Work – life imbalance: Informal care and paid employment in the UK

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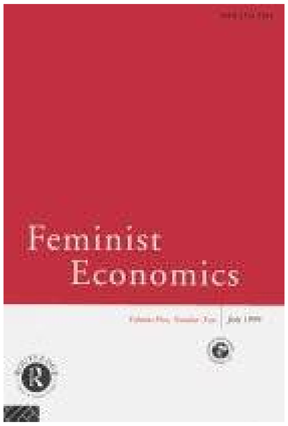

Work-life imbalance: informal care and paid employment

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WORK-LIFE IMBALANCE: INFORMAL CARE AND PAID EMPLOYMENT

Abstract

In the United Kingdom informal carers are people who look after relatives or friends who need extra support because of age, physical or learning disability or illness. The majority of informal carers are women and female carers also care for longer hours and for longer durations than men. Thus women and older women in particular, shoulder the burden of informal care. We consider the costs of caring in terms of the impact that these kinds of caring responsibilities have on employment. The research is based on the responses of informal carers to a dedicated questionnaire and in-depth interviews with a smaller sub-sample of carers. Our results indicate thatthe duration of a caring episode as well as the hours carers commit to caring impact on their employment participation. In addition carers' employment is affected by financial considerations, the needs of the person they care for, carers' beliefs about the compatibility of informal care and paid work and employers' willingness to accommodate carers' needs. Overall, the research confirms that informal carers continue to face difficulties when they try to combine employment and care in spite of recent policy initiatives designed to help them.

INTRODUCTION

In the United Kingdom (UK) informal carers are people who look after a relative or friend who needs support because of age, physical or learning disability or illness, including mental illness (Department of Health, 2006). Only those parents who look after children with disabilities fall into this category of caregiving. Estimates from the 2001 Census show that in England and Wales alone there were 5.2 million people providing informal care, one in ten of the population (National Statistics Online, 2006).[1] Informal carers are not generally paid for their caring responsibilities although they may receive informal payments from the person they care for and in some circumstances they will qualify for state benefits. The peak age for becoming an informal carer (or carer) is between 45 and 64 years (see Hilary Arksey *et al*, 2005) and as in many other countries, women are more likely than men to provide unpaid care (Susan C. Eaton, 2005). Carers who care for longer hours are also more likely to be female (Arksey *et al,* 2005; Nieves Lázaro, Maria-Luisa Moltó and Rosario Sanchez, 2004).[2]

The role and needs of informal carers have attracted an increasingly high profile in the UK over the past decade. This can be seen as a consequence not only of the ageing population but also the recognition that public policy for those who need support to remain in the community is largely dependent upon family carers (Michael Nolan, 2001). Perhaps the most public and visible sign of this shift has been the introduction of the National Strategy for Carers (Department of Health, 1999) in which the Government acknowledged that carers' needs were only being met 'patchily'. The Strategy focussed on provision and availability of information for carers as well as support and care for the carers themselves. In respect of paid employment for carers of working age, the Government's declared objectives were to "encourage and enable carers to remain in work and to help those carers who are unable to, or do not want to combine paid work with caring, to return to work when their caring responsibilities cease" (Department of Health, 1999). These objectives reflect government recognition that caring responsibilities can constrain employment. Nevertheless, the underlying reasons for the implied trade-off between informal care and employment and, in particular, the role of the duration of a caring episode have not been fully explored. In this research we have addressed these gaps in our understanding in three ways. First, we have drawn on the British Household Panel Survey (BHPS) in order to make some comparisons between the employment and earnings of carers and non-carers at the national level. Secondly, we have used a dedicated questionnaireto ask a sample of carers about their current employment, their employment prior to caring, the hours they cared and the duration of their caring episode. Lastly, we have conductedmore in-depth research with a smaller sub-sample of carers. In this part of the research we asked further, more detailed questions about carers' employment and how and why it had been affected by their caring responsibilities. Hence our data is derived from three sources. This triangulation or convergence is intended to address potential problems relating to construct validity.

POLICY CONTEXT

After the National Strategy for Carers was published a number of initiatives were implemented in order to facilitate the achievement of the government's objectives (table 1). These initiatives tended to emphasise the importance of providing services directly to carers rather than indirectly through services provided for the people they care for (Kirsten Stalker, 2003). For example, working carers will have benefited from changes to the Working Families Tax Credit system which were introduced in 1999 and meant that parents with disabled children could claim child care costs for children up to the age of 16. The 2002 Employment Act additionally gave parents with children under six years old or disabled children under 18 the right to ask their employer for flexible working arrangements. Carer friendly policies in the workplace have also been actively promoted to employers by Carers UK (previously the Carers National Association).

Table 1 about here.

Direct support for carers was embodied in the Carers and Disabled Children's Act 2000 (CDCA). This act entitled carers to an assessment in their own right and required local authorities to provide direct services to carers to meet their assessed needs. A related initiative was the Direct Payment Scheme which as it name implies enables payments to be made directly to carers for services they require in their caring role.[3] However the CDCA met with some opposition since it allowed local authorities to charge carers for services received. Policy makers in Scotland took this into consideration before introducing the Community Care and Health Act 2002 which regarded carers as co-workers receiving resources rather than consumers who were obliged to pay for services. This act also introduced free personal care for older people and it was expected that that this would allow carers to have more free time and help them to combine their caring with employment (Stalker, 2003).

In England and Wales the Carers (Equal Opportunities) Act 2004 (CEOPA) placed a duty on local authorities to tell carers about their rights and consider their wishes with regards to employment, education and leisure activities when carrying out an assessment. CEOPA also gives local authorities powers to enlist the help of health, housing and education authorities in providing support for carers. However it did not address the benefits trap many carers find themselves in; carers earning over a threshold amount lose their state benefits including Carers' Allowance, the main benefit payable to carers, and this can prevent carers from seeking work. On a more positive note the Carers Grant saw a further increase of £60 million to £185 million in 2005/6 which would have helped in the provision of services for carers. Further initiatives to support carers are being discussed. For example, in June 2005, an early day motion was issued calling for fair pensions for women missing out on work due to caring responsibilites. This would be in addition to the existing State Second Pension which was introduced in April 2002 and already provides a more generous additional State Pension for low and moderate earners and some carers as well as people with long-term illness or disability. In August 2005, the Department of Trade and Industry published responses to the Choice and Flexibility Consulation on extending flexible working rights, which included a proposal to extend these rights to carers. A Parental Rights Bill, which could include new flexible working rights for carers is also under review.

In spite of the gradual introduction of initiatives and legislation to support carers the notion that carers are not being adequately supported is implied by much of the literature in this area. Indeed a recent systematic review of UK literature published between 1990 and 2001 concerned with social care services suggested that services were not always attuned to carers' and users' needs (David Challis *et al*, 2005). Carers UK (2003) have also claimed that the policies in place are not as effective as they might be since carers are still unable to access the support they require. The CDCA gave carers new rights to an individual assessment of their needs but according to Carers UK (2003) only 32 per cent of respondents in their survey had actually had the assessment, an increase of just 11 per cent from 1997. It also appears that those carers who did receive an assessment were not being assessed on all the issues that could affect them such as the need for a break or the affect their caring role has on employment. Instead, assessments tended to focus primarily on the carer's health.

The Carers UK study also revealed that for many carers, an assessment did not lead to an improvement in service provision and many still felt that they were not receiving the services they required. However, the report does suggest that there has been some improvement since 2001. Carers UK suggest that this may have been because of the increase in the carers' grant. Feedback in relation to Direct Payments was also positive but only a small number of carers were able to access this service.

Tables 2(a) and 2(b) about here.

Initiatives that support carers by encouraging and enabling them to remain in paid employment have been implemented because policy makers believe that many carers who want to be in paid work find it difficult to do so. The view thatit is sometimes difficult for carers to combine paid work and care is supported by employment data from large surveys. For example, data from the BHPS summarised in table 2(a) indicates that informal carers are less likely to be employed than non-carers and when they are employed they work fewer hours. Employed female carers, but not male carers, also earned less than employed non-carers. However, both male and female carers earned less than BHPS respondents who were interviewed in 1991 and did not care in any year between 1991 and 2001. Furthermore, the data in table 2(b) indicate that carers who have cared for six or more years are less likely to be working than other carers, although the number of those who had cared for this length of time was quite small.

Previous research in the UK and elsewhere has shown that at least some of these differences remain when other factors such as age, gender and human capital are controlled for (Fiona Carmichael and Susan Charles, 1998, 2003(a) and 2003(b); Axel

Heitmueller and Kirsty Inglis, 2004; Sandra Hutton, 1999; Nieves Lázaro *et al*, 2004; Linda Pickard, 2000). Lower employment rates, lower earnings and shorter hours of work can be taken to imply that people have little choice about whether to undertake care or not and when they do, their extra commitments make it more difficult to find or maintain paid work especially in the primary sector. According to this interpretation government policy should be directed towards helping carers to remain in employment.

However, if people have a degree of choice about how much care to undertake or whether to undertake care or not, there is another possible interpretation of the generally lower employment rates, hours and earnings of carers. In this case decisions about informal care will depend on a range of factors including an individual's pre-caring employment situation.[4] In relation to the latter and since the shadow price of time devoted to care will be higher for people who are employed in full-time jobs, earning a relatively high income, a rational choice approach[5] suggests that such people may be less willing to undertake care. In contrast, for those people who are not working or who are relatively low earners the opportunity costs of undertaking care will be lower and, to the extent that they have a choice, they should be more willing to take on these extra responsibilities. Such considerations suggest that one reason why carers have lower employment rates, work less hours and are lower paid could be because people with these labor market characteristics are more likely to undertake care in the first place.[6]

It is important to identify whether caring responsibilities impact directly on employment since evidence to the contrary leads to different policy implications. If, for instance, carers are less likely to be employed but this has lessto do with their caring responsibilities than their pre-caring employment situations, policies directed to supporting carers in work may be misplaced. Instead policy would be better directed towards supporting carers in other ways such as through the provision of specialised support packages involving services such as respite care and home visits as well as helping them into work if that is what they want to do (Axel Heitmueller, 2005). Furthermore, if decisions about informal care are influenced by the perceived opportunity costs of caring, then rising female participation rates (the traditional source of care) could lead to a decline in the supply of care (Susan Eaton, 2005:38). This would be at a time when population ageing is likely to lead to increases in the demand for care. A decline in the supply of informal care would therefore force more sick and elderly infirm people to accept institutionalized care instead of being cared for at home even though many would prefer to live in their own homes if possible (Courtney Harold Van Houtven and Edward Norton, 2004, Department of Health, 1998 para 2.7. and para. 2.10). Moreover, a decline in the supply of informal care also has implications for health and social policy since it would increase the demand for alternatives that are more expensive from the perspective of the health care budget.

Nevertheless, the degree of choice that some people have in relation to the care they supply may be quite limited. The reality in the UK is that only quite wealthy people can afford to pay for long-term, private care either for themselves or their relatives. Less wealthy people, for whom the costs of the alternatives are prohibitive and people who feel a very strong sense of personal commitment to the person in need of care may feel that they have little freedom of choice in this regard (as discussed in Arksey *et al*, 2005:29 and SallyBaldwin, 1985). Furthermore, as noted in Arksey *et al*

(2005:150) once a caring episode begins reasoned decisions about paid work and care are very likely to be undermined by a variety of 'uncertainties and unknown factors and/or external constraints' including the carers own health and job insecurity.

To clarify some of these issues researchers have adopted a variety of approaches in an attempt to control for selection into caring. For example they have tested for significant differences between the employment of carers and non-carers using instrumental variables for informal care responsibilities (see for example Susan Ettner, 1996). Panel data has also been used in conjunction with fixed or random effects models to allow for the effect of individual characteristics on labor supply (Heitmueller, 2005). Another approach has been to control for individual characteristics by using longitudinal data to estimate a relationship between changes in hours committed to informal care and simultaneous changes in employment status (Eliza K. Pavalko and Julie E. Artis, 1997; Katharina Spiess and Ulrike Schneider, 2003).

The evidence from this body of research indicates that a direct, negative effect of informal care on hours of employment and earnings remains significant particularly for carers who care for longer hours. However, evidence relating to the impact of caring on employment participation is mixed. The role of the duration of a caring episode is also unclear.[7] Furthermore, this research is based on data from large, general surveys such as the BHPS or the European Community Household Panel in which caring is not a central issue. Respondents (carers and non-carers)are asked closed questions about their current employment and caring status but they are not asked whether or not their employment status has been affected by their caring responsibilities. This means that there is always the possibility that there is some critical determining influence of the employment status of carers that cannot be controlled for in the analysis. In the research reported here we have tried to address these issues by adopting a somewhat different approach. Rather than comparing the employment of carers and non-carers, we use the responses of carersto a dedicated questionnaire to compare their employment before and after they start to care on the basis of the time they commit to care and the duration of their caring episode. In the questionnaire we also ask direct questions about the impact of caring responsibilities on employment. Our premise is that inasmuch as caring responsibilities constrain employment we should be able to observe changes in employment after undertaking care. More specifically, participation rates and hours of work should be lower after undertaking care and those who care for longer hours and/or longer durations should be the most affected. Evidence of this kind would be consistent with the argument that the pre-caring employment situation of carers provides only a limited explanation for the lower employment rates and hours of work of carers. However, quantitative analysis cannot explain how and why caring responsibilities impact on employment. Instead, qualitative research methods are more appropriate for addressing these kinds of 'how and why?' as opposed to 'how much?' questions. We therefore additionally conducted a number of in-depth interviews with a sub-sample of carers.

SUBJECTS AND METHODS

Carer groups across the North West of England were asked if they would be willing to distribute questionnaires to their members. The groups were all voluntary organisations that offered various levels of support to carers ranging from the organisation of social events to the provision of formal services. Eight groups agreed to take part and in total 1483 questionnaires were sent out to carers with covering letters written by the mangersof the respective carer groups. Where it was possible for the carer groups to restrict the distribution of the questionnaires to carers below the state pensionable age they did so. But this wasn't always possible. Other than this, no controls were placed on the distribution of the questionnaire. Therefore the carers who did respond to the questionnaire should represent a random sub-sample of those carers who have taken the extra step of contacting a carer support group.

The questionnaire was restricted to three sides of A4 paper on the advice of a number of the support group managers who felt that the response rate would be negatively related to the length of the questionnaire.[8] Nevertheless, only 272 questionnaires were returned giving a fairly low response rate of 18.3 per cent (eight questionnaires had to be excluded from the analysis as the current caring responsibilities of the respondent were unclear). The low response rate is perhaps not surprising given that carers' time is limited. In addition the research will have been perceived by some carers as unnecessarily intrusive given the highly personal and often sensitive nature of their responsibilities. Some carers may also have worried that the research could somehow affect their eligibility for state benefits.

The questionnaire included closed questions about the carer, their caring responsibilities and their current and previous employment. We also included two questions asking working carers whether they had changed either their hours of work or their job specifically to fit in with their caring responsibilities. The last question on the questionnaire was an open-ended one asking about ways in which employers and the government could help carers to combine work and caring. This question was included on the assumption that carers are well placed to understand the kinds of initiatives that would help them most. (Appendix 1 contains an outline summary of the questionnaire.)

When the questionnaire was distributed we also asked for volunteers to be interviewed as part of the research. Thirtycarers responded to this request and as a result we conducted semi-structured in-depth interviews with 26 carers. Four volunteers who subsequently found it difficult to find the time to take part in an interview completed an extended questionnaire with open questions that followed the interview schedule. The in-depth interviews were loosely structured and open questions were used to encourage the carers to talk about their caring situation (see Appendix 1 for further details).

The sample of carers who responded to the questionnaire included 195 women and 60 men (nine people failed to answer this question). The majority of respondents (54.2 per cent) were over 55 years old. These included 48 respondents who were over 65. Just over a quarter (26.9 per cent) were aged between 45 and 54 and only 47 respondents (17.8 per cent) were less than 45 years old (three people did not answer this question). This age and gender mix is fairly representative of carers in the population as a whole in that, as indicated by the BHPS data in table 2(a), carers are more likely to be female and are generally older than non-carers.

Just over a quarter of the sample (28.8 per cent) did not have any educational or vocational qualifications and 17.4 per cent were only educated up to a GCSE or equivalent level. However, 40 sample members (15.2 per cent) had a degree or higher degree and another 34 (12.9 per cent) had a professional qualification. Nevertheless, more than half of those working (57.6 per cent) had a gross monthly income of less than £1,000 a month.

The sample members cared mainly for close family members or friends. The largest group, 35.2 per cent, cared for their spouse or partner, 33.3 per cent were caring for children with disabilities and a further 26.1 per cent were caring for their parents. One respondent was caring for their grandchild and one respondent cared for a neighbour. Three quarters of respondents were co-resident with the person they cared for.

Since the respondents were contacted through voluntary groups offering support to carers it is not surprising that the majority were caring for either long hours or had cared for a long time or both; 86 per cent of the respondents cared for 20 or more hours a week and the median hours of caring were between 50 and 99 hours per week; 69.7 per cent of respondents had been caring for more than 5 years and the median caring episode was between 5 and 9 years.[9] In contrast, among BHPS respondents, only 29 per cent of male carers and 34 per cent of females carers cared for 20 or more hours a week (between 1991 and 2001). Similarly, the data in table 2(b) shows that among the 1378 BHPS respondents who were caring in 2001 and for whom eleven complete years of data was available, only 14.5 per cent had been caring for 5 or more years. Thus our sample is only representative of those informal carers who are the most time-committed in terms of the hours they care and/or the duration of their caring episode. However, these are the carers thatpolicy makers should be the most interested in since their informal care substitutes for the most expensive kinds of formal care. This is also the carer group that is in most need of support. Nevertheless, 36.7 per cent of the sample received no regular visits from formal services such as a home help, a care worker or a doctor and 42.4 per cent of the sample received no help from family or friends.

THE IMPACT OF CARING RESPONSIBILITIES ON EMPLOYMENT; EVIDENCE FROM QUESTIONNAIRES

In order to investigate whether the caring responsibilities of the respondents impacted on their employment we examined their employment status before and after they became carers. Table 3 shows the employment status of the respondents before and after undertaking care. The figures indicate that after undertaking care there was a clear shift away from paid employment (and full-time employment in particular) into retirement and unemployment; the participation rate for paid employment was 68.9 per cent prior to caring and only 34.4 per cent subsequently (lower than the estimated rates for carers nationally as indicated in table 2(a)). Among the 182 people who had been employed either full-time or part-time prior to caring over half (94) were no longer in paid employment when they completed the questionnaire (among this group 20 carers were no longer working because they had retired and 9 carers were still working but in the voluntary sector). Among the 131 people who had been working in full-time employment prior to caring only 36 were still in full-time employment when they completed the questionnaire[10]; 26 were in part-time employment, 6 were working in the voluntary sector, 39 were no longer employed and 16 had retired.[11] It is also worth noting that among those still working the majority, 73 per cent, were employed in the public sector where employment practices are conceivably more flexible and by implication more carer friendly.

Table 3 about here.

While the shift away from employment is consistent with the proposition that caring responsibilities impact negatively on employment it may also be attributable to other changes in the respondents' lives. Nevertheless in response to the specific question 'have you changed your hours of work to fit in with your caring responsibilities?' 67.8 per cent of the respondents who were currently employed replied in the affirmative. Furthermore, in response to the question 'have you changed your job to fit in with your caring responsibilities?' 54 per cent of respondents who were in employment replied in the affirmative. 47 per cent of those in employment said they had changed both their hours and their job because of caring. These responses suggest that the majority of the carers who were able to remain in employment needed to change their hours or their jobs in order to do just that. The figures can also be taken to imply that at least some of the shift away from full-time employment is explained directly by the caring responsibilities of the respondents.

However, other factors could also be relevant and to explore this we used multivariate analysis to estimate the relationship between hours and the duration of caring and changes in employment whilst controlling for age, gender and human capital. Hours and years of caring are indicated byseven dichotomous variables representing possible thresholds; CAREHRS$\leq$20, CAREHRS20-49, CAREHRS$\geq$20var, CAREHRS50-99, CAREHRS$\geq$100 and CAREYRS5-9, CAREYRS$\geq$10. These variables take the value 1 if the respondent is caring for less than or at least the threshold number of hours or has cared the threshold number of years. Appendix 2 gives definitions for all the variables used in this analysis.

Changes in employment status before and after undertaking care are indicated by five dichotomous dependent variables; CHHOURS, CHJOB, STAYEMP, STAYFULL and HRSLESS. CHHOURS and CHJOB equal 1 if the respondent was employed and said that they had changed their hours or their job (respectively) to fit in with their caring role. STAYEMP and STAYFULL equal 1 if the respondent stayed in paid employment or full-time employment (respectively) after undertaking care. HRSLESS, equals 1 if after becoming a carer the respondent either moved out of full-time employment into part-time employment or moved out of paid employment altogether.

Probit regressions were estimated with these dependent variables and various combinations of the indicators reflecting hours and years of caring were included as independent variables. We also included independent variables to control for age (AGE55to64, AGE65+) gender (FEMALE) and human capital (DEGREE, PROF).[12] We also tried to control for whether the cared-for person lived with the carer (LIVEWITH) since it has been argued that whether the cared-for person lives with or outside the household of the carer is an indication of caring commitment.[13] However, since the majority of the carers were co-resident and the LIVEWITH variable was correlated with hours of caring the influence of this variable does not have a straightforward interpretation.[14]

Tables 4-6 about here

The results of the estimations are shown in tables4-6. In t able 4 the dependent variable is CHHOURS and in these estimations we were unable to include CAREHRS≥100 since all the carers who were in employment and caring for more than 100 hours a week said that they had changed their hours of work to fit in with their caring role. However, since we were able to include the other indicators of hours of caring in these estimations, the influence of CAREHRS≥100 is taken up by the constant and the coefficients of the other caring variables need to be interpreted relative to the effect of caring for 100 or more hours a week. In the first estimation the influences of CAREHRS≤20, CAREHRS20-49 and CAREHRS≥20var are all negative and significant. This indicates thatrespondents who were still in employment were significantly lesslikely to say that they had changed their hours of work to fit in with their caring role (relative to carers caring for 100 or more hours a week) when they cared for less than 50 hours a week or they cared for more than 20 hours a week but their hours of caring varied. Respondents regularly caring for between 50 and 99 hours a week were no more or less likely to have changed their hours to fit in with their caring responsibilities than respondents caring for more than 100 hours a week. In contrast, years of caring has much less significance than hours of caring; only the influence of CAREYRS5-9 is marginally significant.

The second estimation in table 4 includes LIVEWITH and the influence of this variable is highly significant indicating that carers who were co-resident with the person they cared for were significantly more likely to say that they had changed their hours of work to fit in with their caring role. However, since the LIVEWITH variable is highly correlated with hours of caring it is possible that the determining factor here is not co-residency per se but rather time involved in caring (the results in column 1 of table 6 support this contention since carers who undertook more than 100 hours of caring were significantly less likely to have remained in employment after undertaking care while the LIVEWITH variable is insignificant). The inclusion of LIVEWITH in table 4 also lowers the negative significance of AGE65+ suggesting that part of the reason for the negative relationship between being over 65 years old and CHHOURS is explained by residency.[15]

In contrast with the results in table 4, the results in table 5 (where CHJOB is the dependent variable) indicate that among working carers, hours spent caring are not the determining factor leading to job changes; in the first estimation (which does not include CAREHRS≥100) CAREHRS20-49 and CAREHRS50-99 are only marginally (negatively) significant and when CAREHRS≥100 is included (column 2) it is not significant. Instead, the positive significance of CAREYRS5-9 and CAREYRS≥10 suggests that those most likely to have changed their job to fit in with their caring role were those who had been caring for the longest durations. This result taken together with the evidence in table 4 suggests that carers who care for longer hours manage to combine work and care by initially adjusting the hours they work. However, as the duration of a caring episode continues some carers find that they not only have to change the hours they work but also their job in order to continue to combine paid work with their caring responsibilities.

Other carers may find that they are unable to continue working after undertaking care and consequently they drop out of employment altogether. This is implied by the results in table 6 which show that some of the other adjustments made by carers in relation to paid employment are significantly related to their caring responsibilities.

In column 1 the dependent variable is STAYEMP and, as already noted, the negative significance of CAREHRS≥100 suggests that those involved in longer hours of care are the most likely to give up work altogether. However, the negative significance of the duration of care variables in column 2 shows that among respondents who were working full time before they started to care, the duration of the caring episode is also a factor in the decision to move out of full-time employment by working part-time or leaving employment altogether. The results in column 3 can similarly be taken to imply that both hours of caring and the duration of the caring episode are factors that negatively affect hours of paid work. Nevertheless, the significance of years as well as hours of caring in the estimations in columns 2 and 3 of table 6 is not inconsistent with the results in tables 3 since a move from full-time into part-time work could also imply a job change.

In relation to the control variables, female carers were marginally more likely than male carers to have stayed in employment after starting a caring episode and those who were still working were no more or less likely to say they had changed their hours of work or job in order to care. This result is somewhat surprising given that a higher percentage of male carers were working on a full-time basis prior to undertaking care (72 per cent of men compared with 47.8 percent of women). It suggests that caring responsibilities rather than gender are implicated in the trade-off between caring and employment. Respondents over 65 years were significantly less likely to be working after undertaking care but this does not appear to be directly attributable to their caring responsibilities. This is suggested by the negative significance of AGE65+ in table 4 and the lack of significance of AGR65+ in table 5. The significant influence of DEGREE in table 6 suggests that respondents who were educated to degree level were less likely to have changed their employment after beginning a caring episode. This result is consistent with a rational choice perspective in that carers who have more human capital, and consequently face higher opportunity costsof giving up work, are less likely to do so. Nevertheless, these respondents had not given up or refused to undertake informal care responsibilities either. On the contrary they were managing to combine caring with paid employment.

To summarise, our analysis of the questionnaire data suggests that carers who are involved in caring for longer hours and longer durations are more likely to reduce their hours or work, change their job or give up work completely. This evidence can be interpreted as implying that these carers find it difficult to combine paid work and care in spite of recent initiatives designed to support them. However since our sample is quite small these results can only be taken as suggestive. In addition, the underlying nature of the difficulties faced by carers remains a matter for conjecture. It was for this reason that we decided to conduct in-depth interviews with a sub-sample of carers.

EXPLAINING THE DIFFICULTIES CARERS FACE IN EMPLOYMENT; QUALITATIVE EVIDENCE

In the interviews we were able to ask carers whether and how they thought that their employment opportunities had been affected by their caring role. The interview formats were semi-structured since we did not want the respondents' responses to be constrained to fit any of our preconceived ideas about the relationship between paid work and care. The transcripts of the interviews were analysed by identifying recurring themes (in line with Jane Ritchie and Liz Spencer, 1994); broad categories that reappeared in a number of the interviews were identified and more detailed coding or sub-themes were developed from the original themes. The broad themes discussed here relate to the impact of caring on employment and the difficulties faced by carers in employment. The sub-themes are giving up paid work to care, difficulties returning to paid work, longer-term effects on employment, restricted opportunities in employment, lack of flexibility in meeting carers' needs and financial implications.[16]

The 30 carers who volunteered to give up their time to be interviewed or to complete an extended questionnaire allprovided substantial hours of care (more than 5 hours a day). In addition, just under half of the sub-sample (14) had cared for more than 10 years. 25 of the carers were women and 26 respondents were aged between 45 and the state pensionable age (65 for men and 60 for women). All theinterviewees cared for a member or members of their family; eleven cared for a disabled childor a child who suffered from mental illness (ten women and one man who also cared for his wife), seven cared for their spouse or partner (two women and five men), ten women cared for a parent or other relative. Three other women cared for more than one relative. The majority (26) interviewees were caring for people who were living with them although the three women who had multiple caring roles also cared for someone living outside their home.

Eighteen interviewees were in paid employment (16 women and two men) but seven of the women and both men were working part-time. Three women were working in a voluntary capacity. Among the nine carers who were not in either paid or voluntary employment, six were long-term carers who had been caring for over ten years.

Giving up paid work to care

In the interviews we asked the carers whether they had given up work at any point in order to enable them to carry out their caring responsibilities and a majority answered in the affirmative (four men and 13 women). Ten of the fifteen carers who were only educated to GCSE level or equivalent had at some point given up work to care compared with only four of the nine carers with a higher qualification (A level or equivalent or a degree). Nine longer term carers who had cared for over ten years said that they had given up work at some point to care compared with eight carers who had been caring for less time. All carers who had given up work at some point were caring for someone living in their household. One other carer who managed to stay in employment until she reached retirement age said that she felt that she would have given up if she hadn't been due to retire.

One important advantage of the interviews was that we were not only able to ask people if they had given up work to care but, if they had, we were also able to ask them why. Carers' comments in answer to these questions suggested that carers often give up paid work simply because they don't believe that it is compatible with their caring role. As one carer said;

"Either you're caring for somebody or you're working aren't you…I mean it's difficult to juggle the two"

If a family member needed full time care then it seemed to be a natural step for another member of the family to give up work in order to look after them. This is illustrated by the words of one carer speaking about her mother;

"She helped me out there so I always thought well I'll always help her out I would've done anyway but I thought well she's done a lot for me and it's time to give back and I did that for her…….. She was put on a lot of medication so because she lived alone and I didn't like her…in the house…by herself, I packed in the job and went caring for her all the time"

Some of the comments made by carers also seemed to suggest that they thought that combining caring and employment would be too difficult or too stressful for them to deal with;

"We found it very, very difficult my husband and I because my mother lived with us. I gave up a full time job to have my mum"

All those who had given up work seemed to feel that this was their only option in that they didn't believe it would have been possible for them to have combined caring with paid employment;

"I'll take her living with me, she said you can't you're working I said well I'll not work'

This perceived lack of choice is consistent with evidence from other qualitative studies that have found that many carers believe that they have little choice about becoming a carer (e.g. Suzan Lewis *et al*, 1999).

Difficulties returning to paid work

Two interviewees who were not in paid or voluntary work said that they didn't specifically give up work to care, instead they happened to be out of work at the time when they were needed to care. Nevertheless, because of their caring responsibilities they found it difficult to return to employment;

"She ended up being admitted to hospital for about five weeks and that coincided with the end of a temporary contract that I was working with so rather than look for another job I just stopped looking for work instead I had to look after her when she came home from the hospital"

"My son had an accident…and it's left him with a physical disability now so I had to start caring for him then so there was no way I could have got back into employment"

Three of the mothers of children with disabilities also said that they found it difficult to return to paid work after having their children;

"Well I haven't been employed since I had him apart from a few weeks ago I started working here four hours a week"

Three other carers were worried that they might be too old when they had finished caring to return to the labor market;

"I might be too old…I've only got another ten years to go I think I could do with a rest"

The longer term effects of caring

Evidence that as a caring episode continues it becomes more difficult to combine care and work was provided by carers who said that they managed to cope with caring and paid employment for a period of time but were eventually forced to give up work sometimes because the health of the person they were caring for deteriorated;

"I tried to take a job a while back I managed to do it for three months. Chris' fits became worse and I think it was because I was out of the house and it was only four hours a day…so I gave it up"

Only 10 carers managed to stay in paid employment without having to change either their job or their hours of work. Three others who were already working part time when they started caring said that that they would probably have had to make some changes if they had been working full time;

"For the last five or six years now I have been looking after me mum so there's no way I could have done full time"

If working less hours or part-time is an option it may be preferred to giving up work completely and six carers said that they had opted for part-time work when they found it difficult to continue working full-time;

"I went part time because it was becoming too much for me at the time"

One female carer in this category who was not at first co-resident with the person they cared-for was initially unable to continue working full-time because of the time she spent travelling. Subsequently the health of the cared-for person became the determining factor;

"Within that sort of time of looking after her from a distance I reduced my working week down to four days a week and then she came to live with me and at first it was alright but then she went a lot worse and I had to reduce my working week down to two days"

Another interviewee managed to continue working in full-time employment for a while but then felt that she had to look for part-time employment;

"She came home…and I managed to keep working full time for about another 12 months…it was a question then of thinking oh well I'll probably look for part time work in due course"

Four interviewees who had given up work to care felt that after having *'been carers for a while they'd lost skills'* and as a result they would find it difficult to secure employment especially at the level comparable with their previous experience;

"In our line of work…it was difficult to get back at the level that you were at"

However, six carers felt that they had gained skills by becoming a carer although one said that he doubted that future employers would recognise this.

'If employers would look at caring on my CV and understand that I'm not just a jobless dosser and that there are skills that I've learnt through my caring role that can be applied to the workplace that although I've been unemployed, I've not been sat at home not working because caring is work it's just not something you get paid for, but employers don't seem to realise that'

Restricted opportunities in employment

Four of the working carers said that their opportunities for career development were restricted because of their caring responsibilities. One carer said that he felt disadvantaged within the workplace because he was working part time;

"The people I used to work with…are now two or three levels above me and I've had to stay where I am because there are no opportunities for people who work part time like me"

Another carer said that she was forced to take a lower paid job because it fitted in with her caring responsibilities.

"I stopped at home…for about 6 months…and then I went being a dinner lady at Paul's school… and I did that for 18 months"

One female carer went from being the breadwinner in her household to working just seven and a half hours a week;

"I was the breadwinner in my house (before I became a carer)…I was earning more than Andrew, I had a company car and everything and that was just to nothing"

Another carer had taken a step back in her career because she needed to be near the person she was caring for;

"I had to move back north to be with my father this coincided with a chance to take redundancy from my job in Sussex. I eventually got a job in Edinburgh but it was a step down in my career"

Lack of flexibility in relation to carers' needs

When we asked carers why they found it difficult to combine work and caregiving they did not talk in terms of making a simple substitution between time in paid work and time in care (as is implied by standard labor supply model). Instead they gave various explanations in response to this question although a majority (25) agreed that lack of flexibility over work hours and work practices was a particular problem for carers. For example, ten working carers said they had to take time off for routine appointments but this time usually had to taken as unpaid time off, annual leave or made up at a later date;

"If I needed time off for hospital appointments and doctors' appointments for Joan and anything like that all I had to do was let them know the day before and I would be written out for the work schedule for the following day. I didn't get paid for it but they would allow me that time"

Since the Employment Act 2002 employees have been entitled to unpaid time off in an emergency to care for a dependant but only one carer working in the voluntary sector said that she was confident that that she would be able to leave her job at a moments notice if this happened. However, some working carers acknowledged that since the introduction of the 2002 Act some employers had tried to implement policies to accommodate flexible working arrangements. One carer said her employer was "*very flexible and very understanding about her caring role*". Another was a more cynical;

"Flexibility but it kind of it goes one way with employers…they want you to be flexible…it doesn't mean that they will be flexible for you"

One respondent was reluctant to change jobs because she was unsure whether a new employer would allow her to take time off;

"I feel it may be difficult to change now because I need time off work at short notice for hospital appointments this could be frowned upon … time off work interferes with the day to day running of the office."

However, in spite of the legislation, some carers did not receive the support they needed from their employer;

"I know there is legislation…2002 Employment Act said I'm allowed to ask my employer…I did ask my employer and the answer was no because they've got that little phrase that says business need and that was it."

Some carers had specific needs within the workplace that, although relatively simple for employers to administer, were not always met and this made their lives difficult. For example, one respondent said it was *"imperative"* to have a mobile phone in case the person he cared for needed to contact him urgently. However, mobile phones were not allowed in the workplace and his employer would not make an exception to the rule. Another working carer felt it would have been possible to work from home but his employer would not allow it.

However, a few carers acknowledged that it wasn't always possible for employers to accommodate carers' needs;

"You're being paid to do a job at work I mean you can't just suddenly say in the middle of that job right whoever I care for needs me bye-bye can you…you're caring or you're working I can't see myself how that can be worked round really, I really can't"

Some carers also mentioned insufficient flexibility in relation to the formal support services they needed to access. For example one respondent found it difficult to take on paid employment because her son was only able to go to the day centre when he was well and as his health was very unpredictable it was hard to make other arrangements.

Financial implications

The decision to give up work to care is not an easy one since it puts carers under considerable financial pressure. For some carers, their forgone earnings can be very high as indicated by one respondent;

"Where I was working ten years ago I was…bringing home a thousand pounds a month which is good money and now I get forty three pounds a week which is a bit of a difference so the caravan had to go, the car had to go and so financially it's a completely different world"

One carer said he was devastated to have had to give up work but he wanted to care for his wife on a full time basis and so he felt that he didn't really have any alternative;

"Well it's been quite devastating really. I mean I've basically lost everything. I lost my job the career I was aiming for and most of what I had really… I had a very good job and it's all gone, it's all been lost"

Some low-paid carers found themselves in a benefits trap which meant that a wage rise or increase in hours left them no better off since their state benefits were reduced. In 2005 the main state benefit payable to carers, Carers' Allowance (formally Invalid Care Allowance) amounted to £45.50 a week plus a discretionary extra amount of £27.30 in respect of a dependent adult. However, the weekly earnings limit to qualify for these benefits was £82 and carers had to be caring for at least 35 hours a week (Department of Work and Pensions, 2006). Some carers who are not in paid employment may qualify for other state benefits but most of these are also means tested. Carers can therefore find themselves in a benefits trap that acts as a disincentive to take on (more) paid work. The following comments were typical;

"I got a rise under the minimum wage, my wage rose from £23 to £27 but that meant that I came over the allowed allowance, not by much only by about well a pound really and that meant that I lost the £25 income support so I gained £3 and lost £25"

"If I earn above a certain rate I'm going to lose my benefits so if I'm trying to increase my hours I wouldn't be able to…I only work 18 hours now"

One respondent was unable to work full-time because it was too much to cope with along with his caring responsibilities. However, as a part-time worker he was earning slightly too much to qualify for many of the benefits. He felt that he would be better off working for a lower wage:

"If I was working for the voluntary sector I would earn a lot less and so therefore I would be entitled to more benefits. I know it sounds stupid but because I'm on that threshold it prohibits us from some things … it's the housing benefit we don't get any of that we don't get any help with our rent we don't get any help with the house"

The kinds of difficulties referred to by the interviewees and summarised here are very real for carers and arise because of their caring responsibilities. They help to explain why carers find it difficult to combine informal care and paid work. However, the possibility of part-time work, the positive attitudes of some employers who are willing to accommodate carers' and the availability of formal support services such as day care can all help carers to stay in paid work.[17]

SUMMARY AND IMPLICATIONS

Our analysis is based on the responses of a random sample of carers to a questionnaire and in-depth interviews with a smaller sub-sample. The analysis of the responses to the questionnaire showed that the carers in our sample who cared for longer hours and longer durations were more likely to have either changed their hours of work or their jobs, or left employment completely after becoming carers. However, carers who had invested in relatively high levels of human capital were more likely to resist making changes to their labor supply. To the extent that we are able to generalise from these results they can be taken to imply that carers who care for substantial hours remain in work bytrading off hours of work for hours of caring. However, as a caring episode continues some carers need to change their jobs in order to continue combining paid work and care (presumably because they find that the hours in their current jobs are not sufficiently flexible).

Among the carers we interviewed there was a strong belief that caring responsibilities impact on employment. Not only do carers face constraints on their time but carers who remain in paid work have particular needs that employers are sometimes unwilling or unable to meet. These difficulties lead some carers to give up paid work completely and make it impossible for others to return to employment after a period of time out of the labor market. Carers who want to take on paid work have therefore needed to adopt various strategies in order do so. These include working part-time, changing jobs and working for particular employers who have embraced carer friendly practices.

Our interpretation of these results is that informal care responsibilities explain at least some of the differences between the employment and earnings of carers and non-carers. Some people may have a choice about whether to care or not but other people, perhaps those who are less wealthy or who have no siblings or other close relatives with whom to share their caring responsibilities, or those who feel a strong obligation or duty to care, will have less choice as the alternatives will be limited. Gendered norms of responsibility can also mean that the pressure to undertake care is even stronger for women. This was acknowledged by one carer who said *"I think it's especially awful for women because I think you're eaten up with guilt... I still am (because) she had to go into a home. I hated it"*.

Furthermore, the time and effort involved in informal care and the strategies adopted by carers in order to make it easier for them to combine work and care are likely to lead to an erosion of a care-giver's human capital and consequently restrict their employment opportunities still further. This amounts to a gradual, drip-drip effect that weakens carers' longer term employment prospects and ultimately their labor market attachment. This trend is likely to become more difficult to reverse the longer the duration of an individual caring episode and when a long caring episode does end some carers can find themselves stranded without a job and without any state support. As one carer put it "*after being out of work for ten years anything that I did ten years ago is so far outdated now that it's of no value really, ... there's probably nothing out there at the moment that I would be able to do"*.

In the light of these results it was not surprising that in response to an open question in the questionnaire asking carers about the support they needed in order to stay in employment they were keen to offer their recommendations. In their responses they made a number of suggestions that could form the basis of new or revised initiatives. For instance, many carers thought that employers needed to have more information about the needs of carers and that this would encourage them to make simple changes to their working practices that could significantly improve carers' lives. In relation to support services, carers believe that the existing system is not as effective as it should be. There appears to be a lack of communication within social services and across agencies and as a result some carers are falling out of the loop. Measures should also be taken to ensure that the opinions of individual carers are sought by practitioners and more effort should be made to accommodate their requirements. In relation to the financial support that is available for carers, the present benefit system appears to be inadequate. If carers are able to find paid employment they are penalised by restrictions on the payment of benefits such as Carers Allowance. Some of the respondents in our sample suggested that caring should be recognised as a job within the health sector and that carers should receive appropriate recompense for the time spent caring. This possibility should not be dismissed out of hand given the extra demands facing the health and caring services because of population aging (Hancock *et al*, 2003)[18]. Furthermore, the UK government has shown a willingness to subsidise childcare for employed parents but the time and commitment involved in informal care for adults as well as disabled children has been given less attention. Yet, as one carer commented, caring for adult *"can encompass the same responsibilities as* *looking after a child"* and sometimes those responsibilities will be even more demanding.

NOTES

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[1] The percentage of the working age population who are involved in informal care is higher (table 2(a)) and the percentage of the population who have participated in informal care at some point in their lives is higher still; among respondents who were involved in the first wave of the British Household Panel Survey (in 1991) over half (51.8 per cent) of those who were still of working age in 2001 had participated in care in at least one of the years between 1991 and 2001. In the USA the percentage of the population who provide assistance to someone else who needs help appears to be higher than in the UK; 16 per cent of the US population have been estimated to provide care for adults aged 50 or over (Rheba E. Vetter and Susan Myllykangas (2006) citing data from a fact sheet issued by the Family Caregiver Alliance (2005)).

[2] In the UK around 60% of all informal carers are women (table 2(a)). Women also provide the bulk of informal care in other European countries, the US and in traditional cultures such as China (Eaton, 2005). Data from the General Household Survey 2000 indicates that 61% of informal carers in the UK who are caring for more than 20 hours a week are female (Maher and Green, 2002) and in the British Household Panel Survey between 1991 and 1999 just over 63% of respondents who were caring for more than 20 hours a week were women.

[3] Direct payments are local council payments available for anyone who has been assessed as needing help from social services. They are available to carers aged 16 or over and parents (including people with parental responsibility for a disabled child). Direct payments can be used to buy services from an organisation or employ somebody to provide assistance. For example, carers can employ professional help to provide them with a break from caring (see Directgov, 2006).

[4] Willingness to care will also be influenced by factors such as the health of carer, the relationship of the carer to the cared-for person, distances and travelling time, existing financial pressures and the expected duration of a caring episode in question (Sally Baldwin, 1985; Arksey *et al*, 2005:29).

[5] Assuming that individuals are rational (in the limited sense implied in neoclassical economics) and the household production function shifts outwards with care giving (as time spent in the home becomes more productive, see Nancy Folbre, 1995) some people will allocate more hours to home production. Not everyone will respond in this way since the opportunity costs of giving up an hour of employment will be too high for some higher earners. However, this argument assumes that there is complete flexibility over hours of work and there is no negotiation over who in the household undertakes care or for how long.

[6] Using the language of segmented labor market theory, people who are more willing to undertake care are more likely to be either unemployed or employed in secondary labor markets characterised by low pay, part-time and insecure contracts, fewer promotion opportunities and less union representation. Since female participation rates are lower than those of men and more women are employed in the secondary sector, this argument can also explain, in part, why more women are involved in informal care

[7] The BHPS data in table 2(b) illustrates this to some extent as there is no clear relationship between the duration of caring and employment.

[8] One unfortunate consequence of limiting the number of questions in the questionnaire to 16 was that we were only able to control for a limited number of variables in the analysis.

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[9] 12.9 per cent of the sample cared for between 50 and 99 hours per week while over a third of the sample, 39.4 per cent, said that they cared for 100 or more hours a week. In terms of the duration of care 30.3 per cent of the sample had been caring for less than 5 years, 23.1 per cent had cared for between 5 and 9 years and 46.6 per cent had been caring for more than 10 years. There was no significant correlation between gender and either hours of caring or the duration of caring or between hours of caring or the duration of caring.

[10] 2 people who had been working part-time and 6 people who were not working prior to caring as well as 2 people who did not respond to the question relating to prior employment were in full-time employment when they completed the questionnaire

[11] 5 people selected the category 'other' in response to the question relating to current employment. 3 people did not answer the question.

[12] Although the scope for including other control variables was limited by the scope of the questionnaire and the relatively small size of the sample, we did try including an indicator of income and a variable indicating whether a respondents' employment was in the public sector and but the influences of these variables were not significant in the multivariate estimations.

[13] Heitmueller (2005) argues that while caring for someone living in the same household may be simpler in terms of logistical arrangements the needs of the cared-for person may be greater and care hours are likely to be longer. It is also possible that as a caring episode continues a cared-for person who initially lives outside the household of the carer moves in with the carer as their needs increase (especially if the only alternative is institutional care). Heitmueller's argument is supported by Sara Arber and Jay Ginn (1995) who found that co-resident carers were less likely to be in paid employment than extra-resident carers.

[14] The Pearson correlation coefficient between LIVEWITH and a ranked variable indicating hours of caring (by category) is 0.22, Spearman's rho is 0.16, both are significant at the 1 per cent level.

[15] 79 per cent of carers over 65 are co-resident with the person they care for compared with 75 per cent of carers under 65.

[16] The other broad themes were the impact of caring on other areas of life such as relationships and health and the informal and formal support received by carers. These themes did not relate directly to the employment of carers and are not discussed here. They are discussed in detail in Greg Anderson *et al* (2005).

[17] Arksey *et al* (2005) and Agneta Stark also highlight the part played by the support services in carers' labor supply decisions. Stark (2005) suggests that it is limited support for carers in Spain that has lead to a system dubbed 'familia extensa modíficada' whereby elderly parents who need care move between the homes of their children.

[18] According to ACE National (2006) carers currently save the economy £57 billion each year in care costs, the equivalent of a second National Health Service. As the population ages these savings will rise; John Carvel (2006) cites a report by Sir Derek Wanless which asserts that spending on personal care in the UK will have to treble to £30 billion by 2026 to meet the needs of the ageing baby boomer generation . Three million of the six million carers in the UK currently juggles work and care. If carers are to continue to carry the lion's share of care whilst remaining active in the labor market, it is critical that there are good services to support them

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Table 1: Recent initiatives designed to support and draw attention to the needs of informal carers

Year	*Title*	*Summary of issues addressed*
1999	National strategy for carers	Recognition of carers' role and carers' needs.
1999	Working Families Tax Credit	Parents with disabled children entitled to claim child care costs for children up to the age of 16 (previously 12)
2000	Carers National Association (now Carers UK)	Actively promoted work-life balance to employers and continues to produce materials for employers to allow them to develop more carer friendly policies for the workplace.
2000	Carers and Disabled Children's Act	Entitled carers to an assessment in their own right and required local authorities to provide direct services to carers to meet their assessed needs.
2001	Health and Social Care Act	Direct Payment Scheme entitled carers to direct cash payments from their local council to pay for short breaks, nursery placement providing specialist support for children, assistance to attend an activity and personal care
2002	ACE National	Action for Carers and Employment is a project led by Carers UK. The project raises awareness of the barriers facing carers who wish to work, and tests and promotes ways of supporting them.
2002	The State Second Pension	Provided a more generous additional State Pension for low and moderate earners, some carers and people with long-term illness or disability.
2002	The Employment Act	Parents of disabled children under 18 entitled to request flexible working arrangements and unpaid time off in an emergency
2003	Fair Access to Care	Provided councils with a framework for setting their eligibility criteria for adult social care to create fairer and more consistent eligibility decisions across the country.
2004	Carers (Equal Opportunities) Act	The Act came into force in April 2005. It focuses on health, employment and life-long learning issues for carers.

Table 2(a): Employment and earnings of working age carers and non-carers in the British Household Panel Survey (BHPS)*: eleven year averages (1991-2001)

	Carers: respondents who were caring in year data collected	Non-carers: respondents who were not caring in year data collected	Non-carers over period: respondents who did not care between 1991 and 2001**	Current carers 11 year average relative to non-carers	Current carers 11 year average relative to non-carers over period
MEN (number)	376	4010.82	509.73	0.09	0.74
Average age	46.32	37.27	43.01	1.24	1.08
Employment rate (%)	67.00	75.00	88.91	0.89	0.75
Average hours in paid work per week	38.72	39.16	39.71	0.99	0.97
Average hourly wage (£)	9.6	8.68	10.33	1.11	0.93
Average weekly wage (£)	374.05	334.02	403.42	1.12	0.93
WOMEN (number)	568.64	3929.64	497	0.14	1.14
Average age	44	35.43	39.73	1.24	1.11
Employment rate	58.73	63.00	73.00	0.93	0.8
Average weekly hours in paid work	27.23	29.44	28.37	0.92	0.96
Average hourly wage (£)	6.4	6.48	6.95	0.99	0.92
Average weekly wage (£)	183.96	195.78	203.15	0.94	0.91
RATIO OF FEMALES TO MALES	1.51	0.98	0.98	1.54	1.54

*The BHPS is carried out by the Institute for Social and Economic Research. It was first conducted in 1991 and has been conducted annually since. Each adult (16+) member in a sample of more than 5000 households is interviewed, and the same individuals are re-interviewed in successive waves. If they leave the household, all adult members of their new household are also interviewed. Children are interviewed once they reach the age of 16.

** data is only collated for respondents for whom 11 years of data is available

Table 2(b): Years of caring and employment of working age respondents in the 2001 wave of the BHPS (respondents for whom 11 years of data was available)

Years of caring	Total	Not employed	Employed	Employment rate
0	1474	197	1183	0.80
< 1 (new carers)	612	149	396	0.65
≥1 but <2	313	85	199	0.64
≥2 but <3	125	31	82	0.67
≥3 but <4	71	27	38	0.54
≥4 but <5	57	10	42	0.74
≥5 but <6	34	7	23	0.68
≥6 but <7	33	9	21	0.64
≥7 but <8	25	9	15	0.60
≥8 but <9	17	8	6	0.35
≥9 but <10	19	5	12	0.63
≥10	72	31	35	0.49
Total(average)	2852	568	2054	(0.72)
Total carers (average)	1378	371	869	(0.54)

Table 3: Current and previous employment status of respondents to the questionnaire

Employment status	*Number (per cent) of respondents in category prior to caring*	*Number (per cent) of respondents in category at time research conducted*
Employed full-time	131 (49.6)	46 (17.4)
Employed part-time	51 (19.3)	45 (17)
Voluntary employment	6 (2.3)	16 (6.1)
Other type of work	4 (1.5)	8 (3)
Not employed	52 (19.7)	114 (43.2)
Retired	3 (1.1)	33 (12.5)
no reply to question	17 (6.4)	2 (0.8)

Table 4: Caring responsibilities and changes in hours of work; dependent variable is CHHOURS (respondent in work and said they changed their hours of work to fit in with their caring role)

Dependent variable	CHHOURS	CHHOURS
Independent variables		
CAREHRS<20	-1.49 (0.416)***	-1.193(0.445)***
CAREHRS20-49	-0.903(0.412)**	-0.902(0.435)**
CAREHRS50-99	-0.416(0.468)	-0.697(0.504)
CAREHRS≥20var	-1.139 (0.403)***	-1.255(0.423)***
CAREYRS5-9	0.724(0.387)*	0.728(0.4)*
CAREYRS≥10	0.481(0.319)	0.508(0.331)
AGE55-64	-0.045(0.305)	0.212(0.631)
AGE65+	-1.4(0.628)**	-1.259(-1.924)*
FEMALE	0.264(0.732)	0.557(0.383)
LIVEWITH		0.99(0.364)***
PROF	-0.204(0.436)	-0.226(-0.493)
DEGREE	0.124(0.336)	0.726(0.346)
constant	0.645(0.463)	-0.345(0.595)
No. of observations	113	113
Log-likelihood	-56.45	-52.638
restricted Log-likelihood	-71.455	-71.455
Chi-squared	30.004**	37.634***

Notes.

CAREHRS<20 and CAREHRS20-49 included instead of CAREHRS≥100 as not enough variation in the value of the dependent variable for values of CAREHRS≥100 equal to 1; all the working respondents who were also caring for 100 or more hours a week said they changed their hours of work to fit in with their caring responsibilities

Standard errors in parenthesis

***, **, *; t statistic, chi-squared statistic statistically significant at 1 per cent, 5 per cent and 10 per cent levels respectively

Table 5: Caring responsibilities and job changes; dependent variable is CHJOB (respondent working and said they changed their job to fit in with their caring role)

Dependent variable Independent variables	CHJOB	CHJOB
CAREHRS<20	0.008(0.444)	
CAREHRS20-49	-0.802(0.419)*	
CAREHRS50-99	-0.78(0.434)*	-0.206(0.461)
CAREHRS≥20var	-0.636(0.394)	-0.143(0.413)
CAREHRS≥100		0.61(0.384)
CAREYRS5-9	1.038(0.384)***	0.978(0.378)***
CAREYRS≥10	0.977(0.319)***	0.936(0.317)***
AGE55-64	0.48(0.319)	0.424(0.314)
AGE65+	-1.04(0.754)	-1.199(0.747)
FEMALE	0.391(0.385)	0.327(0.386)
LIVEWITH	1.079(0.375)***	0.726(0.392)*
PROF	-0.276(0.42)	-0.37(0.417)
DEGREE	-0.061(0.337)	0.073(0.327)
constant	-1.364(0.609)**	-1.496(0.545)***
No. of observations	111	111
Log-likelihood	-59.203	-60.009
restricted Log-likelihood	-76.574	-76.574
Chi-squared	34.742***	33.131***

Notes.
standard errors in parenthesis;
***, **, *; t statistic, chi-squared statistic statistically significant at 1 per cent, 5 per cent and 10 per cent levels respectively

Table 6: Caring responsibilities and changes in employment; dependent variables are STAYEMP (respondent remained in paid employment) STAYFULL (respondent remained in full-time employment) and HRSLESS (respondent worked less hours, moved into voluntary employment or out of employment)

Dependent variable Independent variables	STAYEMP	STAYFULL	HRSLESS
CAREHRS50-99	-0.331(0.351)	-0.115(0.402)	0.475(0.35)
CAREHRS≥20var	0.013(0.345)	-0.611(0.433)	0.274(0.341)
CAREHRS≥100	-0.899(0.312)***	-1.307(0.41)***	1.218(0.332)***
CAREYRS5-9	-0.37(0.299)	-1.245(0.414)***	0.744(0.311)**
CAREYRS≥10	-0.265(0.256)	-0.888(0.317)***	0.54(0.259)**
AGE55-64	-0.0978(0.231)	0.19(0.292)	0.144(0.244)
AGE65+	-1.4(0.557)***		1.477(0.586)**
FEMALE	0.564(0.29)*	0.548(0.336)	-0.116(0.298)
LIVEWITH	0.537(0.313)	0.28(0.407)	-0.421(0.317)
PROFESION	-0.072(0.39)	-0.083(0.416)	-0.076(0.369)
DEGREE	0.804(0.295)***	0.821(0.331)**	-0.732(0.284)***
constant	-0.454(0.423)	-0.394(0.492)	0.124(0.426)
No. of observations	171	124	176
Log-likelihood	-94.724	-57.311	-85.847
restricted Log-likelihood	-117.869	-74.703	-108.51
Chi-squared	46.291***	34.783***	45.324***

Notes.

AGE65+ cannot be included in the estimation with STAYFULL as the dependent variable as no sample members who were over 65 worked full-time before starting to care

Standard errors in parenthesis;

***, **, *; t statistic, chi-squared statistic statistically significant at 1 per cent, 5 per cent and 10 per cent levels respectively

APPENDIX 1:

Summary of questions included in the questionnaire (responses were elicited through the selection of a category)

1.1 Who is that you care for?
1.2 How long have you been caring for this person?
1.3 Does this person live in the same household as you?
1.4 In total, how many hours a week do you usually spend looking after or helping this person? If it varies, is it usually under or over 20 hours a week?
1.5 Does this person receive regular visits from any of the following?
1.6 Do any of your family or friends help you in you caring role?
2.1 What is your age?
2.2 What is your gender?
2.3 What is your highest educational/vocational qualification?
3.1 Are you employed?
3.2* Which of these best describes your gross monthly income?
3.3* Which sector do you work in?
3.4* Have you changed your job to fit in with your caring responsibilities?
3.5* Have you changed your hours of work to fit in with your caring responsibilities?
3.6 Were you employed before you became a carer?
3.7 How do you think employers and the government could or should help carers to combine work and caring?

* respondents were only asked to answer these questions if they replied in the affirmative to question 3.1

Summary of interview schedule; main themes and suggested initial questions (questions for open questionnaire)

1. Current caring role: Could you tell me a bit about your caring situation? Who is it that you care for?
2. Support for carers: Do you receive any support or help from family or friends and if so what kind of support? Do you receive any formal help or support from the Government and if so what kind of support? (e.g. formal, informal, family or financial support, carer support groups, employer support)?
3. Changes over time in caring role: How has your caring role changed over time?
4. Impact of caring on other areas of life: How has your life changed since becoming a carer? (e.g. impact on health, personal life, finances)?
5. Impact of caring on employment: How does your caring role impact on your work/job/career? Have you ever given up work because of your caring responsibilities?What makes it difficult for you to stay in paid work? What helps you stay in either paid or voluntary employment? How do you see your caring role impacting on your work/job/career in the future over the next six months to a year or longer?
6. Policy input: How do you think employers and the government could or should help carers to combine work and caring? What do you think are the main problems that affect working carers?

7. Future: How do your see your caring role developing over the next six months to a year? Will you have to make any/anymore changes in your life to fit in with your caring role?

APPENDIX 2: Definitions of variables used in the analysis

Variable	Definition
CHHRS	takes the value 1 if the respondent was working when they completed the questionnaire and said that they had changed their hours to fit in with their caring role and zero if not
CHJOB	takes the value 1 if the respondent was working when they completed the questionnaire and said that they had changed their job to fit in with their caring responsibilities and takes the value zero otherwise
STAYEMP	takes the value 1 if the respondent was in paid employment prior to caring and stayed in paid employment (zero otherwise)
STAYFULL	takes the value 1 if the respondent was in full-time employment prior to caring and stayed in full-time employment (zero otherwise)
HRSLESS	takes the value 1 if after undertaking care the respondent either (i) moved out of full-time employment into either part-time employment, voluntary employment or unemployment or (ii) or was in part-time employment and moved into voluntary employment or unemployment. Takes the value zero if the respondent was working full-time or part-time prior to undertaking care and neither (i) or (ii) applied.
CAREHRS<20	takes the value 1 if the respondent cares for less than 20 hours a week and 0 otherwise
CAREHRS20-49	takes the value 1 if the carer cares between 20 and 49 hours a week
CAREHRS50-99	takes the value 1 if the carer cares between 50 and 99 hours a week
CAREHRS≥20var	takes the value 1 if the respondent said they always cared for more than 20 hours a week but the number of hours they cared varied
CAREHRS≥100	takes the value 1 if the carer cares more than 100 hours a week
CAREYRS5-9	takes the value 1 if the respondent has cared for between 5 and 9 years
CAREYRS≥10	takes the value 1 if the respondent has cared for at least 10 years
AGE55-64	Takes the value 1 if the respondent is between 55 and 64 years old
AGE65+	Takes the value 1 if the respondent is over 65 years old
FEMALE	Takes the value 1 if the respondent is female
LIVEWITH	Takes the value 1 if the respondent and the cared for person share the same household
PROF	Takes the value 1 if the respondent's highest qualification is a profession qualification
DEGREE	Takes the value 1 if the respondent's highest qualification is a degree or higher degree