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Quality of jobs and services in the Personal care and Household Services sector in France

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INTRODUCTORY NOTE

This report has been prepared, reviewed and finalised through the research of its authors, the contributions and suggestions of the project partners, the suggestions and remarks made by the participants-members of partners' organisations at the regional seminars (Rome / Brighton / Vienna 2015) and by the Advisory Board members (AGE Platform, Eurofound). The authors wish to thank warmly all these persons for their time and contribution. The report presents the personal care and household services sector in the country at stake and in the framework of the For quality! project objectives, following the methodological grid validated by the consortium, without being exhaustive. Authors have tried to incorporate corrections and comments that were reported to them during this process. However, the content does not necessarily reflect the vision of the project partners who are not responsible for the information contained in this report.

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The information contained in this publication does not necessarily reflect the position or opinion of the European Commission.

CONTENTS

1. NATIONAL OR LOCAL REGULATION AND POLICIES

France has been a frontrunner in creating and promoting a "personal services" (*services à la personne*) sector. This sector includes a series of in-home services dedicated to individual persons. The development of the sector has been given a strong public impetus since the early 1990s. In 1991 a tax deduction was introduced which is still in place. In 2005, the so-called "Borloo Plan" - after the name of the Minister of Employment and Social Affairs, Jean-Louis Borloo – ensured that the sector is defined in legal terms by adopting a list of such personal services (decree of 29 December 2005). This list was necessary to delimit the services granting access to public subsidies for consumers, mainly in the form of a tax deduction. This list includes several services, such as childcare; care for senior citizens, disabled persons or persons needing individualized help at their home or mobility assistance in their immediate environment to keep them in their homes; as well as housework and family services. **At present, more than 20 activities have been defined as belonging to the scope of personal services.** One major difficulty is this very comprehensive definition including two types of services, which are very different in their logic and history and have been pooled in this new sector:

- on the one hand, social services including the care for dependent persons, which is mostly attributed to the non-profit third sector;
- on the other hand, so-called "comfort" or lifestyle services to private individuals with these services mostly attributed to the private sector or direct employment with a specific employer (when someone directly recruits one person for household work, for instance).

Since 2002 (Act on dependency), there is an **individual autonomy allowance** called APA *(allocation personnalisée d'autonomie)*, which enables the partial funding of individual assistance, technical assistance and specific adaptations in the homes of dependent persons. This universal allowance introduced by Act no. 2001-647 of 20 July 2001 is transferred to "any senior citizen residing in France who is incapable of offsetting the consequences of a deficit or loss of independence due to his/her physical or mental situation". It is "intended for persons who - notwithstanding the care they are likely to receive - need help to accomplish essential activities of their daily lives or whose situation requires regular supervision".

It is granted only to persons over 60 following an individual medical and social assessment. APA rates are fixed on the basis of a national evaluation matrix called AGGIR on the groups of gerontological independence on the basis of their remaining internal resources (scale from 1 to 6). Only GIR categories 1 to 4 are entitled to the individual autonomy allowance. The amount of this autonomy allowance is determined by the Ministry of Labour, Social Relations and Solidarity as either in-home assistance or institutional care. The allowance is managed by local authorities, the Conseils Généraux. The allowance is granted upon first application to 76% of the persons asking for in-home assistance and 90% of all persons living in institutional care.

Since 11 February 2005 (Disability Act), services compensating for disabilities (PCH) have been introduced for adults with disabilities (under 60 years of age or over 60 years of age and receiving no APA). This social service will progressively replace the compensatory allocation for third parties (ACTP)

introduced in 1985. In 2008, a decree extended the PCH compensation to children and adolescents with disabilities as a complement to the education allowance for children with disabilities (AEEH).

Another possible assistance may come from CAF or the Conseil Général (ASE-PMI) to provide support for parenthood.

Forms of intervention: Apart from this diversity of services, there is a **strong heterogeneity of service providers and organisational models for service provision.** It is possible to distinguish between service workers employed by a service organisation (1) on the one hand and the service workers directly employed by the recipient of the service on the other (2).

The various forms of intervention for household services financed through APA are as follows:

1- The service provider model: household services make one or several persons working at his/her home available to the APA recipient (Allocation personnalisée autonome or Individual Autonomy Allowance). The persons providing personal care at the home of the senior citizen are employed by the service organisation which covers the full range of employer obligations. The services provided generally result in an invoice to the Département which then directly transfers the APA amount to the service provider. The user pays "the moderator ticket", i.e. a calculated contribution depending on the modalities foreseen by the code of social action and families and considering the recipients resources
2- The direct employment model: the direct employment model has been available for a long time and enjoyed significant support in public policy. Its development is rooted in the tradition of household employment which well-to-do bourgeois families resorted to throughout the 20th century. The employment relations of such workers gave them a special status given the fact that they were directly employed by the recipient of the service. It must therefore comply with the provisions foreseen in the Labour Code and the national collective agreement for employees of private employers. This is the method of mutual agreements.

Irrespective of the employment model, in-home service workers carry out all activities supporting a person without having the authority to perform medical or nursing duties. In-home service workers employed according to the service provider model of employment more frequently (33%) perform activities of daily life (or adl) than directly employed workers (22%). These activities of daily life are such that they include shopping, accompanying the recipient in the house, in his/her daily hygiene or outside the home etc. (Drees 2010). In 9 cases out of 10 and irrespective of the employment model, household service workers also take care of ongoing household activities (Lefebvre, 2012).

Next to this system of services to dependent persons developed since 2002, the state has taken the option to support the more comprehensive sector of "personal care services" since 2005 (Borloo Act). Personal care services include both assistance to dependent persons and services for non-dependent persons (household duties, ironing, small repairs, shopping etc.). Generally, these services share the feature that they are realised at the recipient's home. A list of approximately 20 services has been defined by the government. All these personal care services entitle the consumer to a tax deduction or tax credit of 50%. For APA recipients, this tax credit is calculated on the basis of the amounts paid to personal care

companies or amounts paid in connection with the direct employment of an employee after deducting the APA allocation.[1]

This model of tax incentives has actually existed since the beginning of the 1990s and strongly accompanied the growth of the direct employment sector. With a tax credit amounting to 50%, it is much less interesting to resort to black-market employment than to employ a person directly. Using employment service checks makes it even easier to respect social obligations (declaring taxes). Resorting to a service provider remains a bit more expensive due to the costs of the service provider's structure (associations or private enterprises).

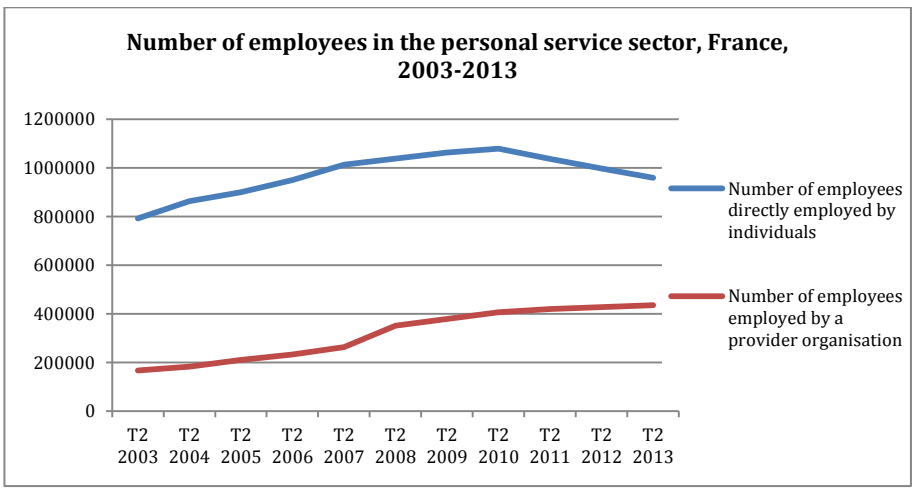
These different tax incentives introduced between 1991 and 2005 follow the logic of creating employment for low-skilled workers. Precise statistical studies estimated the net effect on the creation of employment for such actions. (Carbonnier, 2014).

[1] This deduction or this tax credit comes with a ceiling of € 12,000 per year and may increase to € 15,000 depending on the number of children in the household or persons of more than 65 years of age living in the household (and to € 20,000 for persons with disabilities).

2. WORK AND EMPLOYMENT QUALITY

Work and employment quality in the personal care service sector are directly related to these two different models of employment, i.e. either the direct employment model or the provider organisation model. In 2010, there were nearly 1.5 million workers in the sector. Nearly 1.1 million of them (72%) were directly employed by individuals and 400,000 by provider organisations whose activities were mostly handled by non-commercial organisations representing 70% of the working hours provided. Generally speaking, practically three quarters of all employees are directly employed by individuals and a little more than a quarter (28%) by service provider organisations (70% in the non-commercial sector and 30% in the commercial sector).

From 2010 to 2013, the global activity of the sector has decreased because of an important drop of employment in the direct employer model (-11%). This decrease is due to a combination of the economic crisis and a reduction in public support to direct employers. The reduced support for direct employment can be generally explained by the pressure on public expenditures.



Source: DARES, L. Thiérus, « Les services à la personne en 2013. Un fort recul de l'emploi direct accentue la baisse de l'activité du secteur », DARES Analyses, February 2015. Childminders working at their home not included.

A key factor is the very high share of women among the employees with more than 90% as well as the higher average age of employees in these services (27% of directly employed employees are 55 years or older compared to 17% of all employees in service provider structures and 11% among the entire French labour force).[2]

The analysis of the quality of employment arrives at the following key points:

[2] Baillieul et al. (2013)

Security of employment

- With respect to the **security of employment,** permanent contracts dominate**.** Employees directly employed by an individual (they represent around two thirds of the total number of employees) are normally employed with a permanent contract (CDI). They might be **paid by a voucher** called CESU ('Chèque emploi service universel' or 'universal employment service voucher'). They are employed for less than 8 hours a week and a work contract is not mandatory in their case**.** When the contract is broken, the employee is entitled to severance pay and a severance period.

- The majority of employees employed by a service provider organisation (they represent around one third of the total number of employees) work with a permanent contract: This is the case for 78% of them. 87% of these employees work part-time.

- Generally speaking and irrespective of their status (direct employment or employment with the provider) all employees are covered by collective agreement.

- The key problem is not so much the nature of the work contract and more the insufficient number of working hours: part-time work is the standard. 87% of all employees work part-time. Care personnel working for a service provider organisation show a tendency towards having a higher number of working hours. Irrespective of their current type of employer, 30% of all employees would like to have more working hours. 70% have therefore chosen their working hours deliberately.

Working hours of care personnel and in-home household service personnel

	Personal care workers	**Household service workers**
Occasional	2 %	4 %
< 20 hours	28 %	47 %
20-30 hours	37 %	23 %
> 30 hours	33 %	26 %

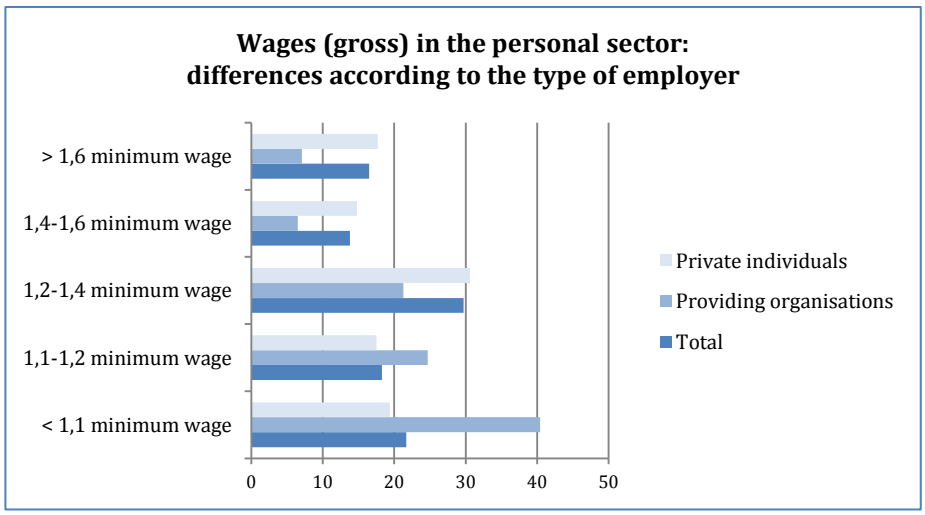
Source: Enquête emploi, Lefebvre 2012

- The second problem concerning the security of employment refers to a potential return to black-market employment. In the years 1990 and 2000, black-market work registered a distinct drop following public policy action (strong tax incentives). But in recent years, the tax incentives were adjusted downward as a result of the pressures on public budgets. Direct employment thus decreased, and it is highly probable that black-market work will again register a peak. This black-market work would also impact migrant workers, who represent 25% of the workers (Lefebvre 2012[3]).

[3] Lefebvre M., Qualité(s) de l'emploi dans les services à la personne, Ph.D. Thesis, Univ. Lille-1

Salaries

The existence of collective agreements (remunerating the worker's seniority) and a minimum salary ensure that, on average, the working hours reach the correct level. The hourly wage is approximately € 12.30 (gross) which represents 1.4 times the level of the minimum wage. But the significance of the salary actually depends on the number of hours worked. Ultimately, the average salary of in-home workers amounted to € 687 in 2010 for 21 working hours per week[4]. In contrast, in-home household service workers earned € 838 per month on average for more than 27 hours of work per week. 76% of household service workers had a salary below the minimum level



Source : I. Benoteau, Y. Baillieul, G. Chaillot, « Les services à la personne. Davantage sollicités dans les zones rurales et âgées », DARES Analyse, juillet 2013.

Social protection

Employees in the sector benefit from the same social protection as workers in other sectors. But the short working hours of many employees in France have led to them benefiting from the Universal Sickness Coverage (*Couverture Maladie Universelle* - CMU), which is the safety net of the French social security system.

Employees employed by private individuals benefit from a relatively good system of social protection (pension rights, mutual insurance, etc.) which is managed by a specific sectoral organisation (IRCEM).

[4] Source: Enquête Emploi, cf. Lefebvre 2012

Skills development and professionalisation

The sector of personal services in France is a sector with **low qualifications**. The majority of employees have little or no qualification. According to Enquete Emploi (Lefebvre 2012), 32% of employees have no qualification at all (26% of in-home care personnel and 46% of housekeepers).

The first professional level or position in the collective agreement of in-home service workers (*convention collective de l'aide à domicile*) is not even linked to a minimum level of qualification. The most important level of qualification for in-home personal service workers corresponds to *DEAVS* level 2 (Diplôme d'ètat auxiliaire de vie sociale) which is held by around 30% of these workers. With in-home care service providers, the most complex tasks are often allocated to these more qualified workers. This qualification is required for all care-related work but not for simple tasks like cleaning the home. A minimum qualification is not required for employees directly employed by private individuals.

It is therefore a challenge to develop training. Many providing organisations have adopted a professionalisation strategy and promote training for some of their employees. The most important diploma used in in-home services is currently DEAVS (Diplôme d'ètat auxiliaire de vie sociale or: Auxiliary State Diploma for social services), which can be obtained through vocational training and in particular by having the worker's professional experience recognised. This professionalisation impacts on the salary structure. In the field of health services provided at the home of dependent persons, the rates are fixed by public agreements. These rates do not necessarily cover the cost of training and professionalisation; and many structures also have to confront budgetary pressures. For this reason, many organisations do not encourage training, as it represents a significant item of expenditure.

Access to training is more difficult for employees directly employed by individual employers (Lefebvre, 2010).

Another important point concerns the need to professionalise the management personnel in the structures. This has an anticipated impact on reducing the hardness of work, which is attributable to a poor management of the workload.

Health and well-being

These jobs are highly exposed to psychosocial risks and emotional factors. The work organisation cannot do a lot towards preventing these risks, but often proposes interaction spaces where workers can voice their difficulties or concerns. It also can mix very demanding activities (for instance with highly dependent persons) with less demanding activities (like cleaning) to give the employees some breathing room. Employees recruited by individuals are often more isolated. Since 2011, these employees should have access to occupational medicine. Only full-time employees are actually concerned. This obligation is not really respected, as occupational medicine does not have the means to accommodate all these employees. Employees working for service provider organisations are nonetheless better followed up by occupational medicine. Another problem is that the occupational health and safety inspectorate cannot

check the ongoing work at an individual employer's home.

The psychosocial risks differ for the two occupations. Several indicators of psychosocial risks show that household service workers represent a level below the average for all professions, while in-home care personnel would report above-average levels of difficulties.[5]

Exposure to psychosocial risks, 2005 (France)

	Care personnel	Housekeeping workers	All employees
Experience tensions with the public	35%	5%	32%
Be in contact with persons in distress	66%	13%	38%
Experience tensions with hierarchy	9%	5%	26%
Experience tensions with colleagues	7%	3%	18%
Have to calm down persons	59%	10%	47%
Be exposed to verbal aggressions	37%	10%	39%

Source: Enquête Emploi, Lefebvre 2012

In terms of physical hardness, jobs in personal care and household services are demanding. Among the physical difficulties the following should be mentioned: standing, carrying loads, handling corrosive substances, hygiene and safety problems, in particular in homes of senior citizens, risk of aggression, road accidents, etc. In France in 2010, in-home personal care services registered a frequency of workplace accidents, which was twice as high as the general average for all professions (76 accidents per 1,000 employees compared to an average figure of 36 accidents). The accident rate was even higher than in the construction sector, for instance (73).

The hardness is also linked to the fact that the employees work for a number of employers to arrive at a full-time job. The aggregation of these contracts creates situations with health-related hazards for the employees.

In conclusion, several challenges exist for employers in the personal care sector and in the household services sector. The poor quality of employment (primarily part-time, poor labour conditions given the prevalence of these working hours, physical and psychological difficulties) lead to a high turnover, which acts as a constraint for the employers and the improvement of service quality. With the crisis, the increase of black-market work is an upsetting phenomenon; this is not acceptable for any of the parties involved (workers, recipients of services, the State).

[5] Other research have estimated that 30% of home carers working with dependent persons are exposed to a job strain hazard. See Messaoudi D., Farvaque N., Lefebvre M., (2012), « Les conditions de travail des aides à domicile: pénibilité ressentie et risque d'épuisement professionnel », Dossiers Solidarité et Santé, n°30, DREES.

3. SERVICE QUALITY

Article 32 of the Bill on adapting to an ageing society provides for the SAAD passing to a uniform authorisation system in five years' time.

While waiting for this Bill to become law, personal care services and household services work according to a service provider model within a "fragile" community (dependent elderly persons, disabled persons, persons suffering from a chronic illness and fragilised families) and are governed by a right to use the available optio s of the authorisation system and the licensing system:

1) When the service is authorised or licensed through an agreement (CPOM), the price of the service is controlled by the government ;
2) When the service is licensed without agreement with a Conseil Général, the price is agreed freely (but its development is supervised)

These two systems have similar quality obligations, but they may be differentiated. In both cases, the French approach to quality places the recipient at the centre of the definition. It is based on the following principles:

1) respect for the dignity, integrity, private life, privacy and safety of the person receiving care;
2) freedom of choice among the services offered;
3) customised provision of care and assistance that promotes development, independence and integration, is adapted to age and needs, and respects the informed consent (a systematic obligation);
4) confidentiality of information on the person receiving care;
5) access to information concerning the person receiving care;
6) information on the basic rights, the legal and contractual protection offered, as well as the possible legal remedies; and
7) participation, either directly or with the help of his/her legal representative, in setting-up and implementing the plans to receive and assist the person.

For implementing these principles, the licensed service must introduce the following tools:

- a draft service document (L311-8 of CASF) establishing the organisational outcome and objectives while insisting particularly on the coordination, cooperation and evaluation of service quality as well as the organisational and operational procedures.

- an individual service document (D.311 of CASF) drawn up with the user or his/her legal representative, this contract or document sets out the objectives and the nature of the care package or support, while respecting ethical principles, professional recommendations and the aims and objectives of the organisation or unit; it sets out the list and nature of the services offered as well as their estimated cost;

- a mode of participation for the recipient in the operation of the service; satisfaction enquiries,

counselling for the social life, interaction groups, consultation etc. (D311-3 and D311-21 of CASF)

- implementation rules (L311-7, R311-33 to R.311-37 of CASF)

- a process allowing a person receiving care from an organisation or unit to call upon a qualified person to advise the service recipient about his/her rights; this qualified person is chosen from a list drawn up jointly by the government representative of the Département, the managing director of the regional health agency and the president of the Conseil Général, and takes into account the interventions of the authorities responsible for monitoring the organisation;

In view of introducing these principles, the licenced service must introduce the following tools

- a service contract
- at least an annual satisfaction enquiry
- a welcome booklet and a charter of rights and freedoms
- the obligation to introduce a liaison specification

Accreditation and licensing system

Quality in the accreditation system

The licence is awarded for 15 years and establishes the basic conditions for the quality required when creating an organisation and renewing its licence. Compliance with these minimum quality requirements is then evaluated during the term of the license by the organisation or the unit itself (internal evaluation or auto-evaluation every five years) or by an external body (external evaluation). The specifications for the external evaluation are defined by decree. The external evaluation must be completed during the seven years following the accreditation being granted or renewed and at least two years before the current licence expires.

Quality in the licensing system

The licence is granted for five years by the departmental prefect after deliberation by the Conseil Général. The licence is granted on the basis of quality criteria for the unit as they are specified in the specifications of 26 December 2011 in the first paragraph of Art. L.129-1 of the Labour Code.

Licenced organisations are subject to an external evaluation. The results of the evaluation are communicated to the prefect in charge of granting the licence at least six months before its renewal. Furthermore, the internal evaluation is not mandatory for licensed organisations and services:

Quality initiatives

Whatever the operating system of the service, the service must be based on the recommendations for good practices issued by the Anesm organisation.

Among others, it might participate in several quality initiatives:

- It may follow the quality charter prepared by the MISAP organisation of the general directorate of undertakings (Direction Générale des Entreprises, DGE).
- It may subscribe to a service certification initiative. Certification is a voluntary procedure that can replace the quality control used by public authorities for accredited or licensed organisations or units. For licensed services, the certification will release them from any external evaluation. For accredited services, the certifications in the French standard NF 311 and Qualicert grant them a partial recognition in their external evaluation initiative. The certifications currently recognised by public authorities meet:
    - the French NF standard X 50-056 for in-home care service (AFNOR, French Standardisation Agency)
    - the certificate registered by Qualicert under "Personal services" (international certification of services by the Société générale de surveillance, SGS)
    - the certificate registered by Qualisap under "Service quality organisations engaged in personal services" /a certification by Bureau Veritas).
- It may subscribe to a labelling initiative. They include the Cap'ahndeo label for persons with disabilities, for example, and are financially supported by public authorities. It offers the beneficiaries a greater visibility of the quality of the service portfolio.

The mandating process

This final possibility bears witness to the innovations presented and debated in the seminars organised by the 4Quality project. In the present case, it is a matter of mandating *in the sense of community law being re-transposed into French law*: this possibility stands for a new accreditation/mandating process to replace the present accreditation system.

In the European community law as well as national law, the existence of a special public service mission authorises funding by a public entity. The room for manoeuvre for public authorities in defining a mission of general interest is rather large, as it refers to the discretionary powers of a public authority. A mission of general interest and the obligations of a public service must be defined as precisely as possible. Art. 106.2 TFUE applies to undertakings "mandated with the management of a SIEG" and demands the existence of an official mandating document. The definition of this mandate is mandatory for the qualification as a SIEG.

The key challenge here is to have SAADs recognised as a relevant activity of a SIEG. In return, from the Départements imposing the definition of obligations of public services on the "mandated" SAAD, a "just

compensation" will be transferred to cover these obligations.

The advantage of such an initiative will enable granting to SAADs a "mandate" to provide customised services, which are appropriate for the obligations of a public service. In return, a financial compensation will be fixed and prevent all "financial overcompensation" as demanded by European law, which only tolerates "reasonable" surpluses.

European law therefore allows passing from a rate-setting/accreditation logic to a mandating logic. The latter exerts a much higher level of responsibility for the receiving structures. Due to its stricter specifications, it also offers a higher level of security for the public authority both in terms of quality and in terms of funding with a regulation of the subsidy according to the principle of a "just compensation" and a reasonable surplus.

The Départements study the opportunity of introducing this mandating system in the SAAD field according to the model practised by the Département Doubs in eastern France.

4. CONCLUSION

France has developed a highly comprehensive model of personal care services covering all services from comfort-related services for individuals to household services for dependent persons. This range of services, which has been in operation for 10 years, had a practical purpose, i.e. the creation of new low-skilled jobs in the new sector. Even though this employment has developed in the field of personal care services, the total number of jobs created did not come up to the expectations. The problems with the quality of employment continue to exist despite the efforts of the social partners to professionalise the workers. This allocation to the single sector of "personal care services", which is often presented as a model abroad, actually hides the reality is associated with the two principal employment models. On the one hand, the model of the individual employer is a good match for certain households and professionals, but traps a high number of employees in precarious employment. On the other hand, there is the model of employment with a service provider, who offers opportunities for professionalisation and guarantees in terms of service quality, but is subject to the constraints of a high-cost logic. The specificities of work in the "care" sector, the attention to dependent and fragile persons, (operating according to a logic of needs), has become blurred by associating household and housekeeping services for well-to-do households with in-home services (operating according to a tax reduction logic). Talking about "personal care services" in a generalised fashion therefore does not permit considering the specificities of the two types of service and the professions, in so far as the quality of employment or services is concerned.

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