Formalising Informal Care in Austria

Experiences of Caregivers and Arising Implications

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1. Introduction

Informal care is commonly understood as "care provided to older and dependent persons by a person with whom they have a social relationship" and represents an indispensable pillar of the overall long-term care provision (Broese van Groenou & De Boer, 2016, p. 271). Estimates suggest that around 80% of all long-term care in Europe is delivered by informal caregivers (Hoffmann & Rodrigues, 2010; Nagl-Cupal et al., 2018). Due to ageing societies and cutbacks in the provision of professional care, the importance of informal care is expected to further increase (Colombo et al., 2011; Kaschowitz & Brandt, 2017; Swinkels et al., 2015).

Despite its essential contribution to long-term care provision, informal care remains unrecognised work: It takes place in the private sphere and is thus characterised by low societal visibility (Maidment, 2016). Moreover, it is provided without formal contractual agreements and remuneration, which leaves caregivers in a situation with no regular income and frequently forces them to combine informal care work with paid employment (Carmichael et al., 2008). These conditions contribute to the fact that caregiving activities are associated with negative effects on physical and mental health, as well as on the overall life-satisfaction of informal caregivers (Bauer & Sousa-Poza, 2015; Cohen et al., 2019). This disproportionately affects women, since unpaid care is to a large extent provided by daughters (in law), wives and mothers (Hoffmann & Rodrigues, 2010).

In order to support informal caregivers, different measures have been introduced across Europe (Zigante, 2018). Caregivers might, for instance, receive direct compensation in the form of care allowances paid through social security and tax systems. In other cases, they might obtain indirect payments in the form of cash-for-care-benefits that are transferred to them by the care recipient as 'routed wages' or 'symbolic payments' (Da Roit et al., 2016; Ungerson, 1997). While these payments can generate some financial compensation for caregivers, they, in most cases, do not aspire to create a formal employment relation and thus do not necessarily guarantee the receipt of regular and stable income.

The recently introduced pilot projects ‘Förderungen der Betreuung von Pflegebedürftigen durch Angehörige’ and ‘Anstellung betreuender Angehöriger’ in the Austrian federal states Burgenland and Upper Austria offer formal employment to individuals who care for dependent family members (e.g. elderly persons or persons with disabilities) and grant access to regular income, social security, paid holidays and sick leave (FAB, 2023; Pflegeservice Burgenland, 2023). Thereby, care provided by relatives within private households becomes paid and formalised work. The aim of these initiatives is not only to enable persons in need of care to continue living at their homes, but also to improve the situation of caregivers by securing their livelihoods. Moreover, given the current shortage of both formal and informal long-term care supply, the programmes aspire to create additional staff for elderly and disability care.

Overall, the impact of informal care on caregivers’ health, employment status, financial situation and well-being has been extensively discussed in academic literature (e.g., Bauer & Sousa-Poza, 2015; Kaschowitz & Brandt, 2017; Skinner & Sogstad, 2022). Moreover, the potentials of direct and indirect policies supporting informal care, particularly those of cash-for-care benefits, have been examined to a great extent (e.g. Da Roit et al., 2016; e.g. Hammer & Österle, 2003; Schneider et al., 2016; Zigante, 2018). Research on the implications of the formalisation of previously informal care in the Austrian context, however, remains scarce. Considering that the formal employment of family caregivers represents a rare approach with regards to the organisation of long-term care, this research gap does not come surprising. Nevertheless, it is crucial to shed light on the impacts arising from the formalisation of care within the familial context – not least, because informal caregivers are an essential resource for long-term care provision, which renders the safeguard of their wellbeing and care providing capacities vital. Furthermore, given that informal caregiving responsibilities are unequally distributed, researching the implications of this particular care arrangement is important from a gender perspective (Lee & Tang, 2015).

For this reason, this thesis aims to explore how informal caregivers experience a formalisation of their formerly unpaid and unrecognised work by drawing on the two employment models of the Austrian federal states Burgenland and Upper Austria as case studies. Following from that, it evaluates in how far these employment programmes have the potential to improve the situation of family caregivers. Thus, the study is guided by the following research questions: 1) How do informal caregivers experience the formalisation of their previously unpaid and unrecognised work? 2) In how far does the formalisation of informal care represent a useful measure to improve the situation of family caregivers? In order to generate insights on this subject matter, six interviews are conducted with caregiving relatives, who are employed through one of the initiatives. These are complemented with three expert interviews to discern the structural implications of the employment programmes.

The thesis is structured as follows: In the first chapter, existing literature on informal care will be presented with a particular focus on the motivation and characteristics of informal caregivers as well as on the impacts arising from informal care provision. Furthermore, emphasis will be put on measures aiming to support or formalise informal care. The second chapter provides information on informal care in the Austrian context including a detailed description of the two employment models, which serve as case studies for this thesis. Subsequently, the data and method used will be explained. Following from that, the results of the interviews will be presented, discussed, and situated in current debates within the field of long-term care in order to derive implications and policy recommendation in the next step. Finally, this thesis will conclude by summarising the potentials and limitations of the formalisation of informal care.

2. Literature Review

2.1 Informal Care

Informal care can be understood as the provision of unpaid care to elderly persons and to individuals with chronic conditions or disabilities. In most cases, it is provided by persons who have a social relationship with the care recipient (Broese van Groenou & De Boer, 2016; Cohen et al., 2019). Informal care is characterised by low social visibility as it usually takes place in the private sphere. Moreover, it tends to be provided without contractual agreement and financial remuneration (Dowling, 2022; Maidment, 2016). The limited recognition of informal care within the familial context can be traced back to the division of productive and reproductive work, whereby reproductive labour is systemically subordinated to productive labour (Fraser, 2017). By continually classifying informal care as non-wage labour, its structural economic devaluation and subordination to the productive sphere is reinforced (Berger, 2021).

Despite its limited visibility and recognition, informal care constitutes a significant share of the total long-term care provision. Studies suggest that around 80% of all long-term care in Europe is supplied by informal caregivers (Glendinning et al., 2009; Hoffmann & Rodrigues, 2010; Miller et al., 2008; Triantafillou et al., 2011). The number of people faced with informal caregiving responsibilities and thus the overall relevance of informal care is expected to further increase (Broese van Groenou & De Boer, 2016; Riedel, 2012). On the one hand, demographic changes, such as ageing populations, imply that the amount of people in need of long-term care will augment significantly (Colombo et al., 2011). On the other hand, reforms aiming to contain costs for long-term care expenditure have been introduced across Europe and resulted in reduced publicly provided care and further de-institutionalisation of long-term care (Da Roit et al., 2007; Gori et al., 2016; Österle & Rothgang, 2021). Thus, governments increasingly rely on informal care provided by family members to meet the growing care needs of ageing societies and to compensate for the cutbacks in publicly funded long-term care services (Gori et al., 2016).

While the demand for informal care increases, demographic and societal developments limit the supply of informal caregivers. These include low fertility rates, increased mobility and changing family structures, reflected in the decline in co-residence of elderly with their children and shrinking family sizes. Furthermore, raising retirement age, long working hours and higher labour-market participation of women reduce the time available for care provision (Broese van Groenou & De Boer, 2016; Riedel, 2012). The growing need of long-term care provision on the one hand, and the limited availability of time resources on the other, reflect the on-going crisis of care (Dowling, 2022). Care services thus tend to become increasingly externalised and commodified. The possibility to outsource care responsibilities to the market sphere, however, is restricted to those, who have the required financial means. If the costs of market-based care cannot be covered, the adoption of informal care responsibilities frequently represents the only option to fulfil existing care needs (Fink & Valkova, 2018).

Who Provides Informal Care?

Given the high relevance of informal care provision to ensure that existing care needs are met, it is crucial to understand which factors are decisive for the adoption of informal care responsibilities. Moreover, considering that informal care largely remains invisible, unrecognised and unpaid work, it is important to shed light on how caregiving activities are distributed among different societal groups.

The informal care model developed by Broese van Grenou and De Boer (2016) explains that individual and relational factors such as general attitude towards care responsibilities, quality of the relationship with the dependent person, normative beliefs and perceived barriers predict the intention to provide care. Perceived barriers that might decrease the intention to provide care include geographical distance, time constraints due to paid employment, limited ability to cope with the physical and mental demands of caring, and financial costs involved in caregiving activities (e.g. travelling expenses or reducing paid work). While these individual circumstances determine if a person forms the intention to provide informal care, external contextual conditions, such as social norms, the availability of formal care, and labour market conditions are decisive if a potential caregiver actually commits to providing informal care.

Other authors similarly suggest that contextual factors, such as prevailing social norms, are a crucial determinant of whether individuals tend to take up informal care or not (Haberkern & Szydlik, 2010). In countries with strong family norms, the likelihood of adopting informal care is higher than in those where care provision is commonly regarded the responsibility of the state (Cooney & Dykstra, 2011). In recent years, family norms and the distinction between kin and non-kin, however, have been weakened, resulting in friendships and other personal networks gaining importance (Suanet et al., 2013). This shift in norms might lead to care increasingly being provided by neighbours, friends or others who diverge from the classic family category. Nevertheless, to this date, spouses continue to represent the largest group of informal caregivers. Without the presence of a spouse, children are more likely to serve

as caregivers compared to other relatives or non-kin, suggesting that kin-based networks remain crucial with regards to the provision of informal care (Jacobs et al., 2018).

Besides existing social norms, the availability and costs of professional care affect the decision to undertake informal care. Hochschild (1995), for instance, highlights that if individuals have the impression that the government provides sufficient support for care dependents, their intention to engage in care activities is lower. Other studies similarly find a negative relationship between the use of formal and informal care (Li, 2005; Swinkels et al., 2015). Li (2005), however, points out that although caregivers – especially male caregivers, caregivers in poor health and those who feel burdened to a great extent – are likely to decrease care activities when publicly paid home services are available, they generally do not entirely withdraw from caregiving activities.

Furthermore, prevalent labour market conditions impact the decision with regards to the choice of long-term care arrangements. Strong incentives for later retirement and attractive labour market policies decrease the willingness and possibility to adopt informal care responsibilities. In contrast, long-term unemployment and employment conditions allowing for the compatibility of paid employment and family care are enhancing the intention to provide informal care (Broese van Groenou & De Boer, 2016; Da Roit et al., 2007).

Besides contextual factors, social characteristics such as gender, ethnicity and socio-economic status are decisive for the likelihood of informal care provision. It is well-established that women are more likely to serve as informal caregivers compared to men (Anderson et al., 2013; Lee & Tang, 2015; Pinquart & Sörensen, 2006). In fact, informal care is primarily provided by wives, daughters (in law) and mothers (Hoffmann & Rodrigues, 2010). Horowitz (1985), for instance, finds that sons tend to become caregivers mainly in the absence of a female sibling and are more likely to pass on caregiving duties to their own spouses. Moreover, research suggest that women do not only devote more time to providing care, but also adopt more intensive care responsibilities (Skinner & Sogstad, 2022; Verbakel et al., 2017; Vicente et al., 2022). This is reflected in the fact that female caregivers are more likely to be involved in intimate caregiving activities, such as feeding, dressing, bathing and incontinence issues than male carers (Navaie-Waliser et al., 2002). Skinner & Sogstad (2022) suggest that lower formal labour market participation of women as well as traditional gender roles and associated normative expectations might serve as explanations for the unequal distribution of informal care between men and women. Overall, the numerical over-representation of women reflects the feminisation of care activities and the cultural assumption of women being ‘natural carers’ (Hrženjak, 2013).

In addition to gender disparities, informal care is also unequally distributed among racial and ethnic groups. Cohen et al. (2019) highlight that Blacks and Hispanics are more likely to provide informal care compared to Whites. Moreover, the study suggests that gender disparities in caregiving activities are

smaller among Blacks and Hispanics than among Whites. This, again, might be attributable to varying cultural expectations and norms.

Finally, existing literature reveals that individuals with lower socio-economic status are not only more likely to provide care, but also to adopt higher care intensities than those with higher socio-economic backgrounds (Brandt et al., 2022). Explanations for this tendency include that groups with lower socio-economic status tend to rely on smaller, but more kin-based social networks and often live in closer spatial proximity to family members. Moreover, lower socio-economic status is generally associated with lower employment rates, implying that this group tends to have higher availability for caregiving activities in terms of time resources. Finally, low-income households frequently do not have the financial means to externalise care to professional market-based care facilities (Albertini & Pavolini, 2017; Ilinca et al., 2017), forcing them to opt for informal care arrangements.

It can be concluded that individual characteristics (e.g. general attitude, relation with dependent person, normative beliefs, perceived barriers), prevailing social norms and values, the availability and affordability of public and formal care, as well as present labour market conditions are decisive factors for whether an individual decides to offer informal care or not. However, it is important to point out that the adoption of caregiving responsibility often happens unplanned and does not always reflect a voluntary choice (Qureshi & Walker, 1989). Studies analysing the distribution of informal care among different groups reveal that social characteristics such as gender, ethnicity and social-economic status impact the likelihood of adopting caregiving responsibilities: women, people of colour and individuals in lower socio-economic groups are more likely to serve as informal caregivers and do so at higher care intensities (Brandt et al., 2022; Cohen et al., 2019; Lee & Tang, 2015). Therefore, intersections between gender, ethnicity and socio-economic background should be considered in order to develop effective policies reducing disparities in care burdens and improving the situation of caregivers.

Impacts of Informal Care on Caregivers

Existing literature highlights that informal care work has significant impacts on caregivers with regards to their mental and physical health, employment status, financial security, and overall life satisfaction (Bauer & Sousa-Poza, 2015). The provision of informal care frequently implies the necessity to balance caregiving responsibilities with paid employment, social life and other obligations (Vicente et al., 2022). Considering the multitude of responsibilities, it does not come surprising that caregivers report high levels of stress and anxiety (Del-Pino-Casado et al., 2021). In fact, various studies find that caregiving activities have detrimental effects on the physical and mental health of informal carers – especially if intensive care provision is required over a longer period (Cohen et al., 2019). Overall, female caregivers tend to experience higher levels of depression, poorer health and reduced subjective well-being than male carers, which might be due to the unequal distribution of care intensity between female and male caregivers (Edwards et al., 2017).

Besides health, caregiving responsibilities tend to negatively impact paid employment. This concerns the quality of work, but also the numbers of hours employed. In order to meet the care needs of the care dependent person, informal caregivers are often forced to reduce the number of hours worked or even to leave paid employment entirely (Bauer & Sousa-Poza, 2015). For this reason, the employment rate steadily declines as the hours of care provided increase (Carmichael & Charles, 2003). Overall, informal caregivers are more likely to be unemployed than non-carers. Thus, informal care activities not only imply a loss in career opportunities, but also a decline in or loss of income, which poses the risk of financial hardship and poverty to caregivers (Colombo et al., 2011). Given that women tend to provide more care hours and are more likely to be sole main carers than men, they have higher chances of experiencing a decrease of working hours and income. Broese van Groenou & De Boer (2016) point out that the increased reliance on informal care might, in fact, "reverse the trend of women's increased labour market participation" (p. 277). This particularly concerns migrant women and those with lower socio-economic status as these groups tend to adopt caregiving activities more often (Brandt et al., 2022).

Taking the aforementioned impacts of informal caregiving into consideration, it can be expected that informal caregivers experience a decline in overall well-being and life-satisfaction (Litwin et al., 2014; Wagner & Brandt, 2017). Support through social networks, however, might decrease the perceived burden and thus reduce negative health impacts for caregivers. Moreover, shared care seems to be less detrimental to health and well-being compared to solo care provision (Verbakel et al., 2017). Finally, the availability of publicly provided formal care services reduces the intensity of family care. Thus, the possibility to outsource care responsibilities can relief informal caregivers from care-related stressors (Floridi et al., 2022). Overall, the reduction of informal caregiving burden and the safeguard of caregivers health and wellbeing is crucial – not least, because strained caregivers are more likely to be abusive with care recipients (Cooper et al., 2010).

2.2 Supporting and Formalising Informal Care

As established previously, informal care represents an essential resource within European long-term care systems (Hoffmann & Rodrigues, 2010; Triantafillou et al., 2011). At the same time, informal care responsibilities are associated with negative impacts on health, well-being, and employment opportunities, which renders informal caregivers a particularly vulnerable group (Bauer & Sousa-Poza, 2015; Wagner & Brandt, 2017). Against this background, the necessity to introduce public support measures for care provided informally within the familial context has become increasingly prominent on long-term care policy agendas (Schneider et al., 2016).

Supporting Informal Care

In general, public support for informal caregivers can be provided through indirect or direct measures. Indirect measures entail the provision of care services and benefits to care recipients with the implicit

objective to relief informal caregivers. Direct measures address informal caregivers themselves, for instance, in the form of monetary remuneration or access to social protection. Regarding that caregivers are operating in private and spatially fragmented places and represent a heterogenous group, the design of effective direct support is considered challenging (Schneider et al., 2016).

Policies aiming to support informal caregivers can be guided by two different logics: On the one hand, support measures might consider informal caregivers as an integral asset contributing to the provision of long-term care and treat them as 'co-producers'. Thereby, the overarching aim is to maintain and expand informal care as a resource. On the other hand, supporting policies following the 'co-client' logic assume that informal caregivers themselves are a vulnerable group, since caregiving responsibilities are associated with various health and social risks (Bauer & Sousa-Poza, 2015). In this case, support measures primarily aim for the protection of caregivers' wellbeing and social rights by assessing and mitigating associated risks and encouraging informal caregivers to claim care relief services (Schneider et al., 2016; Twigg, 1989).

Policy instruments to support informal caregivers can include the provision of information and counselling, the access to education and training as well as the availability of respite care allowing informal carers to take a break from their care responsibilities for a certain period. Furthermore, access to social security, in the form of accident, health and pension insurance represents a common measure directed at the support of informal carers. Moreover, policies which aim to facilitate the reconciliation of care and employment, such as caregiver leave, contribute to the relief of informal carers (Schneider et al., 2016; Zigante, 2018). The way these support measures are being executed can vary depending on whether their underlying assumption considers caregivers as 'co-producers' or 'co-clients'. In any case, such measures can provide a certain degree of support and thus relief for informal caregivers. However, they do not pursue the formalisation of informal care.

Formalising Informal Care

Since the 1990s, a common long-term care policy introduced across European welfare states is the provision of cash-for-care benefits instead of in-kind care services (Da Roit et al., 2007; Österle, 2013; Riedel & Kraus, 2016; Ungerson, 2004). Cash benefits enable care recipients to purchase care services from the market or to reimburse family members, neighbours or other informal caregivers (Da Roit et al., 2016). On the one hand, cash benefits are intended to grant care dependants more individual choice with regards to choosing a specific care arrangement. On the other hand, cash-for-care schemes are considered cost-effective, which became an increasingly relevant aspect during welfare state retrenchments (Österle & Rothgang, 2021). Since these payments tend to be directed at the care recipient rather than explicitly addressing caregivers, they can be regarded as indirectly supporting informal carers.

Ungerson (1997) highlights that cash-for-care schemes foster the 'commodification of care' and create forms of care relationships that are neither entirely formal nor informal. Thereby, the dichotomy of paid and unpaid care work becomes blurry. The design and regulation of cash-for-care programmes, however, varies significantly, resulting in diverse cash benefit systems across Europe (Zigante, 2018). While cash benefits are addressing care recipients in most cases, they might also be directly paid to family carers through tax and social security systems (Burau et al., 2007; Da Roit et al., 2016; Riedel, 2012; Ungerson, 2004). Cash-for-care benefits directed at care recipients, in contrast, can serve as indirect support for caregivers in the form of 'routed wages' or 'symbolic payments' (Ungerson, 1997). Thus, on the one hand, care recipients can use cash benefits to establish a formal employer-employee relationship and compensate the caregiver via routed wages. On the other hand, care users can forward cash benefits as symbolic payments to informally compensate the care providing person (Da Roit et al., 2016; Hammer & Österle, 2003). Riedel & Kraus (2016), however, highlight that these benefits are generally too low to provide adequate wages to caregivers.

Thus, while certain cash-for-care schemes allow for the free disposal of the benefit and the informal compensation of caregiving family members, others are highly regulated and envisage the formal employment of the relative providing care (Da Roit et al., 2016; Ungerson, 2004). This implies that cash benefits can, but must not necessarily entail the formalisation of the relation between care recipient and informal caregiver.

In the countries Austria, Italy, Germany and the Czech Republic, for instance, cash-for-care schemes are unregulated and "intended to provide rather implicit and non-formalised support for informal care, without the establishment of a direct link between the benefit and compensation for the caregivers" (Da Roit et al., 2016, p. 151). In these cases, cash benefits represent a "universal contribution to care-related costs" (ibid, p. 153), whereby agreement on financial arrangements between care recipient and caregivers is negotiated within the private realm (Österle, 2013; Theobald & Hampel, 2014). Thus, although cash benefits might be used for the reimbursement of informal caregivers, they generally do not imply a formalised employment relationship between the two parties.

In other countries such as the United Kingdom, the Netherlands, and France cash-for-care schemes are regulated more strictly. In these cases, the payment intends to establish a formal employment relation between care recipient and caregiver (Grootegoed et al., 2010; Ungerson, 2004; Ungerson & Yeandle, 2006; Zigante, 2018). While in the United Kingdom care users are not permitted to reimburse relatives, the other schemes allow for the employment of informal family caregivers (except for spouses in the case of France) and thereby contribute to a formalisation of informal care within the familial context (Zigante, 2018). Although the employment of informal caregivers can be a result of the provision of cash-for-care benefits, the aim of creating additional employment in the long-term care sector has only been explicitly stated in the case of France (Da Roit et al., 2016; Dussuet & Ledoux, 2019).

In addition to an official employment contract, components such as regular and predictable payment and working hours, access to social security, trainings and validation of caregiving skills as well as the broader legal recognition of status and rights are crucial with regards to the formalisation of informal care. These formalising factors contribute to the classification of informal care as wage-labour and might entail the (financial) relief of informal caregivers (Zigante, 2018).

(De-)Familialisation of Care

Although cash-for-care schemes can be used to externalise care to the market, they, in many cases, re-situate the responsibility for the provision of care within the family (van den Broek, 2013). For example, cash benefits that are paid to caregivers via routed wages or in the form of symbolic payments can strengthen the role of the family with regards to long-term care provision and "reinforce pressure on women to fulfil their expected role in the private domain" (Hammer & Österle, 2003, p. 46). Thus, in contrast to the provision of universal public care services, which decrease the role of the family with regards to long-term care provision, cash-for care benefits might result in a 're-familialisation' and strengthen traditional gendered family care roles (Leitner, 2003; Rummery, 2009) Ungerson (1997) similarly highlights that although cash-for-care benefits contribute to the validation and compensation of care provided within the private sphere, they, at the same time, confine caregivers in their role. Besides the tendency of 're-familialisation', cash-for-care schemes, especially if granted in an unregulated manner, might entail that informal caregivers remain in low-paid and precarious working conditions with no or limited access to social rights (Da Roit et al., 2016).

Concluding, informal care can be supported through direct and indirect measures. Cash-for-care benefits, for instance, represent a common long-term-care policy, which has the potential to financially support informal caregivers, establish employment relations and thereby to some extent formalise informal care activities – especially if regulated accordingly. It is important to note, however, that cash benefits might create 'incentive traps' encouraging family members to informally take on caregiving responsibilities, which might reinforce gender inequalities in caregiving activities. Furthermore, untrained family members entering into formal employment with care recipients carries risks with regards to the (de-)professionalisation of long-term care and thus to the quality of care provided (Da Roit et al., 2016).

While the potential effects of cash-for-care benefits have been studied extensively, research on employment models that establish formal working contracts between public institutions and family caregivers, and thereby enable access to regular income, social security, paid holiday, sick leave and trainings remains scarce. Moreover, literature that highlights the individual experiences and working condition of family caregivers, whose care responsibilities have been formalised is lacking. Regarding that informal caregivers represent an indispensable resource in the overall long-term care provision and that informal caregiving tasks are associated with a multitude of risks, safeguarding the well-being of

family caregivers is crucial. For this reason, researching how caregivers experience a formalisation of their work is essential.

3. The Austrian Context

As a conservative welfare state shaped by traditional family values, Austria heavily relies on informal care provided by family members in order to secure long-term care provision (Esping-Andersen, 1990; Nagl-Cupal et al., 2018). The strong reliance on informal care is reflected in statistical numbers: Almost 80% of all care dependent individuals are receiving informal care from a family member (Blum & Glaser, 2022). In 2021, around 801.000 individuals served as informal caregivers for a relative in a private household and 146.000 cared for a dependent family member in a residential long-term care facility. This implies that almost 10% of the Austrian population were – at least to some extent – occupied with informal family caregiving activities. Children (around 45%) and spouses (around 20%) represent the largest groups of informal caregivers. The remaining caregiving groups include daughters-in-law, mothers, neighbours, siblings and grandchildren (Stilling et al., 2022). This is in line with existing research, which finds that, to this date, informal care is to a large extent provided by kin-based networks (Hoffmann & Rodrigues, 2010; Jacobs et al., 2018). In Austria, the average age among informal caregivers is 63 years and about 68% are female. Moreover, the majority (around 70%) of family caregivers in Austria is unemployed or retired, and 10% of informal caregivers indicate that they were forced to reduce paid employment to be able to meet the needs of their care dependent relative (Stilling et al., 2022).

Currently, measures such as cash-for-care benefits, possibilities of caregiver leave, free access to insurance as well as the prospective family care bonus are providing financial support and thereby offer relief to caregivers to some extent. Overall, however, the eligibility rules for these benefits are tight and primarily target high-intensity family caregivers, as those caring for relatives with a care level below three are not considered in most policies. As a result, almost half of all informal caregivers are not eligible for support measures (Trukeschitz et al., 2022). Moreover, the current support measures do not create formal employment relations and thus do not ensure regular income and financial security. Recently, the two Austrian federal states Burgenland and Upper Austria introduced employment models for informal caregivers that are intended to provide stable income and access to social security, paid holiday and sick leave.

3.1 The Employment Models: Formalising Informal Care in Austria

The pilot project ‘Förderung der Betreuung von Pflegebedürftigen durch Angehörige’ and the initiative ‘Anstellung betreuender Angehöriger’ in the Austrian federal states Burgenland and Upper Austria serve as case studies to investigate how caregivers experience a formalisation of their previously unpaid and unrecognised work. Both programmes intend to formally employ individuals who care for family

members that are in need of care (e.g. elderly persons or persons with disabilities). Thereby, participants receive regular income and are granted access to social security, paid holidays and sick leave.

Burgenland: Förderungen der Betreuung von Pflegebedürftigen durch Angehörige

In October 2019, the federal government Burgenland introduced a pilot project which aims not only to enable persons in need of care to continue living at their homes, but also to secure regular income for family caregivers and to guarantee access to social security by establishing an official employment relation (Pflegeservice Burgenland, 2023; Trukeschitz et al., 2022).

The project identifies persons of working age who are willing to devote themselves to the care of a relative as the target group. When entering an official employment contract with the non-profit organisation 'Pflegeservice Burgenland GmbH', the regional government subsidises part of the labour costs and social security contributions. More specifically, the programme offers three different employment models depending on the care level assigned to the person in need of care. The first model is suitable for persons caring for relatives who have been assessed with care level three. In this case, caregivers are employed for 20 hours per week and are granted € 1.022,21 per month. The second model targets persons caring for family members evaluated with care level four. It entails a contract of 30 hours per week and a renumeration of € 1.443,29 per month. The third model is reserved for relatives caring for persons assessed with care level five, six or seven, offers full-time employment of 40 hours per week and a monthly pay of € 1.750,49. For care level one and two, the programme, to this date, does not offer any employment opportunities or subsidies. The three existing employment models offer 14 monthly salaries per year, access to social security and allow for substitution when the caregiver is on vacation or sick leave. However, vacation and other justified absences must be reported in advance and sick leave testified immediately to the employer 'Pflegeservice Burgenland GmbH' (Pflegeservice Burgenland, 2023).

The wages for caregivers are financed through a deductible ('Selbstbehalt') paid by the care-receiving person and subsidies by the federal government of Burgenland. The deductible consists of two components: first, a share of the care allowance that the person in need of care receives from the state and second, a share of the care-receiving person's income (e.g. retirement payments) that exceeds the social assistance reference rate[1]. Depending on the assigned care level, the share of the deductible ranges from 60% to 90% (see table 1).

All employed caregivers are obliged to complete basic training within the first year of employment which is financed by the federal government. Depending on the assigned care level of the person in need of care, certified health care workers will visit between one and four times a month in order to ensure

[1] Social assistance reference rate: EUR 949 in 2022

adequate quality of care, provide professional advice to family caregivers and offer individual solutions (Pflegeservice Burgenland, 2023).

Table 1 – Burgenland's Employment Models for Informal Caregivers

Model	Care Level	Deductible for Care Recipient	Hours Employed	Wage	Support Visits
1	level 3	90% of care allowance	20h / week	€ 1022,21	1x month
2	level 4	80% of care allowance	30h / week	€ 1443,73	2x month
3	level 5, 6, 7	level 5: 80% of care allowance level 6: 60% of care allowance level 7: 60% of care allowance	40h / week	€ 1738,96	level 5: 2x month level 6-7: 4x month

Source: Pflegeservice Burgenland (2023)

Upper Austria: Anstellung betreuender Angehöriger

Drawing on the example of the pilot project in Burgenland, the federal state Upper Austria initiated the programme 'Anstellung betreuender Angehöriger' in 2021. However, while the model in Burgenland supports all care activities that serve people in need for care (e.g. elderly care, care for people with disabilities), the project in Upper Austria specifically targets care provided for children with disabilities. The project thus offers persons who devote themselves to the care of their impaired child the possibility of formal employment. Thereby, caregivers receive monetary compensation for their service and are granted access to health, unemployment and pension insurance (FAB, 2023).

Participating caregivers are employed with the non-profit organisation 'FAB – Verein zur Förderung von Arbeit und Beschäftigung', which implements the project on behalf of the federal government of Upper Austria. Depending on the care level of the impaired child, the caregiver will be employed between 25 and 30 hours per week (care level 5: 25 hours/week; care level 6: 27,5 hours/week; care level 7: 30 hours/week). For caregivers caring for relatives assessed with a care level below 5, the programme, to this date, does not offer any employment opportunities.

The wages for employed caregivers are financed through a deductible consisting of 50% of the care allowance that the caregiver receives for the impaired child by the state on the one hand, and subsidies by the regional state on the other. However, in case the child to be cared for has to stay in a hospital or rehabilitation facility for more than one month, no compensation will be provided to the caregiver. Moreover, the organisation does not offer substitute care in case of absence of the caring family member. Instead, the caring family member is obliged to ensure a suitable substitute for the respective period (FAB, 2023).

In order to be eligible as an official caregiver for a family member, participants are required to complete 152 units of theoretical and 80 units of practical training organised and financed by the social department of Upper Austria. Moreover, regular visits by professional health care workers have to be scheduled during which the caregiving family member must be present.

Initially, the pilot project operated by the non-profit organisation 'FAB – Verein zur Förderung von Arbeit und Beschäftigung' was limited to one year (01.09.2021 – 31.08.2022) and enabled participation for up to 30 informal caregivers. In October 2022 the regional government decided to continue the programme by providing 20 employment positions for caring relatives. Due to lack of funding from the federal government, however, the pilot project will not be extended any further and gradually phase out (Expert Interview II).

Further Prospects for Formalising Family Care in Austria

In reaction to the implementation of the employment model in Burgenland, the regional states Vorarlberg, Kärnten and Vienna as well as the city Graz expressed interest to organise similar programmes for informal family caregivers (Krotzer, 2022; Scherndl, 2020). In Vorarlberg, the Chamber of Labour actively promotes the establishment of such a model, which, analogously to the approach in Burgenland, should offer an official employment relation for caregivers caring for a relative assessed with care level three or higher (AK Vorarlberg, 2020).

A study by the Institute for Social Research and Consulting (SORA) investigated general attitudes towards employment models for informal caregivers in Austria. More specifically, the study conducted a telephone survey with individuals aged between 50 and 64 as this age group is part of the working age population and faces a higher probability of adopting caregiving activities in the near future than other age groups. The telephone survey was complemented with an online survey addressed at families that currently receive long-term care through 24-hour care services as well as with focus groups including parents who provide care for children with disabilities. Generally, the respondents welcomed the idea of an employment model: 88% of the participants indicated that they consider the possibility of employment for caring family members as very good or good. Especially the prospect of access to social security, paid holiday and sick leave as well as a stable and regulated income have been evaluated positively. The restriction of employment opportunities to those who care for a relative assessed with at least care level three as well as assumed future job prospects after the care period, in contrast, have been rated rather negatively. 57% of all respondents indicate that if they were in the situation of an informal caregiver, they would make use of the employment opportunity. Among those, who consider informal care as the ideal form of long-term care and could see themselves as informal caregiver, even 74% declare that they would opt for the employment model (Blum & Glaser, 2022). Thus, the possibility of formal employment for family caregivers generally seems to be evaluated positively by the Austrian population.

While this study provides valuable insights about the intentions to enter a formal employment relation in case of being faced with caregiving responsibilities within the family, it does not assess how informal caregivers, who actually participate in an employment model, perceive and evaluate the formalisation of their work. To this date, research that investigates the situation of informal caregivers, who are

formally employed through public institutions in the Austrian context is lacking. For this reason, this thesis aims to fill this gap by examining how informal caregivers experience a formalisation of their work and in how far this formalisation has the potential to improve their situation.

4. Methods & Data

Overall, this thesis follows a qualitative approach and aspires to exploratively investigate the individual experiences of informal caregivers, whose previously unpaid and unrecognised work has been formalised (Knappertsbusch et al., 2021). The research questions guiding this thesis are 1) How do informal caregivers experience the formalisation of their previously unpaid and unrecognised work? 2) In how far does the formalisation of informal care represent a useful measure to improve the situation of family caregivers?

4.1 Case Studies

In order to investigate how informal caregivers experience a formalisation of their services and in how far it has the potential to improve the situation of family caregivers, this thesis draws on the employment models 'Förderung der Betreuung von Pflegebedürftigen durch Angehörige' (Burgenland) and 'Anstellung betreuender Angehöriger' (Upper Austria) as case studies. According to Yin (2003), a case study can be understood as an empirical inquiry, which examines contemporary phenomena within real-life contexts. Research that draws on case studies thus explores a rather small number of units in naturally occurring settings in extensive depth (Hammersley, 1992, p. 185; Hammersley et al., 2000, p. 3). Blaikie & Priest (2019) highlight that case studies cannot be considered a method of data collection, but rather constitute a method of data selection, implying that case studies pre-determine the context in which data is being collected.

4.2 Interviews

With regards to data collection, this thesis follows a multi-method approach (Creswell, 2015; Mik-Meyer, 2020). Overall, nine semi-structured interviews have been conducted as part of this thesis: In order to capture individual experiences with the formalisation of previously informal care, six problem-centred interviews with family caregivers, who are employed through one of the employment models, have been carried out. These interviews have been complemented with three expert interviews to gain insights into the structural implications of the programmes. By combining the perspectives of individuals who experience the formalisation of informal care themselves with insights from experts, this thesis aims to generate a broad and, at the same time, deep understanding of the subject matter (Mik-Meyer, 2020).

Problem-Centred Interviews

The primary sample design consists of six problem-centred interviews with family caregivers employed with either of the two employment models. Initially, participants were selected by purposive sampling (Patton, 2014; Robinson, 2014) based on heterogeneity in terms of age, gender and social relation with

the care recipient (e.g. child, parent, grandparent, etc.). However, considering that the number of employed family caregivers in Austria is rather small (approximately 300 people), the access to the field has proven to be challenging. For this reason, snowball sampling (Parker et al., 2023) has been applied for the recruitment of remaining participants. In order to approach potential interview partners in the first place, a call for participants has been distributed through social networks, such as Facebook and Instagram. The call has been spread in various groups with a thematic focus on informal care in Burgenland and Upper Austria. In addition, the project coordinators of each employment programme have been asked to share the call for interview partners with currently or formerly employed caregivers. This request has been met by the programme coordination in Upper Austria, but was denied by the organisation in Burgenland.

The interview guideline, organising the conversations with employed family caregivers, is divided into thematic modules and, among others, compiles questions on the personal care situation, the relationship with the care recipient, social networks and support systems, perceived value of their work, physical and mental health, and financial situation. Emphasis was put on how these aspects have changed with regards to the formalisation of the previously unpaid and informal care. Although the interviews were thematically organised, the mode of inquiry was open, implying that the setting of priorities and structuring of the conversation was left to the interviewee. Thereby, emphasis on the caregiver's personal narrative about relevant aspects with regards to the formalisation of their caregiving responsibilities is ensured (Gubrium & Holstein, 1997, p. 153). In order to collect information on socio-economic characteristics and employment details of caregivers, the participants were asked to fill in a questionnaire after the interview.

The sample consists of five female and one male caregiver aged between 31 and 57 years and is equally represented by caregivers employed with the programme in Burgenland and the one in Upper Austria. Four caregivers are employed for providing care to their daughters, while the remaining two caregivers are adopting care responsibilities for their grandmother and father. Half of the care recipients are assessed with care level six, two persons are assigned care level five and one person level four. Depending on the assigned care level of the care recipient and the respective employment model, caregivers in this sample are employed between 25 and 40 hours per week. While half of the participants are exclusively employed as caregivers, the other half pursues additional paid work with employment contracts ranging from five to ten hours per week (see table 2).

Table 2 – Sample of Caregivers

IV	**Caregiver**	**Gender**	**Care Recipient**	**Care Level**	**Employment Model**	**Hours Employed** (per week)	**Side Job**
1	Irina	female	Daughter	6	Burgenland	40 hrs	yes
2	Lukas	male	Grandmother	5	Burgenland	40 hrs	no
3	Margit	female	Daughter	6	Upper Austria	27,5 hrs	no
4	Maria	female	Daughter	6	Upper Austria	27,5 hrs	no

5	Elfriede	female	Father	4	Burgenland	30 hrs	yes
6	Michaela	female	Daughter	5	Upper Austria	25 hrs	yes

Expert Interviews

In order to gain insights beyond the individual experiences of formally employed caregivers and to receive detailed information about the employment programmes and their structural implications, the six interviews with caregivers have been complemented with three expert interviews. Bogner et al. (2009) highlight that experts can serve as instruments to obtain insights into practical insider knowledge. Expert interviews thus rely on a person's specific knowledge and experience resulting from the actions, responsibilities and obligations connected to their specific functional status within an organisation (Bogner et al., 2009). For the purpose of this thesis, the project coordinator of the employment model in Burgenland (expert I) as well as the project coordinator of the programme in Upper Austria (expert II) have been interviewed as experts. In addition, an interview with the president of the interest group for family caregivers ('Interessensgemeinschaft Pflegender Angehöriger' – expert III) has been conducted to receive external assessment of the employment models. Although the experts might differ in their perspectives, they can all be regarded as vital actors in the (re-)organisation of informal care. They have specific knowledge related to informal care and the potential of its formalisation. Moreover, they can impact the structuring of the field to a certain degree. For this reason, both groups of experts – the two project coordinators as well as the president of the interest group for family caregivers – are well-suited to serve as complementary informing sources. The interviews were conducted in a semi-structured format: While a set of open questions was guiding the conversation (see appendix IV, V), it was ensured that room for deviation during the interview is provided (Whiting, 2008).

4.3 Analysis

After completing the empirical data collection, all previously recorded interviews have been transcribed. Personal information was anonymised and replaced with pseudonyms. While the conduct of the problem-centred interviews followed a different interview guideline and logic than the expert interviews, all transcripts were analysed according to the qualitative content analysis (Schreier, 2012, 2014). By classifying parts of the material as categories of a larger coding frame, this type of analysis allows to systematically describe and conceptualise the meaning of qualitative data (ibid). The coding process followed an inductive approach, whereby thematic codes were developed across passages with similar topics throughout the interviews. In a final step of the analysis, these passages were tied together to allow for the conceptualisation and theoretical generalisation of the data material. Rather than presenting the findings of the problem-centred interviews and the expert interviews separately, they are portrayed together in the results section as they should be understood as complementary (Creswell & Plano Clark, 2011).

5. Results & Discussion

5.1 Reasons & Motivations for the Employment as Caregiver

A study conducted by Blum & Glaser (2022) found that a considerable number of people (around 55%) would opt for the formal employment as a caregiver if they were faced with caregiving responsibilities within the family. To this date, however, little is known about the particular motivation of family caregivers who are participating in existing employment models. The results of this study suggest that one of the main reasons why caregivers opt for a formalisation of their work is the inability to continue combining unpaid care responsibilities with paid employment on the regular labour market. Overall, informal caregivers are frequently forced to reduce the number of hours of paid employment in order to fulfil existing care needs of dependent family members (Bauer & Sousa-Poza, 2015). In line with existing literature, the interviews reveal that as the required care intensity increases, the number of hours employed need to be minimised (Colombo et al., 2011).

> I was working as a day-care-mother in a kindergarden before, but at some point that was no longer possible, because Alina's care was simply too time-consuming, and then I reduced [paid working hours] more and more. And at some point, I was only working for ten hours. That was when I got convinced to get employed through Pflegeservice Burgenland. (Irina, Burgenland)

In many cases, the double burden of employment responsibilities and caregiving tasks can overstrain family carers and thus might force them not only to reduce paid working hours, but to leave paid employment entirely (Bauer & Sousa-Poza, 2015), which becomes apparent in the following quote:

> I went to work and a colleague walked by and I said, 'That's it! I have to quit. I can't go back to work. It's escalating at home - it's a disaster.' (Elfriede, Burgenland)

The interviews reveal that in situations, where paid employment has to be reduced or terminated entirely to ensure proper care provision for a family member, employment models represent an attractive opportunity for caregivers, as they provide financial means to remain at home and to focus on caregiving tasks. Furthermore, in circumstances, where care dependent persons or their family members are reluctant to rely on formal care institutions or external 24-hour care providers, the possibility of employment for family caregivers is appreciated. The fact that the access to the employment models is perceived as uncomplicated by caregivers further enhances the motivation to participate in the programme and to formalise their status.

> The access [to the employment model] was very simple. I just had to fill out a form and send it in, and then I had some sort of job interview. But it I think it was clear from the beginning that you can participate in the programme if you want to. I think they were generally welcoming all applicants. (Michaela, Upper Austria)

Furthermore, the results suggest that individuals caring for dependent elderly (e.g. parents, grandparents) are actively evaluating whether or not they will adapt full caregiving responsibility for

the dependent person. For this group, the existence of employment models seems to be encouraging the decision to fully commit to the provision of care for a relative, as perceived barriers to the adoption of caregiving responsibilities, such as time and financial constraints, are reduced (Broese van Groenou & De Boer, 2016). Those who provide care for their impaired child, in contrast, regard the caregiving obligations as a matter of fact, reflecting that the provision of family care does not always represent a conscious or voluntary decision (Qureshi & Walker, 1989). In these cases, employment models are considered an opportunity to receive access to social security and financial remuneration for work that they would do anyway.

It can thus be inferred that the reasons why informal caregivers opt for employment programmes and thus for a formalisation of their work include the difficulty to combine paid employment with caregiving responsibilities, the unwillingness to transfer care dependent family members to formal care providing facilities as well as the straightforward and accessible employment procedure of the employment programmes. Especially in conservative welfare regimes, where long-term care is to a large extent regarded a familial responsibility (Esping-Andersen, 1990; Nagl-Cupal et al., 2018), employment models allow for the formalisation of care that would otherwise be provided informally and unpaid. For caregiving parents in particular, formalisation mechanisms represent an attractive by-product as they tend to care for the impaired anyway. For kin-related persons other than parents, in contrast, employment models might encourage the decision of adopting caregiving responsibilities.

It is crucial to point out, however, that employment models for caregivers should not represent an incentive to withdraw from the labour market. This would encourage especially women, who are more likely to provide long-term care within the family context than men, to terminate their current jobs, which might result in financial disadvantages, and negatively impact their future career prospects (Carmichael et al., 2008). Thus, a gendered division of labour might be reinforced.

> The most important thing is that the employment programme must not be an incentive system to leave the job. I mean, yes, women are employed then, but if they leave the workforce for that very reason, they will lose out again. At the political level, one has to be very careful that women don't end up in a situation in which they cannot fully assess the consequences beforehand. (Expert Interview III)

5.2 Recognition & Financial Remuneration of Family Care

Recognition & Appreciation

In general, informal care is characterised by low recognition. Since it is provided within the private sphere, family care largely remains invisible and frequently is not financially compensated (Dowling, 2022; Maidment, 2016). The lack of recognition of family care can be explained by the division of productive and reproductive work, whereby reproductive activities are systemically subordinated to productive occupations and thus persist to be poorly compensated or often even unpaid (Fraser, 2017).

The interviews confirm that, to this date, informal caregiving responsibilities receive little societal appreciation and are not acknowledged as work in many cases.

> Actually, I receive very little appreciation. Most of them say 'You're staying at home, you've got a relaxed life.' People don't see what you're really doing, that's a bit difficult. Form outside, it might look quite easy most of the time, but actually, you're occupied the whole time. (Irina, Burgenland)

While reproductive work, which also includes the provision of (in)formal care, has been historically undervalued, the results suggest that a formalisation of long-term care provided within the family enhances the feeling of recognition and appreciation. This is reflected on an individual as well as on a societal level. Caregivers report that, since the formal employment, family members, friends and other individuals in their immediate surroundings began to acknowledge their caregiving responsibilities as actual work.

> Especially within in my family, people always asked me when I will finally go back to work again. I find that not quite fair, it also hurts a bit, because I am working. But since I've been officially employed, they haven't asked me anymore. […] Because now, if someone asks me, I can simply say, 'I am employed 25 hours for my daughter and in addition I also do something else.' And then everyone says, 'Wow, you are working a lot.' although it's the same work than before. I don't do anything else now, it's just that I can say that I'm employed for 25 hours. (Michaela, Upper Austria)

The increased recognition and appreciation of care work is not limited to caregivers' immediate surroundings, but can also be observed on the broader societal level. Interviewees highlight that the formal employment contributes to the feeling of being integrated in the official labour market and reflects the acknowledgement and valuation of their work by the state and the general public.

> The employment implies that your work is appreciated. So, now, I can say, 'I'm employed.' So, I'm part of it too. I'm allowed to be at home, and it is considered work. (Margit, Upper Austria)"

Besides the official inclusion in the labour market, the character of formal work is further strengthened by regular support and control visits of certified health care workers, which are mandatory for employed family carers. These visits give caregivers the impression that long-term care provision within the family is an actual job, which requires the delivery of a certain quality of care. Thus, as Zigante (2018) suggests, regular quality assurance contributes to the formalisation of family care and its recognition. Employed family carers report that regular meetings with professional health care workers and the exchange with programme coordinators create a sense of 'belonging to a company'.

> The support visits are somehow a connection to my, well, yes, to my company (laughs). I think this strengthens this character of you being an actual employee - someone checks up on me and talks to me about my work. I think that's very good. (Margit, Upper Austria)

Financial Recognition

Apart from the rather rhetoric and symbolic increase of recognition, the formalisation of family care entails the remuneration of caregivers and thus a financial recognition of long-term care provided by family members.

> It is a financial recognition and a recognition in terms of pension insurance and health insurance for a service that the formal health care system could not provide at all. (Maria, Upper Austria)

By economically compensating care provided within the familial context, the narrative that care work is provided 'out of love' and affection and therefore would not require monetary reimbursement is being challenged. It situates family care in the general understanding of wage labour and contributes to the classification and acknowledgement of care activities as value-generating work – even if family care, in many instances, might be attributable to 'love labour' (O'Riordan et al., 2010).

However, while the financial compensation for caregiving responsibilities represents a form of recognition, it – in its current form - does not provide an income, which safeguards livelihood. The financing of caregivers' wages by the employment programmes is perceived suboptimal - not only by caregivers themselves, but also by experts (Fiedler et al., 2021). Currently, depending on the assessed care level and the respective employment model, between 50% and 90% of the care recipient's care allowance has to be paid as a deductible in order to finance the wages. This implies that although caregivers receive formal remuneration, the overall household income might decline in certain cases.

The current composition of caregivers' wages is particularly disadvantageous for caregiving parents – not only, because the care allowance of minors is usually received and administered by caregiving parents and thus forms a part of the overall household budget, but also because caregivers might no longer be eligible for other social benefits. The eligibility to social benefits is in many cases dependent on income-levels, which must not exceed a certain threshold. Due to the income earned as an employed family caregiver, care providers declare that they do not qualify for certain social benefits anymore, which they relied on before, and must pay, for example, for the therapies for the impaired child themselves. However, since a considerable share of the care recipient's care allowance must be transferred to the employment organisation, the overall household income frequently does not increase to such an extent that the additionally arising costs can be borne effortlessly by the caregivers themselves. Therefore, the formalisation of informal care provides formal income compensation, but does not necessarily imply the improvement of caregivers' economic situation.

For this reason, the participation in the employment programmes requires the existence of a partner, who provides sufficient additional income to cover all costs.

> For me the employment programme works, because I have a partner, who also earns money. But we don't have a big income, and we try to pursue a cheap lifestyle. (Margit, Upper Austria)

Thereby, the continuation of the male breadwinner model, where the man is considered the main source of income while the woman is responsible for unpaid informal care and domestic work, is reinforced and economic dependency strengthened (Berghammer, 2014; Gleichen & Seeleib-Kaiser, 2018; Pfau-Effinger, 2004). One of the programme coordinators reveals that, for this particular reason, single mothers, who initially have been identified as a target group by the employment models, could not be reached. However, regarding that single mothers are disproportionately affected by income poverty (Hübgen, 2018), providing adequate economic security for this group of caregivers is crucial.

With regards to the height of the income, the results further suggest that although the financial compensation is considered a form of recognition, it is perceived unjust that formal care providers receive a higher salary than family caregivers for the provision of the very same work.

> A nurse that's being hired for your daughter would receive a full salary. But you yourself are not paid like this. I don't understand it, every stranger gets paid more. (Margit, Upper Austria)

Thus, although the formalisation of family care represents a step towards financially valuing this type of work, it does not result in the equal compensation of family and formal care. This is in line with Grootegoed et al. (2010), who find that the payment of family carers contributes to the recognition of their work, but does not imply that the labour market and social security position of family carers becomes equivalent to the one of a 'regular' care worker.

Access to Social Security

Considering that the current financial remuneration does not necessarily imply the improvement of economic situations of caregivers, the interviews reveal that access to social insurance is regarded as one of the primary benefits arising from the official employment relation.

> Financially, there is not much left at the end of the month. So, the only thing that is really good is the pension insurance, that's the main factor for me. The income is really low and not the biggest win I would say, but the pension provision and the health insurance, that's really good. (Maria, Upper Austria)

Although informal caregivers, who are leaving paid employment in order to care for a relative assessed with at least care level three, are granted free access to compulsory insurance (health, accident and pension insurance) in Austria (BMSGPK, 2023), the pension income to be expected is low in most of these cases. Since the income arising from the formalisation process implies that caregivers are paying higher insurances contributions, the pension payments received in the future are projected to increase - especially for those who are employed as a full-time family caregiver (PVA, 2023). This aspect is particularly important from a gender perspective, as many women, who informally devote their time to the long-term care of a relative, are faced with old-age poverty (Heitzmann, 2019).

It can be concluded that the formalisation of informal care enhances the feeling of recognition, both within the personal as well as the societal context. Not only the formal integration into the labour market, but also the financial remuneration of care responsibilities contributes to the perceived recognition and appreciation of family care. It must be pointed out, however, that the formalisation does not necessarily result in an improved economic situation of caregivers, as a considerable share of the care allowance has to be contributed. Moreover, the income-level arising from the employment excludes caregivers from eligibility for certain social benefits, which they relied on before. The access to insurances, however, has been assessed positively, as caregivers can expect higher pension payments in the future than if they adopted long-term care responsibilities without the formal employment.

5.3 Relief of Caregiver Burden

Opportunities for Caregiver Relief

Overall, the formalisation of family care, in many cases, implies that caregivers are no longer faced with the necessity of combining paid employment with caregiving obligations. Participants highlight the relief of previous double burdens. They report that the liberation of facing multiple responsibilities at once has positively impacted their mental and physical state. It thus seems that the formalisation of informal care has the potential to mitigate health consequences arising from caregiving activities (Bom et al., 2019; Brandt et al., 2022). This is important from the 'caregivers as co-producers' perspective, that considers (in)formal family carers as an indispensable resource of long-term care provision, but also from the 'caregivers as co-clients' logic, which views caregivers as a vulnerable group in need of adequate protection (Schneider et al., 2016; Twigg, 1989). Moreover, since the employment as a family caregiver creates additional time resources, it has been highlighted that the condition of the care recipient improved, as caregivers can fully devote themselves to the well-being of the dependent family member.

> I am grateful that I can do this at home now. Because I think that if my father was in a nursing home, these wounded heels wouldn't have grown together yet, because they would not have the amount of time for him, like I have at home now. (Elfriede, Burgenland)

Furthermore, caregivers report that the formalisation contributed to a more intimate relationship between them and the care recipient. Since the quality of the relationship as well as the condition of the care recipient influence stress-levels of carers (Lyonette & Yardley, 2003), the positive developments of these factors might further contribute to the improvement of caregivers' health. In addition, caregivers as well as the experts interviewed point out that the additional time resources enabled through the employment do not only benefit the care recipient and the caregiver, but positively impact the entire family and other social systems as well. For this reason, it can be assumed that the benefits arising from the formalisation might have a larger societal impact that goes beyond long-term care provision.

> Actually, everyone in the family has benefited, including me. We finally have some kind of normality back. And it also benefits a lot of people around us: In the case of the neighbours, the

> mother is a single parent and has to go to work and now her son just eats with us and is looked after. It is not more effort for me and we are glad that he is there. And I can also help my father a little bit, because he also needs care. So, everyone in the family has benefited, including my healthy son, because I have a bit more time for him now too. (Margit, Upper Austria)

Another aspect, which arises from the formalisation of previously informal care and to some extent contributes to the relief of family carers, is the establishment of caregiver networks. The interviews reveal that the mandatory trainings as well as other events organised by the employing institutions foster the exchange among family caregivers and encourage network-building. Thereby, caregivers are able to learn from each other and provide support, which creates a sense of belonging.

> I find it very enriching to see the different challenges that other caregivers are facing. That is very empowering and somehow also motivating. (Maria, Upper Austria)

The networks arising from the formal employment can mitigate feelings of isolation that are commonly found among spatially fragmented working groups (Applebaum, 2015). Moreover, while family care usually remains hidden in the private sphere (Hajek et al., 2021), the exchange with others increases its visibility. Furthermore, the establishment of social networks can serve as the foundation for building alliances and interest groups among family caregiver (Tixier & Lewkowicz, 2016).

Risks to Caregiver Relief

Although caregivers are in many instances no longer faced with the necessity to combine caregiving responsibilities with paid employment and find support through caregiver networks, the formalisation of informal care does not seem to effectively contribute to long-lasting relief of caregiver burden. This is reflected in the number of working hours as well as in the inability to take time off.

Depending on the care level of the care dependent person, the current employment models offer different contracts, which comprise between 20 and 40 hours of employment per week. The interviews reveal, however, that the number of hours employed does not correspond to the actual amount of work provided. In fact, caregivers report that the formal employment merely covers a small share of their working time, as they must be constantly available and are occupied with caregiving obligations almost the entire day. For this reason, the documentation of working hours, which must be reported to the employing institution, is perceived ‘ridiculous’, since it does not allow for noting down extra hours and is limited to the timeframe of Monday to Friday between 07:00 and 20:00 o’clock.

> I have to document my working hours between 7:00 and 20:00, but this should be extended to the whole day. Because if you care for relatives, you cannot schedule your working time as in a normal job, because there is no one to replace you. So, in a nursing home, you just go home at some point and someone else takes over, but for me it's just not like that, nobody else is coming. (Lukas, Burgenland)

> I am not allowed to do extra hours. So, for the monthly documentation I always indicate that I worked from 2:00 p.m. until 6:00 p.m. But, I mean, that's not true, I worked throughout the entire night. (Margit, Upper Austria).

One of the programme coordinators points out that the documentation of working times could not be arranged in another way due to current labour laws. For this reason, the expert explains that a part of the care work is provided in the role of the employed caregiver while the amount of work exceeding the hours employed must be carried out in the role as daughter, daughter-in law, grandson, mother etc (Expert Interview I).

Besides regulated working hours, the formal employment relation entails the entitlement to paid holidays. However, the results suggest that, in fact, employed family caregivers barely have the possibility to make use of the granted holidays, as their caregiving responsibilities require constant availability. Although one of the employment models offers care substitution during the absence of the employed caregiver, the extent of this replacement (two home visits by certified health care workers per day) is considered insufficient by caregivers, as care recipients are often dependent on continuous care provision.

> The problem is that I am too afraid to go on holiday. Last year, I saved all my vacation days until December. And when I finally took some holiday, I was still caring for my grandma most of the time, because they could not handle the care. In the end, this was not a real vacation. I mean, home care services are visiting twice a day, but that is just too little for her current condition. So, I cannot go on vacation and travel somewhere without feeling bad about it. (Lukas, Burgenland)

> They told us we should make use of the five weeks of holiday, because otherwise, it expires. But I mean, it's impossible to take holidays for five weeks. How is that supposed to work? Who will provide care the whole time? (Elfriede, Burgenland)

The reliance on other family members to serve as care substitutes frequently represents the only possibility to withdraw from caregiving responsibilities for a certain period. Even when caregivers need short breaks during their working day to follow leisure activities or to recharge, support from kin-based networks seems to be indispensable.

> With regards to support networks, it is really difficult. There are caregiving parents who have support from grandparents and there are some who don't. And this makes such a huge difference. For instance, I cannot leave her [the care recipient] somewhere for the night and do something else, this is simply not possible. (Margit, Upper Austria)

It can therefore be inferred that despite the formalisation of informal care, the responsibility of covering adequate care provision remains within the family. Without the presence of familial support networks, caregivers barely have the possibility to step back from caregiving responsibilities and take time off to recharge. Thus, similar to unregulated cash-for-care benefits, the design of the current employment

programmes reinforces the idea of family responsibility and re-situates long-term care provision within the private sphere with increasing, but still rather limited, involvement of public institutions (Hammer & Österle, 2003). In short, employment models for family caregivers foster the 'familialisation' of care, which refers to the 'retention of care within the family' (Eggers et al., 2020, p. 872).

5.4 Qualification, Job Security and Prospects

(De-)Qualification

Besides supporting family caregivers, the creation of additional labour in the long-term care sector represents a proclaimed aim of the employment programmes. For this reason, the formalisation of informal care is accompanied by health care education. In order to be eligible for employment, caregivers are obliged to complete the training for domiciliary nurses ('Heimhilfe') or daytime companions ('Alltagsbegleiter:in') within the first year of employment.

Overall, the health care trainings are assessed positively by employed caregivers, as they provide useful information and enable participants to get in touch with other employed family carers. At the same time, however, the attendance of trainings implies the necessity to arrange an adequate care replacement during course times, which is especially challenging for caregivers, who cannot rely on a familial support network (see previous section). Moreover, caregivers report that these trainings would not ultimately be necessary, as, in most cases, they have been caring for the dependent relative already before the employment relation and thus are well-aware about the person's needs. One of the programme coordinators observes that caregivers are developing a sense of being the sole expert for the care recipient and are thus hesitant before starting the education.

> In the beginning, they were sceptical about the trainings. I realised that caregivers have acquired the status of being the sole expert, since, previously, they have been left alone completely with this caregiving situation. (Expert Interview II)

While the mandatory trainings are contributing to quality assurance of long-term care provided within the private sphere, the education does not legally qualify family members to serve as formal and professional health care workers. It equips individuals to support care dependents with daily tasks, such as, feeding or bathing, but does not qualify them to adopt medical health care responsibilities, such as providing medication (BKA 2007; BKA, 2008). As employed caregivers are not formally educated to perform medical tasks, they are carrying them out not in the role as the employed caregiver, but as the relative of the care recipient (Expert Interview I). This therefore represents a legal grey area, which is also present in other long-term care arrangements, such as the 24-hour care provision, where a lack of qualification requirements might harm care recipients, but also increase the precariousness of care workers themselves (Österle & Bauer, 2016). The limited level of education and medical knowledge of family caregivers is reflected in the feeling of being overwhelmed with medical care responsibilities and the fear of causing iatrogenic harm to the care recipient.

> I was so overwhelmed, because the doctor gave a wrong diagnosis, and the medication that he prescribed didn't help and it got worse and worse. That was mentally stressful for me. When we got the correct diagnosis and it got better, I was relieved. But for some months I was psychologically burdened, because I just did not know what was wrong with my grandma and I thought that it was perhaps my fault. The diagnosis was such a relief, because I heard that it was not my fault. (Lukas, Burgenland)

Although extended medical education could improve the overall quality of familial long-term care provision, the president of the interest group for family caregivers highlights that it cannot be expected from family carers to complete a full nursing education, as they are occupied with caregiving responsibilities to a great extent (Expert Interview III). For this reason, the regular support visits of certified health workers, which are an obligatory component of the employment programme, are crucial to ensure a certain level of quality of the care provided. These visits are generally evaluated positively by caregivers.

> Every second week a professional nurse is visiting me, who checks up on me, gives me advise and if I have any question, I can always turn to her. That's great, because I was totally overwhelmed with the whole situation at the beginning. (Elfriede, Burgenland)

Overall, it can be inferred that the formalisation of family care, which requires the completion of caregiver trainings, equips family caregivers with basic skills and therewith contributes to the improvement of care quality provided within private households. At the same time, however, the degree of professionalisation seems to be limited and family members entering into regular employment relationships might contribute to the de-professionalisation of long-term care (Da Roit et al., 2007).

Job (In)security

Regardless of the degree of qualification, the completion of mandatory trainings ensures the formal employment as a family caregiver. The interviews reveal, however, that caregivers do not perceive the employment relation as a stable long-term job opportunity. They report about the fear of losing eligibility for the formal employment status. On the one hand, the death of the care recipient implies that caregivers are forced to find another job on the regular job market. On the other hand, the fact that the possibility of employment is dependent on the care level of the care recipient (minimum care level 3 in Burgenland, or care level 5 in Upper Austria) is perceived problematic. In circumstances, where health appraisers assess the care recipient with a lower care level than previously, caregivers might be faced with the loss of their employment status.

> I didn't want to leave my other job entirely, because there is always the uncertainty of them lowering the care level, and then I will no longer be able to work full time as a caregiver and would struggle financially. (Irina, Burgenland)

In Austria, the vast majority of care dependent people are assessed with care level one, two or three (Trukeschitz et al., 2022). Thus, by expanding the employment programmes to lower care levels, the employment security for caregivers could be increased (Expert Interview III).

Another aspect contributing to the insecurity of the employment relation is that in circumstances, where care recipients must stay in hospital or in a rehabilitation facility for a longer period, the employment relation of the respective caregiver is paused. This implies that in such situations, caregivers are not receiving any further income compensation from the employing institution.

At the same time, however, caregivers report that the formal employment creates a certain degree of stability. Instead of being dependent on constantly requesting caregiver leave or hospice leave, the employment programmes guarantees that they can devote their time to caregiving responsibilities as long as the eligibility requirements, such as the minimum care level of the care recipient, are fulfilled. Moreover, the formal employment grants caregivers access to unemployment benefits once the care situation terminates, which additionally contributes to increased stability. This particular aspect, however, has not been explicitly mentioned by the participants of this study.

Future Job Prospects

With regards to the employment programmes' objective to create additional labour in the care sector and to incentivise family caregivers to remain in the field, the future career intentions of caregivers are ambiguous. Several caregivers – especially those that have been employed in the care sector beforehand – indicate that they intend to continue working in this field after their current occupation. Others, on the contrary, highlight that they would not be willing to care for another person than their relative and thus will search for employment in a different field once the current care situation has ended. This is in line with Da Roit et al. (2007), who highlight that only a few family caregivers decide to become care workers once the care situation within the family terminates.

Within the sample of this study, one caregiver, who was employed as a formal care nurse before, reported that working in a formal care institution after his current role as a family caregiver does not represent a feasible option. He would be willing, however, to serve as a personal caregiver responsible for one person in a private household. Inferring from this case, it seems that additional labour for long-term care provision in private households could be created if the employment models were extended to non-kin relations. Thus, by widening the formalisation of care provided within private households beyond the traditional family, new forms of long-term care arrangements might emerge. To this date, care of non-kin within private households, which often occurs in the form of 24-hour care, is primarily provided by cross-border migrant workers (Bauer & Österle, 2013). By granting the possibility of formal employment through public institutions to caregivers outside family networks, this might widen the resources for long-term care, since it might increase the attractiveness of the sector for local workers (Gottschall, 2023).

Overall, it is crucial that caregivers are assisted in the re-integration in the formal labour market once the employment relation as a caring relative has ended. Thereby, it must be ensured that formerly employed family caregivers are not pushed to remain in the care sector, but are enabled access to other sectors, if they wish (Expert Interview III).

6. Implications & Policy Recommendations

As it has been pointed out previously, informal care constitutes an indispensable resource for the overall provision of long-term care – especially in conservative welfare states, such as Austria (Esping-Andersen, 1990). Due to ageing population and cutbacks in formal and professional long-term care services, the relevance of informal care is assumed to further increase (Colombo et al., 2011; Kaschowitz & Brandt, 2017; Swinkels et al., 2015). At the same time, however, the supply of informal caregivers is limited, reflecting the on-going crisis of care (Broese van Groenou & De Boer, 2016; Fraser, 2017; Riedel, 2012).

Informal care responsibilities are associated with negative impacts on the health, employment status, financial situation and well-being of caregivers, which renders them a particularly vulnerable group in need of adequate public support (Bauer & Sousa-Poza, 2015; Bom et al., 2019; Glendinning et al., 2009). Until recently, cash-for-care benefits that are informally transferred from care recipient to caregiver as symbolic payments represented the only opportunity for family caregivers to receive monetary compensation in Austria over an extended period of time (Hammer & Österle, 2003; Österle, 2013). This leaves caregivers in a situation without economic and social security, which further increases their vulnerability.

The recently introduced employment models by the federal states Burgenland and Upper Austria can be interpreted as a response to exactly these challenges. On the one hand, the employment programmes formalising informal care aspire to create additional supply and resources for the provision of long-term care, reflecting that informal caregivers are regarded as 'co-producers'. On the other hand, the formalisation intends to enhance the well-being of caregivers and to protect their social rights, which suggests that informal caregivers are also perceived as 'co-clients', who must be supported (Schneider et al., 2016; Twigg, 1989). In any case, employment models provide direct support to caregivers and are going beyond the scope of existing support measures: They imply that the provision of care within the private and familial sphere is based on contractual agreement, which grants caregivers access to regular and stable income, social security as well as to paid holiday and sick leave, leading to a formalisation of previously informal care. Considering that this formalisation represents a step towards regulating family relationships, the implementation of employment models for informal caregivers seems to stand in contrast with conservative-familialistic welfare state systems (Da Roit et al., 2016).

Overall, the formalisation of informal caregivers represents a novel approach to the organisation of long-term care in Austria, which, to this date, has not been adequately discussed in academic literature.

Compiling the results presented in the previous chapter, it becomes apparent that the formalisation of informal care does not only grant regular income and access to social security, but also enhances the recognition and appreciation of long-term care provided by family caregivers within private households. Furthermore, the formalisation implies that caregivers are alleviated from the necessity of balancing caregiving responsibilities with paid employment. Thereby situations of double burdens can be reduced. Nevertheless, the formal employment of family caregivers by itself does not automatically imply an improvement of the situation of caregivers.

While the formal financial remuneration contributes to increased recognition of family care, it does not necessarily ensure a level of income that safeguards the livelihoods of caregivers. In the case of the employment models under study, the overall household income levels might decrease despite the formalisation. This is primarily due to the current financing of the wages, which requires a large part of the care allowance to be paid as a deductible. The employment programmes in their current form are thus not designed to contribute to the alleviation of poverty risks among caregiver households or to reduce dependencies on an additional income-earning partner (Fiedler et al 2021). In order to ensure that the formalisation provides economic security for all groups of caregivers, it is crucial that the wages are not financed through the care allowances to such a large extent. Moreover, it is important that the income generated via the employment does not exclude caregivers from other essential social benefits and services, such as subsidised therapies for care recipients. This is especially important for caregiving parents, for whom the care allowance forms part of the overall household budget (Blum & Glaser, 2022) and who have to pay the required therapies for the impaired child from their own pocket.

With regards to the relief of caregiver burden, the employment of informal caregivers has the potential to reduce the double burden of juggling paid employment with caregiving activities (Zigante 2018). Nevertheless, the formalisation alone does not imply effective and long-lasting caregiver relief. As highlighted in the results, caregivers have to be constantly available for the care recipient. The possibility to withdraw form caregiving responsibilities for a certain period is limited to those caregivers who can rely on an extended support network within the family. It can thus be inferred that the formalisation of informal care re-situates long-term care responsibilities within the private sphere, suggesting the ‘familialisation’ of long-term care provision (Eggers et al., 2020). Hence, although the care relationship is being formalised, the care situation remains similar to traditional informal care, where the caregiver serves as the sole care provider and is required to be constantly available (Ungerson, 2005). Thus, the assumption that the formalisation of informal care stands in contrast with conservative welfare states, which strongly rely on family-based care (Da Roit et al., 2016), does not seem to hold true. Rather, it appears that the employment of informal caregivers strengthens the responsibility of the family with regards to long-term care provision and thus upholds the principles of conservative welfare systems.

Considering the quality of care provided within the familial context, the formalisation can contribute to higher standards. In contrast to informal settings, where care activities are usually performed without any official education (van Ryn et al., 2011), the formal employment relation requires caregivers to complete trainings. At the same time, however, the education provided by the employment models under study does not formally equip caregivers with the ability to perform medical care tasks, which compares to other long-term care arrangements, such as 24-hour care services, where medical qualification is frequently lacking. This might harm not only care recipients, but also overburden care workers themselves (Österle & Bauer, 2016) Thus, while the formalisation of informal care has the potential to increase the care quality provided, it, at the same time, might entail the de-qualification of long-term care (Da Roit et al., 2007). Nevertheless, the trainings and care education attached to the formalisation can be regarded as beneficial for both care recipient and caregiver and should thus remain an integral part of the formal employment. In addition, the continuation of mandatory support visits by certified health workers is crucial to ensure a certain quality of care provision.

Although the formalisation of informal care is based on official employment contracts, the employment relation is perceived as rather unstable by caregivers as it depends on the assessed care level of the care recipient. In order to create more secure forms of employment, an extension to lower care levels should be considered. Especially the employment model in Upper Austria, which is directed at caregivers caring for a person with a minimum care level of five, excludes a large part of family caregivers (Trukeschitz et al., 2022) and implies higher risks with regards to losing eligibility. Besides expanding the opportunity of employment to lower care levels, it could also be widened to non-kins, who decide to dedicate their time to care for a dependent person. Considering that changing family structures decrease the overall potential of long-term care within the traditional family (Famira-Mühlberger & Firgo, 2018; Grossmann & Schuster, 2017), extending employment models to non-related carers might contribute to countering resource scarcity in the long-term care sector. However, in how far employment programmes formalising informal care relationships can actually increase the supply of long-term care provision remains unclear.

Overall, it can be concluded that a formalisation of informal care contributes to increased recognition and appreciation of family care. The employment itself, however, does not automatically result in the improvement of caregivers' economic situation, nor does it necessarily imply the relief of caregiving burdens, the provision of adequate quality of care or employment security. For this reason, it is crucial that the formalisation of family care is designed in a way, which ensures economic security and independency for caregivers (Ungerson, 1997). Moreover, additional support measures contributing to the relief of caregivers, and to the guarantee of decent quality of care must be provided on top of the formal employment relation. However, provided that adequate remuneration and additional support is ensured, the employment of informal caregivers can represent a meaningful measure within the long-

term care context – especially for those groups of caregivers, who tend to adopt long-term care responsibilities under any circumstances, such as parents of impaired children (Blum & Glaser, 2022).

Nevertheless, the formalisation of informal care must neither be considered a substitution for adequate professional long-term care provision, nor shift the responsibility of care provision entirely to the private and familial sphere (Fiedler et al., 2021). In contrast, the accessibility to affordable formal and professional long-term care provision must be ensured – not least, because the availability of publicly funded institutional care services reduces the intensity of family care and thus positively contributes to the relief of informal caregivers (Verbakel, 2014; Wagner & Brandt, 2017). Moreover, limited access to publicly funded formal care might force individuals to adopt caregiving responsibilities rather than provide the choice between family or professional care (Fink & Valkova, 2018). Without the possibility of externalising care responsibilities to formal care providers, employment models, similar to cash-for-care benefits, might create incentive traps, encouraging family members to leave the regular labour market and take on caregiving responsibilities instead (Da Roit et al., 2016). This might reinforce gender inequalities in caregiving activities. As Ungerson (1997) points out, even if family care is being paid and formalised, it continues to be located in the domestic sphere, which negatively impacts the ability of caregivers – women in particular – to participate in public life. This points to the dilemma of wanting to recognise and compensate care work provided in the private sphere on the one hand, while aspiring to liberate women from this responsibility on the other (Lister, 1995; Ungerson, 1997). In any case, in order to effectively relief caregivers, it is crucial that policies cover both, the direct support for family caregivers as well as the provision of formal long-term care services (Schneider et al., 2016).

7. Conclusion

The thesis at hand investigated how informal caregivers experience a formalisation of their previously unpaid and unrecognised work by drawing on the recently introduced employment models in Burgenland and Upper Austria as case studies. Moreover, it highlighted the potential of employment programmes with regards to improving the situation of caregivers.

While this study provides first explorative insights on the formalisation of informal care in the Austrian context, further research on this topic is required – within but also beyond the Austrian context. Due to the scope of this thesis, the sample is limited with regards to the number of interview participants, but also concerning diversity in terms of gender, age and the social relation between caregiver and care recipient. Although the empirical results of this study allow to derive primary implications and policy recommendations, the findings are not generalisable. However, since this work follows a qualitative research design and draws on case studies, it does not aspire to generalise, but rather to gain a deeper and broader understanding of the subject matter.

Based on the findings of this study, it can be inferred that the formalisation of informal care can represent a useful measure within the long-term care context – especially in conservative welfare state regimes,

where care is provided within the private and familial sphere to a large extent. The formal employment of caregivers implies the recognition of work that would otherwise be offered informally without contractual agreement and monetary compensation. Nevertheless, it is crucial to highlight that the formalisation as an isolated policy is not sufficient to effectively support and relief caregivers. In fact, the way in which employment programmes are designed and organised as well as the context in which they are embedded are decisive for their potential to sustainably improve to situation of caregivers. In general, the availability of additional (direct and indirect) support measures and the possibility to externalise long-term care responsibility is indispensable. Hence, instead of considering the formalisation of informal care as a substitution for adequate professional long-term care provision, it must be understood as a supplementary policy. Otherwise, employment models targeted at informal caregivers pose the risk of re-situating the responsibility of long-term care provision within the private and familial domain, thereby reinforcing pressure on caregivers.

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