



Developing Compassionate Workplaces in Europe for the digital and green work environment to protect employees' mental and physical health and wellbeing

Deliverable no. D5.2 Report on country-specific care regimes and policies

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Preamble and aims of the deliverable

This deliverable provides a foundational lens on constellations of structural determinants of how care and labour are shaped and experienced in Austria, Belgium, Greece and Sweden, here termed care and labour regimes. Such determinants inform the conditions under which Compassionate Workplaces can emerge and inform employers and employees navigation of informal caregiving responsibilities, living with chronic or serious illness, or being confronted with dying, death, and bereavement (EoL experiences). Thus, along with sectoral dynamics and the organization's own policies and practices, they serve to provide either an enabling or hindering context. In addition, as we began to map country-specific care regimes, it became evident that care and labour regimes are inextricably intertwined.

The ability of citizens in gainful employment to take on caring responsibilities within their social environment, such as for their family or to support ill or bereaved employees, is subject to certain conditions. Beyond the workplace, this depends not only on individual living circumstances and the social environment, but also on the political and structural conditions of the social organisation of care, forms of social security in each society as in the workplace, and culturally developed perceptions of gender roles, the family, and social coexistence.

To sharpen the analytical focus, at the core of our inquiry lies care in and around work – spanning both formal and informal arrangements and both paid and unpaid forms of care. For analytical clarity, we distinguish here between:

- a) Directly affected workers: employees who are themselves undergoing an EoL experience (e.g., death of a family member, loss of a close colleague or significant other, informal caregiving for others in such life situations)
- b) Indirectly affected workers: employees whose teams, services, or client relations are impacted by EoL experiences (e.g. a teammate's prolonged illness or caregiving).

Support in these situations requires a complex web of laws, institutions, values, and norms that continuously structures the organisation of care and work in society, thereby widening action possibilities and stabilising expectation frameworks – for example, in relation to state-funded social security and care support. The particular configuration of this fabric of societal care and working conditions can be summarised by the term “regime” (care and labour regime).

A care and labour regime is the configuration of institutions and norms that shapes, produces, and reproduces the conditions under which care is provided and work is performed thereby shaping gendered patterns of work and care and setting the legal, fiscal, and normative parameters for compassionate workplaces, affecting for example the scope of leave entitlements, income protection, flexible yet secure working-time arrangements, and access to formal care services.

The aim of this deliverable is to identify and map a core of care and labour regime characteristics that enable or constrain Compassionate Workplaces across four diverse national contexts (AT, BE, GR and SE). This provides as for the EU CoWork project to subsequently examine the development of Compassionate Workplace initiatives within different care and labour regimes.

The following guiding question sets the agenda for this deliverable:

- What are salient care and labour regime factors that influence individual and workplace practices of compassion in supporting employees to balance care responsibilities and paid work, to deal with EoL experiences?

To address this question, the deliverable aims to:

- Identify and describe macro-level factors across care and labour regimes that (potentially) shape compassionate practices at work; namely how employees can balance caregiving and paid work, how serious illness is acknowledged, and how dealing with dying, death, and bereavement are supported within organizations.
- Increase understanding of country-specific care and labour regime conditions.
- Compare care and labour regime characteristics in Sweden, Belgium, Greece, and Austria to illuminate shared challenges and divergent conditions.
- Develop an initial integrated analytical lens on care and labour regimes that highlights how different regime configurations enable or constrain the promotion of Compassionate Workplaces.
- Identify tensions, ambivalences, and open questions to be considered in subsequent project phases and in the design, implementation, and evaluation of Compassionate Workplace initiatives.

1 Background and conceptual embedding

The world of work is part of the lifeworld. Existential questions related to EoL experiences do not stop at the doorstep of workplaces. Employees may act as informal caregivers for family members and friends, they may experience serious illness themselves, and may face dying, death, and bereavement. Moreover, they may also be indirectly affected – for example when colleagues become seriously ill, experience grief, provide informal care at home, or even die. These experiences affect individuals personally and reverberate collectively when a colleague (or a client) dies or when illness and caregiving reshape roles, performance, and relationships (Wilson et al. 2020, 2021; Thomson & Lund 2017). How such experiences relate to health, well-being, and the capacity to work – and with what implications for teams and workplace contexts – is a core focus of the EU-CoWork project *Developing Compassionate Workplaces* (Vanderstichelen et al., 2025). In this project, we also explore how employees dealing with EoL experiences can be supported (see public deliverables D2.4 and D3.1).

Co-creative, participatory development processes in the 14 workplaces in Austria, Belgium, Greece, and Sweden are being employed to implement and evaluate initiatives and measures to support employees at various organizational levels. The collection of quantitative and qualitative data on employee experiences, organizational resources, as well as perspectives on the development of the initiatives largely focus on intra-organizational dimensions. Complementing this, and in constant interaction with it, we highlight the contextual, country-specific factors in this deliverable. This dimension receives systematic attention throughout the EU CoWork development process, in line with the conceptually oriented IGLOO framework, which specifies conditions for sustainable employee orientation at five levels: I = Individual, G = Group, L = Leader, O = Organisation, and O = Overarching/Social context (Nielsen et al. 2018).

Care as a societal and political-structural responsibility

Care in a careless world?

In late modern capitalist societies, care, human vulnerability, mutual support, and dependence are structurally marginalised (Lynch, 2022) or, as in the case of care provision, commodified and marketised (Aulenbacher, Décieux, Riegraf 2018; Farris & Marchetti, 2017). This systemic silencing and devaluation of fundamental dimensions of life and social relations, including care and care work, is captured in care research by the notion of the “carelessness of capitalism” (Lynch, 2022; Aulenbacher & Haubner, 2025). These dynamics have intensified in recent decades, marked by multiple crises: the global financial crisis, migration movements, the COVID-19 pandemic, Russia’s war against Ukraine, the rise of authoritarian tendencies, and increased militarisation within Western democracies. Their effects are particularly visible in austerity policies accompanying welfare state upheavals (Papadopoulos & Roumpakis, 2012; Dukelow, 2021). As a result, workplaces, companies, and other organisations find themselves, in multifaceted ways, at the centre of the tension between welfare, care, and neoliberal market orientation. In this context, megatrends – demographic ageing and socio-structural change; the precarisation of work and employment (Hürtgen, 2021; Alberti et al., 2018); digitalisation and automation; the green transition; and care/labour migration – interact with austerity-dynamics, producing uneven capacities to reconcile care and paid work across genders, social groups, sectors, and countries.

At the societal level, the promotion of compassionate workplaces is linked to the hope of giving existential human concerns, care, and questions of social solidarity greater space. Raising the status of care in society and political structures – moving it from the margins to the centre and making it more equitable and democratic – is discussed as a core challenge for a more just social order, in a caring society (Tronto, 2013).

Public health approaches to end-of-life issues

Patterns of social injustice and inequality are particularly evident in end-of-life care. In addition to direct support and care, attention to social and political conditions is therefore crucial (Richards, 2022). A public health-oriented approach – understanding support for seriously ill and dying people, and addressing loss, dying, death, and grief as a collective societal responsibility (Abel & Kellehear, 2022) – plays an important role in EU-CoWork and guides our approach. In line with the concept of health promotion (WHO, 1986), the emphasis is on strengthening knowledge, competences, and confidence at the individual level, as captured by death literacy (Noonan et al., 2016), so that people can better navigate end-of-life situations. At the same time, everyday solidarity and compassion in the social environment – in the communities where we live, love, and work – should be fostered, alongside enabling organisational and political-structural conditions. The existential level of personal involvement is related to the question of everyday and political-structural solidarity. This shifts the emphasis from isolated acts of caregiving to the societal and organisational conditions that enable good care. Within this framework, Compassionate Communities and organisations foreground societal solidarities and civic participation around end-of-life issues, inviting workplaces to serve as vital settings for shared responsibility and mutual support (Kellehear, 2005, 2015; Gilbert & Kelloway, 2021; Gilbert et al., 2021; Vanderstichelen et al., 2025).

End-of-life care infrastructures and policies

Political and structural responsibility is also reflected, among other aspects, in the care support structures available regionally and nationally for employees and their family members, close others, friends and neighbors in challenging end-of-life situations. Specifically, this concerns the institutionalisation, funding, and accessibility of end-of-life and palliative care, as well as bereavement support (Garralda et al., 2025; Tripodoro et al., 2025). Their structural availability – particularly in the home setting (Maetens et al., 2017) – and financial support for informal carers shapes the expectations and scope for action of employees, their families, and communities. EoL relevant infrastructures are therefore an integral part of care and labour regimes, directly influencing the timeliness and adequacy of support available to workers and, by extension, the organisation of partnerships, referral pathways, and internal navigation roles. This is manifested in everyday working life through structural supports shaped by political and legal frameworks – such as care, hospice, and bereavement leave.

Welfare state, care and labour arrangements as the fabric of regimes

Early welfare regime typologies and their value orientations

There are several strands of research and development at the intersection of welfare policy, care, and labour market research. Early welfare regime typologies – most notably Esping-Andersen's social-democratic, conservative, and liberal models (1990) – provided a foundation for analyses of welfare, labour, and care regimes and their subsequent refinements (Höppner, 2024). Important extensions identified a Southern European (Mediterranean) welfare regime (Ferrera, 1996) and further differentiated Central and Eastern European patterns, reflecting familialism, hybrid trajectories, and post-socialist legacies in social rights and service provision (Lauzadyte-Tutliene, Balezentis, & Goculenko, 2018; Cerami, 2006). Each regime reflects distinct cultural-political value constellations with implications for social rights, (in)equality, and labour market stratification. In the social-democratic model, social rights are anchored in principles of equality and solidarity, aiming to reduce hierarchies through universal services and de-commodification. The liberal model is market-centred, treats social rights as residual, and tends to foster socio-structural polarisation and unequal competition. The conservative model reproduces social hierarchies and gendered role assignments, with more conditional social rights closely tied to employment status. These orientations shape how states structure labour markets and family policy, with the

formalisation of care as a key indicator: social-democratic regimes pursue women's full labour market integration alongside public investment in services and formalised care; conservative regimes promote unpaid, family-based informal care supported by transfers; liberal regimes seek higher female employment through marketised childcare that is unevenly accessible. With Southern, South-Eastern, and Central-Eastern European extensions, strong reliance on family care, fragmented benefits, and selective service expansion come into focus; in South-Eastern and CEE variants, post-socialist restructuring and uneven re-commodification are particularly salient.

Limits of ideal types and feminist reorientations

The ideal-typical framing has clear limitations in capturing care and labour regimes. Empirically, women's labour market integration and the expansion of formal care infrastructures do not align neatly with regime labels – for example, high female employment in France or Germany's expanding childcare infrastructure despite conservative classifications (Pfau-Effinger, 2005). Importantly, countries with similar welfare labels can differ markedly in the joint design and enforceability of social and employment rights relevant to care (Frericks et al., 2014), producing distinct practical support landscapes for workers. Feminist scholarship reoriented analysis towards the gendered division of labour and role assignments (e.g., Lewis, 1992), differentiating *weak*, *moderate*, and *strong male-breadwinner states* and linking welfare policy more closely to labour market participation and biographies, the organisation of unpaid/informal and paid/formal care, and the distribution of social risks and protections across genders. This shift broadened welfare state analysis beyond income security and employment to include the cultural norms and policies that structure who cares, who works, and under what conditions. As a distinct emancipated approach beyond welfare state typologies, Ciccia's two-dimensional classification conceptualises labour regimes along separate institutional axes and locates countries accordingly, yielding four clearly distinguishable models (flexible-exclusive, standard-exclusive, standard-inclusive, flexible-inclusive), where "flexible" denotes the prevalence of non-standard contracts and working-time arrangements, and "inclusive" denotes the breadth of social rights and protections beyond standard employment (Ciccia, 2015).

Transformations in informal care and new inequities

For a long time, the extent of informal care was a central categorisation criterion in care-regime research, closely linked to patterns of gender inequality. However, Pfau-Effinger (2005) identified a significant historical shift by demonstrating that informal care can no longer be automatically equated with the male breadwinner "housewife" model. In recent decades, the political organisation and financing of informal care have diversified – through childcare and care allowances, transfers for informal caregiving, differentiated parental and elder-care leave schemes, end-of-life care support, and pension credits for care periods. These instruments have enabled varied combinations of work and care, reshaped labour market biographies, and influenced women's employment rates, while also producing new gendered inequalities, such as the gender pension gap linked to part-time work due to caregiving (OECD, 2025-k). Moreover, undertaking care work involves different patterns of social insecurity along lines of gender, age, and ethnicity across national contexts (Frericks et al., 2014), intersecting with dynamics such as care migration and live-in care (Lutz, 2018).

Care regimes and gendered work–care tensions

Care-regime frameworks analyse how care is organised in society – who is expected to provide care, who pays, who is protected – and how these logics intersect with employment and gendered social risks. Building on this, Pfau-Effinger (2005) conceptualises national "care arrangements" as the interplay between cultural norms and meanings of care and the infrastructures of state, market, family, and civil society, and outlines ideal-typical models with

distinct work–care expectations and gender effects: the family economy model, the housewife model of the male breadwinner family, the male breadwinner/female part-time carer model, the dual breadwinner/external model, and the dual breadwinner/dual carer model. Complementary perspectives – such as the care diamond, which maps responsibilities across state, market, family, and community, particularly in the context of gender and migration (Kofman & Raghuram, 2009), and the “family care regime” lens – show how support is organised either along more strongly familial logics (households as primary care units) or via individualised social rights (portable entitlements to leave, cash benefits, pension credits, and services). Using a family-care-regime perspective, Frericks et al. (2014) compare how policy mixes that recognise informal senior and family care enable social security or entail social risks and may unintentionally reproduce familial care structures. Ciccio and Sainsbury (2018) show that at the intersection of care and labour regimes, the gendered tensions between care and paid work become most salient, as institutional arrangements and policy designs that simultaneously regulate caregiving and employment often generate contradictory incentives and uneven impacts across women and men.

Within this wider organisation of care, senior long-term care (LTC) regimes illustrate how policy choices structure gendered work–care trade-offs. Van Damme et al. (2025) typologise LTC institutions along defamilialisation – how far states relieve families of care responsibilities through benefits, services, or facilitating paid work – and familialism – the degree to which care remains dependent on family. “Explicit familialism” compensates family care, while “implicit familialism” leaves households to absorb costs, effectively privatising care (Leitner, 2013). These dimensions interact with de/commodification and prevailing gender norms to shape who exits, enters, or adjusts paid work when care needs arise, producing distinct configurations of social security and social risks. The core question across care arrangements, family care regimes, the care diamond, and LTC typologies is how responsibilities, resources, and rights are distributed – and whether policy steers support towards familial logics or towards individualised social rights.

Toward a care and labour regime lens

Several studies (Pocock 2005; Anxo et al. 2017), with different substantive and regional foci, have placed an integrated care and labour/work regime at the centre of their analyses. Anxo et al. (2017), in a comparative study of Australia, France, and Sweden, focus on women’s employment outcomes, highlight gendered barriers to employment arising from care responsibilities, as well as how flexibility and labour-market institutions can mitigate or exacerbate these constraints. Pocock (2005), in the context of the Australian labour market, conceptualises the care and work regime within a broader societal gender order – characterised by historically evolved, value-laden gender roles in relation to care and work – that is shaped by, and in turn shapes, the balance of class forces between employers, employees, and the state. This broader order is embodied in a specific, time- and place-bound care-and-work regime.

For the purposes of this deliverable we use the following working definition informed by welfare-policy and care regime pathways (Pfau-Effinger, 2005; Kofman & Raghuram, 2009; Leitner, 2013; Frericks et al., 2014; van Damme et al., 2025), labour-regime research (Ciccia, 2015) and integrated care and work studies (Pocock, 2005; Anxo et al., 2017):

A care and labour regime is the relatively stable configuration of institutions, rules, and norms that simultaneously structures the organisation and distribution of care (who provides care, how, and through which providers) and participation in paid work (who works, under what conditions) across state, market, family, and civil society. It shapes employment and working-time configurations, degrees of de-/commodification and de-/familialisation, and thus produces distinctly gendered patterns of care and labour participation – affecting who shoulders care time, who incurs income loss, and whose labour-market continuity is protected.

Bringing these strands together, we adopt an integrated care and labour regime lens to situate the macro factors relevant to care and labour regime across the four project countries. This lens encompasses care for chronically ill and dying relatives and friends; the emotional and relational dimensions of caring; and the lived experience of serious illness, death, loss, and grief in working life — including bereavement as a workplace event that affects teams, services, and organizational memory.

2 Methodological frame

2.1 Approach and Process

2.1.1 Exploratory, descriptive, and process-oriented

In preparing this deliverable, we first explored the team's interdisciplinary and complementary core competencies to identify key reference discourses, relevant models, and approaches that could improve our understanding of the relationships between intra-organizational dynamics and extra-organizational – political-structural, legal, and socio-cultural - macro-conditions, in the development of Compassionate Workplaces, and to critically reflect on their relevance to our research interest.

Based on this, we then developed a first conceptual framework with a data collection matrix (core dimensions and indicators). Through critical deliberation within the entire team, this approach was iteratively adjusted with the awareness and aim that, in this initial phase of the project, our primary objectives are to develop the descriptive mapping and characterization of country-specific care and labour regimes; then incrementally (inductively) refine this conceptual framework as “provisional model” during the project development process; and, finally, use this foundation to capture more explicitly the linkages between intra-organizational Compassionate Workplace Programmes and care and labour regime factors, after the post-intervention T1 phase.

2.1.1.1 Phases of data collection and analysis

The process of developing the deliverable is summarised in Table 1, along with the phases, objectives, associated intermediate steps, and participation. A key step in the process (Phase 3) was the development of a data collection matrix. Table 2 provides a rough overview of this matrix.

Table 1: Phases of data collection and analysis

	Methodological Frame	Aim	Key activities	Output	Participation
1	Conceptual exploration	Clarifying conceptual linkages care and labour regimes ↔ Compassionate Workplaces	Interdisciplinary reflection on potential political–structural conditions; Interdisciplinary discussions in core team and consortium-wide; initial mapping	Initial conceptual embedding (assumptions, hypotheses, terms, indicators)	- core working group - core group & coordination team - consortium-wide
2	Literature review	Identifying core discourses and models	Scoping and screening; conceptual extraction aligned with disciplinary expertise (end-of-life care, care research, labour studies, organizational studies, etc.)	Consolidation of the conceptual frame of reference	- core working group
3	Development of a data collection matrix (see table 2)	Developing a data collection matrix as analytical lens Anchor point: Employees directly and indirectly affected by EoL experiences & CWP program	Development based on existing concepts and models (as specified under “Toward a care and labour regime lens” above); workshop-based iteration; adjustment of the data logic and matrix final adjustment	draft of data collection matrix with core dimensions and indicators; care and labour regime analytical lens	- core wg - interd. workshop at cons. meeting - enriched with bilateral input from country teams - core group & coord. team
4	Data collection, integration, and framework-oriented mapping and synthesis	Collecting and integrating data; Developing a graphic orientation framework; synthesis guided by the framework	Integration of quantitative/qualitative data into the matrix; development of initial framework graphic; iterative adaptation of the orientation graphic; framework-guided reduction/clustering	Data base and mapping; graphic framework;	- core wg - core wg & coord. team - all country teams - validation adaption with bilateral input
5	Analytical synthesis	Joint reflection and derivation of findings and implications	Analytical reflection meetings and perspective integration	Consolidated descriptive analyses and conclusions	- core wg & coordination team

The following table 2 shows a reduced version of the data collection matrix, offering a brief overview of the data collection logic.

Table 2: Data collection matrix as a framework for guidance

	Dimensions	Indicators
Health & Care infrastructures and aspects	<i>Care services</i>	Long term care, childcare, home care, health care insurance organized by government
	<i>Social protection</i>	Expenditure on social protection as percentage of GDP, general government total expenditure on social protection
	<i>Health</i>	Healthcare coverage, satisfaction with local healthcare quality, private health insurance coverage, health status, health risk and protective factors, health system capacity, health expenditure by service type, self-rated health
	<i>Care</i>	Access to care, quality of care, unmet needs for healthcare, extent of financial coverage, public funding of health spending, health and social care workforce
	<i>Informal Caregiving</i>	Informal caregivers, local government caregiver allowance
	<i>Informal Caregiving & Work</i>	Share of informal daily carers that also work, workers/employees that are informal caregivers
	<i>Chronically/Seriously ill workers/employees</i>	Chronically/seriously ill workers/employees
	<i>End-of Life and Hospice Care Infrastructures</i>	Hospices, palliative care units, bereavement and spiritual care services, palliative care allowance, "Integrated & Indirect" hospice and palliative care services/practices
Specific local/regional conditions?		
Legal and policy frameworks on EoL experiences at the workplace	<i>Care leave</i>	Care leave policies
	<i>Work & Care</i>	
	<i>End-of-life care, hospice and bereavement leave</i>	End-of-life care leave policies
		Bereavement leave policies
	<i>Policies for chronically/seriously ill employees</i>	Support for informal caregiving and employment protection
		Support chronically/seriously ill employees
	<i>Reintegration/rehabilitation after sick leave</i>	Reintegration/rehabilitation after sick leave
	Specific local/regional and/or working sector conditions, preconditions, requirements?	
Labour		Adverse effects of missing structures, regulations and practices
		Meta-analyses and reviews are used here for descriptive purposes, supplemented with quantitative indicators
	<i>Flexible working arrangements</i>	Work-life balance - out of 12 indicators, 2 are represented here
	<i>Employment rates</i>	Employment and unemployment rates for men, women and young people
	<i>Gender and labour market participation</i>	Gender equality index, domain and sub-domain scores, gender pay gap/gender pension gap
	<i>Workers' rights and protection</i>	Union representation and influence, collective bargaining, Social Pro, the OECD tax-benefit model for all countries
	<i>Regulation of work environments workplace well-being and safety</i>	Regulation of work environment/ occupational health as employers' responsibility
	<i>Work ethics</i>	The role/importance/meaning of work/labour in the society
Care regime / arrangement aspects	Meta-analyses and reviews are used here for descriptive purposes.	
	<i>Unpaid care work</i>	Gender care gap in unpaid care work

Long term care		Public expenditures on LTC as % of GDP
Welfare arrangements	Meta-analyses and reviews are used here for descriptive purposes. Taken over by the WP lead and supplemented by the local/national teams during the revision process.	
Demographic Trends	<i>Aging</i>	Aging & increasing life expectancy
	<i>Socio-structural factors</i>	Changing family structures
Social norms & cultural factors	<i>Gender norms</i>	
	<i>Thematization of/attitude toward illness, dying, death, loss and grief</i>	

2.2 Care and Labour Regime lens on Compassionate Workplace Programmes (CWP)

2.2.1 Integrated care and labour regime framework

Figure 1 presents a multi-level care and labour regime framework. This framework results from integrating existing approaches, which were then applied to our data analysis from Austria, Belgium, Greece, and Sweden. It clarifies four ideal-typical levels (depicted as concentric circles with permeable boundaries) of extra-organisational macro conditions that may shape individual and organisational responses to EoL experiences. Each circle is influenced by the next higher-order circle, and some circles may be mutually dependent. The structure shown in the figure also organises the subsequent presentation of data in this report. Against this backdrop, we focus analytically on circles 1 and 2 in this deliverable, use circle 3 as interpretive context, and treat circle 4 as the broader societal horizon.

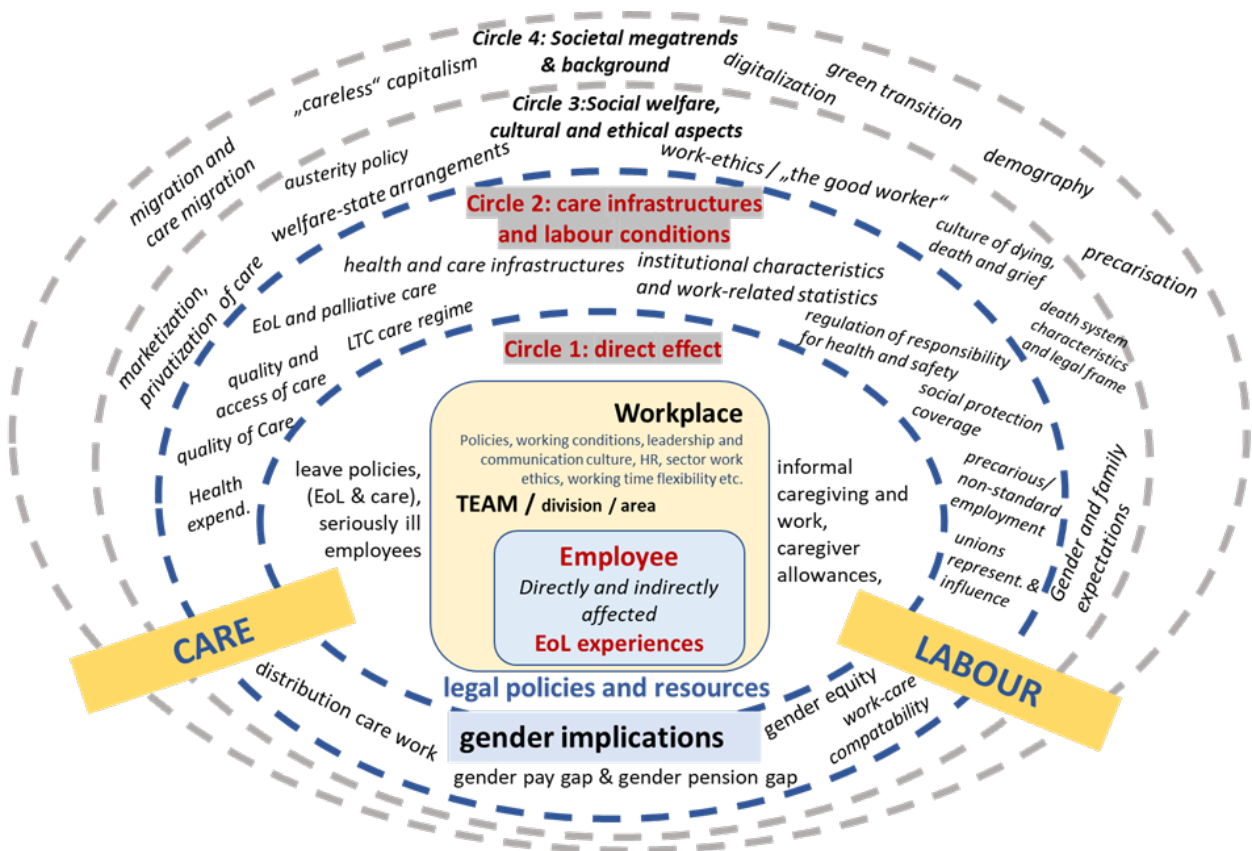
Inner circle - direct effect: legal policies and resources that directly affect employees who are facing EoL experiences at the workplace, such as caregiver allowances, care leave, palliative care and bereavement leave, income replacement, flexible working conditions, etc.

Second circle - care infrastructures and labour conditions: contextual factors that shape individual and organisational capacity to act through the coverage of care infrastructures (hospice and palliative care structures, as well as social and health system infrastructures), and national labour conditions (care and work reconciliation, contract security, collective agreements, part-time and flexible work rights).

Third circle – social welfare, cultural and ethical aspects: Welfare-state arrangements and fiscal conditions – marketization and austerity included – set baseline generosity and access. Cultural and ethical norms around family roles, grief, and the balance between universal and targeted support shape legitimacy and uptake. Work ethics further condition how supportive measures around EoL challenges are perceived and used, determining their accessibility, stability, and equity at work.

Fourth circle - societal megatrends and background: A general background layer – demography, capitalism, socio-structural shifts, migration and, in workplaces, digitalization and the green transition – that interacts in multifaceted ways with the other circles.

Figure 1: Care and labour regime framework as a provisional working model



3 Country-specific characteristics and comparative aspects

3.1 Inner circle: policies and resources directly affecting employees facing EoL experiences

This chapter examines the legal frameworks and policies that directly support employees facing EoL experiences (see Circle 1 in Figure 1), offering a structured analysis of measures across different national contexts in Austria, Belgium, Sweden and Greece. The country-specific analysis is followed by a cross-country perspective, which highlights commonalities and differences in workplace policies.

3.1.1 Informal caregiving and work

Informal caregiving – typically unpaid care provided to elderly, ill or disabled relatives or friends – often conflicts with paid employment. Many caregivers are forced to cut back their hours, move to part-time work, or leave the labour force altogether (Van Houtven et al., 2013; Carmichael & Charles, 1998). These pressures fall disproportionately on women (Dentinger & Clarkberg, 2002) and can have long-term consequences for lifetime earnings, career progression, pension accumulation, and employer productivity, especially given the unpredictability of caregiving demands and the limited support available in many workplaces (Martsolf et al., 2019). Legal frameworks support informal caregiving and work by providing carer's leave, flexible working rights, anti-discrimination protections etc. (European Commission, n.d.-a). At the EU level, the European Pillar of Social Rights serves as a guiding framework for the protection of social rights (European Commission, n.d.-b). All EU member states are required (under the Directive 2019/1158) to ensure that workers are entitled to at least five working days of carers' leave per year to care for a relative or household member with a serious medical condition. In addition, workers with caring responsibilities have the right to request flexible working arrangements, such as remote work or adjusted working hours.

3.1.1.1 Austria

In Austria, employees can take **temporary full-time care leave** (Pflegekarenz) or **part-time care leave** (Pflegeteilzeit) to care for close relatives who have been officially assessed by a physician and assigned a recognized level of care need (Federal Ministry, Labour, Social Affairs, Health, Care and Consumer Protection, n.d.-a; Chamber of Labour, n.d.-a). In case of the temporary full-time care leave, employees can take a full-time leave for maximum of 6 months. During this time, they receive **care leave income** (Pflegekarenzgeld) which amounts to approximately 55% of their net income, with health and pension coverage maintained. In case of part-time care leave, employees can reduce their weekly working time for a maximum period of 6 months and receive during this period **part-time adjusted care leave income**. In both kinds of leave, dismissal is prohibited, and employers must provide written justification if leave is denied or postponed (National Health Insurance, n.d.; Federal Ministry, Labour, Social Affairs, Health, Care and Consumer Protection, n.d.-b). Since November 1, 2023, the Equal Treatment Act (Gleichbehandlungsgesetz, GIBG) has provided stronger protection against discrimination for individuals with caregiving responsibilities. Disadvantages in working life due to parental leave, care leave, part-time care work, or caring for close relatives are prohibited (Chamber of Labour, n.d.-b).

3.1.1.2 Belgium

In Belgium, under the **Family Carer Statute (mantelzorgstatuut)**, employees can take **full or partial care leave** to support vulnerable or dependent individuals in their environment,

provided they are **recognized as caregivers with social rights**. A recognized caregiver is someone who has submitted a declaration of honor to their health insurance through an application for recognition for the granting of social rights. The health insurance decides whether a person is recognized as a caregiver (The National Employment Service, 2026). This recognition requires proof that the care is provided free of charge and in cooperation with a healthcare professional. A caregiver needs to have a relationship of trust or an emotional or geographical connection with the person in need of assistance (The National Employment Service, 2026). Care leave offers several options for employees. A full interruption allows an employee to temporarily stop working for up to three months. A partial interruption allows an employee to reduce their working time to either half-time (50%) or one-fifth (20%) for a period of up to six months. During the leave period, the caregiver is entitled to receive flat-rate interruption benefits, which are equivalent to those granted for other thematic leaves. This is an income-replacement allowance during career leave. This is different from the regional “cash-for-care” budget, which is directly intended for individuals with severe care needs for their non-medical care expenses. Individuals with severe care needs can partly use their care budget to support their informal caregiver, thereby aiding them in their caregiving responsibilities (The National Employment Service, 2026; Christian health insurance, 2026; Flemish Government. n.d.). The leave arrangement supports flexible working conditions while ensuring the protection of the caregiver’s social rights. This care leave framework is aligned with the European Pillar of Social Rights adopted in 2017, which promotes care provision, flexible working arrangements, and access to care services. In addition, cash-for-care policies are designed to provide financial support to caregivers. (Bouget et al. 2017; Glendinning, 2018).

The interruption allowance for informal care leave is fixed. The amount is not calculated based on the caregiver's salary. The interruption allowance for informal care leave corresponds to that for leave for medical assistance, which is established in scales. The period of leave for informal care can be terminated early, subject to the employer's approval. Periods of career breaks taken for caregiving leave are not taken into account when calculating the maximum duration of a career break or the total amount of 'time credit' that one can enjoy over the course of their career. In both complete and partial career breaks, one is protected against dismissal. This protection begins on the day of the agreement or on the day of written notification to the employer. It ends three months after the career break. During this protected period, the employer may not unilaterally terminate the employment contract, except for urgent or valid reasons. A reason recognised by the court as such, which is of a nature and cause unrelated to the career break, is considered a valid reason (The National Employment Service, 2026).

3.1.1.3 Greece

In Greece, caregiver-employees (either full time or part time) are entitled to request flexible working arrangements (such as telework, flexible working hours, or part-time work), and can take up to five unpaid working days per year, provided they have completed six months of employment with the same employer. A medical certificate is required, and the cared-for person must be a relative in the same household. Additionally, employees are entitled to two paid days per year for urgent family reasons (illness or accident of a close relative), with no minimum service requirement (Epioni, Greek Carers Network, 2021; Ministry of Labour and Social Security, 2021; Greek Patients' Association, 2023). The employer must examine the request and justify any refusal. Employees retain their acquired rights, are protected against discrimination and dismissal due to the exercise of these rights, and are entitled to return to the same or equivalent position. Judicial and administrative protection is available in case of violation (Hellenic Labour Inspectorate, n.d.-a).

Parents (biological, adoptive, or foster) of a child up to 18 years old with serious health conditions—such as cancer, need for transfusions or dialysis, transplantation, severe

intellectual disability, or Down syndrome—are entitled to 10 working days of paid leave per year, granted with priority upon request. Additionally, if the child is hospitalized due to illness or accident and requires the parent's presence, each parent may take up to 30 working days of unpaid leave per year, provided that other paid parental leave entitlements have been exhausted. These rights apply individually to each parent and are granted in addition to other family-related leave provisions (Hellenic Labour Inspectorate, n.d.-b).

3.1.1.4 Sweden

In Sweden there are no legal requirements for employers to offer flexible working hours, and usually there are also no provisions regarding this in the central collective agreements either. However, there are flexible time available for carers and parents: If you have children you have the right to work part time up to 25% until the child is 8 years. According to the Act on the Right to Leave for Urgent Family Reasons (SFS 1998:209), a worker is entitled to leave from their employment for urgent family reasons connected with illness or accident which make his or her immediate presence indispensable (Ministry of employment, 2025a).

In Sweden Allowance for caregiving a significant other (Närståendepenning) provides just under 80% of employee's income, up to a maximum limit. The allowance covers 100 days per sick person nearing the end of life, which can be shared among multiple or single persons. This benefit is intended to allow family members or close relatives to spend time with a seriously ill person in a palliative care phase (The Swedish Social Insurance Agency, 2025). Additionally, some municipalities offer economic support known as family support allowance (anhörigbidrag) or home care allowance (hemvårdsbidrag). This is designed to compensate relatives for care work that the local government's home care service (hemtjänsten) would otherwise have provided (National Competence Center for Relatives, 2021).

According to the Swedish Employment Protection Act (LAS 1981:80) employees are implicitly protected in situations involving serious illness, caregiving and bereavement. Illness is for example not valid grounds for termination, and employers must first exhaust all options for rehabilitation and reassignment before terminating an employee with any kind of illness. Employees who take legally regulated leave, such as leave to care for a close relative (for example with the support of the Act on the Right to Leave for Urgent Family Reasons, 1998:209), retain full employment protection. Grief or temporary absence due to death in the family can never lead to dismissal (Specifics about how many days you access for these events are regulated through collective agreements). The only explicit exception in LAS is when an employee is granted full disability pension/sick benefit (Sjukersättning); in that case, the employer may end the employment under the special rule in Section 4b (which says that the employer needs to provide a written statement it). In all other cases, the employment relationship remains protected (Ministry of employment, 2025b).

3.1.1.5 Cross-country perspective

The regulation of informal caregiving within employment law differs considerably across Austria, Belgium, Greece and Sweden. While all four countries provide some form of protection for working caregivers, they vary significantly in terms of leave duration, income replacement, access conditions, and the degree to which caregiving responsibilities are explicitly recognized within anti-discrimination frameworks. Broadly speaking, Austria and Belgium offer structured statutory leave schemes tailored to informal caregivers, Sweden relies more heavily on social insurance and general employment protection mechanisms, and Greece provides comparatively limited leave entitlements combined with procedural safeguards.

The following comparative table synthesizes key cross-country data on informal caregiving rights in employment for the four countries.

Table 3: Cross-country data on informal caregiving and work in Austria, Belgium, Greece and Sweden

Policy Dimension	Austria	Belgium	Greece	Sweden
Duration of Leave	Up to 6 months (full-time or part-time care leave)	Up to 3 months full interruption ; up to 6 months partial	5 unpaid days + 2 paid urgent days (general caregivers); 10 paid + 30 unpaid days for parents of seriously ill child	Up to 100 days per care recipient (allowance for caregiving a significant other)
Income Replacement	~ 55% of net income with maintained health/pension coverage	Flat-rate interruption allowance (not salary-based); separate “cash-for-care” budget	Mostly unpaid (general leave); specific parental leaves are paid	~ 80% of income for up to 100 days; municipal support possible
Eligibility	Care recipient must have a recognized level of care need ; caregiver must be a close relative	Employee must be officially recognized as caregiver by health insurance; caregiver can be anyone with a submitted declaration of honour	Medical certificate; care recipient must be a relative in same household	Serious illness/urgent family reason required; allowance for caregiving a significant other: linked to certification of need ;
Protection Against Dismissal	Yes , during care leave; written justification required for employer’s denial/postponement	Yes , during leave + 3 months post-leave (except for valid, unrelated reasons)	Yes , protection from discrimination/dismissal when exercising rights	Robust general protection under Employment Protection Act
Anti-Discrimination Coverage	Yes , explicit protection under Equal Treatment Act for caregivers	Yes , through social rights framework and employment protection	Yes – protected against discrimination/dismissal for exercising rights	General discrimination law applies but no explicit provision for caregivers

Overall, the comparison illustrates varying policy priorities: Austria and Belgium institutionalize caregiving within labour law structures; Sweden integrates caregiving primarily through social insurance and general employment protection; and Greece maintains a narrower leave entitlement supplemented by legal safeguards against dismissal and discrimination.

3.1.2 Chronically/seriously ill employees

EU member states are legally required to protect chronically and seriously ill employees through anti-discrimination laws, mandatory “reasonable accommodation” to their health situation in the workplace (per Directive 2000/78/EC), and occupational health regulations. These obligations aim to prevent discrimination, ensure safety, and support employment retention for those with chronic diseases (European Commission. Employment, Social Affairs, and Inclusion, 2025). They must uphold minimum standards for sick leave and income protection, including the right to paid annual leave during illness, sick pay, and protections against unfair dismissal (Eurofound, 2012).

3.1.2.1 Austria

In Austria, at the beginning of a sickness employers are responsible for providing support for the sick employee: employees are entitled to continued full wage payment during illness, followed by partial pay, with the duration increasing according to length of service. Once employer obligations are exhausted, social security provides sickness benefits for an

extended period, complemented by rehabilitation and retraining allowances for individuals with temporary but prolonged incapacity. In cases of permanent work incapacity, there is entitlement to a disability pension, and occupational diseases are covered through a separate accident insurance system (Chamber of Labour, n.d.-c).

In Austria, reintegration through part-time work (*Wiedereingliederungsteilzeit*) is regulated by law and allows employees to gradually return to work after a prolonged illness by temporarily reducing working hours while receiving a reintegration allowance (*Wiedereingliederungsgeld*), a benefit that supplements their reduced salary to support the transition back to full work capacity. Working time is reduced by 25–50 %, with a minimum work time of 12 hours per week, and employees retain proportional pay, continued health and pension insurance contributions, and job protection. This statutory framework is enforced and overseen by the health insurance authorities (Chamber of Labour, n.d.-d).

3.1.2.2 Belgium

During the first year of work incapacity in Belgium, workers receive a uniform income replacement set at a percentage of their previous wage, with a reduced minimum benefit applying after the initial months. The employer is obliged to continue paying wages during the initial period of illness (guaranteed wage) but the duration varies: White collar workers receive 100% of their salary for 1 month paid by the employer. Blue collar workers receive 100% for the first 7 days, then approximately 86%, and partially by the employer up to day 30 (Ose et al., 2022). This benefit is calculated per day, and in the first year equals 60% of the person's gross daily wage (the gross daily wage of the last day of the second calendar quarter preceding the quarter in which the disability occurred, or the last gross daily wage). A minimum benefit applies starting with the third month of incapacity for work. During the third month of incapacity, this is the same minimum amount for all insured persons. From the fourth month of incapacity, the person's family situation determines their minimum benefit (National Institute for Sickness and Disability Insurance, n.d.). After one year, individuals transition into a disability regime in which benefit levels are differentiated according to family situation, reflecting a stronger emphasis on household composition in benefit design. This structure underscores Belgium's approach of treating long-term illness as a form of disability managed within the broader social security framework (National Institute for Sickness and Disability Insurance, (n.d.).

The actors involved in shaping the return-to-work integration processes in Belgium include employers, employees, physicians, health insurance funds, employment services, and external prevention and protection services. A Return-to-Work programme can be initiated by the advisory doctor, by the employee, or through regional employment services if the incapacity to work exceeds one year. The TRIO platform and, since April 1, 2024, the Back-to-Work fund at The National Institute for Sickness and Disability Insurance (RIZIV) support this process. The Royal Decree of 11 September 2022 introduced the Reintegration Programme 2.0, which focuses primarily on early contact with employees unable to work due to sickness. The reintegration process has been simplified: greater emphasis is placed on the physician proposing workplace adjustments and adapted work that considers the employee's capabilities and health. Employers' obligations have been strengthened: when exploring adapted work possibilities, they must take maximum account of the occupational physician's recommendations, the collective reintegration policy, and, where applicable, the right to reasonable accommodation at the workplace for persons with disabilities. If the employer cannot offer adapted work, they must demonstrate that they have seriously explored the possibilities (Federal Public Service, Employment, Labour and Social Dialogue, n.d.).

The Court of Audit recommended separating medical force majeure from the reintegration process, leading to a new procedure for terminating employment contracts on medical

grounds. Under this procedure, the employee must have been unable to work for at least nine months without interruption, must be permanently unfit for the agreed work, and no reintegration programme may be in progress (Federal Public Service, Employment, Labour and Social Dialogue, n.d.).

3.1.2.3 Greece

Under Greek law, employees absent due to illness retain the right to receive their salary, with employer deductions for amounts paid by social insurance (Civil Code, Articles 657–658). Short-term illness rules do not apply to chronic or serious illnesses. The employer may terminate contracts during prolonged illness, but courts consider objective factors -such as absence duration, likelihood of return, employee seniority, type of work, employer tolerance - before deciding if the absence constitutes implied resignation (Law 4558/1930) (Gov.gr., n.d.). Individuals with at least 50% disability are entitled to six additional working days of leave per year in addition to their regular leave (Law 2643/98, Article 8) (Hellenic Labour Inspectorate, n.d.-c). Employees who have worked up to four years for the same employer, and who are carriers of or suffer from AIDS, are entitled, from the date of notification to the employer, to up to one month of additional paid leave per calendar year (EGSEE 2004, Article 11) (Hellenic Labour Inspectorate (n.d.-d).

Employers in Greece must ensure workplace health and safety in line with EU Directive 89/391/EEC and Law 3850/2010. They are required to appoint a registered Safety Technician and Occupational Physician through the Labour Inspectorate's online system and to prepare a written occupational risk assessment. Employers must implement general and specific preventive measures addressing building, technical, physical, chemical, biological, ergonomic, and other workplace hazards, as well as comply with additional safety rules for certain high-risk sectors (Ministry of Digital Governance of the Hellenic Republic. 2024).

In addition to employment and income protection measures, Greek law also provides for structured long-term health care services for chronically ill persons through facilities contracted with the National Organization for the Provision of Health Services (EOPYY), ensuring access to systematic nursing care under regulated admission and reimbursement conditions (Ministry of Digital Governance of the Hellenic Republic, 2022).

3.1.2.4 Sweden

As in Austria, Belgium and Greece, Sweden also follows a mixed model that combines short-term employer responsibility with extensive state involvement in medium- and long-term illness. The Swedish system places particular emphasis on rehabilitation, prevention, and sustained income protection, with extended sickness benefits available for severe or long-lasting conditions and permanent compensation granted when work capacity is durably reduced (Swedish parliament, n.d.-a). Collective agreements in Sweden often supplement statutory provisions, further strengthening income security for chronically ill workers.

The sick pay act 1991:1047 (lagen om sjuklön) regulates that on the first day of sickness, no payment is made (Swedish Parliament, n.d.-b; Swedish Social Insurance Agency, 2025). From day two up to day fourteen, the employer pays sick pay amounting to 80% of the employee's regular salary. If the illness continues beyond 14 days, the responsibility shifts to the Swedish Social Insurance Agency (Försäkringskassan) which provides sickness benefit at approximately 80% of income. From the 30th day of sick-leave the employer is obliged to prepare a return-to-work plan if the absence is expected to last a minimum of 60 days in total. The plan should include preparation of adaptations and rehabilitation. Employers also have the responsibility of keeping contact with the employee and can involve the occupational health when needed (Swedish Parliament, n.d.-b; Swedish Social Insurance Agency, 2025). The nationally regulated sick pay can be complemented by some collective agreements.

Swedish legislation around returning to work procedures support early and structured reintegration for employees returning to work after sick leave. Different laws address different parts and stakeholders of the process. The Health and Medical Services Act 1982:763 (Hälsa och sjukvårdslagen) ensures access to medical rehabilitation for the employee with a focus on restoring both physical and mental capacity. This law also regulates the responsibility of healthcare providers to offer medical treatment and rehabilitation (Swedish Parliament, n.d.-c). The work environment act 1977:1160 (arbetsmiljölagen) ensures that the employer maintain safe and healthy work environment but also to adapt work conditions and facilitate the return to work-process of the employee (Swedish Parliament, n.d.-a). Employers are by this law obliged to implement measures such as adjusted tasks, working hours or technical aids.

3.1.2.5 Cross-country perspective

Across all four countries, employers bear initial responsibility for wage continuation during sickness absence, but the duration and structure vary. All four countries transition from employer responsibility to social insurance systems for longer-term incapacity. Belgium formalizes long-term sickness as disability relatively quickly (after one year). Austria and Sweden emphasize rehabilitation before permanent pensioning. Greece combines income protection with broader health service access rather than a highly structured disability transition model. Overall, while all four countries follow a social insurance model, Austria and Sweden are more activation-oriented, Belgium combines activation with disability institutionalization, and Greece emphasizes employment protection and workplace safety compliance.

The following comparative table synthesizes key cross-country data on policies related to seriously/chronically ill employees.

Table 4: Cross-country data on legal provision for seriously/chronically ill employees in Austria, Belgium, Greece and Sweden

Policy Dimension	Austria	Belgium	Greece	Sweden
Initial wage continuation	Strong, service-based	Differentiated by worker type	Salary rights with social insurance deduction	80% (after 1 unpaid day)
Shift to social insurance	After employer obligation	After guaranteed wage	Integrated from start	Day 15
Long-term structure	Rehab → pension	1 year → disability regime	Case-by-case judicial balancing	Extended sickness → permanent compensation
Return-to-work model	Gradual part-time reintegration	Formal multi-actor governance	Safety & legal compliance focus	Early structured rehabilitation
Employer obligations	Wage + reintegration support	Strong adaptation & justification duties	Health & safety compliance	Mandatory RTW plan & adaptation

3.1.3 Loss, dying and bereavement at the workplace

This section examines two critical aspects of workplace support for employees dealing with loss, dying and bereavement: First, hospice and palliative care leave policies enable employees to care for terminally ill close relatives. Second, it turns to bereavement leave policies, which are supposed to support employees in the event of a death by providing time to grieve and address the practical and administrative matters that follow.

3.1.3.1 Hospice or palliative care leave policies

Hospice or palliative care leave enables employees to care for a dying relative, often with paid or unpaid special leave, financial support for hardship cases (such as loss of income), and the option to for flexible working arrangements. There is no specific EU law that gives workers the right to take leave to care for a dying relative. However, the EU sets minimum standards for carers' leave more broadly (see section 3.1.1). Some member states have adopted additional, specific leave policies beyond the EU minimum. It is important to note that the terminology used for such leave is not uniform across countries; in every case, this paragraph refers to policies supporting employees caring for a seriously ill or dying close person. The following sections outline how this issue is addressed in the respective countries.

3.1.3.1.1 Austria

In Austria, Family Hospice Leave allows employees to take temporary leave from work to care for a terminally ill close relative at the end of life. The leave can be taken when a doctor confirms that the relative is expected to die within a short period, usually within weeks to months. Employees are generally entitled to up to three months of full or part-time leave, and the leave can be divided into shorter periods by agreement with the employer. The entitlement is based on the individual employee's employment relationship (and therefore not limited to one person per patient). Several relatives who are employees may take family hospice leave simultaneously or consecutively for the same person. During this time, employees can receive hospice care leave benefit ("Familienhospizkarenzgeld"), which partially replaces their lost income, similar to care leave income ("Pflegekarenzgeld") (see section 3.1.1). Health and pension insurance remain covered, and employment-related rights are preserved. Employers must approve the leave, but employees cannot be dismissed or discriminated against for taking it. Family hospice leave can also be taken in combination with other forms of care leave, if eligibility requirements are met (Chamber of Labour, n.d.-a; Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection, n.d.-a).

3.1.3.1.2 Belgium

Palliative care leave in Belgium allows employees to take time off to care for a seriously ill person. This person does not have to be a family member. The standard duration of this leave is one month, whether it is taken as a complete pause from work or as a partial reduction, such as working half-time or one-fifth of normal hours. If additional time is required, the leave can be extended, with up to two further one-month extensions, meaning that for each patient in need of palliative care, you may take up to three months of leave in total, either fully or partially. Multiple people may also take palliative care leave for the same person. Employees may also, in agreement with their employer, spread their working hours over the month, provided that the average reduction matches the proportion of a full-time position. To be eligible for palliative care leave, a certificate from the patient's treating physician is required, confirming that the employee will be providing palliative care. If the patient passes away during the leave, employees have the option to continue their leave until the originally planned end date or to end the leave early with the employer's consent. Importantly, any days not taken to meet the minimum duration of leave will not be deducted from the total leave entitlement, ensuring that employees can manage their caregiving responsibilities without losing their full entitlement. During the leave period, the caregiver is entitled to receive flat-rate interruption benefits, which are equivalent to those granted for other thematic leaves. This is an income-replacement allowance during career leave (The National Employment Service, 2024) (See also section 3.1.2.).

3.1.3.1.3 Greece

Greek law does not provide specific hospice or palliative care leave; however, employees may use carer's leave instead, which in Greece allows up to five unpaid working days per year to provide care to a relative or a person in the same household with a serious medical need (Epioni, Greek Carers Network 2021) (see section 3.1.1).

3.1.3.1.4 Sweden

Sweden does not have a specific "hospice or palliative leave" law, but employees can get Allowance for significant other (Närståendepenning) as mentioned above (see section 3.1.1), to care for a family member who has a life-threatening condition. This leave is paid and regulated through the Swedish Social Insurance Agency. It provides around 80% of an employee's income for up to 100 days per sick person. This leave is tied to a specific person with life-threatening condition and may be shared among different caregivers. This benefit is not intended for professional caregiving, but to allow family members or close relatives to spend time with a seriously ill person in a palliative stage of sickness (The Swedish Social Insurance Agency 2025). Another right that employees have is regulated through collective agreements called leave for personal matters (Ledighet för enskilda angelägenheter). It applies when a relative or significant other has a life-threatening illness, allowing the employee to be absent from work for 2 to 10 days while maintaining income security. The length and compensation often depend on collective agreements. It is usually used during the final days of a close person's life, the day when a person dies, and for the following days as well as for the day of the funeral. Additionally, employees may use urgent family leave (unpaid by law but sometimes paid under agreements) for critical situations related to illness or accidents (Ministry of employment 2025).

3.1.3.1.5 Cross-country perspective

Across Austria, Belgium, Greece, and Sweden, policies supporting employees caring for a seriously ill or dying relative vary significantly in scope, duration, and financial support. Austria offers up to three months of leave for terminally ill close relatives with partial income replacement, while Belgium provides up to three months for a seriously ill person with flat-rate interruption benefits. Sweden provides up to 100 days of paid leave at 80% of income for close relatives with life-threatening conditions, offering one of the most generous financial support systems. Greece has no specific policy for end-of-life care. Employers may use carer's leave instead (see section 3.1.1).

Table 5: Cross-country data on hospice or palliative care leave policies in Austria, Belgium, Greece and Sweden

Policy Dimension	Austria	Belgium	Greece	Sweden
Eligibility	Terminally ill close relatives	Any seriously ill person	<i>No specific policy for end-of-life care leave. Employees might use carer's leave (see section 3.1.1)</i>	close relatives with life-threatening conditions
Duration	Up to 3 months (full or part-time)	Up to 3 months (in 1-month-increments; full or part-time)	-	Up to 100 days (shared among caregivers)
Financial support	Partial income replacement	Flat-rate interruption benefits	-	80 % of income
Anti-Discrimination-Coverage	Protected from dismissal/discrimination	Protected from dismissal/discrimination	-	General discrimination law applies but no explicit provision for caregivers (see section 3.1.1)

3.1.3.2 Bereavement leave policies

Bereavement leave is paid or unpaid leave from work following the death of a close relative, allowing employees to grieve, organize and attend funerals and settle other matters.

3.1.3.2.1 Austria

In Austria, bereavement leave is not uniformly regulated by statutory law but is primarily governed by collective agreements and individual employment contracts. Nevertheless, special leave is legally protected, meaning the employer cannot deny it if the eligibility criteria are met. Employees are typically entitled to 1–3 days of paid special leave (“Sonderurlaub”) in the event of the death of a close family member, such as a spouse or partner, children, parents, siblings, grandparents, or in-laws. The duration of leave depends on the closeness of the relationship and collective agreements or employment contracts. Some collective agreements or company policies may also provide longer periods of paid leave. During this time, employees retain their regular salary. The leave is usually taken around the time of death or the funeral. The leave can be taken immediately following the death or for the funeral (Chamber of Labour n.d.-e, Federal Chancellery 2024).

3.1.3.2.2 Belgium

In Belgium, bereavement leave is standardized by law but also determined by collective (sectoral) agreements. In 2021, a new Belgian law extended bereavement leave from 3 days up to 10 days. The law explicitly defines entitlements based on the degree of kinship. The death of a spouse, a cohabiting partner, a child or a child of the spouse or cohabiting partner entitles employees to 10 days of paid leave: 3 days may be chosen by the employee during period starting on the day of death and ending on the day of the funeral, 7 days may be taken at the employee’s discretion within one year following the day of death. Deviations from these two periods in which the leave must be taken may be made at the employee’s request, with the employer’s agreement. The death of an employee’s father, mother, father-in-law, stepfather, mother-in-law, or stepmother, or those of the employee’s spouse or cohabiting partner entitles employees 3 days of bereavement leave. The death of a brother, sister,

brother-in-law, sister-in-law, grandfather, grandmother, grandchild, great-grandfather, great-grandmother, great-grandchild, son-in-law, or daughter-in-law of the employee, or of the employee's spouse or cohabiting partner, who lives with the employee entitles employees 2 days of bereavement leave, to be chosen by the employee during the period starting on the day of death and ending on the day of the funeral. The death of a brother, sister, brother-in-law, sister-in-law, grandfather, grandmother, grandchild, great-grandfather, great-grandmother, great-grandchild, son-in-law, or daughter-in-law of the employee, or of the employee's spouse or cohabiting partner, who does not live with the employee: 1 day of bereavement leave, to be taken by the employee on the day of the funeral (Federal Public Service Employment, Labour and Social Dialogue, n.d.). Important to note is that these leave periods can be negotiated at the sectoral level, so they can differ depending on your employment, e.g., as of 2026, white collar workers are entitled to 12 days of bereavement leave in case of the death of a partner or child (extending the days that can be taken at the employee's discretion from 7 to 9), and 5 days in case of the death of a parent or parent-in-law (previously 3) (Liantis 2025).

3.1.3.2.3 Greece

In Greece, employees with an employment contract are entitled to two days of paid leave in the event of the death of a spouse, parent, or sibling. This leave applies not only to blood relatives but also to relatives by marriage of the same line and degree (Hellenic Labour Inspectorate, n.d.). It should be noted that (under Article 93 of Greek National Law 5018/2023) a special 20-day paid leave has been established for employees who have lost a child (KEPEA n.d.).

3.1.3.2.4 Sweden

Bereavement leave in Sweden is not standardized by law but is commonly covered by collective agreements. Some agreements grant from two up to 10 days of paid leave when a close relative dies, typically for funeral arrangements and estate matters. During this time, employees retain their regular salary. The leave is usually taken around the time of death or the funeral. In the absence of a collective agreement, employees must negotiate with their employer or use annual or sick leave. Close relatives include spouses, partners, children, parents, grandparents, and siblings (The Survivor Guidance Portal 2025).

3.1.3.2.5 Cross-country perspective

Compared to one another, bereavement leave policies in Austria, Belgium, Greece, and Sweden differ considerably in terms of structure, length and eligibility criteria. Austria provides 1-3 days of paid leave for the death of a close relative, primarily governed by collective agreements. Belgium offers the most generous and legally standardized bereavement leave, with up to 12 days of paid leave for spouses, partners, or children (starting in 2026 for white-collar workers), and shorter periods for other relatives, depending on kinship and sectoral agreements. Greece has more limited provisions, granting 2 days of paid leave for the death of a spouse, parent, or sibling, and 20 days for the loss of a child. Sweden, while lacking statutory regulation, allows 2–10 days of paid leave under collective agreements, offering flexibility for employees during difficult times.

Table 6: Cross-country data on bereavement leave policies in Austria, Belgium, Greece and Sweden

Policy Dimension	Austria	Belgium	Greece	Sweden
Eligibility	close family member, e.g. spouse, partner, children, parents, siblings, grandparents, or in-laws	close relative	spouse, parent, sibling, and relatives by marriage of the same line/degree	spouse, partner, children, parents, grandparents, or siblings.
Duration	1–3 days	1 to 12 days	2 to 20 days	2 to 10 days
Salary Retention	Regular salary retained during leave.	Regular salary retained during leave.	Regular salary retained during leave.	Regular salary retained if covered by collective agreements

3.1.3.3 Concluding, reflective thoughts regarding a cross-country “comparison”/perspective

Across Austria, Belgium, Greece, and Sweden, care, hospice/palliative, and bereavement leave policies share the common goal of supporting employees caring for seriously ill or deceased relatives, but they differ in scope, duration, and compensation. Austria and Belgium provide structured full- and part-time care leave, with partial income replacement and strong employment protections, while Greece offers limited unpaid or short paid leave with flexible working options. Sweden relies on Allowance for caring for a significant other, providing income support for up to 100 days per patient, rather than formal statutory leave. Concerning seriously or chronically ill employees, all four countries combine employer wage continuation with social insurance schemes. Austria and Sweden focus strongly on rehabilitation and reintegration, Belgium formalizes a transition into a disability regime, while Greece emphasizes employment protection and workplace safety compliance. For hospice or palliative care, Austria and Belgium offer specific leave entitlements with income support, whereas Greece and Sweden lack dedicated laws but allow existing care leave or benefits to be used for end-of-life care. Bereavement leave is paid in all four countries but varies in length: Austria offers 1-3 days, Belgium 1-12 days, Greece 2-20 days, and Sweden up to 10 days under collective agreements. Overall, all countries aim to balance caregiving responsibilities with employment rights, but the level of financial support, statutory coverage, and flexibility differs significantly.

3.2 Circle 2: care infrastructures and labour conditions as context enablers

Guided by our ideal-typical care and labour regime framework, this section outlines the national infrastructural and institutional conditions that serve as contextual enablers or constraints by directly (legally and administratively) shaping the immediate support structures in Circle 1, or by substantially determining the scope for employees to reconcile care and work when experiencing EoL situations.

We begin by descriptively presenting each country’s care and health infrastructures and comparing their key characteristics. As part of this, we first emphasise end-of-life care infrastructures, as these largely determine the formal care arrangements surrounding EoL experiences.

We then set out important elements of the national labour framework. In line with our integrated understanding of care and labour regimes, we explicitly address the interrelationship with care across several dimensions, and we take into account gender

dynamics in the labour market, which directly influence and reflect the societal organisation of care. These issues are closely connected to care-regime questions concerning the reconciliation of care and work, processes of defamilialisation or familialism, and typologies associated with family breadwinner models, as discussed in the section on health and care infrastructures.

In presenting Circle 2, existing international data (OECD, Eurostat, Gender Equality Index, etc.) are complemented by additional national data sources, legislation and studies, as well as international meta-analyses and reviews. This approach also highlights the methodological challenges and limitations, along with inevitable imprecision. We draw on a highly heterogeneous evidence base, both in form and in temporal currency. Therefore, very recent developments – such as the marketisation of care, observed even in Scandinavian social-democratic welfare systems (Szebehely & Meagher 2018) can only be partially captured in this initial mapping.

Nonetheless, through an overview presentation and selected illustrative deepening, core characteristics and configurations of national care and labour regimes can be made visible. This provides a valuable starting point to capture more precisely, as the project process advances, the interactions between care and labour factors, particularly in relation to the organisational, regional and sectoral contextual conditions of the 14 workplaces participating in EU-CoWork.

Therefore, we will outline the following dimensions and characteristics in Circle 2:

Health Care and EoL Care infrastructures and characteristics

- End-of-Life and Palliative Care Infrastructures
- Health and care infrastructures
 - Health system capacity and resources
 - Long term care (health) expenditure
 - Health expenditure from public sources
 - Quality of Care
 - Access to Care
 - Health Care Availability / Coverage and Financial Protection
 - Unmet long-term care needs
 - Informal Caregiving
 - Child Care
 - Summary – A care regime lens on health and care Infrastructures

Institutional characteristics and work-related statistics

- Regulation of responsibility for workplace health and safety
- Social protection: unemployment benefit schemes and sick leave policies
 - Employment rates
- Precarious or non-standard employment
- Unions representation and influence
- Importance of work
- Work-Care compatibility
- Gender equity aspects

3.2.1 Health Care and EoL Care infrastructures and characteristics

3.2.1.1 End-of-life and Palliative Care Infrastructures

The following country-specific characteristics and comparative overview draw on formal indicators and qualitative assessments of palliative and end-of-life care development, primarily based on the EAPC Atlas of Palliative Care in Europe 2025 (Garralda et al. 2025) and the WHO-based global mapping of palliative care development (Tripodoro et al. 2025), supplemented by country-specific information and literature collected by national project teams.

Austria has a highly developed and institutionalised hospice and palliative care system, characterised by a clearly defined tiered model and strong integration into national health planning. Specialist provision – hospital palliative care units, consult teams, specialised home palliative care, inpatient hospices, and mobile hospice services – is complemented by systematic integration into generalist settings, including long-term care facilities. Financing has been substantially stabilised through the Hospice and Palliative Fund Act (HosPalFG, since 2022, Neruda, Pochobradsky 2025). Austria ranks among Europe's most advanced systems, with the highest density of specialised services (3.68 per 100,000 inhabitants) and strong governance for integration into routine care (Garralda et al. 2025; Tripodoro et al. 2025). From a care-and-labour regime perspective, Austria minimises financial barriers for patients and families, yet caregiving time, coordination, and emotional labour remain largely within families – often among working-age relatives. Pressing challenges remain in scaling community-oriented public health palliative care - particularly financing regional networks in end-of-life care, as well as structuring Compassionate Communities and Compassionate Institutions - while demographic and social change (urbanization, changing family structures etc.) strains home-based care, increasing reliance on 24-hour live-in carers and informal caregivers and raising questions about sustainability, quality, and caregiver support.

Belgium's palliative care system is characterised by strong regional coordination and network-based governance, institutionalised since the late 1990s. A central pillar are accredited palliative care networks, which develop palliative care culture, coordinate services across providers, organise training for professionals and volunteers, support palliative home care teams, and inform the public. In total, 25 networks ensure population-wide coverage. Care is delivered across multiple settings, including hospitals, residential care facilities, home care, and dedicated palliative day care centres. The system is complemented by targeted financial instruments. In addition, palliative care delivered by nurses, general practitioners, and physiotherapists is offered free of charge, and further lump sums may be claimed to cover medication, equipment, and related expenses. Belgium demonstrates well-established service integration and governance, albeit with regional variation (Garralda et al., 2025). Substantial organisational and financial support is provided by the state, while families remain central to caregiving and coordination.

Greece's palliative and end-of-life care system is characterised by limited development, fragmented provision, and weak institutionalisation. Specialised palliative care services remain scarce and unevenly distributed, with provision largely concentrated in a small number of hospital-based units and non-governmental initiatives (Garralda et al., 2025). Community-based and home palliative care services are underdeveloped, and palliative care is not systematically integrated into primary or long-term care structures. In the WHO-based global mapping, Greece is positioned in the lower development tiers, reflecting gaps in service availability, integration, education, and community empowerment. A national Palliative Care Feasibility Study commissioned by the Greek Ministry of Health (2019) estimates that while 120,000–135,000 people per year require palliative care, current specialised capacity reaches

less than 1-2% of total need. Families are expected to absorb most practical, emotional, and coordination of work associated with serious illness and dying, often in the absence of formal support.

In **Sweden**, public responsibility and integrated service provision within the palliative care system help limit intensive informal caregiving and related labour-market disruptions, although access and provision vary substantially across regions. National policies emphasise early integration and continuity of care, with responsibility largely within the publicly funded health system. Specialised home-based palliative care plays a central role, supporting patients with complex needs and aiming to reduce emergency department visits and avoidable hospitalisations. However, healthcare governance in Sweden is determined primarily at the regional (county or region) level rather than the national level, shaping how services are organised and delivered. Consequently, despite national policy ambitions, access to palliative care remains uneven across regions, with marked variation in availability and coverage (Swedish palliative registry and the National Advisory Board for Palliative Care, 2026). Palliative care is delivered through a combination of specialised units, mobile palliative teams, and generalist providers, with strong professionalisation and public responsibility. Reliance on intensive informal caregiving by family members is lower than in many other countries, reducing direct work–care conflicts, though there remains substantial regional variation in access and provision.

3.2.1.2 Health and care infrastructures – cross country

Across all four countries, the following combined indicators show that even strong health systems may not eliminate unmet long-term care needs or reliance on informal caregiving, and that childcare affordability remains a critical determinant of parental employment. From a care-and-labour regime perspective, these patterns demonstrate how degrees of de-/familialisation and de-/commodification shape who bears care time, income risks, and labour-market instability. They also explain why care demands consistently spill over into paid work, underscoring the relevance of organisational and workplace-level responses – such as compassionate workplaces – as key meso-level mechanisms mediating between national care infrastructures and individual employment trajectories.

3.2.1.2.1 Health system capacity and resources

Table 7: Health System Capacity and Resources in Selected OECD Countries (2024)

	Health Spending 2024		Doctors	Nurses	Hospital bed
	Per capita (USD based on purchasing power parities)	% GDP	Practising physicians (per 1 000 population)	Practising nurses (per 1 000 population)	Per 1 000 population
OECD	5967	9,3	3,9	9,2	4,2
Austria	8401	11,8	5,5	10,6	6,6
Belgium	7750	11,0	3,4	11,5	5,4
Greece	3607	8,1	6,6	3,8	4,2
Sweden	7871	11,3	4,5	11,0	1,9

The indicators on health system capacity and resources reveal significant cross-country differences in overall health care investment and infrastructural endowment. Austria, Belgium and Sweden all spend substantially more on health care per capita and as a share of GDP than the OECD average, reflecting comparatively well-resourced health systems. Austria stands out with particularly high levels of health spending and hospital bed availability, as well as a high density of both physicians and nurses. Belgium also shows high expenditure levels

and a very strong nursing workforce, while physician density is closer to the OECD average. Sweden combines high health spending with relatively fewer hospital beds, reflecting a system shifting towards outpatient and community-based care rather than inpatient capacity. In contrast, Greece has significantly lower health spending per capita and as a share of GDP. Although physician density is comparatively high, nurse density and hospital bed availability are markedly lower than in the other countries, indicating structural imbalances in workforce composition and service capacity.

Overall, the table shows that higher levels of health spending do not uniformly result in the same mix of human and physical resources but instead reflect distinct health system models and priorities across countries (OECD, 2025).

3.2.1.2.2 Long term care (health) expenditure, 2023

Table 8: Long term care (health) expenditure in Selected OECD Countries (2023)

	Percentage of gross domestic product (GDP) / 2023	EURO per inhabitant / 2023
EU	1,7 (from 2020)	655,85 (from 2020)
Austria	1,45	804,95
Belgium	2,45	1251,85
Greece	0,16	34,73
Sweden	3,1	1576,13

Long-term care (health) expenditure further highlights cross-national differences in the organisation and prioritisation of care for older and dependent populations. Sweden and Belgium allocate a substantially higher share of GDP to long-term care than the EU average, with very high per-capita spending, indicating strong public responsibility and extensive formal provision. Austria holds an intermediate position, with per-capita expenditure above the EU average but a lower GDP share, reflecting a mixed model that combines public provision with family-based care. Greece is notable for its exceptionally low level of long-term care expenditure, both as a share of GDP and per capita, indicating limited formal provision and a strong reliance on informal and family care. These patterns are highly relevant for understanding national care and labour regimes, as low public investment in long-term care tends to shift care responsibilities to households and working-age family members, while higher investment supports greater defamilialisation and reduces work–care conflicts (Eurostat, 2023).

3.2.1.2.3 Health expenditure from public sources, 2023

Table 9: Long term care (health) expenditure in Selected OECD Countries in 2023 (OECD 2025)

	Health expenditure from public sources as a share of total health expenditure, 2023	Health expenditure from public sources as a share of total government expenditure, 2023
OECD	Public (no breakdown): 72% Government transfers: - Social insurance contributions: -	15%
Austria	Public (no breakdown): 77% Government transfers: - Social insurance contributions: -	16%
Belgium	Public (no breakdown): 74% Government transfers: 38% Social insurance contributions: 36%	15%
Greece	Public (no breakdown): 61% Government transfers: - Social insurance contributions: -	10%
Sweden	Public (no breakdown): 86% Government transfers: 86% Social insurance contributions: -	19%

Public financing constitutes the majority of health expenditure in all countries, but to varying extents. Sweden has the highest public share, mainly funded through government transfers, reflecting a strongly tax-based model. Austria and Belgium also rely predominantly on public sources within mixed financing arrangements. Greece, however, has a substantially lower public share and a smaller proportion of government spending allocated to health, indicating greater reliance on private expenditure and higher financial exposure for households (OECD, 2025).

3.2.1.2.4 Quality of Care

Table 10: Quality of Care in Selected OECD Countries in 2023(OECD 2025)

	Safe primary care	Effective primary care	Effective preventive care	Effective secondary care	
	Antibiotics prescribed (defined daily dose per 1000 people)	Avoidable hospital admission (per 100 000 people, age-sex standardised)	Mammography screening within the past 2 years (%women aged 50 – 69)	30-day mortality following AMI (acute myocardial infarction) or stroke (per 100 000 people, age-sex, standardized, unlinked data)	
				AMI	Stroke
OECD	15,6	473	55,5	6,5	7,7
Austria	9,5	440	40,1	6,0	6,0
Belgium	19,1	529	58,0	7,0	8,0
Greece	26,7	N/A	14,5	N/A	N/A
Sweden	8,7	384	83,0	3,4	4,9

The quality-of-care indicators reveal clear cross-country differences in primary, preventive, and secondary care. Sweden performs consistently well, with low antibiotic prescribing, low avoidable hospital admissions, high uptake of preventive screening, and the lowest mortality rates following AMI and stroke, indicating strong coordination across care levels. Austria demonstrates good performance in primary care safety and effectiveness, with low antibiotic use and avoidable admissions, but comparatively weaker uptake of preventive care. Belgium presents a mixed profile, with strong preventive screening but higher antibiotic prescribing and avoidable hospital admissions, suggesting pressures in primary care coordination. Greece is notable for high antibiotic prescribing and very low uptake of preventive care, as well as gaps in available quality indicators, highlighting challenges in both performance and monitoring. Overall, the table shows that quality of care varies substantially across health system levels, with implications for downstream care needs and system sustainability (OECD, 2025).

3.2.1.2.5 Access to Care

Table 11: Health Care Availability/Coverage and Financial Protection in Selected OECD Countries in 2024 (OECD, 2025)

	Financial protection 2023 Expenditure covered by compulsory prepayment, % total expenditure	Population coverage satisfaction 2024 Population satisfied with availability of quality healthcare, % pop.	Service coverage 2024 Population reporting unmet needs for medical care, % population	Health Care Availability 2024 Population satisfied with availability of quality healthcare in area where they live, % population (
OECD	75,1	64	3,4	64
Austria	76,7	78	1	78
Belgium	73,6	86	1,3	86
Greece	60,9	27	12,1	27
Sweden	86,1	75	2,2	75

The access-to-care indicators reveal substantial cross-country differences in financial protection, service coverage, and perceived availability of health care. Sweden and Austria perform strongly, combining high levels of compulsory prepayment with low reported unmet medical needs and high population satisfaction with the availability of quality health care. Belgium also performs well, particularly in population satisfaction and low unmet needs, despite slightly lower compulsory prepayment coverage. Greece has significantly weaker access indicators, including low financial protection, very high levels of unmet medical needs, and low satisfaction with the availability of quality health care. Overall, the table shows that stronger public financing and coverage are closely associated with better access and perceived availability of care, while gaps in financial protection lead to higher unmet needs and lower public confidence in health care systems (OECD, 2025).

Table 12: Unmet long-term care needs among people living at home aged 65 and above with some limitations in activities of daily living in 2021-2022 in Selected OECD Countries (OECD, 2025)

	Unmet LTC needs among those with at least one ADL/IADL limitations / 2021 - 2022	Unmet LTC needs among those with at least three ADL/IADL limitations
OECD	47,1%	38,2%
Austria	44,5%	37,3%
Belgium	42,5%	32,8%
Greece	47,3%	39,3%
Sweden	56,8%	51,6%

Across all countries, unmet long-term care needs among older people living at home remain substantial, particularly for those with multiple ADL or IADL limitations. Even in countries with well-developed health systems, such as Sweden, Austria and Belgium, a large proportion of needs is not met, while Greece also shows high levels of unmet needs alongside weaker formal provision. Overall, the data highlight persistent gaps between health care access and long-term care coverage (OECD, 2025).

3.2.1.2.6 Informal caregiving

Across OECD countries, informal caregiving constitutes a significant part of care provision and is strongly gendered. On average, 61% of informal daily carers are women, and about 11% of daily carers are also in paid employment, highlighting the overlap between caregiving and labour market participation. Austria and Belgium are close to the OECD average for working daily carers, while Sweden has a higher proportion of carers combining work and care, and Greece a markedly lower one, reflecting differences in employment structures and care expectations.

Table 13: Informal daily carers in Selected OECD Countries in 2021-2022 (OECD, 2025)

	Share of informal daily carers that also work, 2021-2022	Share of informal daily carers who are women, 2021-2022
OECD	11%	61%
Austria	11%	64%
Belgium	13%	58%
Greece	3%	71%
Sweden	16%	53%

Table 14: Persons providing informal care or assistance at least once a week in Selected OECD Countries in 2019 (Eurostat 2023)

	Assistance provided mainly to relatives	Assistance provided mainly to non-relatives	No assistance provided
EU	13,4	3,7	83,0
Austria	12,6	2,6	84,7
Belgium	11,0	2,0	87,1
Greece	9,0	5,3	84,7
Sweden	8,2	2,6	89,1

The prevalence and intensity of informal caregiving also vary. Belgium and Austria report relatively high proportions of people aged 50 and over providing informal care, including daily and weekly caregiving, whereas Sweden shows lower daily caregiving despite higher employment among carers. Greece reports fewer working daily carers and a greater reliance on family-based assistance, consistent with stronger familial norms. Across countries, informal care is predominantly provided to relatives rather than non-relatives, underlining the central role of families in meeting care needs. Overall, the data show that informal caregiving remains a key – yet unevenly distributed – pillar of care systems, with clear implications for gender inequality, labour market participation, and economic sustainability (OECD; Eurostat).

In addition, OECD data show that care intensity varies substantially across countries, with daily caregiving most prevalent in Belgium and least common in Sweden, while weekly caregiving is particularly widespread in Belgium. This distinction is relevant for care-and-labour regimes, as daily caregiving is more likely to interfere with continuous employment than episodic or weekly support. At the macro level, the OECD estimates that informal caregiving and associated workforce withdrawal reduce economic growth by around 0.5% per year, underlining the broader economic relevance of unpaid care work (OECD; SHARE; Rocard & Llana-Nozal, 2022).

3.2.1.2.7 Childcare

Table 15: Children receiving formal childcare services by household type, income group, degree of urbanisation and level of difficulty to afford formal childcare services (LEV_DIFF) in 2016 (Eurostat 2023)

LEV_DIFF (Level of difficulty)	Great	Moderate	Some	Fairly easy	Easy	Very easy
EU	3,7	7,6	18,1	32,8	24,6	13,3
Austria	5,1	6,2	18,3	27,1	23,7	19,7
Belgium	4,4	9,9	13,7	20,3	34,0	17,7
Greece	8,7	15,6	70,2	2,7	2,6	0,3
Sweden	3,9	2,3	7,3	26,5	27,1	32,8

Childcare affordability varies significantly between countries. Sweden reports very high affordability of formal childcare, while Belgium and Austria display mixed patterns, with some households still facing access barriers. Greece is notable for widespread difficulty in affording childcare, indicating limited effective access. Overall, differences in childcare affordability have direct implications for parental labour market participation and the distribution of care responsibilities (Eurostat, 2023).

3.2.1.2.8 Summary – A care regime lens on health and care Infrastructures

Taken together, the preceding health and care indicators invite a synthetic interpretation through a long-term care regime lens, as long-term care constitutes the central interface where health system capacity, family involvement, and labour-market participation intersect. Across Austria, Belgium, Greece, and Sweden, the indicators point to distinct care and labour regimes. These differences reflect institutional configurations that structure how care responsibilities are allocated between the state, families, and the market, and how care demands intersect with paid work over the life course (Van Damme et al., 2025).

Sweden corresponds to a historically strong defamilialisation regime, characterised by high public investment, extensive formal provision, and strong financial protection across health care, long-term care, and childcare. While this configuration has traditionally limited labour-market withdrawal in response to care needs, declining long-term care coverage, increasing reliance on family care, and growing for-profit provision indicate processes of marketisation and re-familialisation that may weaken the class- and gender-equalising potential of the Nordic welfare state (Ulmanen & Szebehely, 2015; Szebehely & Meagher, 2018).

Austria and Belgium occupy an intermediate position consistent with regimes of supported familialism. Despite comparatively well-resourced health systems and generally good access and quality of care, gaps in long-term care and childcare provision mean that care needs are frequently absorbed through informal caregiving and working-time adjustments rather than full labour-market exit, resulting in gendered patterns of employment adaptation (Leitner, 2003; Van Damme et al., 2025).

Greece exemplifies a regime of familialism by default, marked by low public investment, limited formal long-term care and childcare provision, weaker financial protection, and high levels of unmet care needs. Care responsibilities are therefore systematically shifted to families, reinforcing pronounced work–care conflicts and discontinuous labour-market participation, particularly among women (Van Damme et al., 2025).

Across all four countries, the persistence of unmet long-term care needs and reliance on informal caregiving – even in comparatively well-resourced systems – highlights the limits of macro-level care infrastructures and underscores the relevance of meso-level mechanisms, including workplace arrangements, in mediating between national care regimes and individual employment trajectories (Rocard & Llena-Nozal, 2022; OECD, 2025).

3.2.2 Institutional characteristics and work-related statistics

This section provides an overview of the following institutional features (or components) pertaining each country and an illustration of current labour market and employment statistics reflecting the possibilities and challenges associated with different national labor regimes.

- Regulation of responsibility for workplace health and safety
- Social protection: Including unemployment benefit schemes and social benefits
 - Employment rates
- Unions representation and influence
- Precarious or non-standard employment
- Importance of work
- Work-Care compatibility
- Gender equity aspects

3.2.2.1 Regulation of responsibility for workplace health and safety

Work environment legislation, together with employers' responsibilities for managing workplace issues, defines mandatory requirements, establishes structures and resources for

psychosocial support, and may shape organizational culture by fostering a climate in which employees feel safe to express their needs. In accordance with the EU Framework Directive on Occupational Safety and Health (Directive 89/391/EEC; European Council, 1989), employers in all Member States have a fundamental responsibility to prevent risks and protect workers' physical and mental health (European Council, 1989). While the directive sets minimum requirements, variations arise between countries in how far-reaching employer responsibilities are and the extent to which psychosocial working conditions are included in the regulation.

3.2.2.1.1 Austria

In Austria, there is no direct legal obligation for companies to implement workplace health promotion (WHP) programs, but employers are required under the Federal ministry of labour Occupational Health and Safety Act [ASchG] (1994) to ensure the safety and health of employees at work, which can include health-related measures. The Austrian Network for Workplace Health Promotion (Blattner & Mayer, 2018; Lang, 2022) and the Austrian Health Promotion Fund (Fonds Gesundes Österreich n.d.) play a key role in supporting and promoting voluntary WHP initiatives by providing guidance, resources, and funding opportunities for companies.

3.2.2.1.2 Belgium

According to Eurofound (2024-e), in Belgium, employers are legally required to protect workers health, safety and overall well-being according to the 1996 law on Well-being at work. This law obligates them to prevent risks, conduct risk assessment and implement measures that make sure the employees are not exposed to any risk of psychological hazard, physical injuries, elements of work organisation, elements of work content, working and living conditions in the workplace and interpersonal relationships at work. The definition also covers harassment and violence in the workplace (Eurofound, 2024-e).

3.2.2.1.3 Greece

According to Eurofound (2024-f), in Greece, employers have legal obligations regarding health and safety at work. Under law no. 4808/2021, all workplaces with more than 20 employees must adapt a violence and harassment prevention policy, which include risk assessment, preventive and awareness-raising measures. National legislation also addresses psychosocial risks (Law no. 3850/2010) which require employers to do a risk assessment related to the work organisation, psychological factors, ergonomic factors and (difficult) working conditions (Eurofound, 2024-f). The Laws on Health & Safety at Work (KNYAE), enacted by Law 3850/2010, apply to all public and private sector workplaces and all employees, including trainees and apprentices (excluding domestic workers), unless otherwise specified (e.g. maritime work). Compliance is overseen by the Labor Inspectorate for Health & Safety at Work under the Hellenic Ministry of Labor (Hellenic Republic – Ministry of Labour and Social Affairs, 2025).

3.2.2.1.4 Sweden

In Sweden, the purpose of the work environment act is to prevent ill health and accidents at work and to achieve a good working environment in other respects (Work Environment Act, 1977). In Sweden this is strictly regulated through Occupational safety and health (OSH), regulations (SAM, systematiskt arbetsmiljöarbete). The Work Environment Act (1977) obliges employers to prevent ill-health and promote a safe working environment, which leads many workplaces to rely on external occupational health services, although this is not mandated by the Act. The Discrimination Act (2008) in Sweden does cover broader aspects of discrimination that could be relevant in cases of sickness, sick leave or caregiving. Additionally, according to

the Swedish Employment Protection Act (LAS 1981:80) employees are implicitly protected in situations involving serious illness, caregiving and bereavement.

3.2.2.1.5 Cross-country summary

In all countries employers are assigned a responsibility for ensuring health and safety, including elements of health-promoting work. However, differences emerge in how this responsibility is regulated and put into practice. For example, while Austria relies on a system where workplace health promotion is voluntary, supported through national networks and funding, Sweden embeds health-promoting and preventive work in binding legislation through the Work Environment Act and mandatory systematic work environment management (SAM). Belgium takes a more comprehensive regulatory approach by legally obligating employers to prevent risks and safeguard employees' physical, psychological and social well-being, while Greece similarly mandates employer responsibility through laws requiring violence- and harassment-prevention policies, along with systematic assessments of psychosocial, organisational and ergonomic risks.

3.2.2.2 Social Protection Coverage: Including unemployment benefit schemes and social benefits

Social protection encompasses systems that provide economic and social security during life events such as illness, unemployment and parenthood, and can reduce individual risks, depending on how comprehensive and accessible they are. Social protection related to illness is covered in 3.1.2 *Chronically/seriously illness* while protection systems related to parenthood is excluded here due to the focus on benefit schemes related to work and employment.

3.2.2.2.1 Austria

According to OECD (2025-g) Austria's social protection system offers support for individuals facing unemployment through two schemes; unemployment benefit (*Arbeitslosengeld*), and unemployment assistance (*Notstandshilfe*). Both are contributory schemes, but the second one is needs-based. The benefit is regulated in relation to time/length of employment, unemployment duration and age and requires registration as unemployed and being available, able and willing to work. The basic amount is 55% of the average net reference income (previous year) before any supplements for dependants family allowances are added (OECD, 2025-g).

The in-work benefit (*Kombilohnbeihilfe*) can be claimed by people who, for example, no longer have right to sickness benefit, people over 50 who are unemployed because of certain circumstances, job seekers with lessened work capability for health reasons, disabled persons, as an active labour market policy (OECD, 2025-g). The amount is individually calculated based on earlier benefits and/or income (OECD, 2025-g).

Austria provides social assistance (*Sozialhilfe*), which is administered by the federal provinces, with support levels varying slightly by region (OECD, 2025-g). This is means-tested, needs-based and not taxable and is a non-contributory benefit. Except for economic benefits the social assistance also include help with housing costs, complemented by additional housing support schemes that subsidize rent for low-income households. These benefits are designed to prevent homelessness and mitigate hardship, particularly for vulnerable groups (OECD, 2025-g).

3.2.2.2.2 Belgium

According to OECD (2025-h) Belgium's social protection system provides support for individuals facing unemployment through several schemes where the main insurance-based

support is the unemployment benefit (Assurance chômage), which is contributory, taxable, and not means-tested. Qualification depends on a proven employment history within a defined reference period that varies by age, and the individual must be involuntarily unemployed, able and available for work, and actively seeking employment (OECD, 2025-h). The benefit amount depends on previous earnings, family situation and the length of the unemployment, beginning with a percentage of prior salary and gradually decreasing over time before transitioning into a flat-rate allowance (OECD, 2025-h).

Unemployed persons with insufficient income may qualify for means-tested social assistance (Revenu d'Intégration Sociale) which is granted only after all other social rights are exhausted. It provides guaranteed minimum income levels that differ according to household type (OECD, 2025-h). Belgium offers in-work benefits to support specific groups of jobseekers where one example is the lone parent childcare benefit (Complément de garde d'enfant), paid to long-term unemployed single parents who resume permanent employment of at least half-time (OECD, 2025-h). This supplement is non-taxable, can be combined with unemployment benefits during the transition into work, and is granted for up to 12 months. Housing support in Belgium generally occurs through reduced rents in social housing linked to household income; there is no national cash housing allowance (OECD, 2025-h).

Belgium has a system of automatic indexation of social benefits and wages to prevent purchasing power from being eroded by inflation (OECD, 2025-h). Indexation occurs when the smoothed 'health index' exceeds the 'pivot index'. When this occurs, social benefits are increased by 2% the following month and wages in the public sector are increased by 2% from the 2nd month. Belgium does not currently provide a national/local Unemployment Assistance programme. Nevertheless, Belgium does provide a Social Assistance programme (OECD, 2025-h).

3.2.2.2.3 Greece

According to OECD (2025-i) Greece's social protection system provides several forms of income support for people facing unemployment. The main insurance-based benefit is the unemployment insurance benefit, which is contributory, not means-tested, and taxable under certain conditions. Access requires a minimum number of insured workdays within a reference period, being involuntarily unemployed, registered with the public employment service, and available for work. The basic amount equals 55% of the minimum daily wage of an unskilled worker, with supplements for dependants (OECD, 2025-i).

For those who have exhausted their unemployment insurance entitlement, Greece offers a long-term unemployment assistance benefit (OECD, 2025-i). It is contributory, means-tested, and provides EUR 200 per month for up to 12 months, with income thresholds that vary by household size. Greece also provides a special lump-sum allowance for vulnerable groups, such as former detainees, victims of violence, former addicts, and single parents. This one-off payment is set at 37.5 daily unemployment benefits and increases with the number of dependants (OECD, 2025-i).

Greece offers a means-tested Guaranteed Minimum Income scheme designed to top up very low household incomes. The basic amount is EUR 216 for a single person, with additional increments for adults and children up to a maximum of EUR 972 per month per household. A separate Housing Benefit supports low-income tenants and starts at EUR 70 per month for a single person, increasing with household size (OECD, 2025-i).

3.2.2.2.4 Sweden

According to OECD (2025-j) the unemployment insurance in Sweden consists of two parts: an income-related benefit (based on previous earnings or a flat rate) for those who are

members of an unemployment insurance fund, and a basic benefit that is contributory for those who meet the work-history requirements but are not members. Income-related benefits replace 80 percent of prior income for the first 200 days and 70 percent thereafter, up to a capped daily amount. Basic insurance provides a flat-rate benefit of SEK 510 per day for full-time workers. The maximum duration is 300 days, extended to 450 days for parents of children under 18 (OECD, 2025-j).

The unemployment insurance in Sweden consists of two parts: an income-related benefit (based on previous earnings or a flat rate) for those who are members of an unemployment insurance fund, and a basic benefit that is contributory for those who meet the work-history requirements but are not members. Income-related benefits replace 80 percent of prior income for the first 200 days and 70 percent thereafter, up to a capped daily amount. Basic insurance provides a flat-rate benefit of SEK 510 per day for full-time workers. The maximum duration is 300 days, extended to 450 days for parents of children under 18 (OECD, 2025-j).

For those without sufficient income or assets, Sweden provides a means-tested system of social assistance (OECD, 2025-j). It is administered by municipalities and intended as temporary support when no other means are available. Social assistance consists of a national norm, varying by household composition, and coverage of certain housing costs, minus any support already received from other programs. Both income and assets are taken into account, and individuals receiving support must seek work actively (OECD, 2025-j).

A separate housing benefit provides income-tested support to low-income households, especially families with children and for young adults aged 18–28 (OECD, 2025-j). Benefit levels depend on income, rent levels and family composition, and are calculated by applying percentage rates to different housing-cost brackets. Benefits are reduced gradually as income increases and can be renewed annually without time limits (OECD, 2025-j). Protection as an employee is also covered by the Work Environment Act (1977) and the Employment Protection Act (1982).

3.2.2.2.5 Cross-country summary

All systems provide income support during unemployment, means-tested social assistance, work related support, and family and parental benefits, but differ in terms of generosity (benefit levels and duration), accessibility (eligibility conditions such as prior employment, membership requirements, or means testing), and the extent to which benefits are institutionally linked to work and employment. Regarding *unemployment protection*, all countries operate insurance-based schemes, yet their institutional configurations vary. Austria, Belgium, and Greece rely on mandatory, state-administered systems in which benefit levels are tied to previous earnings and may be supplemented by means-tested support once insurance entitlements are exhausted. Sweden, by contrast, employs a partly voluntary unemployment insurance model, combining earnings-related benefits for members of unemployment funds with a basic flat rate benefit for non-members. *Unemployment assistance and social assistance* are present in all four countries but fulfil different roles within the broader welfare architecture. Austria and Greece provide complementary support for individuals who have exhausted their insurance-based entitlements. Belgium grants social assistance only once all other rights have been exhausted, while Sweden operates a municipal, strictly means tested last resort safety net that considers both income and assets. Approaches to *in-work benefits* also diverge. Austria target groups with weaker labour market attachment, Belgium provides supplements such as support for single parents returning to work, whereas Sweden and Greece rely primarily on labour market programmes rather than direct in-work financial incentives. Variation is also evident in *housing support*. Austria, Greece and Sweden provide means tested cash benefits to offset housing costs, while Belgium primarily relies on income linked rents within the social housing sector.

3.2.2.3 Employment rates

As shown above, social protection in many countries is largely employment-based, which means that individuals' access to and level of social protection depend on their attachment to the labour market. This makes employment rates central to how many are actually covered by these systems. Individuals with stable employment generally receive stronger protection, while those who work part-time, have insecure employment, or are outside the labour market risk weaker or more limited coverage. Since employment patterns often vary between different groups – for example between women and men, younger and older, or native-born and foreign-born individuals – this can entail systematic differences in the scope and level of social insurance. Against this background, employment rates in the respective countries are presented below.

3.2.2.3.1 Country-specific characteristics and overview

Table 16: Comparative data on working life Austria, Belgium, Greece, Sweden and Europe, 2022 (Eurofound, 2024-a-d)

Indicator	Austria	Belgium	Greece	Sweden	Europe
GDP per capita	37,040	37,040	18,710	46,250	28,950
Unemployment rate (total)	4.8%	5,6%	12,5%	7,5%	6,2%
Unemployment rate (women)	4.5%	5,3%	16,4%	8,0%	6,5%
Unemployment rate (men)	4.9%	5,8%	9,3%	7,0%	5,9%
Unemployment rate (youth)	9.5%	16,4%	31,4%	21,7%	14,5%
Employment rate (total)	77.8%	70,5%	69,4%	83,5%	74,5%
Employment rate (women)	73.4%	66,8%	61,4%	81,3%	69,5%
Employment rate (men)	82.1%	74,2%	77,5%	85,5%	79,4%
Employment rate (youth)	57.4%	31,1%	23,4%	56,9%	40,7%
Reference Eurofound (2024a-d)	[a]	[b]	[c]	[d]	[d]

The table compares GDP per capita and labour-market outcomes in 2022. The indicators are based on standard Eurostat definitions. Real GDP per capita is measured in chain-linked volumes using 2010 as the reference year. Unemployment rates for adults refer to the active population aged 15–74, while youth unemployment and youth employment rates apply to those aged 15–24. Employment rates for adults cover ages 15–64. All figures represent annual averages.

Table 17: Long-term unemployment rate, % of active population aged 15-74, Austria, Belgium, Greece, Sweden and EU, 2024 (Eurostat, 2024-a)

Indicator	Austria	Belgium	Greece	Sweden	Europe
Long-term unemployment rate	-0,9	-0,6	-3,8	-0,1	-0,9

The table presents the change in the long-term unemployment rate over a three-year period (2021-2024), defined as the share of persons unemployed for 12 months or longer as a percentage of the labour force (all employed and unemployed aged 15–74). According to the EU Labour Force Survey (EU-LFS), unemployed persons are those not working during the reference week, available to start within two weeks, and who have actively sought work in the previous four weeks or have secured a job starting within three months.

3.2.2.3.2 Cross-country summary

The four countries display different labour market profiles and economic conditions. **Sweden** has the highest GDP per capita and a high employment rate for both women and men, while overall unemployment is slightly above the EU average and youth unemployment remains relatively elevated. **Austria** is characterised by low unemployment and a high employment rate, particularly among men, with GDP per capita somewhat lower than Sweden. **Belgium** shows moderate unemployment levels and an employment rate below that of Sweden and Austria, especially among young people, indicating more limited labour-market integration for this group. **Greece** has lower GDP per capita and higher unemployment rates than the other countries, particularly among women and young people, while men's employment is closer to the EU average and women's and youths' employments rates are lower. Long-term unemployment also varies across countries: Greece has a higher share than the others, while Sweden, Austria, and Belgium are close to or below the EU average. Overall, the comparison illustrates that the countries occupy different labour-market positions, with Sweden and Austria showing higher employment levels, Belgium situated in an intermediate position and Greece experiencing higher unemployment and lower employment rates in several population groups.

3.2.2.4 Precarious or non-standard employment

Precarious or non-standard employment (i.e., employment forms characterized by higher levels of job insecurity and an overall erosion of workers' employment and working conditions) is increasingly recognized as a key social determinant of health and well-being (Benach et al., 2014). Precarious employment has risen since the 1970s, because of the global increase of flexible employment relations and the related trend toward making employment more flexible (Benach et al., 2014). Precarious employment is related to unequal access to and unequal capacity to enforce social rights (including employment-related care, sick, bereavement and hospice leave entitlements) (Bosmans et al., 2022). For instance, sick leave rights are often related to the number of days worked. For precarious workers, periods of continuous employment are more difficult to obtain, leaving them ineligible for, for instance, sick leave. Moreover, even if precarious workers qualify for sick/hospice/bereavement leave, a non-permanent contract or a low wage might be a threshold for taking up leaves, as this might reduce further chances of employment or they simply cannot afford it, respectively. These workers often need to choose between caregiving or an income (Bosmans, 2023).

3.2.2.4.1 Austria

In Austria, non-standard employment represents a substantial share of the labour market. In 2023, between 40% and 50% of workers aged 16–64 was not employed on a standard contract (Zwysen, 2025). Historically, Austria has been characterised by relatively high levels of part-time work and above-average marginal part-time employment (Broughton et al. 2016). Zero-hours contracts were already reported at comparatively high levels (around 5%) in 2010 assessments (Broughton et al. 2016).

3.2.2.4.2 Belgium:

According to Eurostat (2024-c), in 2024, 24.1% of employed persons work part-time. However, 17.7% of part-time workers report being involuntarily part-time. Temporary contracts account for 7.2% of employment. Temporary agency work remains limited (1.7% in 2024).

3.2.2.4.3 Greece

Greece presents the most structurally vulnerable configuration among the four countries. In 2023, between 40% and 50% of workers were not on standard contracts (Zwysen, 2025). Earlier analyses documented involuntary part-time work at twice the EU average, with a

marked increase during the economic crisis (2007–2011) (Broughton et al., 2016). Freelance activity exceeded the EU average, while satisfaction with working conditions and job security among fixed-term workers was below average (Broughton et al., 2016). In-work poverty was estimated at 17%, and transition rates from temporary to permanent contracts were below 20% (Broughton et al., 2016).

3.2.2.4.4 Sweden

Sweden combines a comparatively high share of temporary contracts with moderate involuntary part-time employment (Broughton et al., 2016). In Sweden, open-ended contracts have been the most common form of employment even within the temporary agency sector (Håkansson & Isidorsson, 2015). This differs from many other countries, where short-term or assignment-based contracts tend to dominate.

Table 18: Selection of non-standard forms of employment in Austria, Belgium, Greece and Sweden (Eurostat, 2024-b-e).

Indicator	Austria	Belgium	Greece	Sweden	Ref. Eurostat (2024)
Temporary agency work	1.9	1.7	0.8	1.6	b
Part-time work	30.5	24.1	6.3	19.5	c
Employed persons with temporary contract	5.5	7.2	6.6	9.7	d
Involuntary part-time work (% of part-time employment)	6.7	17.7	40.7	21.8	e

3.2.2.4.5 Cross-country summary

The range of workers aged 16 to 64 who are not on a standard contract (e.g. working part time or being on a temporary contract, being self-employed or having multiple jobs, see Zwysen, 2025, p12) varies strongly between countries. In 2023, this was the case for between 40% and 50% of workers in Belgium, Greece and Austria (Zwysen, 2025, p 12). In Sweden, in 2023, just below 40% of workers are not on a standard contract (Zwysen, 2025, p 12).

While non-standard employment is widespread across Austria, Belgium, Greece, and Sweden, its composition and intensity vary considerably. Greece exhibits the strongest indicators of structural labour market precarity, particularly in terms of temporary employment and in-work poverty. Austria and Belgium show more part-time and marginal employment patterns, whereas Sweden combines a substantial, but lower in numbers, non-standard workforce with relatively limited short-term temporary contracts.

3.2.2.5 Unions representation and influence

Trade union density, collective agreement coverage and employer organisation density together indicate the level of collective participation and influence in the labour market. These measures reflect the capacity of workers/employees and employers to shape working conditions through organised negotiation and institutionalised cooperation. Across Europe, systems of collective bargaining vary widely, shaped both by national regulations and by long-standing institutional practices and traditions. According to the OECD (2025-b), workers and employers in all member countries organize to articulate their interests and negotiate employment conditions. However, the extent and form of this collective organization differ substantially between countries, resulting in diverse models of union density, employer organization density, and bargaining coverage across the region.

3.2.2.5.1 Austria

According to Eurofound (2024-g) Austria's collective agreements are mostly negotiated at multi-employer sectoral level where blue-collar-workers and white-collar workers unions usually, through a bargaining community, agree on any wage increases for both categories. The agreements are legally binding and address wages as well as wider working-life issues such as working time flexibility and aspects of health and well-being and no employee in Austria is currently covered by a national pay agreement (Eurofound, 2024-g). Some collective agreements have had a change in seniority-based wage schemes which makes it easier for the employer to reduce wage gaps between younger and older employees (Eurofound, 2024-g).

In recent years more attention has been paid to work-life balance in relation to Austrian collective agreements (Eurofound, 2024-g). This has been seen in relation to childcare but also in provisions related to leave which can be used in the caregiving of an older relative for 2 months minimum and 12 months maximum, a compensation for the two weeks leave provided by legislation.

According to OECD (2025-c) Austria, in 2024, reported a trade union density of 20.2% among employees. The adjusted bargaining coverage rate was extremely high at 98%, indicating that nearly all employees with bargaining rights were covered by collective agreements. Employer organization density in the same year reached 100%, showing full employer representation in employer organizations (OECD, 2025-c).

3.2.2.5.2 Belgium

According to Eurofound (2024-h) Belgium's collective bargaining system is regulated by the Law of 5 December 1968 on collective bargaining agreements and sectoral joint committees. Wage bargaining is structured through three interlinked levels: centralised cross-sectoral agreements at national level, an intermediate sectoral level, and company-level negotiations (Eurofound, 2024-h). The sectoral joint committees function as the central arena for bargaining and the making of collective agreements which are legally binding.

Other aspects of working life addressed in the collective agreements in Belgium differs between sectors (Eurofound, 2024-h). Recent bargaining agendas have expanded to include new themes such as development of occupational pension schemes, as well as experimentation with innovation agreements and the introduction of funds aimed at promoting sustainable work.

According to OECD (2025-d) Belgium's trade union density stood at 47.5% in 2023, reflecting one of the highest membership rates in Europe. The adjusted bargaining coverage rate reached 100% in 2024, meaning that all employees with bargaining rights were covered by collective agreements. Employer organization density was recorded at 81.5% in 2014, the most recent year available for that indicator (OECD, 2025-d).

3.2.2.5.3 Greece

According to Eurofound (2024-i) Greece's collective bargaining system was traditionally structured across three levels, national, sectoral/occupational and company level where national agreements (National General Collective Labour Agreement, EGSSE) were setting minimum wages and conditions. However, after 2010, this changed due to a series of legislative reforms making collective bargaining more decentralized through shifting much of the negotiation power to the company level (Eurofound, 2024-i). This reduced the role of national and sectoral agreements and today company-based agreements are the most common form of bargaining in Greece, even though they can set less favourable wages than

sectoral or national agreements (although they cannot set lower than national minimum wages).

EGSSE, the national-level collective agreement, have, since they lost the ability to fix minimum salary and wages, focused on broader labour-market issues and social issues through focus on inclusive labour markets (focus on active inclusion, access and reintegration), measures on undeclared work, racism, workplace discrimination, approving of the national strategy on health and safety at work etc. In 2021 they also agreed to adopt European framework agreement around digitalisation at work as well as just transitions of workers to a low-carbon economy (Eurofound, 2024-i).

According to OECD (2025-e) In Greece, trade union density was 13.4% in 2020. The adjusted bargaining coverage rate was 13.1% in 2017, showing a very limited reach of collective agreements. Employer organization density, also measured in 2017, stood at 48.7%, indicating that about half of employees were covered by employers organized in employer associations (OECD, 2025-e).

3.2.2.5.4 Sweden

According to Eurofound (2024-j) Sweden's collective agreements are mostly negotiated at sectoral level, although it becomes more usual with local-level agreements. In Sweden the national legislation functions as a framework for collective agreements but the negotiated terms can depart from the law, often in favour of the employees (Eurofound, 2024-j). The collective agreements are legally binding, once they are signed and bargaining coverage is higher among blue-collar workers than white-collar workers (Eurofound, 2024-j).

Social aspects covered in the Swedish collective agreements are gender equality and training (Eurofound, 2024-j). Training includes so called 'vocational introductory jobs' which aims to include young, unemployed people with little or no work experience to involve in work while training (Eurofound, 2024-j). Introductory jobs especially for people with various disabilities are also included in training.

According to OECD (2025-f) for 2024, Sweden reported a trade union density of 65.9% among employees. The adjusted bargaining coverage rate was 88%, demonstrating strong collective bargaining structures. Employer organization density was similarly high at 89.1% in 2024 (OECD, 2025-f).

3.2.2.5.5 Cross-country summary

The four countries display clear differences in union density, collective bargaining coverage, and employer organisation density. Sweden has the highest level of union membership, followed by Belgium. Austria's union density is considerably lower, and Greece has the lowest level. In terms of collective bargaining coverage, Belgium and Austria report very high levels. Sweden also has a high coverage rate, while Greece stands out with a much lower rate. Employer organisation density also varies across the countries. Austria has the highest level while Sweden and Belgium also show high levels and Greece has the lowest density.

When it comes to the countries bargaining systems the countries have clear differences, but also some similarities. Austria relies on legally binding multi-employer sectoral agreements covering nearly all employees and addresses social issues such as work-life balance. Belgium operates a three-level system with legally binding sectoral joint-committee agreements and addresses social issues including innovation and sustainable work. Greece has shifted towards decentralised, company-level bargaining after 2010 reforms, with national-level agreements (EGSSE now focusing mainly broader labour-market and social issues such as inclusion, anti-discrimination and health and safety at work. Sweden has a predominantly sectoral bargaining model with legally binding agreements that can improve on statutory rules

and cover themes such as training (for young, unemployed people as well as people with handicap) and gender equality.

3.2.2.6 Importance of work

The European Values Study (n.d) highlights that individuals relate to work in different ways: for some, it represents a basic necessity, while for others it embodies a meaningful or morally grounded vocation. Despite these differences, work constitutes a substantial part of most adults' lives, typically occupying around forty hours per week over several decades. This significant time investment helps explain why a large majority of Europeans, describe work as very or quite important (European Values study, n.d.).

3.2.2.6.1 Country-specific characteristics and overview

European Social Survey European Research Infrastructure (ESS ERIC, 2024) showed that the importance of work in people's lives varies somewhat across the selected European countries. On a scale from 1 ("extremely unimportant") to 10 ("extremely important"), respondents in Austria reported the highest mean score at 7.8, indicating that work holds a relatively strong place in their lives. Belgium followed with a mean score of 7.6, also suggesting a high valuation of work. In Sweden, the average importance was slightly lower at 7.0 but still reflects that work is generally regarded as meaningful. For Greece, data were not available in this dataset. Overall, the results show that work remains a significant part of people's lives across these countries, though with some variation in perceived importance.

Table 19: Share of survey respondents indicating how important work is in their lives in Austria, Greece and Sweden, 2022 (EVS, 2022; Our World in Data, 2024)

Answer category	Austria	Belgium	Greece	Sweden
Very important	49.7%	-	67.5%	60.2%
Rather important	37.7%	-	22.0%	33.7%
Not very important	9.5%	-	3.4%	3.5%
Not at all important	2.6%	-	1.6%	2.3%
Don't know	0.2%	-	5.2%	<0.1%
No answer	0.2%	-	0.2%	0.1%

When looking at the distribution of responses in data from 2022, and the question of *How important work is*, on a scale from not at all important to very important, the pattern changes. These answers show that in Greece, 67.5% of respondents stated that work is *very important*, the highest share among the countries included. Sweden also shows a relatively high proportion in this category at 60.2%, which is notably higher than Austria's share of 49.7%. Data for Belgium was not available in this data set. Austria, in turn, has a larger share of respondents selecting *rather important* (37.7%) compared with Greece (22.0%) and Sweden (33.7%). This suggests that although fewer Austrians describe work as *very important*, many still consider it important, but with slightly less intensity. Meanwhile, Greece displays a clear concentration at the top end of the scale, with far fewer respondents selecting lower levels of importance, only 3.4% stating that work is *not very important*. Sweden shows a similar pattern, though with a slightly more balanced distribution across the top two categories (EVS, 2022; Our World in Data, 2024).

3.2.2.6.2 Cross-country summary

As seen in the table above work is widely valued in all four countries. The share saying work is *Very* or *Rather important* in 2022 is 93.9% in Sweden, 89,5% in Greece and 87,4% in Austria. Data for Belgium is not available for 2022. Across the countries, work seems to be

widely valued according to above mentioned mean score in 2017. The intensity although seems to vary where Austria rate importance of work as 7.8, while Belgium rate it as 7.6 and Sweden 7.0. Data for Greece is not available for the mean of importance to work.

When it comes to rating of how important work is on a scale from not at all to very important Greece shows the highest share of respondents rating work as very important, while Sweden shows the highest combined share of responses on very and rather important. Austria also reports strong overall importance but with more respondents selecting rather important than in Greece. Data for Belgium were only available for mean scores, which indicate similarly high valuation of work, but could not be represented in the specific data of importance to work. Overall, all countries view work as significant, but Greece shows the strongest intensity and Sweden the broadest high-level agreement.

3.2.2.7 Work-Care Compatibility

Experiences of difficulties in combining employment (paid work) and care responsibilities among men and women, and the extent to which they provide long-term care or high-intensity long-term care, as well as the degree to which they rely on relatives, friends or other people for long term care for a main care recipient, can be seen as an illustration of whether and how men and women are differently affected by care responsibilities and labour market demands. Such experiences may also offer insights into opportunities for flexible working hours, remote work, and other supportive working arrangements as well as the capacity of the welfare-system to relieve —or fail to relieve—such strain and difficulties.

3.2.2.7.1 Country-specific characteristics and overview

The table below provides an overview of how much difficulties men and women have combining paid work and care across the four countries as well as the EU average.

Table 20: Frequency experiencing difficulties in combining paid work and care responsibilities, 2022 for Women (W) and Men (M) in Austria, Belgium, Greece, Sweden and Europe, presented in percentages (European Institute for Gender Equality, 2022-a)

Frequency	Austria (W/M) %	Belgium (W/M) %	Greece (W/M) %	Sweden (W/M) %	EU (W/M) %
Every day	8.1 / 6.0	14.8 / 12.8	28.9 / 16.3	13.0 / 15.3	17.4 / 13.8
4–6 days/week	11.5 / 11.4	10.4 / 17.8	12.8 / 13.0	11.1 / 16.7	12.2 / 14.4
1–3 days/week	18.2 / 18.1	23.5 / 22.2	20.4 / 20.8	17.9 / 20.3	28.5 / 27.2
Less often	35.4 / 34.3	30.1 / 24.7	9.9 / 19.5	25.6 / 19.2	25.6 / 19.2
Never	26.7 / 30.2	21.4 / 22.6	9.9 / 19.5	25.6 / 19.2	22.6 / 23.3

The table below provides an overview of how women and men report that they engage in (perform) long-term care as well as how much difficulties they have combining paid work and care across the four countries as well as the EU average.

Table 21: Long-term care for main care recipient and caring responsibilities for Women (W) and Men (M) between 16-74 years in Austria, Belgium, Greece, Sweden and EU in 2022 (European Institute for Gender Equality, 2022-b-e).

Indicator	Austria (W/M)	Belgium (W/M)	Greece (W/M)	Sweden (W/M)	Europe (EU) (W/M)
Involved in long-term care (%)	19 / 17	21 / 25	30 / 30	21 / 21	22 / 21
High-intensity long-term care (≥5 h/day) (%)	15 / 17	10 / 16	16 / 16	23 / 23	19 / 17
Rely on relatives, friends or others for long-term care (> 1 day/week) (%)	35 / 44	39 / 48	36 / 42	35 / 49	36 / 42
Home-based personal care workers (%)	36 / 54	35 / 52	27 / 36	35 / 54	33 / 45
Residential long-term care facilities (%)	34 / 56	30 / 47	15 / 27	29 / 51	28 / 40
Live-in carers (%)	33 / 48	27 / 41	22 / 29	26 / 50	29 / 40
Difficulty combining paid work and care ≥4 days/week (%)	20 / 17	25 / 30	42 / 29	24 / 32	30 / 28
Ref (European Institute for Gender Equality, 2022-b-e)	[b]	[c]	[d]	[e]	[e]

3.2.2.7.2 Cross-country summary

Across the four countries, women and men both engage in long-term care, but with different patterns in intensity, reliance on support networks, and challenges in balancing work and care. According to these statistics men use formal and informal care services more extensively in all countries, while women report more frequent strain in combining work and care, especially in Austria, Belgium, and Greece. Sweden stands out for having smaller gender gaps in caregiving involvement but still shows gender differences in support use and work–care conflict frequency. Greece shows the highest daily difficulties for women, while Belgium and Austria show more moderate differences.

Table 22: Cross country overview (summary of text above)

Country	Long-term care Involvement	High-Intensity long-term care	Support Networks & Formal Services	Work–Care Difficulties	Overall Gender Pattern
Austria	Similar (W 19%, M 17%)	Similar (W 15%, M 17%)	Men rely more on informal and formal care	Women more often daily; men more often never	Small gaps; women higher work–care strain
Belgium	Men higher (M 25%, W 21%)	Men higher (M 16%, W 10%)	Men use more services	Mixed: women more daily; men more frequent overall	Men more care involvement; women higher daily strain
Greece	Same (30% each)	Same (16% each)	Men much higher reliance on support and services	Women far more likely daily	Largest gender disparity in work–care conflict
Sweden	Equal (21% each)	Equal (23% each)	Men rely far more on services	Men more frequent difficulties; women more “never”	Small gaps in care; differences in support use

3.2.2.8 Gender equity aspects

This section compares Austria, Belgium, Greece, and Sweden using key indicators from the Gender Equality Index, focusing on overall equality, equality in the work domain, the gender pay gap, and the gender pension gap. By examining differences in pay and lifetime income, areas where women across the EU continue to earn substantially less than men, this section provides a comparative overview of how gendered economic inequalities can be seen in the four selected countries. Thereafter follows a description of to what extent men and women involves in housework, leisure and childcare for own children in each country, offering a broad picture of gendered patterns in everyday domestic work, leisure and (child) care responsibilities.

3.2.2.8.1 Country-specific characteristics and overview

Table 23: Data based on European Institutes for Gender Equality (2023, 2024, 2025-a, 2025-b). Gender equality index (2025-a), Gender equality Index – Work (2025-b) Gender pay gap (2023) and Gender pension gap (2024) between Austria, Belgium, Greece, Sweden and EU

Indicator	Austria	Belgium	Greece	Sweden	Europe (EU)
Gender Equality Index score (2025-a)	61.2	68.5	57.0	73.7	63.4
Gender Equality Index – Work (2025-b)	67.8	69.1	67.9	80.4	69.3
Gender pay gap (2023 *EU: 2020)	18.3%	0.7%	13.6%	11.2%	12%
Gender pension gap (2024)	35.3%	36.1%	21.4%	22.3%	23.5%

The table below provides an overview of how women and men report that they engage in (perform) housework, leisure activities and childcare of own children across the four countries as well as the EU average.

Table 24: Women and men aged 16-74 years involved in housework, leisure and childcare across Austria, Belgium, Greece, Sweden and Europe, 2022 (European Institute for Gender Equality, 2022-b-e)

Country	Housework (at least 1 day per week) (W/M)	Leisure (at least one day per week) (W/M)	Childcare for own children <12y (W/M)	Ref (European Institute for Gender Equality, 2022-b-e)
Austria	96% / 88%	73% / 85%	21% / 16%	(2022-b)
Belgium	93% / 88%	61% / 66%	13% / 9%	(2022-c)
Greece	95% / 88%	60% / 67%	17% / 20%	(2022-d)
Sweden	97% / 94%	65% / 73%	12% / 12%	(2022-e)
Europe (EU average)	96% / 90%	64% / 72%	16% / 12%	(2022-e)

3.2.2.8.2 Cross-country summary

All countries show gender gaps in both paid and unpaid work, although the extension varies. Sweden has the highest overall and work-related Gender Equality Index scores, while Belgium and Austria lie closer to the EU average and Greece scores somewhat lower. Patterns in the gender pay gap differ, with Belgium showing a very small gap, Sweden and Greece positioned around the EU average, and Austria reporting a larger difference. A similar variation appears

in the gender pension gap, where Austria and Belgium have higher levels, while Greece and Sweden show smaller gaps. In terms of unpaid work, women participate in housework at similarly high levels across all countries, while men's participation varies more, with Sweden showing the smallest gender difference. Leisure activities follow a consistent pattern in which men report higher participation than women in every country, though the size of the gap differs. Childcare involvement also varies: Sweden stands out with equal participation between women and men, while Austria and Belgium show higher involvement among women, and Greece displays a reversed pattern with slightly higher participation among men. Compared with the EU averages, the countries reflect both shared tendencies – such as persistent gender differences in unpaid work – and distinct national profiles shaped by differing levels of gender equality and work-family arrangements.

4 Discussion

An initial and situated mapping of care and labour regimes

This deliverable presents an initial, exploratory mapping of care and labour regime factors shaping how EoL experiences intersect with paid work in Austria, Belgium, Greece, and Sweden. The analysis does not aim to produce a definitive regime classification, but rather to identify configurations of institutions, infrastructures, rules, and norms that condition both employees' possibilities to navigate EoL situations and organisations' capacities to respond compassionately.

While the observed patterns broadly resonate with established welfare, care, and labour regime typologies, the findings also confirm long-standing critiques of ideal-typical approaches (Pfau-Effinger, 2005; Ciccio, 2015). Regime effects are not uniform; they are mediated through regional service provision, sectoral labour-market arrangements, collective agreements, contract forms, and organisational resources. Moreover, national care and labour regimes are themselves shaped by broader, partly converging transformations in care provision and work, including demographic ageing, marketisation and privatisation of care, labour-market flexibilisation, and austerity-oriented retrenchment of public responsibility (Farris & Marchetti, 2017). As a result, similar tensions – such as increased reliance on informal care, uneven access to entitlements, or growing pressure on workplaces to compensate for care gaps – can be observed across countries, albeit with different intensity and institutional expression.

Care and labour regimes are best understood as historically and institutionally embedded orders that shape work–care tensions in concrete and context-specific ways (Pocock, 2005; Anxo et al., 2017). Consequently, this discussion does not foreground fixed national attributions. Rather, while *detailed country-specific characteristics are presented in section 3 in this report*, the purpose here is to illuminate the underlying system logics and recurrent tension fields in a comparative manner.

Legal entitlements, care recognition and employment protection in EoL contexts

The mapping (Circle 1) of legal entitlements and leave and benefit structures shows that, while all four countries provide some form of care, sickness, palliative, and bereavement protection, access and usability often vary depending on welfare-state characteristics, care infrastructures, labour-market conditions and cultural assumptions.

The findings show that legal resources and leave structures are not neutral instruments but key sites where care and labour regimes distribute time, income security, and risk. They reveal how welfare state assumptions about family, work, and dependency intersect with labour market conditions to shape unequal access to support. These tensions help explain why organisational responses to EoL experiences are both necessary and constrained, and why Compassionate Workplace initiatives must be understood not only as cultural or managerial interventions, but as practices operating within – and sometimes compensating for – the limits of existing legal and institutional frameworks.

A key tension concerns the recognition of care relationships. Across countries, leave and benefit entitlements largely privilege legally defined kinship and household relations, while care and bereavement linked to close friendships, extended or chosen families, or other significant relationships remain weakly codified. This tension is particularly evident where parent- and child-related rights are comparatively well developed, while other caring relationships are less explicitly recognised. Such patterns are closely connected to gendered norms of responsibility and unpaid care as a private responsibility (Goossen, 2020) and normalise women's disproportionate involvement in unpaid work. Because many real-life care and bereavement relationships are weakly recognised in law, responsibility for EoL situations

related needs is shifted onto individuals (or workplaces), where support is often provided informally, unevenly, and on ad hoc basis.

Responsibility for EoL-related care is organised across state, market, family, and workplace in ways that differ between national contexts. In Sweden, comparatively strong income protection and employment security at the national level may reduce immediate labour-market risks, yet the specific regulation of leave, flexibility, and bereavement often depends on sectoral and local collective agreements, resulting in variation between workplaces; even between different working groups within the same sector (for example white collar/blue collar workers within the mining industry). Austria and Belgium tend to combine statutory entitlements and well-developed health systems with continued reliance on families for care time and coordination. In Greece, more limited and less EoL-specific leave provisions and weaker care infrastructures are more likely to shift responsibility towards households and organisations, increasing the potential for informal and discretionary solutions.

Another tension concerns how systems respond to serious or chronic illness and the associated risk of exclusion from the labour market. Austria and Sweden tend to prioritise gradual return-to-work arrangements and employment continuity, while Belgium follows more formalised pathways towards disability status after predefined periods, and Greece relies more on employment protection and proportionality than on structured reintegration programmes. These differences are significant because EoL experiences often unfold over extended and uncertain periods. Where support is organised mainly through status-based transitions, this may provide clarity but also increases the risk of earlier detachment from paid work – particularly for workers who rely on flexible and enforceable arrangements to maintain employment continuity.

Care and labour regimes between familialism and defamilialisation

Across the four countries, differences in care and labour regimes can be meaningfully interpreted along a continuum between familialism and defamilialisation, closely linked to breadwinner imaginaries, labour-market structures, and gendered expectations of care. Care-regime research has long shown that the extent to which states relieve families of care responsibilities shapes not only care arrangements but also labour-market participation, employment continuity, and the distribution of social risks (Leitner, 2013; Frericks et al., 2014).

In this mapping, Sweden aligns most closely with a defamilialised, universalist orientation, characterised by high public investment, comparatively strong income protection, and extensive formal provision across health, long-term care, and childcare. High employment rates for both women and men, comparatively favourable work–life compatibility indicators, and strong collective bargaining coverage support a dual-earner model and, to some extent, a dual-carer orientation. At the same time, persistent gender gaps in unpaid care and leisure time, alongside increasing labour-market flexibilisation and regional variation in care provision, point to internal tensions within this model rather than full defamilialisation.

Austria and Belgium occupy more hybrid positions that resonate with conservative-corporatist traditions and supported familialism. While women's labour-market participation is substantial and employment protection relatively strong, long-term and end-of-life care continue to rely heavily on families for care time, coordination, and emotional labour. Labour-market indicators such as high rates of part-time work (particularly in Austria) and sectorally differentiated collective agreements (particularly in Belgium) illustrate how work–care reconciliation is often achieved through working-time adjustments rather than full socialisation of care. These arrangements tend to stabilise employment but also reproduce gendered patterns of labour-market adaptation.

Greece most clearly reflects familialism by default. Limited formal care provision, weaker financial protection, and higher unemployment – especially among women and younger

workers – shift responsibility for care and its associated risks back to households. Labour-market insecurity and lower collective bargaining coverage further constrain the real usability of care-related rights, reinforcing discontinuous employment trajectories and intensifying work–care conflicts. In this context, care responsibilities are less mediated through formal institutions and more directly absorbed within families, often in the absence of supportive labour-market buffers.

These configurations should not be understood as static or internally coherent regimes. Rather, they are tension-laden and shaped by broader transformations, including marketisation, privatisation, and re-familialisation of care, as well as labour-market flexibilisation and austerity pressures (Aulenbacher et al., 2018). As van Damme et al. (2025) argue, universalist principles, supported familialism, and market-based solutions increasingly coexist within the same national contexts, producing uneven degrees of defamilialisation and new forms of inequality across sectors, regions, and employment forms.

Structural vulnerability and unequal access to care–work reconciliation

A central insight of the integrated mapping is that structural vulnerability mediates how care and labour regimes translate formal rights into unequal outcomes. Structural vulnerability arises at the intersection of labour-market insecurity, income position, care intensity, and access to services, shaping not only the availability of support but also its practical usability. Labour-regime research identifies non-standard employment as a key driver of unequal access to and enforcement of social rights (Ciccia, 2015; Ferragina & Filetti, 2022; Bosmans et al., 2022), a dynamic that becomes particularly salient in situations of serious illness, caregiving and bereavement.

While non-standard employment is widespread across Austria, Belgium, Greece and Sweden, its form and intensity vary. Greece shows the strongest labour-market precarity, Austria and Belgium are more characterised by part-time and marginal employment, and Sweden combines a smaller share of non-standard work with more stable contracts (Zwysen, 2025). These differences shape who can effectively use care-related rights when care needs arise.

Across all four countries, formal entitlements to care leave, sickness benefits or bereavement leave coexist with constraints that limit uptake. Eligibility rules linked to employment continuity, partial income replacement and perceived employment risks can make formal rights difficult to use for workers in precarious positions. As a result, care needs are often addressed through unpaid leave, informal arrangements, or private solutions. From a care and labour regime perspective, this illustrates how regimes distribute not only resources, but also exposure to insecurity and cumulative disadvantage.

Care infrastructures and labour conditions interact closely in shaping these vulnerabilities. Where palliative and long-term care services are accessible and well resourced, the intensity of informal caregiving may be moderated, easing work–care conflicts. Where provision is weak or uneven, care demands are more likely to spill over into paid work, increasing the risk of working-time reductions or labour-market detachment. This supports arguments from care-regime scholarship that defamilialisation is not merely a question of service availability, but of how care responsibilities are redistributed across state, market, family and workplace (Kofman & Raghuram, 2009).

Gendered care and labour regimes and their implications

Gender relations emerge as a cross-cutting structural dimension in all care and labour regimes analysed. The mapping confirms that women continue to bear a disproportionate share of unpaid care work across all four countries, including informal caregiving in EoL contexts, with long-term consequences for working time, income, career continuity, and pensions (OECD 2025-k).

While patterns vary across care types, long-term care appears somewhat more gender-balanced than childcare. Men report greater involvement in long-term care but remain less engaged in childcare and are more likely to outsource care responsibilities. In Sweden, men also report greater difficulties in reconciling paid work and care. Across all four countries, men enjoy more leisure time than women, with the widest gaps observed in Sweden and Austria.

Sweden is characterised by comparatively strong overall and work-related gender equality, with relatively small gaps in unpaid work and broadly balanced participation of women and men in childcare. Belgium and Austria are situated closer to the EU average, combining high female employment with persistent gender inequalities in unpaid work and notable gender pension gaps, particularly in Austria. In Greece, gender equality indicators reflect comparatively lower female employment and a stronger reliance on familial forms of care provision. At the same time, across all four countries, women undertake a larger share of housework than men, and leisure time remains unevenly distributed in each context.

Breadwinner assumptions remain embedded in policy mixes and institutional designs, shaping expectations about who should adjust paid work when care needs arise. Even in contexts with high female employment and comparatively strong equality policies, care responsibilities are more likely to be accommodated through women's labour-market adjustments, while men more often maintain continuous full-time employment or outsource care. These patterns are intensified where income replacement is limited, care services are scarce, or employment protection is weak, reinforcing gendered distributions of risk.

For EU CoWork, these findings imply that equity must be treated as a core design principle rather than a secondary consideration. Measures that appear gender-neutral may disproportionately benefit workers with stable contracts and higher incomes, while leaving structurally vulnerable carers - particularly those in insecure employment, with limited income replacement, or restricted access to formal care services - with limited real options. A gender-sensitive approach requires attention to differential take-up, and explicit safeguards against the informal redistribution of care and emotional labour within teams.

Compassionate Workplaces within broader societal transformations

Finally, the mapping situates Compassionate Workplace Programmes within broader societal transformations that increasingly shape care and labour regimes across Europe. Demographic ageing, labour-market flexibilisation, and the gradual retrenchment of public responsibility for care are key factors.

Two interconnected megatrends are particularly salient. The green transition, driven by international climate commitments and policy frameworks such as the EU Green Deal, is restructuring labour markets through sectoral decline and expansion, uneven job quality, and growing demands for retraining (Khalique et al., 2025; UN Committee for Development Policies, 2023). While long-term environmental improvements may benefit public health, short-term disruptions linked to industrial restructuring can intensify economic stress and mental health pressures, and create new tensions between environmental investment and the funding of care infrastructures (Turner et al., 2025). Gendered effects are evident, as women remain overrepresented in care sectors and underrepresented in emerging green industries, risking widened inequalities in the absence of targeted interventions (Santero-Sánchez, 2025).

Digitalisation constitutes a second major transformation affecting both labour and care regimes. Automation, platform technologies, and data-driven systems contribute simultaneously to job displacement, new forms of work, and labour-market polarisation (Acemoglu & Restrepo, 2019). Platform-mediated work challenges traditional employment relations and weakens social protection (Johnston et al., 2024), while digital tools blur boundaries between work and private life (Marsh et al., 2022). In care and health systems, digital technologies promise efficiency gains but raise short-term challenges related to

workload, access, data governance, and inequality, particularly for older adults and disadvantaged groups. Gendered risks persist, as women remain underrepresented in digital occupations and concentrated in sectors more exposed to disruptive technological change (European Commission, Women in Digital Scoreboard, 2024).

Beyond these trends, labour and care migration, together with broader processes of societal precarisation, further reshape how care and labour are organised. Reliance on migrant labour in care sectors – often under insecure conditions – raises questions of sustainability, equity, and responsibility that directly affect work–care regimes and organisational contexts.

Against this backdrop, Compassionate Workplace Programmes are embedded in dynamic and tension-laden care and labour regimes rather than stable institutional settings. Throughout the project, EU-CoWork will therefore monitor how these societal megatrends interact with national work–care arrangements and how they shape, facilitate, or constrain the development of tailored Compassionate Workplace initiatives.

Democratisation and participation add an important normative layer to these transformations. The extent to which workers can exercise voice, co-create supportive arrangements, and have care and grief recognised as legitimate aspects of working life is closely tied to the democratic organisation of care in society (Tronto, 2013). This concerns both the social and political space accorded to care and the organisational practices through which attentiveness, responsibility, competence, and responsiveness are enacted in everyday work. From a care-ethical perspective, Compassionate Workplaces therefore point towards recognising care as a public value rather than a private burden, and towards shared responsibility and participation in shaping how EoL experiences are addressed at work.

Limitations

This report is subject to several limitations, largely inherited from the original data sources. Cross-country comparability is constrained, some indicators rely on self-assessments or estimates (for example in international mappings), and many health statistics prioritise medical metrics over broader social and cultural dimensions. As a result, cultural factors and socio-political developments are only partially captured, and the evidence base remains heterogeneous in both format and timeliness.

The analysis does not address the implications of labour and care migration – despite their significance in certain sectors, particularly home-based and live-in care – nor does it examine wider societal conditions surrounding dying, death, and grief, such as legal frameworks for euthanasia, assisted suicide, or advance directives.

Finally, the exploratory and iterative nature of this work – while enabling responsiveness and triangulation – may result in uneven depth across topics and countries. Taken together, these constraints suggest that the findings should be understood as an initial analytical baseline for further refinement of the care and labour regime framework and for more systematic, in-depth examination of the factors shaping compassionate workplaces.

5 Conclusions and implications for the further project process of EU-CoWork

This deliverable has mapped central care and labour regime characteristics that potentially shape how EoL experiences intersect with paid work in Austria, Belgium, Greece and Sweden. The analysis demonstrates that Compassionate Workplace initiatives are embedded in differentiated configurations of legal entitlements, care infrastructures, labour -market arrangements and cultural norms. These configurations condition both employees' possibilities to navigate EoL situations and organisations' scope to respond to them.

Across the four countries, the mapping confirms that care and labour regime effects are neither uniform nor fully captured by ideal-typical welfare or care regime classifications. Instead, they are mediated through sectoral labour market arrangements, collective agreements, contract forms, regional care infrastructures and organisational resources. As a result, similar formal rights can translate into very different lived realities at the workplace level, depending on how institutional arrangements, labour market conditions and care responsibilities intersect in specific contexts.

In all contexts, structural vulnerability emerges as a particularly powerful mechanism. Non-standard employment, limited income replacement, uneven service provision, regional variation and weak collective protection can make formal rights difficult to access. Gender inequality cuts across these dynamics, shaping both the distribution of care responsibilities and the risks associated with employment interruptions, especially in situations of prolonged illness, caregiving and bereavement.

The analysis also highlights that care and labour regimes are not static backdrops but are shaped by ongoing societal transformations, including labour market flexibilisation and precarisation, marketisation and commodification of care, digitalisation, the green transition and evolving patterns of care and labour migration. These dynamics overlap and interact, producing new tensions and uncertainties that increasingly shape how care, illness, dying, death and grief are experienced in working life. Compassionate Workplaces therefore emerge within shifting and sometimes fragile contexts, underscoring the importance of reflexive, context-sensitive programme development.

Perspectives for the Further Development of EU-CoWork

The findings highlight the importance of systematically considering care- and labour-regime characteristics alongside organisational and societal norms and values related to illness, dying, death, bereavement, and vulnerability in qualitative interview analysis, as well as paying closer attention to extra-organisational support networks and their interactions. Situating EoL experiences within these broader contexts can strengthen interpretation and prevent overly individualised or organisation-centred readings. The mapping also demonstrates that the development of workplace measures is closely connected to care- and gender-related dynamics within organisations, as well as to conditions beyond the organisation itself. Compassionate Workplace initiatives therefore benefit from explicit sensitivity to external factors and from reflexive engagement with how these interact with internal cultures, structures, and resources.

From an evaluative perspective, care and labour regime characteristics are key contextual conditions within a context–mechanism–outcome (CMO) framework (Roodbari et al., 2023). They are relevant for both intervention design and process evaluation, helping to explain how mechanisms of compassion, support, and participation are enabled, reshaped, or constrained across settings. In the T1 post-intervention data collection and analysis, particular attention should be given to the interplay between internal organisational developments and external

institutional and societal conditions, allowing for more targeted analysis of how Compassionate Workplace initiatives unfold in practice.

Building on this initial mapping, the report also opens analytical perspectives for subsequent project phases. A key focus will be on examining which types of Compassionate Workplace initiatives are developed and implemented across workplaces, whether these differ in nature and target level (*Individual, Group, Leader, Organisation, Overarching context* – IGLOO; Nielsen et al., 2018), and which types of initiatives are notably absent in specific care and labour regime constellations. This enables analysis of whether initiatives address the tensions identified in this report – such as structural vulnerability, unequal access to rights, or gendered care expectations – in innovative ways, or whether they risk reproducing or reinforcing these tensions within the workplace. It also allows exploration of how the uptake, visibility, and sustainability of measures are shaped by regime-specific constraints, including labour-market precarity, sectoral agreements, and gaps in care infrastructure.

Finally, the mapping suggests that, depending on workforce composition, organisational culture, and local conditions, additional care- and labour-related issues may become relevant over the course of the project. Alongside digitalisation and the green transition, evolving global economic interdependencies, dynamics such as market volatility, transnational care relations, labour and care migration, and the precarisation of working lives may require increased attention in analysis, programme development, and dissemination.

6 Literature

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