

Family care in the Swedish welfare state: extent, content and consequences

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Abstract

The aim of this paper is to analyse the extent, content and consequences of family caregiving among middle-aged women and men in Sweden today. The analysis focuses on gender and level of education, using data on persons aged 45-66 years from a nationally representative postal survey (n=3630) conducted in 2013. Of the respondents, 28% are caregivers, defined as providing help at least once a week to a family member, relative or friend with a disability or longstanding illness. Almost 80% of the caregivers assist an older person (65+), most often a frail parent.

This paper confirms previous research in that middle-aged women are more frequently caregivers, give more intensive care and are more negatively affected by caregiving than middle-aged men. The gender difference in both the frequency and intensity of caregiving is however only found among highly educated persons, and the gender differences in the consequences of caregiving are more extensive in this group, especially regarding their work situation.

The analysis focuses on educational differences among women and men, respectively. No educational differences were found among women or men in how common it is in the middle-aged population to be a caregiver. Female caregivers with higher education however give more intensive care, on average 7.9 hours a week compared to 4.9 hours a week among other female caregivers. Female caregivers with higher education are more negatively affected than other female caregivers on a number of outcomes concerning well-being, work situation and attachment to the labour market. These outcomes include difficulties to find time to see friends, mental strain, reduced ability to focus on the job, difficulties in keeping working hours, difficulties in managing to accomplish tasks and having to reduce working hours because of caregiving. No significant educational differences between female caregivers were however found in experiencing physical strain, being on sick leave for more than two weeks, having to quit the job or have retired earlier than planned due to caregiving.

No educational differences were found among male caregivers in the intensity of care provided (around 5 hours a week on average). The only negative outcome that differs among male caregivers with different levels of level of education concerns mental strain; those with higher education more frequently experience mental strain due to caregiving.

These results fill a knowledge gap in Swedish research on the extent and consequences of caregiving in middle age. Previous analyses of nationally representative surveys on socioeconomic differences among women and men in the extent and consequences of caregiving in Sweden are almost non-existing.

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Introduction

This paper explores family caregiving among middle-aged women and men in Sweden today, by analysing the meaning of gender and level of education for the extent, content and consequences of caregiving in middle age. The consequences concern caregivers' well-being, work situation and attachment to the labour market. In this study caregiving is defined as providing help at least once a week to a family member, relative or friend with a disability or longstanding illness. As almost 80% of the caregivers in this study assist an older person, most often a frail parent, and the consequences examined mainly deal with caregivers' working life, the main context for this study concern the elder care system, older people's care preferences and the labour market in Sweden. I will start this introduction by describing the main development of Swedish eldercare services, followed by a description of the theoretical framework and context of the study. The introduction is followed by sections on previous research, material and method, results and preliminary discussion and conclusion.

Swedish policy and practice regarding elder care has since long been guided by the goal of giving older people the opportunity to age in their own homes rather than in an institution. This "ageing in place"-policy has led to a gradual downsizing of residential care, driven by measures of cost containment. Today, Sweden has the lowest per capita hospital bed rate in Europe (OECD 2012, p. 77) and every fourth bed in nursing homes have disappeared since the year 2000. As a result, an increasing proportion of frail older people are dependent on help in their own homes. After decades of declining home care services, since the year 2000 they have increased, which have however not compensated for the decrease in institutional care. Therefore, frail older people have become increasingly dependent on their family members, especially their adult children (Ulmanen & Szebehely 2015).

The proportion of older people in Sweden receiving eldercare services have declined sharply since 1980, when 62 percent of older persons (80 years and older) received home care or residential care (Ulmanen, 2015a, p. 21). In 2015, only 37 percent of older persons received any of these services (NBHW, 2017). A part of the decline in services is explained by an improvement in the functional ability among older persons, but the municipalities' assessments have also become stricter, making it much harder to receive eldercare services.

Previous Swedish studies show that older people with care needs have become increasingly dependent upon their children, relatives and friends outside their household since the 1980s, and that this development mostly concern older people with lower levels of education (Szebehely & Trydegård 2012) and help from daughters (Johansson, Sundström & Hassing 2003). In the 2000s, filial care has increased among sons as well as daughters, and among older persons with lower as well as higher levels of education. It is however still most common among older persons with lower levels of education to receive filial care and daughters remain as the primary providers (Ulmanen & Szebehely 2015). Analyses using Swedish nationally representative data from the caregiver's perspective of how gender and socioeconomic position interacts in the extent and consequences of caregiving is however very sparse, therefore it is not known which of the groups give the most extensive care or are most negatively affected by caregiving.

Theoretical framework

The theoretical framework used in this paper takes its inspiration from feminist work on the importance of welfare state provision for care for women's citizenship, including personal autonomy and economic independence (see review in Ulmanen 2015a). As a point of departure, care preferences and the extent of family care are seen as related to the generosity and design of the welfare state.

Older people in the Nordic countries generally prefer publicly financed eldercare to filial care, as these services offer opportunities to establish more independent relationships between generations according to widely held norms of intimacy at a distance (Alber & Köhler 2004; Daatland & Lowenstein 2005). The Nordic welfare states are more generous in offering publicly financed eldercare services than most other European welfare states. Due to the generosity of care services, family care is more common but less intensive in Sweden than in welfare states providing fewer eldercare services (Alber & Köhler 2004; Rodrigues, Huber & Lamura 2012). Gender differences in the intensity of family caregiving are also smaller in Sweden, as eldercare services relieve primarily the more intensive family care provided by women (Schmid, Brandt & Haberkern 2012).

The ideals of the Nordic welfare state concerning universalism and de-familialization provide both a theoretical framework and a normative point of departure for this paper. Universalism regarding care services involves public financing, accessibility guaranteed by social rights and that services are actually used by a majority of the citizens who are in need of them. The same services are directed towards and used by all social groups, implying that services are affordable for the poor as well as attractive for those better off. Care services are thus provided in a way that makes them attractive, accessible and affordable for all citizens (Kröger, Anttonen & Sipilä 2003; Vabø & Szebehely 2012).

Familialization and de-familialization constitute a continuum representing how the welfare state affects the conditions for individuals' engagement in their families. While familialization implies individuals becoming more economically and socially dependent upon their families; de-familialization implies individuals becoming less economically and socially dependent upon their families (McLaughlin & Glendinning 1994; Leitner & Lessenich 2007; Kröger 2011). In offering care services according to the principles of universalism, welfare states contribute to de-familialization by increasing the extent to which family care is voluntary for those in need of care as well as their family members. The degree of de-familialization thus depends on the universality of care services; that is, the generosity of services in terms of coverage and intensity (Rauch, 2007). Eldercare services enables a more genuine choice for both parties regarding the terms and conditions under which they would like to give or receive family care.

The comparatively generous provision of publicly financed eldercare services in Sweden has thus lessened dependency on both the family and the market for older persons in need of care as well as for their family members. As more well off individuals have always been able to purchase services on the market, and thus become less dependent upon their families, publicly financed eldercare services are most significant for individuals in less affluent groups. As women are primarily responsible for the care of children and older people in the family, publicly financed care services are crucial for women's opportunities for gainful employment and economic independence (Anttonen 1990, 1998; Saraceno 2010). As women constitute the majority of older people in need of care outside of their

own household, publicly financed eldercare services are of crucial importance for the personal autonomy of primarily women on both sides of the caring relationship (Szebehely 2005).

From the understanding outlined above, the decline in publicly financed eldercare services in Sweden since 1980 has reduced the extent to which family care is voluntary for both older persons in need of care and their family members.

Swedish eldercare: policy goals and care preferences

The decline in eldercare services and the increase in help from non-cohabiting family and friends since the 1980s were not the result of new legislation or of changing preferences among older people. Swedish legislation and national policy on eldercare have remained unchanged in recent decades in relation to the goals of universalism and de-familialization (Johansson, Long, & Parker 2011). Adult children are not legally obliged to provide care for, or economically support, their parents. Not even spouses have a legal responsibility to provide personal care for each other in old age. Rather, eldercare is ultimately a public responsibility. National policy states that eldercare should be publicly financed, available as needed and not based on the individual's purchasing power, thereby enabling older people to maintain independence as they age. In addition, recent national policy on support for family carers strongly stresses that family care has to be provided voluntarily (Johansson et al. 2011).

Older people in the Nordic countries generally prefer to receive help from publicly financed eldercare rather than from their children (Daatland, 1990). If they can no longer manage in their own homes, most older people prefer to move to a residential care home rather than moving in with their children (Daatland 1990; Daatland and Herlofson 2004). The adult children's wish to help their elderly parents is generally stronger than the parents' wish to receive such help (Daatland and Herlofson 2004; Daatland et al. 2011). Thus the provision of publicly financed eldercare services has enabled older people to establish more independent relationships.

According to the latest available Swedish figures, the preferences for publicly financed eldercare services did not change during the 1990s and there was no difference between educational groups. In year 2000, only around 10 per cent of older people, irrespective of level of education, preferred to get help with cleaning or laundry from children or other non-cohabiting relatives or friends, and even fewer preferred it for more intimate tasks such as help with bathing. In addition, very few preferred privately purchased services. The majority preferred to receive help from publicly financed care services (around 50%) or from a spouse (around 30%) (Szebehely & Trydegård 2007).

Despite these care preferences – and despite the comparatively generous provision of publicly financed eldercare services – also in Sweden frail older people get most of the care they need from children or other non-cohabiting relatives or friends. Non-cohabiting relatives or friends provide around two-thirds of the total amount of care for older persons, while the remainder is provided by publicly financed care services. Thus many older persons, especially women, get much more help from their children and other non-cohabiting relatives or friends than they would like (Sundström et al. 2002; Szebehely 2005).

Women and men in the Swedish labour market

As in most countries, care responsibilities during the life course affect women's activity in the Swedish labour market much more than men's. There are generally three peaks in care

responsibilities during the life course, of which the two first affect the labour force participation of women. The first peak in care responsibilities concerns child bearing, the second appears in middle age and primarily concerns the needs of aged parents, and the third peak concerns assistance to a partner or spouse after retirement.

Having young children or aged parents with care needs while being in paid work is probably more frequent, but less problematic, in Sweden and other Scandinavian countries compared to most other welfare states. This is because Sweden has high fertility rates, high labour force participation among women and a generous provision of publicly financed child- and eldercare services. Although the average Swedish woman has almost two children during her lifetime and it is very common in mid-life to care for aged parents, women remain in paid work owing to highly accessible publicly financed child- and eldercare services.

Sweden has the highest employment rate both among women in general and among mothers in 28 OECD countries. In Sweden, 83 percent of both women and mothers are employed, compared to the OECD average of 72 percent of women and 67 percent of mothers (OECD, 2016a). Among 46 OECD countries, Sweden has the second highest proportion of middle-aged women in employment (OECD, 2016b).

The high proportion of employed women in Sweden is often said to come at the cost of a high proportion of women in part-time work. Therefore, the level of part-time work has to be related to the level of employment in each country. What is regarded as part-time and full-time work however varies between countries. In international statistics, where the line between part-time and full-time work is drawn at 30 hours a week, 18 percent of employed women in Sweden work part time, compared to the OECD average of 26 percent (OECD, 2016c). In the Swedish national statistics, however, 35 hours a week is the dividing line between part time and full time work, which gives different proportions: among women in the labour force, 24 percent work part time and 54 percent work full time, and, among men, 8 percent work part time and 73 percent work full time.¹ Most Swedish part time working women work around 30 hours a week. The most common reason given by both women and men for working part time is that appropriate full time work is not available. The second most common reason among women is childcare, a reason given by very few men (Statistics Sweden, 2014).

The attachment to the labour market is essential for women's possibility for economic independence. To have a permanent job in the form of a full time employment is the strongest form of attachment to the labour market. This kind of employment maximises citizens' possibilities to personal and economic autonomy, and thereby increase their possibilities to control and shape their own lives. On the contrary, temporary and part time employments offer a weaker position for the employee, with worse working conditions and less influence over their work situation. Temporary employments of course also offer less employment security (Bergold, Vedin & Lorentzi 2017).

Table 1 shows how common it is to have a temporary employment and work part time among female and male white-collar and blue-collar workers, according to the Swedish national Labour Force Surveys. Among both female and male white-collar workers, 1 out of 10 have a temporary

¹ Individuals in the labour force are either employed or unemployed. In total, 77 per cent of women and 82 per cent of men in the labour force are employed, and the remaining are unemployed.

employment, compared to 1 out of 4 women and less than 1 out of 5 men among blue-collar workers. Among women, every second blue-collar worker work part time compared to 1 out of 4 white-collar workers. Among male blue-collar and white-collar workers, 1 to 2 out of 10 work full time. Thus, having a temporary employment as well as working part time is most common among blue-collar women.

Table 1. Proportion of employees (%) having a temporary employment, work part time and reasons for working part time by gender among white-collar and blue-collar workers in Sweden, 2016

	Women		Men	
	Blue-collar workers	White-collar workers	Blue-collar workers	White-collar workers
Have a temporary employment (%)	25	10	18	10
Work part time (%)	50	25	14	9
Reasons for working part time (proportion of the total number of employees in every group)				
Appropriate full time work is not available (%)	21	4	7	2
Childcare (%)	5	9	0	2
Physically or mentally demanding work (%)	5	1	0	0
Do not wish to work full time (%)	3	3	1	1
Other reasons (illness/reduced working capacity, studies etc) (%)	15	9	6	4

Source: Statistics Sweden's Labour Force Surveys (Bergold, Vedin & Lorentzi 2017, p. 4-6).

Table 1 also shows the reasons given for working part time. The main reason given among blue-collar women is that appropriate full time work is not available, this concerns 4 out of 10 part time working blue-collar women (21% of all female blue-collar workers). The main reason among white-collar women is childcare, this concerns a third of part time working white-collar women (9 % of all female white-collar workers). It is uncommon in all four groups of workers to work part time because not wanting to work full time (between 1 and 3%).

The pattern of part time versus full time work differs during the life course between blue-collar and white-collar women. Both groups usually work part-time when they have small children, but while white-collar women most often go back to full-time after that period, blue-collar women often continue to work part-time during the whole life course (Bergold, Vedin & Lorentzi 2017).

Previous research

Comparative studies of care patterns in various European countries suggest that generously provided publicly financed eldercare tends to reduce the intensity of family caregiving rather than to replace

it. In countries with less publicly financed eldercare, more middle aged persons provide intensive help and fewer persons provide sporadic help, whereas in countries with a generous provision of eldercare, fewer persons give intensive help and more persons provide sporadic help (Alber & Köhler 2004; Rodrigues, Huber & Lamura 2012).

Furthermore, studies show considerable socioeconomic differences in the use of care from different sources. Older people with low socioeconomic status receive more help from their children and use fewer privately purchased services than older people with high socioeconomic status (Saraceno, 2010; Sarasa & Billingsley, 2008). Although this seems to be true for all welfare regimes, the size of these class-related differences varies with the generosity of publicly financed eldercare. The lower the level of service development in a welfare state, the more the citizens have to turn to their family or to the market to get the care they need. Whether they turn to their family or to the market depends on their income (Saraceno, 2010). Where care services are mainly privately purchased, as in Southern Europe, less affluent persons cannot afford them and therefore rely on their children more than do those who are more affluent. Correspondingly, where care services are mainly publicly financed, as in Scandinavia, the services are also available for less affluent groups, thus reducing their reliance on their children for care (Sarasa & Billingsley, 2008).

Older people with low income receive filial care significantly more often than older people with high income (Sarasa & Billingsley, 2008), and older people with lower levels of education receive care from their children and other non-cohabiting family and friends significantly more often than do those with higher levels of education (Rostgaard & Szebehely 2012; Ulmanen & Szebehely 2015). The extent of publicly financed eldercare not only influences the help given by adult children differently depending on their elderly parents' socioeconomic status, but also depending on their gender. Throughout Europe, it is much more common for daughters than for sons to provide intensive support to their elderly parents, while only slightly more daughters than sons give sporadic support. As generously provided eldercare relieves daughters from providing intensive support, the gender difference in this respect is smaller in Scandinavia than it is in Southern Europe. Nevertheless, even in Sweden more daughters than sons provide intensive as well as sporadic support (Schmid et al., 2012).

To conclude, generous provision of publicly financed eldercare has the potential to decrease inequality with respect to both class and gender, not only for dependent persons but also for those who provide care for them (Saraceno, 2010). If there is not enough publicly financed eldercare, the more affluent people can purchase services at market price, whereas poorer people have no option but to turn to their families. Women, primarily wives and middle-aged daughters, provide the majority of family care for frail older people. As extensive caregiving decreases women's availability for paid work, eldercare services help women to maintain economic independence through paid work (Lilly, Laporte, & Coyte, 2007).

Swedish research on how class and gender interacts in caregiving and its consequences is very sparse, at least concerning recent analyses of nationally representative surveys. According to one of these few analyses, level of education did not affect the likelihood of being a caregiver in middle age for women. It was, however, more common among men with lower levels of education to be a caregiver than among highly educated men. Female caregivers with lower levels of education more seldom work full time and more often have a weak position on the labour market, compared to other

middle-aged female caregivers. Among male caregivers, the pattern was reversed: caregivers with higher levels of education more often had a weak position on the labour market compared to other caregivers (Szebehely & Ulmanen 2009).

Both Swedish and international research show that the caregiver's gender, the intensity of caregiving and the generosity in provision of eldercare services are significant for the occurrence of negative consequences of caregiving. Women give more intensive care than men and women are also more negatively affected by caregiving (Lilly et al 2007). Caregivers in countries with less generously provided eldercare services give more intensive care and are more negatively affected, compared to caregivers other countries (Colombo et al 2011, p. 85-158). According to previous Swedish studies on gender differences in caregiving, middle-aged women give more intensive family care and are more affected in their well-being, work situation and attachment to the labour market due to caregiving than men (NBHW 2012, 2013, 2014; Szebehely, Ulmanen & Sand 2014; Szebehely 2014; Ulmanen 2015b).

Material and method

This paper aims at analysing the extent, content and consequences of caregiving among middle-aged women and men in Sweden today. The analysis concerns the significance of level of education for women and men, respectively, for the extent and content of caregiving and its consequences for well-being, work situation and attachment to the labour market. Caregiving is defined as providing help at least once a week to a family member, relative or friend with a disability or longstanding illness. The extent of caregiving has two dimensions: frequency (how common it is in the general population to be a caregiver) and intensity (how many times or hours a week care is provided). The content of caregiving concerns the tasks performed in caregiving. Lower levels of education means having compulsory or upper secondary education only, while higher levels of education means having a university education.

The analysis is based on a national representative postal survey designed and carried out by a research group (including myself) at the Department of Social Work, Stockholm University. Statistics Sweden assisted with expert reviews, selection and collection of data. The survey was sent out with three reminders in 2013 to 6,000 randomly selected individuals aged 45-66 years who were registered in Sweden. The response rate was 61 per cent (n=3630).

While previous Swedish surveys on caregiving have used a general non-specific screening question, this survey used a more concrete one by asking if the respondent performs a number of specific caring tasks. This is also the first national survey in Sweden asking more detailed questions about whether the work situation has been affected by caregiving. Previous surveys have only included questions about consequences for the attachment to the labour market.

The material has been analysed statistically in bivariate analyses, using Pearson's chi-square test and t-test, and in multivariate analyses, using logistic regression.

Results

Extent of caregiving

Caregiving is common in Sweden: according to the survey, 28% of the middle-aged population are caregivers, defined as providing help at least once a week to a family member, relative or friend with a disability or longstanding illness. Of the caregivers, 78 per cent primarily assist an older adult (65

years and older, most often a frail parent), 15 per cent primarily assist a younger adult (20-64 years) and 3 per cent primarily assist a child (a person younger than 20 years). Some caregivers help several persons, both younger and older.

It is slightly more common among women to be caregivers than among men: table 2 show that 30 per cent of middle-aged women are caregivers compared to 27 per cent among men. Female caregivers provide more intensive help, on average 7.0 hours a week, compared to male caregivers who provide on average 5.0 hours a week. Furthermore, it is more common among female caregivers to provide care every day (19%) than among male caregivers (13%).

Table 2. Extent of caregiving among middle-aged women and men, 2013

	Women (n=1843)	Men (n=1640)	Sig*
Proportion (%) in the population 45-66 years who are caregivers (i.e. provide care at least once a week)	29.8	27.0	0.065
	Female caregivers (n=509-513)	Male caregivers (n=415-416)	Sig*
Average number of hours of help given per week	6.99	4.98	0.001
Proportion (%) providing care every day	19.1	12.8	0.009
Proportion (%) providing care several times a week	26.7	30.8	0.165
Proportion (%) providing care approx. once a week	51.9	54.9	0.349

*Significance test using Pearson's χ^2 , except for average number of hours of help where t-test has been used.

What does level of education mean for these gender differences in caregiving? In the analyses in this paper, lower levels of education means having compulsory or upper secondary education only, while higher levels of education means having a university education. Table 3 shows that there are no significant educational differences among women and men, respectively, in how common it is in the middle-aged population to be a caregiver. 30 per cent of women and between 25 and 28 per cent of men are caregivers irrespective of level of education. Among female caregivers there is however an educational difference in the intensity of caregiving, which is not found among male caregivers: female caregivers with lower levels of education provide on average 6.0 hours of help a week, while those with higher education provide 7.9 hours a week. The corresponding numbers for male caregivers are 5.1 and 4.9 hours of help a week.

The gender difference in the extent of caregiving among middle-aged persons with higher education is in fact significant, while it is not significant among those with lower levels of education. These results concern both the proportion in the population who are caregivers and the average number of

hours of help given per week (analysis not shown in table 3).² The gender difference in the extent of caregiving is thus only found among highly educated persons.

Table 3 however provides some background information on the caregivers in the study, which are relevant for the analyses presented later in this paper. According to previous research, both country of birth and the extent of paid work affects the extent and consequences of caregiving. The caregivers in this study show the same pattern as the general middle-aged population: full time work is more common among men, while part time work is more common among women, especially among women with lower levels of education. Not being in paid work at all is more common among those with lower levels of education than among highly educated, irrespective of gender.

Table 3 shows significant educational differences only among female caregivers in their relationship to the labour market at the time when they answered the survey. Female caregivers with higher education have a higher labour force participation than those with lower levels of education. Among female caregivers with lower levels of education 42 per cent work full time, 32 per cent work part time and 26 per cent are not in paid work. Among female caregivers with higher education 62 per cent work full time, 24 per cent work part time and 15 per cent are not in paid work. Among male caregivers, no significant educational differences was found. Around 70 to 72 per cent work full time, around 7 to 10 per cent work part time and around 17 to 23 per cent do not work, irrespective of level of education.

The survey questions on consequences of caregiving concern the last 5 years before the respondents participated in the survey, and most of these questions concern consequences for the caregivers' paid work. Therefore, table 3 presents the proportions of the different groups of caregivers in the survey who had been in paid work at some time during the last 5 years. This is most common among highly educated caregivers of both genders: 96 per cent of female and 93 per cent of male caregivers with higher education, compared to 86 per cent of female and 87 per cent of male caregivers with lower levels of education.

Around 1 out of 10 caregivers were born outside of the Nordic countries, and there were no significant differences between the groups in this respect.

² Among those with lower levels of education, the gender difference is neither significant regarding the proportion of caregivers in the population ($p=0.406$), nor regarding the average number of hours of help given per week ($p=0.261$). Among those with higher education, the gender difference is significant both regarding the proportion of caregivers in the population ($p=0.033$), and regarding the average number of hours of help given per week ($p=0.001$).

Table 3. Extent of family caregiving among middle-aged women and men, respectively, by level of education (lower levels of education=compulsory or upper secondary education only; higher education=university education), and background information on caregivers, 2013

	Women			Men		
	Lower levels of education (n=391)	Higher education (n=493)	Sig*	Lower levels of education (n=466)	Higher education (n=328)	Sig*
Proportion (%) in the population 45-66 years who are caregivers (i.e. provide care at least once a week)	30.0	29.7	0.897	28.2	24.9	0.135
	Female caregivers			Male caregivers		
	Lower levels of education (n=239-258)	Higher education (n=267-288)	Sig*	Lower levels of education (n=255-275)	Higher education (n=156-163)	Sig*
Average number of hours of help given per week	6.01	7.90	0.060	5.08	4.90	0.803
Proportion of caregivers who...						
work full time (%)	41.5	61.7	0.000	69.5	72.7	0.487
work part time ³ (%)	32.1	23.8	0.032	7.4	9.9	0.364
do not work ⁴ (%)	26.4	14.5	0.001	23.0	17.4	0.163
have been in paid work at some time during the last 5 years (%)	86.4	95.8	0.000	87.3	92.6	0.079
were born outside of the Nordic countries (%)	7.8	9.7	0.417	9.8	11.7	0.544

*Significance test using Pearson's χ^2 , except for average number of hours of help where t-test has been used.

Content of caregiving

According to previous research, including previous analyses of the survey analysed in this paper, the tasks performed by caregivers differ between genders. It is more common among women to give

³ As no limit between full time and part time work was given in the survey, the respondents decided by themselves how to categorize the extent of their paid work. Normally, 40 hours a week is regarded as full time work in Sweden, but in some parts of the labour market the limit is lower. In national statistics, 35 hours a week is the dividing line between part time and full time work.

⁴ Implies being unemployed, student, retired, on long term sick leave, housewife or house husband.

household help (cleaning, buying food, doing laundry, cooking), emotional care (emotional support as well as looking after, reminding, motivating), personal care (bath/shower, get dressed, get out of bed) and medical care (apply bandages, give medicines or injections). Administrative help (paying bills, bank and postal errands) and managerial care (contacts with eldercare services and health care) are just as common among women as among men. Other practical help (repairs, gardening, transports, giving a lift) are the only tasks more often performed by men. Although emotional support was not included in the questions in the survey analysed here, other tasks usually classified among emotional care was included, namely “looking after, reminding and motivating” (Szebehely, et al 2014; Szebehely 2014; Ulmanen 2015b).

In general, household help, other practical help and “looking after, reminding and motivating” are the most common tasks performed by middle-aged caregivers, closely followed by administrative help and managerial care. The more intimate personal and medical care are the least common tasks performed among those included in the survey (ibid).

Table 4 show tasks performed by female and male caregivers, respectively, by level of education. Significant educational differences are found among female caregivers regarding “other practical help” and managerial care, and among male caregivers regarding managerial care and personal care. 72 per cent of female caregivers with lower levels of education provides “other practical help”, compared to 80 per cent of those highly educated. 13 per cent of male caregivers with lower levels of education provide personal care, compared to 6 per cent of those with higher education. Among both female and male caregivers with higher education, 71 per cent provides managerial care, compared to 58 to 59 per cent of caregivers of both genders with lower levels of education.

Table 4. Care tasks performed by middle-aged female and male caregivers, respectively, by level of education (lower levels of education=compulsory or upper secondary education only; higher education=university education). Proportion (per cent) of caregivers, 2013

	Female caregivers			Male caregivers		
	Lower levels of education (n=230-246)	Higher education (n=270-281)	Sig*	Lower levels of education (n=240-265)	Higher education (n=156-162)	Sig*
Household help (cleaning, buying food, laundry, cooking)	73.2	71.2	0.620	60.7	58.8	0.693
Other practical help (repairs, gardening, transports, giving a lift)	72.2	80.0	0.036	90.2	85.2	0.119
Administrative help (paying bills, bank and postal errands)	55.7	57.5	0.685	51.0	59.2	0.105
Managerial care (contacts with eldercare services and health care)	58.0	70.6	0.003	59.4	71.4	0.013
Looking after, reminding, motivating	76.8	82.2	0.123	67.1	75.6	0.067
Personal care (bath/shower, get dressed, get out of bed)	18.4	22.1	0.295	13.2	6.4	0.031
Medical care (apply bandages, give medicines or injections)	23.0	22.2	0.827	13.3	9.6	0.246

*Significance test using Pearson's χ^2 .

Consequences of caregiving

According to previous research, including previous analyses of the survey analysed in this paper, it is more common among women than among men in middle age to be negatively affected by caregiving. Previous analyses of the survey analysed here however show that some types of consequences regarding the caregivers' paid work is as common among men as among women, including difficulties in keeping working hours, difficulties in managing to accomplish tasks and to quit their job. Consequences in three areas are analysed here: well-being, work situation and attachment to the labour market. The most common negative consequences of caregiving among both men and women concern the caregivers' well-being, while consequences for their work situation is not as common and the least common consequences concern their attachment to the labour market (Szebehely et al 2014; Szebehely 2014; Ulmanen 2015b).

Table 5 shows these three areas of negative consequences of caregiving among female and male caregivers by level of education. There are significant educational differences in 6 out of the 10 outcomes among female caregivers, but in only 1 out of 10 outcomes among male caregivers. Among both women and men, caregivers with higher education are more affected than those with lower levels of education.

The only educational difference among male caregivers is that those with higher education more frequently experience mental strain (39%) than other male caregivers (30%). Among female caregivers, the highly educated group more often than those with lower education have experienced difficulties finding time to see friends (49 vs 41%), mental strain (65 vs 53%), reduced ability to focus on their job (43 vs 28%), difficulties in keeping working hours (31 vs 14%), difficulties in managing to accomplish tasks (26 vs 10%) and having to reduce their working hours (14 vs 9%). Regarding the outcomes physical strain, being on sick leave for more than 2 weeks, having to quit their job and retire earlier than planned, female caregivers with higher and lower levels of education are equally affected.

The gender differences in the consequences of caregiving are more extensive among caregivers with higher education than among those with lower levels of education, especially in their work situation (analysis not shown in table 5). Women with higher education are significantly more affected than the corresponding group of men in all three outcomes concerning work situation, while women with lower levels of education are more affected only concerning reduced ability to focus on their job. The other significant differences are that women with lower levels of education more often than the corresponding group of men have retired earlier than planned, while women with higher education more often have reduced their working hours.

Table 5. Consequences of caregiving among middle-aged female and male caregivers by level of education (lower levels of education=compulsory or upper secondary education only; higher education=university education). Proportion (per cent) of caregivers affected, 2013

	Female caregivers			Male caregivers		
	Lower levels of education (n=209-217)	Higher education (n=264-274)	Sig*	Lower levels of education (n=224-234)	Higher education (n=146-149)	Sig*
Well-being						
Difficulties finding time to see friends	40.6	48.7	0.072	27.0	29.7	0.569
Mental strain	53.3	64.6	0.011	30.0	38.5	0.086
Physical strain	30.7	32.0	0.762	16.5	14.4	0.581
Work situation						
Reduced ability to focus on the job	28.1	42.7	0.001	15.8	20.1	0.278
Difficulties in keeping working hours	14.2	31.3	0.000	17.0	23.5	0.122
Difficulties in managing to accomplish tasks	9.5	25.7	0.000	14.4	17.0	0.496
Attachment to the labour market						
Being on sick leave for more than 2 weeks ⁵	5.6	8.5	0.219	3.1	1.4	0.288
Reduced working hours	9.2	14.4	0.081	8.2	8.9	0.818
Quit the job	2.3	3.3	0.517	1.3	2.0	0.595
Retired earlier than planned	6.5	3.7	0.157	1.7	2.7	0.536

*Significance test using Pearson's χ^2 . Only caregivers who have been in paid work at some time during the last 5 years are included in the analysis.

A number of factors other than gender and level of education might affect the risk of experiencing negative consequences of caregiving. According to previous analyses of the material analysed here, the intensity of caregiving increases the risk of being negatively affected (Szebehely et al 2014), and persons (mainly women) born outside the Nordic countries give more extensive care and have a higher risk of facing negative consequences (Ulmanen, unpublished manuscript). The caregiver's age probably affect the risk of some negative consequences, especially the risk for retiring earlier than planned. Previous analyses of other Swedish surveys have also found a relationship between position on the labour market and/or extent of paid work on the one hand, and extent of caregiving on the other (Szebehely 2006; Szebehely & Ulmanen 2009).

Therefore, I have made multivariate analyses shown in table 6, examining whether the educational differences among female and male caregivers in the extent of those negative consequences reported in table 5 could be explained by other differences between these groups. The differences or background variables controlled for in this logistic regression analysis are care intensity (number of hours of help per week), country of birth (in the Nordic countries or not), the caregiver's age and extent of paid work (in full time work or not when participating in the survey).

⁵ Requires a doctor's certificate.

Most of the educational differences in negative consequences among female and male caregivers (shown in table 5) remain when controlling for the background variables in the multivariate analysis (shown in table 6). That female caregivers with higher education more often than other female caregivers have experienced mental strain, reduced ability to focus on their job, difficulties in keeping working hours, difficulties in managing to accomplish tasks and having to reduce working hours is confirmed in table 6. The higher risk among female caregivers with higher education to experience these negative consequences can thus not be explained by the other differences between the groups controlled for in the analysis.

That female caregivers with higher education slightly more frequently than other female caregivers have difficulties in finding time to see friends, which was seen in table 5, however disappears in table 6. This could probably be explained by full time work being more common among female caregivers with higher education than among other female caregivers, as those who work full time have a slightly higher risk of difficulties in finding time to see friends. For the other outcomes, working full time did however not increase the risk for female caregivers to be negatively affected (results not shown in table 6).⁶

Another difference between table 5 and 6 is that the risk for female caregivers with higher education to have reduced working hours becomes stronger when controlling for the background variables in the multivariate analysis. This difference cannot be explained by a higher risk due to a higher proportion of highly educated female caregivers in full time work. As mentioned above, full time work imply a lower risk to have to reduce working hours.

For male caregivers, table 6 show no significant risks for any negative outcome. According to table 5 however, male caregivers with higher education more frequently than other male caregivers experience mental strain. This difference is however not very salient and disappears in the multivariate analysis shown in table 6.

⁶ Compared female caregivers working part time or not working at all, female caregivers who work full time had a lower risk of having been on sick leave for more than two weeks or having reduced their working hours. As the information on extent of paid work concerns the time when the respondent answered the survey, while the information on negative consequences of caregiving concerns the past 5 years, this argument may need to be developed. It is possible to have reduced working hours due to caregiving at some period during the last 5 years, and at the time when answering the survey work full time. But caregivers who work full time when answering the survey have probably a lower risk of having reduced their working hours during the last 5 years, compared to caregivers who work part time or not at all when answering the survey.

Table 6. The effect of educational level on the consequences of caregiving for female and male caregivers' well-being, work situation and attachment to the labour market during the last five years. Logistic regression separately for female and male caregivers controlling for care intensity (number of hours of help per week), country of birth (in the Nordic countries or not), the caregiver's age and extent of paid work at the time of responding to the survey (full time work or not). Odds ratios (OR) using caregivers with lower levels of education (compulsory or upper secondary education only) as reference category.

		Difficulties finding time to see friends	Mental strain	Physical strain	Reduced ability to focus on the job	Difficulties in keeping working hours	Difficulties in managing to accomplish tasks	Being on sick leave for more than 2 weeks ⁷	Reduce working hours	Quit the job	Retire earlier than planned
Female caregivers (n=427-438)	Lower levels of education	1	1	1	1	1	1	1	1	1	1
	Higher education	1,13 ^{ns}	1,53*	1,06 ^{ns}	1,95**	2,73***	4,07***	1,36 ^{ns}	2,64**	2,35 ^{ns}	0,59 ^{ns}
Male caregivers (n=345-357)	Lower levels of education	1	1	1	1	1	1	1	1	1	1
	Higher education	1,03 ^{ns}	1,42 ^{ns}	0,95 ^{ns}	1,51 ^{ns}	1,44 ^{ns}	1,24 ^{ns}	0,23 ^{ns}	1,03 ^{ns}	0,43 ^{ns}	1,01 ^{ns}

T p<0,10, * p<0,05, ** p<0,01, *** p<0,001. Only caregivers who have been in paid work at some time during the last 5 years are included in the analysis.

⁷ Requires a doctor's certificate.

Preliminary discussion and conclusion

This paper confirms previous research in that middle-aged women are more frequently caregivers, give more intensive care and are more negatively affected by caregiving, compared to middle-aged men. The gender difference in both the frequency and intensity of caregiving is however only found among highly educated persons, and the gender differences in the consequences of caregiving are more extensive in this group, especially regarding their work situation.

Women with higher education are more frequently caregivers, give more intensive care and more frequently experience a number of negative consequences due to caregiving than other female caregivers. It concerns difficulties to find time to see friends, mental strain, reduced ability to focus on the job, difficulties in keeping working hours, difficulties in managing to accomplish tasks and having to reduce working hours because of caregiving. No significant educational differences between female caregivers were however found among those experiencing physical strain, being on sick leave for more than two weeks, having to quit the job or have retired earlier than planned due to caregiving.

From previous Swedish studies, which are mainly built on the perspective of the older care recipients, one would expect women with lower levels of education to provide more care and therefore being more affected by it. Maybe the results in this paper could be explained by social mobility among women. Many of the caregiving middle-aged daughters to frail older persons with lower levels of education might in fact have a higher education themselves. So, even though it is more common among older persons with lower levels of education to receive filial care and daughters remain as the primary providers (Ulmanen & Szebehely 2015), these daughters may have a higher education.

This study finds no educational differences among male caregivers in the intensity of care provided. The only negative outcome that differs among male caregivers due to level of education concerns mental strain; those with higher education more frequently experience mental strain due to caregiving. When in a multivariate analysis controlling for the caregiver's age, country of birth and extent of paid work as well as the intensity of care provided, this educational difference in mental strain due to caregiving however disappears.

In the multivariate analysis, greater difficulties in finding time to see friends among highly educated female caregivers also disappear, probably because of full time work being more common in this group. For the other outcomes, working full time did however not increase the risk for female caregivers to be negatively affected.

Why are female caregivers with higher education more affected by caregiving than other female caregivers? I am going to discuss three possible explanations: intensity of caregiving, full time versus part time work and managerial care.

According to previous research, more intensive caregiving increases the risk of negative consequences. Caregiving tend to be more intensive among those who work part time or have a weak attachment to the labour market, at the same time as part time work is regarded as a protection against negative consequences of caregiving. What is cause and effect is hard to establish.

That highly educated women give more intensive care only partly explains the higher risk of experiencing negative consequences, because the higher risk remained in the multivariate analysis controlling for care intensity. Conversely, the less intensive care provided by women with lower levels of education only partly explain their lower risk of being affected.

Full time work being more common among female white-collar workers in general, as well as among the highly educated female caregivers in the study, could be an additional explanation to the higher risks in this group. Nevertheless, as mentioned above, working full time did not increase the risk to be negatively affected and these analyses also controlled for intensity of caregiving. The information about working full time was however given at the time when they participated in the survey, while the information on consequences of caregiving refers to what happened during the previous five years. A person could because of caregiving have reduced her working hours some years ago, and when answering the survey have gone back to full time work again.

On the other hand, the more frequent part time work among female blue-collar workers in general as well as among the female caregivers with lower levels of education in this study, might serve as an explanation to why they are less affected by caregiving than other female caregivers, even when controlling for intensity of caregiving. Female blue-collar workers more often than other female workers work part time during the whole life course, partly because appropriate full time work is not available (Bergold, Vedin & Lorentzi 2017). Female caregivers with lower levels of education have less frequently reduced their working hours at some time during the last five years before participating in the survey, but they also less frequently work full time at the time they participated in the survey. Maybe female caregivers with lower levels of education did not reduce their working hours as frequently because they were already working part time and working less would not ease their situation.

Another possible explanation to the higher risks of female caregivers with higher education is that they more frequently than other female caregivers provide managerial care. In previous studies managerial care has been identified as a demanding care task associated with higher risks of negative consequences for well-being and working life (Rosenthal, Martin Matthews & Keefe 2007; Ulmanen 2015b).

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