Financial Reform of Public Policy on Ageing in France and the Persistent Invisibilization of Caregivers

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A very simple statistical observation can be made in France, as in other European countries: the public policy on ageing mainly concerns women. The community of professionals working with elderly dependent people mostly comprises women (Brendler/Roger 2021), and women make up 73% of residents of nursing homes for dependent elderly people (EHPAD)[1] (Département des Études et des Résultats (DREES) 2021), while almost 52% of declared caregivers are women (Blavet 2023). Despite this highly evident statistic, the question of financing of the policy on ageing is rarely examined from a gender angle, both in terms of the targets as well as regarding impact studies.

This research therefore tackles the following questions: How does the invisibilization of women operate in the financing of public policy on ageing in France? To what extent are accounting and financing systems blind to the social externalities of public institutions such as EHPADs? An understanding of social policies involves considering the gender-related norms and values that these policies put forward (Daly/Rake 2003). At the same time, it involves analysing how these policies impact gender relations through the distribution of resources and social roles. Numerous studies have characterized welfare state regimes at the macro level, notably based on their proximity to the male breadwinner model or the dual-earner model (Lewis 1992). In this article I adopt a micro-sociological angle by comparing the representations put forward by the EHPAD pricing system, following the 2015 reform, with the experiences of the various stakeholders in the nursing home. In particular, I measure the potential impacts of this system on gender relations within the family concerning the production of care, since the place left to families in the welfare mix is a crucial variable for understanding the gendered implications of the welfare state (Orloff 1993; Daly/Lewis 2000).

I draw on a qualitative study carried out in 2023 on the social network of four nursing homes for dependent elderly people. The aim was to compare the subjective experiences of female nursing assistants, nurses, doctors, residents, volunteers and family carers with the definition of the EHPADs' mission as defined by management tools in the sector. I analyze what the actors say and what they practice, and the sociotechnical measures designed to implement the public policy on ageing. I thus propose to examine the welfare state model with a focus on gender inequalities (Lewis 1992; Orloff 1993) by questioning the norms conveyed by the management tools. The EHPAD financing model constitutes a public action instrument as defined by Halpern/Lascoumes/Le Galès (2014, 17, transl. HC):

> A public action instrument is a technical and social measure that organizes specific social relationships between the public authority and its recipients according to the representations and meanings that it conveys.

Chiapello and Gilbert (2013, 63, transl. HC) stipulate that, "management tools are likely to legitimize social hierarchies and in particular the exploitation of one group by another behind their apparent technical nature." I thus set out to break down these tools in order to identify the representations that they convey about women. To do so, I use the definition of social representation proposed by Jodelet (1989, 36, transl. HC): "a form of knowledge, socially elaborated and shared, that has a practical aim and contributes to the construction of a reality common to a social group."
In the rest of this article, I take a close look at the invisibilization of women's contribution to caring for the elderly. Like Krinsky and Simonet (2012, 8, transl. HC), I sustain that "while the paid work done by women is not strictly speaking invisible, it is, in many dimensions (legal, economic, social and even symbolic) invisibilized: sometimes denied, frequently euphemized, and never recognized for its full worth." These two authors point out that to question the invisibilization involves considering that the line between what is work and what is not work is not conclusive, but actually the result of social relations. This invisibilization of female work results from a public policy that extends the scope of free or under-recognised work beyond the domestic sphere, in this case into medical-social institutions. Early studies on care (Gilligan 1982; Tronto 1987; Glenn 1992) have shown that care professions "are perceived as fitting in with the role and values associated with women in the private sphere (mothering, care, caring for others); their qualification is largely unrecognized, and their professionalization limited" (Bereni et al. 2008, 131). Public policy on ageing thus contributes to shifting the non-recognition of women's work in the domestic sphere to the professional sphere. Through our study, I intend to demonstrate that the invisibilization of women in France, in particular in the area of care for the elderly, stems from the configuration of the underlying financing instruments and norms.

The Legal Framework of Elderly Care Provision in France

Like numerous European countries, over the last three decades, France has had to simultaneously respond to increasing demand for care due to an ageing population, and the need to keep down the costs of this support in terms of public finances. To deal with this double challenge many countries have pursued a complex strategy. Pavolini/Ranci (2008) argue that the restructuring of the policy on ageing involves a combination of support in kind with financial support for the elderly, the commodification of dependence, the ambition to associate dependent people more closely with the definition of their care plan, and lastly, the intention to support family carers, in particular financially. According to Pavolini/Ranci (2008), in France this restructuring coincided with the launch of the personal autonomy allowance (APA)[2] and led to greater recognition of the contribution made by family caregivers. This latter assertion is our starting point, given that the analysis made by Pavolini/Ranci (2008) is restricted to the financing of caregivers in the

home, without considering the issue of financing in nursing homes and its impact on the sharing of care work within families. In what follows, I first propose the hypothesis that EHPAD funding and pricing systems are still centred on a familial conception of this policy, drawing from the definition of 'familizing policies' proposed by Lohmann/Zagel (2016, 53):

> (Familizing) policies are defined as social policies or regulations that foster dependencies among family members by actively lowering their social and economic consequences, such as women's financial dependence towards a family provider, children's dependence on their parents' care, and elderly people's dependence on their adult children".

In France, Article 205 of the Civil Code stipulates that children must provide for the needs of their dependent parents, therefore putting the emphasis on filial solidarity.[3] This maintenance obligation continues to underly the finance systems of nursing homes caring for the elderly. The contribution made by carers thus becomes the only way to avoid consuming the family's financial heritage. The gender-based socialization that tends to reduce caregivers' work to a moral duty, which goes hand in hand with a familial conception of care for the elderly, ultimately leads to making caregivers' work invisible (Toffanin 2021).
Secondly, the restructuring of the financing of policy on ageing in France, as highlighted by Pavolini/Ranci (2008), takes the form of a commodification of the dependence sector. This commodification can be seen as the introduction of competition between public- and private-sector actors, accompanied by a standardization of the market (Delouette/Nirello 2017). Thus, the management tools introduced into the EHPAD sector following the decree of 26 April 1999[4] up until the 2015 Act on Adapting Society to Ageing (ASV)[5] put forward an industrial conception of care (Da Silva 2018) which is based on the need to respect quantifiable standards of care quality. This conception of care negates the singularity of the caregiver/patient relationship by reducing care to a standard product that is interchangeable and easy to replicate (ibid., Batifoulier 2012). Care for dependent people is ultimately subject to two simultaneous movements of publicization and privatization:

> Publicization, in the sense that it moves from the intimate, domestic domain into the public space, making it the object of public policies, but also privatization, in the sense that it becomes subject to monetization and commodification so that care becomes a good that can be bought and exchanged. (Krinsky/Simonet 2012, 9, translation by author)

Lastly, our analysis of the different forms of involvement of women in the EHPAD social network allows us to objectivize the entire social production of these nursing homes, in accordance with the aim of Esping-Andersen et al. (2008) to develop a comprehensive accounting of the return on social investments. A comprehensive accounting of social policies should include an analysis of the social and political externalities of this social investment for all stakeholders. Thus, at local scale, the survey illustrates the fact that the women who frequent EHPADs regularly see them

as places of socialization and politicization, and yet this return on investment is not considered as such.
In the following, I first analyze the conception of the policy on ageing that results from the pricing system, by studying women's place as caregivers. In the second part, I look at women's place as care professionals in EHPADs, and then illustrate that this institution constitutes a place of socialization, and even politicization, for these workers.

Methodological Approach

The aim of this research is to measure the gendered social implications of the EHPAD financing system. I opted to investigate interactions within the social network of four EHPADs in Brittany in 2023, chosen due to their status (public, association, etc.), their intake capacity, and their locality (rural, urban, peri-urban, etc.), in order to ensure a varied range. Our initial contact with the communities investigated took place through regulatory meetings organized quarterly by these establishments. These meetings are mandatory as established by the Code on Social Action and Families and consist of the executive board, the social life committee, the social committee of the establishment, representatives of the family members meetings, etc. The sample group was thus built up throughout the investigation, comprising different contacts made at these events coupled with contacts passed on by the people questioned. The observations made during these meetings were crucial in guiding the semi-structured interviews that took place later.
The first part of the interview guidelines centred on the biographical trajectory of the interviewees. The aim of the interviews was to understand what led each of these actors to the EHPAD, determine their representation of ideal care for the elderly and who they think should be responsible for this care, ascertain how they understood the EHPAD financing system, identify the management tools used at the institution, and understand how the financing system influences the way that actors work, their interactions, and their choices. These interviews included a praxeological dimension, because to advance towards the experience of these individuals, I asked them to tell us about their interactions and the challenges they faced every day. The semi-structured interviews thus helped us to "understand the social representations and cognitive patterns that effectively guide actors' practices" (Pinson/Sala Pala 2007, 584, translation by author). In total, I observed eight regulatory meetings and attended several sessions of different meetings, for example, with the management, the healthcare staff or quality meetings. I interviewed a total of 51 individuals from different positions, e.g. doctors, nursing assistants, residents' families, or administration team. I then used these interviews to cross-analyze stakeholders' views on different topics (e.g. how much importance is attached to management tools by doctors, carers, families, management, etc.).

The familialism of the French policy on ageing

While the number of places available in EHPADs in France gives a positive signal in terms of employment for women, compared to working as unpaid carers in the home (Hobson 1990), the social benefits offered by public authorities in the care domain are fewer than those offered by waged labour (unemployment or pension insurance, etc.). At present, there is no guarantee of finding a place in an EHPAD, and access depends on both the capacity of local budgets and the capacity of families to contribute. The decree of 26 April 1999 and the Act on Adapting Society to Ageing (ASV) of 2015 brought changes to the means of financing of EHPADs, by mobilizing three different financing channels according to the type of care given (medical, dependency-related, and accommodation-related care[6]). Accommodation-related care, which constitutes the largest share of the costs in an EHPAD, remains the responsibility of the dependent person, or their families in the case of insolvency. This tends to support a familialist vision of care. However, when the welfare state substitutes the family in the production of care, it finds itself obliged to define the content of that care and give it a value that can then be invoiced to the dependent individual or their relatives, who had formerly provided the care for free. This invoicing of care to the family often puts the family in a position that is disadvantageous for women.

Familialist dimension of the pricing system

EHPAD budgets are funded through three different channels, which depend on the type of care provided. Medical care is financed by the regional health authorities (ARS)[7] in the form of a flat rate indexed on the level of dependence of the patients and their pathologies, as well as the number of places available at the nursing home. Funding envelopes are allocated to each ARS by the National Fund for Solidarity and Autonomy (CNSA)[8] and mostly come from social security contributions. Thus, the financing of medical care in EHPADs comes under the social security system, itself financed by social security contributions, which most residents have paid during their working lives.

Care provided to elderly people due to their dependence is mainly financed by the local councils (the *départements*). Since the decentralization laws of the 1980s, support for the elderly and disabled, also known as autonomy policies in France, has been the responsibility of the local councils. This type of care is funded through a personal autonomy allowance (APA), paid to dependent people whether they live at home or in an institution. Elderly people must also make a smaller contribution to finance the costs of their dependence.

Lastly, accommodation services, which cover all care related to hospitality (catering, entertainment, social life, laundry, etc.) and represent most of the daily support cost (cf. Figure 1), must be paid by affluent users. If they do not have sufficient resources,

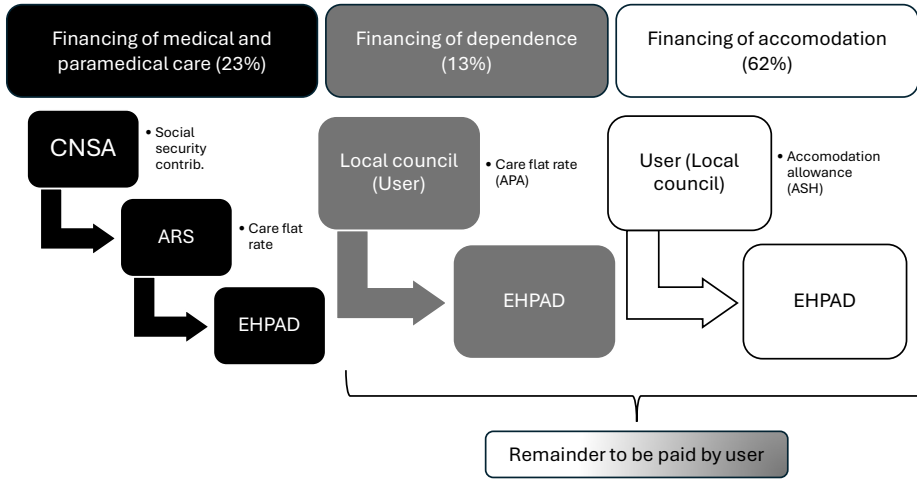
these services must be financed by the dependent person's maintenance providers. In fact, since 1803, Article 205 of the Civil Code stipulates that children must provide for the needs of their dependent parents, therefore putting the emphasis on filial solidarity. If necessary, the judge for family affairs evaluates the capacity of each maintenance provider to contribute according to their respective incomes. As a last resort, in the absence of capacity to contribute by the maintenance providers, the user can claim social accommodation allowance (ASH[9]), which is paid out by the local councils based on social criteria and reserved to people in need. ASH can be reclaimed, meaning that the local council can claim back the funds at the point of succession so that the cost of care falls onto the family, even posthumously.

Based on the works of Fraser (1994) and Nelson (1992), Morel points out the existence of a two-speed social citizenship, whereby men mostly benefit from insurance-type social rights due to their participation in the labour market, while women must be content with social assistance benefits judged to be "less generous than social insurance benefits, but also more arbitrary, whether due to budgetary constraints or for ideological and normative reasons" (2007, 388). The payment of the social accommodation allowance in France illustrates this notion. According to the latest data from the Ministry of Health's statistics department (DREES 2021)[10], the majority of these benefits go to women, who account for 65% of recipients of social accommodation allowance in EHPADs. Obtaining this aid is complex, to say the least, as it is subject to the social action regulations applying to each council, as well as to conditions relating to domicile, income and the ability to pay of those required to provide support, not to mention the fact that this aid can be recovered posthumously. In summary, the way workers are compensated through social insurance schemes such as sick leave is much less complex than compensation based on a social assistance logic.

The above graph illustrating the means of financing EHPADs leads us to make several observations. Firstly, the more technical the care and the more tied it is to the healthcare sector, the more it benefits from a social security type of funding. While medical care is entirely financed by social contributions based on an insurance model dating from the 19th-century objective of maintaining the productivity of workers, the same cannot be said for accommodation-related care, which is the entire responsibility of dependent individuals and their relatives. The cost of dependency-related care is covered by the APA paid by local councils, with users also contributing progressively according to their income. The pricing system therefore shows a clear divide between care, which comes under the public sphere and benefits from financing derived from national solidarity, and care, which is delivered by the institution on a subsidiary basis, with users or their relatives bearing the remaining costs. The financing instrument divides care into types in order to decide on the contribution attributable to each funder. As an example, let us look at the financing of laundry services in nursing homes. Any hygiene specialist will tell you that clean laundry is crucial to prevent the spread of nosocomial infections in healthcare and medical-social institutions: a comparatively large share of infections is said to origi-

nate from laundry (Union des Responsables de Blanchisserie Hospitalière (URBH) 2010). Laundry services are currently widely industrialized and respect the Risk Analysis and Biocontamination Control (RABC) method, which is very different from the standards applied at home. However, in EHPADs, laundry services come under accommodation rather than care, which ultimately implies familial funding of this service rather than public funding. The same issue concerns catering, since diet directly influences residents' health, and dieticians in fact play a key role in nursing homes. These two examples show that the classification of care that forms the basis of the EHPAD financing model stems from a prototypical classification which is approximated and fed by the representations and cognitive patterns of those who designed it (Bowker/Leigh Star 2023). Thus, the division between different types of care in reality seems to rely more on the representations linked to the place of the family as a support for elderly people as opposed to the financing capacities of the public authorities. This classification of care is the fruit of a certain vision of the family and a timely mobilization of available sources of funding. The attributes of science (classification) are used to legitimize public policy.

Figure 1: EHPAD financing channels



Note: Three different financing channels are directed towards EHPADs. The CNSA draws from its revenues to finance care in EHPADs through the ARSs, while local councils finance dependence through the APA, and the accommodation of insolvent residents through the ASH. Lastly, residents make a financial contribution to the cost of their accommodation and the co-payment dependence fee, i.e. the portion not covered by the APA. For a daily support cost of € 82 for the least dependent residents, care represents 23% of the cost, dependence represents 13%, and accommodation 62%. These calculations were carried out by the author using data from the latest available national survey of costs (Agence Technique de l'Information Hospitalière (ATIH) 2022).

Source: Own compilation.

Secondly, the principle of compulsory maintenance support and the refundable nature of social assistance for accommodation underline the family-centred model underlying the pricing system. This system takes the family as the financing unit, rather than the individual. As a result, support for dependent elderly people primarily relies on filial solidarity based on a moral obligation. This familialist conception of support for dependent people has its roots in the Civil Code of the early 19th century, based on a gendered socialization where the male breadwinner model prevailed. Yet in 2023, this obligation persists. As shown by Capuano (2018), even at the time, the debates that preceded the Act on Social Assistance of 14 July 1905, which makes assistance to the elderly obligatory in France, were centred on a fear of seeing families avoid a maintenance obligation towards their ascendents. This obligation, which was primarily a way of reducing public expenditure, was presented as a tool to preserve family bonds and encourage a saving attitude from the responsible father. By continuing to establish the family as the primary institution for dependent elderly people in 2023, the state makes the family the regulator of the distribution of care work within the household, with a risk of maintaining women in their caregiving role. As early pointed out by Orloff (1993), the state, through its social policies, has the capacity to influence the distribution of care work, both between the public sphere and the family, and within the family itself. Hobson (1990) invites us to consider the family as a set of relationships of power shaped by the state and the market. Faced with the costs of EHPAD accommodation services, the in-kind contribution of carers is often the only way of avoiding to consume family assets. With a view to preserving their assets, some elderly individuals may forego formal or institutionalized care (Lockwood 2018) and consequently rely more on family carers. As demonstrated by Carrère et al. (2023), the rate of recourse to nursing homes in France has evolved more slowly than the population of dependent elderly individuals. This relative stagnation is explained by the active presence of family caregivers. Yet as Banens et al. point out, women are overrepresented among these family carers, due to a "gendered distribution of constraints, availabilities, and affinities" (2019, 129, transl. HC). This is exemplified by the following statement of a female caregiver.

> I'm the daughter of Mr and Mrs L., who entered the nursing home in 2013 and 2015. And in fact, the connection I have with this nursing home is that my mum has Alzheimer's disease. And being the carer, I used to go to their place every day. From 8 a.m. to 8 p.m. They were lucky, because I was unemployed at the time. But actually, I couldn't take being a carer anymore. (Daughter of a couple of residents at the nursing home, interviewed on 19.6.2023)

The interviewee describes the strong sense of duty the daughter felt to take over the task of caring for her parents and how that overburdened her at the end. She mentions her unemployment as an enabling factor of her availability. Finally, her parents' transition to an EHPAD was not caused primarily by their growing care needs, but was related to her own physical and mental overload and the resulting lack of her availability.

Moral obligation: a natural, free resource

The familialist character of the EHPAD pricing system also involves an obligation for the public funder to define the care included in nursing home accommodation in order to then invoice it to the user. This means it must produce a definition of care that was generally provided by carers without recompense before the patient's arrival in the nursing home. Thus, the state finds itself in a situation of having to make this care visible and give it a value, despite having made it invisible in the name of carers' moral duty prior to the patient's entry in the EHPAD. An interesting anecdotic example illustrates the mechanisms at work here: In 2015, the working group assigned to the EHPAD pricing reform chose not to include residents' personal laundry in the basic EHPAD services. When asked to justify this decision, a working group member explained the debate that took place on whether or not to include this service in the basic package:

> There was a very femininized relationship to laundry, in the sense of an obligation to go and fetch the laundry in order to wash it and bring it back. Some said, 'Whatever you do, don't do that (make the personal laundry service part of the minimum mandatory services provided by the nursing home), you'll isolate the elderly!' even though it was clearly mostly the daughters and daughters-in-law doing the job, not the guys. Doing the laundry was also a topic of discussion; it maintained family and familiar ties. So that's why we removed personal laundry from the mandatory services in the 2016 specifications. In 2023, it was reinstated[11] because of the Orpéa affair, because some nursing homes were charging extra for it. (Member of the working group on the reform of EHPAD financing, interviewed on 19.12.2023)

This example illustrates how the configuration of the financing instrument implicitly includes the free contribution of carers, particularly female carers, without naming it. The family is established as a free provider of care alongside the state in the name of a moral obligation. More than a century after the 1905 Social Assistance Act, debates concerning obligations on the family unit have ultimately evolved little and remain closely correlated with the control of public finances. In the current EHPAD financing system, because resources allocated to medical care and dependency-related care flat-rate payments, the only adjustment variable that can be employed to balance nursing homes' budgets is the contribution paid by residents and their relatives. This invisibilization of the work done by family carers is also manifest in the argument developed to promote the move to ageing in the home. Since the 19th century, remaining in the home has been put forward as a financially interesting alternative for both the public funder and families, with care in nursing homes being judged more expensive. Recent studies reaffirming the financial interest of staying in the home include a report by the social security accounts committee, which describes the cost of care as three times higher in a nursing institution than in the home. Closer examination of the methodological note accompanying this study nevertheless shows that this comparison does not include the informal care provided by carers, judged as "difficult to quantify" (Laboureix 2021, 149).

EHPADs and the challenge of a widely invisibilized production

In this final section, I will show how the industrialization of care contributes to making the relational work carried out by professionals in these nursing homes invisible. I will then look at one of the little-known externalities of the EHPAD: this institution often represents a place of socialization and even politicization for the women present.

The industrialization of care

The ASV Act of 2015 reformed the EHPAD pricing and financing system and marked the start of flat-rate resources for these nursing homes. It did so by establishing that the public finances paid respectively by ARSs and local councils should be indexed on the characteristics of dependent people, based on two indicators: the Iso-resources Group (GIR)[12] and the PATHOS score[13]. These are used to define the care required based on patients' illnesses and their degree of severity. A resident's profile corresponds to a set of predefined treatments which are then attached to a value. These price equations therefore involve a shift from "opposable tariffs" (social security rates) to "opposable practices" (treatment practices based on predefined social security rates) (Da Silva 2018, 14). These new management tools portray an industrial conception of care. It negates the singular nature of care work and instead proposes a standardized definition that involves applying the same nationwide cost reference to all EHPADs. Frinault (2009, 64) points out that the AGGIR[14] grid, supported by the National Union of Clinical Gerontology, "fits in with the American perspective of 'Casemix Classification Systems', which use a classification system to group patients into homogenous groups of individuals requiring similar resources or generating similar costs". The normalization and standardization of services operated by both pricing tools and the evaluation tools proposed by the high authority for health (HAS)[15] contribute to inaccurately representing the work done by care professionals, who have difficulties relating these indicators to their everyday work with elderly people, as one professional told us:

> If you talk to me about a Gir 5 or a Gir 6, that's just not what we say between colleagues, we talk more about autonomy. It might be less professional, but we're more likely to say: can that person walk? I know what a Gir 1 or 2 is, but we think more about whether they need night pads. (nursing assistant, interviewed on 2.10.2023)

Drawing from the example of the Nursing Intervention Classification (NIC) in Iowa, Bowker and Leigh Star (2008) showed the limits of a breakdown of nursing acts and point out that, "[w]hen discretion and the tacit knowledge that is part of every occupation meet the medical bureaucracy, which would account for every pill and every moment of health care workers' time, contradictions ensue. This is especially true in the 'softer' areas of care" (Bowker/Star 2008, 29). Using an AGGIR grid in-

volves redefining everyday tasks carried out by caregivers and leaves little room for appraising the relational time that is nevertheless the core of their activity.

> They should really change them (AGGIR and PATHOS), because we know very well that a highly dependent person sometimes requires less support time, not less care, but less time, than someone who's starting to have cognitive impairment, even though someone with early cognitive impairment gets a lower rate. Or psychiatry, for example. We've got one lady who rings the bell every ten minutes. That's not counted in the GMP[16] and the PMP[17] (middle manager, interviewed on 7.7.2023)

The only parameters involved in establishing the amount of EHPAD care and dependency flat rates are the level of dependence (average weighted GIR or average loss of autonomy), the level of care required (average weighted PATHOS), and the number of places in the care facility.

Jany-Catrice highlights that the "relational" services mainly operated by women are generally undervalued as a result of the "convergence of institutional and conventional factors: public policies, accounting conventions, and quasi-cognitive mechanisms rendering the skills mobilized invisible" (Jany-Catrice 2007, 16, translation by author). Since the value of relational activities is difficult to measure and standardize, it is subject to controversy. One professional spoke of her frustration at the stereotypical view of her profession, generally breaking it down into care actions and overlooking the relational side:

> I'm sometimes shocked when I see that we're seen as simply wiping people's bottoms, while we do so much more! I try to let people know that our profession is a lot more than that (…) I like being a carer, but not so much caring for the body, what I like is helping out, because if I don't do it, no one else will. And they (the residents) need that, they deserve to be treated with dignity right to the end. That's how I see my job. We're good listeners, we're there for them every day, we notice when they're not feeling good, and when they're happy. Sometimes it's about simple pleasures: doing their nails, going for a walk outside, picking some flowers. Our job is complex, it's just not just about wiping bottoms! (nursing assistant, interviewed on 12.9.2023)

In carrying out a survey of home care services, Benoît, Thomas and Boukabza (2022) show that the unusual character of the relationship established between the care professional and the recipient is what gives meaning to their work for these professionals. The undervaluing of relational activities is explained by Jany-Catrice (2007) as the result of an unfortunate coming-together between domestic and market rationales. The market undervalues this activity because it is associated with domestic work that for a long time was provided by women for free based on a reciprocal exchange. For Zelizer (2008, 19, translation by author), the explanation of the undervaluing of care should be analysed as the result of bitter negotiations that contribute to operating "distinctions in the relationships between individuals and give different values to these relationships". Zelizer thus raises the question of how to explain the difference in value placed on the time that a doctor devotes to her patient and the time

a professional or family carer devotes to an elderly person without considering the gendered inequalities underlying these activities.

EHPADs: A Place of Politicization at the Local Level

The territorial presence of care homes for the elderly is regularly highlighted, based on the fact that almost 80% of French people live at least 15 minutes from an EHPAD (Carrère/Couvert/Missègue 2021). In fact, it could just as easily be expressed this way: 80% of French women live at least 15 minutes from a potential workplace. This institution participates at least as much in the policy on autonomy for the elderly as it does in the policy on employment, and therefore the autonomy of women, particularly low-skilled women in rural and peri-urban areas. According to Orange and Renard (2022, 103, translation by author), "Early familiarity with other people's intimacy creates resources for working in the care profession and participates in the fact that professional experiences are seen as natural vocations." When asked to describe the main positive point of her job, one nursing assistant immediately replied that five minutes after finishing work she is in her kitchen. The same professional carer said that because of family constraints she would not consider the same job at a distance of 20 kilometres. This personal situation illustrates the role played by EHPADs in maintaining part of the female population in work in peripheral France (Guilluy 2014). Geographical proximity means that these women can use their "indigenous capital" (Orange/Renard 2022, 152, translation by author) to dispose of organizational facilities that enable them to combine professional and family life.

The pricing equations that determine the amount of public funds allocated to EHPADs are indexed on the presumed needs of elderly people, contributing to make them the exclusive recipients of the institution's production. Our survey highlights that this premise tends to ignore the place that this institution occupies on a territorial scale as a place of socialization and politicization for the professionals and carers who work there on a daily basis. The social mission of the nursing home is not restricted to elderly people, or even to carers, but also concerns at least the women who work in the facility. For these women, the EHPAD is in numerous ways a place of learning, and an area of peripheral socialization that represents an opportunity for politicization for women who sometimes live outside traditional political parties. Politicization can be defined as "the movement or process that gets (individuals or groups of individuals) interested and involved in politics" (Déloye/Haegel 2017, 321, translation by author).

EHPADs feature at least four avenues of politicization for the communities of women present. The first, relatively common type of politicization is trade union involvement. The second type is an awareness that takes place in inter-generational exchanges between residents and carers. One professional who is a union representative at the institution, described her exchanges with the older women that she cares for:

> For me, the EHPAD is a place of learning. From a feminist point of view too (…) I tell you, we get a lot of women here who say: 'I had no choice! For some things, I had no option. My husband used to hit me, even the dog was treated better than me. I earned my place as a woman. I fought for you, for your right to vote.'" (middle manager, interviewed on 7.7.2023)

The third form of politicization concerns the regulatory meetings that take place quarterly at the institution, during which women act as representatives in their capacity as carers, care professionals, or residents. In the summer of 2023, when energy price inflation was hitting most care homes hard, and federations in the sector were launching national communication campaigns to draw attention to the critical situation, I observed during our survey that these meetings became places of mobilization on government policy. In the face of the alarming discourse of management teams, family representatives spontaneously offered to call on local politicians to influence budgetary decisions.

Lastly, our survey allowed us to identify a fourth type of politicization of carers working at EHPADs, namely the recruitment of carers to local political positions to "guarantee of a certain kind of politics" (Guionnet 2002, 132, transl. HC). EHPADs precisely constitute a public arena, a place where the professional skills and experiential knowledge of carers are recognized. Guionnet (2002) points out that the demand for experiential knowledge legitimizes the recruitment of political outsiders. Thus, the experiential knowledge of caregivers, and the skills of care professionals become resources with a value as political capital (Douillet/Lefebvre 2017). This is illustrated by the following statements of EHPAD professionals, who are local elected representatives responsible for the policy on elderly people in their municipalities:

> I'm a deputy mayor, the mayor approached me, she knew about my qualities of human discretion and empathy. (manager of one of the EHPAD logistics services, interviewed on 11.10.2023)

The medical-social institution facilitates the conversion of the carers' expertise into political capital and thus fosters their participation in local politics. At the same time, EHPADs provide an ambivalent space for politicization of professional and family carers, when the motivations regarding their investment perpetuate the gendered division of work. The following quote exemplifies how these elected women's political roles are almost exclusively linked to the social sphere (Navarre 2015).

> In my municipality, I'm delegated advisor on the voluntary sector, and my mission is the community centre for social action, reception, and social life. It means visiting elderly people at Christmas, meals for older people, etc. (…) their social life. (laundry worker at an EHPAD, interviewed on 11.6.2023)

In summary, our research shows that far from being an exclusively caring space, as the funding instruments might suggest, the EHPAD is a place where carers can socialize and become politicized.

Conclusion

Analyzing the pricing system that operates as part of social policy appears particularly pertinent to question the conventions on which our welfare state regimes are built. This pricing tool is a technically sophisticated investment in forms (Boltanski/Thévenot, 2008) that tends to invisibilize the place reserved to women in caring for the elderly. Our research shows how the representations conveyed by the funding instrument are applied at an ultra-local level, shaping intra-family trade-offs and career paths. An attentive analysis of the system's parameters highlights the persistence of a familialist model and the heavy price paid by the community of family and professional caregivers. The industrialization of care contributes to misrepresenting the singular nature of the relational work carried out by carers. Lastly, the restrictive definition of the production of this institution, on which the pricing system is based, renders comprehensive social accounting impossible (Esping-Andersen et al. 2008). This works to the detriment of the community of women who frequent these care homes. By basing funding solely on the level of residents' dependency or their pathologies, or on the conveniences of rooms, funders overlook an important part of the social production of this type of institution, which represents the main place of socialization and even politicization for a large population of women. While EHPADs in France are going through complicated times following the COVID crisis, the concretization of the move towards ageing in the home, presented as a new Eldorado, only seems to make it more likely that carers will end up making an even greater contribution in the name of their moral duty. This, moreover, marks the end of these medical-social institutions as a place of mobilization and politicization of the carer community.

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Notes

1 Établissement d'Hébergement pour Personnes Âgées Dépendantes.

2 Since 2001, under article L232-1 of the French Social Action and Family Code, any elderly person residing in France who is unable to cope with the consequences of a lack or loss of autonomy due to their physical or mental state has been entitled to a personalized autonomy allowance (Allocation Personnalisée à l'Autonomie- APA) to enable them to receive care tailored to their needs. This allowance is paid by the local council to the person's home or to the EHPAD. The amount of the allowance is calculated on the basis of the elderly person's level of dependency, using the AGGIR scale (see below). The calculation rules differ depending on whether the elderly person lives at home or in an EHPAD.

3 In contrast to e.g. Germany, French law does not set a scale for maintenance obligations. Those obliged to provide support must reach an amicable agreement on the amount of aid to be paid to their relative in need. If the parties are unable to agree on the amount to be paid, the matter may be referred to a family court judge to determine the amount of support that each person must pay to their relative. The judge sets the individual contribution of each person obliged to provide support on the basis of their family and economic situation. If one of the children is unable to make a financial contribution, the judge may require him or her to take in the relative free of charge (Civil Code, Article 210).

4 Decree No. 99-316 of 26 April 1999 relating to pricing and financing of residential care homes for dependent elderly people.

5 Loi d'Adaptation de la Société au Vieillissement

6 Articles 2, 3 and 4 of Decree no. 99-316 of 26 April 1999 introduce a ternary classification of the care provided to elderly people in nursing homes, as follows: The tariff for care covers the medical and paramedical services required to treat the somatic and mental ailments of people residing in the establishment, as well as the paramedical services corresponding to care related to the state of dependency of the people admitted. The dependency tariff covers all the assistance and supervision required to carry out the essential acts of life. The tariff for accommodation covers all general administration, reception, catering, maintenance and social services provided by the establishment that are not linked to the dependency status of the residents.

7 Agence Régionale de Santé.

8 Caisse Nationale de Solidarité et d'Autonomie

9 Aide Sociale à l'Hébergement.

10 Direction de la Recherche, de l'Évaluation, des Études et des Statistiques – French Ministry of Health Statistics Department: https://data.drees.solidarites-sante.gouv.fr/explore/dataset/les-caracteristiques-des-beneficiaires-de-l-aide-sociale-departementale-aux-pers/information/ (27.7.2024).

11 Until 2023, laundry was nearly always included in public nursing homes, often in non-profit ones, and rarely in for-profit EHPADs. The legislation has changed since the Orpéa Affair. The Orpéa Affair denotes the systemic mistreatment observed in many EHPADs, particularly those run by the private group Orpéa, including food rationing and the misuse of public funds.

12 The number of GIR points shows the level of dependence of residents in the nursing home. The AGGIR grid comprises six levels of dependence. The most dependent residents are classified as GIR 1 and the least dependent are classified at GIR 6. The AGGIR grid is an assessment tool completed by doctors and carers. The assessment is then validated by the local council and the regional health agency to determine the amount of funding allocated.

13 PATHOlogie et Soins: The PATHOS algorithm is used to evaluate the level of care required by residents according to their illness and the degree of severity.

14 Autonomie Gérontologique Groupe Iso-Ressources

15 Haute Autorité de la Santé

16 Gir moyen pondéré - Weighted average GIR. This indicator corresponds to the average dependency of residents calculated using the AGGIR grid. The value of this indicator is validated by the regulatory authorities twice in 5 years to update the amount of funding paid by the local council.

17 Pathos moyen pondéré - Weighted average PATHOS. This indicator corresponds to the average medical and paramedical care required by residents. The indicator is calculated using the PATHOS algorithm. The value of this indicator is validated by the supervisory authorities twice in 5 years to update the amount of funding paid by the regional health agency.