4QUALITY

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

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CONTENTS

1. NATIONAL OR LOCAL REGULATION AND POLICIES

France has been a pilot in the creation and promotion of a "personal services" (*services à la personne*) sector. This sector includes a series of in-home services dedicated to individual persons. The development of such a sector has been given a strong public impetus since the early 1990s. In 1991 a tax deduction was introduced which is still in place. But it is in 2005 and the so-called "Borloo Plan", from the name of the Minister of employment and social affairs Jean-Louis Borloo, that the sector is given a legal definition, through the elaboration of a list of such personal services (decree 29 December 2005). It was necessary to define such a list in order to indicate which services opened access to public support for consumers, mainly in the form of tax reduction. This list includes several services, such as childcare; care for the older people, disabled persons or persons needing a personalised help at their home or a mobility help in their close environment with an aim to foster their home support; as well as housework and family assistance. **Actually more than 20 activities have been defined as belonging to the scope of personal services.** One major difficulty is that this very encompassing definition is that two types of services, which are very different in their logic and history, have been pooled together in this new sector:

- on the one hand, social services, including care services to the dependent persons, which mostly are located in the third not-for-profit sector;
- on the other hand, services to private individuals, rather corresponding to comfort or lifestyle services, which are mostly located in the private sector or in the private direct employer system (when someone directly recruits one person for the homework for instance).

Furthermore, alongside this diversity of services, there is also **a strong heterogeneity of providers and organisational models to deliver the service.** One can distinguish between providers employed by a service organisation, on the one hand (1), and direct providers employed by the individual beneficiary, on the other (2).

(1) Providers can be employed by a service organisation either in the non-profit sector or in the profit sector. This is called the "provider organisation" model (*modèle prestataire*)

(2) The direct employment system has existed for a long time and has been strongly supported by public policies. The trajectory is rooted in the heritage of the servant jobs, directly employed by bourgeois families over the 20th century. In terms of employment relationship, the status of these workers is specific, as they are directly employed by the beneficiary of the service.

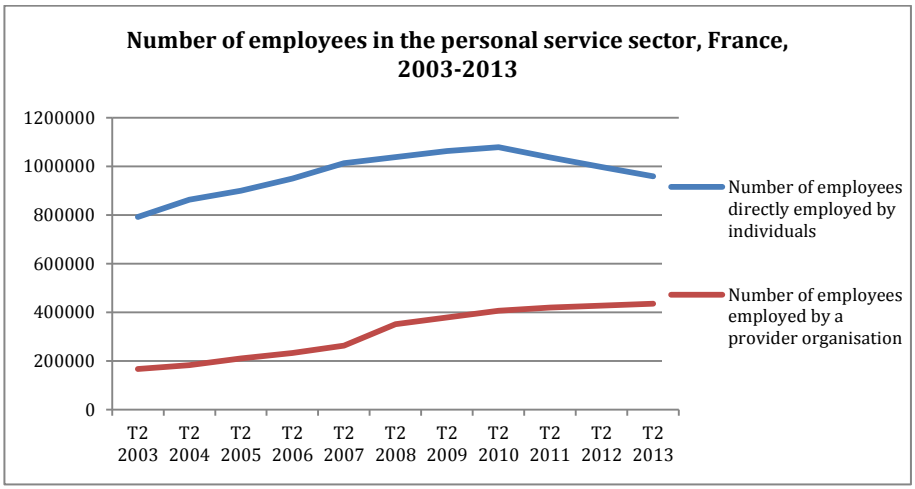
Since 2002 (law on dependency), there is a **public allowance for autonomy** named APA *(allocation personnalisée d'autonomie)*, which allows partial funding for human assistance, technical assistance and specific housing installations for dependent people. It is granted only

to people over 60 years old, after individual medical and social assessment. Autonomy allowance tariffs are fixed by the Ministry of Labour, Social relations and Solidarity for both home assistance and institutional care. Allowance allocation is managed by local governments (Conseil Généraux). The allowance is granted upon first application for 76% of people asking for home assistance and 90% of people seeking institutional care.

2. WORK AND EMPLOYMENT QUALITY

Work and employment quality in the personal service sector is directly related to these two different models of employment, i.e. either the direct employment model or the provider organisation model. In 2010, there were nearly 1.5 million workers in the sector. Nearly 1.1 million of them (72%) were directly employed by individuals and 400,000 by provider organisations. The activity of these provider organisations is principally pulled by non-profit organisations, which represent 70% of the total amount of hours worked.

From 2010 to 2013, the global activity of the sector has decreased because of an important drop of activity from the direct employer model (-11%). This decrease is due to the conjunction of the economic crisis and a reduction in public support to direct employers.



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

2.1. Career and employment security

2.1.1. Employment status

Nature of employer (private individual or organisation; for profit sector or non-profit)

2/3 of employees directly employed by private individuals and 1/3 by providing organisations (70% non-profit and 30% for-profit companies)

55% of housekeepers have several employers.

Contractual relation between employer and employee

The employment status is very different when comparing employees directly employed by individuals or employed by a providing organisation.

- **Employees directly employed by an individual** are normally (around two thirds of the total number of employees) employed **under open-ended contracts**. However they might be **paid by means of a specific voucher** called Cesu (Chèque emploi service universel). In this case, if they are employed for less than 8 hours a week, **then a work contract is not mandatory.** When the contract is broken, the employee has right to severance pay and a severance period.
- **Employees employed by a providing organisation** (around one third of the total number of employees) work **under open-ended contract** in a large majority: this is the case for 78% of them. 87% of these employees work part-time.

If a majority of employees work under open-ended contracts, **only about 1 employee out of 5 works under a full-time, open-ended contract,** compared to 70% of employees in France.[1] This is an example of the low security that they face with regard to employment.

Existence of a collective agreement

All employees are covered by a collective agreement. Employees who resort from the direct employment model are covered by distinct collective agreement, depending whether they work in the not-for-profit domiciliary care sector (covered by three national collective agreement) or in for-profit companies (covered by one specific collective agreement). In the "direct employment" model, employees are covered by a specific collective agreement. The branch is that of the "*particulier employeur*" (individual employer). 1.2 million of persons are employed under this system.

Temporary contracts

Temporary work is not very much developed in the sector. Providing organisations prefer to recruit under open-ended contracts in order to retain employees.

Undeclared work/regularisation of undeclared work

Undeclared work has been strongly decreased thanks to a massive strategy of public incentives given to taxpayers to buy domiciliary personal services or directly recruit employees at home.

[1] Devetter et al., 2009, *Les services à la personne*, Repères, La Découverte.

Nevertheless in recent years these tax incentives have been reduced because of pressure on public budgets. This has resulted in a diminution of the recurse to direct employment and very probably to an increase of undeclared work.

Migrant work

In 2007, 25% of employees directly employed by individuals were immigrants.[2] According to the 2010 Employment Survey (Lefebvre 2012[3]), 26% of housekeepers were of foreign nationality compared to 9% of homecarers.

2.1.2. Income and wages

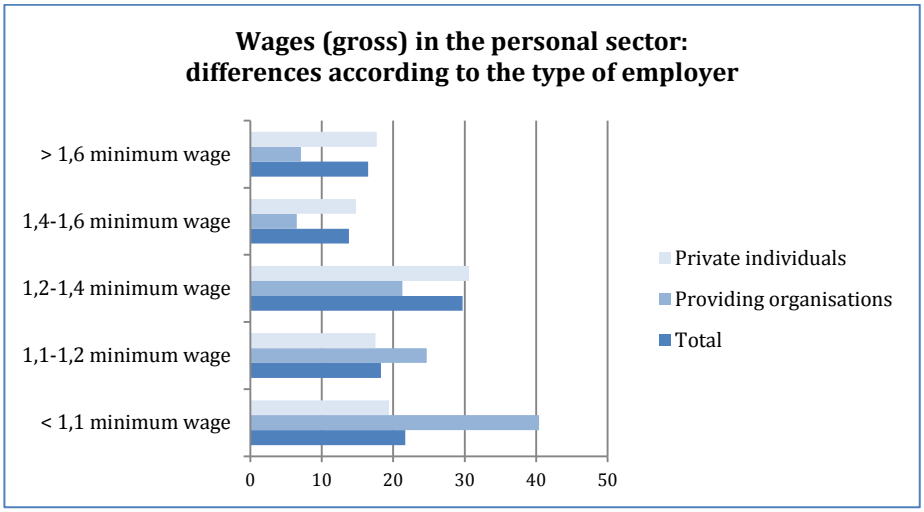
In 2010, in average, an employee received 8,700 € (gross salary)[4] a year. The amount of wage depends on the number of hours worked. The mean hourly wage is approximately 12.30 € (gross) which represents 1.4 minimum wage.[5] Contracts with private individuals are generally better paid compared with contracts with providing organisations (graph below). The mean hourly wage for employees directly employed by private individuals is 12.50 € compared to 10.80 € for employees working for providing organisations. One element of explanation lies in the stronger bargaining power of some employees directly employed by individuals. Another one is the fact that some activities with higher hourly wages (like school support or remedial classes) are the most often provided under this model.

[2] J. Perrin-Haynes, « L'activité des immigrés en 2007 », INSEE Première N° 1212 - octobre 2008

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

[4] He/she also received on average 3,100 Euros (gross) for activities in other sectors than personal services.

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



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

In France, the average net wage for houseworkers (*employés de maison*) was 687 € in 2010, for an average of 21 hours worked by week[6]. In comparison, domiciliary carers (*aides à domicile*) earned in average 838 € by month for more than 27 hours worked by week. 76% of houseworkers were below the low-wage threshold (1016 €) in 2010.

2.1.3. Social protection

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

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

2.1.4. Worker's rights

Right to collective bargaining

Employees working for a providing organisation benefit from the same rights at work as other workers. Organisations with more than 10 employees should have one worker representative. A Workers council and a Health and Safety committee are compulsory over 50 employees. Trade unions can represent workers at work provided they have received more than 10% of the votes

[6] Source: Enquête Emploi, see Lefebvre 2012

at the latest professional elections.

In the direct employment system, workers' rights are less easy to monitor as the employee is directly employed by a private individual. Abuses have been reported from private individuals not respecting or simply ignoring labour law.

All employees are covered by a collective agreement. At the branch level, representative trade unions have a good level of collective bargaining with employers.

2.2. Skills development and professionalisation

2.2.1. Qualification

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

The first professional level or position in the collective agreement of domiciliary care workers (*convention collective de l'aide à domicile*) is not even linked to a minimal level of qualification. The most important level of qualification for domiciliary workers corresponds to a ISCED level 2 (*DEAVS*) which is owned by around 30% of workers. In companies or associations, the most complex tasks are often left to these most qualified workers. It is necessary to have this qualification to work as a personal carer but not for simple tasks like cleaning the home.

By comparison, employees directly employed by private individuals do not have minimum requirements in terms of qualifications.

2.2.2. Training

Many providing organisations have adopted a professionalisation strategy, consisting in developing training measures for some of the employees. The qualification mentioned above (DEAVS) can be obtained through vocational training and in particular thanks to prior recognition of competencies ("validation des acquis de l'expérience"). The issue is that this impacts the wage structure; however in the field of domiciliary care for dependent people the prices are fixed by public agreements. For this reason many organisations do not encourage training.

Access to training is by comparison more difficult for employees directly employed by individuals.

2.2.3. Career development

Career development generally passes through access to training and possibly new, richer tasks. However in terms of manpower management, it is difficult to access new jobs. Some employees may become executives, who manage a small team of employees.

2.2.4. Recruitment and staff shortages

The sector faces many barriers in terms of recruitment and retention of the workforce. The image of work is not very good and wages are not attractive. Most of these jobs are part-time. This is not always an obstacle since many employees do not want a full-time job. However, the volume of work is in general imposed by the employer, whereas employees would prefer to be able to choose.

Intermediation between demand and supply can be fostered thanks to partnerships with Public Employment Services (PES) or training centres so that applicants can easily find an organisation which recruits, and so that organisations can easily find the right candidates to fill vacancies.

2.3. Health and well-being

2.3.1. Work organisation

Access to occupational medecine

Since 2011, all employees employed by an individual should have access to occupational medicine. Thus far only full-time employees were concerned. But in practice this obligation is not really enforced as occupational medicine do not have the means to receive all these employees. Employees working for providing organisations are by comparison much closely followed by occupational medicine.

Is the work organisation protecting the employee or putting her/him at stress?

These jobs are very exposed to psychosocial risks and emotional factors. The work organisation cannot do a lot in terms of preventing these risks, but often propose speeches arenas where workers can voice their difficulties or troubles; they also can mix very demanding activities (for instance with highly dependent persons) with less demanding activities (like simple tasks of cleaning) in order to give the employees some break. Employees recruited by individuals are often isolated by comparison.

2.3.2. Risk exposure and health problems

Health and safety inspection cannot control work as it is done at somebody's home.

Sick leaves

According to some own calculation which might be taken with caution, work leaves would represent around 10% of employees in personal services in 2010, compared to 4.3% for all employees.

Stress-related work

In terms of psychosocial risks, there are differences between the two professions. When considering several indicators of psychosocial risks, domestic workers are always below the average for all professions, while home carers report high levels of difficulties, over the average.[7]

Exposition to psychosocial risks, 2005 (France)

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

Source: Enquête Emploi, Lefebvre 2012

Harshness of work

The hardness of work can be a limit to some employees' wishes to work full-time. Furthermore, as observed on the ground at least in France, many employees arrive in the housework sector after a first professional career in the industrial sector. They might experience physical difficulties due to these former occupations or be more sensitive to the physical constraints at work.

Indeed, jobs in personal and household services are demanding, both physically and, as far as carework is concerned, emotionally. Among the physical difficulties one can mention the following: standing, carrying loads, handling corrosive products, hygiene and safety problems, in particular in the homes for the elderly, risk of aggression, road accidents, etc. Psycho-social difficulties may be due to the relationship with the users/clients, legal liability, stress related to travelling, etc.

In France in 2010, the frequency of workplace accidents in domiciliary care services is twice as

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

high as the general average for all professions (76 accidents per 1,000 employees compared to a mean index of 36). It is even higher than the accident rate in construction for instance (73). 10% of employees have had a work stoppage (workplace accident or accident on the way to work, work-related illness) in 2010, compared to a national mean of 4.3%[8].

Labour surveys give more indications about the difficulties experienced at work. In 2005, around 50% of domestic workers and 64% of carers experienced painful or tiring movements and positions at work, compared to an average of 35% for all employees in France. 90% of both professions are required to stand for long periods (vs. 52% in all other jobs).

2.4. Work/Life balance

2.4.1. Working time and work schedules

Working time. Part-time work (voluntary and non voluntary)

Part-time work is the norm. 87% of employees work part-time. Homecarers working for provider organisation tend to have longer working times.

Working time of homecarers and housekeepers

	Homecarers	Housekeepers
Occasional	2%	4%
< 20 hours	28%	47%
20-30 hours	37%	23%
> 30 hours	33%	25%

Source: Enquete Emploi, Lefebvre 2012

30% of employees, whatever their current type of employer, wish to have longer working times. This means that for 70% of employees their current working time is voluntary.

Non-standard working arrangements (night work, work on Sunday)

In 2010, 33% of employees work occasionally or frequently on Sundays (45% in care work, 8% only in housekeeping). 17% of employees work occasionally or frequently in the evening or by night (21% in care work, 7% only in housekeeping). 30% of employees have working time that changes from one week to another.

[8] Source: CNAMTS.

3. SERVICE QUALITY

There are two main components in the French approach regarding quality. 1) First, the tariff system chosen by the organisation or unit distinguishes the conditions relating to quality. If the fee is controlled by the government, the organisations and units must be *authorised*; if it is set freely (but with monitored development), the organisations and units must be *accredited*. 2) In parallel with these obligations, the organisations or units voluntarily and increasingly have recourse to certification procedures. The government links these voluntary steps to a quality policy that it defines, since certification can replace compulsory accreditation procedures.

3.1. Authorisation and accreditation systems

3.1.1. Quality in the authorisation scheme

Since the law no. 2002-2 of 2 January 2002, which reformed social and health care activities, all organisations or units providing long-term care (LTC) and coming within social and health care sectors are subject to an authorisation process for their establishment, transformation and expansion. For long-term care, this authorisation is issued by the president of the departmental general council when the services provided by the organisations and units are liable to be funded by departmental social aid, or when their operations fall within the scope of competency devolved by law to the department. This authorisation, granted for 15 years, sets out the basic conditions for quality that are necessary when setting up an organisation or unit. Conformity with these minimum quality requirements is then evaluated over the course of the authorisation period, either by the organisation or unit itself (internal or self-evaluation), or by an external body (external evaluation).

Concerning quality conditions for the initial request for authorisation, such authorisation is granted if the service fulfils the following four conditions:

1) It is compatible with the objectives and fulfils the social and health care needs set out by the health care organisational structure to which it is subject.
2) It meets the requirements for organisation and operation expected by the Social Action and Family Code (CASF), and anticipates the evaluation steps and information systems set out in the articles of that code (Arts. L. 312-318 and L. 312-9, respectively).
3) It presents the operating costs, which must not be out of proportion with the service offered or with the costs of organisations or units offering similar services.
4) The fourth condition concerns its compatibility with the inter-departmental programme, if any.

The quality of the services offered is therefore determined upon entering the market, essentially by the provisions of the second condition. The request for authorisation must, in effect,

demonstrate the ability of the organisation or unit to guarantee users' rights and carry out the evaluations planned.

The users' rights are specified as follows:

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

To ensure that these rights are effective, the law expects a certain number of tools to be put in place by the organisations or services; these are compulsory for them to function. These tools are the following:

- a reception booklet containing a charter of the new user's rights, the rules of operation of the organisation or unit, the residence agreement or the personal care document (DIPC), drawn up with the user or his/her legal representative. This contract or document sets out the objectives and the nature of the care package or support, while respecting ethical principles, professional recommendations and the aims and objectives of the organisation or unit. It sets out the list and nature of the services offered as well as their estimated cost;
- a process allowing a person receiving care from an organisation or unit to call upon a qualified person to advise the service beneficiary about his/her rights. This qualified person is chosen from a list drawn up jointly by the government representative of the department, the managing director of the regional health agency and the president of the general council, and takes into account the interventions of the authorities responsible for monitoring the organisation;
- a council of community relations, an authority that allows the client to participate in the operation of the organisation or unit; and
- a document setting out the aims and objectives of the organisation that focuses in particular on coordination, cooperation and evaluation of the service quality, as well as the organisational and operational procedures.

3.1.2. Quality in the accreditation scheme

Accreditation is granted for five years by the departmental prefect after deliberation by the general council. This procedure essentially concerns associations and businesses whose activities apply to home-based care for elderly and disabled persons or others who need personal help in the home or with mobility in their immediate environment, favouring their capacity to stay at home. Accreditation is granted with regard to the quality criteria of the unit as detailed in the specifications of 24 November 2005 concerning the "quality accreditation" planned in the first paragraph of Art. L.129-1 of the Labour Code.

These criteria make up 'quality references' with which the administrators or the organisations or units must conform in order to obtain accreditation. They correspond to the following areas:

1) respect of the persons in care, their individual rights, their private lives, cultures, life choices, personal space, property and confidentiality;
2) the openness of the organisation or unit to its surroundings, i.e. "[t]he local, social and health care context, corresponding to the target public, in order to complement and coordinate with other caregivers and systems";
3) the organisation of high-quality reception;
4) the tailoring of services to users' needs;
5) the clarity and quality of the services offered;
6) the terms and conditions, monitoring and evaluation of operations; and
7) the selection and qualifications of staff.

Accredited organisations and units must be subject to external evaluation. The results of this evaluation are passed on to the prefect in charge of granting accreditation, at least six months before the approval is due to be renewed. As this is valid for five years, accredited organisations or units are evaluated far more often than those that are authorised. On the other hand, internal evaluation is not compulsory for accredited organisations and services

3.2. Certification

Certification is a voluntary procedure that can replace the quality control used by public authorities for accredited or authorised organisations or units.

The certifications currently recognised by public authorities meet the French NF standard X 50-056 for home-based care service standards (AFNOR, French Agency of Standardisation), the certificate registered by Qualicert under "Human services" (SGS-International Certification Service) and the certificate registered by Qualisap under "Quality of service organisations engaged in human services" (a Bureau Veritas Certification).

- Quality control system

Law no. 2002-2 of January 2002 also sets out the quality evaluation to be carried out during the entire period in which the organisation or unit is authorised to function. Two procedures must be implemented. On the one hand is internal evaluation (or self-evaluation), and on the other is external evaluation. The results of these two types of evaluations are passed on to the authority that issued the authorisation.

- Internal evaluation (or self-evaluation)

Internal evaluation (or self-evaluation) must be carried out every five years. It is not subject to detailed specifications except that the evaluation must be conducted notably in relation to procedures, references and recommendations for good professional practices.

- External evaluation

External evaluation relates to evaluation by a body that is not involved in the activities of the organisation or unit, or the quality of services provided. It must be carried out during the seven years after authorisation or renewal, and at least two years before the expiry of the current authorisation.

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