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Carers of Dependent Individuals in Spain: Inequalities, Social Invisibility, and Physical and Psychological Consequences

Cuidadoras de personas dependientes en España: desigualdades, invisibilidad social y consecuencias físicas y mentales

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Key words

Physical/psychological Consequences
- Formal Carers
- Informal Carers
- Inequalities
- Demographic Ageing

Abstract

The working and social conditions of formal and informal carers have historically been insufficiently addressed in social research. Hence, our object of study is to examine, analyse and reflect on the social inequalities, their lack of visibility, and the physical and psychological consequences suffered by female carers. A qualitative methodology was used based on semi-structured interviews with formal and informal female carers and sector experts. The study reveals an underlying gap of social disparities among carers, along with a territorial segregation of care provision in Spain. This highlights the pressing need for public authorities to give visibility to and address the existing social issues within the care market, which have repercussions across the different spheres of the welfare state.

Palabras clave

Consecuencias físicas/mentales
- Cuidadoras formales
- Cuidadoras informales
- Desigualdades
- Envejecimiento demográfico

Resumen

Las condiciones laborales y sociales del colectivo de cuidadores/as formales e informales es una temática que históricamente no ha sido suficientemente atendida en la investigación social. De ahí nuestro objeto de estudio: examinar, analizar y reflexionar sobre las desigualdades sociales, su invisibilidad y las consecuencias físicas y psíquicas que padecen las mujeres cuidadoras. Se aplica una metodología cualitativa, basada en entrevistas semiestructuradas realizadas a cuidadoras formales e informales y a expertos del sector. En el estudio subyace una brecha de divergencias sociales en el colectivo de cuidadoras y una segregación territorial de los cuidados en España que presiona la necesidad de dar visibilidad y atender desde la administración los problemas sociales existentes en el mercado de los cuidados, que llegan a repercutir en las diferentes esferas del estado de bienestar.

Citation

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INTRODUCTION

The demographic profile of the Spanish population is shifting towards a marked increase in ageing, which is characterised by a rise in dependency and a growing demand for care. This, in turn, highlights the increasing need to support individuals who are unable to care for themselves. The issue was identified as the third most important concern by respondents in Study No. 3475 conducted by the CIS (2024). In light of this scenario, this study analyses the role played by *formal and informal female carers*, with the aim of investigating the social inequalities, lack of social visibility, and physical and psychological consequences suffered by female carers of dependent people in Spain. There is clear evidence of a significant gap in social inequalities and dynamics caused by the territorial segregation of care in Spain. This situation underscores the pressing need for the public authorities to give visibility to and address the existing social issues within the care market, which have repercussions across the various spheres of the welfare state.

In tackling this question, we define what is meant by “carer” and how the social category of “formal carer” and “informal carer” is constructed. Formal carers are individuals who are trained and paid to provide care to a person with medical conditions. The tasks involved are performed by a specialised professional (Rodríguez-Rodríguez, 2005). There are two types of formal care: that which takes place in institutions, and that which is contracted by families. Public care services are provided by a bureaucratic organisation and are publicly funded, at least in part. An informal carer, however, is a person who forms part of the family environment and participates in the care of the patient to a greater or lesser extent. Informal care may be understood as:

> Care and attention fundamentally given by family members and other loved ones, as well as by other care agents, which is provided altruistically to people with some degree of disability or dependency (Rogero, 2009: 37).

There are three categories of support: instrumental support, informational support and emotional support (Rodríguez-Rodríguez, 2005).

This study is focused on both types of carers, formal and informal, specifically on women carers, as they make up the majority of care providers. The analysis addresses the varying conditions under which care is provided, including whether or not it is professionalised, as this is an essential aspect for understanding the circumstances of these carers. Factors considered include the time devoted to care, remuneration, prior understanding of the tasks involved, the resulting family and social relationships, as well as the use of an employment contract and any protective provisions contained in it (Rodríguez and Ortega, 2020).

This article is structured into a number of sections. The first section presents a review of the literature and describes the current situation regarding the demographic ageing of the population and the important role played by women carers. The qualitative methodological section details the fieldwork and interviews conducted with formal and informal female carers, as well as the contributions of technical experts from the social health area. In the results and discussion section, studies and scales from the Spanish Centre for Sociological Research [*Centro de Investigaciones Sociológicas* (CIS)] are identified in connection with the choices made by relatives of dependent individuals concerning the type of care provided over the past 20 years in Spain. The analysis explores how territorial segregation and the ensuing heterogeneous care provision in Spain tend to foster social inequality among both formal and informal women carers. The article concludes by highlighting the lack of social visibility of the sector and its practical implications.

THEORETICAL BACKGROUND

Demographic ageing and the provision of care for the population have become major concerns for citizens, health policies and government services in industrialised countries. These concerns began with the transition to an industrial society and intensified with the emergence of the welfare state. These developments have been reflected in the changing roles and perceptions of family (Shorter, 1975) and motherhood (Knibiehler and Fouquet, 1977); the new value attributed to childhood (Ariès, 1973); and a broader range of care work, particularly as examined by the Chicago School (Breckinridge, 1943; Abbott, 1922). A shift took place in the way domestic and care work was understood: the initial drive for recognition in terms of market labour was gradually replaced by an appreciation of the work performed within the household, valued for its own qualities and for its importance in providing care and supporting individual well-being (Abbott, 1934).

Studies by feminist sociologists including Balbo (1980), Bimbi and Pristinger (1985), and Saraceno (1980) emphasised the invisible work performed by adult women in providing care in welfare societies. They measured it by using the subjective perspective of women regarding the time spent on care. The contributions by Graham (1983) established an approach closely aligned with an identity-based framework, emphasising the feelings and emotions surrounding care work and the fact that these tasks were framed as being eminently feminine, and not comparable to the usually masculinised sphere of commodity production and market-oriented labour. Gilligan's study (1982), on the other hand, made a distinction between the ethics of care and the ethics of justice, associating justice as a moral issue with a material and concrete domain—the work sphere—understood in terms of occupation or employment. At the same time, the notion of "care" that emerged in the English-speaking world prevailed and attained hegemonic status. Following Flaquer (2013), the concept of care, together with the increasing presence of the gender dimension, has shifted the emphasis from a male welfare state based on *welfare* (material and monetary in nature) to one increasingly focused on *well-being* (which addresses the needs of individuals). It is in this context that time-related policies concerning dependency have gained prominence on both the political and research agendas.

The origin of the new social needs for care in Spain was fundamentally connected to demographic ageing, according to the scholars who have studied this issue (Adelantado, 2000; Rodríguez Cabrero, 2004). In Europe, this trend has also entailed projections of a significant demographic gap, attributed to the declining presence of women across adjacent generations. These types of questions that relate care work to the issue of dependency (Rodríguez Cabrero, 1999; Durán, 2006) have led specialists in Europe such as Daly and Lewis (2000) to propose the inclusion of "social care" in welfare state policies. Lewis (2007) called for a "new social settlement" that was capable of meeting the daily care needs of the European population. This perspective is closely linked to ethical and moral considerations, placing care at the heart of the European social model's capacity to continue to respond collectively to the challenge of ensuring well-being (Izquierdo, 2004; Vega, 2009; Tobío *et al.,* 2010). This also requires rethinking the foundations from which citizens' rights and responsibilities have been built to date. Recent literature has been shaped by the impact of the COVID-19 pandemic, opening new research avenues on care (Batthyány, 2020; Fantova, 2020; Hernández and González, 2020). These works draw on the crisis brought about by the pandemic in relation to key emerging themes including care provision; public policies; social mobilisation; the return to home-based care; long-term care; work–life balance for working mothers; dependent older adults in care homes; and the invisible nature of care tasks.

Women sustain the formal and the informal care systems in Spain

In 1996, Anneli and Sipilä laid the foundations for an analysis in which two opposing focal points were outlined: on the one hand was Southern Europe (Spain, Greece, Italy and Portugal) and on the other hand were the Nordic countries (Sweden, Norway and Finland). The first group of countries was characterised by having a limited provision of social services, where women took care of the personal well-being of the family on a full-time basis and had low rates of formal labour market participation; whereas the second area of focus had an extensive network of public services and maintained high labour market participation rates for women.

Accordingly, in Spain, the responsibility for caring for dependent individuals continues to fall primarily on families, predominantly on women. The answer to the question as to who the carer should be highlights the beliefs and stereotypes of the social group to which one belongs. When we talk about family carers, we are really referring to the women in the family, since there is a belief that care work is an inherently female task, to be performed not only by the wife or daughters, but also daughters-in-law, granddaughters, nieces, goddaughters. The assumption is that the condition of being a woman is, in itself, sufficient to justify having to take on care responsibilities (Marrugat, 2005).

The basic theoretical framework of care commonly adopted in Spain is grounded in this context and draws on Gender Studies from the 1980s, albeit with a certain lag compared to the level of development achieved internationally, and more specifically within Europe. Studies such as those by Durán (1986, 2003, 2006, 2012, 2018), Martínez (1992, 2006, 2010, 2011), Alberdi (1995), Tobío (2005), Martínez Buján (2010) and Prieto (2015), as well as by the group of researchers formed by Isabel Aller-Gay, Álvaro Briales, Javier Callejo, Pilar Carrasquer, Anna Grau, Tebelia Huertas, Sofia Pérez de Guzmán, José Santiago and Teresa Torns, and the *Ministerio de Igualdad* (Ministry of Equality in Spain) (2010), among others, have analysed a series of issues that have had an impact on the quality of life of people in their relationship with care. These notably include problems of working mothers with dependent children and other family members; unpaid work in the family; the role of the family in society; work-life balance; gender roles in society; and joint responsibility for care.

Among the demands of the feminist movement and thought in the late twentieth and early twenty-first centuries, there has been a growing interest in the care of dependent individuals. This can be illustrated by the three surveys conducted by the CIS in 1997, 2001 and 2009, which examined the recent evolution of preferences within the Spanish population for three types of support: informal, formal or mixed, along with the changing sociodemographic profiles of those who chose each option. Two barometers carried out by the CIS, Study No. 2758 (2008) and Study No. 2844 (2010), showed the degree of agreement with the notion that sons and daughters should take care of their parents when they experience health difficulties; and what their preference would be if their parents needed help with daily dare. The result yielded was that children of dependent adults would seek support from public institutions, rather than providing care within the family. However, the survey carried out in Study No. 3009 of the CIS (2014) pointed to a significant change in the type of household in which dependent people lived, with the number of multi-generational households decreasing and dependents living in single and couple households increasing.

When Law 39/2006 of 14 December on Promotion of Personal Autonomy and Care for People in a Situation of Dependency (hereafter "Dependency Law") (*Ley 39/2006 de 14 de diciembre de Promoción de la Autonomía Personal y Atención a las Personas en Situación de Dependencia, LAPAD)* came into force in 2007, it was aligned with the trends outlined above, which informed the policies aimed at the care of dependent people in Spain. The Dependency Law was intended to generate a subjective right to the promotion of personal autonomy and comprehensive care through a coordinated offer of services. It is important to note, however, that the implementation of the System for Autonomy and Care for Dependent People (SAAD) (*Sistema para la Autonomía y Atención a la Dependencia*) has undergone several modifications and faced considerable limitations related to funding, access to the system, waiting lists and uneven service provision (Huete-García, Chaverri-Carvajal and Morales-Romo, 2021; Carrasco, Borderías and Torns, 2011).

The Study by María Ángeles Durán entitled *La riqueza invisible del cuidado: el cuidatoriado* (2018) (The invisible wealth of care: care workers), addressed care from a broad academic and scientific perspective, and delved into the incorporation of unpaid work into the social structure. Durán coined the Spanish term *cuidatoriado* (referring to *care workers),* whereby carers are considered to be a new social class, within a care market with its own supply and demand. This is concerned with the quality of life of individuals with medical conditions requiring care, as well as that of their carers. It also explores diverse experiences of ageing, end-of-life care and the future of care provision.

The 2020 pandemic highlighted the care crisis and broadened the public debate on this issue. The area of care was already in crisis before COVID-19 and constituted one of the main obstacles to women's equal participation in the economy and to gender equality within families and society. The pandemic led to a chain reaction that involved physical distancing measures which brought rapid and severe changes in family organisation, labour markets and social services, giving rise to new patterns of care (Moré, 2020; Hernández and Pereira, 2021; Marbán *et al.*, 2021).

Overall, demographic and social trends seem to be leading to a possible widening of the gap between demand for care and its potential response, mostly by women.

METHODOLOGY

In light of Spain's ageing population, the main objective of this article is to identify the social inequalities in the formal and informal care sectors, underscore their lack of visibility, and analyse the physical, psychological and social consequences experienced by women caring for dependent individuals.

A qualitative methodology with semi-structured interviews was used. This gave the interviewee full freedom of expression, enabling their point of view to be the focus. During the interview, the communication process revolved around four themes that were perfectly suited to the object of study: training and profession, the care labour market, work-life balance and protective measures, and equality in and visibility of care. This cycle started with the interviewer informing the interviewee of the kind of information that was needed (verbal communication). The interviewee interpreted what was being asked, and then provided the information that they believed was relevant (filtered by their ability and willingness to transmit it) (Valles, 2014).

All interviews were conducted by telephone and lasted approximately one hour. They took place during the COVID-19 state of emergency, from January 2021 to February 2022, which avoided meetings and travel.

The qualitative methodology of semi-structured interviews covered three types of samples: the first sample consisted of 15 formal women carers, the second sample was made up of 15 informal women carers, and the third sample included 12 technical experts in the field of social health care, resulting in a total of 42 interviews (see Table 1).

Social issues may be addressed (Corbetta, 2007) either by only interviewing those directly affected by a specific aspect, or by also obtaining data from individuals who are expert observers, even if they are not part of the phenomenon themselves. These people tend to have a direct, comprehensive viewpoint on the phenomenon, which renders them key informers with access to valuable information. In the study, this direct perspective was provided by a third sample which consisted of 12 participants who held managerial roles and had been trained in the management of social healthcare services. They carried out paid professional work in a company and

TABLE 1. *The characteristics of the sample under study*

Sample 1: Semi-structured interview FORMAL WOMEN CARERS	Sample 2: Semi-structured interview INFORMAL WOMEN CARERS	Sample 3: Semi-structured interview MANAGERS IN THE SOCIAL HEALTH CARE FIELD
15 semi-structured telephone interviews.	15 semi-structured telephone interviews.	12 semi-structured telephone interviews.
Women aged between 23 and 59 years old.	Women aged between 27 and 73 years old.	Two men aged between 44 and 48 years old. Ten women aged between 36 and 61 years old.
Vocational training and professional certificate in social health care for Providing care in both households and social institutions.	No training or qualifications in care provision. Training in other professional fields.	University education.
Home care support workers. Workers in a residential care centre.	Relatives of dependent people who were members of an Alzheimer's Patients' Association.	They were workers (cooperative Claros S.C.A.) from different Spanish provinces (Seville, Cadiz, Malaga, Granada, Cordoba and Segovia).
Average experience of 5 years.	Average experience of 3.5 years.	30 % were managers of social health services. 70 % were social health service provision managers.

Source: Prepared by the authors.

were responsible for leading teams made up of formal carers who provided care to dependent individuals.

RESULTS AND DISCUSSION

The following results are drawn from the theoretical framework and the interviews conducted with the three samples described in Table 1, which were cross-checked with the discussion. Four areas were addressed: the formal and informal markets, the territorial disaggregation of formal and informal care in Spain, the lack of social visibility of carers of dependent people, and the physical and psychological consequences of care work.

Evolution of families' choice of type of care for dependant people in Spain: the formal and informal markets.

Care provision takes place in different settings: residential care homes and day care centres, the family environment, friends and neighbours environments, and non-governmental organisations. The type of care is related to the characteristics of the person being cared for, to the people who provide it and to the setting in which care takes place (IMSERSO, 2009) (see Table 2).

In Spain, the majority of support provided is informal (see Table 3), although the outsourcing of care through the use of public or private services is becoming increasingly common (Spijker and Zueras, 2016). Factors such as increased longevity and changes in the structure of disability (Gómez Redondo and Fernández-Carro, 2015; Serrano *et al.,* 2014), the reduction in household size (Isengard and Szydlik, 2012) and the entry of women into the labour market (Cebrián and Moreno, 2008) have led support networks to become broader and more heterogeneous, extending beyond the family and being characterised by greater diversity and bidirectional support flows (Quilodrán and Puga, 2011).

The trends and evolution in families' choices in formal and informal care for dependent people over the last 20 years have been studied by the CIS. Three studies have been conducted: Study No. 2244 (CIS, 1997), Study No. 2439 (CIS, 2001) and Study No. 2801 (CIS, 2009), which analysed the recent evolution of the Spanish population's preferences for three types of support: informal, formal or mixed, as

TABLE 2. *Characteristics of the formal care market in Spain*

OUTSOURCING	SUBSTITUTION - COMPLEMENTARITY
Ranging from care tasks provided by the family to other professional social resources: day centre, residential care home, domestic support, private professional carer, etc.	Search for balance between a formal and an informal carer (family member or another loved one).
PROFESSIONALISM FORMAL NATURE REGULATION	**MARKETISATION SALARISATION**
Interrelated—albeit not necessarily co-existent— characteristics of this market.	Money begins to mediate the care relationship, with it being subject to taxation and public control.

Source: Prepared by the authors based on the document entitled *Inmigración y cuidados. Una aproximación. Inmigración y cuidados de mayores en la Comunidad de Madrid* [An Approach to immigration and care. Immigration and care for elderly people in the Autonomous Region of Madrid] (Rodríguez Rodríguez, 2012).

TABLE 3. *Characteristics of the informal care market in Spain*

OUTSOURCING	SUBSTITUTION - COMPLEMENTARITY
Ranging from care being provided by the family to care tasks being performed by other people: immigrants, hired staff, other carers who are not family members, etc.	Search for balance between the informal family carer and other formal or informal carers.
INFORMALITY **PRECARIOUSNESS** **IRREGULAR NATURE**	**MARKETISATION** **SALARISATION** **UNDERGROUND ECONOMY**
Interrelated—albeit not necessarily co-existent— characteristics of this market.	Money begins to mediate the care relationship, with it not being subject to taxation or public control.

Source: Prepared by the authors based on the document entitled *Inmigración y cuidados. Una aproximación Inmigración y cuidados de mayores en la Comunidad de Madrid* (Rodríguez Rodríguez, 2012).

well as the development of the socio-demographic characteristics of the people who would opt for each of them. The results showed that, although the preference for formal care has grown substantially, the family is still the preferred and most-used form of care. The percentage of the population that would prefer to be cared for by relatives was over 70 %. However, there was also a gradual increase in the inclination for formal care exclusively or for a combined mode of formal and informal support. In 1997, 84 % of the respondents were of the opinion that, if they had a disability, they would prefer to receive help from a member of their social and family network. In 2001, the percentage had dropped slightly, to 79 %, whereas in 2009, it stood at 70 %. This decrease represented a significant increase in the preference for formal care, which went from 8 % in 1997 to 21 % in 2009. The preference for mixed care remained relatively stable, going from 7 % in 1997 to 9 % in 2009. At the end of the study period, more than a quarter of the interviewees, 30 %, would opt for a support model that involved formal support either fully or in part.

The barometer carried out by the CIS (2008) within Study No. 2758 showed that 75 % of the Spanish population either very strongly agreed (35 %) or strongly agreed (40 %) with the view that adult children should care for their parents in the event of health-related difficulties. Along the same lines, data from the barometer carried out by the CIS (2010) as part of Study No. 2844 showed that 63 % of respondents disagreed with the idea that it is preferable to rely on public assistance rather than family support when the elderly need help to carry out daily routines. Questions were also asked about the reliability of different institutions and individuals as potential sources of support. On a scale of 0 (not dependable) to 10 (fully dependable), the family was considered to be the most reliable source of support, with a dependability rate of 8.5, closely followed by other figures in their social network such as friends (7.6). Public services were given a reliability rate of 4.5. Furthermore, 44 % of the people interviewed were totally confident that their family would meet any of their needs, compared to 4 % who had total confidence in public services. This widespread perception of the family as the most reliable form of support, in turn, made it the most desirable.

On the other hand, the survey conducted in Study No. 3009 by the CIS (2014) entitled *Cuidados a Dependientes* (Care for Dependant people), involved 2,473 residents in Spain of both sexes aged over 25 and pointed to a shift in the *type of household* in which dependent people lived. There was a more even distribution across different household types, a decline in multigenerational households, and an increase in dependent people living in single or couple households. This marked a significant trend towards change, more in line with recent developments across Europe. At present, 33.7 % of households in Spain require a highly intensive level of care. Among them, 10.8 % were families providing long-term care, the most intensive and non-reversible care, as it is associated with old age or chronic illness. Of these households, it was found that in 88.1 % of the cases, the main care was provided by a family member, and in 64.1 % of these cases this person was a woman. Finally, the gender gap in care provision was considerable, with 67.9 % of the women surveyed who lived with dependent persons being the main carer, compared to 36 % of men who were the main carers.

The territorial disaggregation of formal and informal care in Spain

Two distinct characteristics can be identified regarding the territorial heterogeneity of care in Spain. The first relates to the production sector stemming from the employment of formal carers. This sector is predominantly female; its workers have been trained and qualified to perform care tasks, and they have a contractual relationship with a company operating in the sector.

[...] Our work is mainly done by women, there are only a couple of male carers. It's always us women in this sector (Female formal carer 1).

[...] My brothers sometimes help me to take care of my father, but it is really me who takes care of him. It's normal, they are men, it's up to us women to do care work. It is my duty as a daughter (Informal female carer 1).

There is another characteristic that emerged from the interview data about informal women carers. They are trained by individual experience and have a familial and emotional bond with the people they care for. In many cases, informal carers cover all the needs and shortcomings in the care of family members, including those left unattended by the benefits or social resources provided under the Dependency Law (formal care).

[...] I take care of my mother, and what I know, what I have learned about taking care of her, I have learned as I've gone along, looking after her. I haven't been trained. It's true that I've had some advice from health professionals, but I have no training. I don't have set hours either, she needs daily attention, especially at mealtimes and bedtime (Informal female carer 2).

EAPN-ES (2021) carried out an analysis of Social Services across Spain, focusing on the individuals receiving care and the regional perspective. This analysis highlighted the territorial heterogeneity and the lack of standardisation in the distribution of employment, economic and social resources. This revealed a significant inequality gap within the care sector and it identified unequal funding across the different Autonomous Communities, which had a direct impact on families caring for dependent people.

[...] We're waiting for an official resolution on his degree of dependency, so that he can go into a care home. The process is very slow here. I'll be taking care of him for as long as I can. All my siblings chip in to give me a little money every month for my expenses, since I spend many hours taking care of my father, and while they work, I earn some extra money looking after him (Informal female carer 3).

The same applies to formal carers, given the diversity of employment arrangements currently in place across Spain's various regions, which are not uniform. This lack of consistency has an effect on the sector in employment terms. Hence, there is a disparity within the care workers in terms of workload, working conditions and salaries.

> [...] The professionals (female carers) always say that their salaries are low, that they have to improve and that the working hours prevent them from having the work-life balance they need. They get ill and often need sick leave as a result of work strain, which is why we do a lot of occupational health and safety prevention (Expert 1).

In sum, these inequalities expose the various dimensions through which the organisation of care and the socio-labour circumstances of female carers of dependent individuals are shaped in Spain.

THE SOCIAL INVISIBILITY OF WOMEN CARERS OF DEPENDENT PEOPLE

The Dependency Law does not promote genuine social visibility. What has come to be known as professional care is based on *precarious employment*, both in the public sector (including subcontracting, given the growing precariousness of public employment) and in the private sector, both for-profit and not-for-profit (with the addition of voluntary work). Proximity services are a key element in these new sources of employment, which are characterised by dual employment conditions: few jobs with good conditions and many jobs with very precarious conditions (OECD, 1998).

> [...] Our work is complex, there are daily conflicts between the interests of the person being cared for, the professional carer and the family. Incidents are always due either to a lack of adaptation of the user to the service, or to demands by relatives in the care provided; or to professional carers claiming their rights (Expert 2).

The formal carers interviewed linked the insufficient remuneration to a lack of both professional and social value attached to their work, and to the little recognition given to the tasks they perform. They sometimes feel that the rights of the people they care for take precedence over their rights as professional carers. There is no balance, but rather a conflict between the care needs of the person cared for and the carers' interests in connection with balancing their work, family and personal life.

> [...] Our work is still not recognised; we are still called 'the girl who does the care work' or 'the cleaner'. They don't realise that, in order to care for the elderly in a home, you have to be trained, and we have those skills (Formal female carer 4).

In the sphere of informal carers, the interviewees also reported suffering from personal strain due to the lack of time for leisure and for spending time with friends; and sometimes due to feeling isolated, lacking support from their environment and feeling socially disengaged.

> [...] I don't have time to do things for me, it's complicated when you have a parent to take care of 24 hours a day, every day of the year. At most, on some occasions, my sister takes my place and looks after my father so that I can have a day off when she is off work. But I don't do it very often, because only I can understand my father's care needs [...] As a family, we are trying to apply for support for children who take care of their parents, to see if this can improve things (Informal female carer 5).

The lack of personal time experienced by both formal and informal carers, along with their significant difficulties in achieving work-life balance, was a key micro-level aspect of lack of social visibility that was further exacerbated by the COVID-19 pandemic. In fact, carers came to be deemed to be ubiquitous people, that is, expected to be present in all spheres of care in their personal and working life at the same time.

> [...] I take care of my mother-in-law at home. Over the last two years, she has deteriorated and needs help with everything. Before Covid she lived alone, I would go to visit her, clean her house, take her to the doctor... But then her mobility worsened, and we decided to bring her home (Informal female carer 6).

> [...] I worked as a professional carer for a few years, but when my mother fell ill, I had to leave my job and take care of her. It was impossible for me to do both things (Informal female carer 7).

The degree of difficulty in balancing work, personal and social life differs between formal and informal carers. Formal carers are entitled to the benefits and measures for work-life balance provided for in Law 39/1998 on work-life balance, of 5 November (*Ley 39/1999 de conciliación, de 5 de noviembre de conciliación de la vida familiar y laboral)*; in contrast, informal carers do not have established employment rights provided by law, as they constitute a residual, non-standardised resource and are part of the underground economy. The ability to achieve work-life balance relies on altruistic arrangements and strong personal and emotional commitment to the person being cared for or to their relatives, which places informal carers in a more vulnerable position than those in the formal care market.

> [...] There aren't many alternatives for mothers to balance work and family life. And the ones that there are, many of them cost you money, and you wonder whether it is worth working or staying at home (Formal female carer 5).

> [...] You live permanently with the same illness, 24 hours a day, watching your loved one suffer or having a hard time. You either don't go out or you try to go out as little as possible, and you say to yourself, I'd rather not go shopping, I'd rather have coffee here... and in the end you are a hermit. It is impossible for this work to be seen in society, you shut yourself up at home, and you are invisible to the world (Informal female carer 8).

Ultimately, the sector of professional carers is perceived as a relatively privileged group compared to that of informal carers, both socially and in employment terms. Informal carers are seen as an invisible social resource and as a form of unpaid labour embedded within the social structure. Moreover, the lack of social visibility becomes even more pronounced as a result of territorial disparities across regions in Spain and the unequal distribution of labour and social resources available to carers.

> [...] As informal carers have no training, no set hours and no legally established salary, they are more unprotected than professional carers (Expert 3).

In the wake of the pandemic, a number of studies have emerged that show the social lack of visibility of formal and informal women carers. This can be illustrated by the numerous studies (Bellido and Martínez, 2022a; Bellido and Martínez, 2022b; Bellido, 2023, 2024) which have investigated the relationship between ageing, the high level of commitment to care work, the serious difficulties women carers face in balancing work and family life, and the social inequalities in the sector for the provision of care services for dependent individuals. An example of this can be seen in some of the verbatim statements from the experts interviewed:

> [...] In our work, the most important thing is the hours needed to cover and care for the residents. Workers' work-life balance problems are taken into account, but it must be acknowledged that managing both sides can be a real challenge (Expert 4).

> [...] Work-life balance measures do facilitate women's entry into the labour market. And the public authorities do assist companies in promoting their workers' work-life balance; in fact, companies are required to do so (Expert 5).

[...] During the pandemic, work-life balance was practically non-existent, it took second or third place; what prevailed was attending to the residents and having enough staff to cover shifts (Expert 6).

[...] There's no perfect recipe for work-life balance. And not all jobs are the same, so work-life balance can't be arranged in the same way (Expert 7).

The physical and psychological consequences of caring for dependent persons

The normalisation of women's participation in productive work and the limited redistribution of reproductive work within households and families have brought the different roles played by women into conflict. Problems such as women's "double shift", lack of personal time, as well as significant physical and psychological strain, have prompted a search for alternative solutions such as the hiring of private care services and the request for public care provision to look after dependent people. Despite the growing demand, the social policies implemented provide only minor support and are intended to serve the population that lacks economic and social resources (Ranci and Pavolini, 2013).

The formal female carers who participated in this study highlighted the physical and psychological problems they experience as a result of their work. They often suffer from "physical and psychological distress", which is not considered to be an occupational disease but as a common illness and, therefore, has an economic impact on them, as it is treated as standard sick leave.

[...] Our work is not recognised in terms of earnings either. Other jobs are not so hard and have better salaries. And on top of that, we have poorer health when we get older, we're worn out with bad neck and back pains... (Formal female carer 2).

The participating carers reported that during the pandemic their distress became stronger and more pronounced, and they persisted over time. In addition, the experts in the social health care field who took part in the study generally perceived that formal carers experienced burnout syndrome, which is usually associated with a high rate of absenteeism and work-related illness rates.

[...] In the pandemic I was very scared. My children didn't go to school and stayed at home, while my husband worked remotely. I worked shifts of up to 15 hours, because every day my colleagues in the care home were on sick leave with Covid. You were also scared of coming home and infecting your family (Formal female carer 3).

Compared to formal carers, the difficult health situation of informal carers was even more serious. As informal carers carry out work that is neither standard nor a legally regulated activity, they experience various forms of distress, illnesses and/or medical conditions similar to those suffered by formal carers. However, these are not recognised by the public healthcare system as occupational illnesses, since their work is not considered a profession. Instead, these conditions are merely classified as common illnesses, a situation that has negative economic consequences for informal carers and leaves them in a state of precarity and social vulnerability.

[...] I tend to have muscle aches and pains from the load of helping [the person I care for] move about. And strong headaches, often because of the number of hours I spend giving care. Especially during the pandemic, I had more of these illnesses, I suppose, because I was scared of catching something, or not knowing what was going to happen. I was literally terrified (Informal female carer 4).

Finally, formal and informal carers associated care work with physical and psychological strain, which impinged on their quality of life. They felt that “it was the toll” they had to pay for caring for dependent persons.

CONCLUSIONS

The demographic ageing of the population is advancing unstoppably towards a sharp increase in dependency and a growing demand for specialised healthcare services. Both public and private care services are increasingly in demand and viewed more positively than they were in the past. Families are more frequently using professional care services to cope with the needs of their dependent members. Nevertheless, the family continues to be regarded as the central pillar in the organisation of care activities and as a “lifeline” for the social system. It is assumed that the family unit is capable of meeting all care needs and compensating for the shortcomings left unaddressed by the benefits or social resources provided under the Dependency Law.

Hence, there is a social need to develop proposals for action that address the challenge of caring for an increasingly ageing population, while also safeguarding the labour rights and social protection of both formal and informal carers. This issue has been explored in our study and underpins the various ways in which care provision and the working and social conditions of carers of dependent individuals coexist in Spain. In the case of formal carers, the territorial heterogeneity of employment agreements causes a significant gap in terms of employment and economic inequality among these workers. The same is true of the precariousness suffered by informal carers; the territorial disparity in funding, coverage, social resources and economic benefits generates a social gap among them that widens or narrows depending on the Autonomous Community in which they live.

The high number of hours spent on providing care leads to difficulties in balancing work and family life, and in the physical and mental health of both formal and informal carers. Although there are a series of measures in place for formal carers to achieve work-life balance and deal with professional contingencies, some symptoms and injuries are not recognised by the health authorities as occupational illnesses, which has economic repercussions for them if they are on sick leave. Informal carers, on the other hand, have no social protection in this regard. It is worth noting that all these challenges were particularly accentuated and exacerbated during the COVID-19 pandemic.

The views of the experts interviewed in the study corroborate the existing work and social problems in the care sector, and indicate how they affect carers’ levels of absenteeism and health issues. Every day experts experience the pressures of the care system, as they find themselves caught between, on the one hand, the demands from those receiving care and their family carers, and on the other, the demands from formal carers concerning their labour rights. This creates a conflict of competing interests, leading to strain and fatigue in all parties involved.

This results in a lack of social visibility and recognition of the work performed by carers and their importance within the social structure. Over the past 20 years, some progress has certainly been made in the professionalisation and improved recognition of carers. However, much remains to be done to ensure these workers are truly visible in society. Achieving this requires fair wages, social recognition, acknowledgement of their expertise and related social rights.

This paper has highlighted the need to adapt social policies in Spain to suitably address the social issue of care provision and those who provide it. This involves moving away from fragmented approaches that do not consistently uphold the labour and social rights of carers across the country. It points to a new avenue of research focused on integrating labour and social criteria to tackle discrimination and territorial disparities in resource distribution, while also enhancing the professional status of care work through full recognition and the promotion of carers' quality of life.

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