margareta Carlberg (Sweden), and Sue Everitt (United Kingdom).

Furthermore, in several of our project meetings, we have had academic expert guests who have commented and advised our ongoing research work. Jeanne Fagnani, Nadine Lefaucheur and Christine Chambaz participated in our meeting in Rennes in March 2001. In our meeting in Canterbury in November 2001, we were joined by Linda Hantrais, Clare Ungerson, Rosemary Crompton, Keith Pringle, Sharon Lewis, Peter Moss and Claire Cameron. In June 2002, João Peixoto, Fernando Luis Machado and Maria das Dores Guerreiro commented our work and its preliminary results in a workshop in Lisbon. The SOCCARE Project has benefited considerably from the comments and suggestions of these experts.

Last but not least, we wish to thank Hannele Auffermann and Susanna Airila, the Research Officers of the University of Tampere. Their broad experience and professional expertise, particularly concerning Framework Programmes of the European Commission, have been an invaluable resource for the co-ordination of this European research project.

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## 7. Annexes

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## 7.2. List of deliverables of the SOCCARE Project

DL		Deliverables list		
Deliverable No	Deliverable title	Planned delivery date (month)	Actual delivery date (month)	Status
1	Report on 'the state of the art' and the methodology of the project	3	13	Completed
2	Workshop on care in single parent families	12	12	Completed
3	Report on care in single parent families	15	22	Completed
4	Workshop on care in multi-career families	18	20	Completed
5	Report on care in multi-career families	21	36	Completed
6	Workshop on care in migrant families	24	26	Completed
7	Report on care in migrant families	27	43	Completed
8	Meeting of the international expert group	27	25	Completed
9	Workshop on care in multi-generation families	30	43	Completed
10	Report on care in multi-generation families	32	43	Completed
11	Final project report	36	43	Completed
12	International conference for dissemination	36	38	Completed

### **7.3. List of publications of the SOCCARE Project**

#### **SOCCARE Project Reports (all available at [www.uta.fi/laitokset/sospol/soccare/](http://www.uta.fi/laitokset/sospol/soccare/))**

- SOCCARE Project Report 1.  
Teppo Kröger: Comparative Research on Social Care: The State of the Art. April 2001. European Commission, Brussels.
- SOCCARE Project Report 2.  
Claude Martin & Antoine Vion: Lone Parent Families, Work and Social Care. January 2002.
- SOCCARE Project Report 2.1.  
Teppo Kröger & Minna Zechner: Care Arrangements in Single Parent Families. National Report: Finland. March 2001.
- SOCCARE Project Report 2.2.  
Claude Martin & Antoine Vion & Arcelia Machado: Care Arrangements in Single Parent Families. National Report: France. March 2001.
- SOCCARE Project Report 2.3.  
Rossana Trifiletti & Alessandro Pratesi & Simonetta Simoni: Care Arrangements in Single Parent Families. National Report: Italy. March 2001.
- SOCCARE Project Report 2.4.  
Karin Wall & José São José & Sónia Correia: Care Arrangements in Single Parent Families. National Report: Portugal. February 2001.
- SOCCARE Project Report 2.5.  
John Baldock & Jan Hadlow: Care Arrangements in Single Parent Families. National Report: United Kingdom. February 2001.
- SOCCARE Project Report 3.  
Trine P. Larsen & Jan Hadlow: Multi-Career Families, Work and Care in Finland, France, Italy, Portugal and the UK. March 2003.
- SOCCARE Project Report 3.1.  
Katja Repo: Care Arrangements in Multi-Career Families. National Report: Finland. September 2001.
- SOCCARE Project Report 3.2.  
Claude Martin & Armelle Debrouse & Blanche Le Bihan & Antoine Vion: Care Arrangements in Multi-Career Families. National Report: France. October 2001.
- SOCCARE Project Report 3.3.  
Rossana Trifiletti & Alessandro Pratesi & Simonetta Simoni: Care Arrangements in Multi-Career Families. National Report: Italy. October 2001.
- SOCCARE Project Report 3.4.  
Karin Wall & José São José & Sónia Correia: Care Arrangements in Multi-Career Families. National Report: Portugal. October 2001.
- SOCCARE Project Report 3.5.  
Jan Hadlow & John Baldock: Care Arrangements in Multi-Career Families. National Report: United Kingdom. October 2001.
- SOCCARE Project Report 4.  
Karin Wall & José São José: Immigrant Families, Work and Social Care. October 2003.

- SOCCARE Project Report 4.1.  
Minna Zechner: Care Arrangements in Immigrant Families. National Report: Finland. May 2002.
- SOCCARE Project Report 4.2.  
Claude Martin & Armelle Debrouse & Blanche Le Bihan: Care Arrangements in Immigrant Families. National Report: France. April 2002.
- SOCCARE Project Report 4.3.  
Rossana Trifiletti & Alessandro Pratesi & Simonetta Simoni: Care Arrangements in Immigrant Families. National Report: Italy. April 2002.
- SOCCARE Project Report 4.4.  
José São José & Karin Wall & Sónia Vladimira Correia: Care Arrangements in Immigrant Families. National Report: Portugal. May 2002.
- SOCCARE Project Report 4.5.  
Jan Hadlow & John Baldock: Care Arrangements in Immigrant Families. National Report: United Kingdom. May 2002.
- SOCCARE Project Report 5.  
Rossana Trifiletti & Simonetta Simoni & Alessandro Pratesi: Work and Care in Double Front Carer Families. October 2002.
- SOCCARE Project Report 6.  
Teppo Kröger: Families, Work and Social Care in Europe. October 2003.

#### **Other publications from the SOCCARE Project**

- Teppo Kröger & Jorma Sipilä (eds.) Special Issue of the Journal *Social Policy & Administration*, based on articles from the members of the SOCCARE Project Team, forthcoming.
- Teppo Kröger: “Studying care strategies of European families (SOCCARE)”. In L. Hantrais (ed.) *Researching Family and Welfare from an International Perspective*. European Commission, Brussels, 2001.
- Teppo Kröger: “New kinds of families, new kinds of social care: shaping multi-dimensional European policies for formal and informal care (SocCare)”. In L. Hantrais (ed.) *Policy Relevance of ‘Family and Welfare’ Research*. European Commission, Brussels, 2003.
- Teppo Kröger: “Having an influence, after all? Experiences from a policy-relevant EU research project”. In I. Julkunen (ed.) *Socialt arbete och samhällsengagemang: diskurser och lokala praktiker*. Konferensrapport. Social- och Kommunalhögskolan, Helsingfors, forthcoming.
- Blanche Le Bihan & Claude Martin: “L’assistenza agli anziani non autosufficienti in Francia”, *L’Assistenza Sociale, Revista Trimestrale sulle Prospettive del Welfare*, n°4, ottobre-dicembre 2001, p. 259-274.
- Blanche Le Bihan & Claude Martin: “Comparer les paniers de services aux personnes âgées dépendantes en Europe”. In *Les personnes âgées dépendantes. Quelles politiques en Europe ?*, (sous la direction de C. Martin), Presses universitaires de Rennes et éditions ENSP, 2003, p. 339-355.
- Claude Martin: “Fondements et figures de la protection par les proches : quelles leçons pour la définition de l’action politique ?” In *La qualité de vie dans les sociétés vieillissantes. Approches sociologiques comparées France-Japon*, Université René Descartes – Paris V, Faculté des sciences sociales. Edité par Koken Sasaki, La société japoно-française de sociologie, Bureau de sociologie, Faculté des Lettres, Université Soka, Tokyo, Japon, mai 2001, p. 31-38.

- Claude Martin: “Familles et générations : grandes tendances”. In *L'état de la France 2002-2003*. Paris, édition La Découverte, 2002, p. 88-94.
- Claude Martin: “Solidarités familiales : l'illusion du renouveau”. In J-F Dortier (dir), *Familles. Permanence et métamorphoses*. Paris, éditions Sciences humaines, 2002, p. 107-112.
- Claude Martin: “L'accueil des jeunes enfants en Europe. Quelles leçons pour le cas français ?” In F. Leprince, *L'accueil des jeunes enfants en France : Etat des lieux et pistes d'amélioration*, Paris, Publication du Haut Conseil de la Population et de la Famille, La Documentation française, 2003, p. 137-192.
- Claude Martin: “Vieillir autonome : un défi européen”. In *Les personnes âgées dépendantes. Quelles politiques en Europe ?*, (sous la direction de C. Martin), Presses universitaires de Rennes et éditions ENSP, 2003, p. 9-25.
- Karin Wall & José São José & Sónia V. Correia: “Mães Sós e Cuidados às Crianças” [Lone mothers and childcare], in *Análise Social*, Vol. 163, summer 2002, pp. 631-663.
- Karin Wall & José São José & Sónia V. Correia: “Trabalhar e Cuidar de um Idoso Dependente: problemas e soluções” [Work and care of a dependent elderly: problems and solutions]. In *Cadernos de Política Social*, 2002 (available at the web-site of the Institute of Social Sciences, <http://www.ics.ul.pt/>).