The professionalisation of domiciliary care for the elderly: a comparison between public and private care service providers in Belgium

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Abstract
Purpose - The objective is to explore how the professionalisation of care jobs is constructed in the public and private sectors and to discuss whether the instruments used by public and private care providers contribute to solve the ambiguities linked to this type of work and which are the consequences for caregivers.
Design/methodology/approach - This paper compares the way in which the professionalisation of home care services for elderly people is achieved in the public and private sectors in the region of Brussels. The findings are based on the analysis of interviews with professional actors working in the care sector in Brussels.
Findings - 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.
Originality/value - The divergencies are not only the result of the strict institutional framework to which public care providers are bound, in opposition to the relative freedom of the private sector, but they also derive from a different understanding of care work.

Keywords Professionalisation, Care work, Public care provider, Private care provider, Emotional labour

Paper type Research paper

Introduction
The concept of “professionalisation” has been used in sociology and other disciplines in a number of different – and sometimes contradictory – ways. In a broad sense, professionalisation can be associated with a behaviour opposite to amateurism, to denote expertise and qualifications or to make a distinction between paid labour market activities and unpaid voluntary or informal activities. Focussing more strictly on the labour market, this term is sometimes 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 the recognition of the work as “real work” (Ribault, 2008). According to Aballéa (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 Dussuet, 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 with the notion of “caring” (Clergeau and Dussuet, 2005; Puissant, 2011).
The specific challenges linked to the professionalisation of home care work can be related to at least two factors, which both contribute to the lack of valorisation and the low status of care work.

The first is the gendered dimension of care work, as it has been emphasised by the scholarship (Anderson, 2000; Gerhard et al., 2005; Cox, 2006; Lutz, 2011; Devetter et al., 2009; Avril, 2014). Due to the traditional role of the family – and of female family members in particular – in providing informal care, care work is still strongly associated with female reproductive labour and constructed as a “natural” attitude of women, even when remunerated and officially regulated within the labour market (Ungerson, 2000). Analysing the professionalisation of home care necessitates tackling the traditional dichotomies between productive/reproductive labour, private/public sphere and paid/unpaid work (Anderson, 2000; Theobald, 2003; Weicht, 2015). Additionally, the emotional labour and the intimate tie between the caregiver and the cared for, which are intrinsic elements of care work, tend to be essentialised as feminine duties, as part of the traditional family obligations held by women, and are hardly admitted in the professional field (Hochschild and Ehrenreich, 2002). The gendered stereotypes associated with care work, combined with the blurred distinction between productive and reproductive labour and the emotional labour which is demanded from carers, contribute to explaining the non-recognition of care work as “real work” (Anderson, 2000; Lutz, 2011), as well as the high prevalence of care work in the informal economy [1] (Farvaque, 2013).

The second is the private nature of home care work. Because it is performed in private settings, it presents specific challenges, including the invisibility of the work, the lack of inspections and control over working conditions (Cox, 2006; Devetter et al., 2009) and the ambiguity of the employment relationship, which typically oscillates between a contractual relationship and a family-like relationship (Parreñas, 2014; Baldassar et al., 2017). As several studies have shown, the relationship between the worker and the beneficiary is based on unequal power relationships, regardless of the degree of intimacy between the two parties (Rollins, 1985; Parreñas, 2001). While the distance between the employer and the caregiver was formerly justified by social class and educational level, it is nowadays articulated in more complex forms, where the function of the “otherness” is often fulfilled by the nationality and/or the ethnic group (Sarti, 2008; Lutz, 2011).

For all of these reasons, the question of the valorisation of the work plays a crucial role when discussing the professionalisation of home care work. Currently, not only is care work largely performed in the undeclared economy (Giordano, 2018), but even when “formalised” in the form of external paid services offered by public or private care providers, it is still characterised by extremely poor working conditions everywhere in Europe and tends to attract the most vulnerable workers in the labour market – namely women and migrants (ILO, 2013). Despite the attempts to professionalise it, care work is still considered as female work, which does not require specific skills and qualifications, and work with a poor reputation and a low social status (Lutz, 2011).

The strengthening of formal home care services and the increased competition among care providers and the emergence of new private solutions in the market, which are trends common to most European countries, are crucial to the debate on the professionalisation of home care services (Theobald, 2003; Clergeau and Dussuet, 2005; Bonnet, 2006; Stolt et al., 2011; Puissant, 2011; Schwiter et al., 2018). The increased marketisation of home care work and the diversification of care providers have been promoted as instruments for meeting the growing demand for care work, while at the same time reducing public costs, in line with the general shift towards neo-liberal economic measures in all Western countries (Schwiter et al., 2018). Moreover, the marketisation of care has been viewed as a modern solution allowing Western women to conciliate family and professional responsibilities and offering care recipients the possibility to choose among varied options (“freedom of choice”)
However, not only the marketisation of care work has significant consequences for both caregivers and families, but it also raises important ethical questions. On the one hand, it may exacerbate inequalities between families who can afford marketised services and families who cannot (Rummery, 2009) and between caregivers, whose employment conditions increasingly depend on their employer. On the other hand, the introduction of a “market logic” in care provision, where the elderly person is encouraged to act as a customer, as well as the very concept of commodifying care, poses serious ethical questions (Ungerson, 2000; Farris and Marchetti, 2017).

Starting from the features of the Belgian elderly care system – and in particular the regulation and the subsidisation of the elderly care sector, as well as the increased privatisation of services (Willemé, 2010; Giordano, 2019) – in this paper, I discuss some of the problems linked to the professionalisation of home care services for elderly people, and I compare the way in which private and public care providers conceptualise it. The findings are based on the analysis of in-depth interviews with key figures in the field of home care for elderly people in Brussels, including public and private care services providers.

Given the lack of unanimity on how professionalisation can be achieved, especially in the field 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 constructed. Specifically, 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 ambiguities linked to this type of work – namely the gendered dimension of care work and the unsolved tension between productive and the reproductive labour performed for free by women (Rollins, 1985; Anderson, 2000; Cox, 2006; Lutz, 2011).

Formal home care services for the elderly in Belgium

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 1980s (Gilain and Nyssens, 2001; Willemé, 2010; Degavre and Nyssens, 2012). The state intervention 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 familialism (Leitner, 2003) was based on the idea that the state would intervene when the informal care of family members 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 economic, societal and demographic changes paved the way to transformations of the elderly care sector. On the one hand, the ageing of the population, the increased female participation rates in the labour market, as well as changes in family structures and mobility, contributed to increasing the demand for care (Bettio et al., 2006; Simonazzi, 2009; Anderson and Shutes, 2014). On the other hand, the reinforcement of neoliberal ideas and the retrenchment of welfare states, as well as the constraints imposed by the economic crisis, have influenced the recent reforms in old age care in all European countries (Guo and Willner, 2017; Schwitter et al., 2018). Among the most visible trends in Belgium are the strengthening of home care services and the marketisation and privatisation of elderly care services (Giordano, 2019). As elsewhere, both trends are linked to the wish to reduce public expenditures and to grant care recipients a “free choice”, based on their assumed desire to remain in their home as long as possible (Rostgaard, 2007; Stolt et al., 2011; Guo and Willner, 2017).

While 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; Willemé, 2010). The complete transfer of the responsibilities from the Federal to the
local levels in the field of domiciliary care, implemented with the last institutional State
reform in 2014, was accompanied by an explicit encouragement to promote publicly financed
home care for the elderly (Giordano, 2019). Currently, the Belgian elderly care sector is based
on a system of public subsidisation, which in the field of home care remains exclusively open
to non-profit organisations [2]. The organisations that have an official accreditation with a
public body have to comply with the public regulation applying to the field of home care,
which includes a precise definition of the entitlements, the nature of the tasks to be performed,
the number and the type of professionals involved, as well as the price for care recipients,
based on institutional ladders (De Donder et al., 2012).

While up to the 1980s the role of the market in the provision of care was almost
non-existent, starting from the 1990s several private for-profit providers began to offer
alternative options in both residential and home care (Giordano, 2019). Currently, 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 size of the private sector is more difficult to define, as a result of the heterogeneity and the
multiplicity of private service providers [3].

Although the distinction between public and private home care providers is not
straightforward, as a result of the complex system of subsidisation and the division of
institutional powers in the Belgian federal state, for the purpose of this paper, I will consider
“public” the non-profit organisations that have a public accreditation (or a public
subsidisation) and “private” all the non-profit or for-profit organisations that do not have
agreements with public bodies and do not receive public funding [4].

Public care providers offer prices that vary from approximately 0.50 euros to 7.50 euros
per hour and are calculated on the income of the care recipient. 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 to
which the beneficiary is entitled. Despite slight differences in the way institutional
regulations are implemented, public care providers show homogeneous characteristics in
terms of entitlements and types of services, as well as job descriptions and qualifications
required to workers. Front-line care workers include nurses, health assistants (aides-soignantes),
family assistants (aides familiales) and housework attendants (aide-ménagères) (Godard and Sammiez, 2007; De Donder et al., 2012). A Joint Industrial Committee (CP 318.01)
regulates their working conditions, including wages, which vary from about 1,600 to 1,900
euros per month (after taxes) [5]. Concerning care recipients, they are usually entitled to a
limited number of hours per week, with services lasting between half an hour and three hours,
usually between 8 a.m. and 4 p.m. Apart from specific exceptions, evenings, nights and
weekends are not covered.

On the contrary, private care providers vary greatly in terms of the prices and the type of
services provided, as well as the employment status and working conditions of caregivers.
Prices offered to care recipients are either calculated on an hourly basis (starting from 10/15
euros per hour) or based on flat rates (per night or per month). The employment of caregivers
can take different forms (i.e. employee, self-employed or specific contractual agreements for
pensioners, unemployed or occasional workers), and none of these providers is bounded to
specific regulations fixing the qualification of care workers or the definition of tasks and
entitlements.

Although this distinction does not convey the complexity of the Belgian elderly care
system, it has two main advantages for the purpose of this paper. First, because it is clearly
mirrored in the prices offered to care recipients, it corresponds to the common understanding
of the public/private divide for Belgians. Second, it allows exploring whether private and
public care providers differ in their way of professionalising care services, which represents a
topical concern for the implementation of public policies.
Methodology

The respondents

The findings presented in this paper are based on 15 in-depth interviews with key figures working in the field of elderly care in the region of Brussels, conducted in the period between October 2018 and May 2019. The interviews are part of an exploratory study carried out in the framework of a broader research on elderly care in Belgium. Since the main objective of this exploratory study was to shed light on the functioning of the elderly care sector and on the main services available to elderly people in Brussels, the choice of the respondents was based on a strategic sampling method, as described by Gaudet and Robert (2018). In addition to selected experts in the field of the elderly care sector (i.e. public bodies in charge of the services accreditation, trade unions, etc.), several care service providers were recruited, based on specific criteria. The first criterion was to cover the most important and well-known care providers in Brussels, based on a preliminary analysis of the literature on Belgian care services and of the available sources (texts of legislation, online websites of institutional actors and/or care providers, etc.). The second was to include both public and private care providers, meaning organisations with and without public subsidisation. The third criterion was to include both care providers working in the entire territory of the Brussels’ Region and others working at a more local level (i.e. the different municipalities). This choice was based on the assumption that the demand for care services, as well as the supply, may vary depending on the characteristics of certain neighbourhoods (i.e. differences in the characteristics of the population, in terms of its socioeconomic level and origin).

Respondents include the service in charge of domiciliary services of the Commission Communautaire Française (COCOF), the Brussels’ regional ministry of economy and employment (Bruxelles Economie et Emploi), a non-profit organisation offering counselling services for older people (Infor-Homes), a trade union (FGTB), a mutual health insurance, the federation of home care services in Brussels (FSB), as well as public and private care service providers. The latter include four care providers with a public accreditation (one active in the 19 municipalities of Brussels and three only at the municipality level [6]), a non-profit organisation subsidised via a public programme of reintegration of long-term unemployed [7], and four private for-profit care providers. The private care providers that accepted to be interviewed include two for-profit organisations, offering general care services (garde-malade); a for-profit care agency recruiting female caregivers in Romania (and occasionally in other Eastern European countries) and offering 24-h live-in services; and a recently established organisation that “matches” supply and demand for care services, through its online platform [8].

Because the objective of this analysis was to explore the institutional context and the functioning of the elderly care sector in Belgium, from the employer’s point of view, the respondents only include managers and administrative staff and exclude front-line workers. The extracts reported in this paper, which have been translated by the author from French to English, are part of the interviews with the nine care service providers included in the sample, whose details are provided in Table 1.

The interviews

All the respondents have been initially contacted by email and invited to participate in face-to-face interviews. The email sent to the respondents included a brief presentation of the research, the main objective and an overview of the points to be addressed during the interview. While institutional bodies, trade unions and public care providers generally provided a prompt and positive reaction, private providers were more difficult to access, and the organisation of the interviews demanded multiple contacts by email and telephone. All the respondents provided their orally informed consent to participate in the research and to be recorded, following email exchanges and prior to the interview.
The method chosen for this part of the research was to conduct semi-directive interviews, which represented the most suitable option for completing the background analysis of the elderly care sector in Brussels. In line with the overall objective of the study, the interview guide was prepared so to include a common initial input, followed by a flexible list of themes to be addressed during the interview (Gaudet and Robert, 2018). The common initial input included a brief description of the research, as well as a general question on the functioning of the organisation (for care providers) or on the elderly care sector in Brussels (for other experts). The list of themes, which was not elaborated in the form of structured questions, included the following: the type of services provided (prices, characteristics, entitlements); the demand side (characteristics of beneficiaries and families; specific demands/needs of families; problems with beneficiaries), the supply side (number and characteristics of workers, including origin, gender, education; specific problems beneficiary/worker and organisation/worker); problems and challenges of the organisation; the care sector in Brussels; the undeclared work with elderly people in Brussels. After the initial question, respondents were free to address the different themes in a flexible order and using their own discursive tools.

The interviews, lasting between 45 min and 2 h and a half approximately, have been entirely transcribed (verbatim) and treated with thematic analysis (Ramos, 2015).

<table>
<thead>
<tr>
<th>Care provider</th>
<th>Respondent (pseudonym)</th>
<th>Role</th>
<th>Number of front-line workers</th>
<th>Place of interview</th>
<th>Length of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public 1</td>
<td>Christelle</td>
<td>Manager/social assistant</td>
<td>13</td>
<td>Office</td>
<td>1 h 30 min</td>
</tr>
<tr>
<td>Public 2</td>
<td>Myriam</td>
<td>HR/social assistant</td>
<td>13</td>
<td>Office</td>
<td>1 h 02 min</td>
</tr>
<tr>
<td>Public 3</td>
<td>Chantalle, Daphné, Ophélie</td>
<td>Social assistant – manager – stagiaire</td>
<td>34</td>
<td>Restaurant of rest home</td>
<td>45 min</td>
</tr>
<tr>
<td>Public 4</td>
<td>Sylvie</td>
<td>Manager</td>
<td>&gt;300</td>
<td>Office</td>
<td>51 min</td>
</tr>
<tr>
<td>Public 5</td>
<td>Vincent</td>
<td>Manager</td>
<td>90</td>
<td>Office</td>
<td>2 h 40 min</td>
</tr>
<tr>
<td>Private 1</td>
<td>Catherine</td>
<td>Manager/founder</td>
<td>30</td>
<td>Coffee shop</td>
<td></td>
</tr>
<tr>
<td>Private 2</td>
<td>David</td>
<td>Manager/founder</td>
<td>±700</td>
<td>Office</td>
<td>2 h 04 min</td>
</tr>
<tr>
<td>Private 3</td>
<td>Samuel</td>
<td>Manager/founder</td>
<td>30</td>
<td>Office</td>
<td>2 h 31 min</td>
</tr>
<tr>
<td>Private 4</td>
<td>Jacques</td>
<td>Manager/founder</td>
<td>50</td>
<td>Coffee shop</td>
<td>1 h 24 min</td>
</tr>
</tbody>
</table>

Table 1. Care services providers
Specifically, the analysis included three steps. The first was a descriptive analysis of the material and allowed to restructure the content along with the main themes, as elaborated in the interview guide. The second included a transversal in-depth analysis on the narrative of respondents with respect to the professionalisation of care services and allowed to identify the four themes that constitute the structure of the following section – namely the question of the polyvalence versus the division of tasks; the question of the continuity versus the fragmentation of services; the question of the skills and qualifications; and the additional ad-hoc strategies. The last analysis was the comparison between the various respondents with respect to the aforementioned themes. The findings overall confirm the distinction between public and private care providers adopted in this paper.

The professionalisation of home care services in the public and private sectors
What clearly emerges from the interviews is that professionalisation is acknowledged as the primary goal of both public and private care providers, who repeatedly stress the importance of offering “professional services” that should guarantee a good quality of services, 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 professionalisation in the home care sector is primarily seen as the formalisation of services that pertain to other spheres: the domestic and the informal (Ribault, 2008). However, while their distinctiveness with regard to undeclared/irregular work is repeatedly emphasised, their narrative shows that the distinction between professional/formal and family/informal work is more difficult to draw. The strategies that care providers put in place to pursue the objective of professionalisation are considerably different and often based on dichotomous oppositions.

Division of tasks or polyvalence?
The first divergence between public and private care providers is linked to the question of the division of tasks and the definition of job descriptions. Views differ with respect to whether home care providers should offer specific services, each of them based on a list of authorised/non-authorised tasks, or whether they should provide more holistic services, aimed to cover the entire needs of frail elderly people.

According to public care providers, the clear repartition of tasks among different caregivers, which is imposed on them by the institutional regulation, represents their main instrument of professionalisation and is beneficial for a series of reasons. First, it allows differentiating professional services from the care of family members. While it is part of the nature of unpaid family care to cover the entire needs of the care recipients, the very nature of professional care services is that they do not (Puissant, 2011). Second, the fact that each care worker is specialised in different tasks is a way to ensure professionalism, in that each worker becomes an expert and is fully responsible for his/her own work. This is necessary in order to guarantee high quality of services, but also to valorise the expertise and the competencies of care workers, by avoiding that a qualified worker be asked to perform lower-skilled tasks.

We remain very clear that there are specific competencies and that polyvalence also kills the quality of the service. 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. (Vincent)
Third, the respect of the division of tasks is a way of protecting both caregivers and care receivers from potential risks and limiting 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 cannot, 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. (Ophélie).

However, most respondents, including public care providers, 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 to do more than expected. This is usually considered by public providers as a break of the rule, made necessary to respect the human dignity of the elderly person, which must be always framed as an exception, rather than the norm.

On the contrary, private care providers consider the division of tasks as a clear limitation: a limitation for the organisation, which has to comply with unrealistic constraints, and a limitation for the elderly person, who is denied adapted services. The services proposed by private providers intend to offer a more holistic type of assistance, which according to them is better suited to meet the needs of frail elderly people. All private actors repeatedly emphasise the rigidity of public services, which are not only scarce in terms of length of services and time schedules, but also limited in terms of the actual activities that they are able to perform. Talking about public care providers, the director of a private care agency states:

People on the ground are generally great, they do this with a lot of heart. But they are blocked by the functioning of the organisation. They have to say ‘no’ very very often [...] So, it’s little adapted. It’s logical from the point of view of the organisation, 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 organisation and to be more efficient. But no elderly person understands why they can do certain things and not others”. (David)

Interestingly, this private provider attributes to public services features that are commonly linked to market logic, such as the evaluation of efficiency costs and resources management.

According to private providers, high-quality services should be based on a sort of polyvalence of workers, who must be able to adapt to the situation of the elderly person, which varies depending on the degree of dependence, but also on personal characteristics. In opposition to the public sector, the real advantage is the flexibility of services, meaning that caregivers are not limited in their actions and 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 (Catherine)

They [the workers] can actually do everything. everything that a member of the family would do, without questioning themselves: “Am I allowed or not?” (David)

Overall, the opposition of public and private care providers over the question of polyvalence shows two opposite intents, as well as two distinct understandings of home care work. On the one hand, while the emphasis on the division of tasks promoted by public providers ultimately aims to valorise the work of caregivers and to protect them from possible risks, the emphasis on the polyvalence of caregivers proposed by private providers is entirely tailored to the care recipient. According to the respondents from the private sector, the professionalisation of care work is closely linked to the flexibility of services: they use the freedom they enjoy as private organisations to offer services based on “the sense of mutual assistance”. In line with the findings of Schwiter et al. (2018), private care providers tend to emphasise the “progressive” aspects of the marketisation of care, by picturing themselves as actors offering services for the collective good, rather than actors driven by economic interest.
By leaving aside the commercial nature of their services, they adopt a discourse that focusses on elements of compassion and humanity, rather than the profit. It is not clear whether these justifications are expressed as the individual view of the respondents or whether they are internalised in the culture of the organisation.

On the other hand, while public providers consider the division of tasks the main instrument to distance professional services from family care, private providers consider professional home care services as an extension of domestic help. In this sense, private care providers do not deny – but on the contrary, encourage – the overlap of formal home care services and family help and thus emphasise the intimate/familial nature of care work. According to them, this overlapping does not jeopardise professionalism, but simply helps to refocus the attention on the care recipient. By omitting the potential dangers that this may represent for caregivers – such as the worsening of working conditions, including excessive demands and long hours, as well as the strengthening of unequal power relations based on class, gender and race – private care providers promote this ambiguity as to an ideal form of care, combining professionalism and humanity.

Continuity of services or fragmentation?
The second point stressed by the respondents concerns the question of the continuity of services, which refers both to the personnel and to time intensity. In the first case, in line with traditional family obligations, the focus is placed on the belief that the elderly person needs to be attended by someone of trust – ideally only one person – who becomes an “external member of the family” (Parreñas, 2014; Baldassar et al., 2017). In the second case – and linked to the issue of the polyvalence of workers – the emphasis is placed on the intensity of care, in terms of the number of hours provided.

According to private care providers, both types of continuity are crucial elements of their understanding of professional care services. For some of them, the possibility to assign a single caregiver to cover long shifts, up to 24 h, is 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 cannot guarantee this, I refuse. [...] Since my workers are self-employed, they do not have limits on the number of hours. (Samuel)

Since it supposedly responds to the “natural” wish of the care recipient, continuity is considered synonymous with high quality of services, as well as the best way to promote the well-being of the older person.

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 the workers with whom they have to do. (David)

Assigning the same person to the same care recipient may have advantages also from the point of view of the management of the organisation.

And then I have fewer 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. (Catherine)

Similarly, the continuity in terms of long-lasting services and the possibility to cover nights and weekends are considered by private providers an important tool to guarantee a high-quality service. In opposition to public services, some private providers organise their services so to ensure the longest possible care of care recipients, up to 24 h. The provision of long shifts is also highlighted as an advantage for caregivers: because their hourly pay is extremely low – about 9/10 euros per hour before taxes for self-employed, and as low as
4 euros per hour for workers under other contractual statuses – they need long shifts to earn a full salary.

According to public care providers, the continuity of services is not a viable option, because of organisational constraints and because of the employment regulations that fix the working conditions of caregivers. However, according to the respondents in the public sector, staff changes and shorter services are not perceived as a failure of the system, but as useful instruments for 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. (Vincent)

The need to vary the personnel is primarily used as a means of guaranteeing fair and decent working conditions to caregivers and protecting them from the risks associated with the “emotional labour” (Hochschild and Ehrenreich, 2002). The hardship of the work is repeatedly expressed by public providers as a problem linked to the very nature of care work, which inevitably oscillates between emotional involvement and distance. The emotional labour and the bond that ties the caregiver and the care receiver are considered a risk, 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... (Vincent)

This touches on the dilemma on whether professional care should be based on the distance between carer and cared for or whether the human relationship should be given the priority. The strategies adopted by private and public providers differ considerably. Although both types of providers acknowledge the emotional and human dimensions implicit in care labour, public care providers try to limit the risks, by introducing professional tools to support workers (psychological coaching, staff meetings, etc.). On the contrary, private care providers encourage the strengthening of the emotional ties, and they do so through the provision of services based on continuity. Instead of promoting a vision of professional services based on the distance between the caregiver and the care receiver, family-like relationships are voluntarily reinforced. One of the strongest advantages they claim over public services is precisely to be able to guarantee a service that is both professional and based on a family-like care model. The result is that care recipients benefit from the intensive 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 may put caregivers in a very vulnerable situation. Furthermore, while they describe long shifts as beneficial for both caregivers and care receivers, the many disadvantages for caregivers (i.e. excessively long shifts, stress and physical and mental fatigue, etc.) are absent from their narrative.

**Formal qualifications or soft skills?**

In line with the literature, which stresses the importance of competencies as a key element of professionalisation (Abbott and Meeraboue, 1998; Clergeau and Dussuet, 2005; Ribault, 2008), the care providers that I have interviewed highlight the question of competencies as a core concern in their daily work.

According to the accredited care providers, who are bound to the institutional regulations, the professionalisation of care work must be linked to a recognised system of qualifications. Qualifications are needed in order to provide caregivers with the competencies and
knowledge necessary to perform the work, on the one hand, and 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: (1) the formal qualification of care workers, according to institutional educational programmes that vary from six months for general household assistants to two years for health assistants; (2) a number of compulsory training sessions each year; and (3) the weekly staff meetings, which include elements of exchange, coaching and support for workers.

The possession of a diploma is the first instrument for the qualification of caregivers and the recognition of their professional status as workers and represents the “proof” 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 both the informal economy and the private sector, where formal qualifications are not required.

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 training sessions, that the person knows how to deal with problematic situations? (Christelle)

Apart from specific notions on how to perform the work, caregivers are also asked to learn elements linked to the “ethics” of care work. All public care providers stress the importance of what they call “the deontology of work”, which is considered a crucial element for the well-being and the security of both caregivers and care receivers.

Besides formal qualifications, front-line caregivers are also asked to regularly attend a fixed number of training sessions per year, whose cost is included in the budget provided by the state. These lifelong learning programmes are compulsory, and the content varies according to the needs and the interests of the workers and the organisation. Finally, staff meetings, which are usually provided by the public providers on a weekly basis, aim to strengthen the competencies of caregivers, foster team building and provide support to workers. Both training programmes and staff meetings are considered by public providers as important instruments for strengthening the professionalisation of their services.

Contrary to accredited services, private providers do not have to comply with formal requirements concerning the qualifications of caregivers. According to them, the lack of formal qualifications does not jeopardise the quality of services, but it is seen as a rather positive element, for a series of reasons. First, contrary to the arguments used by public providers, qualifications are generally judged as unnecessary, because the tasks required from caregivers do not imply specific knowledge or competencies.

The tasks do not require any qualifications. 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 (David)

Furthermore, the multitask profile that they expect from caregivers would hardly adapt to workers who have obtained a formal diploma. Thus, unskilled workers may be preferred, as they are supposedly more adaptable to the requests of the care recipients.

On the whole, I do not 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 the experience and who feels good with elderly people. (Jacques)

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. All the respondents insist on the importance of “soft skills”, which are deemed to be the real assets of their caregivers. The most mentioned among these skills are patience, positive attitude, willingness to help, empathy, humanity and most of all what they call a “vocation”.

Professional home care for the elderly
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 do not have the choice, but I feel it immediately when they do this because they do not have the choice. Well, I really look for people that do that with a love of the elderly, who enjoy doing it, and who do not do it only for money (David).

When someone comes and says: “No, I do not do that, I do not do that, I do not do that… I want to know how much I earn”, I immediately understand that this is not her vocation (Samuel).

So, the first diploma I ask for is coming from the heart and from patience. It’s like this. […] Because since we do not offer medical care – it’s only a presence – I do not 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… (Samuel).

The recurrence of terms such as “vocation” and “love” in the narrative of private care providers is demonstrative of the emphasis placed on the specificities of care work. According to them, instead of calling into question the professionalism and the quality of services, the lack of formal qualifications is counterbalanced by the presence of soft skills and the professionalisation is precisely built on these qualities. As it emerges from the extracts, the discourse of private providers seems to imply that not only the work required from caregivers does not require competencies, but that it is something “enjoyable” for those who naturally appreciate the company of elderly people. Despite the formal discourse around professionalisation, this suggests a vision of home care that reinforces the stereotypes on care work and the lack of recognition as real work.

However, although formal qualifications are explicitly considered as unnecessary, private care providers may indirectly take advantage of the (over)qualification of their workers. Two situations seem to be particularly common – and advantageous – for private care providers. The first concerns workers who have obtained the qualifications required in the public sector, but work – part-time or full-time – in the private sector.

The majority has a paramedical 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. (Catherine)

The second concerns foreign workers who have obtained their professional qualifications in their country of origin, but whose diploma is not recognised in Belgium:

We have caregivers who are medical doctors in their country! But here, well… since they cannot practice here as they do it there, being a caregiver is an entry point, actually… (Vincent).

To sum up, while the question of the competencies is crucial for all providers, there is no agreement on which competencies should be privileged. While public care providers stress the importance of formal qualifications, private providers build the professional profile of caregivers on other competencies, mainly linked to personal/behavioural traits. From the point of view of caregivers, the risk of a system of competencies that is not institutionally constructed and recognised is that their work is not collectively recognised, including with regard to their wages (Ribault, 2008). It is interesting to notice a contradictory element in the narrative of private care providers: while they firmly deny their importance, they take advantage of the formal qualifications of their workers. This suggests that for a service to be professional – or at least “professionally legitimised” – some formal guarantees, such as qualifications, are considered useful even in the private sector.

Additional strategies
Finally, care providers put in place additional strategies to foster the professionalisation of their services. These strategies are aimed to provide more adapted services to care recipients – such as
the provision of *ad-hoc* medical/paramedical services in addition to general services – or to guarantee a better quality of jobs, depending on the philosophy and the resources of the structure.

A key strategy used by the private providers that I have interviewed is the possibility offered to care recipients to choose the caregiver, or to refuse him/her, based on 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 does not work you stop, you take someone else and you continue. (David)

You can have someone very competent, but you do not feel her, there is no chemistry, you know, between the two parties. So, I always tell them: a trial period of 15 days, if there is no connection after 15 days, then we change the caregiver. (Jacques)

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 intimate environment of the older person. The possibility of choosing this privileged relationship is considered by private actors as a “right” of the care recipient.

Although the possibility to choose the worker is ultimately meant to make the service as suitable as possible for the care recipient, this has dramatic consequences for caregivers. Because of the very high price of private services, care recipients and their families feel entitled to express their preferences, often in the form of discriminatory preferences for female workers – in accordance with ideas and values that link care work to feminine traits – and for workers from certain ethnic groups or nationalities.

**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 region of 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. The findings show that the divergencies are not only the result of the strict institutional framework to which public care providers are bound, in opposition to the relative freedom of the private sector, but they also derive from distinct visions of care work.

Although the concept of professionalisation encompasses a wide range of definitions, the analysis of the interviews with care providers in Brussels clearly shows that respondents in the public sector tend to build their professionalism on the features that are typically considered elements of the “professional field”, according to the general understanding of professionalisation (Abbott and Meerabeau, 1998; Aballéa, 2005; Clergeau and Dussuet, 2005). These features include, for instance, the focus on decent working conditions for caregivers, the focus on a recognised system of qualifications and on a specific deontology of work, the protection of workers from potential risks, which are all meant to valorise the expertise and competencies of workers and to upgrade the status of the jobs. On the contrary, the efforts towards the provision of professional services in the private sector are almost exclusively directed to providing flexible and adapted services and generally neglect elements that are commonly valued as elements of professionalism, such as formal qualifications, working conditions and monetary reward of caregivers, as well as the status of care jobs.

Given the specificities of care work, a deeper analysis allows to discuss whether the instruments used to professionalise home care work contribute to solving, or on the contrary, to intensifying, the ambiguities linked to this type of work – namely the gendered dimension of care work and the unsolved tension between productive and the reproductive labour
performed for free by women (Rollins, 1985; Anderson, 2000; Cox, 2006; Lutz, 2011) – as well as the role of marketisation in the provision of care.

With this respect, two points can be stressed. The first concerns the understanding of professional home care as an extension of family care, in opposition to a vision of professional care built on the distance between the carer and the cared for. What clearly emerges is that the private sector tends 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 one would expect from a family member. Instead of questioning the traditional distinction between formal/informal, paid/unpaid, public/private and solving the ambiguities linked to the notion of “caring”, private care providers build the professionalisation of their services precisely on the ambiguous position of home care. This may reinforce the stereotypes linked to care work, including its gendered dimension (Anderson, 2000; Ungerson, 2000; Lutz, 2011). 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 point concerns the actor – between the carer and the 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 build their professionalisation by focussing on the caregiver. Even though the care recipient remains in the centre of the attention, in their case the professionalisation is clearly focussed on the workers and is meant to guarantee a good quality of care jobs. The narrative of the respondents in the private sector brings to light interesting insights. In line with recent findings, the emphasis on the needs of the care receiver and the overuse that they make of a language of love and compassion intend to promote a vision of marketised care services as social goods at the service of the community (Swither et al., 2018). The shift of the focus from the profit and the economic interest to the well-being of the elderly person and the emphasis on elements such as humanity and empathy hide the other side of the medal of the marketisation of care work.

These different logics of “doing professionalisation” have important consequences for both elderly carers and families. Concerning caregiver, the most striking consequence is linked to the quality of jobs, with workers employed by private providers enjoying the worse working conditions. The better quality of jobs in the public sector includes not only the basic aspects of the employment relationship (wages, working hours, paid leaves, progressive reduction of working time, lifelong training, etc.), but also an adapted organisation of work, which privileges the division of tasks and the work with multiple care recipients. Conversely, caregivers in the private sector enjoy worse working conditions in all the aforementioned 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, makes 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.

These different types of professionalisation also have significant consequences for families and care recipients. Although private care providers describe their services as community services based on principles of mutual assistance, the profit logic – which is reflected in the prices of services – makes them a viable option only for a few. A clear cleavage is likely to emerge between those who can afford to choose the most adapted solution and those who are left to (limited and fragmented) public services, without any other option. The fact that even undeclared solutions may be too expensive for a part of the Belgian population means that low-income families will have access only to public care services and only for a limited amount of time. This raises concerns about the social and economic inequalities in the access to care services for families, and it casts doubt on who – among the elderly population – is really enabled to enjoy the “freedom of choice” and who will continue to enjoy it in the future.
Notes
1. Although the estimates on undeclared work vary considerably depending on the source, care work is usually identified as one of the occupational sectors with the highest share of undeclared work (Giordano, 2018). According to the New Special Eurobarometer on “Undeclared work” (Eurobarometer 498), published in February 2020, the sector “personal services” – which includes childcare and elderly care – is the one showing the highest share of undeclared work, before the constructions and the hospitality sectors.
2. The non-profit organisations with an accreditation can be either external or part of the CPAS (Public Centre of Social Action). The public subsidisation of both residential and domiciliary care services is managed by the French, the Flemish and the Common Community Commissions (COCOF, VGC and COCOM).
3. Despite the lack of a comprehensive study on private care services in Belgium, their increase is regularly reported by the organisations working in the field, as well as by the press (see, for instance, Greoli et al., 2013).
4. It is important to notice that this distinction may vary depending on the context. For instance, under different care systems non-profit organisations are clearly separate from the for-profit private sector.
5. These conditions vary depending on seniority, but also depending on the profile and the status of the worker. Workers recruited through unemployment programmes, for instance, are subject to a different Joint Committee and different regulations.
6. The choice of the three municipalities was based on the analysis of the demographic characteristics of the 19 municipalities of Brussels, according to the data of the Belgian statistical institute (Statbel).
7. For a purpose of simplification, this non-profit organisation is included in the public sector. Even if this care provider does not have a public accreditation with the bodies in charge of elderly care services, it nevertheless receives public subsidisation that allows offering care recipients “public prices” – that is, affordable prices based on the recipient’s income. The analysis of the interviews largely confirms the similarity of this care provider with accredited providers.
8. This care provider works under the new 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.

References


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