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Reconciling work and informal care across organisations: a question of capabilities?

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Abstract:
Individuals are increasingly faced with informal care tasks during their working lives. While women have consistently taken on the majority of informal care tasks, men are increasingly faced with informal care tasks as well. Several processes influence this development, including the ageing of the population, the increased multi-morbidity of old age, longer working lives, retrenching welfare states, and the push towards a 'big society', in which individuals and social organisations are increasingly held responsible for caregiving activities. Within this context, work organisations are integral to the ways in which individuals reconcile work and informal care tasks. While existing literature recognizes the importance of organisational policy in providing work-care reconciliation policies and organisational culture for making these arrangements accessible to employees, there is little attention for employees' capabilities to actually engage with work-care reconciliation policies in the workplace. The capabilities approach as outlined by Sen (1992) and Hobson (2014) offers a theoretically innovative way of looking at individuals' capacity for reconciling paid work with informal care responsibilities.

The capabilities approach recognizes that the ways in which individuals reconcile work and care are not only a reflection of agency but a reflection of what individuals are genuinely capable of achieving. These capabilities can entail individuals' capabilities, including behavioural and cognitive aspects (e.g. ability to deal with stress), the capabilities provided by personal networks (e.g. social support, perceived social support) and capabilities within the organisation (e.g. the organisational environment). In this paper, we explore to what extent a capabilities approach is applicable for understanding employees' reconciliation of work and informal care tasks. Using interview data from line managers, personnel managers and employees, we are able to provide an in-depth analysis of how individuals make decisions about reconciling work and informal care, providing important insights into the usefulness of this new theoretical framework for understanding care in modern welfare states.

1. Introduction

Pressure to provide informal care during working lives is increasing. The ageing of the population (Blome, Keck, & Alber, 2009; Harper, 2014; Saraceno, 2008), the increased multi-morbidity of old age (Mercer, Smith, Wyke, O'Dowd, & Watt, 2009), longer working lives (Colley, 2011; OECD, 2014), retrenching welfare states and the push towards a 'big society' (Merens & Brakel, 2014; Veldheer, Jonker, Noije, & Vrooman, 2012), in which individuals and social organisations are progressively held responsible for caregiving means individuals are likely to face informal care tasks at some point during their working lives. Yet not all individuals are equally capable of taking on these responsibilities (Arksey, 2002; Carmichael, Hulme, Sheppard, & Connell, 2008). While paid work can also have a positive influence on carers, such as providing an outlet away from caring roles and reducing the chance of social exclusion, paid work and care are dual obligations that are not easily met (Arksey, 2002). The fact that many individuals face these competing obligations during their working lives make organisations integral to understanding whether and how individuals are able to reconcile work and informal care tasks. While existing literature recognizes the importance of organisational policy in providing work-care reconciliation policies (Dikkers et al., 2007) as well as organisational culture (Allen, 2001; Behson, 2005) and the role of managers (Den Dulk et al., 2011; Peper et al., 2009) in making employees feel entitled to make use of work-care arrangements, there is little attention for employees' capabilities to reconcile work and informal care within the organisational context (see Takahashi et al., 2014 for an exception). The capabilities approach as outlined by Sen (1992) and Hobson (2014) offers a theoretically innovative way of approaching this issue.

Informal care encompasses a broad range of care responsibilities, but is often defined in the Netherlands as long-term care provided for at least 8 hours a week or for a period of three months or more (Oudijk, Boer, Woittiez, Timmermans, & Klerk, 2010). However, restricting the definition to a specific number of hours per week can unnecessarily exclude a large group of informal carers who provide care on a structural basis. We therefore define informal care as unpaid, voluntary care provided on a structural basis for someone in your family, household or social network with a physical, mental or psychological disability (see also Kruiswijk, Da Roit, & Hoogenboom, 2014). In several European countries, such as Sweden and the UK (Brennan, Cass, Himmelweit, & Szebehely, 2012) as well as the Netherlands (Da Roit, 2012; de Klerk, de Boer, Kooiker, Plaisier, & Schyns, 2014; Grootegoed & Van Dijk, 2012), governments have been increasing market principles in care services, rolling back

state-funded long-term care provisions, cutting care services and budgets, and tightening eligibility criteria for care services. In countries where informal care services, such as long-term care for the elderly have traditionally been minimal, like Spain and Italy, family members have historically taken up these physically and time intensive care tasks (Brandt, Haberkern, & Szydlik, 2009; Haberkern & Szydlik, 2009). In countries where informal care services have been well developed, however, informal care has often taken the form of more frequent but less intensive help and support (Brandt et al., 2009; Haberkern & Szydlik, 2009). In these countries, where informal care has seen significant reforms in recent years, the increased responsibility being placed on individuals and families to provide makes the issue of how individuals combine these informal care tasks with paid work particularly urgent. We investigate individuals' capability to reconcile work and informal care in organisations in the Netherlands.

The Dutch case offers a particularly salient example of the changed expectations and responsibilities relating to work and care. The Dutch welfare state is witnessing a return to the principle of subsidiarity, whereby individuals with care needs are expected to ask for help from family and their social network before relying on government care services. Dubbed 'the participation state', the government is promoting not only high labour market participation but high social participation as well (Merens and Van den Brakel, 2014). The underlying assumption, however, is that men and women are available to provide informal care. We question to what extent individuals are genuinely capable of reconciling paid work and care. In this article, we explore to what extent a capabilities approach is applicable for understanding employees' reconciliation of work and informal care tasks across four organisations who provide so-called 'informal care friendly' policy. The question we focus on is: Under what conditions does an informal care friendly policy contribute to a sustainable reconciliation of work and care? By focusing on the conditions necessary, including individual, social and institutional conditions, we investigate individual capabilities for reconciling work and care. Using interview data from line managers, personnel managers and employees, we are able to provide an in-depth analysis of how individuals make decisions about reconciling work and informal care, providing important insights into the usefulness of this new theoretical framework for understanding care in modern welfare states.

2. A Capabilities Approach: reconciling informal care with paid work

The capabilities approach is a theoretical and normative approach that is increasingly being applied to social policy issues such as employability or life-long learning (Klink et al., 2011) and work-life balance (Hobson, 2011, 2014). The attractiveness of the capabilities approach in the work-care arena stems from the inability of existing theoretical approaches to explain the variation in individuals' ability to reconcile paid work with care tasks. Applying a capabilities framework is not a means of explaining this variation, but rather a means of describing and understanding such variation. As Robeyns (2005: 94) points out, the capability approach is not a theory that can explain poverty, inequality or well-being; instead, it rather provides a tool and a framework within which to conceptualize and evaluate these phenomena." While the term evaluation also suggests an attempt at providing an explanation, we would argue that the advantage of the capability approach is that it allows for an unpacking of the complex interaction of individual, organisational and instittional mechanisms that play a role in how employees reconcile work and care.

The capabilities approach was originally developed by the Indian economist and philosopher Sen (1992). Sen argues that social inequality is not just about an inequality of outcomes, but rather that social inequality stems from individual differences in freedoms and capabilities (see also Yerkes and Den Dulk, 2015 forthcoming). In this manner, through Sen's capabilities approach, the focus shifts from the given resources an individual has at his or her disposal, or how the experience a given situation, to individual capabilities and the distribution of these capabilities (Van der Klink et al., 2011). In relation to work and care, capabilities can be seen as the freedoms individuals have, or genuine choices, for reconciling work and care (Hobson 2014; Korpi et al,, 2013). As Hobson defines it, these freedoms stem from individuals' access to work and care arrangements as well as their right and sense of entitlement in using these arrangements.

Once a demand for care arises, individuals are faced with questions of whether and to what extent to be involved in providing care, and how to reconcile these care tasks with other responsibilities, such as paid work. By taking a capabilities perspective, we start by looking at this demand for care and the goods and means individuals have at their disposal to reconcile work and care. Goods and means include work-care policies at the macro or meso level, or arrangements in collective bargaining agreements, which allow individuals to translate into capabilities to reconcile work and care through so-called conversion factors

(Robeyns, 2005). Goods and means need to be both accessible and available to individuals. For example, short-term care leave may be available within a country's social policy arrangements or within an organisation, but access to this leave may not be equal for all individuals. In order to make use of goods and means, however, they must be converted into individual capabilities. This conversion process takes place at the individual, institutional and socio-cultural level (Hobson, 2014). In Hobson's interpretation, these individual, institutional and socio-cultural factors are seen as goods and means that can be converted into capabilities. This contrasts with the approach of Robeyns (2005), who sees conversion factors as the bridge between goods and means on the one hand, and capabilities on the other. She explains Sen's approach to conversion factors using the example of a bicycle. The characteristics of a given good (a bicycle in this case), can allow us to achieve a particular capability (mobility, for example). Using a bicycle, we have more mobility then when we have to rely on our own two legs to bring us places. But our ability to be mobile is affected by certain conversion factors – such as our physical condition or ability to cycle. In relation to work and care, the policies provided at the national and organisational level only increase an individuals' capability to reconcile paid work and informal care insofar as the individual is able to convert these goods and means into meaningful capabilities.

[Insert Figure 1 about here]

Applying this understanding of conversion factors to the issue of work and informal care, we can still apply Hobson's (2014) delineation of individual, institutional and socio-cultural levels. At the individual level, factors such as gender, age, one's physical and mental health, educational level, social class and available social network determine whether it is possible to convert work-care policies into the capability to reconcile work and care. Previous research on the capabilities approach in relation to work-life balance shows the importance of accounting for individual differences in relation to gender, age, ethnicity and social class (Hobson, 2014). Gender differences shape to a great extent the ability of individuals to make use of available work-care policies. Women are much more likely to take up care responsibilities than men (Crompton, 2006; Gornick en Meyers, 2004), in part due to dominant gender roles in society (Bianchi et al., 2000; Grunow, Schulz en Blossfeld, 2012). These dominant gender roles shape individual choices and could make it easier for women to access work-care policies as they are assumed to take on primary responsibility for care-giving tasks. Women are not just overrepresented in the care of children; they are much more

likely than men to be informal carers as well (Kruiswijk et al., 2014; Kahn, McGill and Bianchi, 2011). And while men's involvement in providing informal care is growing, research suggests they are less likely to receive workplace support (Arksey, 2002).

Choices around informal caregiving are also contingent upon age (Carmichael et al., 2008) and the carer's own health (Arksey et al., 2005). Carers with lower educational levels are more likely to exit paid employment at some stage in comparison to more highly educated carers (Carmichael et al., 2008). The authors found that carers who had given up work had done so because they felt they had no choice – continuing to combine paid work with informal care tasks seemed impossible. Findings such as these emphasise the need to include educational level when evaluating individuals' capability to reconcile work and informal care. Social class is closely related to educational level. Ethnicity is also impotant in relation to reconciling work and care, both in terms of care preferences of the care receiver as well as in relation to the carer (Van der Valk en Schans). Lastly, an individual's social network is integral to their capacity to reconcile work and care (Kruiswijk et al., 2014). The social network of a carer can include the care recipient, one's nuclear and extended family, friends, neighbours, care and welfare professionals as well as community members (e.g. membership within religious or ethnic communities). Research has shown that these broader care networks shape the specific contributions men and women make to informal caregiving, contributing to the gendered nature of care (Kruiswijk et al., 2014).

Institutional level conversion factors are also important for understanding how individuals can use various work-care arrangements to develop capabilities for reconciling work and care. In previous approaches (Hobson, 2014), institutional factors are defined as welfare regimes, and their characteristics, workplace characteristics and working time regulation. Given our focus on the organisational context, we focus on looking more closely at the workplace, considering not only the characteristics of the job but also socio-cultural norms at work and power relations at work. Job characteristics are important factors in explaining the choices people feel they can and cannot make within the workplace. Employees at various levels throughout the organisational hierarchy can have more or less autonomy to make decisions around work and care. Differentiation in contract type, working hours, flexible working arrangements and tenure within the organisation can further impede or improve an individual's decision-making capacity, access to work-care arrangements or sense of entitlement to make use of available policies.

In addition to job characteristics, socio-cultural norms in the workplace regarding the combination of work and informal care are important. Workplaces, like society as a whole, embed explicit and implicit norms regarding what is acceptable in terms of absence from work, flexibility in working time and place, phone calls at the workplace, and so forth -- issues which can be central to carers with paid work responsibilities. Broadly speaking, the work-care organisational culture, or the shared norms and assumptions within an organisation (McShane and von Glinow, 2010) about paid work and care can make employees feel more or less entitled to make use of care arrangements (Thompson, Beauvais & Lyness, 1999; Peper, Van Doorne-Huiskes & Den Dulk, 2009). In a study on work-care culture regarding care for children in Japan, Takahashi and colleagues (2014) have shown that men are unable to 'convert' work-care policies into the capability to care due to an organisational culture that emphasises long working hours and high work performance. The further support or lack of support from colleagues and managers can also be crucial for creating a workplace in which paid work is more easily reconciled with care responsibilties (Den Dulk et al., 2011; Peper et al., 2009).

The final set of conversion factors are societal conversion factors. These can include socio-cultural norms in society (e.g. the need for self-reliance), the media (e.g. how care is portrayed in the media) and social movements (e.g. interest groups representing informal caregivers). Socio-cultural norms are important for shaping the choices individuals make in relation to work and care. The relationship between norms and behaviour is often reciprocal: norms drive behaviour and in turn, behaviour helps to maintain or challenge socio-cultural norms. In countries with well-developed care regimes, such as Scandinavian countries and until recently, the Netherlands, national attitudes tend to reflect the idea that families are not responsible for caregiving. Attitudes reflect the belief, for example, that elderly people are autonomous and should be able to live independently of family members. These socio-cultural norms contrast with those in Southern European countries, for example, where norms about family caregiving reflect a greater caring role for families, even in relation to intensive, phsyical caregiving. The media and social movements can also challenge or confirm existing socio-cultural norms around informal caregiving, although research on these topics is more available in relation to the reconciliation of work and care for children (Kremer, 2006).

In sum, we contend that the capabilities perspective allows for a more thorough exploration of individuals' capability to reconcile work and informal care than what has, until now, been provided for in the literature. By taking a dynamic approach to understanding what arrangements are available to employees (goods and means at the macro and meso level) and how these are 'converted' into capabilities at the individual, institutional and societal level, we can arrive at a more thorough understanding of what is driving individual outcomes in relation to work and informal care and the role of organisations in this process. These outcomes -- the actual combinations of work and care of individual employees -- are termed 'achieved functionings' within the capabilities approach. From Sen's point of view, individual wellbeing is a salient functioning to be achieved (1992; see also Robeyns, 2005), and the ways in which individuals combine work and care can improve their wellbeing (Hobson, 2014). Taken together in a single analytical approach (see Figure 1 below), we can see our application of the capability approach as a dynamic understanding of cares in the workplace.

3. Method

To answer our research question we chose an explorative research design that is qualitative and limited in scale based on an existing dataset. This is consistent with the aim of understanding the mechanisms related to capabilities that facilitate and/or impede the reconciliation of paid work and informal care (Miles, Huberman & Saldana 2014).

Context of the research

Until recently, the Dutch welfare state was known for its universal and generous system of social care for people in need of support, including good-quality home and residential care, largely available at relatively low costs for the users. However, since the late 2000s, the Dutch government has been rolling back long-term care provisions, cutting care services and budgets, tightening eligibility criteria for care services, as well as decentralizing public care as much as possible to the municipal level (Da Roit 2012). At the same time, citizens as well as voluntary and work organizations have been encouraged by government information campaigns and subsidy programs to take the place of (some aspects of) care formerly provided by state-sponsored professionals and professional organisations. Currently the Netherlands is in a process of recalibrating the responsibilities for informal care in which citizens, municipalities, voluntary organisations and work organizations are searching for a new division of labour in the care for people in need of support (SCP, 2012; Putters 2014).

These changes make the Dutch context a salient one for exploring the capabilities of individuals for reconciling work and informal care.

Research design and selection of respondents

The data was collected in 2012 by MOVISIE, a Dutch research centre for social development.[1] The research was commissioned and funded by ZonMW.[2] The main objective of the original research was to establish to what extent employee/informal carers, line managers, and personnel managers in work organizations are familiar with the challenges and problems involved in the combination of paid work and informal care; are familiar with public policies and special arrangements established by their work organisation to reconcile paid work and informal care; and have been involved in attempts to make the combination of work and informal care for their personnel and/or colleagues tolerable by searching for made-to-measure solutions (Oude Avenhuis & Kruijswijk, 2013: 6). Therefore the objective of the original research neatly coincides with the objective of the current article. The main difference between the original research and the research for the current article is the specific theoretical focus: whereas the original research was aimed at detecting concrete obstacles for the reconciliation of paid work and care, we search for specific mechanisms related to capabilities that facilitate and/or impede the reconciliation of paid work and informal care.

To be able to test the workings and effectiveness of special arrangements established specifically by work organisations to reconcile paid work and informal care of their employees, four work organisations were selected that were certified as "informal care friendly organisations" by the Dutch Organisation for Work and Informal Care (Stichting Werk & Mantelzorg):[3] a municipality, a social welfare organisation, a social care organisation, and a healthcare insurer, (see for details Table 1 in Section 4). For confidentiality reasons in this article the names of the organisations have been anonymised.

[Insert Table 1 about here]

[1] www.movisie.nl.
[2] Both the organisation involved in this research (MOVISIE) and the financer of the project (ZonMW) have explicitly authorized the authors to use the data collected for this article.
[3] www.werkenmantelzorg.nl.

Data collection and analysis

The original research consisted of a quantitative survey (N = 1,991; see Plaisier, Broese van Groenou & Keuzenkamp, 2014) and qualitative interviews. For our analysis, we used only the results of the qualitative interviews, since we were specifically interested in the mechanisms related to capabilities that facilitate and/or impede the reconciliation of paid work and informal care. In total, 56 respondents were interviewed during the qualitative part of the research: 15 line managers, 6 personnel managers, and 35 employees/informal carers. The line managers and personnel managers who participated in the interviews were selected in cooperation with the management of the four organisations. Two strategies were applied to select the employees/informal carers. First, respondents from the quantitative survey were asked whether they were willing to cooperate in an interview (leading to 29 positive responses); second, personnel managers were asked to suggest colleagues they knew were combining paid work and informal care (leading to a further 7 positive responses). A disadvantage of this selection strategy is that the self-selection of the respondents may have biased the interview results.

The interviews were conducted by six trained interviewers who, to enhance reliability, received intensive instruction at the start of the research. All respondents received information about the purposes and methods of our research, were guaranteed full confidentiality and were asked for express permission to tape record the interview. All interviews were recorded and transcribed. For the sake of confidentiality, the names of all the respondents have been anonymised.

The interviews with line managers and personnel managers were used to map the special arrangements in place aimed at allowing employees to reconcile paid work and informal care at the time of the interviews in each of the four organisations. The interviews with the employees/informal carers were subsequently used to analyse the mechanisms related to capabilities for reconciling work and care (details of the employees/informal carers are provided in Table 2, Section 4). The interviews of the employees/informal carers were analysed by all three authors of the article by means of QSR NVivo 10, software for analysis of qualitative data. In the first phase of coding, we used codes derived from the theoretical exploration in Section 2 (Miles et al., 2014). These concerned: the demand for care (type, duration and intensity of care); goods and means for reconciling work and care (government policies and employer policies); individual conversion factors (gender, age, physical and

mental health, etc.); institutional conversion factors (job characteristics, socio-cultural norms concerning combination of work and informal care at work, etc.); societal conversion factors (the influence of societal norms, media, social movements, etc.); the capability set; and the achieved functionings (the actual care situation of the respondent, the consequences of the actual care situation, and the respondent's evaluation of the care situation (for more details, see the code tree in Aappendix 1). In a second phase of coding, the interviews were analysed again, but now using a number of new codes inductively derived from the first phase of coding during the interpretative process and in the course of several discussion meetings among the authors (Miles et al., 2014).

4. Results

In this section, we focus on exploring the mechanisms related to employees' capability to reconcile work and informal care. We start by providing an overview of the goods and means for reconciling work and informal care, which includes government and employer policies that -- in theory -- provide carers with possibilities for combining work and care.

4.1 Government and employer policies concerning reconciling paid work and informal care

Government policies for reconciling work and care are not extensive in the Netherlands.[4] At the time the interviews were conducted, employees were entitled to short and long-term care leave. Short-term care leave is available as emergency leave (*kortdurige zorgverlof*) and provides employees with the right to two times the amount of their usual weekly working hours in paid leave (at a minimum of 70% of their current wage) per year. Long-term care leave is unpaid, and provides employees with six times their usual weekly working hours per year. It should be noted, however, that these policies are only available to dependent employees. The self-employed, a growing sub-category of workers in the Netherlands, (CBS, 2015) are not entitled to such leave options, which can lead to a signficant impediment in reconciling work and care (see Yerkes and den Dulk, forthcoming). In addition to leave, employees in the Netherlands can make use of flexible work arrangements, for exmaple flexibly negotiated start- and end times, telework or flexible hours. Part-time work is a much-used strategy among informal carers in the Netherlands (Oudijk et al., 2010), which is related

[4] For the purposes of our analysis here, we focus on policies aimed at care providers and the need to reconcile work and care. We exclude care policies aimed at the care receiver, such as cash-for-care schemes and personal care budgets.

to the fact that part-time work is well-protected in the Netherlands, (Yerkes, 2009) including the individual right to adjust one's working hours in either direction unless the employer can prove such an adjustment would be harmful to the business.

Alongside government policies for reconciling work and care, employer policies provide an important resource for individuals with informal care responsibilities. Employer policies can differ significantly across organisations, but in the Netherlands, employer policies are, to some extent, governed by collectively negotiated bargaining agreements. A recent study of collective agreements in the Netherlands shows that some form of short-term care leave was available in 69 of 100 sampled collective agreements (MinSZW, 2014). In 25 of these agreements a top up is provided, bringing the payment level up to 100% of the employees' wage. Fewer collective agreements contain arrangements related to long-term care leave: 43 of the 100 studies agreements has some type of long-term care arrangement (MinSZW, 2014). In some cases, these arrangements provide for some form of wage replacement, which the government policy does not require. But the level of the payment varies considerably. In the case of both short and long-term care leave, the definition of eligible care receivers (e.g. partner, parent, neighbour) is broader in the collective agreement than in government policy.

Outside of collective agreements, employers are not obliged to develop informal care friendly policies, nor are there currently any government campaigns to encourage the development of such policies.

Employer policies among our four cases[5]

The four work organisations selected for this research were all certified as "informal care friendly organisations" by the Dutch Organisation for Work and Informal Care (Stichting Werk & Mantelzorg). This means that these organisations were found to structurally pay attention to and support employees who combine paid work and informal care, promote care leave policies, and allow their line management to find and implement tailor-made solutions in order to make the combination of paid work and informal care sustainable for their employees.[6] The informal care friendly policies of the four organisations are largely comparable. They all aim at expanding the awareness of the subject of their board members,

[5] Since the work organisations were anonymised for this research, the sources of the descriptions in this sub section cannot be disclosed.

[6] www.werkenmantelzorg.nl/aan-de-slag/erkenning. Retrieved 25 August 2015.

line managers and employees by means of newsletters posters and the like, and circulate manuals and organize meetings to inform their personnel about the possibilities of care leaves and flexible work. In one respect the policies of the four organizations differ though. While the municipality and the social care organisation tend to concentrate their efforts on the employees who combine paid work and informal care themselves, the social welfare organisation and the health insurance organisation tend to focus their informal care friendly policy on the enlargement of awareness and information among the line managers and trained them to handle concrete situations. The social welfare organisation has deliberately chosen this focus since its personnel is dispersed over a large number of units and cannot be monitored by the central organisation; the health insurer reports that it focuses on training its line management in view of the large number of employees.

[Insert Table 1 about here]

4.2 Employees combining paid work and informal care

A total of 35 employees were interviewed for this study, all of whom reconcile paid work with informal care (see Table 2 for an overview; for more details see Appendix 2). The large majority of them are female, reflecting the results of earlier research showing that women on average provide (far) more informal care than men (Le Bihan, Martin, & Knijn, 2014), also in the Netherlands (de Boer & Keuzenkamp, 2009; Oudijk et al., 2010). Most of our respondents are between the ages of 36 and 55 years old, again, similar to the ages of informal carers more generally (Oudijk et al., 2010). Approximately one-third of the respondents work full-time, which reflects the high levels of part-time work in the Netherlands (CBS, 2015).

[Insert Table 2 about here]

Demand for care: care as a process

Most of our respondents are either caring for a child, often with a physical or mental handicap, or a parent (in-law) with complaints related to old age, such as dementia. On average, respondents spend anywhere between 8-20 hours per week providing care. It is vital to stress that many respondents view their caring – and the reconciliation of care and work – as a process. About one quarter of the respondents not only cares or has cared for more than one person (either at the same moment in time or consecutively) the intensity of care also

fluctuates across time. In some cases, this makes it more difficult to reconcile work and care and to find solutions at work for combining these two domains, particularly if long-term difficulties are encountered. We will return to this subject below.

Individual conversion factors: the importance of the care network

In the interviews, we did not find signs indicating that age, gender, educational level or social class affect the extent to which respondents are able to combine paid work and informal care, or the ways in which they manage reonciling these two domains at work. In addition, most respondents indicate that the reconciliation of paid work with informal care does not affect their physical health. Yet many respondents report psychological stress – not only as a result of planning and rushing around, but particularly arising from a feeling of inadequacy. As a woman who works full-time for the health insurer and cares 8-20 hours per week for her ageing parents remarks:

> There is always this frustration that you want to do more for them. […] You really want them to do well. And you can only accomplish that partially – that's very difficult for me. [Respondent HI-11]

In addition, what seems to be important is the social network of the respondents, and particularly the elasticity of the care network, i.e. the extent to which the care network is able to adapt to changing circumstances (Kruijswijk, Da Roit & Hoogenboom, 2014). While most respondents have made formal or informal arrangements at work to enable them to perform their "normal" and plannable care tasks, in cases where the care receiver requires extra, unforeseen care (e.g. a sudden deterioration of their health situation, going to the hospital etc.) some of them can ask their partner or a relative to help out. The availability of individuals' care network not only makes the situation both practically and mentally more tolerable for the caregiver, it also prevents extra pressure being placed on the arrangements the caregiver has already made at work, and makes it unnecessary to, for example, ask a colleague to take on tasks normally carried out by the caregiver or a manager for extra lenience.

[QUOTE]

Institutional conversion factors: the risk of flexibility

Two institutional conversion factors stand out as important factors influencing the extent to which respondents can reconcile work and care and find solutions when reonciliation of the two is difficult: the characteristics of the respondent's job and socio-cultural norms at work. As for the former, in many cases if the caring obligations cannot be planned ahead of time and other people in the care network do not step in, work and care can only be combined in a sustainable way if the employee's tasks at work can be performed flexibly. This means that tasks can be performed either at another moment in time (numerical flexibility) or at another place (usually at home or at the care receiver's residence; spatial flexibility) that suits the employee. Interestingly, such flexibility was possible in the large majority of the cases, which likely can partially be explained by the fact that we only interviewed employees working in (social) service organisations where such flexibility is more common. However, tasks that can be performed flexibly are typically also tasks that are not and cannot be standardised and/or organised using standard protocols. A female account manager, working for the health insurer and caring for a sister with psychological problems, explains:

> I am the one who makes the deals with board of directors [of hospital managers, doctors' associations etc., authors]. You build up a special relationship with these people and know all the ins and outs. [Respondent HI-7]

In these cases, the tasks cannot be handed over to colleagues and flexibility does not reduce the employee's overall burden. This means that extra care tasks are simply added on to existing care tasks and tasks at work, which are now often performed at home or in the evening or weekend. This problem can be dubbed the "risk of flexibility": employees who have to perform tasks at work with high degrees of both numerical and spatial flexibility can easily combine their work with informal care, but are at the same time extremely vulnerable to being overburdened with work tasks, care tasks or both.

[QUOTE]

Thus, in many cases the rescheduling of or movement of flexible work tasks to a different time and/or place usually does not reduce his/her total workload nor does it increase the workload of colleagues. In many cases, "all" that is required is the permission of the employee's line manager. Yet in cases where employees have unforeseen care obligations

and his/her work tasks are standardised, this precludes work tasks being performed by the employee at a different time or place and requires tasks to be handed over to a colleague. In those cases, socio-cultural norms at work concerning the reconciliation of work and care become crucial.

As to socio-cultural norms at work, the large majority of the respondents experienced understanding colleagues and managers at work in relation to difficulties related to the reonciliation of work and informal care. In general, line managers were willing and active in making special arrangements at work that facilitated respondents' reconciliation of work and care. Similarly, in most cases, colleagues were willing to take over tasks if necessary. However, in order to be able to make such arrangements, colleagues and line managers had to be informed by respondents about their informal care duties and the (possible) consequences of this for their duties at work. Some respondents experienced this as problematic. For example, a female employee of the social care organisation, who at a certain moment experienced difficulties at work as a result of caring for her demented mother, says:

> Well, then I have to talk about it and explain how it affects me. I find it very difficult to share that with my colleagues. I would rather share that at home. [Respondent SC-1]

And one of her colleagues, caring for her handicapped husband, explains:

> It's not that I have something to hide, but colleagues are colleagues […] I just want to keep my own skin [I want to keep my private life private, authors]. [SC-6]

Respondents often expressed a desire to keep their work and private life as separate as possible, although reasons for this varied. One reason is that respondents do not want to bother colleagues with their private problems - they feel they need to solve their problems on their own:

> It's not that colleagues don’t want to help me. Absolutely not. But I'd rather do it myself. I don’t want to be a burden for anyone. [Respondent SW-1]

Another reason mentioned by some of the respondents is that they do not want their private life interfering with their work because they see work as a place where they can forget about problems related to caring. This is especially true for those respondents who care for a person who is living with them in their home, usually a child or partner (cf. Hochschild 1997). A female employee of the municipality who is caring for a child with psychological problems says:

> Maybe it sounds strange, but for me, work is also a means of letting off steam or unwinding. Work is not my private life, and I am good at keeping work and private life separate. At work I have to deal with other people's worries, not my own. Here [at work] I can oversee things; I have to keep things running. [Respondent M-4]

Societal conversion factors

Interestingly, none of the respondents refers to socio-cultural norms at the societal level, norms or images in the media or those put forward by social movements when discussing their reonciliation of paid work and informal care, and the role their organisation plays in making this reconciliation possible. In their perception, their own norms, as well as those of the people in their social network and at work are seen to be decisive, which is, of course, not to say that these norms are not implicitly linked to norms in society at large.

Capability set:

The above analysis shows that the availability of government and employer policies intended to facilitate the reconciliation of paid work and informal care is not enough to create a situation in which the reconciliation of these two domains is tolerable and sustainable for the caregiver. A number of individual and institutional conversion factors condition whether an employee actually uses options available to them. These factors include the elasticity of the care network, the degree of numerical, functional and spatial flexibility of the job, the socio-cultural norms at work and the characteristics of the care situation (co-residency). The combination of conversion factors is different for each employee, and consequently affects their ability and willingness to make use of available options in various ways.

Achieved functionings: satisfaction and feedback mechanisms

Thus, ultimately, the specific capability set of an employee is decisive for whether he or she actually uses available government and/or employer policies in a manner that creates a

tolerable and sustainable reconciliation of paid work and informal care. In the first instance, the large majority of our respondents has made some sort of arrangement at work and is satisfied with the options offered by their employer as well as the willingness of their colleagues and line managers to make the reconciliation of work and care tolerable and sustainable. Yet many of the respondents who have made special arrangements at work still experience various degrees of stress and still feel guilt, both towards the care receiver(s) and their colleagues.

[QUOTE]

In addition, in some cases respondents slowly realise, across time that the specific arrangements made at work at an earlier stage no longer suffice. A woman working for the health insurer (with flexible working hours) and caring for her sister with psychological problems explains:

> Suddenly it was all too much for me. […] Nothing was left of my weekends; on Sundays I did what I had to do on Fridays. And I had to do my own housekeeping too. It just wasn't working anymore. [Respondent HI-7]

For her, the only solution was negotiating a new arrangement at work.

5. Conclusion and discussion

In this paper, we investigated the extent to and the ways in which employees make use of government and employer policies to reconcile paid work and informal care, and how they evaluate their work-care arrangements. Applying a capabilities approach, we interviewed 35 employees who combine work and care in four organisations. We used the capabilities approach because it recognises that the ways in which individuals reconcile work and care are not only a reflection of agency, but also a reflection of what individuals are genuinely capable of achieving. These capabilities can entail individual capabilities, such as behavioural and cognitive aspects, the capabilities provided by personal networks and capabilities within the organisation. By taking this approach, we were able to explore to what extent a capabilities approach is applicable for understanding employees' reconciliation of work and informal care tasks.

The analysis in this paper demonstrates that, as the capability approach "predicts", the specific capability set of an employee is ultimately decisive for whether he or she actually uses the available government and employer policies to make the combination of paid work and informal care tolerable and sustainable. These factors include the elasticity of the care network, the degree of numerical, functional and spatial flexibility of the job, the socio-cultural norms at work and the characteristics of the care situations (co-residency). The combination of conversion factors is different for each employee, and consequently also their ability and willingness to make use of available options.

In theoretical terms, the analysis in this paper shows that in its current form, the capability approach is still too static to be able to catch the dynamism of situations where people are continually looking for ways to reconcile paid work and informal care. In practice, there are ways in which the "outcome" – the achieved functionings – becomes part of the "input" – the conversion factors – in a new process in which a new capability set is "created". In other words, a more effective application of the capabilities approach would reflect the existence of various feedback mechanisms. These feedback mechanisms should be taken into account in order to understand how employees reconcile paid work and informal care, as well as why they do or do not use options available to them.

On the basis of the analysis in this paper we distinguish two forms of feedback mechanisms (see Figure 2). First, the outcome of the process in which government and employer policies, via various conversion factors, results in some sort of care-work arrangement in a certain care situation – in our terminology the "achieved functionings" at time t – can result in different achieved functionings in time t+1. Once it becomes clear to the caregiver, his/her colleagues, and persons in the caregiver's social network how various factors interact, resulting in a specific work-care arrangement for the caregiver, and how this arrangement affects the caregiver, it may lead to different evaluations by all persons involved. Thus, the eventual work-care arrangement can interact differently with the same individual and institutional conversion factors, and more specifically with the caregiver's norms and those of his/her colleagues, family members and friends, at a later moment in time.

Second, the burden of a specific work-care arrangement of a caregiver can change across time, even if the arrangement itself does not change. Hence a given combination of paid work and informal care can be tolerable in the first months or years of one's "care career" but can become intolerable in the long run, for example because it gradually undermines the caregiver's health or his/her social life.

[Insert Figure 2 about here]

Limitations:

Due to the exploratory nature of our research and our specific research design, the above conclusions should be taken as preliminary and are intended to serve as hypotheses for further research. The limitations of our research pertain to the number of cases analysed (35 respondents), the specific character of the cases ((social) service organisations)), and the specific national context of the research (government policies in the Netherlands). Future research could focus on other types of organisations, for example those in te manufacturing or other economic sectors in which tasks are more standardised and less flexible.

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Appendix 1: Code tree

Code tree, first phase:

0. Demand for care (what is needed by person; who has to be cared for)
    1. Type of care (ADL, IADL and/or SEA)
    2. Duration of care (number of years)
    3. Intensity (number of hours per week)

I. Goods & means (availability AND accessibility)
    1. Government policies: (including special arrangements in collective labour agreements)
        a. Short-term care leave (max. 10 days in a year; 70% of wage)
        b. Long-term care leave (max. 30 days per year; 0% of wage)
        c. Ad hoc leave (100% of wage)
    2. Policies employer:
        a. Numeral flexibility:
            i. Flexible work hours (number)
            ii. Flexible work (when)
        b. Functional flexibility: tasks
        c. Spatial flexibility (where)

II. Conversion factors
    1. Individual conversion factors:
        a. Gender
        b. Age
        c. Physical and mental health
        d. Educational level
        e. Social class
        f. Social network: facilitating and impeding factors (nuclear family, extended family, friends, neighbours, other communities (religious, ethnic, etc.), care and welfare professionals)
    2. Institutional conversion factors:
        a. Characteristics job:

i. Hierarchical position
ii. Contract duration (fixed-term / permanent)
iii. Number of hours per week
iv. Numeral flexibility:
    - Flexible work hours (number)
    - Flexible work (when)
v. Functional flexibility (tasks)
vi. Spatial flexibility (where)
vii. Number of years

b. Socio-cultural norms concerning combination work and informal care at work:
    i. Colleagues
    ii. Manager
    iii. Organisational culture
c. Power relations at work:
    i. Colleagues
    ii. Manager
    iii. Organisation

3. Societal conversion factors:
    a. Socio-cultural norms (society)
    b. Media (way informal for example: care is portrayed in media)
    c. Social movements (for example: interest groups for informal caregivers)

III. Capability set (= Layer 1 → 2)

IV. Achieved functionings: (Layer 3-1 via Layer 3-2)

1. Actual care situation of respondent
2. Consequences of actual care situation:
3. Respondent's evaluation of actual care situation

Code tree, second phase:

…

…

Appendix 2: List of respondents (informal carers)

Label	Gender	Age	Number of working hours	Number of care hours	Care receiver(s)	Health complaints of care receiver(s)
Municipality						
MU-1	Female	26-35	≤ 24	8-20	Mother	Psychological problems or vulnerability
MU-2	Male	36-45	>36	>20	Child	Mental disability
MU-3	Female	46-55	≤ 24	8-20	Child	Mental and physical disability
MU-4	Female	46-55	25 tot 35	>20	Child	Psychological problems or vulnerability
MU-6	Female	36-45	25-35	>20	Child	Mental and physical disability
Social care organisation						
SC-1	Female	46-55	25-35	1-7	Parent	Physical handicap; Decline in mental health / (early) dementia
SC-2	Female	46-55	≤ 24	1-7	Parent / neighbours	Decline in mental health / (early) dementia & general health limitations due to old age
SC-3	Female	36-45	≤ 24	8-20	Child	Mental and physical disability
SC-4	Female	26-35	≤ 24	>20	Child	Mental and physical disability
SC-5	Male	>56	>36	1-7	Partner	Physical disability or handicap
SC-6	Female	36-45	25-35	8-20	Partner / volunteering mentor for woman	Mental and physical disability
SC-7	Female	>56	25-35	1-7	Parent	Decline in mental health / (early) dementia
SC-8	Female	46-55	>36	8-20	Parent	Sensory disability or handicap / general health limitations due to old age
Social work organisation						
SW-1	Female	46-55	≤ 24	8-20	Parent / neighbours	Physical disability or handicap
SW-2	Female	46-55	25-35	8-20	Parent	Cancer
SW-3	Female	46-55	≤ 24	8-20	Child	Psychological problems or vulnerability
SW-4	Female	46-55	25-35	8-20	Child	Sensory and physical disability
SW-5	Female	36-45	25-35	8-20	Mother / mother-in-law	General health limitations due to old age
SW-7	Female	36-45	≤ 24	8-20	Child	Physical disability or handicap
SW-8	Female	36-45	25-35	8-20	Child	Physical disability or handicap
SW-9	Female	46-55?	≤ 24	1-7	Parents / parents-in-law	Mental disability and general health limitations due to old age
SW-10	Female	36-45	25-35	1-7	Sister	Physical disability or handicap
Health insurer						
HI-1	Female	36-45	≤ 24	>20	Partner	Physical disability or handicap
HI-2	Female	46-55	≤ 24	1-7	Aunt	Mental disability and general health limitations due to old age
HI-3	Female	36-45	25-35	>20	Child	Mental and physical disability
HI-4	Female	26-35	≤ 24	8-20	Partner	Physical disability or handicap
HI-5	Male	46-55	25-35	1-7	Mother	Mental disability and general health limitations due to old age
HI-6	Male	46-55	25-35	8-20	Child	Physical disability or handicap
HI-7	Female	46-55	25-35	1-7	Sister	Psychological problems or vulnerability
HI-8	Female	46-55	≤ 24	8-20	Mother / mother-in-law	Mental disability and general health limitations due to old age
HI-9	Female	46-55?	>36	8-20	Parents	Mental disability and general health limitations due to old age
HI-10	Female	46-55	>36	1-7	Mother-in-law	Mental disability and general health limitations due to old age

Label	Gender	Age	Number of working hours	Number of care hours	Care receiver(s)	Health complaints of care receiver(s)
HI-11	Female	46-55	>36	8-20	Parents	Mental disability and general health limitations due to old age
HI-12	Male	46-55	25-35	1-7	Child	Mental disability
HI-13	Female	46-55	25-35	8-20	Partner / brother / parents	??

Figure 1: The capabilities approach (combination of Robeyns 2005 and Hobson 2014)

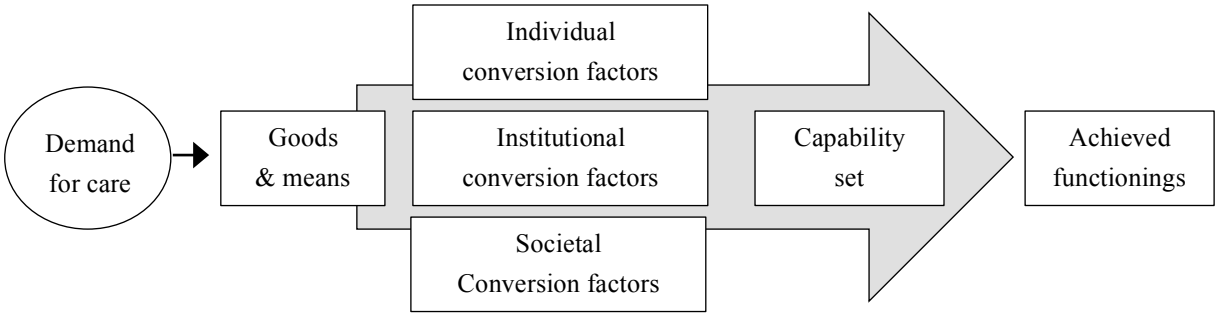

Table 1: Main characteristics of the four organizations in 2012[1]

	Number of personnel (fte)	**Annual turnover** (Million Euros)	**% of personnel combining work & care**	**Notes**
Municipality	210	40	13	c. 25,000 inhabitants
Social care organisation	2,300	130	33	c. 7,000 clients and 3,000 volunteers
Social welfare organisation	280	15	40	c. ??? clients and c. 2,000 volunteers
Health insurer	1,800	5,000	17	c. 2.1 million insured clients

Table 2: Overview of the characteristics of the respondents

	Municipality	**Social care organisation**	**Social welfare organisation**	**Health insurer**	**Total**
Number	5	8	9	13	35
% of total	14	23	26	37	100
Sex (%)					
Male	20	13	0	23	14
Female	80	88	100	77	86
Age (%)					
≤ 24	0	0	0	0	0
25-35	20	13	0	8	9
36-45	40	25	44	15	29
46-55	40	38	56	77	57
≥ 56	0	25	0	0	6
Number working hours per week (%)					
≤ 24	40	38	44	31	37

[1] Since the work organisations were anonymised for this research, the sources of the descriptions in this sub section cannot be disclosed.

25-35	20	38	56	23	34
≥ 36	40	25	0	46	29
Number of care hours per week (%)					
1-7	0	50	22	38	31
8-20	40	38	78	46	51
> 20	60	13	0	15	17
Care receiver (%)*					
Child	80	25	56	23	40
Partner	0	25	0	23	14
Parent (in-law)	20	50	44	46	43
Brother/sister	0	0	11	15	9
Other	0	25	11	8	11
Complaints care receiver(s) (%)*					
Physical handicap / disease	100	63	67	38	60
Mental handicap / disease	40	50	22	23	31
Old age related problems / dementia	0	50	22	46	34

* Some caregivers care for more than one person

Figure 2: Capabilities and outcome and time feedback