Chapter 9

Care as a social construct: the case of home care workers in contemporary Belgium

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Introduction

Francophone researchers in the social sciences have been focusing attention on the dynamics of proximity services.[1] The trend is towards the development of complex, interrelated principles of reciprocity, household administration, marketing and redistribution in relation to the way these services are funded, utilise human resources and relate to the institutional environment. These services meet highly varied and often emerging social demands (Laville and Nyssens 2000).

In this chapter we examine the development of home-care services provided to elderly dependants. Our hypothesis is that this is incomplete in a number of ways.

[1] The French expression '*services de proximité*' approximately equates to 'household and community services' in English. However we are using the more literal translation 'proximity services' here (see Laville and Nyssens 2000).

Indeed, since this sector is undergoing profound change, it is interesting to analyse the emerging processes that define the way the services are organized. To this end, we have examined one specific service – that provided by 'home care workers'.[2] These workers need to develop a (relatively) long term relationship with the dependant person.[3] These services are intended mainly for elderly people who wish to remain at home despite experiencing difficulties in performing some domestic tasks.

In our view, two aspects of these services stand out. The first is that they have been set up recently and are meeting emerging needs. The second is that they bring together several professional and non-professional individuals – usually female – to provide services to the care receiver. The service provided by the home care worker thus offers a useful vantage point from which to observe developing socialisation mechanisms.

Firstly, we will establish our analytical framework. The 'home care service' mobilises numerous market, public and voluntary resources and requires analysis based on a broad approach to socioeconomic organization. We have developed a framework inspired in particular by the arguments of Polanyi (1944). Feminist theories on the socialisation of care allow us to rethink the particular social relationships at issue in these services, in which women are the principal actors. Secondly, this will allow us to analyse the home care service as a social construction, at the intersection of different types of socioeconomic rationales revealed by the

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[2] We use the term 'home care workers' for '*garde à domicile'*, the French expression for the profession we are exploring here. These workers offer a wide variety of integrated home services to families.

[3] The role of home care worker is different to that of cleaners and nurses. Their main objective is to spend time with the dependent person. They offer emotional support, make sure the dependent person is in a safe and hygienic environment and that they are taking their medication properly. They can also prepare and serve meals.

financial resources as well as the human resources placed at the disposal of care-receivers. Thirdly, we will see how this new service may be considered a social innovation, lending itself to greater equality between men and women, certain aspects of which nonetheless still need to be perfected. Analysis of the social innovation dynamic reveals additional unresolved tensions that prompt us to question the policies set up by governments. The last section will raise questions about the responsibility for care giving in welfare states.

Proximity services: a social construction at the intersection of several socioeconomic rationales and gender relationships

The contribution of feminist approaches to 'care' in the debate over proximity services

The various debates on care within the social sciences, particularly in women's studies, shed light on different issues. These include emotional associations linked to the term 'care', and the unequal share of domestic care work between men and women.

Many debates in Great Britain over the idea of 'community care' took place during the 1950s and continued through the 1960s. This particular term refers to the policy – introduced to reorganize formal care – of reducing the number of hospital beds and, to offset this reduction, to improve coordination between health services, hospitals and services relying on local authorities, such as institutions for the elderly. At the same time, Titmuss (1963) compares the good intentions of supposedly 'ideal' community care policies with the realities of the care provided to the elderly. He very clearly raises the issue of the fate of individuals placed in institutions. This type of analysis helped to discredit the placing of the elderly in institutions and, as a result, strengthened the concept of care undertaken by the 'community'.

Researchers also endeavoured to demonstrate the importance of 'informal' care undertaken by families. Some highlighted ways in which the care of dependants can place a burden upon families. However, there was a lack of research raising questions about the particular involvement of women, and it was not until work by feminist researchers was published that this issue was dealt with seriously. Land (1978) and more particularly Finch and Groves (1983), demonstrated how the policy of 'community care' ran counter to the liberation of women in fundamental ways. They developed a critique of what they called the 'double equation': 'that in practice community care equals care by the family and in practice care by the family equals care by women' (Finch and Groves, quoted in Ungerson 1987: 10). The early work of these researchers had a major impact on the conceptualization of care, making the informal work performed by women more visible. They also established, and in fact legitimized, the care-giving role performed by women as a focus for study, providing the impetus for numerous studies on the sexual division of care-giving tasks and the way the relationship between dependent individuals and those who provide their care is negotiated. Ungerson (1987) concludes, amongst other things, that the nebulous position of women in the labour market is a significant reason why they take care of dependent individuals. She writes: 'lower wages and lack of protection for periods off work, linked to part-time working, all combine to make women rather than men the likely carers should it become necessary to care for a relative at home' (Ungerson 1987: 84).

Thus material conditions seem to influence the decision to provide assistance and care, but responsibilities, cultural assumptions and indeed the entire ideological structure defining female duties also play a role. Terms such as 'love' and 'responsibility' become embroiled in the complex social context in which care for

dependent individuals is provided. ‘Love’ could be perceived as a form of work – an unpaid and invisible type of work, to be sure – yet an integral part of what is meant by community care.

To clarify, care can be understood as ‘formal’ and ‘informal’. ‘Formal’ care refers to paid work provided by professional services. ‘Informal’ care is performed by family care givers. However, as much feminist writing has shown, this general distinction between ‘formal’ and ‘informal’ obscures fundamental issues within the management of care giving; the distinction between the private and public spheres fails to adequately reflect women’s experience. This distinction could lead to a belief that there is no flow between these two spheres. In terms of home care, we will demonstrate that, on the contrary, the work of professionals is connected to the contribution of care givers within the family. The distinction also implies that different mechanisms are operating in the two spheres. However, the work of numerous researchers demonstrates that there are identical mechanisms operating in both spheres and that some relational aspects (in terms of feelings and a sense of duty) are experienced by both professionals and family referents. Feminist literature sheds light on the social process that results in women taking responsibility for care giving, what we might refer to as ‘the care giving imperative’.

The relational aspect of care also significantly limits the services themselves in terms of the pursuit of greater productivity (Gadrey 2003). That is why it is particularly useful to examine how these services are financed. The diversity of resources mobilised and of care-giving actors also raises questions about the socioeconomic rationales underlying these services.

A Polanyi-oriented framework

Using a historical and anthropological approach, Polanyi (1944) distinguishes the profit motive characterizing the capitalist economy from other economic practices not oriented towards accumulation of profit: redistribution, reciprocity and household administration. His analysis is part of a substantive approach that advances a broad conception of the economy whereby all actions deriving from the interaction of individuals or individuals and nature, qualify as 'economic'. This conception contrasts with formal, more restrictive approaches to the economy limiting economic activity to rational choices of maximization carried out in conditions of scarcity. If we follow this substantive approach, the economy may be treated as 'plural' and characterized by various forms of exchange:

- The market principle facilitates the matching of the supply and demand for goods and services for the purpose of trade through price setting. Feminist research shows how market mechanisms can contribute to inequality between men and women (Dawson et al. 2000).
- Redistribution is the principle whereby production is handed over to a central authority responsible for distributing it. This presupposes the existence of a mechanism defining the rules for raising taxes and allocating them. In this way, a relationship is established, for the duration, between a central authority, imposing an obligation, and the agents subject to it. In modern societies, redistribution falls primarily under the welfare state, combining (i) a modern form of redistribution sustained through compulsory deductions; (ii) the payment of monetary allowances; and (iii) the provision of social services. Feminist theory has discussed at length the role of the welfare state in women's access to paid work and autonomy, as well as its role in reproducing sexual hierarchy (Waylen 1998)
- Reciprocity constitutes an original principle of economic activity based on the gift as a basic social fact; it calls for a counter-gift, which takes the form of a paradoxical obligation whereby the group or individual who receives the gift has an opportunity to exercise their freedom. It only has meaning when there is a manifest desire for a

social bond among stakeholders. The cycle of reciprocity is opposed to market exchange because it is an integral part of human relationships that brings into play the desire for recognition and power. Yet, it is different from redistributive exchange because no central authority is imposing it. Regarding gender, reciprocity can be analysed from the point of view of the rules that lie behind the gift and counter-gift and how they oblige or liberate the one and the other sex.

- A special form of reciprocity is practised within the basic family unit, which Polanyi calls household administration. For Polanyi, it involves the autarchic production of an institutional unit (such as the family). Household administration deserves discussion and clarification based on a feminist analysis of gender relationships in the family. As mentioned above, the family does not constitute a sphere which has no contact with the public sphere, but, rather, is an institution: 'located at the boundary between the public and the private spheres, a boundary whose position and definition are constantly changing' (Pitrou 1995: 194). In this sphere, the roles 'performed' are, to varying degrees, conditioned by public policies, labour market conditions and the gender relationships which intersect these policies and conditions.

A form of socialisation in the making: 'home care service' as a hybrid construction and compromise between the private and public spheres

We will next examine how the linking of different rationales inherent to care giving is carried out, utilising this Polanyian framework. Our examination is based on the empirical observation of organizations providing home care services in Belgium. One survey was carried out from November 2002 to March 2003, at seven institutions, consisting of:

- Five non-profit organisations providing services

- A '*Centre Public d'Aide Sociale'* (CPAS, public welfare centre) providing services
- An official representative of the Walloon region with jurisdiction over family services.

We interviewed seven persons in charge and five employees at the services we visited. The interviews were qualitative in nature.[4] The first part of each interview dealt with the dynamics of implementing these new services within the organisation. The second part dealt with the interaction between the care giver and the dependant's family circle. We sought to understand the role played by these services in the socialisation of care giving tasks performed by families. These interviews were designed to be exploratory. They allowed us to formulate several hypotheses that subsequent research would need to explore more closely. Our research was also shaped by a previous enquiry in 2003 (Oulajh and Nyssens 2004a), based on a questionnaire sent to about a hundred care receivers and their main familial care giver(s). The questionnaire explored the relationship between care givers and care receivers.

Historically, care services for dependent people were provided by the family within the domestic sphere. Associations often have taken a pioneering role in clearing the way for meeting emerging social needs and by developing the first care services for families, most of the time based on voluntary work. With the development of the welfare state after World War Two, social policies have recognized the importance of these services. In corporatist states like Belgium, there is a lasting tradition of partnership between the state and associations for the provision of social services (Laville and Nyssens 2001). Public authorities regulate these activities *inter alia* by providing financial support. But beyond the initial phase of

[4] The citations in this text are based on these interviews (Degavre, Nyssens and Oulhaj, 2004).

social innovation, associations still retain an important role in the provision of social services within the corporatist model; the state has to respect the autonomy and the role of associations and support them in achieving their objectives linked to the provision of public goods. Within home care, 'family workers' (*'aides familiales'*) became key actors in providing non-medical care services. The first 'home care workers' appeared 20 years ago outside any legal framework, to meet needs that family workers could not. Home care workers are focused, as described, on providing relatively long periods of help, whereas the 'family worker' is allowed to provide a maximum of 15 hours per week. The aim of the home care worker is to help dependent people to stay at home despite a loss of personal autonomy. They assist with tasks, but also listen, talk and support (Lhuillier, Nyssens, Oulhaj 2005).

The co-construction of supply and demand

The service provided by home care workers is complex, most aspects of which are not and probably cannot be, standardized. Zarifian (2000) has analysed the service relationship using several examples drawn from the field of personal services. In his view, the service consists of simultaneously providing a solution and effecting real changes among 'client-care-receivers'. He distinguishes between three types of services: those that have been completely routinized and do not involve any interpretation of expectations; services that respond to an expectation requiring interpretation and understanding, but which are still quite standardized; and services for which, in addition to interpretation and understanding, a unique solution is required in relation to a particular client-care-receiver. In the latter situation, the care receivers themselves often help to find the solution; the relational density of the service is of course greater in such a scenario. This is why we can speak of co-construction of supply and demand. For Gardin and Laville (2007), there is co-

construction when there is involvement by both suppliers and demanders in the definition and implementation of the service provided, and when the arrangement thus formulated has a public existence or finds itself written into a contract.

This is precisely what occurs in the case of services provided by home care workers, in which the social worker consults the care receivers and their family circle in the search for how best to take responsibility for a dependant. The social worker decides how many hours the care receiver is entitled to work at the user's house.

Solutions can be extremely diverse; in fact, they are as diverse as care receivers' expectations regarding the care provided. Knowledge of what constitutes the appropriate 'balance' in a particular family is fundamental in meeting needs; this means that the service must be adjusted from case to case. In addition, the interviews revealed that those in charge of the services feel they are dealing with genuine cases, as pointed out by one of the interviewees: 'Assistance plans for individuals, though it is necessary to establish the boundaries of each case.' However, as another pointed out: 'The home care worker is not doing somebody else's work, she is not the nurse. She is the missing link between the professionals and the families.'

Care for dependent individuals is, first of all, the responsibility of the family. In all cases where there is intervention by a home care worker, the service identifies a 'family referent', who takes decisions if the care receivers can no longer take them themselves. One particular individual in charge said: 'Referents are necessary, it's tricky when there is no family; professionals cannot be referents.' In cases of elderly dependants, the referent is generally a daughter or daughter-in-law. At each stage, the involvement of the care receiver's family circle was complementary. For example, one worker said: 'When it comes to home support for individuals, you can not only count on services and the dependent user. The family, the family circle and the

neighbours must get involved.' The organizations conduct a social survey which takes into account the presence (or absence) of close relatives upon whom the dependant can rely. If such relatives are indeed present, the organization then arranges with these individuals how services should be provided. This dynamic of co-construction as well as the multiplicity of actors involved illustrates how care giving is an activity performed on the basis of multiple socioeconomic rationales, in the Polanyian sense of the term.

Care performed by a relative falls under the category of household administration. But household administration should not be portrayed in idyllic terms; it was precisely this critique that formed the basis of feminist suspicions regarding 'community care' in Great Britain. Nonetheless, the redistribution principle can play a role in this family context when social protection mechanisms recognize certain categories of familial care as work. When family care givers leave their job in order to provide care, they may be able to draw on redistribution resources, such as those available within the framework of labour market policies. Belgium's social security system allows people with a very sick relative to take leave of up to one year (*'congé pour maladie grave d'un membre du ménage ou de le famille'*) or leave of one to two months for palliative care ('*conge pour soins palliatifs'*). However, a recent survey reveals that this type of category is under-utilized.[5]

[5] In December 2008, 7,691 women and 1,589 men took (paid) parental leave or leave for taking care of a sick family member in the Walloon region. This amount is considerably less than in the Flemish Region, where 7,726 men and 23,714 women took this kind of leave. This difference can be explained by the fact that the Flemish Region pays a more for leave than Wallonia. However, the percentage of the population that is on specific leave (career interruption, time credit or parental leave or leave for taking care of a sick family member) is growing: it represented 4.4 per cent of the active population in 2004 and 4.9 per cent in 2008. See:

Volunteer work could also provide opportunities for reciprocity. This kind of unpaid work is generally utilised when an individual gets involved as a volunteer through a non-profit organization (such as a service providing transport for dependent persons). In our interviews, most often professionals were suspicious about this type of resource. As a rule, it is not available from organizations providing home care services. One interviewee in charge of a service explained: 'Voluntary work in the field of home care cannot be sustained. We tried but did not really succeed in working with voluntary networks involved in home care. It's impossible.'

Volunteering and domestic work cannot be treated equally. Both are unpaid work but the (gendered) social relations at the heart of this work are not of an identical nature and result in a different quantity (as well as quality?) of work.

Our interviews also revealed that there is a lot of undeclared or clandestine employment in this field.[6] This type of employment straddles the market and reciprocity spheres. Neither the profit motive nor the gift-counter-gift movement completely explains transactions between care receivers and illegally working care givers. While the work performed by clandestine home care workers falls within the sphere of the market rationale, they often have close, long-term relationships with their care receivers, and this important relational aspect of the exchange seems not to be limited strictly to a profit motive.

Professional workers are generally employees of a non-profit organization or a public service organization. In order to function properly, these organizations

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http://www.onem.fgov.be/Frames/frameset.aspx?Path=D_stat/&Items=1&Language=FR (accessed 12th August 2009).

[6] Despite its growing importance, there is no estimation up to now in Belgium of the amount of work performed in the 'black market' for care.

mobilize different socioeconomic rationales which can be analysed through the financial resources they use.

Financing and resources

Care receiver fees (that is, market resources) are established according to the level of the care receiver's income, though in recent years they have been increasing constantly, thereby limiting access to this service for individuals with limited income. However, while the cost remains high, it is generally lower than that of an undeclared or clandestine care giver, who is frequently required at times of the day when professionals are unavailable.[7]

Home care services also rely on redistributive resources which should guarantee equity regarding access to the service. When organizations began implementing these services, most were already active in the area of family services. They began to cobble together solutions in order to develop a new line of service. Since there was no structured public financing for this type of service, they relied on programmes, supported through public financing, designed to combat unemployment. The objective of this kind of measure was to favour the labour market integration of poorly qualified individuals experiencing long term unemployment, while fulfilling unmet social needs. In order to give the maximum number of workers a chance to enter the labour market, some of these programmes require a turnover of individuals. This turnover requirement sharply illuminates the problem of continuity in the delivery of services, both for the home care workers who lost their jobs and for the care receivers. Indeed, care receivers have often established a relationship of trust with their home care workers. When the latter have to leave their job, the trust needs

[7] Because home-care services are subsidised, the amount paid by the care receiver is always lower than the real costs and than that of an undeclared or clandestine employee.

to be built up again with new workers.

This characteristic illustrates a paradox in the history of the home care service. On the one hand, the existence of this type of labour market programme allowed innovative social forces to mobilize public resources. On the other hand, the jobs created were often low skilled. In addition, to avoid missing out on funding for positions for which they were eligible, organizations using these unemployment programmes would occasionally hire individuals without the specific skills required for home care work. One organizer noted: 'I already had the experience of having to hire a person just to safeguard my occupational transition programme positions, for which I had to fight over a period of several years.' Progressively, the service reached a point where adequate financing was needed, as well as a more sustainable status for the home care worker. Lately, there have been some reforms in government programmes – potentially the first attempt at a solution to problems encountered by organizations financing their services through these transitional labour market programmes. Recent reform in the Walloon region attests to the fact that the public authorities are increasingly aware of these problems, with priority given to increasing employment and improving the status of activities of recognized public utilities. The reforms seem to favour, amongst other things, greater direct control over resources, given the organizations delivering the services paid the home care workers themselves (and not via the unemployment benefit services). The organizations also no longer have to deal with the problem of turnover of workers in these positions.

Figure 9.1 illustrates how care is a social construct built on various types of resources and embedded in many socioeconomic rationales: market, redistribution, reciprocity and household administration.

INSERT FIGURE 9.1 ABOUT HERE

Even though home care workers are employed by these organizations – which draw upon market and public resources and rationales – one might ask whether the close relations workers keep with care receivers sometimes also develop a rationale of reciprocity (point 1 in Figure 9.1). Supplementary unpaid hours of work for the care receiver, or even some undeclared paid work, when needed to help out in urgent situations can indeed be underpinned by a reciprocity rationale. The same question can be raised for undeclared irregular home care workers (point 2 in Figure 9.1).

The special links between market, public, voluntary and domestic resources have played a central role in making the service possible through the dynamic of co-construction (point 3 in Figure 9.1). It is the variety of human and financial resources that allows organizations to experiment with practical solutions related to the realities of this sector. This diversity of resources gives them a measure of flexibility in furthering social innovation. All organizations that were interviewed recognized that this process would have been impossible without the involvement of family resources. Salaried work, undeclared paid work, family work, voluntary work appear to be more complementary than in opposition with each other.

Social innovation at the heart of the 'care giving paradox'

The paradox of socialisation

Throughout our survey, we highlighted aspects of care giving which could be regarded as paradoxical. The survey reveals the complementarities of professional care givers and the mobilized family circle. However, from the standpoint of women, this observation raises questions about changes in socialisation. If there is indeed a trend away from 'informal' care toward 'formal' care – the household workload becoming less onerous – we also observed a significant (re)mobilization of the close family circle, in particular of women. The 'care imperative' that women bear is

alleviated by individuals providing personal services; however, this constitutes only a partial alleviation of women's role, since women continue to be either home care workers or family referents. Socialisation is a complex process that can also operate 'the wrong way', that is, by assigning women to care giving via a different route. Another paradox emerged from our observation that women in the family circle usually *want* to help with care giving. This can be explained by considering the remaining emotional and relational aspects of care.

Consequently, one can reasonably ask whether the services in such a paradoxical area of care giving serve as vehicles for the emancipation of women involved in care work. These paradoxes invite us to interrogate the limits of social innovation in home care services, particularly from the point of view of the family circle, and, as we will see, from the point of view of the workers themselves who are considered low status and suffer low levels of remuneration.

Are home care services bringing social innovation?

An innovation is characterized by change that affects several aspects of an organisation: the mode of production of goods and/or services, consumption patterns, financing and regulation (Osborne 1998). The objective of social innovation is (i) to improve social cohesion and (ii) to share the benefits (Nussbaumer and Moulaert 2007). Social cohesion refers to the collective benefits these services generate – beyond the personal benefits obtained by the immediate care receivers – that potentially involve all of a given territory. For example, the impacts of home care include preventing the isolation of the elderly, a more efficient labour market (as a result of the increased availability of the care receiver's family circle and job creation in these services), increasing equality between men and women, and reductions in public health expenditure by offering a less expensive alternative to hospital or

nursing home provision. The vocation of sharing refers to the fact that those who bring about change (which includes both the result of change and the change process) do not do so for the purpose of profit maximisation, but to propagate the change across networks within a territory.

Lastly, for social innovation to succeed, the change must be approved by social actors. In general, it is the market that accepts – or rejects – an innovation. In the case of social innovation, acceptance does not originate with the market alone, but with other affected actors as well. If producers and care receivers are caught up in a market rationale, they do not spontaneously take into account collective benefits in their production and consumption choices. Stated differently, if a service meant as a vehicle for collective benefit is left to the devices of the market, then it is inadequately developed (or not developed at all) since it is only available at a relatively high (and possibly unprofitable) price, and hence is within the reach of only a small proportion of potential care receivers. To 'internalize' these collective benefits, governments can intervene to foster the development of this type of service. Within this context, complete approval for a social innovation involves not only the explicit acknowledgement of care receivers and service providers, but also of governments.

Our enquiry is inconclusive as to the complete success of the innovation. In the following paragraphs, we will examine which points of friction continue to affect the durability of these various changes. For the moment, it only provides an unclear professional identity of the home care worker, financially undervalued professional activity and hardly any recognition at all for the family helper.

The need to recognize and construct the professional identity of the 'home care workers'

All respondents mentioned the need for governments to officially recognize home care workers (backed by regulation). This means giving them a special status; for some, this must also include training. The recent emergence of home care as a service explains why home care workers consider it very important for their activity to be recognized as work, not only by the families, but also by their colleagues and the government. We observed that there was a logic for constructing the professional identity of the home care workers that activated two mechanisms: (i) situating the position of this identity vis-à-vis the profession of 'family worker', an activity already recognized by the government and (ii) identifying its professional content (ethics, professional confidentiality, and so on) and specialized activities.

The evidence gathered leads us to believe that the home care profession continues to seek professional autonomy, within both the organization and vis-à-vis the care receivers and families. The creation of a home care service within already existing family workers' services created a great deal of tension among workers, with family workers fearing that their work would be sidelined (Degavre et al. 2004). The function of the family worker, a regulated profession, is to ensure the greatest welfare of dependent individuals by constantly monitoring their material environment. In contrast, the home care worker must be available for contact with the care receiver. However, conveying the boundary between the two functions has been something of a challenge. The tension has forced those in charge to precisely delineate the functions of home care workers. Consequently, the principal features of this profession have been clearly identified: authorization for night work (which does not apply to family workers), attendance and monitoring. In contrast to the family worker, who may perform household tasks, the purpose of the home care worker is to be present for an allotted time, taking action (as necessary) during it. One manager commented: 'All of

their time is at the disposal of the care receiver'. Another added: 'They are there to make the care receiver comfortable.'

In relation to the family, the challenge faced by the home care worker is in trying to avoid being viewed as the cleaner. One explained: 'Some families say, "You're there to work and you get paid", though they do not always understand the exact function of the home care workers.' These situations require that the family be provided with a clear explanation about the aspects of dependence that justify intervention by a home care worker and the limits beyond which this is no longer their remit. The workers maintain that in this nuanced division of responsibilities, medical scales (such as the Katz scale [Katz and Lyerly 1963]) do not fully comprehend the scope of dependence. Consequently, it is up to the home care worker to stipulate what they intend to take on, or not.

Since our survey, the government of the Walloon region has recognized home care workers in a decree of 29 January 2004. It makes explicit reference to them and to their specific mission, particularly with regard to the tasks they may perform. The decree of 7 December 2007 defines the mission of the home care worker as 'to stay with the beneficiary of the service who needs continuing care and, for reasons of health or disability, cannot leave their home. The mission of home care workers is to aim to ensure, day and night, an active presence in collaboration with the family of the beneficiary and to maximize the mental, physical and social well-being of the beneficiaries through the tasks allowed by the law to the home care worker.' Still unresolved are issues concerning what form training should take, and the level of monitoring.

Economic independence for home care workers is still limited

It is questionable whether the jobs created in the field of home care services provide real economic independence for practitioners of this profession. Work is often part-time, due principally to its difficulty and the flexible working hours. In addition, from the employer's perspective, this type of full-time caring work is difficult to manage. One employer said: '[W]e only hire half-time employees, rather than full-time employees, who are too hard to manage. When a full-time employee falls sick, the situation can be disastrous; but when a half-time employee falls sick, another half-time employee can work full-time to replace her. It's easier to juggle half-time staff than full-time staff'.

A half-time worker earns about 550 euros, aside from a possible unemployment programme supplement. However, one of the main issues surrounding the home care service resides in its ability to create jobs facilitating financial autonomy which are likely to be held by women who are unskilled at the outset. Another issue is in the capacity of the home care service to relieve the burden on women providing assistance and care within the context of unpaid family work.

What kind of recognition for familial care-giving?

As mentioned above, our research pointed out the crucial role played by members of the family in taking responsibility for dependants, mostly women. These family care givers receive little recognition and the work they perform in conjunction with professionals is undervalued. First, when 'aid plans' for dependent individuals have been drawn up, there has, to date, been no explicit recognition of the family care giver role in legal texts regulating home support services. Only in the decree of 7 December 2007 are some quite vague measures suggested in favour of the family care giver. If we wish to promote genuine co-construction of the service, it would seem essential to recognize this work alongside that of the professionals. There is also the issue of

supporting and coaching these ‘informal’ care givers. Lastly, there is urgent need to question their status in relation to social welfare and the labour market. As mentioned previously, a recent survey revealed that very few family care givers benefited from having some status within the social welfare system. Lastly, we need to investigate the valorisation of the experience of care givers, which could improve their qualifications.

Proximity services and the welfare state: rethinking de-familialisation

This situation can function in a way that favours reproducing inequality within families (since women are more easily mobilized) and in society (since the least fortunate cannot always avail themselves of this service). Moreover, the sector of domiciliary care developed in the framework of social policy suffers from a severe shortage of supply facing an increasing demand. This situation forces families to seek out the hire of ‘black market’ care workers, or incites family members – mostly women – to leave, partially or totally, the labour market in order to take care of their relatives.

Understanding the reasons for this incomplete social innovation requires raising awareness of the paradoxical aspects of care, themselves being highlighted by feminist thought. These paradoxes involve several levels of investigation, from the care relation to the design of public policies in the welfare state. Should the state itself deal with the issue of care or leave it to other actors? In the latter case, should it be dealt with through a collective approach or should individual solutions be developed? The paradox of care work as described above underlines the problem of social policies still assuming a clear boundary between the private sphere and the public sphere.

Our study has demonstrated the complex role of women in care work. This was overlooked initially within social policy work. The first studies on the welfare state endeavoured to understand the foundations of public action, its scope and its

impact in improving the welfare of individuals and communities (Esping-Andersen 1990). In so doing, they completely ignored the hidden care work performed by women. From the early 1980s, feminist researchers became interested in welfare states and developed theoretical tools for examining conventional disciplines and introducing the issue of gender relations. First, they raised the question of whether, on the whole, the state was 'good' for women, and what one could expect from it in terms of support for their liberation. Analysis during the 1980s, principally amongst Anglo-Saxon Marxist-feminists, linked (i) the capitalist mode of production (ii) reproduction, within the family, of the labour force and (iii) social relations. It postulated that the state is a manifestation of patriarchy and that it made the system even more oppressive by upholding the responsibility of the family in reproducing the labour force and through inadequate socialisation of household tasks. A critical literature emerged demonstrating that, to the contrary, the actions of certain welfare states were emancipatory (Sainsbury, 1994). This research revealed that the growth of public employment was of benefit primarily to women and that social protection allowed them to acquire a measure of independence, especially in Scandinavian countries. In all cases, household care tasks played a central role in the analysis – a role that was placed on an equal footing with paid work. In addition, financial independence became a recurrent criterion for evaluating whether or not social policies were liberating.

Feminist thinking, though heterogeneous, had two effects on ideas about the welfare state. On the one hand, it recognized gender as an organizing principle in contemporary society, especially in welfare states; on the other hand, it made clear that market, state *and* family were central. In fact, it made household production – generally absent from mainstream analyses – the other pillar of welfare (Lewis 2003).

Feminist researchers then rebuilt welfare state models on the basis of other dimensions, including de-familialisation (Lister 1997: 173), a concept advanced for thinking about women's financial independence towards family within the framework of social policy.

While much of the work of feminist researchers over the past ten years falls within the framework of power relationships within the family, it has also revealed the meaning and importance that women assign to care giving for dependent adults or children (Sevenhuizen 1998, Paperman and Laugier 2005). In addition, there has been a significant increase in the status of 'invisible' work performed by women – a growing recognition of its complexity, the knowledge that it requires and its usefulness in reproducing social cohesion (Cresson 1998).

Giullari and Lewis (2005) use the 'capabilities' approach to produce a reversal in the feminist perspective. Instead of starting with an analysis of the family that ends up advocating the need to share care work, they characterize care as a 'legitimate choice' that makes life in society meaningful. They write: 'From the point of view of human welfare, it is impossible to choose not to care or not to work' (Giullari and Lewis 2005: 21). Consequently, it is justified to want to share responsibility among members of family and society in general: between individuals and communities, men and women. However, in order to give women and men a 'real choice' to participate in activities of care, and an 'equal' one, it is necessary to admit that men's capabilities in relation to care have to be addressed. This requires a shift in public policies where women *and* men are considered as carers. As Giullari and Lewis (2005: 21) state:

> In short, this requires a radical transformation of the male employment model which has continued to inform the shift to the adult worker model. The logical end of the argument presented here is a universal carer/worker–worker/carer model (see also Lister 1997, 2003), which requires a commitment to provide time to care and affordable, accessible,

high-quality services, as well as cash for care.

This perspective might be a helpful basis for interpreting our observation of the complementarity of the home care workers and the family circle: the fact that this relationship might not have the appropriate balance is a consequence of the failure of a carer/worker – worker/carer model. In relation to proximity services, the observed complementarities with the family circle must therefore be examined from the standpoint of the capabilities of the members of the family circle to get involved in care giving, capabilities whose causes and limits must be understood in terms of gender and an unequal access to the labour market.

The collective benefits attached to care work suggest that the government is responsible, at least in part, for the balance between the formal and informal care provided, for it has input via its design of social and employment policies, and thus via the gender contract that sustain them (Gadrey 2003). Formal care is supported through the financing of professional services. Informal care is provided through various channels of support. However not all concepts advanced have the same value. For example, ‘taking time for others’ is an appealing concept; yet vigilance is required here, since it is primarily women who leave work temporarily (or partially) and this has long-term consequences for the financial autonomy of women. Withdrawal from the labour market, even when combined with a social protection plan, still invokes the ‘care imperative’, a social construction designed with women in mind. By engendering policies and using gender sensitive work-life balance policies in organizations and enterprises (focused on men and women), one can influence this ‘care imperative’. These observations reflect a desire to combat the significant imbalance between men and women in terms of the informal time devoted to caring.

The structure of public policies, especially the traditional division between

social policy and employment policy, profoundly affects the field of care giving. The introduction of a vast array of programmes, within the home care sector, to reduce unemployment (public policies that are half social policy, half employment policy) epitomizes the issue. We need to consider these two levers simultaneously. On the one hand, we must assess the role of the state in structuring professional home care services through *social* policy. On the other hand, both the training and status of professionals and family care givers fall within the remit of *employment* policy. Stated plainly, care giving should not be considered only as a way of creating jobs but also as a right to ensure the protection of citizens. There is good reason for supporting, through social protection, a sector that is organized and controlled by social actors who meet a local need, and who circulate within the complex weave of reciprocity, household management, and market and redistribution principles.

Conclusions

The Polanyian and feminist framework we have presented in this chapter seems to be particularly interesting regarding its ability to highlight the different socioeconomic rationales sustaining care work for elderly, dependent people. Many principles are at work in this sector, at the intersection of markets, redistribution, reciprocity and household administration. This perspective, generally left aside in socioeconomic analysis, offers an interesting articulation of feminist thinking. Care, in this perspective, becomes a complex social construct, taking into account the dependent person, the family circle and the professionals, and the ways these interrelate.

This becomes important when discussing issues of well-being as a gendered process. We mentioned the fact that proximity (home care) services could become spaces able to untie some household obligations and to tie them up around another type of compromise that might be more satisfactory, at least for the family circle. We

can add the idea of a proximity space able to reorganize the household sphere to the general idea of proximity spaces as intermediaries between private and public. In order to conduct an emancipatory and egalitarian intervention, proximity services should take into account the particular form of care they are mobilizing among professional care workers and close relatives. Both types of care work should be associated with rights and find their place in public policies that offer a decent wage and status to workers of the care sector.