The role of gender and country of birth for the extent and consequences of informal caregiving in Sweden

Abstract

Formally provided eldercare services have declined in Sweden since the 1980s, followed by an increase in assistance from children, relatives and friends. This kind of informal care is most common among older people with lower levels of education and among older people born outside the Nordic countries. Although previous studies have concluded that daughters are the main providers of informal care regardless of country of birth, we still lack studies comparing the intensity and consequences of informal caregiving across different population groups in Sweden.

The aim of this paper is to analyse the role of gender and country of birth (born in Sweden or other Nordic countries vs in non-Nordic countries) for the extent and consequences of informal caregiving in Sweden. The analysis is based on a nationally representative postal survey (n=3630, aged 45-66 years) from 2013.

Results: In the middle-aged population, 26% are caregivers, defined as providing help at least once a week to a family member, relative or friend with a disability or longstanding illness. 80 per cent of caregivers primarily assist an older adult (65 years+). While the proportion providing care does not differ significantly between the groups, non-Nordic immigrant women provide the most intensive care (13.2 hrs/week), compared to immigrant men (6.7 hrs/week), and both women and men born in the Nordic countries (6.1 and 4.7 hrs/week respectively).

Of the four groups, immigrant women most frequently provide the most demanding forms of care (personal and/or medical care as well as co-resident care), and are the group most negatively affected by caregiving, also when controlling for the amount of care provided. Country of origin however matters also for men. Compared to Nordic born men, non-Nordic immigrant men do more frequently provide the most demanding forms of care, and are more negatively affected by caregiving when controlling for the amount of care provided.

Among female caregivers, immigrants are more affected in all four areas examined: well-being, work performance, labour force participation and economy. Among male caregivers, immigrants are more affected in all areas except labour force participation.

Altogether, the study points to the conclusion that non-Nordic immigrants are more negatively affected by caregiving than persons born in the Nordic countries are, and that this is valid for both genders, although immigrant women are the group most affected.

That immigrant caregivers, both women and men, provide more demanding forms of care, may reflect that the persons they assist do not have access to care services to the same extent as other groups,

and/or that the services are not suitable for their needs. This raises questions about inequalities in access to care services and needs of culturally sensitive care services.

Even when controlling for the amount of care provided, immigrants are more affected by caregiving, and this is valid for both genders, which may be related to their general weaker positions on the Swedish labour market. Only among female caregivers, however, immigrants are more affected in their labour force participation, which points to caregiving as a threat to primarily immigrant women's economic independence.

Introduction

Similar to other European countries, the provision of long-term eldercare services in Sweden has been characterised by austerity in recent decades (Theobald & Luppi, 2018). This development has coincided with the introduction of market-oriented policy reforms in publicly funded services and an increase of informally provided care, such as help and support from children, relatives and friends (Ibid; Pfau-Effinger & Rostgaard, 2011; Ulmanen & Szebehely, 2015). In Sweden as elsewhere, to receive informal care is most common among older people with lower levels of education (Bauer & Sousa-Poza 2015; Ulmanen & Szebehely, 2015) and among older immigrants, primarily from non-European countries (Pfau-Effinger & Rostgaard, 2011). For example, in Sweden older people born outside the Nordic countries are the group that most frequently uses informal care services (Szebehely, 2015).

International comparisons show that regardless of country of birth, women – predominantly daughters – are the main providers of informal care (Pfau-Effinger & Rostgaard, 2011). Studies also show that women tend to be more negatively affected by informal caregiving compared to men in relation to personal well-being, labour force participation, work performance and earnings from paid work (Bauer & Sousa-Poza 2015; Keating et al 2014; Moussa 2018). In Sweden, however, we still lack studies comparing the intensity and consequences of informal caregiving across different population groups.

Against this backdrop, the aim of this paper is to analyse the role of gender and country of birth (born in Sweden or other Nordic countries vs in non-Nordic countries) in informal caregiving in Sweden. Specifically, the paper explores how gender and country of birth affects the extent and consequences of informal caregiving in four different areas: well-being, work performance, labour force participation and economy.

The information on country of birth in the data analysed in this paper only concerns the caregiver, not the care receiver. This also means that in relation to immigrants, our data includes no information on when the caregiver or care receiver moved to Sweden. However, as a majority of the informal caregivers in our data primarily help an older person in the family, we assume that most informal caregivers who are non-Nordic immigrants also help an older person who is a non-Nordic immigrant.

Previous research

Swedish policy on formal and informal eldercare

When analysing the extent and consequences of caregiving in middle age, the issue of 'working carers' (i.e. combining care responsibilities with paid work) is essential. In the Nordic countries, the issue of informal care in general, and the issue of 'working carers' in particular, were only recently established in policy and research; while many other, especially English-speaking, countries have a long tradition in these issues (Kröger & Yeandle, 2013).

Although Sweden has high ambitions in both eldercare policy and gender equality policy, caregiving for a (in most cases older) family member with a disability or longstanding illness have seldom been included in these policies. That provision of care services would increase possibilities to combine care responsibilities with paid work, which have been a main idea in childcare policy, has until recently been a blind spot in Swedish elder care policy (Ulmanen, 2013). The corresponding blind spot has until recently characterised Swedish gender equality policy, which almost exclusively has focused on easing the combination of paid work and childcare, thereby excluding other care responsibilities in the family, such as for an aged parent or partner (Ulmanen, 2017).

These blind spots could possibly be understood in relation to two aspects in the Swedish context. Firstly, that the provision of eldercare services used to be more generous, which made the gender equality problem regarding combining care responsibilities with paid work less prominent. Secondly, that the goals of universalism and de-familialisation expressed in Swedish legislation and national policy entail no obligation to provide care for adult family members, which together with the formerly more generous provision of eldercare services may imply a risk to confuse ambitions with reality.

In Sweden, adult children are not legally obliged to provide care for, or economically support, their parents, and not even spouses have any 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 (Johansson, Long, & Parker, 2011).

As legislation and national policy have remained unchanged in these aspects in recent decades, the decline of eldercare services and increase of informal caregiving are not the result of legislative or national policy changes. Instead, this development could be understood by the fact that publicly financed eldercare services are not legally enforceable rights, and that laws and regulations do not clearly define what type of services municipalities should provide. Instead, the municipalities can decide the type, eligibility criteria and coverage of eldercare services (Jolanki, Szebehely & Kauppinen 2013).

The decline of eldercare services and increase of informal caregiving is opposed to the goals of universalism and de-familialisation expressed in Swedish legislation and national policy. Even recent national policy on support for family carers strongly stresses that family care has to be provided voluntarily (Johansson et al, 2011). However, the decline of publicly provided eldercare services imply the opposite, that caregiving becomes less voluntary both for caregivers and the persons they assist, which in turn increase the risks of negative consequences for both parties in the caregiving relationship.

Not only do legislation and national policy reflect citizens' values; they also shape citizens' expectations, together with perceptions of how, in this case, eldercare services used to be provided. When family members of frail older persons are described as voluntary helpers in national policy, and this used to be the case to a greater extent a few decades ago, they might not be prepared when they have to act as an essential part of the care system. This could probably result in disappointment and increased risks of negative consequences.

Research on the extent and consequences of caregiving

International research reviews show that informal caregiving imply increased risks of negative consequences for caregivers' well-being and work performance (Bauer & Sousa-Poza 2015), labour force participation (Keating et al 2014; Bauer & Sousa-Poza 2015; Moussa 2018) and economy (Keating et al 2014), primarily for women and caregivers providing more demanding forms of care. A more demanding caregiving is indicated by high caregiving intensity and provision of co-resident or personal care (Bauer & Sousa-Poza 2015; Moussa 2018).

Comparative studies have shown that in countries with a more generous provision of eldercare services, such as the Nordic countries, family care is less intensive and caregivers are less negatively affected by caregiving, compared to countries providing fewer eldercare services. The mechanism explaining this pattern is that formally provided eldercare services primarily relieve the most intensive forms of informally provided care (Colombo et al 2011, p. 85-158; Kotsadam 2011; Rodrigues, Huber & Lamura 2012, p. 60-69). As women commonly provide the most intensive forms of informal care, eldercare services primarily relieve women's caregiving, which entail smaller gender differences in caregiving intensity in the Nordic countries (Schmid, Brandt & Haberkern 2012).

Previous internationally published Nordic studies using larger survey materials have explored negative consequences for well-being (Gautun & Hagen 2010; Hansen, Slagsvold & Ingebretsen 2012; Hansen & Slagsvold 2014; Ugreninov 2013), and labour force participation (in addition to the studies reviewed in Moussa 2018: Gautun & Hagen 2010; Jakobsson, Kotsadam & Szebehely 2013; Ugreninov 2013). To our knowledge, consequences for work performance have been explored in one study only (Gautun & Hagen 2010), and consequences for economy have not been previously explored at all. The existing studies however mainly show the same pattern as studies from other countries, namely that negative consequences of caregiving do exist in the Nordic countries, although they tend to be less frequent than in other countries, and that women and caregivers providing care that is more demanding are more frequently affected.

Qualitative studies on working carers' experiences of combining paid work with informal caregiving are still relatively scarce in the Nordic countries, but existing studies from Sweden and Finland report similar findings to studies in other countries (see review in Jolanki et al 2013). For example, working carers experience practical problems of time use when trying to combine work and care, as well as emotional and moral dilemmas, which may result in stress and exhaustion. Studies also indicate that two ways for carers to seek balance in their lives are to maintain their paid work, and to involve other family members and formal eldercare services in providing the care needed. Although paid work can offer

respite from the demands of caregiving as well as possibilities to develop other skills, social contacts and an identity apart from being a caregiver, paid work can also be a source of strain (ibid).

Although there are similarities in working carers' experiences, one review (Jolanki et al, 2013) identified two distinctive aspects of caregiving in Sweden and Finland. Firstly, carers expect joint responsibility with formal care services, i.e. they expect formal care services to be available to meet the needs of the person they care for. Secondly, both male and female carers stress the importance of paid work as a means of achieving balance in life, which could be understood in relation to the long tradition of women in Sweden and Finland to be in paid work almost to the same extent as men. A higher proportion of middle-aged women are in paid work in in these countries than in the EU as a whole, and more middle-aged women work full-time or long part-time hours (around 30 hours a week) than in most countries (ibid).

Older immigrants, care needs and Swedish eldercare policies

Several studies indicate that there are differences between native-born and immigrants in the use of informal care (e.g. Hovde et al, 2008; Forssell & Torres, 2012; Szebehely, 2015). The majority of older immigrants in Sweden come from other Nordic or European countries and arrived to Sweden in the 1950s or 1960s (Brodin 2019). Although the number of older immigrants from non-European countries has increased in recent years, they are still in minority. Of the Swedish population 65 years and older, 5 per cent are immigrants from another Nordic country, 5 per cent from the rest of Europe and 3 per cent from non-European countries (Statistics Sweden 2019). Most of older immigrants in Sweden tend to live in the biggest cities. In Stockholm, for example, about 20 per cent of the city's older population is born in another country compared to 13 per cent in the country in general (Brodin, 2018).

As pointed out by Torres (2006) it is difficult to generalise the care needs of older immigrants, because there are huge differences between ageing as an immigrant and to immigrate as an older person. These experiences mirror divergent complicated situations and social and economic sufferings. In addition, older immigrants in Sweden come from about 200 nations, which vary in social and economic development. Even older immigrants from the same country of origin may have very various experiences and needs depending on factors, such as education, gender, ethnicity, and rural or urban background.

Nevertheless, in Swedish eldercare policies older immigrants have tended to be grouped together as one single category marked by vulnerability and marginalisation. For example, in eldercare policies 'older immigrants' have frequently been assumed to have poorer health, lower education, lower incomes, and more exposed to isolation and loneliness than older native Swedes (Brodin, 2017; 2018; 2019; Forssell & Torres, 2012; Torres, 2006). However, studies comparing health and care needs among older immigrants and older native Swedes show at mixed and contradictory results. While some studies have found no significant differences between older immigrants and older native Swedes, others have found that older immigrants generally suffer from worse mental health and have greater IADL-needs compared to older native Swedes (Hovde et al, 2008).

Immigration and family caregiving

Although non-European immigrants are in minority, Swedish eldercare policies have tended to describe this particular group as representative for the older immigrant population (Brodin, 2017). In this context, Swedish policies have also drawn upon discourses, which outline non-European immigrants as "family oriented", i.e. non-European immigrants' families are supposed to take care of their own older adults and older non-European immigrants prefer to be taken care of by their own family (Brodin, 2018; Sagbakken et al, 2018; Torres, 2006; Wezel et al, 2016). These discourses not only increase the pressure on women from non-European countries to perform as informal care givers, but also conceal the fact that informal care giving is a process shaped at the intersection of gendered, ethnic and class-based inequalities (cf. Brodin, 2017).

Even though official statistics in Sweden do not include country of birth of service users, studies have shown that older immigrants from non-Nordic countries are underrepresented in formally provided care services (e.g. Hovde et al, 2008; Szebehely, 2015). In addition, older immigrants born outside of the Nordic countries receive more help and support from relatives (Szebehely, 2015), and it is also more common in this group to have relatives employed by the municipal home help services as family carers, compared to older persons born in the Nordic countries (Hovde et al, 2008). The majority (70 per cent) of employed family carers in Sweden are born in countries outside of Europe. Another form of economic support for family care provided by some municipalities in Sweden is the attendance allowance, a symbolic payment given to the person in need of care, which does not provide any social rights to the family carer (NBHW, 2007). In Stockholm, attendance allowance is seven times more common among older people born outside of Europe compared to native-born (NBHW, 2009). These two forms of economic support for family care are the most common ways for Swedish municipalities to meet needs of culturally sensitive care services (NBHW, 2007).

One particular vulnerable group among older immigrants from non-Nordic countries is later-life migrants. Because of their age, they have not been able to work since the arrival to Sweden. Interview studies indicate that later-life immigrants from non-Nordic countries combine a puzzle of small incomes to survive, such as, Swedish minimum pensions, social assistance and money from relatives (Brodin & Mattsson, 2014; Linné, 2005). Lack of financial resources also affects access to formal care services in that way that some later-life immigrants are forced to turn down offers to receive home help services because they cannot afford it (Ibid.). Furthermore, lack of proficiency in Swedish make this group of older immigrants very dependent on relatives to act as proxy for them in contacts with authorities and formal service providers.

In relation to informal caregiving, there are to our knowledge no Swedish studies that so far has compared the frequency and intensity of informal caregiving between immigrants and native Swedes. However, international research shows that immigrants generally provide more frequent and more intense help and support than native-born (Wezel et al, 2016). The literature offers various explanations to this pattern, e.g. limited knowledge of formally provided care services, negative images of professional care and difficulties to afford formally provided care (Ibid; Brodin, 2018; Gou et al 2019; Sagbakken et al, 2018). In addition, similar to patterns of informal caregiving among the native-born population, also among immigrants, factors, such as, education, employment status, family and

household structure and poverty affect the frequency and intensity in informal caregiving (Chappell & Funk, 2012).

Some Swedish studies indicate that immigrant family carers generally have poor working conditions and compromised labour market opportunities (Brodin, 2018; Forssell & Torres, 2012). This could be related to the combined consequences of the burden of informal caregiving and immigrants' weaker position on the Swedish labour market. Although interviews with persons who combine paid work with informal caregiving reveal that native Swedes and immigrants have similar perceptions of how responsibilities associated with informal caregiving affects their well-being and work performance (Sand, 2012), immigrants in Sweden face much more difficulties in accessing the labour market and finding jobs that matches their education. Even immigrants with higher education who have lived five years or more in Sweden have much higher unemployment rates than native Swedes with higher education; furthermore, compared to native Swedes with higher education it is much more common that immigrants with higher education are employed at positions that require no or low formal skills (Statistics Sweden, 2017). Against this backdrop, it is likely to assume that informal caregiving adds to the problems immigrants experience on the Swedish labour market and that informal caregiving might generate more negative consequences for immigrants than for native Swedes in relation to labour force participation and earnings from paid labour.

Although some studies indicate that there are similarities in experiences of informal caregiving among immigrants and native-born (e.g. Chappell & Funk, 2012; Sand, 2012); others emphasize that informal caregiving among immigrants is a complex phenomenon that involves a combination of expectations rooted in cultural values, traditions and language barriers, but also in the immigration process itself and changing socioeconomic positions (Brodin, 2018; Forssell & Torres, 2012; Wezel et al, 2016; Sagbakken et al, 2018). For example, many immigrant family carers express the idea that taking care of their aging parents is a duty and that family care is superior to professional care because the family carer has the same background as the recipient (Wezel et al 2016). Some family carers also express a wish to protect their ageing parents in the new country (Forssell & Torres, 2012). However, studies also show that these understandings vary depending on age and time in the new country. For instance, young family carers (i.e. under the age of 40) or family carers who have lived for a longer period of time in the new country often have a broader interpretation of family care than newly arrived immigrants; for example, supervising that formal care services are properly provided instead of performing the care services themselves (Forssell & Torres, 2012; Wezel et al, 2016). Consequently, existing differences in perceptions and patterns of informal caregiving among immigrants and native-born are both related to the age of immigrant informal carers and how long they have lived in the new country.

Regardless of reasons for and differences in informal caregiving among immigrants and native-born, the literature shows consistent findings in relation to how gender shapes informal caregiving. Women provide more care, and are also more negatively affected in relation to personal health and income and work opportunities than men are (Bauer & Sousa-Poza 201; Keating et al 2014; Moussa 2018). However, studies also show that although perceptions of informal caregiving might vary across immigrant groups, the pressure on female relatives – in particular daughters – to take care of older relatives is generally very high (Brodin, 2018; Forssell & Torres, 2012; Wezel et al, 2016; Sagbakken et al, 2018). Sometimes,

this may lead to family conflicts, because other relatives who are not informal caregivers do not understand the burden it involves to take care of someone with, for example, dementia (Sagbakken et al, 2018).

Material and methods

The study presented in this paper draws upon a national representative postal survey designed and carried out by a research group (including the main author) at Stockholm University. Statistics Sweden assisted with expert reviews, selection and collection of data, and was responsible for sending out the survey 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 identified caregivers by asking 'Do you usually help any family member, relative (in or outside your household), friend or neighbour who needs help because of high age, disability or illness?' with a number of specific tasks. For each task, the response alternatives were 'Yes' and 'No'. The tasks were (with the terms used in this article to categorize them in italics):

1. *household help*: 'cleaning, buying food, laundry or cooking';
2. '*other practical help* like repairs, gardening, transports and giving a lift';
3. *administrative help*: 'paying bills, bank and postal errands and the like';
4. *managerial care*: 'contacts with authorities, health care, home care services and the like';
5. *monitoring*: 'looking after, reminding or motivating by visiting or telephone';
6. '*personal care* like bath, shower, get dressed, get out of bed and the like'; and
7. *medical care*: 'apply bandages, give medicines or injections'.

In the analyses in this paper, the respondents who answered that they at least once a week provided help with at least one of these tasks were identified as caregivers. The analyses concern the significance of gender and country of birth (born in the Nordic countries vs born in other countries) for the extent of caregiving and its consequences for caregivers' well-being, work performance, labour force participation, and economy. The analyses compares firstly males and females, and secondly, males and females, respectively, by country of birth. The information on consequences of caregiving builds on self-reported information with a recall period of 5 years. As some of the dependent variables in the analyses on consequences of caregiving concern consequences for paid work, the analyses on consequences only include caregivers who (according to self-reported information) had been in paid work at some time during the last 5 years prior to participating in the survey.

The analyses used information on country of birth obtained from a national register as part of the sampling process, and self-reported information on gender and level of education. The response alternatives to the question 'What is your highest level of completed education?' were dichotomized into 'lower levels of education' (primary or secondary education only) and 'higher education' (tertiary education). The extent of caregiving is captured by how common it is in the general population to be a caregiver and by caregiving intensity (measured as average number of hours of help given per week and as proportion of caregivers providing care every day). Additional variables used to validate the

information on the extent of caregiving are the provision of co-resident care and personal and/or medical care.

Consequences of caregiving regarding well-being and economy were measured by the questions 'Due to caregiving, have you experienced…': 'difficulties in finding time to see friends?', 'mental strain?', 'physical strain?', 'worsened economy due to reduced income?' and 'worsened economy due to increased costs?'. Of the response alternatives, 'Yes, to a large extent' and 'Yes, to a certain extent' were used as "Yes", and 'No, not at all' was used as 'No'.

Consequences of caregiving regarding work performance were measured by the questions: 'Have you experienced any of the following at work during the last 5 years due to caregiving? Have you (temporarily or during a longer period)…': 'had problems in focusing on the job?', 'declined overtime or new projects', 'had difficulties in managing to accomplish tasks?'. Response alternatives were 'Yes' and 'No'.

Consequences of caregiving regarding labour force participation were measured by the questions: 'Have your job been affected in any other way by caregiving during the last 5 years? Have you…': 'reduced your working hours?', 'retired earlier than planned?', 'quit the job?'. Response alternatives were 'Yes' and 'No'.

Chi-square tests and t-tests were performed to test the statistical significance between subgroups of caregivers concerning the extent and consequences of caregiving. Logistic regression analyses were performed in two steps for each of the examined types of consequences of caregiving. The first step of analysis studied the effect of gender on consequences of caregiving, using male caregivers as reference category. The second step of analysis studied the effect of country of birth on consequences of caregiving among female and male caregivers, respectively, using caregivers born in the Nordic countries as reference category. These analyses controlled for care intensity (number of hours of help per week), and the caregiver's age. The analyses in step one also controlled for country of birth (born in the Nordic countries or in other countries). The information on age builds on self-reported information.

Additional background information on caregivers presented in this study concern the extent of paid work, the proportion of high-income earners and the proportion of caregivers primarily assisting an older (65+) adult. The extent of paid work builds on self-reported information and concern the time when participating in the study. Low-income earners were measured as the bottom quartile of annual earned income two years before participating in the survey, using information obtained from a national register as part of the sampling process.

Results

Caregivers' background and living conditions

Table 1 provides some information on background and living conditions for the caregivers in our material, comparing firstly by gender, and secondly by country of birth (born in the Nordic countries or in other countries) among male and female caregivers, respectively.

Female caregivers are on average 57 years old and male caregivers are on average 56 years old, with no differences due to country of birth. Almost a quarter of caregivers have children living at home, with no gender difference, but it is more common among non-Nordic immigrant male caregivers (49%) compared to the other groups. In relation to education, it is more common among female caregivers to have tertiary education (53%) than among male caregivers (38%), with no significant differences due to country of birth. The most highly educated caregiver group is however non-Nordic immigrant female caregivers, with 63 per cent having tertiary education.

To be a low-income earner is defined here as having an income in the lowest quartile of the income distribution. This is more frequent among female caregivers (29%) than among male caregivers (23%), and much more frequent among non-Nordic immigrant caregivers of both genders (male 47%, female 52%), compared to Nordic born caregivers (male 20%, female 27%).

Most caregivers (90 %) have been in paid work at some time during the last 5 years, with no differences due to gender or country of birth. Table 1 also shows their extent of paid work when participating in the survey. Among caregivers, men do more frequently work full time (70%) than women do (51%), who in turn more frequently work part-time (28%) than men (8%). 21 per cent of both male and female caregivers do not work. Among male and female caregivers, respectively, there are no significant differences in the extent of paid work due to country of birth; except that it is more common (a tendency) for female non-Nordic immigrant caregivers not to work at all, compared to female Nordic-born caregivers (32% vs 20%).

Table 1. Background and living conditions among female and male caregivers, respectively, by country of birth (the Nordic countries vs other countries), 2013

	Male caregivers (n=406-416)	**Female caregivers** (n=492-510)	**Male caregivers**		**Female caregivers**	
			Born in Nordic countries (n=362-371)	**Born in other countries** (n=42-45)	**Born in Nordic countries** (n=448-464)	**Born in other countries** (n=44-46)
Average age (number of years)	56.2	57.0 *	56.3	55.9 ns	56.7	57.3 ns
Proportion of caregivers who…						
have children living at home (%)	25.2	22.4 ns	22.4	48.9 ***	22.8	17.4 ns
have tertiary education (%)	38.0	53.3 ***	37.3	43.2 ns	52.3	63.0 ns
are low-income earners (%)	22.8	29.2 *	19.9	46.7***	26.9	52.2 ***
were in paid work at some time during last 5 years (%)	89.2	90.6 ns	89.5	86.7 ns	91.2	84.8 ns
Extent of paid work when participating in the survey, proportion of caregivers who…						
work full-time (%)	70.4	51.2 ***	71.0	65.9 ns	51.6	47.7 ns
work part-time (%)	7.9	27.8 ***	8.0	6.8 ns	28.6	20.5 ns
do not work (%)	21.7	20.9 ns	21.0	27.3 ns	19.9	31.8 T

Significance test using Pearsons's chi^2. T p<0.10, * p<0.05, ** p<0.01, *** p<0.001

Extent of caregiving

Table 2 provides information on the extent and other characteristics of caregiving, by gender and country of birth. In the middle-aged population, 24 per cent of men and 27 per cent of women are caregivers (defined here as providing informal care at least once a week), with no significant differences due to gender or country of birth. However, female caregivers provide more intensive care compared to male caregivers, on average 6.7 vs 4.9 hours a week, and 20 vs 13 per cent provide care every day.

Among both male and female caregivers, respectively, non-Nordic immigrants provide more intensive care than Nordic born do. Among female caregivers, non-Nordic immigrants provide on average 13.2 hours per week and 48 per cent provide care every day, while Nordic born provide on average 6.1 hours of care per week and 18 per cent provide care every day. Among male caregivers, the difference due to country of birth is significant regarding the proportion providing care every day (11 vs 31%), but not regarding hours of care provided per week (4.7 vs 6.7 hours).

To provide co-resident care, and personal and/or medical care, is in the caregiving literature regarded as especially demanding. Table 2 shows the same pattern as for care intensity; female caregivers, as well as non-Nordic immigrant caregivers of both genders, more frequently provide these demanding forms of care, with non-Nordic immigrant female caregivers as the group most frequently providing them. The only exception from this pattern concerns the provision of co-resident care, which is as common among male as among female caregivers (14 vs 16 per cent).

Among male caregivers, 11 per cent of Nordic born and 33 per cent of non-Nordic immigrants provide co-resident care. Among female caregivers, the corresponding proportions are 14 and 42 per cent. Personal and/or medical care is provided by 14 per cent of male caregivers and 28 per cent of female caregivers. Among male caregivers, 12 per cent of Nordic born and 36 per cent of non-Nordic immigrants provide personal and/or medical care, and among female caregivers, 25 per cent of Nordic born and 53 per cent of non-Nordic immigrants.

As it is common among caregivers to assist several persons, they were asked who they primarily assist. Table 2 show that most caregivers primarily assist an older adult (65 years and older), with no differences due to gender, and for female caregivers no difference due to country of birth. However, among non-Nordic immigrant male caregivers, only 49 per cent primarily assist an older adult, compared to 80 to 84 per cent in the other groups. Most caregivers for older adults assist a parent or a parent-in-law, but this is less common among immigrant caregivers of both genders, probably as they more seldom have a parent living in the same country. Compared to the other caregiver groups, immigrant female caregivers however more frequently provide spousal care to an older adult (not shown in table), which could be related to a possibly greater age difference in heterosexual couples among non-Nordic immigrants than among Nordic born. This is supported by the information in table 1, that immigrant male caregivers more frequently than the other caregiver groups have children living at home.

Table 2. Characteristics of caregiving among middle-aged women and men, respectively, by country of birth (in the Nordic countries vs other countries), 2013

	Men (n=1706)	**Women** (n=1924)	**Men**		**Women**	
			Born in Nordic countries (n=1529)	**Born in other countries** (n=177)	**Born in Nordic countries** (n=1726)	**Born in other countries** (n=198)
Proportion (%) of caregivers in population 45-66 years	24.4	26.5 ns	24.3	25.4 ns	25.4	23.2 ns
	Male caregivers (n=401-416)	**Female caregivers** (n=494-510)	**Male caregivers**		**Female caregivers**	
			Born in Nordic countries (n=360-371)	**Born in other countries** (n=41-45)	**Born in Nordic countries** (n=453-464)	**Born in other countries** (n=41-46)
Average number of hours of care given per week	4.93	6.72 **	4.72	6.71 ns	6.12	13.19 **
Proportion (%) of caregivers who…						
provide care every day	13.2	20.2 **	11.1	31.1 ***	17.5	47.8 ***
provide co-resident care	13.6	16.2 ns	11.4	33.3 ***	13.7	42.2 ***
provide personal and/or medical care	14.4	27.9 ***	11.7	36.4 ***	25.4	53.3 ***
primarily assist an older (65+) adult	80.0	79.8 ns	83.6	48.8 ***	79.7	80.5 ns

Significance test using Pearsons's chi^2, except for average number of hours of help for which t-test was used. T p<0.10, * p<0.05, ** p<0.01, *** p<0.001

Consequences of caregiving

Table 3 provides information on negative consequences of caregiving during the last five years, by gender and country of birth, in a number of outcomes in four main areas: well-being, work performance, labour force participation, and economy. There are three main findings:

1. Female caregivers are more frequently affected than male caregivers in all of the areas examined: well-being, work performance, labour force participation and economy.
2. Among both male and female caregivers, non-Nordic immigrants are more frequently affected by caregiving than Nordic born are.
3. Of the four caregiver groups, which are compared in this paper by gender and country of birth, immigrant female caregivers are the group most frequently negatively affected by caregiving.

The first main finding is that female caregivers are more frequently affected than male caregivers in all of the areas examined: well-being, work performance, labour force participation and economy. The gender differences are especially pronounced regarding well-being. Female caregivers more frequently experience difficulties in 6 out of the 11 outcomes examined in this paper: finding time to see friends, mental strain, physical strain, reduced ability to focus on the job, retired earlier than planned (tendency), and reduced income. Female caregivers experience these difficulties around twice as frequently as male caregivers do. For example, mental strain is experienced by 60 per cent of female and 33 per cent of male caregivers, and reduced ability to focus on the job by 35 per cent of female and 17 per cent of male caregivers.

The second main finding is that among both male and female caregivers, non-Nordic immigrants are more frequently affected by caregiving than Nordic born are.

Among male caregivers, immigrants are more frequently affected in all areas except labour force participation: well-being, work performance, and economy. Regarding well-being, this concerns difficulties in finding time to see friends and physical strain, and for work performance, having to decline overtime or new projects and having difficulties in managing to accomplish tasks, and for economy, reduced income due to caregiving. Non-Nordic immigrant male caregivers experience these difficulties around twice as frequently as Nordic born male caregivers. For example, among male caregivers, difficulties in managing to accomplish tasks by 34 per cent of immigrants and 13 per cent of Nordic born, and reduced income by 29 per cent of immigrants and 12 per cent of Nordic born.

Among female caregivers, immigrants are more frequently affected in all four areas examined – well-being, work performance, labour force participation, and economy – and the differences are especially pronounced regarding labour force participation and economy. Regarding well-being, this concerns physical strain, and regarding work performance, declining overtime or new projects. Regarding labour force participation, immigrants have more frequently reduced their working hours and retired earlier than planned; and regarding economy, they more frequently face reduced income as well as increased costs due to caregiving. Non-Nordic immigrant female caregivers experience these difficulties around two or even three times as frequently as Nordic born female caregivers. Regarding labour force participation, among female caregivers 22 per cent of immigrants and 10 per cent of Nordic born reduced their working hours, and 14 per cent of immigrants and 4 per cent of Nordic born retired earlier than planned. Regarding economy, among female caregivers, 38 per cent of immigrants and 19 per cent of Nordic born had reduced income, and 44 per cent immigrants and 22 per cent of Nordic born had increased costs.

The third main finding is that of the four caregiver groups, which are compared in this paper by gender and country of birth, immigrant female caregivers are the group most frequently negatively affected by caregiving. Although table 3 does not report significance tests between all four groups, the tendency is clear regarding both the number of outcomes and the proportion of caregivers experiencing them. The most striking examples are found in labour force participation and economy. To retire earlier than planned concerns 22 per cent of immigrant female caregivers compared to 4 per cent of Nordic-born female caregivers, and 3 per cent of male caregivers irrespective of country of birth. In addition,

immigrant female caregivers are the group that most frequently had reduced income (38%), and the same was true for increased costs (44%).

Table 3. Consequences of caregiving during the last five years among male and female caregivers, respectively, by country of birth (the Nordic countries vs other countries). Proportion (per cent) of caregivers affected, 2013

	Male caregivers (n=354-400)	**Female caregivers** (n=445-489)	**Male caregivers**		**Female caregivers**	
			Born in the Nordic countries (n=315-327)	**Born in other countries** (n=35-37)	**Born in the Nordic countries** (n=405-415)	**Born in other countries** (n=32-37)
Well-being						
Difficulties finding time to see friends	28.3	44.4 ***	26.9	41.7 ^{T}	43.6	55.6 ^{ns}
Mental strain	33.3	60.1 ***	32.8	38.9 ^{ns}	59.1	60.0 ^{ns}
Physical strain	17.1	34.0 ***	14.6	30.6 *	30.2	48.6 *
Work performance						
Decline overtime or new projects	18.3	22.5 ^{ns}	16.9	30.6 *	21.2	37.1 *
Difficulties in managing to accomplish tasks	15.4	17.2 ^{ns}	13.4	34.3 **	16.4	27.3 ^{ns}
Reduced ability to focus on the job	17.3	35.1 ***	16.5	24.3 ^{ns}	34.2	45.7 ^{ns}
Labour force participation						
Reduced working hours	8.7	11.3 ^{ns}	8.8	8.3 ^{ns}	10.4	21.6 *
Quit the job	2.0	3.1 ^{ns}	1.9	2.9 ^{ns}	3.2	2.9 ^{ns}
Retired earlier than planned	2.8	5.1 ^{T}	2.8	2.8 ^{ns}	4.3	14.3 *
Economy						
Reduced income	13.3	20.8 **	12.0	28.6 **	18.5	37.5 *
Increased costs	21.6	25.0 ^{ns}	20.4	27.8 ^{ns}	22.1	44.1 **

Significance test using Pearson's chi^2. Only caregivers who had been in paid work at some time during the 5 years prior to participating in the study are included in the analysis. T p<0.10, * p<0.05, ** p<0.01, *** p<0.001

Table 4 shows that the main differences between male and female caregivers in consequences of caregiving (shown in the bivariate analysis in table 3) remain when controlling for country of birth, care intensity and age in the multivariate analysis. Thus, female caregivers' higher risks of experiencing difficulties in finding time to see friends, mental strain, physical strain, reduced ability to focus on the job, and having their income reduced by caregiving cannot be explained by the fact that they are older, provide more intensive care, or differ regarding country of birth compared to male caregivers. Women's more frequent experiences of reduced income due to caregiving remain, but as a tendency, in table 4.

Nevertheless, the bivariate analysis shows that women more frequently than men retire earlier than planned due to caregiving, a tendency that disappears while controlling for age, care intensity and country of birth. This indicates that female caregivers' higher tendency to retire earlier than planned could be explained by women's more intensive caregiving and/or immigrant women's higher frequency in retiring earlier than planned due to caregiving. This is supported by the bivariate analysis, which compares female caregivers by country of birth, and shows that primarily female immigrant caregivers retire earlier than planned due to caregiving.

Among both male and female caregivers, several of the differences between Nordic born and non-Nordic immigrants shown in the bivariate analysis disappears when controlling for care intensity and age (see table 4). Among male caregivers, the higher frequency among immigrants in experiencing physical strain, difficulties in finding time to see friends, and having declined overtime or new projects, disappear in the multivariate analysis. Only two differences remain; male non-Nordic immigrants have higher risks of experiencing difficulties in managing to accomplish tasks and reduced income (tendency) due to caregiving, compared to Nordic born men.

These results might indicate that among male caregivers, immigrants' higher frequency of negative consequences in well-being and work performance compared to Nordic born could partly be explained by their more demanding caregiving. As the bivariate analysis in table 2 shows no significant differences between these groups regarding hours of care given per week, another possible interpretation is that the loss of significant differences in the multivariate analysis compared to the bivariate analysis is due to the low number of immigrant caregivers in the material. (These results points to the need to try another variable for a demanding caregiving, such as the proportion of caregivers providing care every day, as a control variable in the multivariate analysis.)

Among female caregivers, immigrants' higher frequency in experiencing physical strain, having to decline overtime or new projects and reduced working hours disappears when controlling for care intensity and age. Thus, these results indicate that female immigrant caregivers' higher exposure to negative consequences in well-being, work performance, and partly in labour force participation could be explained by their more intensive caregiving. Another possible interpretation is that the loss of significant differences in the multivariate analysis compared to the bivariate analysis is due to the low number of immigrant caregivers in the material.

Three differences, however, remain in the multivariate analysis for female caregivers; non-Nordic immigrants have higher risks of retiring earlier than planned, having reduced income (tendency), and increased costs (tendency) due to caregiving, compared to Nordic born. The fact that female immigrant caregivers provide more hours of care can therefore not explain these increased risks.

Table 4. The effect of gender (for all caregivers, panel A) and country of birth (Nordic countries or not) (for male and female caregivers, respectively, panel B) on consequences of caregiving during the last five years. Odds ratios (OR:s), using male caregivers as reference category in panel A, and caregivers born in the Nordic countries as reference category in panel B.

	Difficulties finding time to see friends	Mental strain	Physical strain	Decline overtime or new projects	Difficulties managing accomplish tasks	Reduced ability to focus on the job	Reduce working hours	Quit the job	Retire earlier than planned	Reduced income	Increased costs
Panel A	1.78 ***	2.74 ***	2.31 ***	1.17 ns	1.01 ns	2.50 ***	1.19 ns	1.08 ns	1.62 ns	1.44 T	1.04 ns
All caregivers (males ref. cat.) (n=778-798)											
Panel B											
Male caregivers (born in Nordic countries ref. cat.) (n=349-361)	1.42 ns	1.14 ns	1.87 ns	1.59 ns	2.55 *	1.15 ns	0.81 ns	0.60 ns	2.68 ns	2.35 T	1.20 ns
Female caregivers (born in Nordic countries ref. cat.) (n=428-441)	0.81 ns	0.82 ns	1.62 ns	1.30 ns	1.37 ns	1.21 ns	1.93 ns	0.62 ns	5.02 *	2.27 T	2.04 T

Logistic regression controlling for country of birth (in the Nordic countries vs other countries) (panel A only), care intensity (number of hours of help per week), and age (panel A and B). Only caregivers who had been in paid work at some time during the 5 years prior to participating in the study are included in the analysis. T p<0.10, * p<0.05, ** p<0.01, *** p<0.001

Discussion

This paper has analysed the role of gender and country of birth (born in Sweden or other Nordic countries vs in non-Nordic countries) in informal caregiving in Sweden. Specifically, the paper has explored how gender and country of birth affects the intensity and consequences of informal caregiving in four different areas: well-being, work performance, labour force participation and economy.

The results show that of the four groups compared in the paper (i.e. Nordic born and non-Nordic born male and female caregivers), immigrant women most frequently provide the most intensive and demanding forms of care (i.e. personal and/or medical care as well as co-resident care). In addition, they are the group who is most negatively affected by informal caregiving, also when controlling for the amount of care provided. However, country of origin matters also for men. Compared to men born in the Nordic countries, non-Nordic immigrant men do more frequently provide the most demanding forms of care, and are more negatively affected by caregiving, also when controlling for the amount of care provided.

The results also show that immigrant women are the group most negatively affected of informal caregiving in all four areas examined in the paper. Hence, immigrant women experience most negative consequences of informal caregiving in relation to personal well-being, work performance, labour force participation and economy. Among male caregivers, immigrants are more affected compared to Nordic born in all areas except labour force participation.

That immigrant caregivers, both women and men, provide more demanding forms of care, may reflect that the persons they assist do not have access to care services to the same extent as other groups, and/or that the services are not adopted to their needs. This raises concerns about inequalities in older immigrants' access to care services in Sweden and indicates needs for developing formally provided care services that are sensitive to the linguistic and/or cultural backgrounds of various groups of service users.

However, the results presented in this paper also demonstrates that even when controlling for the amount of care provided, non-Nordic immigrants are more negatively affected by informal caregiving compared to Nordic born, and this is valid for both genders. When controlling for caregiving intensity, female immigrant caregivers' higher risks of negative consequences in their labour force participation and economy remain, and so does male immigrant caregivers' higher risks of negative consequences in their work performance and economy, compared to Nordic born caregivers. This may be related to immigrants' general weaker positions on the Swedish labour market and the overall difficulties immigrants face in finding jobs that matches their education.

Altogether, the results point to the conclusion that non-Nordic immigrants in Sweden are more negatively affected by informal caregiving compared to persons born in the Nordic countries, and that this is valid for both genders, although immigrant women are the group most exposed to negative consequences of caregiving. Only among female caregivers, immigrants are more affected in their labour force participation. This indicates that in Sweden, informal caregiving is especially a threat to

non-Nordic immigrant women's economic independence, as this group of women more frequently have to reduce their working hours or retire earlier than planned due to their care responsibilities.

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