WP3 Care arrangements in multi-career families
National report: Portugal

KARIN WALL
JOSÉ SÃO JOSÉ
SÓNIA CORREIA

INSTITUTO DE CIÊNCIAS SOCIAIS
LISBOA, PORTUGAL
2001, OCTOBER 29

SOCCARE Project Report 3.4

Contract No. HPSE-CT-1999-00010

Written for
European Commission
5 th Framework Programme
Improving Human Potential and Socio-Economic Knowledge Base
Key Action for Socio-Economic Research

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PART I

THE PORTUGUESE CONTEXT: MULTI-CAREER FAMILIES AND CHILD/ELDER CARE POLICIES

1. Families and the Division of Labour: Background data

The division of labour within the family and the behaviour of families in relation to the labour market have changed significantly in Portugal over the last few decades. Of particular importance have been the increased labour force participation of women, especially of married women and those with young children, and the rise in women's levels of educational attainment.. Women (aged 15-64) as a proportion of the total labour force rose rapidly from 18.3% in 1960 to 52.8% in 1991, and 62% in 1998.

The overall growth in female employment is related to profound changes in the activity rates of different age groups (Table 1). Expansion of female employment in the 1960s was largely based on the increased activity rates of women in younger age groups and single women. Marriage and, in particular the birth of the first child were, until the 1970s, major barriers to continued economic activity. This difference gradually diminished in the 1970s and 1980s, partly due to changes in social values and legislation introduced by the 1974 Revolution, and partly to the economic advantages of female labour and the growth of employment in certain economic sectors as well as the rapid development of female educational levels. By 1998, the activity rates of women in the childbearing age groups between 25 and 44 had greatly increased and become similar: 80% of women aged 25-34 and 77% of those aged 35-44 were professionally active in 1998.

Table 1 – Female activity rates by age groups

	1960	1970	1981	1991
10-14	8,6	13,4	8,3	6,2
15-19	27,3	44,8	42,3	34,7
20-24	26,5	45,5	59,0	64,7
25-29	19,8	33,1	62,4	74,1
30-34	16,6	29,0	56,3	72,3
35-39	15,3	23,1	49,2	69,0
40-44	14,7	21,5	43,7	62,5
45-49	14,2	19,8	39,2	53,0
50-54	13,6	17,7	33,4	42,0
55-59	13,3	15,5	27,6	30,7
60-64	12,1	13,6	17,9	16,1
65 e +	7,8	8,0	3,4	2,9

Sources: Population Censuses, 1981 and 1991

In this context, it is also important to underline that the majority of women in Portugal work full-time. According to the last population census (1991), only 15% of the female labour force (6% of the male) was working less than 35 hours per week. Most men and women work between 35 and 44 hours per week (57% of men and 60% of women) but quite high proportions still work 45 or more hours per week (36% of working men and 24 % of working women). Women's unemployment has also been fairly low: 9% of the female labour force in 1991 and 6% in 1998 were unemployed and women represent 56% of total unemployed (1998).

If we analyse the impact of these changes on families and how they have adapted their relationship to the labour market in recent years, it is important to examine the labour market behaviour of

spouses/partners in families with children. Data show that the dual-earner family has become the most common pattern of families' relationship to the labour market, even if not a fully predominant model. In the 1991 population census, 56% of families with children under age eighteen contained dual-earner couples and, in a 1999 national survey on couples with children, 68% of families were dual-earner (Wall, 2000). The second most adopted pattern is the male breadwinner/female housewife model, which still represents just under one-quarter of all couples with children (24%).

If we go beyond practices and look at values, it is interesting to note that opinions on women's work have shifted sharply. Surveys show general agreement that women should go out to work. In the 1999 European values Study, 79% of Portuguese men and women agree that "having a job is the ideal way for a woman to be independent (average for all EU countries:76%) and another 90% think that "both husband and wife should contribute to household expenses" (average for all EU countries: 75%). Maternity seems to interfere slightly with this attitude toward working women. The Portuguese are less likely than persons in other countries to believe that working women can have as good a relationship with their children as at-home mothers (67%; average for all EU countries 74%, France 77%, Sweden 84%), and they are more likely to believe that children suffer if their mothers work (73% believe this, compared to an average of 57% for all EU countries, 56% in France, 38% in Sweden). This seems to indicate a fairly strong tension, in Portuguese society, between work and motherhood, a fact which must probably be analysed in the light of men and women's long working hours and the high proportions of working mothers with small children.

Practices and views on gender roles inside the family have also changed but not quite so sharply. The 1999 European values study shows that the Portuguese, and especially Portuguese women, are less likely to believe that fathers are capable of educating their children as well as mothers, and the 1999 survey on couples with children (mothers aged 25-49) showed that while a high proportion agree that ideally all domestic tasks should be divided equally by the couple (70%), 30% think that the wife should do everything alone or with some help from her husband. Egalitarian views on the division of household work have thus steadily if slowly increased, but the gap between attitudes and practices is great, with numbers of those saying that household chores should be shared having grown more than of those actually sharing. In the 1999 survey on couples with children, only two in ten couples were sharing, on a daily basis, the main household chores such as cooking, cleaning and doing the laundry (Wall, 2000).

Family strategies for the care of very small children have also been changing over these years, in fact quite significantly. Data from the national survey on families with children showed that patterns of day care for babies aged one to two years in the 1970s were very different from those in the 1990s (Wall, 2000). Babies born in the 1970s were cared for predominantly by mothers at home. Nearly half of all mothers (44%) stayed at home with their baby. Leaving the child with close kin (34%) was the next most important solution, whereas childminders (11%) and formal day care (7%) were clearly minority arrangements. In the 1990s, on the other hand, care arrangements developed in a more pluralist direction and the delegation of care, including formal day care, increased strongly: only one in four mothers stayed at home to care for children aged 1-2, while care by kin (36%) and childminders (12%) maintained their relative importance, and formal day care increased to 18%.Changes in caring strategies for the 3-5 age groups has also been significant: in 1998, 55% of three-year-olds, 65% of four-year-olds and 78% of five-year-olds were in pre-school education.

Although we do not have such detailed data on the division of labour patterns of families who are caring for a dependent elderly person, it is important to note that in Portugal the 'very old' (over age

80) live in four different types of household situation: 26% live alone[1], 30% live with a partner, 4% live in an institutional household[2] and 40% live with their children or other relatives/friends (European Commission, The Social Situation in Europe, 2000, data for 1995). This proportion of elderly persons living with their children or other persons is very high when compared to the same values for many other European countries (average for all EU countries: 19%; Finland 15%, France 15%, UK 15%, Italy 26%; only Spain has a higher value – 46%). The proportion of those living in institutional households is also relatively low (4% compared to an average of 10% for all EU countries). This shows us that in Portugal the provision of care for dependent elderly persons is strongly centred on the family and that the delegation of elder care tasks on extra-family providers is quite weak. On the other hand, family values regarding the best caring solution for frail or disabled elderly persons strongly stress the advantages of a family, home-based caring arrangement: in a 1998 national survey on values across the generations, 87% of respondents believe that "the children should care for the elderly parent, in their home" (Vasconcelos, 1998). Only a small proportion believe that the best solution is an institution. The important question here is 'how do families cope', in particular when both partners work and have to care for a dependent elderly person?

With regard to the division of labour in families who are caring for a dependent elderly person, available data show that it is mostly women who take on caring tasks (Survey on Time Use, 2001). However, the same survey shows that men participate more in care for the elderly than in child care. The difference (in time use) between men and women in relation to the division of caring tasks is more marked in the child care domain than in the elder care domain (INE, 2001, Survey on Time Use).

Data from a survey on paid and unpaid work (national sample of 1700 individuals, between age 20 and 50) also showed that 13 % of individuals in this age group have an elderly relative needing care (Torres at al., 2000). The "main caregivers", as indicated by the respondents, are spouses (10%), other relatives (82%), paid informal or formal caregivers (5%) and others unpaid (3%). The importance of caregiving by spouses and services is greatest when the elderly person is in residential care or living in his/her home. By contrast, when the dependent elderly person is living in a relative's home, caring is taken on predominantly by the family.

2. Policy and Service Provision

Policy and service provision regarding child care was developed in the previous report on lone parent families (Wall, São José, Correia, 2000) so we have included it in the present report as an Annex (Annex 1). However, analysis shows quite clearly that employment and parenting policies since the mid-1980s have strongly supported the gradual "de-familialisation" of child care. The changes in parental leaves and the slow but steady increase in service provision have both contributed to a shift from child care centred on at-home mothers or grandmothers to a more pluralist model centred on the delegation of child care to both formal and informal providers.

Policy and service provision regarding care for the elderly have not followed quite the same trend. As in other European countries, family policy in this domain has expressed concern about the

[1] The elderly persons that live alone are, in Portugal, mostly women (INE, 1999).

[2] The elderly persons living in institutional settings are, in most cases, the oldest ones and women. This situation is related to the higher life expectancy of women (INE, 1999).

implications of an ageing population and has developed new policy responses. Overall, however, they are less developed than the policy measures for child care and there has not been a strong move in the direction of de-familialisation. Policy measures and family obligations tend to underline the importance of keeping the elderly persons "at home" and looked after by intra-generational (spouses) or intergenerational care (mainly adult children). Institutional residential care is seen as a less favourable solution for elderly persons and the low quality of many homes has tended to reinforce families' aversion to this type of care.

Debate and measures relating to elder care have centred over the last decade on the following problems:
a)Increasing and developing service provision.
b)Improving the quality of care
c)Supporting carers (leave arrangements and financial support for carers).

a)**Increasing and developing service provision**
Until the 1970s institutional care for elderly persons was the only social policy response in this domain. After the April Revolution (1974), the new Constitution (1976) formally recognized the need to develop social policy and service provision for elderly persons. As a result, new services for elderly persons were created. The first day care centres were set up after 1976 and have been increasing gradually over the last two decades. Home-based care services were also started up, but only expanded more rapidly over the last decade. More recently (1991), another service was created in which families take elderly persons into their own homes and are paid for this service (Fernandes, 1997; INE, 1999). Although the expansion of elder care services has been quite significant during the last decade, service provision is still insufficient for existing needs (waiting list for homes are particularly long). At present, expansion of service provision is being promoted/stimulated through several public Programmes, such as the *PAII* (integrated support programme for elderly persons) and *PILAR* (programme especially designed to develop residential services). Recently, the government created a national plan for social inclusion (*PNAI*) in which it aims to expand home-based care services for dependent elderly persons (to increase the offer of services and to extend opening hours to longer periods during the day and 7 days a week).

There are three main types of services available: domiciliary services, day care centres and residential care (a fourth type of service, of families who are paid to receive live-in elderly persons, also exists but only covers a very small number of cases: 396 in 1998).

Domiciliary home-based care services were initiated timidly in the eighties and were increased slowly during the nineties: up from 20,568 users in 1992 to 24,934 in 1994 and 34,942 in 1998. Public domiciliary services provided directly by local health/social security centres are negligible compared to provision offered by the private non-profitmaking sector which is financially supported by the State (payment depends on family income). The services offered include meals on wheels, cleaning and personal care but they do not provide more permanent home helpers (caring for several hours or all day caring). Private profit-making services, on the other hand, have developed services that are adapted to family needs: occasional care, home helpers for part/all of the day or 24 hour care for highly dependent elderly persons; they are highly expensive.

Care in day centres has also increased, up from 11,370 users in 1987 to 27, 967 in 1992 and 36,110 in 1998. They accept elderly persons with a low or medium level of dependency and offer daily care services roughly from 9 to 5 on week days. Some of them also offer transport services. As in the case of domiciliary services, these establishments are almost totally provided by the private non-profitmaking sector which has agreements with the social security centres (94% of all establishments).

The supply of **Residential care in homes** has been traditionally low when compared to some other countries. Data for the early nineties show that Portugal (and Italy) offer places for only 2% of people 65 and over, compared to 5% in France and 10% in the UK (Ditch,1995). Although there has been some increase in the nineties (up from 31351 users in 1992 to 41826 in 1998), supply continues to be low and to lead to long waiting lists.

b) Improving the quality of care

Concern about the poor quality of care, especially in residential care, has been a constant trend in public debate and policy over the last decade. A study carried out in 1995 by DECO, a consumer organization, showed that in the Lisbon area most of the homes had very poor conditions and were expensive for elderly persons with low pensions. A report carried out by the government in 1990 had already pointed out the same problems and had shown that, in a sample of 298 homes, only 59 were licensed. This led to different governmental programmes not only to increase the number of residential places but also to create systematic inspection of homes. Over the last nineties, this led to the closing down of many homes.

c)Supporting carers

Public policy in the 1980s began to address the issue of family life and employment not only from the point of the traditional problems of the protection of working women and furthering gender equality but also from the point of view of making it easier to reconcile family care and employment. This implied producing public responses along three main lines: the expansion of service provision, the building up of leave arrangements and the introduction of carer's benefits. The 1984 law entitled wage-earners to miss work up to 30 days per year to care for a sick dependent child under ten years of age and up to 15 days to care for a sick child over ten years, a spouse or a relative in ascending line. In 1995, replacement pay (65% of wages) was introduced for wage earners caring for a sick dependent child under ten but not for those caring for a sick spouse, a relative in ascending line or a child over age ten.

Modest benefits for caring (of dependent disabled children and of dependent invalid pensioners) were introduced in 1989[3]. The *Allowance for Assistance by a Third Party (*recently renamed the *Supplment for Dependancy)* is a non-means-tested benefit available to pensioners needing permanent care by a third party. In 1999 two levels of benefit were introduced: one for pensioners who are dependent on others in the course of daily life (housekeeping, getting around, personal hygiene); and a second one for pensioners who are not only dependent but also bed-ridden or with severe mental problems. The first level entitles claimants to 50% of the value of the social non-contributory pension and the second level to 80% of the same amount (changed to 90% in 2000).[4]

Some tax benefits for families caring for a live-in relative in ascending line were also introduced in the nineties. A tax-free allowance (19,400 escudos) was introduced for taxpayers who have a live-in relative in ascending line who is part of a joint family economy and does not have an income above the social pension (non-contributory regime) and health-care expenses concerning live-in relatives (in ascending line or collateral kin up to the third degree, able or disabled, but with income below the national minimum wage) and expenses with residential care may be deducted from income.

[3] Decree-Law 29/89, 23 January.
[4] Decree-Law 309-A/200, 30 November.

3. Elderly Persons in the Lisbon Region: demographic data

As in all industrialised countries, the Portuguese population has been ageing. Between 1960 and 1998 the proportion of children (0-14) decreased by 35,1%, while the proportion of elderly persons (65 +) increased by 114,4% (INE, 1999).

In 1991 there were 266 053 elderly persons (over 65 years old) living in the Lisbon region, representing 13% of the total population of this region. Amongst these, 4 620 were over 90 years old (1,7% of the total elderly population of this region) (IDS, 1999).

Table 2 – Ageing Ratio (65 + / 0-14), Lisbon and Portugal (%)

Year	Lisbon	Portugal
1991	77,4	71,4
1992	81,1	74,4
1993	84,4	77,1
1994	88,1	80,2
1995	91,7	83,5
1996	94,7	86,1
1997	97,4	88,5

Source: IDS (Instituto para o Desenvolvimento Social), 1999, p.51

We can see in Table 2 that the ageing ratio in the Lisbon region has been higher than the ageing ratio in Portugal. In 1997 in Lisbon there were 97 elderly persons (65 +) for every 100 children (0-14), whereas in Portugal there were 89 elderly persons for every 100 children. However, compared to other regions of the country, the population of Lisbon has not been ageing as strongly as some (more rural) regions in the centre and in the south of the country (INE, 1999).

Table 3 – Dependency Ratio (65 + / 15-64), Lisbon and Portugal (%)

Year	Lisbon	Portugal
1991	19,0	20,7
1992	19,4	20,9
1993	19,7	21,1
1994	20,2	21,4
1995	20,7	21,7
1996	21,2	21,9
1997	21,8	22,2

Source: IDS (Instituto para o Desenvolvimento Social), 1999, p.51

In relation to the dependency ratio, we can see that the ratio for Lisbon has been slightly lower than for Portugal. In 1997 in the Lisbon region there were 22 elderly persons for every 100 persons between age 15 and 64. However, the dependency ratios have increased over the last decade both in Lisbon and in Portugal as a whole.

Table 4 – Families with Elderly Persons (65 +), Lisbon region

	Families with Elderly Persons	Families with 3 or more elderly persons
Lisbon	195 134	2 337
Portugal	967 904	11 939

Source: INE, Census 1991, in IDS, 1999, p.52

In 1991 Lisbon had 195 134 families with elderly persons. They represent 27,7% of all families in the region of Lisbon and most of them have one or two elderly persons (only 2 337 - 1,2% - had 3 or more elderly persons).

4. The Portuguese Sample

This report is based on information gathered from 25 families living in Lisbon. The families belong to three types of dual career couples with caregiving responsibilities (see Tables below): couples caring for young children[5] (16 cases); couples caring for young children and a dependent elderly person (5 cases), and couples caring for a dependent elderly person (4 cases). The elderly relative needing care is always a relative in ascending line: a mother, a father or both parents of one the partners in eight families and a grandmother in one family. Practically all the couples caring for young children (15 cases) live in nuclear family households (at a national level too, nine in ten couples with children live in nuclear families). By contrast, most of the couples caring for the elderly live with the relative needing care (7 cases).

To be included in our sample, both members of the couple had to have full-time jobs. Their professions are varied, including highly qualified jobs such as doctors, engineers, lawyers, university professors and managers as well as other professions such as hairdressers, taxi-drivers or secretaries. Although some of the couples do not have highly demanding careers, all the respondents have a high commitment to work.

The couples caring for children were recruited through a network of personal contacts and through snowballing within these networks. The couples caring for a dependent elderly person (with or without children) were recruited through personal contacts and also through institutional contacts with service providers.

Couples caring for children

	Nuclear Family		Sub-total	Extended Family		Sub-total	Total
	Age of youngest child			Age of youngest child			
	Under 4	4 - 11		under 4	4 - 11		
High - Income	4	3	7				7
Average - Income	4	2	6	1		1	7
Low - Income		2	2				2
Total	8	7	15	1		1	16

[5] Children below age 12

Couples caring for children + elderly persons

	Nuclear Family						Sub-total	Extended Family						Sub-total	Total
	Elderly person's level of dependency							Elderly person's level of dependency							
	Low		Medium		High			Low		Medium		High			
	Age of youngest child		Age of youngest child		Age of youngest child			Age of youngest child		Age of youngest child		Age of youngest child			
	0-3	4-11	0-3	4-11	0-3	4-11		0-3	4-11	0-3	4-11	0-3	4-11		
High-Income					1		1		1					1	2
Average-Income					1		1						2	2	3
Low-Income															
Total					2		2		1				2	3	5

Couples caring for elderly persons only

	Nuclear Family			Sub-total	Extended Family			Sub-total	Total
	Elderly person's level of dependency				Elderly person's level of dependency				
	Low	Medium	High		Low	Medium	High		
High-Income					1	1	1	3	3
Average-Income						1		1	1
Low-Income									
Total					1	2	1	4	4

Number of four Generation Families in our sample:
4 families (2 average-income families caring for children; 1 average-income family caring for children and an elderly person; 1 high-income family caring for an elderly person only).

PART II

CARE ARRANGEMENTS

1. CHILD CARE ARRANGEMENTS

1.1. Introduction

Findings from the interviews conducted in Portugal show that there are four types of childcare arrangements:

1. **Strong Family Support**
1.1 Strong family Support without Formal Care
1.2 Strong family Support with Formal Care
2. **Mother Centered + Formal Care**
2.1 Supported
2.2 Isolated
3. **Shared Parental Care + Formal Care**
4. **Varied Arrangement**
4.1 Varied Rich (including full-time domestic employee)
4.2 Varied Restricted

The four patterns were identified on the basis of the following criteria:

a) **The structure of care arrangements** (including number and type of care providers, and the degree of support provided especially during working hours);
b) **The sharing patterns between partners**
c) **Attitudes, values, perceptions**

The first criterion was essential to distinguish between families with or without formal care and, on the other hand, to distinguish between families whose daily care arrangements are centered mainly on the parents (or one of them), those where care arrangements involve two providers (one/ both parents and another family provider, mainly grandparents), or three providers (one/ both parents, school/nursery and another family provider) and, finally, those who have multiple or varied arrangements (more than three informal, paid or unpaid, providers).

The second stresses the sharing patterns between partners. This enables us to understand in what way the father's participation or non-participation influences the type of care arrangement.

The third criterion points up the attitudes, values and perceptions in each care arrangement. This criterion underlines the way families feel in relation to the care arrangement, to work, to their partners, etc.

1.2. Typology of Child Care Arrangements

TYPE 1: STRONG FAMILY SUPPORT

Main characteristics:

- Strong levels of involvement by the grandparents in daily child care.
- Living with a relative or nearby (family who can offer regular, reliable support).
- Gaps in school timetable filled in by grandparents.
- The level of the father's participation in caring tasks is low

Sub-type 1: **Strong Family Support without Formal Care**

- Parents + grandparents (daily care).
- Children under 3 years old.

Couples with children: (Interviews 2 and 4)
Couples with children and elderly person: (Interviews 6 and 9)

Sub-type 2: Strong Family Support with Formal Care

- Parents + grandparents + formal care.
- School age child.

Couples with children: (Interview 11)

STRUCTURE OF CARE ARRANGEMENTS

This type of care arrangement is characterised by strong levels of involvement on the part of grandparents. They play a very important role in child care and the support they provide is very frequent and regular. It takes place every weekday and is very reliable. Grandparents also provide support in occasional circumstances such as when the child is ill or when parents want to engage in some leisure activity.

In **sub-type 1** the children are younger and grandmothers stay with them all day. They provide all the care the child needs during the week and, on some occasions, at weekends.

In **sub-type 2** children are of school age. Because of the incompatibility between parents' working hours and the crèches'/ state schools' hours, parents choose to have the grandmothers stay with the children. Once they are at school/crèche grandparents stay with the children for part of the day. Usually the schools' timetables have gaps, and the children stay at their grandmother's home until classes start. The grandmother leaves the child at school.

In terms of reconciling child care and working hours, Strong Family Support families do not have many problems. These mothers do not suffer much stress in connection with this issue because even

if they all work in full-time jobs (7/8 hours a day), they have regular hours and all leave work around 5 p.m.
Their husbands have full-time jobs and long working hours. One has regular but inflexible hours and on some occasions he has to work at weekends (Int. 11); there is another father who usually works until 7 p.m. but often has to stay extra hours (Int. 2); and there is yet another father who really does not have regular working hours because he works on a freelance basis.

SHARING PATTERNS BETWEEN PARTNERS

As far as patterns of care sharing between partners are concerned, the Strong Family Support care arrangement is homogenous. In this type the level of the father's participation in caring tasks is low. However, it is our opinion that this low level of participation by the father is not related to any lack of willingness to take part in childcare, but is conditioned by two different factors: on the one hand, the lack of confidence the mother has in his care skills and patience for dealing with the child (Int. 2 and 11); on the other hand, the grandmother's strong role in the care arrangements and sometimes in the household (Int. 4).

> *"I must say, between ourselves, that I do not trust him very much (…) Sometimes he says he wants to take her to the parents' house or… I always make a point of going along with her: I'm always afraid he won't know what to do."*
> (Int. 2, 26 years old, Assistant Radio Producer)

> *"He always helped (in looking after the children) but with my mother, that's a different matter, as we know.. it's different, he doesn't take as much part in that as he did with the children .. my mother is here with us…"*
> (Int. 4, 40 years old, Civil Servant - Librarian, 3 children, with her mother living at home)

In spite of their low levels of participation in child care tasks, these fathers do take some part in different domestic tasks: shopping (Int. 11); helping or preparing meals (Int. 4 and 11); doing the laundry (Int. 2); ironing (Int. 4); doing some cleaning (Int. 2 and 11), etc. However, this participation occurs more frequently at weekends.

> *"X does what has to be done, if necessary, when I'm not at home, if I'm ill or anything, thank goodness he manages all right with all the household chores. At weekends he cooks (…) we more or less chose the chores we want to do and which the other one doesn't enjoy doing."*
> (Int. 4, 40 years old, Civil Servant - Librarian)

> *"While I'm finishing the ironing, my husband cooks the rest of the supper. And sometimes he prepares the whole supper (…) he helps me to wash up (…) On Saturdays it's he who goes shopping at the market."*
> (Int. 11, 33 years old, Secretary)

ATTITUDES, VALUES, PERCEPTIONS

In this type of care arrangement mothers feel that the care support given by family members is very important. They say that it is very important for them to know that the children are "in good hands".

> *"I know that when Miguel is with her (his grandmother) he is a thousand times better off than with me (…) she has a lot more experience (…) when I'm desperate at home, I call her, not the hospital."*
> (Int. 2, 26 years old, Assistant Radio Producer)

ADVANTAGES

For these families the strong presence of grandmothers in daily child support is very important. It is seen as an advantage because grandmothers feel that they have something to do for other people, and the children are in a secure family environment. This aspect is very important when children are below the age of 3.

> *"It is very healthy for the babies to have family around them."*
> (Int. 4, 40 years old, Civil Servant - Librarian)

Another aspect pointed out as an advantage is the fact that they do not have to pay grandparents to stay with the child.

> *"My mother offered, and there's also the money aspect, because a crèche nowadays, a good crèche (…) would be an extra outlay which isn't exactly convenient right now."*
> (Int. 2, 26 years old, Assistant Radio Producer)

> *"This year, because I am really in a bit of a jam financially, and my mother saw this and so offered to help look after the baby, and I said: yes, yes, please do!!!"*
> (Int. 4, 40 years old, Civil Servant - Librarian)

DISADVANTAGES, CONSTRAINTS, TENSIONS

The disadvantages have to do with the lack of privacy. The strong dependence on support from grandmothers makes it difficult to balance the parents' need for child care and the independence and privacy they want.

It seems that, on some occasions, grandparents are a little bit "invasive". This invasion takes two forms: for some mothers (Int. 4 and 11) it is associated with different points of view on how to care for the child or how to provide care to the child when he/she is ill. For another (Int. 2), it relates to the private life of the couple (the husband complains about his mother-in-law, saying that she's invading their daily life).

> *"My mother gets in a panic because G has F on his lap. But we think G also has a right to be with F, to pull on his arm etc..."*
> (Int. 4, 40 years old, Civil Servant - Librarian)

"My mother started to interfere, like any grandmother.. and the paediatrician said straight away "It's the mother who knows best for her child"… But she continues to interfere in the children's lives..."
(Int. 11, 33 years old, Secretary)

TYPE 2: MOTHER-CENTERED + FORMAL CARE

Main characteristics:

- Formal care + mainly the mother + some occasional help from grandparents/ other informal providers.
- These mothers have flexible working hours even though they have full-time jobs (8 hours a day).
- The mothers regard themselves as the main providers of care. And strongly value their roles as mothers.
- Children spend long hours in childcare (at least 8 hours).
- Self care sometimes emerges for children over 10 (when they leave primary school and have no ATL to fill in the gaps in the school timetable).
- Very little or even no participation of fathers in caring tasks.

Sub-type 1: Supported

- With some occasional family/ informal support
- Grandparents have an active role only in occasional situations.

Couples with children: (Interviews 5,13 and 14)
Couples with children and elderly person: (Interview 8)

Sub-type 2- Isolated

- No family/ informal support
- Children's grandparents live far away from the family household.

Couples with children: (Interview 16 and 24)

STRUCTURE OF CARE ARRANGEMENTS

This type of child care arrangement is characterised by the fact that mothers see themselves as the main providers of care.

Nevertheless, those in **sub-type 1 (Supported)** are aware that the ability to reconcile their work with their family depends on the availability, on an occasional basis, of the family support provided, mainly by the grandmother.

However, this is not true for all the cases included in this type. In **sub-type 2 (Isolated)**, the fact that the grandparents live far away from the family household implies even longer hours with formal carers. The mother depends entirely on the educational institutions (crèche/school) to reconcile her working life, child care and family life.

To simplify their life these families opt to put the children in a school near their house or workplace.

As far as reconciling child care and working hours is concerned, families in this type of care arrangement do not have many problems in reconciling their own hours with those of the formal

care institutions. However, some moments of tension do exist because these mothers are full-time workers and, for some of them who work until 6 or 7 p.m., it is very difficult to deal with the schools' timetables.

Besides having full-time jobs, their husbands also have long working hours. One works until 6 p.m. but in his case it is usual to have meetings at the end of the day (Int. 5); another works until 7 or 9 p.m. and often works at weekends on his university projects (Int. 13); another works until 8 or 11 p.m. (Int. 14); another works between 9 and 6 or 7 p.m. (sometimes he has to do some extra-hours) (Int.16); and another works during the night between 4 or 6 p.m. and 4 or 5 a.m. (Int. 24).

The conciliation between career and family isn't considered as problem by these mothers. Despite the commitment and personal involvement in their work, they say that balancing work and family isn't a problem because on the one hand, they feel their families are more important than their jobs/ careers and on the other hand, they feel that their work and caring roles are complementary rather than conflicting.

> *"I believe that the two functions are complementary and this is very important. If I only had one of them I am sure I would not be carrying them out as well as I do. What I mean is, I think that a family structure with children makes me do more. On the other hand, if I were to be only with the children, I would probably get fed up of them because my work is also a way of getting away from the children. So, in a way, they complement each other perfectly."*
> (Int. 5, 32 years old, Historian/ Researcher)

> *" I do not want to lose my son's childhood because of a PhD."*
> (Int. 16, 38 years old, University teacher)

SHARING PATTERNS BETWEEN PARTNERS

Unlike what happens in the previous care arrangement, the low or even the total lack participation of fathers does not derive from the strong presence of a grandmother or the lack of confidence the mother has in her husband's care abilities. In this type of care arrangement the fathers do not take part in child care tasks on account of their working hours and, in most cases, because they are not willing to do so.

> *" Last weekend he (the husband) was at home but we two were always alone (...) he didn't help at all."*
> (Int. 13, 37 years old, Civil Servant - works in the National Library)

> *"I'm the one who takes care of M. His father has never bothered. I'm always the one who has to do everything because he just doesn't do a thing. So I end up doing it all."*
> (Int. 14, 45 years old, Secretary in a Hospital)

Two of these mothers stated that even when they have to work at weekends, or go abroad to work, their husbands leave the children with their mother-in-law all weekend.

> *"Even when I have to go away, for work reasons, instead of staying with the kid he,…she goes to my mother's (…) because he is incapable of looking after her."*
> (Int. 13, 37 years old, Civil Servant - works in the National Library)

As in child care tasks, these fathers do not take part in household tasks. There was only one who sometimes did so; however, he does this more frequently at weekends.

> *"We're out of butter, the shopping needs to be done, and there's a precious little sod (husband) there at home who isn't with us, he doesn't do a thing!"*
> (Int. 13, 37 years old, Civil Servant - works in the National Library)

> *"That's how it is, everything to do with the house is my department (…) I do the shopping. He looks at the fruit basket and says "Look, there aren't any apples! You've got to buy some apples!" Father is a bit old-fashioned… he doesn't lift a finger at home."*
> (Int. 14, 45 years old, Secretary in a Hospital)

> *"I don't like ironing, he's the one who does the ironing. He hoovers. I do everything else (…) He does do some shopping… but not always.. more at the weekend."*
> (Int. 5, 32 years old, Historian/ Researcher)

ATTITUDES, VALUES, PERCEPTIONS

In relation to the father's participation in child care, mothers feel that it would be very important for the fathers to be with the child and to take part in child care.

> *"(I'd like my husband to spend more time with the kids) That's important. The kids need a lot of time (..) especially at weekends (…) their father has to give them time. It's that type of time I'd like my husband to give them more of."*
> (Int. 5, 32 years old, Historian/ Researcher)

> *"(...) Yesterday I noticed that in the Estrela gardens there were a lot of couples with children, and it really stuck in my mind because I really didn't feel like being there on my own .. I feel he could be more involved, it's important for her."*
> (Int. 13, 37 years old, Civil Servant - works in the National Library)

With this feeling of a major need for the child to be with the father comes the concern with about the relationship between father and child, and they complain about the lack of intimacy between them.

> *"That need I feel to spend as much time with her as I can (…) he doesn' t seem to feel the same way , and I find that a bit shocking sometimes, just a little bit, it makes me feel uneasy."*
> (Int. 13, 37 years old, Civil Servant - works in the National Library)

> *"I feel he could be more involved, pay more attention, do more things with her."*
> (Int. 14, 45 years old, Secretary in a Hospital)

DISADVANTAGES, CONSTRAINTS, TENSIONS

In this type of child care arrangement, the father's non-participation in child care tasks means that these mothers have to make a much greater effort. They often complain about the situation and, in most cases, they go through periods of stress and tiredness.

> *"It's the physical tiredness, because I'm the one who fetches her from school, I haven't got a car so I go to fetch her on foot, I take her..."*
> (Int. 13, 37 years old, Civil Servant - works in the National Library)

Because of this constant pressure and the fact that the father does not help with care and domestic tasks, these mothers say that they have no time for their own privacy as persons and as women.

> *"In the little day-to-day practical things, because I have to take her, I work a full day, I have no lunch hour any more … then I have to go and fetch her, and sometimes I need the time, you know, even if it's just to go and have my legs waxed"*
> (Int. 13, 37 years old, Civil Servant - works in the National Library)

> *"I don't go to the cinema any more! That, for me, is serious! (.. I was a cinephile. It was very important to me.. If he (the husband) did it (stayed with the children) on one of the days of the weekend (…) that would be important for me too… but as he won't, then I'm the one who has to."*
> (Int. 5, 32 years old, Historian/ Researcher)

These mothers feel very unsatisfied with their husband's non-participation in child care tasks.

> *"I'd like him to do more (…) he doesn't give up any of the things he likes doing in order to do something which the kids enjoy doing."*
> (Int. 5, 32 years old, Historian/ Researcher)

> *"The point is, I've got used to it just being me. And I think it gets to me more and more (the lack of help with looking after the children), on the one hand because I am tired, and on the other hand because actually I don't think there is any real sharing at all."*
> (Int. 13, 37 years old, Civil Servant - works in the National Library)

TYPE 3: SHARED PARENTAL CARE + FORMAL CARE

Main characteristics:

- Formal + parents + informal (very rarely)+ grandparents (sometimes or in school vacations).
- Based on conjugal care with daily shared tasks.
- Although working long and atypical hours, fathers share in the domestic and caring tasks.
- Fathers "easily substitute mothers" in every task.
- Children spend long hours in formal childcare.
- Self care sometimes arises for children over 10 (when they leave primary school and have no ATL to fill the gaps in school timetable).
- May have flexible or inflexible working hours. This makes a difference.

Couples with children: (Interviews 15, 18 and 19)
Couples with children and elderly person: (Interview 1)

STRUCTURE OF CARE ARRANGEMENTS

In this type of child care arrangement there is strong participation by the children's fathers. Parents share all the domestic and caring tasks. Besides feeling they can rely on their husbands to provide all kinds of childcare, mothers say that they also really do help in domestic tasks. The care arrangement is shared and depends strongly on the way parents manage to mutually adjust their hours in order to ensure that childcare is provided. For example, in Int. 19, the father always leaves the child at school, the mother only leaves the child at school when her husband has the morning shift. At the end of the day, when the father is at home, he receives the child and stays with her, and while he's with the child the mother goes shopping or does something else.

However, even with this strong participation by husbands, the children spend long hours in formal care. This happens because both parents have long working hours.

To simplify their life these families opt to put the children in a school near their house or workplace. With this strategy they believe they are protecting the children from spending too many hours per day in public transport and in formal care.

As far as reconciling working hours and child care is concerned, some parents, in particular those without flexible hours, have a difficult time combining their work with the school /ATL timetable. The mothers work in full-time jobs and some of the families live far away from their workplace. The fathers have full-time jobs with long hours. They may have irregular hours. One father works 8 hours per day but he is a managing director what makes him work longer hours (Int.15); another works in shifts and may work at weekends and at night (Int. 19); another does not have regular hours because he is a driver in the Ministry of Justice and he stops working when he is no longer needed. Combined with this he may work at night or at weekends (Int. 18). Due to these timetabling constraints, these couples have to work out their care arrangements carefully on a day-to-day basis.

Finally, by contrast, those with flexible hours find it easier to combine child care and work. For example, in Int. 1 (where the husband is self-employed and the wife a researcher), both parents can adjust their hours to caring if necessary.

Reconciling careers is not a problem for these families. For different reasons, they are all able to reconcile both the mother's and the father's professional careers: in Interviews 18 and 19 this concern does not seem to be present because these mothers, despite their commitment to work, do not have highly demanding careers, so this problem does not even arise in terms of career commitment; in Interview 15, despite her commitment and personal involvement in her career (University teacher, husband is an engineer and managing director), this concern does not arise because the mother has flexible hours and is also less involved in her work/career than her husband is (she does not place her commitment to work above her commitment to child care). As a result, she is more readily available than her husband.

> *"I don't take work home with me, not even at weekends (…) I am not a workaholic, not at all (…) I never put my profession in front, because for me it is not the most important thing."*
> (Int. 15, 35 years old, Assistant in an University)

SHARING PATTERNS BETWEEN PARTNERS

In the Shared Parental Care arrangement fathers play a very important role in both domestic and caring tasks. Parents share many daily tasks and try to help each other.

> *"The girls were small and he was always very good at giving them their bath, he was good at feeding them, took them for walks, took them to the beach."*
> (Int. 18, 45 years old, Civil Servant - administrative worker)

> *"He is a good friend to me, he helps me a lot. At home he often does the washing-up, often does the hovering, does a lot of washing-up for me."*
> (Int. 18, 45 years old, Civil Servant - administrative worker)

> *"He helps me a lot (…) he does everything, cleans the house, dusts. Perfect. If I leave the washing machine on he'll hang the clothes out to dry… He even said to me once: Look I'm sorry I don't know how to iron so I could help you.."*
> (Int. 19, 33 years old, Medical Assistant)

ATTITUDES, VALUES, PERCEPTIONS

These mothers feel that it is very important for the child to have a father who takes part in domestic and caring tasks. They state that the child feels happy to see both parents helping each other and making things work.

> *"It's very important for him to see that we help each other, that we get on".*
> (Int. 19, 33 years old)

Fathers "easily substitute mothers" in all tasks related to the home or child care.

> *"Yes…everything he does is well done… like a woman..."*
> (Int. 19, 33 years old, Medical Assistant)

"If I go out (at night), he stays at home with the kid and looks after her. And I tell you, he is much more of a perfectionist doing things around the house than I am."
(Int. 18, 45 years old, Civil Servant- administrative worker)

ADVANTAGES

The advantage of this care arrangement is the fact that there are no problems as far as non-participation by the father in both caring and domestic tasks is concerned. These mothers say that they are very happy with their husband's support.

"Yes, he helps a great deal, I never thought it possible. Perfect."
(Int. 19, 33 years old, Medical Assistant)

Another thing pointed out as an advantage is the fact that the mothers feel they are less stressed with the care arrangement or the household tasks because their husbands help a lot in every way. However, this does not mean that they are not stressed with the situation of living away from work and with the tiredness this condition brings.

"I get home very tired. I have to leave home very early and then I get so tired and I've still got to give the kid her bath and make dinner … Even with his help..."
(Int. 19, 33 years old, Medical Assistant)

DISADVANTAGES, CONSTRAINTS, TENSIONS

One of the main tensions in some of these families is the time they spend getting to work. Some mothers feel very stressed and tired. They want to rest a bit when they get home, but this is impossible because they have a lot of things to do.

"By the time I get to bed I'm flat out. It's tow hours there and back, plus the whole working day … and I still have to make supper..."
(Int. 19, 33 years old, Medical Assistant)

"Sometimes I am just so tired .. it's so tiring..."
(Int. 18, 45 years old, Civil Servant - administrative worker)

The other main tension reported by these mothers and related to the need for time to rest on getting home, was the lack of time to be with the children and the feeling of guilt that comes with this.

"I end up feeling very guilty because I don't spend much time with them, and the little time I do have with them I'm always getting cross with them because I want them to hurry up... and because I want to get things done myself... so I can have a bit of a rest..."
(Int. 15, 35 years old, University teacher)

The same applies to the lack of time for being with their partner.

> *"That's the big problem. Having time for the couple, because we don't have the time (…) Both P and I miss the nights out, I miss them."*
> (Int. 15, 35 years old, University teacher)

Two families (Ints. 18 and 19) mentioned that they had to put their children into private schools because there are no state schools which keep the children occupied all day long until their parents get home from work. They said that there are no state child care institutions for children over 10 years old in their residence area.

> *"I had to put my daughter into a private school because there was nothing close by and the other schools do not look after the children for the whole day ."*
> (Int. 19, 33 years old, Medical Assistant)

TYPE 4: VARIED ARRANGEMENT

Main characteristics:

Sub-type 1: Varied Rich

- " All day domestic employee" + Formal support + extra-occupational activities + informal providers (most week days).
- Strongly centered on paid informal services at home.
- Both parents have demanding full-time jobs (they work very long hours) and are strongly committed to their careers.
- Care is strongly delegated and both parents have a low level of participation in the daily care arrangements.
- Mothers tend to be the main "organisers" of care arrangements.
- High income families.

Couples with children: (Interviews 10, 20, 21 and 22)
Couples with children and elderly person: (Interview 7)

Sub-type 2: Varied Restricted

- Paid informal services + family + at work with women.
- Mothers prefer "informal" care to formal care.
- Many gaps in informal care (the unpaid): uncertain and not always reliable.
- Children often "loosely supervised" by women carers who are working.
- Children's father has a low level of participation in caring and domestic tasks.
- Average income families.

Couples with children: (Interview 17)

STRUCTURE OF CARE ARRANGEMENTS

In **sub-type 1 (varied rich)** the care arrangement is very diverse. There are many providers, who may be formal or informal. The main characteristic in this sub-type is the fact that the children spend a great deal of time with the domestic help (who works between 6 and 9 hours a day).

These mothers feel that the presence of a housekeeper is very important because on the one hand it ensures permanent help with the cleaning of the house; on the other hand, it is very helpful in the context of child care and, at the same time, the children remain in their own environment.

In **sub-type 2 (varied restricted)** the care arrangement is constituted by a large diversity of informal providers. However, in this varied restricted pattern, it is not the number of providers that really counts but the issue of whether they are available and reliable. The mother (a hairdresser) leaves the child with an unlicensed nanny just next door to the hairdressing salon. However, when the nanny has to go out, she leaves the child with the mother. On Saturdays the child stays with her grandmother (who has a restaurant) during part of the day, or with her aunt or paternal grandmother

or, if necessary, goes to work with the mother. In this case there are many gaps in informal care which must be filled in by the mother while she is working.

These mothers have full-time jobs with very long hours. They have a strong commitment to their profession and in some cases (Int. 20 and 17) they have more than one professional occupation. One mother works 8 hours per day and usually has work meetings after hours (Int. 10 - Bank Clerk); another (Int. 20-paediatrician) works around 5 hours in the public sector and 2 hours in the private sector. On one day a week she works 24 hours, and once a month she has to work all weekend; and the other (Int. 17-hairdresser) works 8 hours per day, works on Saturdays (all day) and works in other job during the week for more or less 2 hours per day, on Saturday nights and all day Sundays; another works about 8 hours per day and works at home (Int. 21); and another works about 12 hours per day (Int. 22)

Their husbands have the same kind of working hours and have the same kind of career commitments. One works 8 hours a day, but usually has work meetings (Int. 10); another has more or less the same working hours (Int. 20); another works 8 hours a day and sometimes has to travel all over the country (Int. 17); another works long hours and he frequently goes abroad (Int. 21); and the last one works 12 hours per day (Int. 22).

The conciliation between career and the family, in **sub-type 1(varied rich)**, as in the previous types of care arrangement, isn't a problem. As in other types, despite the commitment and personal involvement in work, most of these mothers (except for the paediatrician) put their families first:

> *"I certainly wouldn't exchange a PhD for the children I have! All my schedule is organised around my family life but my husband's schedule is not. His schedule is organised around his professional life, and therefore…I think that the mother has a fundamental role and as I believe this I am not capable of saying: I'm going now, you stay with them…"*
> (Int. 21, 44 years old, University Teacher)

SHARING PATTERNS BETWEEN PARTNERS

In **sub-type 1 (varied rich)**, household tasks and caring are strongly delegated during the week. It is only during weekends that parents share some caring and household tasks.

> *(...) that happens more at weekends, because during the week I have my maid here and she does everything. But when we have to share the caring tasks, he does them."*
> (Int. 10, 33 years old, Bank Clerk- Client Account Manager)

> *"My husband can only help out at weekends. He has less time available."*
> (Int. 20, 41 years old, Paediatric Surgeon)

In **sub-type 2 (varied restricted)** the father does not play a very large part in child care tasks. He leaves and picks up the child at his mother's home, at weekends, and during the week, when the mother has to work at night, he stays with the child after dinner until she falls asleep.

"When there are dinners (in the mother's restaurant) I stay there, V goes home with the little girl (…) On Sundays I go to work there and my daughter goes to her paternal grandmother's house.. while her father stays at home..."
(Int. 17, 26 years old, Hairdresser)

Fathers' participation in child care arrangements is related to their participation in domestic tasks. What we mean by this is that fathers who take part in caring tasks usually take part in domestic tasks; fathers who do not take part in childcare tasks do not usually take part in domestic tasks.

"My husband does the laundry – in so far as he puts it in the machine – (…) he tidies up the children's room (…) everything is divided. It happens more at weekends."
(Int. 10, 33 years old, Bank Clerk- Client Account Manager)

"I have to do the housework because he doesn't help, I have to do all the laundry because he doesn't do any washing, and I have to do the ironing because he doesn't…"
(Int. 17, 26 years old, Hairdresser)

ATTITUDES, VALUES, PERCEPTIONS

Because of their commitment to work and the their long working hours all these mothers feel bad about the lack of time they have to spend with the children.

"I feel guilty. There are times when I suffer on my daughter's account. I would like to have more time to spend with her, I'd like to have more time for myself."
(Int. 17, 26 years old, Hairdresser)

"I have a permanent guilty conscience because I am never with them."
(Int. 20, 41 years old, Paediatric Surgeon)

Because of this strong sense of guilt, these mothers feel they have to make up to their children for all the time they spend without their parents by staying with them at the end of the day.

"When I get home the only thing I do is stay with them , it's important for them and for me, then the older children go to bed and I stay with the baby and with the father (...)."
(Int. 10, 33 years old, Bank Clerk - Client Account Manager)

To illustrate this concern, **sub-type 1 (varied rich)** mothers even said that sometimes they prefer the children to go to sleep later than going to bed without being with them.

"I prefer them to lose some sleep so that we can have some time to be with them."
(Int. 20, 41 years old, Paediatric Surgeon)

Besides this strong concern with the need to be with the child, all these mothers state that it is equally important that they have some time for themselves.

"(...) I stopped being a wife (woman) and became a mother (…) I need my own time and my own space and peace and quiet. I miss being on my own, reading, having time to myself…"
(Int. 17, 26 years old, Hairdresser)

"I also need some space for myself."
(Int. 20, 41 years old, Paediatric Surgeon)

ADVANTAGES

In **sub-type 1 (varied rich)** the care arrangement is almost totally delegated and is very stable/ reliable, allowing both parents to commit to their careers.

The advantages of the care arrangement in **sub-type 2 (varied restricted)** is that the mother feels that having the child with a nanny who lives next door to her workplace and staying with the child for some moments of the day makes her feel that she is more aware of the child's needs.

"(…) I think it's better that she's near me, that I'm near her, I know she's with people I can trust, that she is being properly fed because I'm the one who brings her food and I see what she eats..."
(Int. 17, 26 years old, Hairdresser)

DISADVANTAGES, CONSTRAINTS, TENSIONS

In **sub-type 1 (varied rich)** the disadvantage is that parents spend little time with their children.

In **sub-type 2 (varied restricted)** the fact that the care arrangement is not very reliable is one major disadvantage. This family depends, to a large extent, on the unpredictable availability of informal providers. And, in fact, to fill in the gaps, the mother has to care for the child while working:

"There are times when the nanny can't stay with her (my daughter) and then I have to have her at the hairdresser's (..) but it's stressful because she touches all the bottles and sometimes the products are toxic (…) It gets on my nerves because she crawls all over the floor and gets full of hair..."
(Int. 17, 26 years old, Hairdresser)

These mothers feel very tired. One of them (Int. 17, 26 years old) says it is very difficult for her to wake up early every day because she is always very tired and does not get enough sleep.

"I feel very tired, really very tired.
(Int. 17, 26 years old, Hairdresser)

"You go around feeling very tired… there are some days I'm really, really tired."
(Int. 20, 41 years old, Paediatric Surgeon)

1.3. Resources / Constraints

Our analysis of the data enabled us to identify several types of resources and constraints which in varying degrees affect the way in which the provision of daily child care is organised. Amongst them are **occupational** and **financial** resources and constraints, as well as those related to informal and formal **support networks**.

1.3.1. Occupational Resources/Constraints

The occupational resources/constraints which may affect the ability of dual career families to reconcile their working hours with child care are the **number of hours** they have to work, the **type of working hours** (whether typical or atypical, flexible or not flexible) and the **high commitment to work**. This strong involvement in professional life applies not only to highly qualified persons (doctors, engineers, etc) but also to couples who have lower qualifications (hairdressers, taxi-drivers, etc).

Number of hours of work

In overall terms these couples work on average 38 hours per week, equivalent to more than 7 hours per day. In most cases the hours of work are from 9 a.m. to 6 or 7 p.m. In some couples, both work an average of 7 to 8 hours per day, in others, fathers work longer hours.

The number of working hours is a significant variable, to the extent that it may or may not allow parents to reconcile their working hours with the opening hours of crèches/schools. The only families who can manage to fit in work and childcare without difficulty are those who fall into the "strong family support" and "varied rich arrangement" categories. The reasons are, on the one hand, the fact that some of them, even working in full-time jobs, have the grandmother's strong presence in care and sometimes in the household (strong family support).

"My mother comes to fetch him from the house, he stays with my mother , I go to the radio station to work until 5, and then when I get home I fetch him from my parents' house (…) sometimes he also sleeps over at my parents'."
(Int. 2, 26 years old, Assistant Radio Producer)

On the other hand, in the varied rich arrangement care is extensively delegated to all-day domestic employees, formal and informal support and extra-occupational activities.

"I had to employ a babysitter (between 6 p.m. and 8 p.m.). *My maid is excellent, but she is human after all (...) She starts at 9 a.m. and leaves at 6 p.m. I prefer her to look after the kids rather than do the dusting, the laundry or whatever."*
(Int. 10, 33 years old, Bank Clerk - Client Account Manager)

The remaining families are aware that reconciling work and family may be more difficult and is strongly dependent on the daily organisation and negotiation of care arrangements. For example, in "shared parental care", couples have to reconcile their working hours to see who has the greater availability. In the "varied restricted arrangement" unpaid informal support is sometimes available but not always reliable. Finally in the "mother centered + formal care" arrangement, everything depends on the mother, a situation which creates a certain strain.

In sum, the child care arrangements and the ability to reconcile work and family does not depend on the number of working hours, given that all these parents work in full-time jobs, but on the availability of formal and informal providers.

Type of working hours

As far as the type of working hours is concerned, some mothers and fathers have atypical working hours (e.g. they work long or irregular hours, or they work in shifts), which may also involve working at weekends (or at least on Saturday mornings). However, as we mentioned above, the working hours are not a significant variable in the way child care arrangements are structured, given that we have found parents in that situation in all models.

In the same way, with regard to the **regularity** of working hours, having regular hours does not seem to be a critical variable in the way child care arrangements are organised. In "strong family support with formal care", "mother centered + formal care" and "shared parental care" care arrangements, the regularity of the hours is not sufficient to make working hours compatible with school opening hours. They all have to combine **formal care with other kinds of providers such as grandmothers and other informal providers.** Only the "mother- centered + formal care" couples rely somewhat more on the regularity of mothers' hours (especially the time at which they leave work).

"If the Director did not let her stay on in the crèche, I don't know how things would be … I'd have to make some other arrangement... (...) I don't leave work very late, I have regular hours … but I don't know (…) even so , sometimes I have to ask my friend to help out, bless her..."
(Int. 18, 45 years old, Civil Servant- administrative worker, shared care arrangement)

We found that some families did have **flexible working hours**. The "strong family support with formal care" and the "mother centered + formal care" care arrangements are examples of families which have some degree of flexibility in their working hours, but even so they are unable to do without the occasional support they receive throughout the week.

"They are flexible (the working hours)… Of course there is always.. my mother has always stayed with them, it's just that this year things became complicated for her (…) I won't leave my daughters alone in the house."
(Int. 11, 33 years old, Secretary)

1.3.2. Financial Resources/Constraints

Financial resources/constraints are significant in terms of how these families live. Amongst other things, the amount of such resources determines whether they are able to own their home, and whether they are able to afford **paid services** (formal or informal), both in the area of child care arrangements and in the area of domestic services (e.g. cleaning and laundry services).

Our analysis of the interviews showed that family income, to some extent, influences the way child care arrangements are organised. High income families can afford to buy multiple formal and informal paid services (including private schools as well as paid domestic help and a variety of after-school activities for children). Average and lower income families have more difficulty in accessing all these types of paid services.

However, in some care arrangements we may find families with different income levels. This happens in the "shared parental care" arrangement where there are two low-income and one high-income family. Both buy in private formal services for children because they offer longer caring hours. However, this creates severe financial problems for low-income families and no financial problems at all for the high income family.

Average/low-income families are found in the "shared parental care" (Int. 18 and 19), in the "varied restricted" and in "mother-centered + formal care" arrangements. The families which fall into these types are those which have the greatest practical problems in reconciling their working lives with child care arrangements. Most of these problems derive, in particular cases, from the degree of access to paid forms of formal and informal support. For example, in order to fill in gaps in the school timetable, some of these couples cannot afford to pay a regular babysitter or a maid.

Most of the **high income families** fall into the "multiple varied rich" model. These families do not have practical problems in reconciling their working lives and child care arrangements. They combine an availability of financial resources with the availability of both formal and informal support in providing those arrangements. Parents are able to afford paid services (formal and informal), which is reflected in a wider range of possible solutions.

"There are a series of alternative mechanisms to make things work (...) We've managed to make things work and there is always some alternative available."
(Int. 10, 33 years old, Bank Clerk - Client Account Manager)

In **other cases** it is not so much the resources/constraints of a financial nature which affect the way daily child care arrangements are structured, but rather the parents' preferences in relation to the various types of possible solutions (formal or informal) and their availability. For example, some average income families clearly prefer to leave their children with family members rather than in paid services, because they think this is best for the child.

1.3.3. Support Network Resources/Constraints

Once parents have felt the need for support (whether formal and/or informal), there follows a phase in which they must find out if those forms of support exist, and to what extent they are available. Availability of formal and informal support, both public and private, ranges from unrestricted availability, to severely restricted availability, or to complete non-availability.

Family Support

A number of factors may affect the availability or non-availability of family support: the relation between parents and the rest of the family; the fact that they may be working, the distance between the family and their own home; the health of potential family providers; or even the fact that the potentially available family providers may no longer be alive.

Some family support is available in nearly all families[*]. However this availability and permanence varies between care arrangements: some have strong levels of involvement by grandmothers in daily child care ("strong family support"); some other families have occasional help from grandparents, ("mother centered + formal care" and "varied arrangement"); others have grandparents sometimes available during school vacations ("shared parental care").

Informal Support

However, these types of models do not derive just from the degree of availability of family support but from the existence or non-existence of other types of informal providers and the way the family establishes the combination of care arrangements between them. These informal providers may or may not be paid.

In our sample, focusing on the **degree of participation** of informal providers, we have found two types of participation. In "shared parental care" there is a very rare instance of participation by informal providers. This participation is occasional and arises when there is no one to take care of the child; and in "varied arrangements", the informal providers take part in the care arrangement on most weekdays.

In relation to the **diversity and nature of informal providers** we have found a number of different situations. In "shared parental care" informal providers, apart from appearing very rarely as providers, are few and unpaid; in "varied arrangements", the "varied rich arrangement" has a large diversity of informal providers, usually paid (all-day domestic help, babysitters), and in the "varied restricted arrangement" the informal providers are almost always present in large numbers but they are uncertain, not always reliable and most of them are unpaid (the only one who is paid is the nanny).

Formal support

The extent to which (both public and private) **formal support** is available is related to the quantity and diversity of supply of institutions and services for children. For example, if the public sector primary schools do not occupy the full day from 8 a.m. until 6 or 7 p.m. (this is still the case in many schools), these families will have to seek out private schools (profit or non-profit)/leisure time centres) in order to fill the gaps in the care arrangements.

There are therefore a number of variables which come into play in the area of formal support: the quantity and diversity of services and facilities, their hours of operation and whether they are in the public or private sectors (profit-making or non-profit making). The nature of the supply of formal services is defined by the combination of these variables, and is an integral part of the set of constraints which affect the way daily child care is structured.

[*] Two families have no family support whatsoever. In one of the cases ("shared parental care"), the grandparents have died or live far away. In the other case ("mother-centered care arrangement"), grandparents on both sides live very far away.

1.4. Unsatisfied needs

1.4.1. Unsatisfied needs/tensions

In overall terms the main unsatisfied needs, in descending order according to how often they were mentioned, are as follows:

- the **need to spend more time with the child**;
- the **need to rest**; the need of **time to be alone** and **to do "women's things"**;
- the **need** for **fathers' participation in domestic and caring tasks**;
- the **need for greater practical support** from state educational institutions.
- The need to **reconcile both parents' careers**

Spending more time with the child

Most families mentioned this issue as being one of their most unsatisfied needs. They feel they spend very little time with their children. Many of them state that this happens because, at the end of the day, they are too tired to have *"quality time"* with their children .

"I would like to have more time to spend with her, I myself would like to have more time for her."
(Int. 17, 26 years old, Hairdresser)

"I find it hard, not spending a lot of time with them."
(Int. 22, 41 years old, Paediatric Surgeon)

Having time to rest and to do "women's things"

The respondents often say *"I need to rest"*. They feel it is very tiring for them to balance childcare and their professional and domestic tasks. They often complain about some of the stressful periods of the day and about the lack of time to be on their own.

"I miss being alone, of having time for myself, space."
(Int. 17, 26 years old, Hairdresser)

"Sometimes I am short of time, for the little things, practical day-to-day things."
(Int. 13, 37 years old, Civil Servant, works in the National Library)

Having time for the couple

One of the things less explicitly stated by these families, but implicitly present, was the lack of time to be with their partners. In most interviews there is an explicit feeling of guilt for being too occupied to have "quality time" with the children. However, concern with being "too busy to be with the partner" also appears:

"(…) That for me was the worst part. Apart from time for him, I ceased to be a wife (woman) and became a mother."

"We have no time for ourselves any more, no space."
(Int. 17, 26 years old, Hairdresser)

Father's involvement in caring tasks

Related with the sharing patterns between partners we found the need for greater involvement on the part of fathers in the caring tasks. This need finds expression in three different caring types: the "strong family support", the "mother centered + formal care" and the "varied restricted arrangement." Although the reasons for this need are different in each type, all these families feel that fathers do not take part regularly and intensively in child care tasks, and that this situation may bring out many relational problems between father and child.

"The children need some time, a lot of time, particularly at weekends they have no alternative but to be with their parents, so parents must give them time. It's that time which I would like my husband to give more of."
(Int. 5, 33 years old, Historian/ Researcher)

Father's involvement in domestic tasks

Unlike what happens in the previous scenario, the need for the fathers' participation in domestic tasks does not appear to be a serious problem. However, in some types, this kind of help is more permanent and necessary. In the "mother-centered + formal care" and in "varied restricted arrangement" this need seems to be more frequent, a little bit more than the others, because these respondents stated more often that they feel very overburdened by domestic and caring tasks.

"Generally he does not do any (of the chores), and we do have a few little problems because of this."
(Int. 14, 45 years old, Secretary)

In "varied rich arrangement" this kind of problem does not arise, because the household tasks, like caring tasks, are strongly delegated during the week.

Tensions between partners

In some interviews we felt that there were some moments of tension between partners. It seems to us that these moments are frequently related to a low level of participation in domestic or caring tasks.

"(…) he is incapable of looking after her and this on top of everything else weighs me down in the end (…) I notice that in the Estrela gardens there were a lot of couples with children , and it affected me a great deal because I really didn't want to be there on my own (…) but I have him there and it must be for a reason, otherwise I wouldn't have him, would I?"
(Int. 13, 37 years old, Civil Servant, works in the National Library)

"Well for a start we begin to talk to each other in a different way, we start shouting at each other, not him so much, but I do, I think it was more me because … you know, it's despair or tiredness maybe … It's the ironing, turning the washing machine on , hanging the laundry out, cleaning the house, and goodness knows what else, and I'm the one who has to do everything (…) I think you start to lose control, then one day you say one thing and the next day you say the opposite..."
(Int. 17, 26 years old, Hairdresser)

Reconciling both parents careers

Regarding the need to reconcile both parents' careers, we found two different scenarios. **In families with children** it is possible to reconcile careers, but there is usually some inequality between the partners. In these families mothers often have a lower involvement in their work/career than their husbands.

"I don't take work home with me, not even at weekends (...)I never put my job first, because it is not the most important thing for me."
(Int. 27, 35 years old, University Teacher)

In other cases, the commitment may be similar (for example, in the couple where both are medical doctors) but it is the mother who is the child care organiser; the father is totally absent from childcare problems or organisation.

In couples which have children and an elderly person care arrangements are more difficult to maintain and to organise. Parents have a lower investment in their careers and, in some cases, they even have to set aside their commitment to a career.

"It has been very tiring and it has affected my work a lot, and P's work. We get home and it's all work, and then you can't make that extra effort in work itself, in your career…it was lucky that P. was self-employed, he has flexible hours, of course he has to meet clients in the office but then he can work at home at night and at weekends. Even so, it's very hard."
(Int. 1 , 37 years old, Researcher, living with her husband, 3 children, a dependent elderly person and a disabled person)

More support from state educational institutions

This type of unsatisfied need is mostly expressed by some mothers of the "shared parental care" model types. This type is the one in which some families stated that they do not have sufficient state educational institutions with long school hours (crèches/schools) in their area.

However, while the "strong family support with formal care" and "varied rich arrangement" types receive, in addition to the support provided by educational institutions, support from their families and an extensive group of multiple providers, those in the previous type (shared parental care) face restrictions of varying degrees in the availability of formal and informal support to complement the care provided by the crèche/school. They have to spend much of their income on a private school with long opening hours. It is accordingly mainly these last families ("shared parental care") who express the need for greater practical support from state educational institutions.

1.5. Conclusion

Bearing in mind the suggested analytical framework we reached the following general conclusions:

- Three main factors differentiate between the **types of models for the provision of day child care** which we identified: the structure of the support network (size, who are the main providers, etc.), the sharing patterns between partners and the families' values and perceptions concerning child care. The types found were: the **"Strong family support"** with 2 sub-types, "strong family support without formal care" and "strong family support with formal care; the **"Mother centered + formal care**" with 2 sub-types, "Supported" and "Isolated"; the "**Shared parental care"** and finally, the **"Varied arrangement"**, with 2 sub-types, "varied rich" and "varied restricted".

- The models containing the **most vulnerable care arrangements** are the "shared parental care"; the "mother centered + formal care- isolated"; and the "varied restricted arrangement" models. These families are more vulnerable to unforeseen events, such as the case where care providers become, for some reason, temporarily or permanently unavailable. They also have the greatest problems in reconciling work and care. **At the opposite end of the spectrum** are mothers in the "strong family support" and in the "varied rich arrangement" model types. They have a large diversity of providers who may be formal or informal. These types of care arrangements are less vulnerable to unforeseen events.

- The way daily child care arrangements are organised also depends on the equilibrium between families' available **resources** and the **constraints** they face. The way child care arrangements are organised is mainly affected by the combination of financial resources/constraints and the availability and reliability of the different types of practical support (formal or informal). Families who cannot afford to buy multiple formal and informal paid services (including private schools as well as paid domestic help and a variety of after-school activities for children), have the greatest problems in reconciling their working lives with child care arrangements.

- Families mention several problems or unsatisfied needs. The **need for more time with the children** is found in all families, without exception. The **need to rest, to be alone and to do "women's things"** is another unsatisfied need which is found in all families. The **need for the child's father's involvement in caring tasks** is found in all care arrangements except in the "shared parental care" arrangement. However, it is important to say that the low level of participation or even non-participation of fathers is conditioned by different kinds of factors: the lack of confidence the mother has in his child care skills; the grandmothers' strong presence in care and sometimes in the household; the father's working hours; the extensive delegation of tasks, during the week, to the domestic help and the lack of willingness to take part. The **need for the father's involvement in domestic tasks** is more permanent and necessary in some types: the "mother-centered + formal care" and in "varied restricted arrangement". **The need for more practical support from state**

educational institutions arises basically in those models where formal and informal support is not so readily available. It appears in some families of the "shared parental care" and in the "mother centered + formal care, isolated" sub-model where, faced with the restrictions on the availability of informal support, the care arrangement is maintained only between the mother and formal care. **The need to reconcile both careers** appears not only in families with children but also in families which have children and an elderly person to care for. In the first case (families with children) there are families where reconciling both parents' careers is possible, but usually with some inequality between the partners, and there are other cases where the commitment may be similar but it is the mother who is the child care organiser. In the second case (families with children and an elderly person) parents have a lower investment in their careers than other families and, in some cases, they even have to set aside their commitment to a career.

2. Elder Care Arrangements

2.1. Introduction

The typology was constructed on the basis of 2 main criteria: **the type of care needs** ("heavy" care needs in the case of highly dependent elderly persons, or "light" care needs, such as keeping an eye on or cooking for the elderly person, in the case of low dependency), and **the type of care sharing patterns** between family members (who, in the family, provides care) and between family and paid services (paid services may be occasional or extensive).

The data we collected enables us to distinguish **two main types** of care arrangements: family care arrangements and mixed care arrangements.

Under family care arrangements the provision of care is centred on the dependent person's family and, more precisely, on his/her close relatives (sons/daughters, spouses…). Within this type there are 2 sub-types: the first is characterised by family support for heavy care needs ("hands-on" family care) and the second by family support for "light" care needs ("watching over" family care). The provision of care may be shared between two or more members of the family (i.e. by the couple or by one member of the couple and the spouse of the elderly person) or may be taken on by only one person (this is what we have called "single-handed" family care).

Mixed care arrangements are characterised by a combination of family care and other types of care providers (informal or formal). We found 4 sub-types of mixed care arrangements: the "day care" solution, "hands-on" extensive home-based care, the "organiser" solution and, finally, "watching over" mixed care. Within the second sub-type there are two different ways of combining family care with "hands-on" home-based paid services. In the first case, provision of care is shared between family members, including a member of the household (often the spouse of the elderly person) who keeps an eye on the elderly person during the day. Part-time paid services come in to help with housework, cooking and personal hygiene. In the second case, provision of care is also shared between family members, but they have the support of permanent and full-time paid services.

2.2. Typology of Elder care Arrangements

TYPE I: FAMILY CARE ARRANGEMENTS

SUB-TYPE I-A: "HANDS-ON" FAMILY CARE

I-A.1. Shared "hands-on" family care

(son/daughter + other household family members)

- 1 family included (interview number 1)

«No, no, there are no specific tasks (tasks carried out only by the interviewee and other tasks carried out only by the interviewee's spouse), but there is some division. Sometimes it might be me, I'm the one who changes her nappy (referring to mother-in-law), for reasons of modesty. And he might be the one who feeds her, because I don't have much patience for that (…). »

(Interview 1, married, aged 37, with 3 dependent children, daughter-in-law of the dependent adult person, living with the latter)

BRIEF EXAMPLE OF THE CASE THAT FALLS INTO THIS SUB-TYPE (A TYPICAL WEEKDAY)

During the week, after leaving the respondent at work and the children at school, the respondent's husband returns home to administer insulin and give his mother breakfast. Then he cleans and changes his mother's nappy. After this, he goes to work and the mother stays alone at home with her nephew (48 years old, partially handicapped), who lives with them. The latter keeps an eye on his aunt while the other family members are not at home. At lunch time the respondent's husband returns home and gives his mother lunch. At teatime it is the respondent's oldest child or the respondent's godmother who gives her tea. At the end of the day, it is the respondent's husband who gives her dinner, and the respondent deals with her mother-in-law's hygiene.

DESCRIPTION AND EXPLANATION OF THE SUB-TYPE

In this sub-type of care arrangement all care (except medical care) is totally provided by family members in the household, even during weekends, on holidays and in occasional situations. It is a household solution, because all the care providers are members of the household where the dependent elderly person lives.

The latter lives with his/her family caregivers. The elderly person has a high level of dependency and, because of this, he/she cannot be left alone during the day and night. There are several daily tasks which he/she is unable to perform: bathing, dressing, standing up/sitting down, taking medication, and similar activities. In other words, the elderly person needs permanent and extensive care. This situation implies that one or more persons have to be available to be with him/her, mainly during the day, while other family members are working. Therefore this solution only arises because one or more family members in the household are available to ensure the provision of care, on a permanent basis, avoiding the occurrence of self-care. In this particular case, there is one family member who stays with the dependent elderly person during the day, and there is another (the son of the dependent elderly person) who can go home every day in order to prepare and give his mother lunch. He is able to do this because he has reasonably flexible working hours.

The "hands-on" care provided to the dependent adult person is strongly shared between the family members in the household, although there are one or two main caregivers: in most cases, the main caregiver is a son/daughter.

The following statement sheds some light on the level of sharing of caring tasks between the family members in the household: *«In the morning we all leave and António (the interviewee's husband) comes back to the house before going to work to give mother her insulin, give her breakfast and change her nappy. When all that's done, he leaves. (…) Then he comes back to give her lunch…then she has to be given tea… usually it's Carla (interviewee's daughter) who gives it to her, then he gives her dinner, and at night I deal with her personal hygiene »* (Int. 1, p.20).

The elderly person's high level of dependency explains, at least in part, the strong level of shared care between the family members in the household: it would be practically impossible for one member of the family to provide care on his own, because this would involve heavy and hard work. However, apart from having time to share in the caring tasks, it is also necessary that family members be willing to do so. Therefore a family solution for an elderly person with high level of dependency is only possible if the family members in the household are available, able and willing to share in the caring tasks.

This sub-type of care arrangement is seen by the main caregiver as the best one for her/his mother/father, because he/she is at home with her/his things in a familiar environment. Therefore the main caregiver thinks that this type of solution satisfies all of an elderly person's needs.

In the future, if the person receiving care gets worse (even more dependent) or when the caring tasks become too heavy, the main caregiver would prefer to buy in home-based care services on a permanent (i.e. full-time) basis. An old people's home is seen as the last resort. The respondent in this sub-type said that her family never thought of putting her mother-in-law in an old people's home: *«There was no way round it. Between looking for a home, a place to leave her.. and because we'd ruled that out.. the was only one thing for it and that was to have her at home »* (Int.1, p.23).

However, this sub-type of care arrangement can impact family members' lives in a number of ways, particularly in the case of the main provider of care. The negative

impact on social and leisure activities (decrease in this type of activity, including extreme difficulty in going away on holiday) is that which respondents mention most often. The following statement is a good example of this type of impact: *«We don't go out all together any more, because she cannot be left alone. So family leisure time was quite badly affected, we had to find other things to do in our spare time, we stay at home together (...)»* (Int. 1*).*

In terms of suggested measures, the main caregiver tells us that there should be adult day care centres for elderly persons with high levels of dependency[6], where they could stay during the day. On the other hand, the main caregiver thinks the State should make an effort to develop and provide home-based care services.

Finally, it is important to stress that the stability of this sub-type of care arrangement depends on the availability, willingness and capability of the family members in the household to provide care and, on the other hand, on the elderly person's level of dependency. A change in one of these variables may oblige the caregivers to reorganise the care arrangements. For example, in this family, the need to get external support (home-based care services) has already arisen, because the caring work has become too demanding. We may conclude that it is difficult to maintain a care solution like this one, especially when the person who is receiving the care has a high level of dependency.

[6] Portuguese adult day care centres do not accept persons with high levels of dependency. This type of institution was created to provide care to persons with some autonomy (those who do not need personal care, such as help with going to the bathroom, or with eating).

SUB-TYPE I-B: "WATCHING OVER" FAMILY CARE

I-B.1. SINGLE-HANDED "WATCHING OVER"

(son/daughter + (unproblematic) self-care)

- 1 family included (interview number 23)

«(...) without letting on that I'm watching her I keep an eye on things and basically I let her do things, but I'm always over here watching (…) I've always got my eye out (...)»

(Interview 23, married, aged 50, with one adult child, daughter of the dependent adult person, living with the latter)

BRIEF EXAMPLE OF THE CASE THAT FALLS INTO THIS SUB-TYPE (A TYPICAL WEEKDAY)

During the week the respondent and her husband leave home early in the morning (about 6:30). The respondent's daughter also leaves home early. They leave home before the respondent's mother wakes up. When the mother wakes up she prepares and has breakfast and takes her medicine, the latter prepared by the respondent (the respondent leaves her the pills she has to take). After breakfast, she sometimes goes shopping for anything that may be needed at home (small things). She prepares her own lunch. During the day she is at home on her own, except when her grand-daughter has lunch at home. On those days the respondent's mother prepares her grand-daughter's lunch. The respondent usually gets home about 16:30. Her husband arrives later. The respondent prepares dinner. The respondent says her daughter does not help her with household chores. It is her mother and her husband who help her in those tasks. After dinner all family members talk for a while and then go to bed early. Before that, the respondent checks to see that her mother has taken her medicine. In general terms the respondent provides discreet help to her mother.

DESCRIPTION AND EXPLANATION OF THE SUB-TYPE

Two main factors contribute to the definition of this sub-type of care arrangement: the dependent adult person has a low level of dependency (needs supervision in only a few daily activities, and is not capable of managing administrative matters, like going to the bank, paying bills...) and, on the other hand, the "light" care he/she needs is provided by one person only (in most of the cases by a son or daughter).

The elderly person is a widow(er) and, in spite of her/his low level of dependency, he/she cannot live alone, because he/she does not have full control over some daily domestic activities, like turning off the gas, switching off the lights, and other similar activities. So in order to avoid unnecessary expense and particularly the risk of serious

accidents, it was decided that it was better for the elderly person not to live alone. Another important factor in this decision is to avoid the elderly person's feeling lonely.

Usually the elderly person starts living with her/his son/daughter after widowhood. This was the what happened in this case.

However, we should not forget that one of the variables operating as a resource or a constraint is the size of the son/daughter's house. Having a big house can facilitate cohabitation, while the opposite situation may be an obstacle.

The caregiver may or may not be the only child. When there are other sons/daughters another type of care arrangement may arise, characterised by the circulation of the father/mother between the children's houses (the elderly person spends one month in turn in each child's home). We describe this as "watching over" by rotation. The low level of dependency of the elderly person may facilitate this kind of solution. However, this variable may also explain the non-participation of other sons/daughters in their father/mother's daily care. The sharing of caring tasks is probably not felt as a need by either the son/daughter who lives with the father/mother or the other sons/daughters, because the caring tasks are intrinsically neither time-consuming nor expensive. So the fact that care responsibilities are centred on one of the children may not be felt to be a problem by any of those involved.

In cases where only one of the children is responsible for providing care to her/his father/mother, most often the decision that leads to this is not negotiated: as the respondent said, *«it just happened»* (Int. 23). The respondent in question gave two main reasons why her mother was living with her and not with her sister. Normally their parents went to her home when they came to Lisbon (so it was a habit). On the other hand, the respondent thinks that the other factor in this situation was her job as a health professional.

In this type of care arrangement self-care is frequent, mainly during the week. The person receiving care stays at home alone while the caregiver and other household members are working. However, the person receiving care is not left in a high-risk situation, because he/she still has some autonomy.

When there are other members of the household, they do not usually take part in the care of the elderly. This probably arises because such participation is not felt to be necessary, on account of the elderly person's low level of dependency .

However, during weekends, holidays and in occasional situations other persons may provide some kind of support (e.g. a relative may provide help when the person receiving care is ill).

One of the perceived advantages of this sub-type of care arrangement (from the caregiver's point of view) is, as we reported above, that it avoids the elderly person feeling lonely, cuts out unnecessary expense and, above all, reduces the risk of serious domestic accidents. This sub-type of care arrangement is also seen as the ideal solution for the elderly person, and when the latter eventually begins to need personal care (body hygiene, dressing...) the caregiver accepts the idea of buying in home-based care services for the period of time he/she is working. An old people's home is seen as only

a last resort: *«(...) while she can be at home, and if I can get hold of someone who can, well, care for her while I'm out… I think that's better, because basically she stays in her own surroundings, doesn't she, now whether that will always be possible in the future, I don't know...» (Int. 23).*

The impact of this type of care arrangement on the caregiver's life is felt mainly in the decrease in social and leisure activities, including holidays.

The stability of this sub-type of care arrangement is dependent on the elderly person's health. When the dependent adult person eventually begins to need personal care, there will then be a need to reorganise the care arrangements.

TYPE II: MIXED CARE ARRANGEMENTS

SUB-TYPE II-A: THE "DAY CARE" SOLUTION

II-A.1. SHARED FAMILY CARE + DAY CARE CENTRE

(son/daughter + other family members in the household + adult day care centre)

- 2 families included (interviews number 12 and 25)

«(...) the first job is to wash her, get her dressed... (...) then I leave the house, because I have to catch the train, my brother stays and takes her (to the Day Care Centre) in the morning (...)»

(Interview 12, married, aged 36, with no children, daughter of the adult dependent person, living with the latter and her brother)

BRIEF EXAMPLE OF ONE OF THE CASES FALLING INTO THIS SUB-TYPE (A TYPICAL WEEKDAY)

During the week the respondent usually wakes her father up. The latter dresses and does his basic personal hygiene (e.g. washes his face) unaided. Sometimes the respondent helps him to shave. The respondent's husband prepares breakfast for everyone in the household. The respondent's father has his breakfast unaided, but the respondent checks his medication. When the respondent's father wakes up during the night to urinate in a chamber pot and some urine falls on the floor, it is the respondent or her husband who cleans the floor in the morning. After breakfast it is the latter who takes his wife to work and his father-in-law to the Adult Day Care Centre. The respondent's father stays at the Centre from 9:00 to 17:30 (the Centre closes at this hour). However, the respondent's husband only picks him up about 18:00/18:30. Normally he stays outside, in the front of the centre, there is a cleaning-woman who looks after him. When the respondent and her husband need to go shopping the respondent's father stays at home on his own (about 1:00/1:30). He also stays at home on his own when they want to engage in social and leisure activities. However, on these occasions they wait until he falls asleep before they leave home, and don't tell him anything, because he does not like to be at home alone during the night.

DESCRIPTION AND EXPLANATION OF THE SUB-TYPE

In structural terms, the main characteristic of this sub-type is the combination of family care and an adult day care centre. The person receiving care has a medium level of dependency, which implies some sort of personal care, supervision and accompanying

services. This means that the person receiving care cannot be alone during the day: he/she needs permanent supervision and personal care during some specific periods of the day. Because of this, the person receiving care – a widow(er) – lives with his/her main caregiver, namely with a son or a daughter. The person receiving care had already lived with her/his son/daughter or, in other cases, he/she went to live with the latter after widowhood.

The main caregiver (son/daughter) may be the only child or one of the children. When there are other children, and if they do not live with the person receiving care, they do not usually take part in the regular care of the elderly.

However, caring tasks are shared between the family members in the household, even during weekends and holidays. Occasionally a friend or another relative may help out. Sharing between the family members in the household may also take place in the area of household chores.

The role of the adult day care centre (in most of the cases it is a private non-profit organisation) is to provide care to the elderly person while the main caregiver (and other family members in the household) is working. The adult day care centre operates from Monday to Friday and it supplies lunch.[7] Resorting to an adult day care centre is justified by the non-availability of other practicable alternatives. When faced with the impossibility of implementing a household care solution (care provided by the family members in the household), the adult day care centre option seemed to be the most practicable. For example, hiring permanent (full-time) home-based care services is not easy (because there are not many of these services) and it is also expensive.

So there is a difference between this sub-type and the first sub-type (shared "hands on" family care): the impossibility of adopting a care solution without getting in external care providers. In this sub-type, there is no-one available to be at home with the dependent elderly person. In other words, family members in the household are unable to ensure full care provision. These can only provide partial care.

One of the factors which permits this sub-type of care arrangement is the availability of adult day care centres at a short distance from the caregiver/care receiver's home. Moreover, at least one of the family members in the household can reconcile his/her working hours with the adult day care centre's hours.

From the main caregiver's point of view the advantages of this sub-type of care arrangement are mainly two: it is good for him/her because he/she is not worried while at work during the day, and it is good for the person receiving care too, because he/she is occupied and supervised during that time. A married respondent, aged 36, the daughter of the dependent adult person, said the following on this: *«(...) it's like this, if anything happens to her we know that they (the Day Care Centre) will let us know (...)»* (Int.12). On the other hand a married respondent, aged 60, also the daughter of the dependent adult person, said: *«(...) over there in the Day Care Centre he's always kept busy, he's not alone (...)»* (Int. 25).

[7] Some adult day care centres also offer transportation.

The main caregiver believes the present care arrangement is the best solution for the dependent elderly person. In the future, when he becomes more dependent, the main caregiver would prefer to buy in permanent home-based care services. An old people's home will be the last resort.

However, maintaining this sub-type of care arrangement involves some costs for the family members in the household, particularly for the main caregivers. Feelings of being constrained by the caring responsibilities are common. The main caregiver reports a decrease in social and leisure activities and difficulty in going away on holiday outside the city. Another negative factor is the possible decrease in privacy, due to fact of cohabitating with the dependent elderly person. Let us see what one respondent, aged 36, said about the decrease in social and leisure activities: *«(...) we're tied down, well let's say 'we're stuck' quote unquote, our movements are always conditioned by what we have to do at the end of the day, and I can't make any arrangements like 'tomorrow I'm going out to dinner without having to think what I have to do for…' or, for example, I can't be at work and think "look, I'm going out to dinner, I won't be sleeping at home tonight, I'll stay at a friend's house". I know she needs me (mother)»* (Int. 12, p.23).

This sub-type of care arrangement is usually relatively stable, but its continuity depends on the elderly person's state of health. We have to remember that adult day care centres in Portugal only accept elderly persons with a low/medium level of dependency.

SUB-TYPE II-B: "HANDS-ON" EXTENSIVE HOME-BASED CARE (family care + home-based paid services)

II-B.1. Shared family care + part-time home-based paid services

(son/daughter + other family members in the household + part-time home-based paid services)

- 2 families included (interviews number 8 and 9)

«(...) they come round (the home help service), they bring the meal, lunch, they bring it to the house (…) a lady comes in the morning to wash my mother, that's already a great help to me »

(Interview 8, married, aged 37, with one child, daughter of the adult dependent person, living with the latter)

BRIEF EXAMPLE OF ONE OF THE CASES THAT FALLS INTO THIS SUB-TYPE (A TYPICAL WEEKDAY)

During the week the respondent's husband leaves his son at his mother-in-law's home and then (about 9:30) he goes to his parents' home in order to provide care to his father: he baths and dresses him, prepares his breakfast and gives him his medicine. On Mondays, Wednesdays and Fridays the respondent's mother-in-law does hemodialysis: she leaves home by taxi at 7:20 and returns at 13:00. The respondent's father-in-law stays on his own during that time, except for the time his son visits in the morning to bath him and prepare breakfast. About 13:30, the respondent's in-laws make use of the services of a non-profit institution for elderly persons, which takes them lunch. During the afternoon the respondent's in-laws stay at home. Their mobility problems prevent them from going out for a walk. At the end of the day the respondent's husband (and sometimes the respondent) help them to prepare dinner (normally the left-overs from lunch). When the respondent's husband arrives home his son is already asleep.

DESCRIPTION AND EXPLANATION OF THE SUB-TYPE

There is one main difference between this sub-type of care arrangement and the previous one: in this sub-type the elderly person has a high level of dependency (so a "day care" solution is out of question). He/she may or may not be married and, on the other hand, he/she may be living alone with his/her partner or with other relatives. Regardless of with whom the dependent elderly (and her/his spouse) lives, there is a son/daughter who operates as the main caregiver/care organiser. However, when there are other sons/daughters, they do not take part in the regular care of the elderly. This situation is frequently the cause of conflicts between siblings.

The main structural characteristic of this sub-type of care arrangement is the sharing of the caring tasks between a son/daughter and other family members (care receiver's spouse, main caregiver's wife/husband...), with complementary/periodical intervention by home-based care services (from Monday to Friday). These services may be provided on a formal or informal basis, but they are paid for.

The sharing of caring tasks between family members may or may not include the participation of the main caregiver's partner. It seems to us that the sharing of the caring tasks between the partners depends on the gender of the main caregiver. If he is a man (son), his wife probably shares in the caring tasks, but if she is a woman (daughter), the tendency is for her husband not to share in those tasks, especially if there are other family members available to provide care.

This sub-type has a very important characteristic: there is one (or more) family member who is available to be with the care receiver during the day (e.g. a retired spouse with some autonomy). So, while the main caregiver (and other family members) is working, there is a relative who provides, in the main, supervision and "light" care, but he/she also may provide some "hands-on" care. At lunch-time home-based care services deliver lunch and deal with the elderly person's body hygiene (e.g. changing nappies).[8]

The family caregivers provide personal care (basic hygiene, bathing, dressing, standing up/sitting down, medication...) and supervision, while the home-based care workers provide services such as body hygiene (not bathing) and lunch during the day. They also may help the care receiver to eat.

Therefore, the family caregiver who is with the elderly person during the day sometimes has an important role: he/she avoids the occurrence of self-care and, on the other hand, he/she makes this care solution possible. Without his/her participation it would be necessary to have permanent (and not occasional) home-based care services.

The role of home-based care services is to provide some services that cannot be totally guaranteed by the family caregiver who stays with the dependent adult person during the day (e.g. body hygiene and cooking), because these services are too demanding for him/her.

In spite of the fact that a family member is available to stay with the dependent adult person during the day, there are some constraints on this care solution: the main caregiver, care receiver and other family members suffer from certain financial constraints. Without these constraints the main caregiver and the other family caregivers would probably have the support of a permanent home-based care service, in order to give them some rest. On the other hand, the availability of informal support (other relatives, friends...) is very restricted (e.g. they live far away).

This care solution is seen by the main caregiver as the best one for the dependent elderly person, because he/she is at home with the family, receiving quality care. For the main caregiver an old people's home will be the last resort. A married respondent, aged 37, providing care to her mother, said the following with regard to this issue: *«No, no, it's*

[8] However, in some cases, the home-based care services go twice a day: in the morning (they do the personal hygiene) and at lunchtime (they deliver lunch).

like I say, I hate homes, only as a last resort, that'll be the last thing I do to my parents » (Int. 8, p. 14).

But, on the other hand, this mixed solution is highly demanding for family caregivers, because they carry out a lot of the care provided (every morning, every evening and, in some cases, also from time to time during the night). This care solution may be even more demanding if the dependent elderly person is not living with the main caregiver. Because of this high level of demand, the family caregivers would prefer a different solution, such as having more support from home-based care services (support for a longer period of time during the day). However, it is not easy to find affordable examples of this kind of service (third sector institutions have waiting lists for this type of service and they give priority to the poorest families). On this issue, a married respondent, aged 37, the daughter of the dependent adult person, tells us the following: *«What would really help me out is someone who could look after them, I wouldn't mind if it was at home »* (Int. 8, p.17).

The main caregiver (son/daughter) reports that caring responsibilities impact on his/her life/family life in several ways: a decrease in social and leisure activities, difficulty in going away on holidays, psychological and physical distress and, if he/she has children, a decrease also in the amount of time spent with them. This last type of impact occurs in both these particular cases in this sub-type: *«(...) now with this business of my parents it's those who need it who get the attention, I mean, basically my son ends up suffering a bit because of this. I'd like to be able to give him a bit more attention. Sometimes he goes on at me 'Mum, Mum..' and I have to say "Son, just wait a minute until I've finished dealing with Grandma"»* (Int. 8, p.22).

The stability of this sub-type of care arrangement depends on the dependent elderly person's state of health and, on the other hand, on the level of availability of the family member who stays with him/her during the day. If the latter ceases to be available to provide care (e.g. a spouse who also starts to need personal care), this will make this type of solution impractical.

II-B.2. Shared family care + full-time home-based paid services

(son/daughter + other family members in the household + full-time home-based paid services)

- 1 family included (interview number 3)

«(...) I had to get a lady in (…) I've never had a maid to do anything for me, but there was nothing else I could do, first because even though we always try to help, whether it's my daughter, my son-in-law, or my husband, in spite of all that there would have been a long period when she would have been left on her own, and we didn't want that (...)»

(Interview 3, married, aged 54, with 2 adult children, the dependent elderly person is the husband's grandmother, the respondent lives with the latter)

BRIEF EXAMPLE OF THE CASE FALL INTO THIS SUB-TYPE (A TYPICAL WEEKDAY)

During the week the respondent does the personal hygiene (including bathing) for her husband's grandmother. Her husband helps her to put the dependent elderly person into the bath and to take her out. Then the respondent prepares the elderly person's breakfast, helps her to have it, and gives her medicines. Meanwhile, the maid arrives and stays at the respondent's home until 17:00. The latter provides domestic services (cleaning, ironing and cooking), supervision and personal care (helps the elderly person to have lunch, helps her to sit down/stand up...). The respondent's husband and the respondent's son-in-law have lunch at home. During this period of time they check that everything is all right with the elderly person. During the rest of the afternoon the maid provides all the care the elderly person needs. Normally at the end of the day the respondent is the last one to arrive home. The respondent's husband arrives about 17:00/17:30 and takes over from the maid until the respondent arrives. If he is unable to get home at this hour, the respondent's daughter stays with her great-grandmother until her mother arrives. When the latter arrives she prepares dinner and after dinner she again deals with the elderly person's personal hygiene. She has her husband's support whenever she needs it.

DESCRIPTION AND EXPLANATION OF THE SUB-TYPE

This sub-type of care arrangement is characterised by the **extensive and permanent support of a paid home-based care worker**. The dependent elderly person – a widow(er) with a high level of dependency – lives with a son/daughter or a grandchild and is cared for by the former in conjunction with other family members and a full-time home-based care worker. The main family caregiver may be the only child (grandchild) or one of several children (grandchildren). If there are other children (grandchildren), they do not usually take part in regular care of the elderly.

Therefore care is shared between the family members (including the respondent's partner, or not). The sharing takes place in the morning, before the working members of the family leave home, and at the end of the day after they arrive home. Sometimes the dependent elderly person needs care during the night. In this situation it is only the main caregiver who provides care. During the day it is the home-based care worker who provides all the care the dependent elderly person needs. The home-based care worker may or may not live at the family caregivers' home.

There is an important factor that makes this care solution possible: the family caregivers are well off. This type of solution is expensive and, moreover, it is not easy to find a person to do this kind of work. However, a permanent home-based care service provided by a private for-profit institution would be more expensive. In general terms, private-non profit institutions do not provide permanent (full-time) home-based care services.

In the morning it may be difficult to reconcile the working caregivers' hours with the home-based care worker's hours, in order to ensure that the dependent elderly person is not left on her own. One factor which may help to reconcile these hours is flexible working hours (for at least one of the family members). This is what happens in this case.

The advantages of this care solution are, from the family caregivers' point of view, that the elderly person stays at home in a familiar environment and, on the other hand, the caregivers are not worried while they are at work. For the family caregivers the best solution for an elderly person is to be at home. A home for elderly persons would be the last resort. The respondent included in this sub-type said the following about this issue: *«(...) at one point I did go to look at a home, we phoned round a few and asked for references from I don't know how many, then I went to look at one which is really close to my home and which looked good to me (...), except that I started to look at these 23 people doing nothing and looking into the big wide open, and there were 23 of them, and it affected me so much that I said "my God I can't put Grandma in here," she'll go back on all the progress she's made up to now, because when we're with her we get her to do things, we say things to her, make her laugh, and while we can provide this sort of stimulus, in a home you can't do this for 23 people (...) so we chose to have her at home (...) I'll take her into hospital or put her in a home only as a last resort »* (Int. 3).

The most frequently reported disadvantages are, first, the risks associated with having a stranger at home all day long. Secondly, this solution is expensive, and the cost is not tax-deductible.

With regard to the impact of this sub-type of care arrangement on the family caregivers' lives, they frequently report a decrease in social and leisure activities and difficulties in planning and going on holiday. The following statement shed light on this type of impact: *«(...) I feel I'm becoming brutish, I don't go to any plays (...) I love the theatre, I can't really ask my daughter to go over there at night (…) I just feel the need to go to things I like, to a book launch, things like that… I don't go any more (…) at night I'm really tied down (...)»* (Int. 3).

In summary, the stability of this sub-type of care arrangement is highly dependent on the elderly person's state of health and, on the other hand, on the reliability of the informal home-based care workers.

SUB-TYPE II-C: THE "ORGANISER" SOLUTION (family organisation + part-time home-based paid services)

II-C.1. Shared family organisation + part-time home-based paid services

(family organisation + "hands-on" home-based paid services)

- 1 family included (interview number 6)

«(...) there are some weekends I don't visit (father's house)… I phone him regularly (…) he (interviewee's father), for example, he'd probably like it if I went there more often (to his house) (...), but I can't always do that and sometimes I really don't feel like it »

(Interview 6, married, aged 37, with one child, son of the adult dependent person, not living with the latter)

BRIEF EXAMPLE OF THE CASE THAT FALLS INTO THIS SUB-TYPE (A TYPICAL WEEKDAY)

During the week the domiciliary worker visits every day to deal with the personal hygiene of the respondent's father, cleaning and ironing. The respondent's parents pay for this service (through their pensions). The respondent's mother only needs supervision in some domestic tasks (e.g. warming the meals, shopping…). The respondent's mother takes lunch and dinner from a restaurant near home. The respondent's mother helps her husband to dress, sit down and get up. The respondent's father supervises some domestic tasks taken on by his wife (e.g. warming the meals) and her medication. Almost every day the respondent calls his parents to know how they are, but he and his wife do not provide personal care (except if it is absolutely necessary). In some periods of the year, the respondent's parents go to another region of the country (Alentejo) where they have inherited properties. During those periods it is a Day Care Centre (domiciliary services) which provides them with the care they need.

DESCRIPTION AND EXPLANATION OF THE SUB-TYPE

One of the characteristics that differentiates this sub-type from the others is the non-participation by the son/daughter in the regular care of the elderly. While in the other sub-types there is a son/daughter who takes an active part in the regular care of the elderly, taking on the role of main caregiver, in this sub-type there is also a son/daughter but he/she plays a care organiser role. In other words, he/she is not with his/her father/mother every day and does not provide him/her with "hands-on" care on a regular basis. He/she only organises her/his mother and father's life at a distance, since he/she does not live with them (he/she calls them to know if everything is all right). When there are other children, they do not help with the regular care of the elderly. One of the

sons/daughters provides only “hands-on” care during weekends (not all weekends) and in occasional situations.

In this sub-type, the elderly person has a high level of dependency, he/she is married and lives alone with his/her spouse. The latter is retired and has some autonomy. The elderly person’s spouse provides the daily care of the elderly in conjunction with the periodical services provided by a part-time home-based care worker. The former provides mainly supervision and help in some daily tasks (e.g. standing up/sitting down, dressing, medication...), while the latter provides personal care (basic personal hygiene and bathing) and does the ironing and cleaning. He/she provides these services from Monday to Friday, normally for only a few hours a day. The role of the home-based care worker is to provide the care that cannot be totally provided by the elderly person’s spouse. The elderly person and her/his spouse pay for these services through their pensions.

Therefore it is the elderly person’s spouse who makes this type of care solution possible, because he/she stays with her/him all day: it is not necessary to have a permanent (full-time) home-based care service.

The non-participation of the dependent elderly person’s children (if there are any) in the regular care of the elderly may be explained by several factors: they live far away, they do not have enough time to provide “hands-on” care or they have a bad relationship with their parents (or with one of them). This latter situation occurs in this particular case: *«(...) my father is a rather difficult person to deal with the relationship…, our relationship was not very close (the respondent’s relationship with his father) (...). And their relationship (the relationship between the respondent’s sister and her father) is also... they fight a lot... it’s not an easy situation (...). It would be impossible for me to go and take care of my parents, for all sorts of reasons, because I can’t do it, because it would upset my family life, you know »* (Int. 6).

Apart from the non-participation of the elderly person’s children, there are no other informal providers available to provide care.

Finally, we conclude that the stability of this sub-type of care arrangement depends on the state of health of the dependent elderly person in conjunction with the capacity of his/her spouse to provide the care he/she needs.

SUB-TYPE II-D: "WATCHING OVER" MIXED CARE (family + home-based paid services)

II-D.1. Single-handed family "watching over" + full-time domestic employee

(son/daughter + full-time domestic employee)

- 1 family included (interview number 7)

«(...) she was always used to having a maid around, and, it would be difficult, it's not at this stage of her life that she's going to get used to a different scheme of things, and apart from that there are things that start to go wrong, like leaving the gas on and things like that (...)»

(Interview 7, married, aged 44, with one child, daughter of the adult dependent person, living with the latter)

BRIEF EXAMPLE OF THE CASE THAT FALLS INTO THIS SUB-TYPE (A TYPICAL WEEKDAY)

During the week the respondent's mother stays at home and is cared for by the respondent's domestic employee (she works Mondays to Fridays from 9:00 to 17:00). The respondent's mother is still able to do her own personal hygiene and dresses without any help. However, the respondent's domestic employee prepares the meals and supervises her medication. In addition, she stays with the respondent's mother during the day. Normally the respondent's mother wakes up about 11:00, does her own personal hygiene and has breakfast. She watches TV and listens to the Radio until lunchtime. During the afternoon she does the same things. The respondent calls home twice a day to check that everything is ok (she talks with the domestic employee). It is during dinner that the respondent talks with her mother, because the latter goes to bed early. However, it is not easy to talk with her mother, because, in the respondent's opinion, her mother has a negative attitude to life. The respondent has to go with her mother to medical appointments, because she cannot explain everything to the doctor (she often forgets important details).

DESCRIPTION AND EXPLANATION OF THE SUB-TYPE

This sub-type of care arrangement contains many similarities to sub-type I-B.1. (single-handed "watching over"). For example, in both sub-types the dependent elderly person is a widow(er) and has a low level of dependency. Apart from this, in both cases the dependent elderly person does not live alone (he/she lives with a son/daughter), because he/she needs company (someone to talk in order to avoid the loneliness), supervision, and discreet/"light" help with some daily activities.

All the other characteristics of sub-type I-B.1. are also found in this sub-type. So it is better to stress the differences between these two sub-types. First, in sub-type I-B.1. one person alone (son/daughter) watches over the dependent elderly person, while in this sub-type two persons carry out this task (son/daughter + domestic employee). Secondly, self-care in this sub-type is occasional and not very frequent, because the domestic employee is at the caregiver/care receiver's home during the day or for most of the day (Monday to Friday).

Another difference between the sub-types is that families in this particular sub-type are better off. This factor may explain the presence of a domestic employee on every weekday. The maid already provided domestic services before the elderly person starting needing care. So she was not employed for the purpose of providing care for the elderly. While she is doing the chores (cleaning, ironing...) she also looks after the elderly person. So the main caregiver in this sub-type is less worried at work, because she/he knows that her/his mother/father is not alone.

The stability of this sub-type, as well as of sub-type I-B.1., depends on the elderly person's state of health. If and when the latter starts to need personal care, it will then be necessary to reorganise the care arrangements.

2.3. Resources / Constraints

In our sample we have cases where the family was completely taken by surprise by the fact of having to care for a dependent adult person (it was an unexpected responsibility), and others where the family was expecting to take on caring responsibilities in the short/medium term.. Among the first cases we have, for example, a daughter who had to deal with her father's situation after the sudden and unexpected death of her mother (Int. 25). In the second category of cases we have a son who was expecting to take on care responsibilities for a short period of time, because his father was becoming gradually more dependent due to his health problems (Int.9).

However, caring responsibilities do not imply the same level of demands: in some cases they imply hard, heavy "hands-on" work, and in other cases they imply only "light" work involving duties of "watching over" the dependent person: the extent of the duties is determined by the elderly person's level of dependency.

The most demanding situation is therefore that where the family has, unexpectedly, to take on caring responsibilities which imply heavy "hands-on" work. By contrast, to take on anticipated caring responsibilities, which imply only "watching over" tasks and supervision work is a less demanding situation. Within our sample we have cases of these two extreme situations.

With regard to the elderly person's level of dependency, we verified that this variable is always present when we analyse the influence of other variables. For example, the influence of the working timetable (number of hours, level of flexibility...) on how the care solution is configured, depends on the elderly person's level of dependency, because care needs differ and, consequently, the level of demand for caregivers is also different. Caring for an elderly person with a low level of dependency is completely different from caring for an elderly person with a high level of dependency, both in terms of financial and time requirements and in terms of (physical and psychological) energy.

For a better explanation of the main resources/constraints that influence the reconciling of work and care of the elderly, we will divide our analysis according to the elderly person's level of dependency.

2.3.1. Families caring for an elderly person with a low level of dependency

Starting with the cases where the elderly person has a **low level of dependency** (care needs include, mainly, supervision in some daily tasks, accompanying them to services, managing administrative matters...), we can see that it is relatively easy to reconcile work and care. The caregiver only needs to take on a supervisory or "watching over" role. During the day **the dependent elderly person can stay at home alone** until the caregivers arrive. So the influence of the caregivers' working timetable is not crucial. However, having a typical timetable is always a factor that makes it easier to reconcile the two, even when the elderly person has a low level of dependency.

There is another factor, which may further help to reconcile work and caring: having a person at home during the day. For example, the family representing the "single-handed family watching over + full-time domestic employee" sub-type has a domestic employee at home during the day. However, having a full-time domestic employee is dependent on the level of financial resources. As already mentioned, the family included in the "single-handed family watching over + full-time domestic employee" sub-type has a greater financial resources than the family in the "single-handed watching over" sub-type.

On the other hand, having a dependent child does not operate as a very significant constraint, because the family caregivers are not overburdened by the care of the elderly.

Finally, the care providers' level of availability does not play an important role in these cases, because the family caregivers are not yet in need of strong support, either informal or formal.

To conclude, reconciling care of the elderly and work is not a problem in cases where the elderly person has a low level of dependency, because the caring tasks (supervision, discreet care, "watching over"...) are not too demanding. Let's see how a middle age woman, who cares for her mother with a low level of dependency, answered the question "do you feel your caring responsibilities have a negative impact on your work?": *«Not yet, not yet, not for the moment. Well, it doesn't mean that now and again I don't make a change to my hours so that she's not left alone for too long (…) but thank God I don't have that kind of problem just yet »* (Int. 23).

2.3.2. Families caring for an elderly person with a medium level of dependency

Families with an elderly person with a **medium level of dependency** (the care needs include supervision, accompanying them to services and also some kind of "hands-on" care, like bathing and dressing) have to deal with greater demands. The elderly person needs permanent supervision in some daily tasks. So, in these cases, unlike the preceding cases, **the elderly person cannot stay at home alone**. He/she needs someone to be with him/her during the day.

In these circumstances, family caregivers have to find a solution which satisfies their own preferences and the elderly person's preferences about the type of care solution. However, there are other factors affecting the decision about the type of care solution to be adopted: the availability of informal and formal care providers, the working timetable of the family caregivers, the opening hours of formal services and, finally, the family income level. These are the main factors that constitute the context of resources/constraints in which decisions will be taken.

With regard to the caregivers' preferences about the type of care solution, all 25 respondents said that they prefer to **keep the dependent elderly person at home**. A woman aged 50, the daughter of the dependent elderly person, said the following in relation to this issue: *«(...) while she can be there (at home) and if I can get hold of someone who can give her, well, the basic care while I'm out.. I think that's better,*

because basically she stays in her familiar surroundings.. now what the possibilities will be in the future, or if it will even be possible, I don't know (…) having her stay in her own surroundings, that's what I think is best, have her tied to the family (…)» (Int.23).

This preference may be put into practice in different ways. For an elderly person with a **medium level of dependency**, this preference may imply several care solutions: a family solution, a mixed solution combining shared family care with part-time home-based paid services, a mixed solution combining shared family care with full-time home-based care services, a mixed solution combining shared family organisation with part-time home-based paid services, a "Day Care" solution or, finally, a self-care solution (no cases in our sample).

The choice between these several possibilities depends on the combination of all factors mentioned above, which form the context of resources and constraints.

If one (or more) family members are not available, able and willing to stay with the dependent elderly person during the day, it is not possible to adopt either a family solution or a solution based on the combination between shared family care and part-time home-based care services, nor even a solution combining shared family organisation with part-time home-based paid services. As we saw when outlining our typology, these care solutions exclude the occurrence of self-care. So they depend on there being one or more family members available to stay with the elderly person during the day. So we are left with the solution centred on full-time home-based paid services, the "Day Care" solution or, in last instance, the self-care solution.

If the remaining first two care solutions are available, the decision about which one to choose depends mainly on the family income level and on family caregivers' working hours. Full-time home-based care services are expensive, because the third sector (non-profit making institutions) does not usually offer this kind of service. It is the private profit-making sector and the paid informal sector that offer these services. By contrast, to resort to a Day Care Centre is a cheaper solution, because, with the exception of few cases, it is the private non-profit making sector that provides this type of service.

In any case, the viability of a "Day Care" solution depends on whether it is possible to reconcile the family caregivers' working timetables with the Day Care Centre's opening hours.[9] In Portugal Day Care Centres usually open at 9:00 and close at 17:00/17:30. These hours are very limited, and this makes it difficult to reconcile them with the caregivers' working hours. Moreover, this difficulty may be greater if the Day Care Centre is too far away from the family caregivers' workplace/home. In both cases in the "the day care solution" sub-type, one of the family caregivers has reasonably flexible working hours. For example, a married respondent aged 36, the main caregiver for her mother, said the following with regard to this issue: *«I leave (earlier) in the morning, catch the train, and he (the brother), as he works near here, (and has some flexibility), he finishes his breakfast and then they both go out, he is the one who takes her (to the Day Care Centre) »* (Int.12, p.17).

[9] Even when the Day Care Centre has a transportation service, the problem of compatibility between timetables remains, because it is necessary for one of the working caregivers to be at home to deliver and receive the dependent elderly person.

2.3.3. Families caring for a highly dependent elderly person

Finally, families with a **highly dependent** elderly person may resort to the same care solutions available for elderly persons with medium dependency, except for the "day care" solution. As we emphasised earlier, Day Care Centres in Portugal do not accept elderly persons with a high level of dependency.

The cases where we found the greatest variety of care solutions were precisely those where the elderly person has a high level of dependency. This variety is the result of different resources and constraints contexts.

In these cases there is one key factor in the organisation of the care of the elderly: the presence (or absence) of one or more family members with the availability, capability and willingness to stay with the dependent elderly person during the day, while the other family members are not at home. If there is such a family member, it may be possible to develop a family solution, that is, a solution similar to the sub-type I-A.1. (shared "hands-on" family care) solution. However, this family member (e.g. the retired spouse of the dependent elderly person) may not be able to provide all the care the dependent elderly person needs (e.g. cooking, helping to eat, changing nappies...). In this case, a family solution will only be adopted if one of the working caregivers is available to go home during the day, in order to cover those gaps. This implies that this family caregiver has reasonably flexible hours, even when he/she works near home. This is what occurs in the case representing sub-type I-A.1. (shared "hands-on" family care).

If there is nobody to stay with the dependent elderly person during the day, even if he/she only can watch over the dependent elderly person and, on the other hand, if there no working caregiver available to go home during the day in order to cover some care needs, it will not be possible to implement a family solution, because this care solution excludes self-care. If there is no alternative solution the probability of self-care occurring is high.

However, there may be intermediate solutions between a family solution and a solution based on full-time home-based paid services: a solution which combines shared family care with part-time home-based paid services or, on the other hand, a solution that combines shared family organisation with part-time home-based paid services.

The first type of solution, which we called "shared family care + part-time home-based paid services" also depends strongly on the presence of a family member at home who can be with the dependent elderly person during the day (often the elderly person's retired spouse), thus avoiding the occurrence of self-care.[10] It is the presence of such a family member that makes it unnecessary to resort to full-time home-based care services. As we already mentioned in our description of the "shared family care + part-time home-based paid services" sub-type, part-time home-based services carry out the tasks that cannot be carried out by the family member who stays with the dependent elderly person. So they play a complementary role.

[10] In this type of care solution having reasonably flexible working hours may also operate as a factor which helps to maintain the daily care of the elderly. For example, this occurs when the main caregiver also has to go at home during the day in order to provide some specific care or to see if everything is all right.

The second type of solution, which we called “shared family organisation + part-time home-based paid services”, also depends, strongly, on the presence of a family member who can be with the dependent elderly person during the day. Home-based care services play the same complementary role: to provide the services that cannot be provided by the family member who stays with the dependent elderly person.

However, it is important to stress that the care solutions which include shared family care (“hands-on” or organisation) do not depend, exclusively, on a family member being available to stay with the dependent elderly person during the day. It is also necessary to have other family members available to share in the caring tasks.

Finally, when there is no a family member with who is available, able and willing to stay with the dependent elderly person during the day and, on the other hand, other informal providers are not available to provide regular care for several reasons, the solution might be to buy full-time home-based paid services. We called this solution “shared family care + full-time home-based paid services”. This type of solution is the result of the following main constraints: there are no family members in the household to stay with the dependent elderly person during the day and, on the other hand, there are no community facilities (non-residential facilities) for elderly persons with a high level of dependency (like a Day Care Centre). Therefore, the only way to keep the dependent elderly person at home (which the main caregivers prefer to do), avoiding self-care, is to buy full-time home-based services. However, the viability of this type of care solution depends on the family income level, because it is expensive.

In this type of care solution the caregivers’ working timetable may or may not help to reconcile work and caring: it depends on the compatibility between their working hours and the home-based care worker’s hours. In the case representing sub-type II-B.2., the main caregiver has working hours which are sufficiently flexible to allow him to wait for the home-based care worker’s to arrive.

Finally, it is important to analyse the influence of other caring responsibilities, particularly child care responsibilities, on the organisation of care of the elderly. In general terms, we established that having dependent children operates as a constraint, because the those who care for the elderly also have to provide care to them. So they are overburdened in relation to those who have only one type of responsibility. However, in some cases, there is a dependent child (usually the eldest one) who takes part in regular care of the elderly, as in the case representing sub-type I-A.1. (shared “hands-on” family care).

Families with a highly dependent elderly person and also with a dependent child are included in different sub-types of our typology: shared “hands-on” family care, shared family care + part-time home-based paid services and shared family organisation + part-time home-based paid services. So it seems to us that having a dependent child does not have a significant influence on the way in which families care for the elderly.

The existence of a dependent child does, however, have influence on the tensions and problems in the family. This is especially true when the main caregiver for children is also the main caregiver for the dependent elderly person (only one case in our sample). This double caring responsibility produces extreme tensions. The most frequently reported problems are extreme physical tiredness, less time to be with the child, lower

mental capacity to respond to the child's requests and difficulties in maintaining a high commitment to work.

2.3.3.1. Sharing patterns in caring responsibilities

In our typology the sharing of caring tasks between family members only arises in cases where the elderly person has a medium/high level of dependency. In cases where the elderly person has a low level of dependency, "light" care is of the "single-handed" type: it is provided by a single family member. So the sharing of caring tasks seems to be related, according to our data, with the elderly person's level of dependency.

As we emphasised earlier, the occurrence of shared family care depends on family members being available, able and willing to take part in the care of the elderly.

We found 3 different sharing patterns: shared family care centred only on two members of the couple (Int.25), shared family care including both members of the couple and other family members – mostly the partners of the dependent elderly person, but also grandchildren and some other relatives - (Int.1, 3, 6 and 9), and shared family care based on one member of the couple and another family member – such as the brother/sister of the main caregiver or the spouse of the dependent elderly person - (Int.8 and 12).

The concentration of care provision on the couple depends on two main factors: there are no other living family members or, if there are, they are not available to share in caring tasks. In our sample, this is often the case for the brothers and sisters of the main caregiver.

On the other hand, the participation of the main caregiver's partner in regular care of the elderly depends on a different factor. As we saw earlier, when the dependent elderly person belongs to the wife's family, her husband has a tendency not to share in the caring tasks, especially when there are other family members available. When the dependent elderly person belongs to the husband's family, his wife usually shares in the caring tasks. This tendency may be explained by the social construct that still exists, which perceives the woman as the main and "natural" caregiver of dependent family members.

It is important to stress that we found some cases where partners also share domestic tasks (chores). This sharing may be seen as an integral part of the strategy for dealing with the responsibilities for care of the elderly.

A woman aged 33, gave the following reason for sharing the care provided to her father-in-law: *«I don't know why. It's because they need it and because they are my husband's parents ».* In answer to the question "do you think that daughters-in-law have an obligation to care for their parents-in-law?", the same respondent said: *«I think they do, yes. Just as later on… my parents luckily are still healthy, but if ever later on they need it I would certainly like it if my husband, and I know he would do it, I would like it if my husband had the same attitude. »* (Int. 9, p.27 and 28).

On the other hand, another woman, aged 37, said the following in relation to her husband's non-participation in the care provided to her mother: *«(...) but I don't hassle him too much about it either, I prefer to do it myself, I prefer to be the one who has to do it all (..)»* (Int.8, p.19).

2.3.4. Conclusion

As we have seen, there are several factors that may operate as resources or constraints in reconciling work and care for a dependent elderly person. It seems to us that the most important ones are the following: the elderly person's level of dependency, the degree of flexibility in working hours, the level of income and, finally, the extent of availability of care providers (informal and formal for watching over the elderly as well as "hands-on" tasks).

Let us see, in summary form, how these factors affect the ability to reconcile work and care of the elderly.

The **elderly person's level of dependency** is undoubtedly a crucial factor, which operates as a very important independent variable in reconciling work and care of the elderly. We cannot analyse the influence of other factors without taking into account the elderly person's level of dependency. We confirmed that providing care to a highly dependent elderly person is completely different from providing care to an elderly person with low dependency. The types of demands are quite different: an elderly person with low dependency only needs "light" care, such as being watched over and supervision, while an elderly person with medium/high dependency needs "hands-on" care (e.g. bathing, standing up/sitting down...). It was on account of this difference that we divided our analysis of the resources/constraints according to the elderly person's level of dependency.

The influence of the remaining factors mentioned above is mainly to be seen in cases where the elderly person has a medium/high level of dependency.

With regard to the **occupational resources/constraints**, the most important factor within this set of resources/constraints is the **degree of flexibility in working hours**. Having reasonably flexible hours operates as a very important factor in helping to reconcile work and care of the elderly, even when working hours are atypical. We have some caregivers with atypical working hours, but who have some flexibility. It is precisely this flexibility which enables them to go home during the day in order to provide some specific care or to see if everything is all right. This flexibility may also be important when there is a "Day Care" solution, because Day Care Centres in Portugal have limited opening hours (they open too late and close too early) or, on the other hand, when the caregivers have to reconcile their working hours with the hours of the full-time home-based care worker.

The **family income level** is another important factor, because it may or may not permit access to paid services. Moreover, it enables carers to buy some specific items in order to increase the elderly person's well being (e.g. pomades, technical aids...). We established that families with full-time home-based care services have a high level of

income. Other families would like to have this type of service in order to get some rest, but they do not have sufficient financial resources for this purpose.

The **level of availability of care providers** is another determining factor. Starting with the **informal care providers**, we established that the presence of family members in the household with the availability to provide regular care is a crucial factor in reconciling work and care of the elderly. These family members may make it possible to adopt a family solution or a mixed solution combining shared family care with part-time home-based care services. Moreover, to have a family member available to stay with the dependent elderly person during the day (often the elderly person's spouse) is a valuable resource, which may exclude the need to buy in full-time (or even part-time) home-based care services. On the other hand, this family member's availability may help to reduce the influence of working hours: family caregivers who work are not too pressurised in relation to how the various timetables are organised. Besides this, caregivers who work are less worried at work, because the dependent elderly person is not alone. Therefore this family member may be a key element in reconciling work and care of the elderly.

With regard to family members from outside the household, we established, with the exception of one case, that they are not available to provide regular care for many reasons (they work and do not have sufficient time, they live too far away, they have a bad relationship with the respondents or with the respondent's partner...). Other informal providers (friends, neighbours...) are not available to provide regular care either.

Finally, we have the influence of the **degree of availability of formal care providers**. This degree of availability depends on the quantity and diversity of supply of institutions and services for elderly persons. In Portugal there are more facilities for elderly persons with low dependency than for elderly persons with high dependency. There are two main formal services for elderly persons with high dependency: home-based care services (part-time or full-time) and residences. The full-time home-based care services and residences are provided, mainly, by the private profit-making sector. This means that it is more difficult for low/average income families to obtain access to these services.

Elderly persons with medium dependency are also able to use Day Care Centres. These are mainly in the private non-profit making sector. With regard to Day Care Centres, good geographical coverage is not sufficient to satisfy families' needs. It is also necessary to take into account the hours during which they are open. As mentioned earlier, the majority of Portuguese Day Care Centres open too late and close too early.

2.4. The Impact of Elder Care Responsibilities

Being involved in providing care for the elderly may impact on several aspects of the caregivers' life. The impact may be felt at the individual level (health, available time, working hours...) or at the family level (social and leisure activities with the family, relationship with other family members, marital life...).

We identified 6 main domains of the caregivers' life that are affected by taking on responsibilities for care of the elderly: daily routines, work, social and leisure activities, time available for being with the dependent children, family relationships and personal health.

Taking on responsibility for the care of the elderly leads, first of all, to changes in the caregivers' **daily routines**. For example, some caregivers had to start taking and/or picking up the dependent elderly person at the Day Care Centre, other caregivers had to start waking up earlier in order to provide care before going to work, others had to start going home during the day in order to provide care or to see if everything was all right, others started to wake up during the night to verify if everything was all right with the dependent elderly person, and so on. The consequences of these changes for the caregivers were an increase in workload, because they had to start carrying out some new tasks, which involve time and (physical and mental) energy. However, it is important to stress that these changes only take place in families which provide "hands-on" care.

In the **work domain**, except for one case, all the main caregivers who provide "hands-on" care were affected. The most frequently reported effects were **changes to working hours** and the **loss of concentration**.

In relation to the first type of impact, the changes may imply reducing the time taken for lunch, arriving later in the morning, or both. A woman, aged 54, a public relations officer in a state university, had to apply for flexible working hours when she started providing "hands-on" care to her husband's grandmother: *«(...) I don't come in at 9:30 like other people, I come in at 10:30/11:00. I asked for permission to do this, because I leave my grandmother dressed and ready. Then I don't take any lunch hour, or restrict it to half an hour, I don't take more than half an hour, which is enough to go round the corner to get something to eat and get back here (...)»* (Int. 3).

Another woman, aged 33, an administrative worker, the caregiver for her father-in-law, had to ask for a reduction in her lunch hour in order to leave work earlier: *«I explained that I would like to stay with the new hours. Some people leave work at 17:30, others at 18:00 and others at 18:30, and I explained that I would like to leave earlier, and I had to give my reasons (having to look after my father-in-law)»* (Int. 9, p.30).

In these cases, reconciling work and care of the elderly was only achieved (or was made possible), because it was possible to make this type of change.

On the other hand, some caregivers did not have to change their working hours, but they felt that their performance at work was adversely affected, due to a loss of concentration. This occurs because, while they are working, they are worried about the dependent elderly person's well being. A woman, aged 37, a sociologist/researcher, the

caregiver for her mother-in-law, answered the following to the question "do you think that your husband's work was affected by caring responsibilities?": *«He was affected because his mind was elsewhere, because it is a rather difficult situation, and there is always his mother, not my mother, his, and it is not a happy situation…it makes us a bit depressed, and that affects one's ability to focus on work (...)»* (Int. 1).

Another caregiver, aged 37, a school helper, the caregiver for her mother, said the following on this: *«(...) there are some days when I'm worried, and my performance probably drops »* (Int. 8, p.22). Apart from this, this caregiver occasionally has to be absent from work.

With regard to **social and leisure activities**, we found there was an impact in all families which provide "hands-on" care. An impact on this domain is also found in one family that provides only "watching over" care.

In practice, the ways in which the impact is felt in this domain may take on different forms. We identified 3 forms: a **general decrease in social and leisure activities** (going to the cinema, going to a restaurant...), **difficulties in going out from the city during weekends** and **difficulty in going on holiday**.

The following statements shed some light on the decrease in social and leisure activities:

«I don't go out, I don't get out, because to get out with one lot I can't go out with the other lot, and then things get complicated. Just after we've finished lunch (at weekends)we go out for a bit, we go and have a coffee somewhere, go round the block and then come home again. My son suffers a lot, because of course a child needs to get out and play (...)» (Int. 8, p.23).

«(...) we just can't get out at weekends, we just can't… there are several things we can't do, we're very limited in what we can do. Well that's how it is, we just have to grin and bear it …I prefer not to think about the bad things, and to look on the good side of things, so OK, we don't go out, we stay at home...» (Int. 1, p.18).

Some caregivers, on the other hand, are still able to enjoy some social and leisure activities for short periods of time, but they cannot go out of the city during weekends. This is what happens, for example, in this family (even though the elderly person they care for has low dependency): *«(...) who's grandmother going to stay with? This is a limiting factor, so really I can't get around to going out in the morning and coming back in the evening, I worry, unless I've sorted out where she is, with whom she's going to stay, and in the last resort if she doesn't stay with anyone, if the food is cooked, if it's ready and, of course, knowing that I will get the sulks for going out, I'm going to have to pay for it with a whole week of sulking and meaningful silences, ill-feeling at table, of making me feel, well, that I did something wrong… So it's not easy to work out how we're going to spend a weekend away, you see (...)»* (Int. 7, p.12 and 13).

Finally, the difficulty in going on holiday may imply having no holiday at all. This is the case of a son, aged 39, who stays with his mother during the summer holidays, while his wife and children go to the Algarve: *«I went to the Algarve with the kids (the mother), António stayed here. António had no holiday. It'll be the same this year.. we*

don't think about it too much, It's not worth it. It's not worth thinking about how it's going to be. We've got our house. We've been taking our holiday in the same place for 13 years, so I go down there with the kids, my mother in law is at that stage when you just don't know if she is going to pop off today or tomorrow, she might last another year, or more… we can't look into the future, so we don't do anything, we just wait » (Int. 1, p.11).

All the families providing "hands-on" care to the dependent elderly and which also have to provide care to dependent children report that there is an impact on **the time they have available for being with their children**. There is one case in which the care provided by the main caregiver to the dependent elderly person is limited to watching over that person, but she also feels this impact.

In our sample, the ways in which the amount of time available for being with the children was affected take on 2 different forms: **less free time** to be with them (talking, playing...) or **less mental breathing space** to respond to their requests.

A woman, aged 37, the main caregiver for her mother, with a child of 9, said the following with regard to this issue: *«(...) now with this business of my parents all the attention goes on those who need it, I mean, basically my son ends up losing out a bit, I'd like to give him more attention, sometimes he goes on at me "Mum, Mum..," and I have to say "Son, just wait a minute because I have to deal with Grandma now" »* (Int. 8, p.22)

Another woman, aged 33, the caregiver for her father-in-law, with a child of 2, said: *«I would like to be able to spend a bit more time with him. When we get home after a day's work there's a lot to do with supper and tidying everything up, so there's little time left over for being with him »* (Int. 9, p.14).

At another point in the interview the same respondent underlined this idea: *«One's day is fully occupied, because one is at work, and then one gets home and still has to make supper and look in on the in-laws and leave everything ready for the next day. It's usually the little one who suffers on account of all this, because by the time we're cleaning him up it's already time to go to bed and he wants us to be with him. (...) He asks us to play with him, to go to the park with him or to go for a walk with him … simple things »* (Int. 9, p.31).

The statement of a woman, aged 37, the caregiver for her mother-in-law, with 3 dependent children, is also very elucidating about the decrease in the amount of free time available for being with them: *«What do I miss?? Time, time to be with them without having to say "put your sweater on, take your sweater off, have your bath, hurry up, put your bag away, have you got your swimsuit, have you got your gym gear". To have time to be with them or watch a video with them, or to chat about a book with them, or to have an ice-cream with them... just being with them without always having to say... the simple fact of enjoying my children's company. That's what I miss most »* (Int. 1, p.19).

In the area of **family relationships**, we observed an impact only on families providing "hands-on" care. We found 2 main types of impact in this domain: **conflicts between**

siblings (2 cases, all cases where the main caregiver has other brothers/sisters who do not take part in the regular care of the elderly) and **marital conflicts** (1 case).

In the first 2 cases, the decision to take on the responsibility for caring for the dependent elderly person was not negotiated between the siblings: one of the siblings voluntarily took on that responsibility. In one case, this happened mainly because the dependent elderly person was used to staying in the respondent's home when he went to Lisbon for medical appointments (Int. 8). In the other case, because the respondent's husband had already been providing care to his mother before he got married (Int. 9).

When the brother/sister who had voluntarily taken on the responsibility for caring for one of their parents started to ask for the support of the other brothers/sisters and these (or most of these) did not provide it, conflicts between them gradually started to emerge. In both cases the main caregivers believe that their brothers/sisters could provide some kind of support on a regular basis. So this situation makes them feel sad and unsatisfied.

Let us see what a respondent said about the non-participation of her husband's brother in the care provided to her father-in-law: *«(...) He (the husband's brother) doesn't share in anything. But my sister does. (...) He doesn't share in the care because he doesn't want to. His job is actually simpler than ours, he gets home earlier and all that, but he just doesn't want to help. He distanced himself from his parents and I think it's also for marital reasons. His wife doesn't like him getting close to these situations and he respects her wishes»* (Int. 9, p.23). When the interviewer asked if the respondent's husband feels that his brother should give more support, the respondent said*: «Yes, of course For sure. I've even told him so, but there you are, you can't force people to do what they don't want to, can you? »* (Int. 9, p.23).

With regard to marital conflicts, the family where this happens is responsible for caring for the wife's mother. The latter and her husband live with the respondent, the respondent's husband, the respondent's son and the respondent's mother-in-law. From the respondent's point of view, the conflicts with her husband started to arise because the latter thinks that she should not take on all the responsibilities of care (his wife has other brothers/sisters).

This statement sheds light on this issue: *«It hasn't been easy, and then I start to have problems with my husband (…) He thinks all the children should help and he's right of course, but people say to me "you're the weakest one", i.e. while everyone else is having a good time, I'm not (...) and then we start to argue and things get complicated, very complicated, but I don't even let my parents see this, because in the end they would be the ones who would suffer most. If I start telling my father that I'm having problems with my husband, he'll get even worse. (...) I say to him that he's right, but then he starts "of course it's only you who..", and now for the last five months I haven't seen any money out of my sister, there's no help at all, nothing, I mean, it all falls on me, all the responsibility falls on me »* (Int. 8, p.16).

Finally, we have the impact on **personal health**. All the main caregivers who provide "hands-on" care feel the impact on their personal health. By contrast, all the main caregivers who do not provide "hands-on" care do not feel this kind of impact.

All the effects we have analysed above (changes in daily routines, in working hours, decrease in social and leisure activities...) are reflected, in the final analysis, in caregivers' health, in particular in the main caregivers' health.

In talking about personal health we include the physical and psychological components.

The following statements represent some examples of this type of impact:

«(...) it's too much. I've noticed that I'm not too good in the head lately either, and now with this pneumonia problem I've been very low, really very low. Sometimes I even say "with all this on top of me one day I'll go crazy, you'll see me in the Júlio de Matos (psychiatric hospital)". It's true, I tell you, because my head is really tired , sometimes I can't think straight, I really can't think straight. This is what tiredness really is. I take supplements, things for the brain, and all. » (Int. 8, p.23).

«(...) I've never slept very much, but now it's worse because I'm always worried about having to go and see her (during the night), and then sometimes I get here (to work) and I'm absolutely shattered » (Int. 3).

A woman, aged 36, the main caregiver for her mother, said that she rests at work and works at home. For her the real work starts after she arrives home: *«I think I get much more tired at home. I tell them (colleagues at work) "I'm coming here for a rest now , now's the time I'm going to be able to relax." And they laugh, they know me very well, they know perfectly well, OK they don't know all the details but they know it's a permanent merry-go-round, sometimes someone says "look, I only got up half an hour ago" and I say "look mate, I've been working for God knows how long already." Yes, well, that's how it is and they know it's true »* (Int. 12, p.38).

2.4.1. Expectations / Suggested Measures

In the context of the different types of impact we analysed, which lead to reduced satisfaction or even to some needs not being satisfied at all (e.g. social and leisure activities, having personal time, having time to be with the children....), the families we interviewed expressed their opinion on some measures which they feel should be adopted in order to help reconcile work and the care of the elderly.

All the families which provide "hands-on" care and do not have the support of (informal or formal) care services from outside the family or, on the other hand, only have these services on a part-time basis, would like to have them on a permanent (i.e. full-time) basis (interview 1, included in the "shared hands-on family care" sub-type, and interviews 8 and 9, included in the "shared family care + part-time home-based paid services" sub-type). These families provide a great deal of "hands-on" care and, because of this, it has been very hard for them to maintain a balance between work and care of the elderly. So they would like to obtain full-time home-based care services:

«What would be really helpful to me is to get hold of someone who could look after them (full-time), I wouldn't mind if it was at home » (Int. 8, p.17).

«Look, if we could afford it, then we would certainly have hired someone full-time.. if we could have done...» (Int. 9, p.28).

Families in the "shared family care + day care centre" sub-type think that day care centres should have longer opening hours (they should open earlier and close later). In both cases, reconciling the day care centres' opening hours with the caregivers' working hours is only possible because one of the couple's members has reasonably flexible working hours.

A woman, aged 60, tells us the following about the opening hours of the day care centre where her father stays during the day: *«(...) the problem is that it closes very early (the Day Care Centre), like I said it closes at 17:00/17:30, that's too early for me, it's too early »* (Int. 25).

On the other hand, one of these families said that there should be day care centres for elderly persons with high dependency, where the families could leave them during the day.

Finally, there are some families which suggest other type of measures, such as improving the professional qualifications of the persons who provide care to elderly persons and increasing state aid for families with responsibilities for the care of the elderly:

«(...) but it would have to be someone, I think someone with some experience, because I think people who go to work in old people's homes and day care centres go there because they can't find jobs anywhere else (...) there are some professions where it's important that people should enjoy what they're doing, because that's the only way you're going to make these people comfortable. (...) those people would be motivated and willing , and would have the experience to help them, to give them a better quality of life in the short period of time they've got left (...)» (Int. 12, p.31).

«(...) financial support for this type of situation (having the elderly person in an old people's home or having home help) I think that's totally irrelevant… it's supposed to be tied to the possibility of getting good treatment at a certain social level, and that's all very complicated, isn't it. So I think financial support for this type of situation and specific training for those people could possibly improve things a great deal (...)» (Int. 7, p.25).

2.4.2. Conclusion

On the basis of our data, we may conclude that the **quantity** and the **types** of **impact** on the **caregiver's life** due to **taking on responsibilities for the care of the elderly** depend on the **type of care** they **provide**: "hands-on" care or "watching over" care.

We observed that, except for one case, no family providing "watching over" care suffers any impact in the domains mentioned above. By contrast, **all the families** providing "hands-on" care suffer an impact at the level of **daily routines**, **social and leisure**

activities and **personal health**. With the exception of one case, **all of these families** also report an impact on the **main caregiver's work**.

On the other hand, **all the families** which provide "hands-on" care of the elderly and have dependent children report an impact on the **time available** for being with them.

Finally, it is interesting to see that in **all cases** in which the main caregiver for the dependent elderly person provides "hands-on" care and has other brothers/sisters who do not take part in the care of the elderly, there are **conflicts** between the former and the latter.

Marital **conflicts** were only found in one case.

Expectations/measures reported by families can be grouped into 3 main types: adapting services for the care of the elderly to families' needs (home-based care services for longer periods of time, including full-time services; day care centres with longer opening hours and day care centres for elderly persons with high dependency); better professional qualifications for providers of care to the elderly; and the increase in state support for families with responsibilities for the care of the elderly (e.g. subsidising the costs of services).

PART III

PROFESSIONALS IN THE AREA OF CARE FOR ELDERLY PERSONS

1. The Views of Professionals

The professionals we interviewed[11] stressed that dual earner families caring for an elderly person have to face the following main difficulties/problems:

- **Limited informal support**. Caregivers (couples) have almost no informal support. Close kin living in other households (such as brothers and sisters) usually provide occasional support or no support at all. Other informal providers such as neighbours and friends are systematically absent. They can only rely on each other and sometimes on their live-in children.

- **Insufficient formal support**. In general terms, the coverage rates of services for elderly persons (day care centres, home-based care services…) are still low, especially for elderly persons with specific health problems (e.g. Parkinson disease, Alzheimer disease…).

- **The services provided by the state and the non-profit making sector do not satisfy all the families' needs**. For example, the majority of day care centres open too late and close too early. On the other hand, the home-based care services only operate on a periodical / part-time basis (for short periods of time during the day). Moreover, these services have no responses for occasional needs (e.g. when the elderly person's family members want to get some rest, when they want to go on holidays…).

- **Only the private profit-making sector or the paid informal sector**, as mentioned in the chapter on policy and provision, **provide services adapted to family needs**, such as home-based care services 24 hours a day, full-time home-based care services (8-12 hours per day), home-based services during the night, etc. The families who use these types of services are high income families. In general terms, the services which are in more demand are the 24 hour service and the full-time day service. The former is frequently asked for when the elderly person lives alone and the latter when the elderly person lives with other relatives. Usually these institutions find it difficult to provide services on an occasional basis (e.g. on weekends, during the holidays…). Another problem that these institutions have to face is the difficulty in finding and recruiting people with an adequate professional profile.

[11] Two professionals were interviewed: a social assistant who has worked in different institutional settings (homes, day care centres, Association for persons with Alzheimer disease…) over the last few years, and a manager of a private profit-making institution for home-based services.

- **State financial support for families that provide care to dependent elderly persons is still insufficient**. Caring benefits are low and there are some costs that are not subsidised or that are not tax deductible (e.g. the costs with a paid informal helper).

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ANNEX

THE PORTUGUESE CONTEXT: CHILDCARE POLICIES, MAIN TYPES OF CHILDCARE PROVISION AND CHARACTERISTICS OF LONE PARENTS

Portugal is usually described as a country with a strong and explicit ideological commitment to the family, but a low profile as far as family and child policies are concerned. The idea of a rudimentary welfare State underlines the precariousness of state provision, especially of care services, which are compensated by traditional welfare guarantees stemming from strong families and informal support networks. This vision of welfare provision is partially correct, in as much as Portugal has been lagging behind other EC countries. Social policy measures were introduced and improved later than in other member states, in the seventies and eighties (and even in the nineties), and usually in the context of severe economic constraints. In this setting, the family, and women in particular, have been seen and taken largely for granted as basic providers, carers and problem-solvers for individuals. Nevertheless, **over the last two decades, there have been important changes and developments**, in society and in social policies, which have affected family life and caring patterns. The following developments should be considered if we want to update the above-mentioned profile:

- The period from the 1970s into the 1990s was characterised by **growth in women's employment**, mostly on a full-time basis: in 1970, only 29% of Portuguese women aged 15-64 were economically active, whereas by 1998 this proportion had increased to 62%. The activity rates of women in the childbearing age groups also increased greatly, from 29% to 80 % for the 25-34 age group and from 22% to 77 % for the 34-44 age group.

- During the seventies and early eighties, specific measures with significant impact on the daily lives of families with young children were centred on the question of **women's protection in the labour market**, mainly through a variety of maternity provisions. In the mid-1980s, but especially **during the 1990s**, there were some further changes and developments in public policies. Overall, we can say that public policies began to address the issue of **family life and employment** not only from the point of view of the traditional problems of motherhood protection and furthering gender equality, but also from the point of view of making it easier for both parents to conciliate family life and employment. This implied producing public responses along three main lines (Wall, 2001): the increased protection of working mothers before and after childbirth; the building up of leave arrangements for parents (both mothers and fathers);the expansion of service provision for young children.

- Government *per se* remained a secondary actor in Portuguese social welfare until late in the twentieth century. Expansion of the government's social role came only in the 70s, 80s and 90s, with a stronger impulse in the late eighties and nineties in the context of more political and economic stability. In terms of **financial support** for families, the welfare state may still be considered as limited (for example, cash

benefits have low levels) but there has been some build-up of support measures: in the nineties, these have included measures such as the introduction of a Minimum Income guarantee, the reinforcement of social protection for unemployed persons over 45 years of age, the increase of full-paid maternity leave to 120 days and the introduction of replacement pay (65% of average daily wage) for parents taking leave to care for a sick dependent child under age ten (according to the 1984 law on the protection of maternity/paternity, either parent is entitled to miss work up to 30 days).

- In terms of **care provision,** the specific role of the State, as a co-ordinator, planner and financial supporter of services rather than a direct producer, also emerged more clearly during this period. In the nineties, the development of a new logic of partnership led to the strengthening of co-operation between the State, non-governmental organisations, local government, and representatives of civil society such as parents' associations in order to expand service provision for families. Take-up rates for child care services, day centres for the elderly or home-help services are still lower than in many other European member states but they have expanded since the late eighties, mainly thanks to non-profit-making social organisations, and more rapidly for certain population or problem groups (such as pre-school children and disabled children).

In this chapter, we shall describe in more detail the trends and developments in child care policy and provision. We will also look more closely at policy for lone parents as well as the characteristics of lone parent families in Portugal

1. Child care in Portugal: policy and service provision

Government policy towards the provision of child care falls roughly into three broad phases over the last fifty years. During the Salazar regime, educational provision for children aged seven (for three, then four years of primary school) was the only publicly-provided form of institutional child education or care. The child-care commitments of working women were not even addressed, as mothers and their families were seen to have full responsibility for nursing and caring for babies and small children. Nevertheless, as women moved into the labour market in the 1960s, the private and voluntary sectors began to provide some services, few and far between, for preschool children (Bairrão et al., 1990).

The second phase entailed a radical change in attitude but a certain difficulty in expanding collective child-care institutions. Public policies after the 1974 revolution addressed the child-care commitments of employed mothers in two ways: through legally-secured entitlements to leaves of absence, in particular paid maternity leave, and through formal recognition of the state's duty to develop a national network of child-care assistance (Art. 67 of the 1976 Constitution). During the first years after the revolution, there was a generalized consensus on the need to create alternative sources of support and care for small children, especially in economically and socially depressed areas. This led to an initial spurt in the number of nursery schools, of special schools for disabled children, and training courses for educators (Bairrão et al., 1997).

Most of the increase in child-care institutions, however, was based on the initiative of work-place communities, grassroots movements, and voluntary organizations. It did not lead to a sustained increase in provisions for early-childhood education and care, not only due to difficulties in renewing this initial impetus but also due to the fact that most private and public financial investment in education was first directed towards the urgent development of other sectors of the educational system, such as basic compulsory education. Thus in the late 1980s, when the first reports on child care in Portugal came out (Bairrão et al., 1989; Ramirez et al., 1988), early childhood education was found to be incipient and poorly developed: only 31% of the three-to-five age group were in institutional child care compared to practically all children in Belgium and France and to high proportions of children (64% or more) in all other European countries except Greece (Bairrão and Tietze, 1995). In Portugal's second-largest city (Oporto), the percentage of children in preschool education was as low as 28% in 1984.

This slow expansion of nursery schools for the first ten years after the revolution was, nevertheless, accompanied by some policy measures. Two main co-ordinating bodies were established for early-childhood education and care: the Ministry of Education and the Ministry of Employment and Social Security (now the MLS: Ministry for Labour and Solidarity). The ME was put in charge of nursery schools for the three-to-five age group in educational establishments belonging to the ME and in private schools; the MLS was put in charge of crèches and nursery schools belonging to the MLS and to private non-profit voluntary organizations. Another measure taken in order to provide a framework for institutional development was the legislation (No. 519-G2, 1979 and No. 119, 1983) on private non-profit institutions with 'social solidarity' aims, whereby the state recognized the important role of voluntary organizations in providing goods and services to children, families, elderly persons, and communities and established state sponsorship (Capucha, 1995). Finally, a law on crèches and childminders (No. 158/84,17 May, Ministry of Employment and Social Security) established a new form of child care called 'family crèches': childminders who provide care in their own homes for a small number of children, the difference being that they are registered, sponsored, and monitored by a public or publicly-sponsored establishment.

The third phase in the provision of child care has seen levels of provision grow steadily over the last fifteen years and has brought them somewhat closer to those of other European countries. In 1994/95, 55% of the three-to-five age group were in pre-school education (compared to 29% in 1985/86), and by 1998/99 this had risen to 65%.

Policy relating to the development of formal child care facilities for **very small children below age three** has not been as high on the political agenda as preschool education. By focusing on preschool education for the over-threes, child care has essentially been envisaged from the point of view the child's education career, rather than from the point of promoting the reconciliation of work and family life. Despite this focus, consideration of families' needs is now underlined in the new laws and current debate on the ways to solve these needs shows that this issue represents has acquired a new legitimacy. Governmental recognition, within the 1999 government programme[12], of the need to support families through service provision and to promote the reconciliation of work and family life, also points to some of the relevance that this

[12] Cf. Programme of the XIV Constitutional Government, Presidency of the Council of Ministers, 1999, part D – Renovating policies for the Conciliation of work and family life and for Equality of opportunities between men and women, pp. 56-57 and also pp. 65-66.

issue has begun to acquire. Within the chapter of the above-mentioned government family policy aims, the need to expand service provision is linked for the first time to the establishment of a precise goal in terms of expansion of crèche facilities: to double the number of children under three that have access to crèches by the year 2003.

The responsibility for provision services for children below age three is mainly in the hands of the voluntary sector (particularly non-profit social solidarity institutions and establishments belonging to the *Misericórdias*), with State support from the M.L.S. and limited assistance from parents who are responsible for paying for some of the costs of child care arrangements. The State (M.L.S.) provides early-childhood institutions for a small proportion of users, never more than one tenth while the state-supported "third sector" includes over 80% of all users; the private profit-making sector compensates for the remaining gaps.

At present, formal provision for under three year olds includes three main types of services: **crèches (**open five days a week, usually all day long) run either by the private sector, by the public sector, or by not-for-profit social organizations (by far the most prevalent child care arrangement for this age group); **registered childminders** and **family crèches** (a group of registered childminders linked to a crèche). **Unlicensed childminders** and **leaving the child with close kin** are the other informal child care solutions which families often use.

Formal childcare facilities for the under-threes have increased lowly but quite steadily over the last 15 years: up from 650 establishments with crèches in 1987 to 944 in 1992 and 1385 in 1997.[13] This implies that family strategies for the care of very small children have also been changing over these years, in fact quite significantly. Data from a national survey on families with children in Portugal showed that patterns of childcare of babies aged one to two years in the seventies were very different from those existing in the nineties (Wall, 2000). Care of babies born in the seventies was predominantly mother-at-home-based. Nearly half of all mothers (44%) stayed at home with the baby. Leaving the baby with close kin (34%) was the next most important child care solution whereas childminders (11%) and formal day care (7%) were clearly minority solutions. In the nineties, on the other hand, baby care solutions for this age group seem to have developed in a more pluralist direction and no single form of care occupies the main ground as in the past: only one in four mothers used the mother-at-home solution for children aged 1-2 while the kinship solution (36%) and the childminder solution (12%) maintain their relative importance and the formal day care solution increases to 18% (Wall, 2001).

With regard to child care for the **3 to 5 year olds**, the levels of provision of preschool facilities grew steadily over the last 15 years. In 1994/95, 55% of the 3 to 5 age group were in preschool education and by 1998/99 this had risen to 65%. If we break these figures down by age group, we find a coverage rate of 53% for three year olds in 1998/99 (42% in 1994), 65% for four year olds (55% in 1994) and 78% for five year olds (63% in 1994). Coverage still varies by region, with higher coverage rates being reached more rapidly in the rural and semi-industrialized areas than in the large cities where many families with young children are concentrated. Many preschools located in

[13] Social Security Statistics. The coverage rate for children aged 0-2 years was estimated at 12.2% in 1993/94. Cf. Maria do Rosário Ramalho, Maria do Pilar González and Margarida Ruivo "Report on Care – Portugal", Porto, 1998.

highly populated urban centres have waiting lists. In the Lisbon area, where the interviews took place, the coverage rate is close to the average (66%), whereas in two other big cities the coverage rates are still well below the average: Porto with 52.7% and Setubal with 48.2% (Wall, 2001).

During **1990s**, strategies for development of pre-school provision have clearly passed from an initial model based on the idea of state ownership of a "public network" to a more pluralistic model characterised by institutional differentiation and a shift toward a private/public mix in which three main sectors are responsible for provision: the public sector (establishments belonging to local authorities and to national government, either the Ministry of Education or the Ministry of Labour and Solidarity), the private non-profitmaking sector and the private sector. Responsibility for the development of preschool education is very much shared between the three sectors. In 1998/99 the private share (profit and non-profit-making) of establishments for the 3 to 5 age groups was 54% (in number of users) with almost two thirds (63%) of this share belonging to the private non-profitmaking network. In the large urban regions, however, the relative importance of the private sectors is higher: 75% in the Lisbon area, 67% in the Porto area, 75% in the Setubal peninsula.

In **1995**, the development of preschool education was defined as a priority of the Ministry of Education and new policy goals aimed to include 90 percent of five year olds, 75% of four year olds and 60% of three year olds by the year 2000.[14] During the **late nineties** the main policy instrument was the law on preschool education which passed in parliament in December 1996, followed up in 1997 by Law 147/97 which set out in detail the strategies for the development of pre-school education. They were preceded by vigorous debates in 1996 and one of the most controversial issues was the extent of State involvement in promoting and paying for preschool education. Some actors, such as trade unions, strongly defended the creation of a public, free of charge, preschool network. The resulting law is a compromise between this view and the one, closer to initial proposals by the Ministry, more centred on an outlook where the family, the private sectors, central administration and local authorities are all involved in the expansion of facilities (Wall, 2001).

The new law defines preschool education for the three to five age group as a first stage of basic education. It is defined as optional, on the basis that the family is, first and foremost, responsible for the education of these children. The Ministry of Education (M.E.) and the Ministry of Labour and Solidarity (M.L.S.) share the responsibility for the preschool establishments (for children from three to five years old). With the new law for preschool education, the M.E. has the responsability for ensuring the educational component (curriculum activities) of all state-funded preschools (public, private non-profit and others). The educational component is defined as "free of charge" for all the state or state-funded establishments. On the other hand, the M.L.S. guarantees the "social" component: the extended day cover while the parents are working, meals and extra-curriculum activities. This component is subsidised by the State (M.L.S.), but families may also contribute according to their economic resources.

[14] Cf. *Grandes Opções do Plano para 1997*, Law nº 52-B/97 and Law 147/97, 11 June.

Thus the costs of operating **public preschool facilities** are divided between the national government (and between two Ministries), the local authorities and the parents[15]:

- In **nursery schools belonging to the public network** the operating costs are shouldered by the M.E. (educational component) and the M.L.S. (social component), although financial responsibility for the "social" component may be transferred, by agreement, to the local authorities. In many preschools, however, the "social" component still has not been developed and this is an issue which is in discussion and that parents associations are trying to push forward. When there is no "social component", the nursery school is open five hours a day, closing for two hours during the lunch hour. The absence of canteens and these short opening hours often make it difficult for parents to reconcile work and child care responsibilities.
- In **nursery schools belonging to private non-profit institutions**, the State pays for 62% of expenditures and families for 38%.[16] Funding is carried out on the basis of the cost of each child, and the amount per child is fixed annually by the State (jointly by the M.E. and the M.L.S.) after hearing the organisations that represent the interests of these institutions. These nurseries are open for ten to twelve hours, with canteens and after school activities.
- In **private and cooperative school establishments** families pay for almost all expenditures (95%); families are supposed to shoulder the costs here, but the law on preschool education allows for some sponsorship in these schools via the establishment of special development programmes. Opening hours are also long and the schools usually have canteens and heating-up services for meals. Many of them also provide paid after-school activities such as music or sport classes and help with homework.

In summary, the role of the State is thus fourfold, according to the new laws: to promote, fund and supervise a public network of preschool education; to promote, support and supervise the preschool establishments run by other entities (private establishments, non-profit-making social solidarity institutions, other non-profit institutions); to define the general norms of preschool education; and to give special support to the regions of the country which are more vulnerable in educational and cultural terms.

The new law of preschool education also attempts to influence the care model of state-run preschool institutions by establishing that "the timetable should be adapted to the possibility of giving children meals" and take into account not only time for educational activities but also the needs of families (article 12). Up till now, the care model in state-run and in private nurseries has been different: the nurseries run by private establishments (profit as well as non-profit) are open for long hours (sometimes up to 10 or 12 hours), serve or heat up meals and provide activities or supervision after nursery school; state nurseries have five hours of preschool activities, finishing at 15:30, and close for two hours during the lunch hour, making it difficult for parents to reconcile work and childcare responsibilities; the development of the "social" component of the public preschools is therefore likely to remain an important issue over the next few years.

[15] Cf. Law 147/97, 11 June which sets out the rules of co-operation between the different funding bodies.
[16] Department of Financial Administration, Ministry of Education.

Finally, with regard to **school facilities for children over age six,** it is important to mention that six is the official age for starting full-time education and that compulsory schooling (universal and free) was extended from six to nine years in the late eighties. It includes three "cycles": the first (primary) school cycle last for four years, the second (preparatory) cycle for two years and the third cycle for three years. School hours are usually from 8.30 or 9 a.m. to 15.30 but many children may have school either in the morning or in the afternoon due to the fact that schools may have two shifts to fit in more pupils. In the second and third cycles, on the other hand, timetables may be variable, with classes starting at different times in the morning and with some "gaps" in classes during the day. This is a frequent problem for families with young children and one of the advantages of private schools, where children have a regular school timetable and other activities after school.

Another solution for families is to use publicly-supported leisure time centres (ATL) provided by local authorities or non-profit social organizations and with means-tested payment; some of the latter even provide transport facilities, to fetch the children from school and take them to the ATL. Efforts are also being made by some schools, in cooperation with local authorities and parents' associations, to introduce canteens and after-school activities in public schools. However, the development of these facilities depends on the success of these partnerships as well as existing space in the school buildings and thus varies considerably. If access to leisure time centres or to informal child care services is difficult or too expensive, this means that children are left to themselves for many hours.

In summary, the care model of public school institutions is not adapted to the needs of families. Provision of leisure time centres (ATLs) is expanding but is still insufficient. Publicly-supported ATLs have long waiting lists and many children do not have access to this type of facility. In fact, local experts in the Lisbon area estimate that ATL provision should be almost double of what it is at the moment. Efforts are underway: for example, the Lisbon municipal authorities have a programme since 1992 (the "RODA" project) to support ATLs set up by schools, by parents' associations or by ONGs. Development has been steady but very slow: in 2000/2001 they were supporting 21 ATLs (covering 1200 children) in the city of Lisbon.