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▶ **To cite this version:**

Ingrid Jönsson, Anne-Marie Daune-Richard, Sophie Odena, Magnus Ring. Becoming dependent: How is eldercare implemented in France and Sweden ?. RC 19 Conference "Social Policies : Local Experiments, Travelling Ideas", International sociological association (ISA), Aug 2009, Montréal, Canada. halshs-00449790

HAL Id: halshs-00449790
https://shs.hal.science/halshs-00449790

Submitted on 22 Jan 2010

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August 20-22, 2009

Social Policies: Local Experiments, Travelling Ideas

Session: Embedding new ideas – the example of ageing

Becoming dependent: How is eldercare implemented in France and Sweden?

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Abstract
The communication discusses results from a comparative project on the implementation of eldercare in France and Sweden. The entrance into dependence is understood as a *process*, and eldercare is seen as a part of the organisation of social care in society thus reflecting different welfare traditions. An overview of eldercare on the institutional level in the two countries is supplemented by an interview study identifying ways of cooperating between actors such as public eldercare, family members and help provided by profit and non-profit organisations departing from elderly persons' everyday experience. The interview study includes about twenty elderly persons in each country as well as a limited number of administrators and adult children. The study sheds light on how policies actually are implemented on the local level and puts the focus on *who* actually do *what* and *when* for the elderly persons. The different roles played by the state, the family, the market and civil society clearly appear in the elderly persons' everyday experiences. Family members in France take on a more active role both as coordinators of care and as actual caregivers. The study further shows that gender and class background still have implications but that such differences are much larger in France than in Sweden.

Keyword: eldercare, welfare tradition, class and gender differentiation

Current demographic trends put the care of elderly on the political agenda in most European countries. Demographic changes, such as decreasing fertility and mortality rates and increasing longevity, coupled with changes in family structures, in social protection systems and in value systems are all important factors for the possibility to receive the help and support we need in old age.

Eldercare is part of the organisation of social care in a society, which could be defined as "the activities and relations involved in meeting physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out" (Daly and Lewis 2000:285). According to this definition, social care covers the relationships between different kinds of financing, provision, organisation and social relations at different levels of society and the relationships between macro and micro levels. The economic and social framework gives an idea of different welfare traditions, where the state, the market, the family or civil society play different roles. The concept is also useful for tracing changes at the macro level in society as well as for identifying the implication of such changes on the micro level, i.e. in everyday life (ibid.).

This analytical approach was applied in a comparative project run in 2007 and 2008 to study the trajectories of eldercare in everyday life in Sweden and France.[1] The aim of the project was to study the entrance into dependence as a *process*, i.e. how elderly persons' need of help and support over time is attended to (or not) and by whom. In doing so we tried to identify everyday experiences among elderly persons in the two countries, especially their interaction with the welfare systems. The aim of the communication is to point out the importance of including both the macro and micro perspective and the interaction between them to obtain a fuller understanding of how the two systems of eldercare function in reality.[2]

Starting from an elderly person's trajectory of becoming dependent in the old days sheds light on how policies actually are implemented on the local level and puts the focus on *who* actually do *what* and *when* for the elderly persons. Comparisons limited to the institutional level often underestimate the importance of the organisation of the care of elderly at the local level (e.g. Kröger 1997, Le Bihan and Martin 2006).

The article starts with a short presentation of the two case studies followed by an overview of structural differences between the two countries as a background to how care and support is organised and experienced by the elderly persons

[1] The project "Les trajectoires d'entrée en dépendance des personnes âgées du point de vue du *care*. Approche comparative France-Suède" was financed by DRESS-MIRE and conducted by Anne-Marie Daune-Richard (CNRS) and Sophie Odena with the contribution of Francesca Petrella (Université de la Méditerranée) at LEST (Laboratoire d'Economie et Sociologie du Travail), France, and by Ingrid Jönsson and Magnus Ring at Lund University, Sweden.

[2] Marie-Thérèse Letablier at Université de Paris 1, France, has also contributed to the theme as a co-writer of a preparatory paper on "Everyday life in the old days: the organisation of eldercare in France and Sweden" (together with Ingrid Jönsson and Anne Marie Daune-Richard), which presents differences in the two institutional settings of eldercare. The paper was presented at the 8th Conference of the European Sociological Association, "Conflict, Citizenship and Civil Society", Glasgow, UK, 3–6 September 2007.

included in the study. What are the options for the elderly persons in need of care and who will actually care for them? How is information obtained? How is assessment of needs done and on what grounds? Answering such questions helped us to identify ways of cooperating between actors such as public eldercare, family members and help provided by profit and non-profit organisations. Such an approach also draws attention to the different logics that access to help and support from different sectors builds upon (Rainwater et al. 1986).

Case studies of becoming dependent in France and Sweden

The two case studies include an overview of national eldercare policies as well as of local implementation and how everyday life was experienced by about 20 elderly persons in each country. All of them received some kind of public support (APA[3] in France and public home help in Sweden). The elderly persons were chosen to represent different household compositions, gender, class and geographical residence (urban/rural).[4] In Sweden, six adult children and four care managers were also interviewed separately from the elderly persons, while adult children or relatives often attended the interviews in France, not least due to the elderly persons' health status. Six social workers and the head of the department responsible for APA at the Conseil général[5] were also interviewed separately. Actually the French elderly persons were usually in a worse health condition than the elderly persons receiving home help in Sweden.

Structural differences between Sweden and France

Distribution of responsibilities

According to Esping-Andersen's typology of welfare regimes (1990), France and Sweden can be assigned to the corporative and the social democratic welfare regime type respectively. The most crucial criterion of the typology is the role played by the state in the organisation of welfare. The role of the state is identified

[3] See below for further information about the APA allowance (*Allocation Personnalisée d'Autonomie)*

[4] In Sweden access to the 22 interviewees was made possible with the aid of administrators at the local social welfare board distributing information packages including a form to be completed by the elderly person stating their willingness to participate in the study. Totally, 10 single elderly persons and 6 couples were interviewed, of whom 3 single persons and 3 couples lived in a rural municipality and 7 singles and 3 couples lived in an urban area. Thirteen of the interviewees were women and 9 were men.

[5] The French case study included 21 persons: 12 single, 7 couples and 2 sisters living together. Ten of them lived in their own homes, 9 in special housing and 2 in short-term housing for medical rehabilitation. Thirteen of the interviewees were women and 8 were men. In France, the study was located in two big towns and several villages situated in the region of the Bouches du Rhône. Access to elderly persons was organised by the social workers who asked the old persons if they would agree to participate in the inquiry.

as being much more important in Sweden than in France, where the family, voluntary organisations and the market play larger roles.

Since the 1950s responsibilities and obligations between generations are regulated through the welfare system in Sweden (Millar and Warman 1996). Before then, according to the Poor Law the main responsibility for older generations lay with the children and the municipality stepped in only as the last resort. Although the municipalities since 1956 cannot charge children for the cost of care of elderly parents, all intergenerational responsibilities were not removed until 1978 and the marriage law continues to regulate to some extent the relationship between spouses while most other social rights are individualised (including pension rights). In the social democratic welfare regime, the degree of de-familialisation is high, which means that much care work is performed outside the family (Lister 1990). Social services for children, elderly and handicapped are tax-paid and are to a large extent publicly organised. The social democratic welfare regime is also characterised by a high rate of de-commodification, i.e. access to social benefits and services is based on citizenship rather than on previous labour market participation (Esping-Andersen 1990).

National social policies are path-dependent, and historically as well as today Swedish municipalities play a crucial role in the implementation of national eldercare policy. The official goal for the care of elderly in Sweden is universalism and extensive coverage, and according to the Social Services Act the benefits come as benefits related to *needs* rather than being related to purchasing power (Regeringens proposition 1997/98:113).[6] Although eldercare became a pronounced national issue and a state responsibility in the 1950/60s, municipalities continue to hold the responsibility for its implementation, which in practice leads to large differences at the local level. Some researchers would even use the concept of "municipal welfare regimes" (Kröger 1997). Changes in the legal and economic frameworks together with the transfer of medical care for the elderly, the care for the handicapped and for persons with psychiatric handicaps from the state to the local level further increased the municipal responsibilities in the 1990s.

In France, historically eldercare was the main responsibility of the family and still is in legal terms, as responsibilities between generations continue to be laid down in the civil law (Weber 2006). Over time, the responsibility for eldercare has increasingly become shared between the state (social assistance to those in need[7]), the insurance system (work-life related pension schemes[8]), the social

[6] In addition to the Social Services Act, other frame laws such as the Occupational Safety and Health Act, the Act on Health Services and the Act Concerning Support and Services for Persons with Certain Functional Impairments belong to the legal framework surrounding the national policy for eldercare.

[7] In the 1940s and 50s, "allowance for the elderly" and an "allowance for mothers" were created for the poor elderly who were not included in the pension scheme, and in 1956 an allowance was introduced to guarantee a minimum living standard for all elderly (*minimum vieillesse).*

[8] The French retirement system is mainly made up of statutory schemes accounting for about 90 percent of total pension expenditures and financed by social security contributions and taxes. The functioning of these schemes varies along with economic sectors. The general scheme cohabits with statutory supplementary schemes established by collective agreements and pay-as-you-go

economy (mutual insurances and associations[9]) and the family. In contrast to public childcare policies that developed early in France, it was not until the 1990s that eldercare policies appeared on the political agenda.

In the 1990s, a voucher system and tax deductions were introduced for eldercare-related jobs. The PSD allowance (*Prestation Spécifique Dépendance*) that was related to both income and level of fortune was introduced in 1997 for the age group 60+. In 2002, it was replaced by the APA allowance (*Allocation Personnalisée d'Autonomie)*, which is a social assistance scheme managed at the local level (*département*), guaranteeing similar benefits everywhere in the country. Eligibility for the allowance, as well as its amount, is based on dependency criteria defined in a national grid. In one sense the benefits can be considered universal as they are not connected to former work-life positions and work-life-related insurance,[10] even if the amount is related to the level of income. The APA allowance can only be used to buy home services or to pay for special housing. It may be used for paying family providers of care, except the spouse who is considered as having an obligation of care for the dependent partner. However, as will be pointed out below, the principle of *cash-for-care* still means extensive family involvement, as actual carers as well as of organisers of care and services for the dependent old person.

Distributions of costs

Social services in Sweden are mainly tax-financed (80% paid by local taxes and 16% by state grants) and only a minor part (4 %) of the cost for eldercare is covered by fees paid by the recipients themselves. In the 1990s, as a consequence of the economic situation, the level of fees increased and in order to ensure equal access for all, a law was implemented in 2002 stating that all elderly persons must have a fixed sum at their disposal every month after having paid fees for care. The aim was to protect care recipients with low pensions from excessive fees. Between 2002 and 2005, the rate of care recipients paying no fees at all increased from 14 to 30 percent (Care of the Elderly in Sweden Today 2007).

Swedish eldercare is traditionally publicly organised and financed but since the 1990s the rate of other providers is increasing and help bought from the market is becoming more common (Szebehely 1995, 1998a, 1998b, 2000). In 2006, 11% was privately organised, although it is still publicly financed (Socialstyrelsen 2007). In 2007, tax deduction for costs of various kinds of home services, including services and help for elderly persons, was introduced (Regeringens proposition 2006/07:94). As in France, this reform is part of a wider employment policy.

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financed in which benefits are calculated on the bases of a point system ensuring close links between contributions and benefits.

[9] Mutual benefit organisations, "mutuelles", supplement the national health care system and reimburse part of the medical expenses that are not met by the national health insurance. Most of them provide services and accommodation for dependent elderly members and thus contribute to the elder care system.

[10] A clause in the PSD benefit concerning the possibility for the state to reclaim some of the costs on the recipient's legacy was removed in the APA.

In France, more sectors contribute to the financing of care of the elderly (see note 8 and 9). The idea behind providing dependent elderly with a cash benefit was to allow them to choose the type of care according to their preferences. The idea of promoting "freedom of choice" in eldercare as well as in childcare is in line with care policies in corporate welfare states. Promoting care services for elderly was also part of an employment strategy. During the last decade, the number of employees in human services (*services aux personnes*[11]) has doubled and is expected to increase in the future. This strategy has been encouraged by the introduction of a voucher system (*Chèques emploi service* and *Titre emploi service*). Recently, the system has become simplified by the introduction of a universal voucher system (*Chèque Emploi Service Universel, CESU)*. In 2006, 1.9 million used CESU to pay for such services from private employers (Chol 2008). Adjerad (2005) reports that 55 percent of all privately paid domestic services involve assistance for the elderly (including housework).

The local organisation of eldercare

In *Sweden*, the care of elderly is a decentralised social service and the organisation is much dependent on local municipal socio-political traditions, economic and political contexts (Trydegård 2000, Runesson and Eliasson-Lappalainen 2000). There are large differences in the expenditure per capita for eldercare between municipalities, especially with regard to eldercare services for those living in regular housing. The interpretations of the national frame laws made by the municipal social welfare board which is lied down in local goals and regulations and the actual implementation of these made by the administrators who work with eldercare in their daily life all influence the eldercare experienced by those in need of care and support (Thorslund 2002).

The home help organisation started to develop in the 1950s and was initially run by voluntary organisations, but the activities were successively taken over and expanded by the municipalities. The aim was to limit the number of old people's homes (residential homes) which carried heavy connotations of poverty and class differences. The first earmarked state grant introduced in the mid-1960s aimed at expanding the home help services for elderly. The home help organisation implied that everyone irrespective of social background would have the possibility to continue to live in their own homes (ibid.).

According to Szebehely (1995), home help was organised in a traditional way until the 1980s – the old person had access to a certain amount of home help according to a decision taken by the care manager. The help was delivered by the same home helper, at the same hour, week after week. It was organised in a non-bureaucratic way and was easily adjusted to the old person's needs. What was to be done was decided between the old person and the home helper. Difficulties in staff recruitment and the fear of growing economic costs led to changes in its organisation. In the 1970s, the work became organised more in line with a Taylorist division of labour. At the same time, services houses for elderly were

[11] The content of human services (childcare, eldercare and home help) has been extended by law from July 2005 to include activities related to e.g. extra teaching or computer aid delivered at home.

being built with the intention of economising the home help system. Since the 1980s, rationalisation continued and the economic efficiency of the public sector became focus of the political discourse.

The municipalities currently provide elderly with *home help*, which includes social services such as cleaning, washing, shopping etc. as well as social care which refers to satisfying the emotional and physical needs of old persons. They also offer *special housing* for those who have difficulties living by themselves. Further, *home medical services, meals on wheels, personal safety alarms, home adaptations* and *transportation services* are arranged. The municipalities are responsible for measures directed to relatives, such as *benefits for relatives giving home medical care and care allowances for home care*, while *economic benefits for family care providers* are handled by the local social insurance office. The municipalities further organise different kinds of *relief for relatives, short-term care* and *daily activities for elderly*.

In 2006, the rate of elderly in the age group 65–79 with public home help living in regular housing amounted to 3 percent compared to 21 percent among persons aged 80 or older. Since the year 2000, a slight decrease has taken place among the age group 65–79 while there has been an increase among those aged 80 or over. The total number of home help hours has risen by 21 percent since 2000. In 2006, in addition to 140,300 persons living in regular housing receiving home help, another 98,600 were living in special housing. The number of elderly living in special housing has fallen by 19,700 persons since 2000, which means a decrease from 8 to 6 percent; among the 80+ age group the rate decreased from 20 to 16 percent. Seventy percent of those living in special housing are women. In 2006, 14 percent of special housing was run by private companies compared to 11 percent in 2000 (Socialstyrelsen 2007).

In *France* too, the implementation of public eldercare relies on the local level (*département*). However, the state decides a national rate of benefits and allowances which are applied all over the country, so it could be said that the decentralisation above all refers to the management of the elderly policy. Over the last decade, the sector of eldercare has been structured around approved organisations playing a major role for supplying and improving the professional organisation of the carers. Organisations intervening in the sector are mainly non-profit organisations: associations (83%) and municipal centres for social assistance (12%). Private enterprises are increasingly operating in the sector of eldercare (5%): their number increased from 85 to 2774 between 1999 and 2006 but they delivered only 5 percent of the number of worked hours in the whole sector of human services. A law introduced in 2004 allows enterprises to act as proxy between individual employers that are recipients of care services and care providers. Thirty-five percent of the activity of private enterprises operating in the sector of human services concerns care and services for dependent elderly persons (Chol 2008).

In 2008, one million dependent people were dependent on the APA benefit, 62 percent of them continue to live in their homes while 38 percent are

accommodated in special housing (in this case the benefit is delivered to the establishment) (Espagnol et al. 2008).[12]

Assessment procedure and access to help

The evaluation process of an old person's needs is crucial for access to help and support. The procedure differs greatly between the two countries and builds on two different principles. In Sweden, access to public home help is based on the elderly person's *expressed needs*, which are assessed by a care manager working at the municipal social welfare office. The role of the care manager is acknowledged as crucial and complex (Dunér 2005). As "street level bureaucrats" (Lipsky 1980) they are in direct contact with the elderly and are the actor that takes the actual decisions about the amount and kind of care and services that are to be offered. As the municipal representative the care manager is also the actor whom most elderly confront as they experience need and apply for care and services. The meetings take the form of a face-to-face situation, sometimes at the hospital, but mostly (either as a first meeting or as a part of a follow-up process) in the home of the elderly. It is during these meetings that the care manager tries to get a picture of the elderly person's actual needs.

It is the *expressed needs* of the elderly person that are in focus for the care manager's assessment. The care managers develop different strategies to handle their complex work situations, involving formal and informal guidelines within the municipality – connected to financial frameworks, a work ethos (norms and values connected to the actual role of the care manager), the actual need of the elderly person expressed in applications and meetings, the "pressure" from relatives and other actors close to the elderly person, and (more vaguely and indirect) societal norms and values regarding the situation of elderly people (rights, standard of living etc.) partly expressed by the law text. Sometimes relatives may have other wishes than the elderly person. The interviews with the care managers indicated that children sometimes pushed for special housing while the care managers gave priority to the wishes of the elderly persons and instead provided them with more home help.

In France the need for support is considered not so much in terms of the elderly person's own expressed needs, but rather from the *medical* standpoint of the degree of dependence. The French approach towards elderly persons was initially medical, but social considerations are being progressively taken into account. Elderly persons' dependency has long been treated in the same way as that of disabled persons, until the introduction of the PSD allowance in 1997 which made a break with the medical idea of dependency (Bigot and Rivard 2003) and introduced a distinction between elderly persons' dependence and that of adult (but not aged) persons with disabilities (Ennuyer 2003). However, in practice medical ideas are still prevalent in eldercare (as well as in childcare).

[12] According to Espagnol et al. (2008), the APA benefit covers on average 67 percent of the dependence expenses for people living in establishments.

The APA allowance is allocated after an evaluation of the dependence of the elderly person, which is defined by the law[13] according to "the need for help to carry out the essential acts of everyday life or to be watched over regularly" and is measured with a national grid called AGGIR (*Autonomie Gérontologie Groupe Iso Resources*: Autonomy, Gerontology, Iso Resources Group)[14]. Ennuyer (ibid.) notes that it is more oriented towards "what the person is not able to do" than to support his or her autonomy. So it is basically a medical judgement measuring such things as ability to move and the like. If the elderly persons are without economic means, dependence of level 5 and 6 entitles them to social assistance paid by the local authority (*département*).

The old person sends the application or a request (with an attestation by his/her doctor) to the local authority. The request is examined by administrative staff who can reject it. If not, it is examined by socio-medical staff and one of them (in our case study only doctors made the examination) visits the old person to specify the level of dependency and the rate of APA. Then a qualified social worker from the local authority goes to the elderly person's home and draws up a "care plan". This plan combines three types of help: housework, personal services (washing, dressing) and technical equipment (wheelchair or bed, for example) (Campéon and Le Bihan 2006). The social worker provides the old person with the addresses of persons and organisations providing services and/or care, very often non-profit organisations but nowadays also for-profit organisations. Many municipalities offer some services such as home help and delivery of meals and the charges are related to the person's resources. Along with the principle of "freedom of choice" it is up to the old person to choose the provider and contact him. The French case study pointed to difficulties for the elderly and their relatives to understand and manage the procedure.

Available services are not always adjusted to the needs and often not implemented in phase with the elderly person's needs. Needs of sociability are not taken into account and the interviews indicate that there are dependent elderly persons who would live in social isolation in their own homes if they did not have a family or a network of friends that could satisfy their social needs.

As we noted above, in Sweden there is usually *one* person – the care manager – that the elderly person turns to with his/her application and for discussions about personal needs and the like. In France, this stage is often delicate for the elderly persons and their entourage. Some of the elderly persons had difficulties establishing contacts with the social worker that was in charge as she was only available one half-day a month and could only be met by appointment the rest of the time. To have adjustments made in the house often takes a long time and involves several steps and problems regarding transmittance of adequate information between the involved parties. Adjustments of flats and houses as well as the provision of personal assistance are not effected until all the steps in the

[13] Law 2001:647, 20 July 2001.

[14] This grid has been used all over the country since 1997 to evaluate the loss of autonomy among persons aged 60+. It defines six levels of dependency and determines the services and financial support related to each. The applications for the allowance for autonomy are received for the four most severe levels (1 to 4).

decision process are completed. Meanwhile, the elderly and their relatives have to find their own solutions. In the region concerned, it usually takes up to two months and often much longer. The slow process obliges families to set up (on their own expense) an assistance system and make adjustments in the house before the APA-plan is implemented. Nor are there any emergency procedures, although these might exist in other regions. And if temporary housing as a relief measure for relatives exists, the fee is very high, and not accessible for low-income families.[15]

The system of *cash for care* means that benefits in the form of vouchers or tax deductions can be used to pay for care and services bought from different providers. It seems to be difficult for the elderly persons and their relatives to comprehend as they have to orientate themselves among several actors. In order to face it, municipal centres for information and coordination (CLIC – *Centre local d'information et de coordination*) were established in 2001 to help with information about all the dimensions of elderly care. Sometimes the elderly person is assisted by a social worker to arrange care and services, but family members or friends play the most crucial role in the organisation of care and services in everyday life. From a Swedish point of view, the French system of eldercare is fragmented in provision as well as in financing.

Sweden has a comparatively transparent system which has been functioning since the 1960s. The existence of the local social welfare office and the role of the care manager are well-known to the public. Rather vague national frame laws might lead to different implementation at the local level and municipal decisions can be contested. Until the 1990s, only public providers existed, and although public and private providers coexist today, the assessment of needs is always made by care managers at the local social welfare office. There is printed information and information is also available on websites published by the National Board of Health and Welfare, by the Swedish Association of Local Authorities and Regions as well as by individual municipalities. The more uniform organisation of eldercare as well as a relatively limited number of actors facilitates the contacts between eldercare and the elderly persons.

Most of the interviewed Swedish elderly persons came in contact with the eldercare system after being hospitalised or being ill. The route to home help thus often goes through the medical system. A care plan for the old person is then made already at the hospital with the attendance of a care manager, an occupational and/or physical therapist as well as adult children or other relatives. In those cases, available care and services are presented personally to the old person and their relatives. Some of the interviewed elderly persons had been informed about available support on the initiative of the care managers who contacted them due to their high age. Others were already familiar with the system as their spouses were receiving or had previously received home help. A few of the elderly French persons had likewise been frequently helped to apply for the APA allowance while hospitalised, but the initiative was more often taken by

[15] Temporary housing or rehabilitation centres exist for post-medical treatment and the fee is then covered by the medical insurance.

adult children, nieces or friends. And the coordination between hospital and/or rehabilitation centre and the implementation of the APA care plan was an exception.

Recent changes in the organisation of eldercare – implications for the elderly

According to Esping-Andersen's welfare regime typology, the role of the state is crucial for the provision of welfare. Following Daly and Lewis (2000), analytical schemes asking questions about more or less state measures help to identify changes in the organisation of social care and the relationships between caregivers and care recipients. The historical background of welfare systems also means different attitudes towards state responsibility and intervention and involves different patterns of values and norms related to family responsibilities and gender roles. Western European welfare states are in different stages of the "defamilialisation" process, i.e. to what extent it is becoming legitimate to externalise caring functions traditionally confined to the family and women (Lister 1990).

Defamilialisation – refamilialisation?

In Sweden, the defamilialisation process related to eldercare started in the 1950/60s and all formal obligations between family members have been removed first from the poor law and later from the civil law. The removal implied a change in the relationship between the individual and the state (Antman 1996). However, some obligations still exist between spouses according to the marriage law. The idea of defamilialisation of social services within eldercare (as well as childcare) is still prevalent and implies that the responsibility for the care of elderly persons rests upon public authorities, and it means that individuals have the right to public help and support and that the costs are covered by taxes. The national action plan for eldercare from 1998 underlines that eldercare should be publicly financed, with equal access to all citizens and available according to needs rather than purchasing power (Regeringens proposition 1997/98:113).

However, contrary to the goals of the national action plan, which also stated that consideration should only be shown to the individual and not to the family when deciding about care and support, recent studies point to an increasing amount of help and support being performed by family members (Szebehely 1998b, 2000, Sand 2004, Rauch 2007). Further, a study conducted by the National Board of Health and Welfare on home help in ordinary housing also showed that the economic situation of the elderly is taken into account and an increasing number are buying help from the market (Socialstyrelsen 2004). During the last fifteen years, the availability of family help as well as the elderly person's economic situation has had an impact on the public help that elderly persons have access to.

Another Swedish national survey of the change within eldercare between 1988/89 and 2004/05 points to the increasing amount of informal help given especially to low-educated elderly persons (Szebehely and Ullmanen 2008). The

increase of informal help and support from family members implies a change in public eldercare policy. Starting in the 1950/60s, the care of old persons in their own homes was prioritised at the same time as the number of places in special housing was reduced. Consequently, the number of persons in need of extensive care and services living in their own homes increased and home help became more and more targeted. The targeting to those in need of most help made less home help available for groups of elderly with less acute needs. As a consequence the latter group has increasingly become reliant on informal help or help bought from the market.

Simultaneously, budgetary restrictions led to a decrease in the number of places in hospitals and the number of days that patients spend in hospital. At the same time, the number of persons over 80 increased by 22 percent from 1992 until 2003 (Larsson and Szebehely 2006). Thus a large number of elderly persons with care, service and medical needs of help continue living in their own homes, with consequences for the home helpers' working conditions and the home medical help organisation.

In France, it was not until the post-war period that the eldercare started to become institutionalised though the introduction of social security benefits and an old age pension. Traditionally, the responsibility for the care of frail elderly is shared between public providers, the insurance system, the social economy and the family. The vision for universal public actions for the elderly formulated in the Laroque Report in the 1960s was not realised until the end of the 1990s. In the APA law from 2001, the care of the elderly is for the first time formulated as a universal right eligible to those in need of practical help with their everyday life, without any considerations for their own economic means. But the amount of the APA allocation is related to their income. The system builds on the elderly persons' own choice of providers and of living in their own homes or in special housing. To conclude, the APA is a right for everyone, wherever the person chooses to live, but the amount of the allowance is income-related according to a national income scale.

Although the APA benefit implies a universal support system, the care of the elderly is not yet fully individualised or defamilialised (Lister 1990) The civil law still prescribes intergenerational obligations according to a complicated system specifying the obligations between parents and adult children, young children and grandparents (Weber 2006).

Since the 1990s, the role of the state has decreased in Sweden while it increased in France at the same time as the family continues to play a crucial role. The introduction of the APA allowance did not decrease the support given by family members: the time of care provided by the family (mainly women) is twice as much as the care provided by professional home helpers (Rivard 2006). In 2006, the Family Conference (*Conférence de la Famille*) proposed measures supporting family carers, which are progressively being implemented; e.g. a three-month leave to care for a family member and a legal status for family carers since April 2007. The focus of the Family Conference is on family solidarity and how it may be better recognised. The government suggested that family carers should be better supported because of their contribution to reinforcing bonds between

generations. Since January 2007, family carers of old dependent relatives or disabled adults are eligible for three months of "family support leave" that can be extended up to one year. The employer cannot refuse such a request. Although the leave is unpaid, recipients are entitled to pension rights. Additionally, family carers can validate their care experience as "professional experience", allowing them to shift towards social care jobs.

Since the late 1990s, the Swedish government has given economic priority to opening and developing of centres for relatives/meeting points, to establish positions for staff responsible for the support of relatives, to improved organisations and information as well as to increased access to supportive measures such as day activities and short-term housing, while economic support (as a replacement for labour market participation) to those who themselves care for a relative has decreased over time (Care of the Elderly Today 2006).

A comparison of the development in the two countries indicates that de-familialisation is still a cornerstone of the Swedish public eldercare policy while in practice trends towards refamilialisation or at least informalisation can be noticed. In France, the public eldercare policy supports defamilisation to some extent through the APA system, at the same time as the role of the family is supported both institutionally and economically.

Marketisation

In France, public help for the elderly is organised as *cash for care*, i.e. help for the care of the elderly is supported either with cash benefits or as tax deductions for buying human services from different kind of providers. The supply of paid services is organised along two modes. The most widely used is a direct relationship between the elderly and the employed person who cares for his/her needs. In the second one, care and services are delivered by organisations, traditionally associations or public providers such as the municipal social welfare office *(Centre Communal d'Action Sociale* – CCAS). Since 1996, also private companies delivering human services are allowed, and although their numbers are still limited it should be noted that there has been a sharp increase since 2005.

The human service sector has developed since the end of the 1980s after being included as a part of the French employment strategy. The introduction of *Chèque Emploi Service* followed by *CESU (Chèque Emploi Service Universel)* strongly contributed to the development of the market for human service jobs. The organisation of care for the elderly has taken new forms, and nowadays eldercare appears on a market consisting of several different kind of actors providing human services. The future does not seem to be bright for associations that are not getting involved in this logic of the market.

The French situation can be described as a care system that is very much organised along market principles at the same time as it is controlled by rules and regulations laid down by the state. The system of *cash for care* is very clearly related to a labour market made up of staff with low qualifications having to put up with poor working conditions. Recently, quality issues in the human service sector have started to be discussed. The law on social and socio-medical actions from January 2002 draws further attention to quality issues. Also the national

agency for human services (*Agence Nationale des Services à la Personne*, ANSP), has paid attention to the low level of qualification among the employees and to the fact that there is no control of persons who are directly employed by the elderly persons, which forms the bulk of these new jobs (CERC, 2008, pp. 87, 90).

In Sweden, the main trend is rather towards *informalisation* and *re-familialisation* (Szebehely, 1998) as *marketisation* of human services through the introduction of private providers into the system is still limited but also comes under the public control of the eldercare system. Although private providers account for 11 percent of eldercare, it is still the municipality that is responsible for the quality and the control of it. Private providers have to follow the same rules and regulations as public providers. However, the reliance on the market has increased among groups of elderly persons other than those targeted as most in need of care and services.

A summary of the development in the two countries shows that marketisation of eldercare plays an important role in French eldercare policy, partly because it is incorporated in a more general labour market strategy, while in Sweden marketisation is still relatively limited and is subject to public control.

The implementation of eldercare: social and gendered differentiations

Most of the old persons who were interviewed in France and Sweden seemed to be surrounded by their families. Nevertheless, in France the family plays a much more crucial and necessary role during the whole process of becoming dependent, while in Sweden the family could rather be seen as something extra, a "plus" in this process. In spite of the fact that adult children attended the "care plan meetings", it was the elderly person's needs and not the family's needs that were in focus. A look into the everyday life of elderly persons in France showed that adult children, relatives and friends provided more practical help to the elderly persons. In fact, none of the elderly persons in Sweden who lived by themselves came close to the problems experienced by the elderly persons in everyday life in France. The French system seems to function properly towards elderly living alone and in need of help only if they are supported by relatives or families. And this kind of inequality is further aggravated by the fact that elderly persons possess different amounts of social capital as well as economic capital. Those who have difficulties in managing everyday life without help from outside, and who have not yet received help, will have to pay for private help until the APA application procedure is finished (which works slowly) or when they are not eligible according to criteria for the APA allowance. The social differentiation found among the French interviewees is further strengthened by social norms among old women of working-class background who take a pride in managing by themselves and thus do not ask for support.

Such differentiations are also gendered, and it is mostly females who provide help to dependent elderly persons: above all spouses but also daughter, nieces, granddaughters etc. To take the responsibility for care in the family is often seen as "natural" among females and their entourage, i.e. among family members as well as among professionals. Women of older generations who did not work

outside their home do not seldom experience it as an encroachment on their lives when others have to help them manage their daily domestic chores.

In Sweden differentiation along social and gender lines seems to be less pronounced. In Sweden, during the process of becoming dependent the elderly person is supported by the municipal welfare system through the care manager. The care manager assesses the needs, decides what kind of help the elderly person will receive and arranges for it to be implemented. The implementation of the help does not rely on the intervention of the entourage, in practice and also in principle, as it is the expressed needs of the elderly which should be taken into account by the care manager.

Moreover, increasing economic differentiation among the elderly during the 1990s was counteracted in 2002 by the introduction of a ceiling on the fees the elderly persons are charged. In Sweden, as in France, there is a difference between elderly persons with greater or lesser economic means; the former group is used to paying for services (primarily for cleaning and gardening) and continues to do so when getting older. Nor did they express any feelings of encroachment that they could not handle when receiving help from outside. Such feelings could be noticed among the French females from less affluent social classes in society, while more wealthy groups of women did not bring this up. Working-class women usually take charge of as well as perform the actual help to the elderly person, while in more affluent families women rather take the role of an organiser of others helping the elderly person, in a way similar to that of the care manager in Sweden. And, according to Da Roit et al. (2007: 668), "the system has strengthened the role of informal carers as 'care managers'". In France this care package might consist of public help as well as of informal help and paid help.

In France there was a close relationship between the public help offered to elderly and the mobilisation of females especially in the old person's entourage. In Sweden, elderly persons seldom rely on family members or friends for practical help. However, informalisation of support for elderly parents is more common among low-educated families and as in France, more informal help seems to be given to females than to males. A Swedish national survey covering the 1990s and the beginning of the 21st century finds that informal help is significant, especially for low-educated elderly persons. The care gap is filled with the aid of relatives living outside the household, primarily by daughters and daughters-in-law, while the help provided by the spouse and by sons and sons-in-law remains the same (Szebehely and Ullmanen 2008).

In the Swedish case study, males in couples with a dependent wife often helped their spouses as a complement to public home help. They told us about how they did the shopping, cooking, the dishes and the laundry and the extra cleaning that was not included in the care plan. Many women in the Swedish case study used to have a paid job, which might mean that the old couples were more used to sharing household chores even before they got old. However, in couples where the woman had been a housewife, the old man also took more and more responsibility for the house when the spouse became ill or handicapped. The fact that the interviewed daughters, and most Swedish women in general in these age groups, were working might explain why family help is less gendered in Sweden.

The European comparative project SHARE found that it was quite common in France for an old dependent person to live with a child, while this seldom happens in Sweden. This was repeated in the French case study.[16] When elderly people live alone, "help at a distance" is more often offered by a family member or by friends and neighbours in Sweden (42%) than in France (26%). Intergenerational cohabitation hardly exists in Sweden, and the loneliness following on widowhood or divorces is compensated by "help at a distance". In France, almost half of daughters of lone parents compared to one in four sons reported that they helped their single parent at a distance, while in Sweden the figures for sons were close to those for daughters (Fontaine, Gramain and Wittwer 2007:105).

In both case studies, we found a traditional gender division in the tasks that adult children help their parents with; sons take care of the garden, help to repair things in the house, take care of financial issues and the like, while daughters help to buy clothes and do other kinds of shopping as well as taking care of the laundry and preparing meals.

We also found that the gender differentiation is less marked in Sweden than in France, especially among couples. Most of the interviewed Swedish couples remained living in their homes and managed with the public home help irrespective of whether it was the male or the female who became dependent. In contrast, in France, whether or not to stay living in their own home was very much dependent on whether it was the male or the female who became dependent. The spouse more often took care of a dependent male than vice versa. Also when males received help to care for their spouses, they often reported difficulties in taking care of the house and as a solution both of them moved to special housing. Elderly Swedish men seem more capable of managing daily household chores such as shopping, cooking and cleaning in addition to the professional help from the home help organisation.

Who helps whom with what and under what conditions?

Following Rainwater et al. (1986), claims for support from the state or the public system are based on needs and build on the presumption that society has a moral obligation to support its elderly members. The logic is embedded in legislation and social policy. The logic differs from claims made within the family or towards the market. Claims on the family build on filial obligations, emotions, blood relationships, social customs etc and are negotiated in a personal manner. Claims on the market are based on economic principles, i.e. help is given as long as it is paid for.

According to the Swedish welfare tradition, access to public support is based on needs, and no consideration should be given to the extent to which help could be claimed from the family or to the elderly person's own economic resources. The claims towards the public system come as rights, and according to the official

[16] The French case study revealed several examples: one man lived with his brother and had difficulties after his death, two sisters were living together and a woman was living with and caring for three dependent relatives – her mother and her uncle and aunt.

eldercare policy expressed in frame laws it should be individual and be provided to those in need and without consideration for purchasing power. However, the rather vague formulations in the national frame laws supplemented by municipal policies for provision of eldercare open up for "considerable discretion as regards their (municipalities) admission procedures. Thus discretion allowed them to apply criteria of physical and practical needs but also financial and family related criteria to exclude service applicants from admission. Furthermore, the lack of expansion rules granted municipalities the autonomy to decide over the pace of service expansion" (Rauch 2006:294). Recent studies of eldercare point to trends counteracting the goals of the official eldercare policy: e.g. that ideas of gender roles have an impact on the access to eldercare; having a daughter living nearby is sometimes included in the assessments made by the care managers; women in the families are considered (Szebehely 2000, Sand 2004) and that the access to home help sometimes can be said to be means-tested as those with economic means are referred to market solutions (Szebehely 2000). These two trends of *informalisation* and *marketisation* are contradictory to the idea of universal access to social services which lies in the social democratic welfare regime and the idea that home help from the public system comes as an individual right. The decrease of assistance from the public eldercare organisation has led to increasing family support with implications for the relationship between elderly persons and their relatives. A survey made by the National Board of Health and Welfare finds that one in ten women want to be helped by a relative to take showers, while one third of them actually are helped this way, and although only one in ten women want to get help with the laundry from a relative half of them actually do (quoted from Szebehely and Ullmanen 2008). The goal of integrity, which is a cornerstone in the Swedish public eldercare policy, is thus not fulfilled for large groups of elderly people.

In France, despite the increasing responsibility taken by the state since the end of the 1990s and especially since the introduction of the APA allowance, the main responsibility for the care of the elderly still lies with the family. The public system contributes in a universal way to cover the costs through the APA system for the payment for help from a range of different providers, while it still mostly relies on the family to arrange access to public help, to coordinate the help from different providers – public and private – and to compensate for the deficiencies of public help (practically and financially).

According to Rainwater et al. (1986), there is a clear difference between the two countries with regard to where the claims for eldercare are directed and discussed in society. In France the main claims are directed towards the family. Although claims towards the family are increasing in Sweden, they differ from the claims directed to the family in France as here they rather take the form of obligations for family members according to civil law and are supported ideologically and institutionally at the political level and are not mainly the result of insufficient resources.

The construction of support for eldercare as a system of *cash-for-care* gives the market a more prominent position in France than in Sweden, where help from the market is still publicly controlled with regard to costs and quality. Private

companies work under fixed rules and still make up a minor part of eldercare providers. In France, eldercare is organised according to market principles and human services are bought from the market from different providers at different prices and of varied quality. The logic behind the market is that you can only claim a service as long as it is paid for, whether it is privately or publicly paid.

The market principle leads in reality to large variations in price and quality. Besides, the number of institutions offering special housing at a price corresponding to public institutions is limited. Public economic support can also be used to employ a helper in the home of the elderly, employment which is outside of any kind of control. The principle of “free choice” actually increases inequalities in access to human services of high quality.

As previously pointed out, results from a range of studies show that universal access to eldercare can be questioned in Sweden and that the differences between discretion for admission between municipalities, considerations shown to the family and the economic means of the individual elderly person lead to a situation which presents some similarities to the French situation. In our case studies of the trajectory of becoming dependent as a process, however, we found that there are still large differences between the two countries; at the policy level as well as at the everyday level as reported by the elderly persons in Sweden and France. The claims on the public system are still experienced as rights that are related to the individual, most clearly expressed by adult children and as expectations with gratitude among the old persons in Sweden, while in France, the claims of necessity have to be directed to the family as the public system is difficult to comprehend for both the elderly and their relatives and covers only part of the needs. The interviews show that family members in France take responsibility for the actual help as well as for the coordination of different actors on the human service market, being paid by public allowances or from private pockets. According to our findings, being old, living alone, being a woman and of working-class background still have different implications in the two countries, but these differentiations are much larger in France than in Sweden.

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