CARE FOR DEPENDENT ELDERLY AND GENDER EQUALITY IN FRANCE

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Introduction

In France, as in many European countries, the demographic challenge has become a central issue. The proportion of people over 60 has almost doubled over the last century: in 1900, they accounted for about 13% of the population and now for more than 22%. In 2010, 16.6% of the population is over 65 (19% of women and 14.2% of men). If real dependence is defined in terms of the over-75s, the figures drop to 10.8% of women and 6.7% of men. It is estimated that the number of over-80s (3.4% of the population) is due to double over the next 10 years and that this age group accounts for 11.9% of social expenditure.

Table 1: Distribution of the population by gender and age on 1 January 2010 (%)

	Women	Men	Total
Under 15 years	17,5	19,6	18,5
15-24 years	12,0	13,1	12,5
25-34 years	12,1	12,7	12,4
35-44 years	13,6	14,2	13,9
45-54 years	13,4	13,7	13,6
55-64 years	12,4	12,5	12,5
65-74 years	8,2	7,5	7,8
75 years or over	10,8	6,7	8,8
Total	100,0	100,0	100,0

Source: Insee, estimations de population (résultats provisoires arrêtés fin 2009).

The primary factor regarding ageing of the population concerns life expectancy. According to Hervé Lebras (2007), until the Second World, life expectancy at 65 was stable at about 10 years. But afterwards, from the 1950s onwards, it speeded up and increased from 10 to 18 years for men and from 10 to more than 22 years for women.

Now, life expectancy is 27 years for women and 22 years for men over 60. France leads in this area along with Spain (2 years longer life expectancy than the European average). Moreover, the after-effects of the baby-boom are beginning to be felt with the big generations born after the war now reaching retirement, thus accentuating the ageing process of the population. In his New Year greetings to the social partners on 15 January, N. Sarkozy announced that 2010 would be "dependence year": "It represents a colossal medical, organisational, financial and human challenge".

But Hervé Lebras explains that this process is positive as, thanks to progress in the areas of hygiene, medicine and prevention, the proportion of people in poor health has dropped. Thus, ageing in France poses, above all, a problem of funding those who are not working, rather than a problem regarding poor health. Moreover, it should be recalled that the French fertility rate is the highest in Europe (2 children per woman).

Table 2: Life expectancy at various ages and infant mortality

	Men					Women					Infant mortality rate per 1,000 live births
Year	0 years	1 year	20 years	40 years	60 years	0 years	1 year	20 years	40 years	60 years	
1999	74,9	74,3	55,7	37,0	20,2	82,5	81,8	63,1	43,7	25,3	4,4
2006	77,1	76,5	57,8	38,8	21,8	84,2	83,5	64,7	45,1	26,7	3,8
2007 (p)	77,4	76,7	58,0	39,0	21,9	84,4	83,6	64,8	45,3	26,9	3,8
2008 (p)	77,6	76,9	58,2	39,1	22,0	84,3	83,6	64,8	45,3	26,9	3,8
2009 (p)	77,8	77,1	58,4	39,4	22,2	84,5	83,8	65,0	45,4	27,0	3,8

(p) Provisional results at the end of 2009

Interpretation: in 2009, life expectancy of 60 year old men is 22.2 years. This figure represents the average number of years that 60 year old men still have to live with the conditions of mortality at each age observed in 2009.

Source: Insee, estimations de population et statistiques de l'état civil

In France, the elderly mainly live at home or with their family. But the number of people in institutions increases with age: **6% of the over 60s and 25% of the over 90s are in institutions.** This is of course also the case with loss of independence: half of the dependent elderly are in institutions. It is estimated that there are about 650,000 places in institutions (sheltered housing (logements autonomes offrant des services), retirement homes (maisons de retraite) and long term care units in hospitals (unités de soins de longue durée)).

First of all, it is difficult to define dependence, as very diverse situations exist: is it the situation that the person concerned feels or objectification by the institutions? A survey entitled "Handicap, invalidité, dépendence" (called HID), which was carried out in 1999, illustrates this situation.

Table 3: Diverse approaches to disability and dependence in the whole of the population

Percentage of the people stating that they:	Men	Women	Total
Are affected by an infirmity	38.3	42.4	40.4
Have a recognised level of disability	8.3	5.3	6.8
Have a problem regarding employment*	13.6	14.1	13.9
Are in education that is adapted to their situation**	5.7	4.3	5
Resort to technical aids	10.2	13	11.6
Resort to human help	7.7	12.7	10.3
Are helped for going out	3.4	5.5	4.4
Are confined to bed	0.3	0.7	0.5
Receive an allowance	5.9	3.2	4.5

These are people both at home and in institutions

* among those who are 20 years and over: who are unfit for work and have to occupy a job that is adapted for health reasons

** amongst the 6-16 year olds in school

Source: HID 1999

On the basis of this survey, Colin et Kerjosse (2001) calculated that there are **1,5 million dependent elderly in France**. But, as we will see below, if the criteria used is the number of people receiving the Personalised Autonomy Allowance (Allocation personnalisée à l'autonomie[1], APA), the numbers drop to about **1 million** (see part 1), because those with minor disabilities do not receive an allowance. In the following table, it can be seen that dependence increases especially after 85 years and that there are more women in older age.

Table 4. Number of dependent elderly by age and gender

Age	Men	Women
75 years	4,59%	4,13%
80 years	6,34%	7,81%
85 years	11,31%	15,53%
90 years	23,24%	28,03%
94 years and over	33,67%	38,74%

Source: Enquête HID de la DREES

What is in common with the situation throughout Europe, is the share of women amongst the dependent elderly and the fact that a majority of carers are women (both in the family regarding parents and in-laws) and amongst professional carers. Thus about **75% of the dependent elderly are women and about 70% of carers are women (daughters, daughter-in-law and so forth),** whose careers are affected by these needs (about 5.5 hours per day are devoted to these dependent elderly). In addition, the great majority of professional carers are women. The issue of gender regarding dependence is thus a central one from this twofold perspective: who cares for the elderly who are mainly women and how should they be cared for? What kind of career for the professionals in this sector? What are the occupational and personal constraints for women who are responsible for caring for the elderly?

PART 1. PROVISIONS AND PROVIDERS OF ELDERLY CARE IN FRANCE

1.1.Availability and affordability of provisions

A. Time allotted to families

Extra leave and flexible working time in France are essentially reserved for looking after children and not for the dependent elderly. This is revealing about the place given to the elderly regarding reconciling times for families, who have to "manage", whereas arrangements (although definitely insufficient) exist for children. However, since 2009 a new measure has been introduced for a short period, namely for accompanying an elderly person's end of life, although this situation can sometimes go on for years.

Family Solidarity Leave (Congé de solidarité familiale) in the private sector

Beneficiaries

Family Solidarity Leave (ex-End of Life Leave (Congé d'accompagnement de fin de vie) is available for all employees, whose ascendant, descendant or someone sharing their home

[1] Allocation personnalisée à l'autonomie, APA: in our 2008 Report (Rachel Silvera, 2008), we used the following translation: 'Personalised Independence Allowance'

suffers from a life-endangering pathology. The leave can, with one's employer's agreement, be turned into a period of part-time work.

Duration

Family Solidarity Leave lasts for **a maximum of 3 months, which is renewable once.**

Occupational activity

Throughout Family Solidarity Leave or part-time work, the employee cannot do any other kind of occupational activity.

End of the leave

Family Solidarity Leave ends:

- either after 3 months,
- or 3 days after the death of the person who has been cared for, in addition to other leave for personal and family events,
- or at an earlier date.

At the end of this leave (or period of part-time work), the employee returns to their job or a similar one with pay that is at least equivalent to their former pay.

The length of the leave is taken into account for advantages that are related to length of service, **but it is not paid.**

- Since 17 February 2009, **an end of life allowance during 3 weeks** concerns people who stop working in order to accompany a close relative, who is near the end of their life and living at home. It is €47 per day and is only available for the elderly who are at home (not in hospital and thus only concerns 20,000 people).

B. Allowances provided for dependency and associated services.

It is impossible in France to distinguish between allowances and services. Allowances are now given to dependent people, who use them, or not, for outside services. The only distinct allowance is the one mentioned above, namely 15 paid working days for close relatives, who stop working to be carers.

According to Campéon et alii (2008), "In France, the development of policy relating to the frail elderly was a very slow process. It appeared on the political agenda in the mid-1980s, but there was no specific policy for dependency until 1994, only political debate and many expert reports. Until the mid-1990's, the main social care policy towards the frail elderly was the one used for the disabled: the Allocation compensatrice pour tierce personne (ACTP) (Compensatory Third Party Allowance), which was freely used by the elderly without any control. Since 1994, a specific long-term care scheme has been implemented, progressively enlarging the number of recipients: 1994-1995 saw the implementation of an experimental pilot scheme developed by a few local authorities, then in 1997, a temporary national scheme, the "Prestation spécifique dépendance" (PSD) (Specific Dependence Benefit) was created, implemented at the level of the *départements*[2]. The many criticisms of the PSD, particularly the fact that only 15% of the frail elderly received the benefit (150,000 recipients) called for a reform of the system. The aim of the 2002 reform was clear: to move away from the PSD scheme, based on a cost containment objective, and to increase the number of recipients. The Allocation personnalisée à l'autonomie, "Personalised autonomy allowance", was therefore created (APA), based this time on a universal principle, and, unlike the PSD, without any possible recovery from inheritance (Martin, 2003)".

According to Campéon et ali, the long-term care policy is based on a specific scheme – the APA – which is organized around three main elements. Firstly, the APA is a benefit given to

[2] *département*: middle-level (county) local authority

the elderly who live at home and in institutions, according to their level of dependency. The French care system is based on a unique assessment grid, the AGGIR, which distinguishes six levels of dependency (see below); the APA is allocated up to the 4th level. As the French scheme is a national scheme implemented at a local level, and in order to guarantee access to the same services across the country, care packages (Plan d'aide) are defined according to the level of dependency, the GIR level, and gives rights to a certain amount of benefit (see table 4). Secondly, a main characteristic of the French scheme is that the benefit is paid to finance a precise care package, determined by professional teams, according to the needs of the recipient. The use of the benefit is therefore controlled, and can only finance the services identified as necessary by the professionals. Finally, France has adopted a mixed financing system of the care packages. On the one hand, this is based on an 'assistance principle': under a fixed income threshold (€669.89), recipients do not contribute at all to the funding of the care package. On the other hand, above the threshold, a 'user fee' or co-payment system is introduced: the recipient contributes to the payment of the care package, according to their level of income.

According to the Drees (2009), in 2009**, 1,128,000 persons received the APA** among whom women represent a majority (seven out of ten), as shown by the age and gender structure of APA beneficiaries: APA beneficiaries are rather old (85% are at least aged 75 and 45% are at least aged 85) especially when in institutions (55% are aged 85 or over) and feminized (women represent 77% of the APA beneficiaries aged 75 and above, while they represent 64% of the whole population in the same age bracket). APA beneficiaries are in their majority cared for by relatives (mostly the spouse or partner and/or children), family carers being also predominantly women (six out of ten), and by professionals (nurses, auxiliary nurses, personal service workers, etc.), who are also mainly women. Note that sometimes APA beneficiaries (8%) employ their relatives (mostly their daughter or daughter-in-law; 88% are women) to care for them. For the elderly who are not eligible for the APA, because they are considered as sufficiently independent, but who need some help, another provision was created in 2002, namely Cleaning aid. This aid benefited 228,000 people in 2007; however no gendered data exist for this aid. (Based on Anne Eydoux, 2009).

Data in the following table show that those who are most dependent only account for less than 8% of APA beneficiaries. The majority are in an intermediate situation (GIR 4, see below for the definition). The great majority of those who are most dependent (GIR 1) are in institutions (79% of them), but we observe that 18,000 manage to remain at home (21%). This reflects the French desire to keep them at home as long as possible, even if this means that families (and especially women) are called upon more. Although the biggest number of APA beneficiaries in institutions (43%) are GIR 2 (assistance needed for all every day life activities); here again, 126,000 people in this situation are still at home (i.e. 40% of GIR 2).

Table 5. APA beneficiaries, by degree of dependency in 2009 (thousands)

	At home		In an institution		Total	
	Number	%	Number	%	Number	%
GIR 1	18	2,6	69	15,9	87	7,7
GIR 2	126	18,2	190	43,8	316	28
GIR 3	150	21,6	69	15,9	219	19,4
GIR 4	400	57,6	106	24,4	506	44,9
Ensemble	694	100	434	100	1 128	100

Source: Drees 2009

Dependency criteria: "GIR 1 to 6"
GIR 1: (severe level) people confined to bed or armchair, who have lost their mental, bodily, locomotor and social independence, thus requiring indispensable continuous presence of carers. Maximum monthly financial help in 2009 was €1,224.63
GIR 2: people confined to bed or armchair, whose mental functions have not totally changed and who require help for most every day life activities, or whose mental functions have changed, but who have kept their motor abilities: €1,049.68
GIR 3: people who have kept their mental independence and part of their locomotor independence, but who need help with bodily functions several times a day: €787.26
GIR 4: people, who cannot get up but once up can move inside their home. They need to be helped with washing and dressing: €524.84
GIR 5 and 6: people who are mildly dependent, or not at all dependent, are not entitled to the APA.

C. Domiciliary services

According to another less recent source (2000) quoted by the CERC 2008, there are about 700,000 people who are 60 or over and receive help from an *authorised* domiciliary personal service (Bressé, 2004a). They were on average 82 years old and three quarters of them were over 75. Two thirds were not physically dependent, 24% required help to go out, 8% needed help with dressing and washing and 2% were confined to bed or an armchair. According to the same source, **66% of them were only receiving help with housework; help with essential life functions concerned only 15% of them**. These dependent elderly received on average 15.5 hours of help per week (3 hours for those who were most independent). People's original socio-occupational category plays an important role: 6.5 hours for ex-executives; 3.75 hours for ex-workers.

D. Institutions

Box 1: Residential Housing for the Elderly (Etablissements d'hébergement pour personnes âgées, EHPA)
There are several kinds of residential housing for the elderly in France: sheltered housing with collective services (logements autonomes offrant des services collectifs) (restaurant, meeting room, first-aid room, laundry, etc.), retirement homes (maisons de retraite) (which are either medicalised and linked to a hospital or autonomous), temporary residences (for the elderly who need temporary care) and long-term care units (unités de soins de longue durée, USLD) in hospitals. Since 2002, several sheltered housing schemes and retirement homes have signed tripartite agreements with local authorities (*départements*) and the health insurance system (sécurité sociale) to become Residential Housing for Dependant Elderly (Etablissements d'hébergement pour personnes âgées dependants, EHPAD) equipped with medical services for dependant persons.
Based on: Anne Eydoux 2009

On 31 December 2007 (Prévot, 2009), EHPAs offered 684,000 rooms mainly in retirement homes (i.e., 10,300 institutions) for 657,000 people. Since more and more elderly people are dependent, EHPAs tend to offer more and more medicalised places (363,000 in 2003). Three out of four people cared for in EHPAs are women, 84% are aged 75 or over and nearly 50% are aged 85 or over. They are mainly individuals without a spouse or partner. Among people aged 75 or over, about 10% live in EHPAs; this percentage increases to 20% for people aged

85 and above. Women live twice as much in such institutions as men: 14% of women aged 75 or over (7% of men) and 33% of women aged 85 and above (17% of men) live in an EHPA. Since women's life expectancy is longer, they are more liable to be alone in old age and to be cared for in an EHPA: 18% lone persons aged 75 and above live in an EHPA compared with 3% of those in the same age group when in a couple. More than 397, 000 people (i.e., 340,000 full-time equivalents) work in these structures, i.e., 52,000 more than in 2003. This increase primarily concerns nursing auxiliaries and nurses.

Costs that have to be paid by the elderly:

- **In institutions**, residents pay for accommodation and part of the cost of dependency. The daily rate varies depending on the *département*, the type of institution and the standard of living of the elderly person. It varies between €1,050 and €1,400 per month on average (2003).
- **At home,** it is difficult to assess the cost for the elderly as it depends on the kind of help received and the availability of the family. Above a certain threshold, APA beneficiaries must contribute. The extreme case of the cost of total is estimated to be €6,500 per month (2003). However, we have seen that the maximum amount of APA is €1,200. There is a tax reduction for employing help at home, which covers some of the cost for those who are better off (i.e. paying taxes). It can be seen in the following table (simulated data for 2005) that for the most dependent people (GIR1), **costs for families drop from 67% for those on low pay to 23% for those on high pay because of tax reductions.**

Table 6. Assessment of the annual cost remaining for families for the dependent elderly

Annual income	Remaining annual cost for families in Euros and as a percentage of income							
Euros	GIR 1 (105 hours per month)		GIR 2 (88 hours per month)		GIR 3 (69 hours per month)		GIR 4 (44 hours per month)	
7756	5194	67%	4573	59%	3823	49%	2460	32%
14 400	7942	55%	6820	47%	5543	38%	3539	25%
21600	10124	47%	8458	39%	6609	31%	3910	18%
28800	11568	40%	9357	32%	6938	24%	3544	12%
36000	10745	30%	8375	23%	5789	16%	3109	9%
43200	9773	23%	7403	17%	4908	11%	3109	7%

Source: calcul de la Cour des comptes, 2005

1.2. Acceptability and quality of service provisions

It is difficult to assess the quality of services for the elderly.

From the point of view of declared **home care**, these services only cover a small part of real needs:
- 7/10 of dependent people say that they cannot do their shopping on their own, but only a third of them have help.

- a little less than half say they have difficulties with washing, but only 1/5 have help with it.
- 8/10 say they have another kind of help (i.e. informal and undeclared) and half receive help from their family.
This reveals the extent of family help and use of undeclared labour in addition.

From the point of view of **institutions**, a criteria used concerns the staffing rate, namely the number of jobs (carers and administrative staff) in terms of full-time equivalents per hundred places. The rate was on average 50 in 2007, i.e. 6 points more than in 2003. Institutions for those who are most dependent have the highest rate (78 full-time equivalents) compared with 20 in ordinary retirement homes. These calculations take into account all staff concerned. If we look at staff who have direct contact with the residents, the staffing rate is only 39% (72% for les établissements d'hébergements personnes âgées dépendantes (EHPAD).

There are **problems of abuse** that are not referred to much in the sector. An association called "Hello, elderly abuse" (Allo maltraitance personnes âgées, ALMA) was created in 1994. It is difficult to tackle the topic because it concerns dependent people, who have difficulties in speaking and are often isolated. In 2006, ALMA received **11,308 calls** which led to **5,331 cases** of abuse being reported**.** These cases are most frequent in elderly people's **own home** (86% of the cases). In 65% of the cases, family members are involved in abuse (only 3% concern professional carers); the main forms are of a psychological (24% of the cases) and financial (22%) nature. The reasons most often referred to are difficult family relations (33% of the cases); alcohol- and drug-related problems (13%) and lastly financial problems (12%). In **institutions**, nursing staff are the main source of abuse (33% of the cases); followed by non-medical staff (9%) . They are also of a psychological nature (23%), but above all in the form of negligence (31%). Explications given by the victims concern not being listened to (24%) and lack of staff (20%).

1.3. Gender and labour market equity

A. the sharing of elderly care within the family;

According to Petite, Weber, 2006, the majority of dependent elderly (75% of APA beneficiaries) call upon those close to them (partner, daughter and daughter-in-law) for daily help. In the majority of cases – symmetrically with care for children – women in the family are the first to be involved (60% of cases). Involvement in terms of time is on average twice that of professional staff (i.e., personal home help services are far from being sufficient). This help is mainly provided by one carer (it is not a matter of wide-ranging family solidarity), who is more often than not the partner. Family help is of a broader nature than professional help (which is limited to housework, shopping and washing). But we will see that this is related to the work that is laid down for professionals, but does not take into account the real situation (often professionals do in fact do more than this framework: see below).

As is well-known, in France, the majority of couples with children are dual-earning (65%). With a fertility rate of 2 children per woman, the problem of work-life balance is essential for women, given that sharing of domestic chores is inegalitarian (80% done by women). But discussions are centred on childcare and not on care of the dependent elderly. They are clearly not the same generations of women. Here, it is a matter of the "pivotal" or "middle" generation (between 50 and 65 years). "This generation does in fact have to support both children, who have become young adults (…) and also parents and in-laws, who, as they get

older, are (…) dependant on the daily help of others" (Le Bihan, Martin, 2006). These researchers made a survey of women who work and are also carers. According to the HID survey, referred to above, in 1999, 1,521 women carers were identified – half of them were partners, and 600 were daughters and daughter-in-laws (39.3%). 250 of them work (i.e. almost 42%). "Only 38, **i.e. 15%, rearranged their occupational activity because of their caring role** (changes in their work schedules or reduction in working time)".[3] According to the survey, only 15% of these women indicate that the role of carer changed their leisure activities. However, for 53% of them, holidays pose a problem (finding someone to replace them). For the great majority of them (87%), this situation had little impact on their life with their partner.

- **France has 3, 700, 000 informal carers the majority of whom are women**
- The average age of carers is 60
- They are mainly a member of the dependent person's family (89%):
- - 60% are their children
- - 25% are their partners
- - 15% are less direct relatives (niece, etc.)
- **65% of carers are also engaged in a paid activity**
- **In 69% of the cases, the carer is a woman**
- 55% of carers live with the dependent person
- 40% of carers say they no longer go away on holiday and 30% think that this rôle has a negative impact on their health.

Source: Étude IFOP pour la Macif « Connaître les aidants et leurs attentes » - janvier 2008

A qualitative survey of these women made it possible to know more about the impact of care. Even if the pressure is great (depending on the degree of dependence of the elderly person), these informal carers seek to maintain their occupational life: even if when they were looking after their children, they chose to withdraw temporarily from economic activity (part-time, parental leave, career break), this is not the case for their parents and in-laws**. Maintaining their occupational activity is a priority**, which is explained by various factors: maintaining their independence; accessing a strategic point in their career; compensating for sacrifices they made earlier for their children; and finding a place for removing stress related to difficult family situations: "in the most difficult moments experienced as carers, these women got the necessary strength to continue managing the many problems related to their parent's dependency from their life at work environment"[4]. Their social time that serves as a reservoir is in fact their personal time. If that does not suffice, they give up time devoted to other members of the family rather than touch their occupational time. "The fact of taking on board a parent who has become dependent has many consequences: the first is quickly finding a way of dealing with the need for care, presence and solicitude, by squeezing the time they have, even to the extent of exhausting time resources, but at the same time maintaining their occupational activity, which is considered even more crucial than it seems fundamental in order not to become just a carer".[5] In order to carry out this role of carer and keep their work, these women observe that the time devoted to other members of the family, especially children, drops. Although time devoted to their couple suffers, the surveys shows that their partner is more often a support than a victim of caring. It should be recalled that these women carers sometimes look after their parent-in-laws, instead of their partner doing so!

[3] Le Bihan, Martin, 2006
[4] idem
[5] idem

B. Career prospects, pay, turn-over rates or stress for elderly carers[6]

Since the 1990s, France banks on new "deposits" of jobs in the area of home-helps – primarily in order to fight against unemployment, the aim is to create 500,000 such jobs. It is also a matter of meeting huge needs regarding home-help (for older and dependent people, as well as children), given ageing and the increasing number of women who work. Finally, there is also the clear interest regarding taxation, namely limiting the use of undeclared work, by introducing tax and financial help for employers (via service job cheques), in order to facilitate declaring such workers.

But "the highly gendered, insecure, inegalitarian and depreciated nature is what appears at the heart of the issue of services provided in the home" (Angeloff, 2005).

These jobs have a two-fold origin – both domestic and social: cleaners, chambermaids, domestic workers, home-helps... the terms have changed, but social reality has changed very little – 99% of them are women and tend to be middle-aged (over 40) and, although nothing is said about this because French legislation prohibits it, most of them have foreign origins.

Their role involves helping individuals regarding certain essential aspects of daily life (washing, preparing meals, cleaning, shopping, administrative procedures and so forth). This kind of job is most often part-time (the needs and resources of dependent people do not add up to full-time work) and are often at the beginning and end of the day, and even on the weekend.

The great majority of these jobs are filled by women and, until recently, were hardly professionalised. The introduction of the APA, which, as we have seen above, is managed by the *département* councils, imposed skills for looking after dependent people. However, generally, the sector is still marked by poor employment, training and working conditions – atypical hours, fixed-term contracts, low levels of education and vocational training. As the Economic and Social Committee report (2007) indicates: "the whole of the sector should call upon both school leavers and men – of whom there are few or none in occupations that until now have been considered to be essentially women's jobs and very often part-time with limited prospects of mobility and career advancement. But there is very little training available for jobs in the area of personal services to individuals – and it is far from sufficient in view of the needs of the sector. This is the case both of courses within the education system and those in vocational training. There are also very few professionalisation contracts, apprenticeships and work-based courses in general".

Still depreciated working conditions

In spite of various programmes giving priority to these jobs, working time and both financial and symbolic promotion of them is still impossible. On average, these jobs involve 70 hours per month and only 5% of them are full-time (more than 165 hours per month). Home-helps have several "clients", insecure hours and pay, and also daily distances between each person's home. None of these employees have ever protested, as if this situation is internalised and goes without saying – the notion of "total availability" seems obvious and no law guarantees minimum working hours for them.

[6] Here we partly use our report, R. Silvera (2008).

Moreover, their low level of qualifications explains why these jobs are more often than not paid at the minimum level (hourly SMIC) – and not even paid on a monthly basis, as provided for in the legislation. Length of service is only recognised by the same employer. For example, if Ms. X worked for 20 years with Ms. Y, when Ms. Y dies, Ms. X's length of service begins again at 0! "How can jobs that involve sensitive activity related to the intimacy and dignity of individuals be socially valued (...), when pay remains so low?"

Besides pay, required skills pose a problem – is it a matter of simply reproducing tasks that women carry out at home, "without" any particular skills? Or should not other required skills be recognised, such as interpersonal skills concerning the family and the person they are looking after? In spite of the desire to professionalise these workers and develop training, there is a tendency to under-estimate the interpersonal skills required that are sometimes considerable when the person concerned is very ill or psychologically fragile. The technical nature of the work is also sometimes denied – some home-helps give medicine, as well as certain treatment, even though it is not prescribed.

But a search for professionalisation
An association[7] proposed working on skills – identifying all the work carried out by such employees, who think they "do not know how to do anything". The list was long:

Skills acquired on the job:

- Autonomy at work: they often work alone and have to adapt to the needs of each person they work for (foreign, deaf, sick people and so forth).
- Ability to work with a project: it is a matter of adapting to the needs of each person, without replacing them or the people close to them.
- Perseverance: managing crisis situations and finding solutions.
- Ability to adapt to situations: know how to pass from one family and culture to another in the same day.
- Ability to listen and make oneself heard: besides the material tasks, there is much heavy-going work involved in providing moral support and advice, as well as enabling them to confide.
- Ability to physically deal with dependant people: help with washing and moving, as well as stimulating them.
- Ability to work in a team: even if the employee is isolated, s/he must take into account the people close to the person, the person him/herself and also respect family practices.
- Self-confidence: ability to reassure others and make decisions quickly.
- Ability to work under pressure: put up with the complaints and idiosyncrasies of the individuals they work for – and sometimes several different people during the same day.
- activities (reading, walks and so forth)

Overall, this work with home helps has made it possible to give them confidence, formalise "innate" and "invisible" skills and should, in the long-term, make it possible to promote these occupations. **However, what has not changed yet is that few men are attracted to these jobs, in spite of the needs that exist in this sector and men's unemployment.**

[7] Brigitte Croff Conseil

According to Campéon et ali, 2008, "the reform of the care system and creation of the APA has had a real impact on carers (…). Three main elements can be identified: the type of services used, the qualifications of carers, and the number of carers working with the frail elderly. Through the APA scheme, the majority of hours are now paid through the service provider, considered as the most qualified service. This also means that the employer is no longer the care user, but the organisation itself. In other terms, the 'cash-for-care' system in France is modified and becomes specific. This shift corresponds to the policy objective of enhancing the level of quality and professionalisation of care. Secondly, services towards the frail elderly are now covered by a 'quality agreement' and the professionalisation of personal assistants is organised. Until March 2002, the CAFAD (Certificat d'aptitude aux fonctions d'aide à domicile) was the only qualification available to personal assistants and only a few of them had it (only 18% of personal assistants had a qualification in the social and health sector, and 9% the CAFAD). Training has since been improved with the DEAVS (Diplôme d'Etat d'auxiliaire de vie). Therefore, and this is the third consequence of the APA scheme, although working conditions are still precarious because professional carers are paid according to the numbers of hours they have worked, and still do not systematically receive a stable monthly wage, the APA has significantly increased the numbers of qualified workers. The creation of a specific benefit allowance has to some extent helped to free family members".

Although these professional developments are thus globally positive, qualifications can be made: home helps remain in an unenviable occupational situation: mainly women, who are often foreign, with complex relations between the elderly, their families and their carers. Often, the functions expected of these staff go way beyond what is stipulated.

Jobs in institutions

These jobs are different because they are not in the framework of totally individual working relationships (between the family, the elderly person and staff), but in the framework of an institution.

Those working in EHPAs are mainly women (88%). The majority of the staff are composed of nursing, paramedical and service staff (67.6% of total staff). Women constitute 95% of service staff, 84% of management staff, but only 42% of medical staff (see table).

Table 7. Staff working in EHPAs

	EHPAD			Total in EPHAs		
Functions	**Numbers of staff**	**Full-time equivalents**	**% of women**	**Numbers of staff**	**Full-time equivalents**	**% of women**
Management staff	22 444	18 142	83	28 658	22 566	84
General administrative staff	45 944	38 892	60	60 487	50291	63
Supervisors	4 371	3 820	91	5 068	4 355	90
Educational, social and leisure activities staff	22 246	19 687	93	26 287	22 747	93
Medical staff	6 465	2 312	42	7 150	2 561	42
Para-medical and nursing staff	141 493	125 471	92	159 280	140 670	92
Hospital service staff (public) and service staff (private)	97 246	85 726	95	109 304	96 049	95
Undeclared	1 011	694		1 119	730	
TOTAL	**341 220**	**294 744**	**88**	**397 353**	**339 969**	**88**

Source: Drees, 2009

C. **Evidence on attrition between (formal) employment and (informal) care of among women and men**.

While in Europe, commerce is the biggest sector leading to undeclared economic activity, in France, this is the case for personal services, especially for the elderly; and it comes well ahead of the building industry. In 2007, "35% of people who said that they did undeclared work did so in personal services. 25% say they did undeclared work for between 6 and 19 hours per week; 9% for between 11 and 20 hours and 25% for more than 21 hours." (Devetter et ali, 2009).

Various factors explain why people resort to undeclared work:

- In spite of simplifications introduced for managing jobs (Universal Service Employment Voucher (Chèque emploi-service universel, CESU), which simplifies recruitment procedures), it is nevertheless easier simply to give cash.
- A ceiling is applied to the tax reduction for employing home-helps, so the reduction is a financial help to those whose income is below the ceiling; those with income above do not necessarily declare all the hours worked by the person(s) they employ.
- With the development of service jobs, in fact, hours are accumulated: those working in the sector seek additional work as the jobs involve only a few hours. This encourages developing undeclared hours in addition to a declared job.

Thus, paradoxically, the development of declared and increasingly market-based service jobs is accompanied by an increase in undeclared hours, even if some of the jobs have been legalised. Indeed, the forms of service jobs are becoming more complex: direct jobs by mutual agreement between elderly individuals and their carer, or jobs via service providers or an agent (association mandataire). In the last case, an association proposes home help and deals with the administrative side, but the person who is cared for remains the employer (the collective agreement is the same as that for individuals who are employers and mutual agreement arrangements). Finally, in the case of service providers, the structure proposes the

same services, but is the employer of the home help; this structure is increasingly private and profit-making (the collective agreement is the one that covers home helps).

1.4. Labour market sustainability

The development of service jobs is one of the priorities of recent governments and all forecast indicate that they will continue in the future. Several factors that have already been referred to are involved: the elderly's needs because of the ageing process of the population: their health is improving, and all forecasts show that they will live longer, but that they will need to be cared for. However, changes in family structures (end of intergenerational cohabitation) mean that family carers (children) do not live under the same roof. Moreover, the development of women's employment limits their availability for looking after the elderly. All of this will contribute to the development of the sector, with jobs that are more or less declared, with insecure working conditions and the use of foreigners, who are sometimes undocumented workers. This is the case even though government policy is to move towards recognition and professionalisation of these jobs. Thus in 2008, a movement of undocumented women working in the home-help sector was created. These women criticised "their pay and the daily humiliations of modern slavery » (Devetter, 2009). They also denounced an agreement that was made by the Minister of immigration and the Minister of the Economy, which provides for recent immigrants, who arrived via the family entry and settlement system (regroupement familial), to go to the National Personal Services Agency (Agence nationale des services à la personne) for training in personal services jobs.

Although this sector is growing, the type of jobs created should be examined more closely. The number of institutions in the public, voluntary and private sectors has greatly increased over the 15 years, but it is the "fruit of a fairly clear substitution between public and voluntary sector institutions on the one hand, whose growth has stagnated since the beginning of the 2000s, and the very great increase in private commercial companies, especially since 2004-2005." (Devetter et alii, 2009).

According to the CERC (2008), forecasts of job creations show that jobs devoted to caring for the elderly will increase from 643,000 in 2005 to 840,000 in 2015 and that there will be 260, 000 additional jobs between 2015 and 2025, both at home and in institutions. This is a total of almost 500,000 additional jobs – a statistic that is based uniquely on the increase in the number of dependents in France. This situation requires much recruitment and it is well known that tensions on this "market" are likely to appear, given working conditions and proposed pay. The CERC (2008) recognises that the use of immigration would be necessary, but this remains a taboo subject in France, except via the use of undeclared work.

PART 2. POLICIES

2.1. Overview

As we have recalled in the introduction, the government announced that 2010 would be "Dependence Year". This is follow-up to an election campaign promise to introduce a "5th risk". However, this proposal - which came from associations involved with this issue - to create a new section of the social security system (namely a fifth risk[8] has been abandoned: part of the costs involved should come from national solidarity, but other sources are envisaged, such as the participation of elderly people's patrimony (reimbursement after their death for help provided) and the development of an insurance system based on individual

[8] The other 4 risks are: sickness, family, retirement and unemployment.

responsibility. A new draft law regarding paying for dependence may be proposed: the dependence budget is 1% of GDP (€19 billion) and is due to increase 50% by 2015.

Proposals made in this area focus almost exclusively on the funding of dependence, but not on living conditions, distribution of the role of carers within families and the quality of official care and institutions… Certainly, we will come back to an ongoing longer term plan, but it is not highlighted in official comments. **It appears very clearly that in France the issue of reconciling life times is posed above all for parents (in relation to looking after children), but not in relation to dependent elderly**.

Moreover, a priority remains topical, namely enabling as many dependent elderly as possible to remain at home. This is based on social analysis (the majority of them want to); and also financial analysis (institutions are expensive). Above all, families have to do significantly more in this case.

Finally, it should be recalled that the will to professionalise the sector of personal services in the home remains great, but the results are disappointing. Taking into account the fact that this sector is one where there is great job insecurity for women – especially foreign women – still does not seem to be a priority.

2.2. Availability, affordability and quality.

A. Innovations in the nature or the accessibility of provisions

Funding: the government has thus abandoned the idea of creating a "5th risk", which is said to be a "5th deficit". It is a matter of finding sources of funding. Minister Darcos[9] made the following statement on this issue:

"Three levers are available.

1. We can firstly use **national solidarity**, which must remain an essential pillar. We currently devote more than 14 billion Euros per annum on dependence, but we must improve coverage. National solidarity must occur between individuals and also between *départements*. In certain rural *départements*, such as Creuse, Gers and Corsica, expenditure on the APA exceeds 20% of their total budget and sometimes half of their income from local taxes. We should therefore examine how to consolidate financial equalisation between *départements* and optimise management of the APA. (…)

2. Given the economic context and the state of public finances, we must also find long-term innovative permanent funding: I am thinking of **family solidarity**, which should be consolidated, as well as collective and individual welfare schemes**.** I have already mentioned the fundamental role of family solidarity. I think it is the first and most natural of all forms of solidarity, which has always existed – the kind that is represented, for example, in paintings when one thinks of the hero Aeneas carrying his old father Anchises on his back in order to build Troy again. I want not only to encourage and support such family solidarity, but also to think about ways of consolidating it, for example, by not hesitating to pose the question of the role that patrimony can play in contributing to such support.

[9] Opening of the day devoted to "Dependence – 5th risk", 10 March 2010

3. As for **collective and individual welfare schemes** – as I said during my recent meetings with insurance companies - I am open to all innovative solutions, such as establishing a public-private partnership with them. I also think that we must encourage our fellow citizens to take out dependence insurance."

It is thus clear that an insurance-based model is going to be developed for taking dependence on board and that the role of family carers will be consolidated.

But what is also clear from these plans is that **the situation of carers is not taken into account in spite of the difficulties faced by women carers as been referred to above (in the previous part of the report). Nothing more is planned, in terms of available time or cash transfers.**

2.3. Gender equity

- Even though the issue of dependence is now part of public discussions in the same way as the future of pensions, it cannot be said that these public debates and actions include gender: nothing is said **about women family carers,** apart from a few researchers, whose work we have quoted. No measures are taken to make it easier to reconcile work and care. The role of fathers in work-family balance is hardly referred to – and even less so that of adult sons or sons-in-law! **Whereas, with future difficulties regarding dependent elderly, there is no guarantee that those women who are most vulnerable in the labour market will not be forced to withdraw from it in order to help their parents.** The danger exists in the future, even though qualitative surveys seem more optimistic.

Measures promoting the careers and professionalisation of carers.

The only area where the issue of gender is referred to is regarding the use of home helps and the situation of these (insecure and low paid) workers, who are almost all women, foreigners and even undocumented workers.

In spite of new training, which we have already referred to (DEAVS), training is still very varied and ministries find it difficult to harmonise. The scheme for Validating skills acquired on the job (Validation des acquis de l'expérience, VAE) is becoming more widespread in this sector: thus a majority of women who have obtained their DEAVS have done so via the VAE (4,487 diplomas in 2007) (CESE, 2008). Likewise, an "occupation plan » has been drawn up for this sector. It involves creating regional plans for occupations regarding people who have lost their independence. There are three pilot regions and an agreement between the National Personal Services Agency (Agence nationale des services à la personne) (see below) and all the bodies concerned (Joint Registered Collection Agency (Organisme paritaire collecteur agréé, OPCA), employer organisations, National Association for Adult Vocational Training (Association nationale pour la formation professionnelle des adultes, AFPA), and so forth). This measure should help to promote the sector, especially as, in future years, it is likely to be difficult to recruit people into the sector. Without being directly centred on equality, these measures will improve the situation of many women.

2.4. Labour market sustainability

Plans drawn up between 2006 and 2009 for developing personal services have all been very ambitious regarding the development of employment in this sector (all together, including childcare and domestic chores, as well as services for dependent elderly).

- the 2006 plan - with a view to promoting personal services, which represent a "source of jobs" (estimated to be 500,000 positions) - aimed at:

- making services solvent in order to make them more accessible to as many people as possible (…);
- increasing and structuring the supply of services by limiting the fragmentation of operators;
- developing the quality of services proposed and provided;
- **qualifying and professionalising the workers involved.**

A National Personal Services Agency has been created to develop high-quality services. One of its functions is to guarantee the quality of services with the "aim of reducing undeclared work and improving the image of this work, which is too often seen as being insecure and unqualified".
Likewise, "promoting collective bargaining in the sector is a priority". The VAE is also promoted.

The government considers the result of this initial stage to be positive:

- 100,000 jobs were created each year between 2006 and 2008;
- In 2008, 2 millions people worked in the sector. 7/10 worked for individuals who are employers.
- The sector's turnover was €15.6 billion;
- ¾ of households use Universal service employment vouchers (CESU).
- 16,000 service providers have been registered.

The 11 measures of the 2009 plan

1st objective: support the creation of personal services jobs

Measure 1: In 2009, provide €300 M in the form of CESUs that are pre-funded by the State for target populations, in the framework of the recovery plan.
Measure 2: Extend tax advantages to new personal services.
Measure 3: Implement the project regarding Internet for everyone.
Measure 4: Consolidate the supply of services in Employment Centres (Pôle Emploi) in the personal services sector.
Measure 5: Promote company start-ups in the personal services sector.

2nd objective: professionalise the sector and improve the quality of jobs

Measure 6: Develop employee training.
Measure 7: Experiment the creation of resource centres.

Measure 8: Create a barometer of the professionalisation and quality of jobs.

3rd objective: simplify and render more flexible dissemination tools regarding the pre-funded CESU

Measure 9: Encourage the development of pre-funded CESUs by making the rules more flexible.
Measure 10: Encourage the *départements* to provide the APA and Disability Compensation Allowance (Prestation de Compensation du Handicap, PCH) in the form of CESUs.

Measure 11: Simplify the rules for accessing personal service providers.

CONCLUDING SUMMARY

The issue of taking the dependent elderly on board is at the heart of the problem area regarding gender equality. Dependence is going to become an urgent issue in coming years and concerns mainly women, as life expectancy differs so much. Moreover, whatever ways

are used to tackle it – whether with paid care workers or family carers - the majority of those involved are women.

The ways in which dependence is taken on board vary a lot and identification is complex. Depending on the degree of dependence, those concerned may use personal services at home via direct employment by mutual agreement (the majority), or via an agent or a service-providing company. They may have to be in a more or less medicalised institution: sheltered housing, retirement homes or long-term care units in hospitals. In all cases, if the dependence is relatively serious, they receive the APA and choose the form of care that is best adapted to their situation (staying at home as long as possible is acclaimed by everyone).

In spite of policies aimed at making it easier to take dependence on board and promoting job creation ("sources of jobs" are referred to), in fact this issue remains of secondary importance, is poorly treated and is far from meeting needs in France.

From the point of view of dependent elderly, we have noted that their needs are far from being met, even if the APA constitutes progress. Services that are offered are insufficient (2 to 4 hours per day) and only those with financial means or much family help can manage. For the others, retirement homes are the only solution, and sometimes conditions are very difficult (promiscuity, abuse, dilapidated accommodation and so forth). To top it all, the principle of tax reductions in addition to the APA means that paying for personal services (especially for many hours, sometimes even at night) is significantly cheaper for the rich!

The system is mainly based on "family solidarity". And this term really means women (daughters and daughters-in-law), who after having taken on board responsibility for their children, then look after the dependent elderly around them. This activity is totally invisible and unmeasured, except in 8% of cases, when women stop working and receive the APA in order to help a relative (other than their partner). In other words, "care" is "on top" of all their existing occupational and family loads. A qualitative study shows that the impact of this caring role does not affect their occupation too much, as these women do not want to sacrifice their career and prefer to "eat" into their free time and family time rather than their occupational time. These results are thus rather positive, but we do not necessarily have sufficient hindsight and complete data: what is the situation for women in insecure jobs with arduous and very difficult working conditions? Will they be able to manage between their (nuclear) family, work and caring for dependent elderly? An overall statistical survey would be very useful in this area.

Finally, the most sensitive point concerns the status of paid home helps. Their working conditions, pay, absence of real professionalisation are still real problems, even though attempts to improve their status have been made: all the programmes in this area have shown a will to achieve real professionnalisation, by access to training, recognition of required skills, opening up of collective agreements (those concerning home helps and individuals who are employers). Likewise the VAE has been developed in particular in this sector. Nevertheless it remains the case that most home helps have individuals as employers (and generally several of them), thus evoking a "domestic" relationship. It is also difficult to have schedules that are close to full time employment and bearable travelling time. Finally, the presence of migrant women, who are sometimes undocumented, both makes it more complicated and increases the invisibility of care. Individualised work relationships have been partly limited by using third parties (agents or service providers). But the development of the private sector in this part of

the non-market field leads to other risks (rationalising work and so forth). The intervention of public authorities is thus more than necessary, but current policies are rather in favour of direct employment, which is not controlled much and is insecure. Thus, for example, by wanting to professionalise employees in this sector, the law on modernising social services adopted in 2002 invited employers to participate in programmes for providing their employees with diplomas for their qualifications, especially by promoting access to the State diploma of social care assistant (Diplôme d'Etat d'auxiliaire de vie sociale) via the VAE. Three years later, the Borloo plan changed this by focusing more on measures he introduced to professionalise structures, rather than on professionalising personal service staff who are in direct contact with service users. Given this situation, one cannot be surprised that associations have difficulties in coping with "economic and social dumping" resulting from this multiplication of direct insecure jobs. At the same time, thanks to the generous tax reductions, which the State renews each year, it does not hesitate to spend nearly €3.6 billion per annum, according to the most recent report of the National Audit Office (Cour des comptes) (2010), to fund comfort services which mainly benefit the 10% richest families.

The bankruptcies and closures of associations are not epiphenomena, but are the result of profound restructuring of social services in France. As 98% of personal services jobs in the home are carried out by women, who often have few if any qualifications, inconsistencies and shortcomings of employment policies weigh in particular on them. "Closures occur in silence, which will not be disturbed by the elderly who are socially the most fragile population and who will, at best, turn to arrangements by mutual agreement, or, at worst, resort to undeclared work, provided they do not give up what should be a right, namely dignified old age" (Jany-Catrice, 2010[10]). Worse still, the possibility of temporary agencies entering this "market" has been announced.

In the long term, the opening of this market up to the private sector is problematic for the most fragile elderly. It is clear that private companies are becoming increasingly interested in personal services in the home. However, one must be extremely careful not to mix up people who are quite able to be consumers in the market of personal services (such as families seeking childcare, help with school work, housework or gardening, and so forth) with fragile elderly, who are sometimes isolated, need real care and should be considered as people who need to be helped rather than as consumers.

Finally, much can be said about the new proposed forms of funding. In the framework of creating this new area of social protection, the actors concerned (pensioners, elderly, families, professionals, trade unions) demand funding based on national solidarity: taxes, social contributions, and so forth; with funding via private insurances only as top-up. Funding part or all of the service via patrimony can be envisaged, provided that all patrimonies are made to contribute according to their size, and above all, that it should not only be the patrimony of fragile elderly people. Otherwise, this would lead to a situation where a 90 year old woman who suffers from a heart condition would benefit from medical care which is sometimes very expensive (hospital or clinic, etc.) and would continue to be able to bequeath all her patrimony to her children; whereas, another 90 year old lady with Alzheimer's, who is living in an institution would only be able bequeath part of her patrimony, because the other part would be recuperated to pay for the institution. This would constitute a source of great inequality between the elderly, depending on the kind of illness they have – and is

[10] Le Monde, 25 février 2010.

unacceptable. Finally, we should not forget a specifically French problem, namely that children have a duty to contribute financially if their elderly parent(s) cannot cover all their ongoing care costs during the elderly person's lifetime.

In spite of real efforts, the sector is thus in crisis, and overall, it is possible to imagine that the most fragile dependent elderly will be penalised. As for the situation of women in this debate, we have already seen and said that they are at the heart of the system and the wind of equality does not seem to have reached dependence, as far as family carers and paid care workers are concerned.

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Grid 1. Types of provisions and their usage according to stage of disability.

Type of provision	Brief description	Prevalent use at different stages of disability: mild (1), moderate (2), severe (3)
Time related provisions Family Solidarity Leave (Congé de solidarité familiale)	3 months (renewable once) of unpaid leave for private sector employees	This leave concerns severe cases (3) because it is for looking after people who are at the end of their lives
Cash transfers, including 1. Personalised Autonomy Allowance (Allocation personnalisée à l'autonomie, APA) 2. End of life allowance (Allocation fin de vie)	1. The APA is an allowance that is awarded to the dependent person, who uses it as they (paying for help; for a family carer other than their partner; or for an institution) 2. Allowance of €47 per day for 3 weeks	1. The APA implies that the state of health is moderate (2) or severe (3) 2. Severe (3)
Services, including **Home care** 1. Basic home care (cooking, meals on wheels, cleaning, bathing, minding, remote assistance) 2. Home nursing 3. Paramedical and medical care (chiropodist, physiotherapist, mental therapist etc.) 4. Respite care Other **Semi-residential care** 1. Outpatient clinics 2. Day-centres 3. Community social services Other **Residential care** 1. Nursing home 2. Sheltered homes or flats/residential houses Other	**Home care** In France, there is a strong desire to keep people at home. 61% of dependent APA beneficiaries remain at home with paid or family carers looking after them. - **Home nursing services** (Services de soins infirmiers à domicile, SSIAD) aim at avoiding hospitalisation. Nursing auxiliaries carry out various functions (1/3 of the care concerns washing; 85% concerns skin care and hydration problems, etc.). Between 12% and 35% of dependents receive such care. But given there is very little home hospitalisation, this kind of care is becoming increasingly onerous. - For GIR 4 and 6 (mild) who do not receive the APA, there are **home helps** who prepare meals, non medical care, shopping, etc. **- home hospitalisation** is limited and recent (1999/2003) It is estimated that only 18.7 places are available per 1,000 people over 75 years old. - **Residential home** : around 657,000 persons	e.g. a combination of basic home care, home nursing and respite or semi-residential care may be the prevalent arrangement for moderately disabled elderly (stage 2)

Grid 2. Source of care for the elderly (not available see grid 2b)

Source of care services	Home care (% share)	Institutional care (% share)
Family and/or friends		(not applicable)
Not-for-profit organizations		
Public authorities		
Private carers / for profit firms		

Note: This grid asks about actual providers of care, i.e. those who deliver the care; if the percentage share is not available, please, give rough estimates or simply describe the prevalent combination.

Grid 2b. Distribution of personal services by employer

Source of care services	Home care (% share)	Institutional care (% share)
Family and/or friends	Nd (about 30%) sometimes on top of other help	(not applicable)
Local authorities	10,9%	
State – public hospitals	0,8%	
Private carers	2,1%	
Private/public companies and agents (associations)	86,2%	

Source: CERC, 2008

Grid 3. Coverage rates* (breakdown by gender if possible)

Age group	Home care	Semi-residential care	Residential care
60+	4,9%	Nd	3%
75+	Nd	Nd	10%

Note: *% share of elderly cared for in the age group.
These data concern APA beneficiaries

Grid 4. User fee for different services (moderate level of disability)

Type of services	User fee, Euro (specify also year if not the current figure)
Publicly subsidized nursing home or equivalent residential care (specify): the APA is used for services provided either in residential homes or at home	APA: Depending on the degree of disability: €1,224.63 (severe handicap) €1,049.68 (permanent help); €787,26 (help several times a day); €524.84 (help from time to time) For the cost remaining for families, see table 6
Home care package if publicly provided (about 3 hours daily) idem	idem

Note: *If average is not available, please give the range.

Grid 5. Gender of (paid) care workers*

Type of care worker**	Share of women in	
	Home care	Nursing home care
Basic care worker (no or little formal qualifications required)	99%	nd
Nurse	88%	

Note: * If figures are not available, describe prevalent gender composition, e.g. overwhelming majority of women.

Grid 6. Pay for care workers, by skill level *(please, breakdown by gender if available)*

Type of care worker*	Average salary per hour or month, Euro (specify hourly/monthly, and consider full-timers for monthly data; please, also specify year)	
	Home care	Nursing home care
Basic care worker (no or little formal qualifications required)	Average monthly pay 2005: €457 Average number of hours worked: 23 per week (30% work less than 15 hours per week)	nd
Nurse	Basic pay (starting pay) monthly average of €1,300 for full-time in 2008 (25% part-time)	