The professionalisation of domiciliary elderly care in Belgium between public and private services

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Abstract

Since the 1990s, and even more intensively after the last State reform in 2014, reforms of the elderly care system in Belgium have increasingly given priority to home-care services, rather than residential services. At the same time, the Belgian elderly care system has been subject to a process of marketisation and privatisation of services. Both trends, which are commonly indicated as responses to the wish to offer 'free choice' to care receivers, have required the elaboration of different strategies aimed to professionalise home care services.

In this paper, I discuss the difficulties linked to the professionalisation of home care work and I analyse how the professionalisation of home care services for the elderly is achieved in the public and private sector in the Brussels' region. The objective is to highlight the differences in the way public and private providers construct the professionalisation of home care and to discuss the consequences that different forms of professionalisation have on elderly carers. The discussion is based on the analysis of the most recent reforms of the elderly care system in Belgium and of a series of interviews with care providers in Brussels.

The analysis shows that there is no agreement over the best way of professionalising home care services for the elderly and that the efforts made by public and private providers are profoundly different. In the public sector, the professionalisation is realised through a (over)regulation and monitoring of services. The strict definition of job descriptions (time schedules, tasks, etc.) and of the qualifications and professional trainings required to perform elderly care work are meant to ensure a high level of quality of services and of jobs in the sector. On the contrary, the private sector tends to de-regulate services in all the above-mentioned aspects (time schedules, tasks and qualification of workers). In this case, the professionalisation is more oriented towards the care recipient and is meant to ensure flexibility and to reinforce a family-like model of home care.

Introduction

The concept of 'professionalisation' has been used in sociology in a number of different – and sometimes contradictory – ways. In a broad sense, professionalisation can be associated to a behaviour opposite to amateurship, to denote expertise and qualifications, or to make a

distinction between paid labour market activities and unpaid voluntary or informal activities. Focusing more strictly on the official labour market, it can be used to define certain occupational groups, which are recognised as 'real' professions, often through a system of qualifications, in opposition to jobs with semi-professional or non-professional status (Abbott and Meerabeau, 1998). Leaving aside the formal recognition of 'professionals', which also depends on the contextual regulations of labour markets, professionalisation is often linked to the question of the valorisation and recognition of the work as 'real work' (Ribault, 2008: 103). According to Aballea (2005), a profession exists when its activities are based on a qualification – meaning an established and validated knowledge –, on a deontology – meaning recognised rules – and when it provides workers with a distinctive title and status. Thus, professionalisation can be analysed in terms of the status of the job, in terms of the qualifications and competencies required to perform the work (Clergeau and Dusset, 2005), and in terms of the working conditions, including the monetary reward (Abbott and Meerabeau, 1998).

The question of professionalisation is particularly controversial in the field of home-care services – be that for children, elderly or other dependant people – because of the specific features associated to the notion of 'caring' and because of the private nature of the caring relationship (Clergeau and Dusset, 2005; Puissant, 2011). Analysing the professionalisation of domiciliary care requires to tackle the traditional dichotomies between productive / reproductive labour, private / public sphere and paid / unpaid work (Anderson, 2000; Theobald, 2003; Lutz, 2010; Weicht, 2015, among others). First, due to the prevalence in the past of informal family care – mainly provided by female family members – within the households, care work is still strongly associated with female reproductive labour and constructed as a 'natural' attitude of women (Ungerson, 2000: 636). The strengthening of formal home-care services requires the elaboration of practical, but also theoretical, solutions to a series of challenges, such as the blurred distinction between formal and family care and the emotional labour which is implicitly and explicitly demanded from carers. In other words, it requires to solve the dilemma of the social expectations linked to formal care work, which is expected to replace the caring role of the family with professionalised external services, while at the same time maintaining its domestic and familial nature. Second, the problems associated to the work in private settings – including the invisibility of the work and the lack of inspections of working conditions – make the professionalisation of home-care services particularly challenging (Lutz, 2008, 2010). Thus, the question of the valorisation and the recognition of care work as real work, especially when it is performed in private setting, and the recognition of which are the

required competencies and how they can be transposed into a professional status, is crucial in the definition of professionalisation of home care.

The strengthening of formal home-care services, as a relatively new solution offered to families, as well as the increased competition among care providers and the emergence of new private solutions in the market, are trends common to most European countries and have generated a debate on the professionalisation of home-care services (Theobald, 2003; Stolt et al., 2011; Bonnet, 2006; Bressé, 2003; Clergeau and Dussuet, 2005; Puissant, 2011). However, the heterogeneity of care receivers, of social expectations and of care providers make so that the job of elderly carers changes continuously and that a definition of what professional home-care means is still to be agreed upon (Bonnet, 2006).

Starting from the trends that are observable in all Western elderly care systems – and in particular the strengthening of formal home-care, the privatisation of services and the focus on the 'free choice' of care recipients – in this paper I discuss some of the problems linked to the professionalisation of home-care services for elderly people and I analyse how professionalisation is pursued in the public and the private sector in Belgium. The objective is to compare the way professionalisation of care work is built in the private and public sectors and to discuss some of the consequences that different types of professionalisation can have on elderly carers. The analysis is based on a series of in-depth interviews to elderly care providers in Brussels, which include both public and private providers, as well as public bodies in charge of the financing of home care.

Starting from the assumption that there is no unanimity on how professionalisation can be achieved, especially in the controversial case of home care, the arguments used by public and private care providers allow me to identify the elements that are deemed important in the process of professionalisation of care jobs and to analyse commonalities and differences in the way professionalisation is built. Finally, the findings allow me to discuss whether the instruments used to professionalise home care work contribute to solve, or on the contrary, to intensify, the main problems linked to this type of work, which have been thoroughly emphasised by the scholarship: namely, the strong association with the reproductive labour performed for free by women, the low value/reputation accorded to it, and the resulting overrepresentation of women and of migrants in care work (Rollins, 1985; Anderson, 2000; Cox, 2006; Lutz, 2010).

In the first part of the paper, I present a brief description of the elderly care sector in Belgium and of the most recent reforms that have been promoted starting from the 1980s. This section focuses on the way home-care services have been institutionally reinforced in recent years and

on the increased marketisation and privatisation of elderly care. In the second part of the paper, I discuss the issue of the professionalisation of home-care services and how it is achieved in the public and the private sectors. This section is constructed around the key arguments emphasised by public and private care providers as their efforts/instruments adopted to professionalise the sector. At the end of each thematic part, I discuss some of the consequences that these different forms of making 'professionalism' have on the work of elderly carers, with a focus on the reproduction of gender and racial stereotypes, as well as their working conditions. Finally, the main findings are discussed in the conclusion.

Home-care services in Belgium between public and private services

Since the development of its modern welfare state, the Belgian elderly care system has been founded on the close interconnection between the state and the family, while the role of the market has been initially less important, at least until the 1970s (Gilan and Nyssens, 2001). The state responsibility in the provision of elderly care services was predominantly directed towards the provision of residential services, mainly in the form of homes and geriatric hospitals, while home care was implicitly left to families. This implicit familialsm (Leitner, 2003) was based on the idea that the state would intervene when the care of family members in private settings was no longer sufficient and the placement in residential care was made necessary by medical or intensive care needs.

As in other Western European countries, the pressures made by demographic changes, by transformations in the labour market (i.e. the increased female participation rates in paid work), as well as by important changes in the way gender roles and the provision of care are conceived, paved the way to profound transformations of the elderly care sector. Among the most visible changes are the strengthening of home-care services, which in Belgium had had a more peripheral role compared to residential services, and the marketisation and privatisation of elderly care services. As elsewhere, both trends are linked to the wish to reduce public expenditures, on the one hand, and to grant care recipients a 'free choice', based on their assumed desire to remain in their home as long as possible, on the other (Rostgaard, 2007, for Denmark; Guo and Willner, 2017, Stolt et al., 2011, and Szebehely and Trydegard, 2012, for Sweden; Kröger and Leinonen, 2012, for Finland).

Starting from the 1980s and increasingly from the 2000s, the Belgian government introduced a series of reforms specifically encouraging the provision of home care. While formal home care services already existed before the 1980s and were already regulated through a system of subsidisation of mainly non-profit organisations, these services were not addressed specifically

to elderly people, but rather to families in need (Gilain and Nyssens, 2001). The state reform of the 1880, which transferred part of elderly care responsibilities from the Federal level to the Communities and the Regions, was accompanied by an increased use of home care services by elderly people, which reflected the changing demography in the country. The complete transfer of the responsibilities from the Federal to the Regional level in the field of domiciliary care, implemented with the last State reform in 2014, was accompanied by an explicit encouragement to promote public home care for the elderly. Today, the system of public subsidisation in the field of domiciliary care remains exclusively open to non-profit organisations, which are therefore the only care providers offering 'public' services. The regulation of the home care system, which had already started in the 1880s, includes a precise definition of the entitlements, the nature of the tasks to be performed, the number and the type of professionals involved in the care, as well as the price for care recipients, based on institutional ladders (De Donder et al., 2012).

While up to the 1880s the role of the market in the provision of care was almost non-existent, starting from the 1990s a number of private for-profit providers began to offer alternative options both in residential and home care. Today the privatisation of residential care is particularly visible, with private companies owning about 80% of residential facilities for elderly people (Infor-Homes, 2017). In the field of home care, the presence of private providers is less homogeneous and harder to identify, compared to that of residential care, due to the multiplicity of forms and types of services provided. Additionally, because of the system of subsidisation of non-profit organisations in the field of home care, the distinction between public and private home-care providers is not straightforward. In this paper, I will consider 'public' those non-profit organisations that have an institutional agreement – and a public funding – and thus are able to offer care recipients 'public prices' (that is, prices based on the recipient's income, according to the public ladder defined by the state). On the contrary, private care providers include all the other non-profit or for-profit organisations that do not have agreements with public bodies and do not receive public funding. This distinction, which is mirrored in the services and prices offered to care recipients, corresponds to the common understanding of public/private care for Belgians.

The professionalisation of home-care services in the public and private sectors

In this section I discuss the question of the professionalisation of home care services, by analysing the main arguments brought about by public and private providers offering home care services in the region of Brussels. The analysis is based on fifteen in-depth interviews with

public bodies in charge of subsidies for home care, associations providing services and counselling to families, trade unions, mutual health insurance, as well as public and private care providers in Brussels. The nine interviews with care providers (five with public and four with private providers) are treated with thematic analysis, as described by Ramos (2015).

The public care providers interviewed in the framework of this study include three municipal 'home care services for families', one 'coordination centre of domiciliary services', covering the 19 municipalities of Brussels, and an organisation subsidised via a programme of reintegration of long-term unemployed. All these providers offer prices calculated depending on the income of the care recipient and based on a common ladder, which vary from approximately 0.50 euros to 7.50 euros per hour. Apart from the services that require only household tasks, the entitlement of the care recipient is based on a medical assessment, which defines the type of care service and the approximate number of hours allocated to the beneficiary. Despite slight differences in the way institutional regulations are implemented, these care providers show homogeneous characteristics in terms of entitlements, allocation of services, types of services, as well as job descriptions and qualifications required for workers to do a particular job. Specifically, they distinguish care professions into nurses, health assistants (*aides-soignantes*), family assistants (*aides familiales*) and housework attendants (*aide-ménagères*) (Godard and Sammiez, 2007; De Donder et al., 2012). Care recipients are usually entitled to a limited number of hours per week, with services lasting between half an hour to three hours, usually between 8 am to 4 pm. Apart from specific exceptions, evenings, nights and weekends are not covered. Because they depend on public funding, they share the same mission, namely, to provide services to the largest possible share of the population and giving priority to those in financial or health need. Among the public providers, the only exception is represented by the non-profit organisation receiving public funding linked to unemployment. This organisation offers prices that vary from 3.5 to 7.5 euros, but is not bound to institutional regulations defining job descriptions, allocation and entitlements. This means that this organisation is the only 'public' care provider offering services longer than 3 hours, as well as night shifts.

The private care providers that accepted to be interviewed include two for-profit companies, offering general services of 'caregivers' (*garde-malade/dame de compagnie*), whose caregivers work under a status of self-employed; one for-profit organisation recruiting female workers in Romania (and occasionally in other Eastern European countries) and offering 24-hour live-in services; and finally one recently established online platform working under the legal framework of the 'collaborative economy, which allows private individuals to offer care

services (without any employment contract), in exchange of a non-taxable income, up to a certain amount per year. All of these services vary greatly in terms of prices, type of services provided, activities, as well as status of the workers, which reflects the diversity of private care providers in Brussels. Prices offered to care recipients are either calculated on an hourly basis (around 10 to 15 euros per hours), or based on flat rates (per night or per month). Although the employment of caregivers can take different forms (i.e. employee contract, self-employed, or specific contractual agreements for pensioners, unemployed or occasional workers), none of these providers is bounded to specific regulations in terms of qualification and trainings of care workers, definition of tasks, entitlements and activities performed.

What clearly emerges from the discourse of all care providers, be them public or private, is that professionalisation is acknowledged to be their primary goal. Both types of providers stress the importance of offering professional services that should guarantee a certain level of quality, while at the same time avoiding the risks associated with informal care work. According to both types of providers, the 'formality' of their services – which is represented by the legal framework under which they work – enables them to differentiate themselves from the informal work provided by family members, as well as from undeclared work. In this sense the conceptualisation of professional home care primarily refers to a simple externalisation of services that pertain to other spheres: the domestic and the informal (Ribault, 2008). However, while their distinctiveness with regards to undeclared work is repeatedly emphasised, the narrative of care providers shows that the distinction between professional work and family help is harder to delimitate.

As it will be discussed in the next sections, the strategies that they put in place to pursue the objective of professionalisation are considerably different and often based on dichotomous oppositions.

Division of tasks or polyvalence?

According to Belgian care providers, one of the main issues linked to the professionalisation of home care services concerns the division of tasks and the definition of job descriptions. Therefore, a first difference in the construction of professionalisation depends on whether home care providers should offer a variety of specific services, each of them focus on specific tasks, or whether they should provide more holistic services, aimed to cover the entire needs of frail elderly people. With this respect, public and private care providers show clear opposite views on professionalisation.

According to public providers, which are bound to institutional regulations, the clear repartition of tasks among different caregivers represents their main instrument of professionalisation and is beneficial for a series of reasons. First, it allows to differentiate professional services from the care of family members. While it is part of the nature of unpaid family help to be able to cover the entirety of the needs of the care recipients, the very nature of professional care workers is that they do not (Puissant, 2011).

The fact that each care worker is specialised in certain tasks and is not allowed to perform others is the main way to guarantee the professionalism, in that each care worker will be expert and fully responsible for his/her own task. This is necessary in order not only to guarantee high quality of services, but also to valorise the expertise and the competences of care workers, by avoiding that a qualified worker would be asked to perform lower-skilled tasks.

> *We remain very clear that there are specific competences and that polyvalence also kills the quality of the service that is offered. So, I'm not saying that we need 36000 people, but… I mean, the care assistant is not a nurse, it's not a family assistant, the family assistant is not a nurse, it's not a housework attendant, etc. And so I think that we must indeed be careful and continue in the specificities of each one, by strengthening competencies to provide a quality of services and a quality of life for the beneficiaries […]. I think that a person that does everything cannot do everything well, it's impossible (Public actor)*

The respect of the division of tasks is a way of protecting both caregivers and care receivers from potential risks and limit caregivers' activities to those covered by employment insurances.

> *The beneficiary has the right to ask whatever he wants. But, as professionals, we have to say that we can't, that it's not in our tasks. We cannot put the person in danger, and we cannot put in danger ourselves, because if anything happens, the sanction will be for us too. (Public actor).*

However, most public actors acknowledge that the division of tasks, as it is currently regulated by the state, may be little adapted to the needs of elderly people, and some situations may require overruling the law and do more than expected. This is usually considered a break of the rule that is necessary to respect the human dignity of the elderly person, but which must be framed as an exception, rather than the norm.

> *She is in her bed, she did diarrhoea everywhere, etc. We are not supposed to bath her […] The nurse comes in 5 hours: do we leave Madam like this? No, we act immediately […] Another example: a person who has a tracheotomy, so a tube here, to breath, eat, etc. […] often the tube gets clogged, but we cannot intervene […] But at the same time if we don't it can be considered 'failure to assist a person in danger'. […] So, we are*

faced to these situations and we don't have the right to intervene, but if we don't, the consequences can be dramatic. (Public actor).

In opposition to public actors, all private care providers consider the institutional regulation of tasks as a clear limitation: a limitation for the company, that has too stick to a series of constraints and is not free to provide adapted services, and a limitation for the elderly person, who needs more flexible services. The services proposed by private providers intend to offer a more holistic type of assistance, which according to them is better suited to accommodate the needs of frail elderly people. All private actors repeatedly emphasise the rigidity of public services, which are not only scarce and limited in terms of time, but also in terms of the actual activities that they are able to perform.

The people on the ground are generally great, they do this with a lot of heart. But they are blocked by the functioning of the organization. They have to say 'no' very very often […] So, it's little adapted. It's logic from the point of view of the organization, but from the point of view of the user it is not what really matters. […] Actually, they have eliminated the sense of mutual assistance, in order to meet the needs of the organization and to be more efficient. But no elderly person understands why they can do certain things and not others". (Private actor)

According to private providers, a high quality service is a service based on a sort of polyvalence of workers, who are able to adapt to the situation of the elderly person, which varies depending on the degree of dependence, but also on personal characteristics, and are not limited in their action. The real advantage they have compared to the public sector is that they have the freedom to offer what really matters to elderly people, just as a family member would do.

Here we can really do whatever we want […] because there are no rules. Actually it's not – how could I say ? – it's not recognised. So, this is an advantage compared to subsidised things (Private actor)
Of course, it is an asset to be able to be more flexible with this respect, to keep some freedom… this is really good. (Private provider)
They [the workers] can actually do everything… everything that a member of the family would do, without questioning themselves: "Am I allowed or not?" (Private provider)

According to private providers, the professionalisation of care work is based on the flexibility of services. They use the relative freedom they enjoy as private actors to offer services based on 'the sense of mutual assistance'. In this sense, they do not deny – but on the contrary, they encourage – the entanglement of formal home care services with family help and emphasise the intimate/familial nature of care work. According to them, this entanglement does not jeopardise

the professionality of their services, but simply readjust the focus on the care recipient, rather than the worker, who must adapt to the needs of the elderly person.

In some cases, institutional regulations are even feared by private providers, as unwelcome constraints that may limit their freedom of action and thus the provision of high-quality services:

> *Concerning legislation… for the moment there is not a lot of it. So, we are still quite free. But the day it will be regulated, I don't know if I will still be able to offer this type of service, whether we will still be legal… because, well, we won't be allowed to do this, to do that […]. By dint of regulating, we would probably be denied the possibility to offer a quality service (Private actor).*

Overall, the opposition of public and private care providers over the question of polyvalence shows two opposite intents, as well as two distinct understanding of home care work. On the one hand, while the emphasis on the division of tasks proposed by public actors ultimately aims to valorise the work of caregivers, the emphasis on the polyvalence of caregivers proposed by private providers is entirely tailored to the care recipient. On the other hand, while public providers consider the division of tasks the main instrument to distinguish professional services from family care, private providers conceive professional home care services as an extension of domestic help.

The question of continuity

The second point stressed by care providers with respect to the professionalisation of home care concerns the question of the continuity of services. As it emerges from the narratives, the continuity in the provision of home care refers both to the personnel and to the time intensity. In the first case, and in line with traditional family obligations, the focus is placed on the belief that the elderly person needs to be attended to by someone of trust – ideally only one person – who becomes then an 'external member of the family', or a 'professional stranger' (Weicht, 2015: 51). In the second case – and linked to the issue of the polyvalence of workers and the ability to provide comprehensive services – the emphasis is placed on the intensity of care, in terms of hours provided.

Both types of continuity are considered by private care providers as crucial in order to provide a professional and adapted service to care recipients. In some cases, they use the continuity in terms of personnel and the provision of long-lasting services as their main strategy to differentiate themselves from public home care services.

Some services are a lot cheaper than ours, but they do not offer the option to have always the same person. [Sending the same person] is our calling card. If I can't guarantee this, I refuse. […] It is what we guarantee. Since my workers are self-employed, they don't have limits in the number of hours […]. (Private actor)

In line with the traditional home care provided within the family, this responds to the natural wish of the care recipient and is considered a factor contributing to the high quality of services, as well as to his/her well-being.

It's crucial! When you have someone with Alzheimer, who is already troubled in his/her sense of time and in his/her reference points… if you send someone different every two days… […] And then it is a comfort for the patient and for the family, to know those with whom they have to do. (Private actor)

According to private providers, care needs must be ensured with continuity, in an optic of family help. Also in this case, the professionalisation is built around the reinforcement of family-like relationships, considered as the core feature of home care, and services tend to be situated between external and family help. One of the strongest advantages they claim over public services is precisely to be able to guarantee a service which is both professional and based on a family model.

Apart from responding to the natural wish of the elderly person, assigning the same person to the same care recipient can be an advantage also from the point of view of the company.

And then I have less troubles if I send the same person, compared to sending 5 different people in one week… that would mean 5 different problems to manage. If I assign only one person for 5 days, it's a lot easier for everybody. (Private actor)

However, even if the continuity is always acknowledged as the ideal, some private care providers intentionally decide not to comply with this request, because the turnover of caregivers can have advantages in terms of the quality of services. First, because it allows to have a feedback on the caregiver and to control his/her work; and second, because working with more than one care recipient protects the caregiver against the risk of unemployment, which represents one of the major risks for self-employed caregivers.

I find it better to have at least two people, or three, to… already, in order to replace her, to plan… But also to be sure that the work… if I send one person and that the family never says anything and that everything is fine, at the end I don't know exactly how that works […] Otherwise, the person does what she wants and sometimes I don't know what happens (Private actor)

Even for the caregiver, because it means that if she only has that person, the day this person is no longer there, she will lose her job… So, also because of this, I try to share beneficiaries with two or three workers. (Private actor)

Similarly, the continuity in terms of long-lasting services and the possibility to cover nights and weekends is considered by private providers an instrument to guarantee a high-quality service. In opposition to public services, which are not able to cover the entire needs of care recipients, public providers organise their services so to ensure the longest possible care of care recipients, up to 24 hours. Again, the idea is to provide a service that can entirely replace family care.
Moreover, the provision of long shifts is also highlighted by private providers as an advantage for caregivers, who are often self-employed. Because their hourly pay is extremely low – between 9 and 10 euros before taxes, which corresponds to 5-6 euros net – they need to work long hours to supplement their wages.

According to public care providers, the continuity of services, be that in terms of personnel or time intensity, is not possible, mainly because of organisational constraints and of the employment regulations that fix the terms of their contract.

But it's true that in an organisation it is difficult to guarantee the same person […] The workers have a regular contract, so they are entitled to holidays, they can be sick, etc. (Public actor)

However, according to the public sector, staff changes and shorter services are not perceived as a failure of the system, but on the contrary as useful for the purpose of providing professional services. Thus, not only the continuity of services is not sought for, but the opposite is beneficial for both care recipients and caregivers.

It is not just because we really like a caregiver that everything works fine and that the caregiver is satisfied. The caregiver… for her well-being, and also for the psychological burden, we need to vary her situations, otherwise it becomes extremely heavy […]. For caregivers it can be extremely heavy, depending on the pathology of the beneficiary. (Public actor)

Contrary to private care providers, the need to vary the personnel is not due to management issues (i.e. the wish to control what happens in the private home of the care recipients or the need to provide caregivers with a protection against unemployment), but rather to guarantee fair and decent working conditions to caregivers.
The hardship of the work is repeatedly expressed by public providers as a problem linked to the emotional labour required for care work. Even in the case of paid formal services, the work of

the caregiver inevitably oscillates between emotional involvement and distance. As long stressed by scholars (Hochschild, 2002; Cox, 2006; Lutz, 2008, 2010), the emotional labour and the bound that ties the caregiver and the care receiver involves a series of risks, especially for the worker:

> *Actually, the emotion, the relationship, is strong… and sometimes stronger than that of children and parents, due to the proximity, the relationship developed with the caregiver… which is not easy to handle for the caregiver… (Public actor)*

This touches at the core of the dilemma on whether professional care should point towards maintaining a certain distance between carer and cared for at all costs, or whether the human relationship that naturally establishes should have the upper hand. To remedy the main risks associated with this insolvable dilemma, the strategies adopted by private and public providers differ considerably. Although they acknowledge the emotional and human aspect implicit in care labour, public providers try to limit as far as possible the risks, through the provision of support services addressed to workers (psychological assistance, exchange and support during staff meetings, and so on). On the contrary, private providers encourage the strengthening of the emotional ties typical of care labour also through the provision of services based on continuity. The result is that care recipients benefit from the emotional labour provided by caregivers, but caregivers are maintained in a domestic relationship towards their work (Puissant, 2011), without the psychological and relational support from the company. This put caregivers in a particularly vulnerable situation.

Formal qualifications or soft skills?

As highlighted by scholars, another key element of professionalisation concerns the competencies required to perform care work (Abbott and Meerabeau, 1998; Clergeau and Dussuet, 2005; Ribault, 2008).

According to public care providers, the professionalisation of care work must be linked to a recognised system of qualifications, providing caregivers with the competencies and knowledge necessary to perform the work, on the one hand, and enabling to fix their working conditions according to their level, on the other hand. Such knowledge and competencies are guaranteed through the use of three main instruments. The first refers to the formal qualification of care workers, according to institutional educational programmes that vary from 6 months for general household assistants to 2 years for health assistants; the second implies a number of compulsory training activities each year; and the third concerns the weekly staff meetings, which include elements of exchange, coaching and emotional support for workers.

The possession of a diploma is the first instrument for the qualification of care workers and the recognition of their professional status as workers. The content of educational programmes varies depending on the diploma, but always includes training on household and care activities, on how to provide specific treatments, on how to act in front of specific illnesses and psychological situations, as well as on the deontology of the work. The possession of a diploma constitutes the guarantee that caregivers possess the necessary requirements to perform care work in a professional way. Public care providers stress this element as their main asset, in opposition to undeclared workers and private companies that do not require formal qualifications to caregivers.

> *Those who call on people that do this secretly [in black]… yes, they can actually have some help… but do they have the guarantee that the person has attended trainings, that the person knows how to deal with problematic situations? (Public actor)*

Apart from notions on specific tasks and illnesses, caregivers are also asked to learn elements linked to the ethics of care work. All of them stress the importance of the deontology of work, as a crucial element for the well-being and the security of both caregivers and care receives.

Besides formal qualifications, attested by a diploma, caregivers are also asked to regularly attend a fixed number of trainings per year, whose cost is included in the budget provided by the state. These lifelong learning programmes are compulsory, and the content vary according to the staff needs and the interests of the workers and of the organisation. The content of training can vary from practical activities, specific situations that workers may be faced with, problems linked to the management of the relationship with the care recipient (conflict resolution, how to manage stress and/or emotion, etc.). These trainings are considered by public providers as important instruments for strengthening the professionalisation of their services.

> *Trainings are useful precisely for this, because they say « well, we have to be professional and any task we do must be professional" (Public actor)*

A last aspect touching at the qualification of workers concerns staff meetings, which are usually provided by the public structures on a weekly basis. Since meetings are instruments aimed to strengthen the competencies of caregivers, foster team building, and provide support to workers, they are considered by public providers as important instruments for the professionalisation of services.

> *Because actually the personnel is supported, there is a structure behind… and then, well, we have a philosophy of work, of caring… and this work we also do it with our people (Public actor)*

As already mentioned, private providers do not have to stick to the formal requirements concerning the level of qualifications required for home care. According to them, the lack of formal trainings and qualifications required to perform care work does not jeopardise the quality of services, but on the contrary is seen as something rather positive, for a series of reasons. First, contrary to the arguments used by public providers, qualifications and trainings are generally judged as unnecessary. On the one hand, the actual tasks required from caregivers do not imply specific knowledge or competencies.

> *The tasks do not require any qualification. It is the kind of tasks we all do for ourselves, in our everyday life, and that they [caregivers] just need to do for someone else in a respectful way (Private actor)*
>
> *To put these people [caregivers] in a room to talk for a day is not going to improve the quality… (Private actor)*

On the other hand, because the multitask profile they expect from caregivers would hardly adapt to workers who have obtained a formal diploma, they may give preference to unskilled workers, who are supposedly more adaptable to the requests of the care recipients.

> *On the whole, I don't think it [the diploma] is an asset. Why? Because, actually, what we ask the caregiver is to manage the household in a broad sense. This means doing also cleaning, laundering, ironing, cooking… If I ask this to a nurse she tells me: "But I'm a nurse!". So, in a way, I think that the most polyvalent profile is that of the person who loves elderly people, someone who has experience and who feels good with elderly people. (Private actor)*

According to some, imposing trainings for a work that anybody can do would even be offensive, as it would call into question the 'natural skills' of caregivers.

> *If I was asked to attend a training I would say no. Maybe I'm mistaking, but I don't have the impression I need it. (Private actor)*

The arguments used to maintain the uselessness of qualifications are similar to those put forward in favour of continuity and seem to go in the direction of a professional, but family-like type of care. The professionality of caregivers is built on the image of a work that any family member is capable of doing, provided that the person is willing to do so.

The second reason that makes the possession of a diploma irrelevant for the provision of professional services is that other competencies are unequivocally judged as more important. The majority of private providers insist on their careful and personalised selection of caregivers, based on a series of soft skills, which are deemed to be the real assets of their caregivers. The

most mentioned skills include patience, positive attitude, willingness to help, empathy, humanity and most of all what they call a 'vocation'.

> *I'm very demanding in my selection and I really look for people who have almost a vocation, we can say… Because there are some people who work because they don't have the choice, but I feel it immediately when they do this because they don't have the choice. Well, I really look for people that do that with love of the elderly, who enjoy doing it, and who do not do it only for money (Private actor)*
> *When someone comes and says: "No, I don't do that, I don't do that, I don't do that… I want to know how much I earn", I immediately understand that this is not her vocation (Private actor)*
> *So, the first diploma I ask for is coming from the heart and from patience. It's like this. […] Because since we don't offer medical care – it's only a presence – I don't need diplomas […] There are people with diplomas, who are less patient and who have less heart than people without a diploma. What I need is the human characteristic, a splendid heart, patience… (Private actor)*
> *If you replace the family with someone who commits and who is willing to help the person, for me it is fine. I really think it is… it is having, you know… to be willing to listen attentively to the elderly person. It's exactly what it needs. If someone comes only to have a salary… […] What I noticed is that at the end it is the kindness, the positive attitude, that make this work. (Private actor)*

The recurrence of the term 'vocation' in the narrative of private care providers is demonstrative of the emphasis they place on the specificities of care work. Instead of calling into question the professionalisation and the quality of services, the lack of formal qualifications is counterbalanced by the valorisation of emotional skills and vocation and the professionalisation is precisely built on these qualities. Again, the demarcation line between formal home care and family help is voluntarily maintained blurred.

In some cases, the parallel with family care is even emphasised as a characteristic of care workers:

> *These are people who have – I would say – a strong sense of the elderly person […] and who basically consider the person they look after as their mum or dad. (Private actor)*
> *Actually, we recruit persons who don't necessarily have… who have never had specific contacts with this field or with this profession, etc., but who on the contrary had an experience, as they looked after their grand-parents, or a partner, a sick child... (Private actor)*

However, although the pointlessness of formal qualifications is constantly evoked, private care providers concede that in some cases they take advantage of the qualifications of their (overqualified) workers and even highlight this as a clear advantage. Two situations seem to be

particularly common – and advantageous – for private care providers. The first is when workers have obtained the qualifications required in the public sector, but work – part time or full time – in the private sector.

> *The majority has a paramedic qualification, like health assistant… most as health assistants, and I also have some nurses, some social workers: so, people who have some kind of competence. Because the idea is to propose quality services, with competent people […], with qualified personnel. (Private actor)*

The second is the case of foreign workers who have the professional qualifications in their country of origin, which are not recognised in Belgium:

> *Most of my workers it's the same [they are overqualified]… We have caregivers who are medical doctors in their country! But here, well… this type of profile, actually… since they cannot practise here as they do it there, being a caregiver is an entry point, actually… (Private actor)*

To sum up, while the question of the competencies is crucial for all providers in the process of professionalisation of home care, there is no agreement on what competencies should be wanted. While public providers frame their professional services in a system of formal qualifications, private providers build the professional profile of caregivers on other kinds of competences, mainly linked to personal/behavioural traits (patience, kindness, positive attitude, etc.). From the point of view of caregivers, the risk of a system of competences which is not institutionally constructed and recognised is that their work will not be collectively recognised, including with regards to their wages (Ribault, 2008).

Additional strategies

In addition to the above-presented elements, whose importance is stressed by all care providers, both public and private actors highlight some additional strategies that they develop in order to provide high-quality professionalised services. These strategies are aimed at providing a more adapted service to care recipients, higher quality of services, or higher quality of jobs, depending on the philosophy and the resources of the structure, and include a heterogeneous range of services.

Examples of additional services that may be offered by public care providers are initiatives to meet the elderly population in the neighbourhood, or participation in civil society projects aimed to reach elderly people with limited access to services.

Concerning private care providers, examples of additional strategies include the provision of ad-hoc medical/paramedical services in the framework of more general services, or the creation

of a personalised relationship with clients (informal visits, invitations to events, etc.). A last strategy used by several private providers, which is worth mentioning, is the possibility offered to care recipients to choose the caregiver, or to refuse him/her, on the basis of their preferences.

> *We notice that one of the recurrent elements is to be able to choose. In a classical organisation, again, it is impossible: you will have the person who is free at that moment. […] But it is very intimate… it is someone who comes to my place, in my home, and who helps me, with whom I must get along, discuss… here you can choose and if it doesn't work you stop, you take someone else and you continue. (Private actor)*
>
> *You can have someone who is very competent, but you don't feel her, there is no chemistry, you know, between the two parties. So, I always tell them [the workers]: trial period of 15 days, if there is no hanging up after 15 days then we change the caregiver. (Private actor)*

Home care work is acknowledged as a space of intense and private relations and implies a privileged relationship between the care receiver and the caregiver, where the latter is inevitably plunged into the domestic sphere. The possibility of choosing this privileged relationship is therefore considered by private actors as a right of the care recipient.

Although the possibility to choose the worker is offered in order to make the service as suitable as possible to the needs of the beneficiary, private actors experience perverse effects. The main problem is that, even when the possibility of rejecting a worker is not explicit, beneficiaries and their families express discriminatory preferences. The problem is aggravated by the fact that, given the very high price of private services, customers feel entitled to express their preferences. The (sometimes violent) expression of their preferences is usually directed against non-Europeans, and especially against black people and/or people of Muslim confession. While the preference for female workers is recognised by all providers as a natural preference, in accordance with ideas and values that link care work to feminine traits, ethnic or nationality preferences are recognised as discriminatory and represent a source of discomfort for providers. The discomfort is due both to the acknowledgment of a serious problem of discrimination, and to the impossibility to accept the request of beneficiaries, due to the high prevalence of foreign-born caregivers among their personnel.

> *Unfortunately, certain families also ask not to have black people. Well, this… unfortunately this happens very often. […] And sometimes they ask: « I want 24h, but only Europeans". But then I say: "Look, it's impossible! », because it is impossible. Only women, only Europeans: at one point I have to say "stop!" (Private actor)*
>
> *I explain them, I tell them: "Look, I understand this. But if I could give you the same price that I give you and find a nice little Belgian lady, no worries… but I will not find her! (Private actor)*

There is another problem: racism. Well, of course I never asked the question, but sometimes I understand… that generation can have a problem with black people. And this is a big problem, because families do not dare express this clearly, so I have to ask the question… But it is illegal to ask that question, I cannot do it, because it is discriminatory… But the problem is that when I send black people families always make the same remarks. (Private actor)
Well, if it is a name that sounds Muslim, it is sure that people will ask me: "Is she veiled?" (Private actor)
When I tell them that it is a Romanian woman: "Oh my god!" (Private provider)

Although all racist requests are without exception a source of frustration, private care providers tend to justify them by emphasising the 'exceptional' behaviour of that specific generation of elderly people, with whom they do not share the same education and values, or the health and mental conditions of frail elderly.

And I can understand. I mean, it is a generation… well, elderly people who still call a black person a "nigger". […] When they [the caregivers] go to someone with Alzheimer, when I send an African lady, she tells me: "Look, he called me nigger, he said that we are stealing their jobs". But these people have Alzheimer, they don't know what they are saying, they just repeat things they've learned. (Private actor)

Although all care providers are careful to distance themselves from any racist intention, in some cases the choice of their workers is based precisely on a kind of ethnic hierarchy, through which certain nationalities are attributed characteristics that would supposedly better suit care work. As exemplified by the following extract, the justification for the choice of caregivers can be based on both economic or behavioural attributes:

Let's take the example of Poland, for instance. Often Polish women speak good French, but the problem of Polish people is that it is never for long periods […] Maybe it's linked to the culture, which is more fearful… Romanians are people that… well, you need to get their trust, at the beginning they are very suspicious, because I think they have been fooled often. So, you really need to – as I always say – to tame them […] We also worked a little with Portugal. The problem – and it is very clear – is that in Portugal, you know, the wage difference is not the same as that between Belgium and Romania. So, yes, Portugal suffers from an economic point of view, but I think their wages are not as bad as in Romania. So… not always very motivated! […] There is also the fact that Romanians are more willing to make efforts […] somehow they are used to very harsh working conditions in their country. So, I think that they are inevitably more prepared, you know, to accept everything, compared to people who work here in Belgium, who tend to say: "it's too hard, I quit". (Private provider)

Conclusions

In this paper I discussed some of the difficulties linked to the professionalisation of home care work and I analysed how the professionalisation of home care services for the elderly is achieved in the public and private sector in the Brussels' region. The analysis shows that there is no agreement over the best way of professionalising home care services for the elderly and that the efforts made by public and private providers are profoundly different.

A first significant difference between the services offered by public and private care providers concerns the question of the division of tasks, namely on which tasks should be allowed and by whom. While public providers maintain that only a clear division of tasks can guarantee both high quality of services and high quality of care jobs, the polyvalence – in the sense of the entire adaptability to the needs of the care recipient – is identified by private providers as the best possible option.

A second key element discussed in the paper concerns the continuity of services, both in terms of the personnel and in terms of time coverage of the services. If a thorough time coverage cannot be guaranteed by public providers, because of budget and structural constraints, the turnover of caregivers is clearly identified as a voluntary strategy, in order to protect workers from the risks associated to the emotional burden of care. On the contrary, private providers tends to acknowledge both types of continuity as the ideal form of professional home care.

Concerning the competencies required to perform care work, the analysis shows that while public providers stress the importance of the recognition of a formal set of qualifications, private providers emphasise the importance of emotional skills.

The analysis of these elements shows that the way professionalisation is conceived in the public and the private sector differs with respect of two aspects. The first concerns the understanding of home care as a prolongation of family care, in opposition to a type of home care that intends to distance itself from the features associated to the domesticity. What clearly emerges is that the services provided in the private sector tend to promote a vision of home care work as a sort of continuation of family help, where the worker can cover the entire needs of the care recipients, just as a family member would do. Instead of questioning the traditional distinction between formal / informal, paid / unpaid, public / private, private care providers build their professionalisation precisely on the ambiguous position of home care. On the contrary, public providers try – at least formally – to build their professionalisation on a clearer separation between paid services and family help.

The second aspect concerns the actor – between carer and cared for – to whom the priority is accorded in the process of professionalisation. While in the private sector the strategies intended

to offer professional services are entirely tailored to the needs of the care recipient, public providers tend to build their professionalisation by focusing on the caregiver. Even though the care recipient remains in the centre of the attention, in that the primary mission of public providers is to offer affordable services to the vastest majority of the elderly population in need, the focus of the professionalisation is clearly addressed to the workers and is meant to guarantee a good quality of care jobs.

To use the classification of the different logics of professionalisation proposed by Ribault (2008), the analysis presented in this paper allows to clearly identify which of them predominates in the public and the private sector. The dominant logics of professionalisation of public actors are: the industrial (based on the collective, rather than the individual, and on competencies as formal qualifications), the political (based on an institutional guarantee of the quality of services and based on a mission of equality in the access to services), and the regulatory (based on the respect of institutional rules and the delimitation of the perimeter of intervention of workers). Conversely, that of private providers are: market-oriented (capacity to adapt to the need of the beneficiary in their multiple dimensions, capacity to generate a 'company identity' and to compete with other actors), vocational (emotional and vocational competencies acquired through experience and based on love for the work they provide) and ethic (human and emotional competencies).

These different logics of professionalisation have direct consequences for elderly carers. Overall, the findings show that the two types of professionalisation have different outcomes in terms of quality of jobs, with private elderly carers enjoying the worse working conditions. The highest quality of jobs in the public sector include not only the basic aspects of the employment regulation, such as wages, working hours, paid leaves, progressive reduction of working time, and so on, but also other aspects usually associated to the quality of jobs. These include the system of support to workers (weekly meetings and psychological coaching), but also the internal organisation of the work, privileging the division of tasks and the work with multiple care recipients. Conversely, caregivers in the private sector enjoy worse working conditions in all the above-mentioned aspects. In particular, the accent placed on the continuity of care work, coupled with the lack of support and the isolation typical of home care, make private caregivers particularly vulnerable. This is aggravated by the gender and ethnic discrimination they suffer, especially when care recipients are offered the opportunity to assert their preferences and choose the worker.

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