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Original research article

Gendered impact of caregiving on older nonmedical healthcare workers

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Abstract

Background: The paper deals with older workers and the issue of combining informal care for family members with paid employment, which is increasingly important in the light of socio-demographic changes in society – namely demographic ageing and the lengthening of working life. The topic is highly relevant to the group of non-medical healthcare professions studied, as they combine care in the professional and domestic spheres.

Purpose of the research: The aim of the research is to point to gender inequalities in how the combination of formal and informal care impacts the work and personal spheres of (pre-) retirement-age nonmedical healthcare workers.

Methods: The article is based on the analysis of 36 qualitative interviews with nonmedical healthcare workers in Czechia. We used thematic analysis and approached the issue of (un)doing gender from a social constructivist perspective.

Results: The results suggest that women and men in nonmedical healthcare professions face differences in relation to the double care burden in older age. Women are more likely to be affected by a combination of dual care, which has implications for their workload, financial remuneration, *etc.*, whereas men are under greater pressure to perform at work, which becomes increasingly difficult at older ages.

Conclusion: Gendered character of double care has implications for gender inequalities in mental and physical health and for the gender pension gap.

Keywords: Ageing; Gender; Nonmedical healthcare workers; Nursing

Introduction

Sociodemographic changes in society, namely demographic ageing and the extension of working lives, increase the need for older workers to combine informal care for family members with paid employment. Informal care responsibilities lead to decisions to reduce working hours, accept lower wages or pensions (Dudová, 2018), limit time for leisure and self-care, and can have negative effects on mental and physical health (Spann et al., 2020) and personal life. While informal caregiving can also be gratifying, even experiencing greater feelings of gratification is often associated with high levels of difficulty and stress (Grünwald et al., 2021). These negative effects of informal care can be reduced through flexible retirement arrangements and organisational health support (Grünwald et al., 2021). The impact of double care is influenced by work flexibility, the workplace situation, and the social skills to negotiate workplace conditions and get support from community care organizations (Detaille et al., 2020). Women are more likely to be informal carers. Our research focuses on Czechia, where the burden of informal care is reinforced by the emphasis on family care and the distrust of institutional care (Dudová, 2018), which stems from the criticism of the quality of institutional care during state socialism. As a result, families provide 52–72% of informal care (Malý, 2018). Given the strong gender inequality in the division of domestic work and the symbolic association of care with women, the provision of informal care for the elderly remains a burden for women (80% of care for the elderly is provided by women (Dudová, 2018)).

There is likely to be an increasing number of situations where direct care workers provide informal care for their family members in their pre-retirement period, in addition to their formal care work (Cottingham, 2020). The impact of this double care is reflected in career choices, work opportunities, financial situations, and personal and health decisions (Spann et al., 2020).

The interplay between formal and informal care has received little scholarly attention (Grünwald et al., 2021). They have largely been studied separately, and the gendered aspects of the combination of formal and informal care have tended to be overlooked (Ward-Griffin et al., 2015). This study focuses on nonmedical healthcare professions (such as nurses, midwives, and paramedics) with specific features of direct care and

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work organisation (shift work, specific career and pay arrangements, *etc.*) and clearly separate from the medical profession. Our focus is on the experiences of people of pre-retirement age who are still in paid work and are thus involved in formal care, which they combine with informal care – mostly for their parents.

Background

The focus of our study is the unequal impact of double care (formal and informal) on gender equality between female and male nonmedical healthcare workers of pre-retirement age in the professional and personal spheres. The practice of combining formal and informal care, and the narratives that justify it, are influenced by gender schemas that are used and, in some cases, redefined. The process of using and redefining gender schemas is a process of "doing" (West and Zimmerman, 1987) and "undoing" gender (Deutsch, 2007). Gender intersects with aged expectations in a process of doing gendered age (Riach et al., 2015). We interpret the findings within the specific organisational context of healthcare professions, where gender and age are done (and undone).

Gender in direct care professions

The focus of the analysis is on nonmedical healthcare workers involved in formal direct care, where gender aspects are evident in at least three areas:

First, care-based professions contain an often conflicting element of feminine care and masculine professionalism. Care tends to be constructed as women's work, based on the essentialist assumption that women are naturally caring. Men working in feminine professions have to cope with not conforming to heteronormative practices and with their masculinity being "subordinate" (Weller et al., 2021). Men use various strategies to cope with the feminine nature of the profession – emphasising leadership, technical skills, absolute dedication to work, and other masculine characteristics (Smith et al., 2020). Formal care is seen as motivated by altruistic motives, and a proper carer submits to the needs of the patients (McIntosh et al., 2020). Conversely, professionalism is generally associated with masculine characteristics such as "success", "financial gain", full-time employment and flexibility (*i.e.*, willingness to work overtime, *etc.*) (McIntosh et al., 2020). Women have to contend not only with competing ideas of a proper "professional" and "carer" but also of a proper woman, mother or daughter who prioritises informal care for her family, children and home over work and self-care. For people working in direct care, professionalism is specific. Relatives of healthcare professionals expect them to take care of sick relatives due to expectations around greater knowledge and social capital in this area (Jones et al., 2021). However, health care workers cannot be treated as uniform professionals (van der Cingel and Brouwer, 2021), although they are often treated as such. Individuals vary in their motivation, approach to the profession, *etc.*

Second, nonmedical healthcare professions can be gendered in various ways. Examples include the nursing profession, which is associated with attributes such as female, nurturing, helpful, kind, cheerful and caring, or the profession of a first responder, which is associated with being male, considerate, fast/attentive, and young. Occupations with masculine characteristics are associated with greater prestige (Pelley and Carnes, 2020).

Third, ageing is also gendered. The loss of youth and beauty signifies a move away from the dominant standard of femininity, and the loss of physical strength signifies a move away from the standard of masculinity (Ayalon and Tesch-Romer, 2018; Vaculíková and Vávrová, 2019). In the case of ageing men, there may be an increase in the importance of characteristics understood as feminine – weakness, passivity, dependence (Wehrle, 2020) – which men have to cope with in some way. In old age, masculinity moves away from the framework of the dominant male heterosexual ideal, and this may help men to redefine dominant frameworks.

Therefore, providing formal and informal care involves the constant balancing of feminine and masculine aspects, as well as the need to re/construct one's role for oneself and one's surroundings.

Organisational framework of nonmedical healthcare professions in Czechia

The nonmedical healthcare professions and their gendered nature are influenced by the institutional conditions outlined below. In the text we present the most recent data with respect to the year of data collection (2019).

(a) *Working time and financial conditions*. Remuneration in nonmedical healthcare professions is low compared to other similarly demanding professions. Nurses' salaries are above average (CZSO, 2019c), but only as a result of the high work commitment and long working hours. Overtime and unsocial working hours affect workers' health, their ability to provide informal care at home and, consequently, the quality of care. In the healthcare sector, the gender wage gap for the same work in the same workplace was 9% in 2016 (Křížková et al., 2018), which is almost double the average gap in the public sector as a whole.

(b) Heavy *feminisation of the healthcare sector* in Czechia [women make up 78% of all healthcare workers (CZSO, 2019a)]. The most feminised professions are midwifery, with practically no men, and general nursing (98% women), where the proportion of women is above the EU average – 89% (WHO, 2019). An exception is first responders, of whom 43% were women in 2019 (CZSO, 2019c).

(c) The Czech healthcare system has long suffered from a *shortage of staff*, which for those working in these professions, often means greater pressure to perform and to work overtime as well as less work flexibility. Between 2010 and 2018, the number of nurses and midwives decreased by 2.5% (IHIS, 2018). With 8.1 nurses per 1,000 inhabitants, Czechia is around the EU average of 8.2, with a stagnating trend. Western EU countries have a higher availability of nurses and their numbers are increasing (OECD, 2018).

(d) The *ageing* of the nursing professional workforce is associated with a worsening of the projected shortage in the future. It also means that older staff are being "pushed" into working beyond retirement age. The average age of general nurses and midwives with a specialisation in Czechia increased by 1.5 years between 2012 and 2017 from 44.6 to 46.1 years (CZSO, 2019b). 24% of nurses are now over 55 years of age, which is above the EU average of 20% (WHO, 2019).

There are gender differences in the impact of caring responsibilities. When carers (more often women) reduce their working hours due to informal care, or, as in the case in nonmedical healthcare professions, they do not take better-paid shifts – and this affects their pension level. Czech women's pensions are significantly lower (by 13.5% in 2017) than men's, and women spend more years in retirement (5.2 years longer) (MoLSA, 2019). Older women (65+) are almost three times more likely to face poverty and social exclusion than men (Eurostat, 2022). At the same time, they have fewer opportunities for self-care and a higher burden of informal care.

Materials and methods

The focus of the analysis is on how the social construction of gender and age in the combination of paid and unpaid care work affects older nonmedical healthcare male and female professionals unequally. We also focus on sub-objectives: to capture how the combination of formal and informal care is experienced by older female and male nonmedical healthcare workers, how these gendered experiences are shaped by the organisational context, and what impact gender inequalities in double care can have on workers of pre-retirement age. We used an exploratory research design (Brink and Wood, 1998), which is appropriate for studying phenomena that are currently under-researched. We collected 36 qualitative semi-structured biographical interviews with older people about their experiences in nonmedical healthcare.

We focused on nonmedical healthcare professionals involved in the direct patient care and interviewed both men and women in various professions (first responders, nurses, *etc.*) of pre-retirement and retirement age (47 years and older) working in Czechia. The lower age limit chosen was 50, but this was later expanded to 47 and over to obtain enough participants. The proportion of men is lower due to the feminisation of healthcare. See Table 1 for more detailed characteristics of the research sample. Data collection took place between February and November 2019. Participants were recruited through associations of nonmedical healthcare professionals, and others were recruited through acquaintances of those approached (snowball sampling).

The interviews focused on professional careers, personal biographies, family situations, informal care and household care commitments, the character of the job, health status and opportunity for self-care, and institutional support for care. The interviews lasted between 45 minutes and two hours and were conducted by female researchers. The researcher's gender may have influenced the way respondents understood their role in in/formal care.

Table 1. Sociodemographic characteristics of the sample

	Women	Men
Total number	25	11
Age		
range	50–73 years	47–63 years
average	57 years	54 years
Marital status		
single	1	2
married	14	4
divorced	3	0
living with a partner	1	2
widowed	1	0
remarried	5	3
Profession		
nurse	23	5
midwife	1	0
carer	1	1
first responder	0	4
orderly	0	2
Current working time		
full-time	19	11
more than half-time, but less than full-time	5	0
less than half-time	1	0

The interviews were recorded with the consent of the respondents and transcribed verbatim. The recordings were deleted after transcription, and only anonymised transcripts were used for analysis in ATLAS.ti software. We used thematic analysis (Kallio et al., 2022) as a method for identifying, analysing, and reporting the themes – important patterns related to the research objectives in the data. In the first phase of the analysis, we familiarised ourselves with the data by repeatedly reading the transcripts. We then carried out open coding and thus created basic data segments. In the third step, we identified the themes by merging the codes at a higher level of abstraction, creating themes and subthemes. Then we revised the themes and selected those that were relevant to the research objectives. We defined and labelled these themes choosing the most appropriate definitions for the research objectives – *Doing gender and age in nonmedical healthcare professions* (example of codes: *Social construction of professionalism and expertise*) and *Organisational framework of work* with subthemes *Work schedule*, *Remuneration*, and *Job position*. The results are structured according to the listed themes. Based on the literature, we then interpreted the data.

Given the need to ensure validity and reliability, we took the following steps (Long and Johnson, 2000). Concerning reliability, the decision making was subject to an audit – a description of the individual steps in which the analysis took place, including data collection, data reduction, and the achievement of results. To increase the validity, we wrote notes reflecting on the interviews, which were then discussed within the research team.

Results

Doing gender and age in nonmedical healthcare professions and its impact on informal care

Analysis of the interviews revealed how concepts of feminine care and masculine professionalism and expertise are combined, and how nonmedical healthcare professionals navigate conflicting interpretations and demands. The emphasis on the feminine and masculine aspects varied with age. Age was also a significant factor in the unequal impact of double care.

In many cases, being a formal carer also meant a commitment to care for the loved ones within their own family (mainly parents). Many of them felt that this role was expected of them as health professionals. For men and women, different perceptions of themselves as care professionals had different implications for informal care and the understanding of "proper" care. Women were more likely to emphasise the emotional side of care and to see the provision of any kind of activity, including personal hygiene or cleaning, as part of the care profession. Men were more likely to talk about a "professional" approach, emphasising the importance of emotional detachment from problems at work, the masculine aspects of professionalism such as the use of new and digital technologies, the prestige of their job category, and the avoidance of "dirty" activities such as cleaning. Emphasising masculine aspects was one of the strategies men used to justify their place in a feminine profession. Another strategy was to construct themselves as a slightly different kind of man, more feminine in their approach (to both formal and informal care) than other men: *"Maybe it comes from working with women, or it is the way my parents brought me up, but I can do anything. I can cook, I can mend anything"* (Patrik, aged 54, general nurse, long-term care unit).

Women understood caring for their loved ones, as in the professional sphere, in emotional terms; it was often uncondi-

tional and regular, and they also did "dirty" tasks. Men tended to provide more "technical" care, which was irregular and less emotional and time-consuming. Jaroslav's example shows that he sees the use of the human capital gained from his profession in caring for his relatives to be that of technical care provision: *"I drive them* [parents] *to doctors and stuff like that, which I enjoy* [laughs] *because I'm in the ambulance service"* (Jaroslav, aged 58, paramedic).

The distance that men had in the professional sphere from providing intimate and emotional care was also manifested in their informal care, with an emphasis on the incompatibility of these activities with their roles as men and sons: *"We only washed Mommy a couple of times. I don't know about my father – it's a man-to-man thing. […] I'm on my own. The only one I can tell is my wife"* (Mikuláš, aged 49, nurse, neurology).

The impact of this combination of formal and informal care was related to how men and women understood their roles in both spheres and, on the other hand, how they perceived care (in both spheres) as rewarding and fulfilling. With increasing age, both men and women felt themselves to be more tired and needed more time for regeneration. However, women were more likely than men to devote their time to informal care. Women found it more difficult to manage their "competing" roles as professionals and women (daughters, grandmothers, wives, *etc.*) but in some cases felt more fulfilled by managing both roles personally. When they put self-care and work first, they felt they were not fulfilling their "female" role: *"I have elderly parents and I can't cope anymore. […] As their daughter, and a nurse to boot, I am ashamed that I don't have more time for them"* (Monika, aged 55, general nurse, radiology).

It was easier for men to refuse informal care and devote themselves fully to their profession. The reason given was their role as breadwinner or fear of being perceived as underperforming at work.

Most communication partners, especially women, saw the use of institutional care for their family members as their failure. The argument used was that they provided care at work, so, logically, they would not avoid it at home: *"If you take care of other people, you take care of them* [parents]*"* (Dagmar, aged 53, practical nurse). The reasons for choosing home care were also related to the perceived low quality of institutional care. However, some participants used institutional care or outpatient care. Although they worked in the healthcare sector, some expected that this type of care would not meet their ideal of "good care" and were surprised when their standards were met: *"I never expected that there could be such an empathetic attitude and exemplary care in these aftercare facilities – not to mention that I would be a protectionist healthcare worker"* (Zdenka, aged 59, paediatric nurse).

Zdenka saw empathy in institutional care as something that only relatives of those working in the health sector would receive. For men, the dilemma of placing a relative in institutional care was not so great. They argued mainly on the basis of their heavy workload: *"There are plenty of solutions, either a retirement home or moving closer to us, which we have suggested repeatedly. But honestly, we've got enough to worry about. There's not that much room for it* [daily care for a relative]*"* (Prokop, aged 52, paramedic).

Ageing is associated with characteristics such as slowness, inflexibility, forgetfulness, and so on, all of which are not very compatible with professionalism. However, nonmedical healthcare professions were often seen as requiring physical strength. Although physically demanding work was considered suitable for men and young people, it depended very much on individual circumstances. Men perceived "slowing down" and a "loss of strength" as more significant. They were more likely to see it as a failure of masculinity.

The impact of the organisational framework of care on double care

The organisation of work in formal care, which includes work schedules, remuneration and position within organisational structure, influence the experience of older workers with double care.

The *work schedule* determined how much time respondents had for informal care and self-care. Shift work and overtime were experienced as physically and mentally demanding. Older workers experienced an increased need for self-care, either because of significant age-related health problems or because working in a demanding job was more exhausting in later life, or both. However, staff shortages meant that their employer did not adapt working conditions to their older age needs (for example, by reducing their working hours) but, instead, there was a pressure to work overtime a lot. Apart from self-care, they had less time for the informal care of others. Refusal to work overtime was perceived as professional failure. Self-care was often put last in the pre-retirement period.

Respondents worked different types of shifts and attributed different meanings to them depending on their gender, age, and stage of life. Shift work allowed some women flexibility in household care. Housework could be done at a time when no one was at home, making the work "invisible" (which they saw as an advantage). Men, on the contrary, saw shift work and overtime as a reason for not being involved in informal care at home. Igor, for example, had a father who needed care. He found it stressful and bothersome that his father asked him not to work overtime. Igor saw his job as his first priority and did not consider adjusting his working hours to take care of his father: *"My father couldn't understand that you just couldn't put down the pencil in the hospital and go home* [when his father needs him]*"* (Igor, aged 55, paramedic).

From the perspective of older age, single-shift work is considered suitable for older workers, but it often meant lower prestige, lower pay, and less interesting and less specialised work.

Financial remuneration for formal care appeared in the interviews to be linked to the work schedule and therefore had an impact on informal care. Basic wages rates without bonuses were often perceived as low. Men, in particular, considered it insufficient for breadwinners. Some women mentioned that financial rewards were not important to them and mentioned non-financial benefits of care. However, many of them were co/breadwinners and supported their grandchildren financially.

Satisfaction with earnings could be achieved mainly through bonuses for shift work, overtime, unsocial work hours, and working in difficult and risky work environments. However, the financial pressure to perform physically and mentally demanding work was perceived to be at odds with their understanding of an ageing formal carer. Prokop worked as a paramedic and described how he perceived pre-retirees as losing the skills needed for the job: *"What I see about older drivers just before retirement is how different their reactions are. These people tend to be more cautious when driving, they don't drive like fools anymore. However, unfortunately, it's worse for those who are still driving at full speed, because their brains, eyes and reactions don't keep up anymore. It's dangerous"* (Prokop, aged 52, paramedic).

Wages are important at (pre)retirement age, especially with regard to the level of future pensions, which were generally perceived to be low. Some participants considered it

important to "hold on" and work until retirement age. Ivana (aged 62, general nurse, psychiatry) worked beyond the retirement age mainly for financial reasons, partly motivated by the desire to help her grandchildren. She compared her situation with that of her husband, who had a higher pension, although he had a comparable job. Unlike Ivana, he had no reason to continue working and was already fully retired.

Fears of financial uncertainty related to retirement age and the pressure to perform at work are more prevalent among women because they have lower pensions and live to a higher age than men. On the other hand, some felt that the demanding nature of the work and the lack of time for self-care and caring for family members were so fundamental that they planned to retire early and thus receive an even lower pension: *"I'm going to retire three years earlier, and I don't even think about how much money I'm going to get. I don't care"* (Pavla, aged 59, general nurse, long-term care unit).

Thus, some women chose to work beyond retirement age because of lower pensions and the financial aspects of caring for the loved ones. Other women experienced the burden of informal care and the need for self-care so intensely that they accepted the financial loss of early retirement.

Although non-financial benefits of direct care emerged for some, in most cases financial rewards were important to respondents, particularly in terms of their ability to care for themselves and their relatives – men (as well as a few women) emphasise their role as breadwinners, and women are more likely to use their wages to care for others. On the other hand, women were more likely to reduce their working hours or retire early if they were not in the main breadwinner position. In this case, the financial losses were "compensated" by the rewarding feeling of caring for a loved family member.

Discussion

Existing literature describes the gendered nature of formal and informal care (Cottingham, 2020). Our work adds to this by showing how these aspects combine specifically for older nonmedical healthcare professions and how they intersect with age (Riach et al. 2015). Institutional support plays an important role in managing dual caregiving (Detaille et al., 2020), which is not widely available in the Czechia (Dudová, 2018).

Older workers in a double care situation experienced mental and physical exhaustion (Spann et al., 2020) and a lack of time for self-care and rest, although sometimes they didn't find double care so burdensome because they found it fulfilling (Grünwald et al., 2021). The burden of dual care often leads to exhaustion and thoughts of early retirement. The burden of double care can have negative effects on both men and women, and our work shows how these effects can vary. Women are paid less than men in the sector (Křížková et al., 2018), and the burden of care is more likely to lead to them considering early retirement or a reduction in workload, which may deepen current pension inequalities (MoLSA, 2019) as well as staff shortages. Men are more likely to face problems associated with working in a feminised profession (Weller et al., 2021). Some reinforce their masculinity by emphasising a high level of professionalism (Smith et al., 2020). However, this can mean a high workload (overtime), which is problematic at older ages. Those men who have worked in professions with masculine characteristics, are more at risk of being perceived as incapable of performing the job at older age and run the risk of losing their job. This was even more threatening for them than women, as they were more likely to be breadwinners.

The combination of double care in health professionals is specific in that they are expected to have expertise and involvement in home care as well (Jones et al., 2021). However, our work shows that working men and women perceive these expectations differently with respect to what they perceive to be their expertise in their profession – women empathic care, often more time-consuming, and men knowledgeable and technical, often more one-off.

Our research also highlights the under-researched topic of the impact of organizational context on the combination of formal and informal care (Grünwald et al., 2021), particularly for nonmedical healthcare professions. We show the role of remuneration, shift work and structural problems, such as staff shortages (IHIS, 2018). The organisational context of healthcare is very specific with regard to the pre-retirement age. It is seemingly gender-neutral, but the way in which it is organized leads to gender inequalities. It influences the extent to which respondents are able to fulfil their roles at home, but also to perform at work. The strict organization of work shifts in formal care and the low degree of flexibility, as well as high pressure to work overtime, do not meet the needs of informal care arrangement, which is mostly provided by women (Dudová, 2018). As a result, it leads to stress and to conflicts between formal and informal roles, especially for women. Failure to fulfil this double role leads to limited self-care and decisions about early retirement. The different ways of coping with the expectations of professionals are also connected to the fact that workers in a particular profession are often treated as a homogeneous group and uniform expectations are placed on them, regardless of their diversity (van der Cingel and Brouwer, 2021). We have shown that the perception of how challenging a combination of double care is depends very much on the individual's abilities and health status, but also on the individual's interpretation of the challenge. Even situations that appear to be equally challenging can be perceived quite differently by two different people. This may also be due to a varying sense of fulfilment found in providing care (Grünwald et al., 2021). In this case, the benefits of a qualitative methodology are evident. We can also find situations where some people do not complain of heavy workloads. Nevertheless, they may be heavily burdened by double care and the recommendations mentioned below would also make their situation easier. Thus the paper shows that there is a need to look at the situation of workers in context, and to extend research further to include an intersectional perspective – to examine not only the influence of gender and age, but also, for example, ethnicity, socio-economic status, and other aspects of their social location.

The research findings are influenced by the high level of feminisation in the health sector. A limitation of this research may be that the men in the sample tended to come from more masculinised positions, very few were nurses. We took this sample composition as an opportunity to highlight gender inequalities, not only among nurses, but also in the non-medical health profession in general. It would be useful to follow up with further research specifically targeting male nurses or female paramedics.

Recommendations

To reduce the unequal impact of double care on women and men working in nonmedical healthcare professions in the pre-retirement period, the recommendations based on our analysis are as follows:

(1) Reduce stereotypes associated with care. Examples: creating positive male models in care professions; showing exam-

ples of how both women and men successfully combine family and work.

(2) Support institutional care and home care services, focusing not only on accessibility in terms of capacity and availability, but also on improving quality.

(3) Increase remuneration and reduce the gender wage gap. Healthcare should be seen as a key sector of the economy. It is also advisable to introduce transparency in remuneration and to conduct regular gender pay gap audits.

(4) Address the worker shortage by increasing the number of staff in nonmedical healthcare professions, for example through specific recruitment campaigns and by improving working conditions for parents and other informal carers, and by introducing new and digital technologies in care to reduce its physical demands and to allow older workers to stay in the profession longer.

(5) Introduce flexible retirement schemes in accordance with the demanding nature of the profession and its impact on physical and mental health. Use good practices from abroad in designing flexible schemes.

(6) Improve access to flexible arrangements in nonmedical healthcare professions. Carers should be entitled to flexible working arrangements.

Conclusion

The conceptualisation of care as a feminine profession affects both women and men. It influences their work burden, their career choices in pre/retirement age and, finally, their quality of life in retirement (health impacts and pension levels). Our research shows how gendered perceptions of the nursing profession influence these impacts and the respondents' own understanding of their role. We show how the combination of formal and informal care is influenced by the specificities of the Czech context, in particular mistrust of institutional care and its low availability, low financial remuneration and staff shortages. The organisational context of non-medical health professions, in particular shift work, strict working conditions and physically demanding work plays a decisive role here, especially in the case of older workers. The workload and physical demands of the profession are high, while the introduction of new technologies has been very slow. However, technologies that make physically demanding care work easier could prevent health problems and help nurses stay in the profession longer, as well as to better combine formal and informal care.

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Ethical aspects and conflict of interest

The authors have no conflict of interest to declare.

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