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Implementing the French elderly care allowance for home-based care: bureaucratic work, professional cultures and gender frames

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ABSTRACT
Care realities are characterised by important differences between men and women. At the end of the 1990s, women were over-represented among the oldest sections of the French population, as well as among their unpaid and paid helpers. Nevertheless, when the current national benefit scheme for elderly people needing long-term care (the APA (*Allocation Personnalisée d'Autonomie*)) was adopted in France, it was not explicitly framed with gender issues in mind. French subnational governments (the *départements*) were charged with implementing the new scheme, but also have the capacity to transform it. How has this policy been applied on the ground and with which gender-related effects? In order to answer this question, this article draws on 33 interviews and several observations conducted with street-level bureaucrats in charge of implementing the APA in a French *département*. Through street-level organisation analysis, frame analysis and discursive institutionalism, it analyses how subnational governments and street-level bureaucrats use their room for manoeuvre in policy implementation, and the frames they use to take decisions. Special attention is given to the implications of these frames from a gender perspective. This article explores three different dimensions of this issue: (1) the discursive frames attached to the APA at national and subnational organisational levels; (2) the way street-level bureaucrats perceive institutional constraints and resources, and interpret their work, and how the gender implications of these frames influence the decisions they make in practice; and (3) the consequences of administrative decisions for the public affected by them.

KEYWORDS
Implementation; long-term care; frames; gender; professional cultures

Introduction

For a long time, policy implementation studies have demonstrated that street-level organisations and frontline workers are central to the shaping of welfare policies. Through their practice, they contribute to the essence of politics, by determining who gets what and how (Brodkin & Marston, 2013). In this context, frontline workers are

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neither fully autonomous agents nor do they do what they are told to: 'they do what they can under organizational conditions' (ibid, p.23). In very different welfare administrations, sectors and countries, organisations and street-level bureaucrats develop coping practices to address the tensions they face. The mass processing of demands, the principle of treating all citizens alike and the ideal of being responsive to individual cases are the main challenges (Lipsky, 1980). These coping behaviours can bring frontline workers and their organisations to develop routines, simplifications, stereotypes and frames. However, we know little about the place of gender in the resolution of these tensions and their consequences. What are the gender dimensions of the frames, and the coping behaviours used by street-level organisations and bureaucrats to carry out their work and solve their problems?

The example of the *allocation personnalisée d'autonomie* (APA) in France can help to understand the gendered nature of these frames and practices. This allowance, adopted in 2001, was discussed and conceived as gender-neutral, even though its elderly beneficiaries, and those who take care of them, are overwhelmingly women. After more than 15 years of implementation of the APA in France, this article aims to bring together gender analysis and implementation studies in order to understand the gendered dimension of the frames and practices of street-level organisations and workers. The research question we address is the following: how do the organisations and bureaucrats in charge of the APA deal with the dilemmas they face; what routines, simplifications, stereotypes and frames do they adopt to solve the problems they identify, what are the implications of these mechanisms from a gender perspective, and what effects do they produce? We argue that the nature of the routines, stereotypes, simplifications and frames that street-level organisations and bureaucrats build to cope with the problems they face, and their gendered effects, depends on the type of professional cultures they belong to.

After showing how we articulate street-level bureaucracy analysis with frame and gender analysis (1), we will present the methodology we followed (2). Then, we will discuss the discursive frames for the APA developed at the top of the hierarchical scale at national and local levels (3), before studying the coping strategies of street-level bureaucrats: how do they interpret their work within a specific institutional and organisational context, and how does this interpretation guide their practices (4)? Finally, before concluding, we will identify some of the main gendered consequences of policy implementation for those impacted (5).

A discursive institutionalist approach to policy implementation

Implementation analysis is now well established as part of public policy literature, and there is a growing understanding of how implementation intersects with gender (Engeli & Mazur, 2018; Forest & Lombardo, 2012; Lombardo & Mergaert, 2013; Mazur & McBride, 2006; Verloo, 2005). Different classical approaches to implementation can be adopted in order to understand its gendered dimensions: from strategic analysis (Crozier, 1964; Pollack & Hafner-Burton, 2000), to culturalist (Gusfield, 1984; Pfau-Effinger, 2004) or neo-institutionalist models (Forest & Lombardo, 2012; Mahoney & Thelen, 2010). Discursive institutionalism (Schmidt, 2008) captures how different norms are conveyed, adopted and adapted in institutional contexts. This approach considers how institutions provide

guidelines and prescriptions for action, ways to interpret problems, and administrative resources and constraints. Policy frames are important to study since they guide action (Goffman, 1974; Gusfield, 1984). They transform '*fragmentary or incidental information into a structured and meaningful policy problem, in which a solution is implicitly or explicitly included*' (Verloo, 2005, p. 20). Explicitly or implicitly, policy frames convey gender norms and discursive institutionalism takes ideas and discourse seriously, sets them in an institutional context and attributes a certain power to them. This approach is now well established but has been used to understand policy controversies and agenda-setting much more than policy implementation (Forest & Lombardo, 2012; Schmidt, 2008).

Nevertheless, public policies can only exist if there are organisations in charge of their implementation, and if frontline workers interact with the public, answer people's questions, assess their needs, allocate benefits and distribute sanctions. Organisations in which frontline workers act also '*define the institutional contexts within which repertoires of more or less acceptable ideas and discursive interaction develop*' (Schmidt, 2008, p. 314). Frontline workers are those with whom ordinary citizens experience government policies (Brodkin & Marston, 2013; Dubois, 2010). They also have a social function: they assign citizens a role and (gender) status which can later influence the way citizens perceive themselves and are perceived by others (Dubois, 2010; Lipsky, 1980; Perrier, 2015; Spire, 2005). Frontline workers are central to making citizens accept their (gender) status and the decisions applied to them.

Frontline workers find spaces in which they can take decisions and identify methods to solve their problems, which can be of different natures: the conflicts related to the mass processing of demands, citizens' personal reactions to their decisions, and the tensions between their own normative orientations and those of the organisation. They are required to serve ever greater numbers of citizens while showing flexibility and responsiveness (Lipsky, 1980). Routines, simplifications, stereotypes or stabilised frames can protect them from citizens' reactions, insulate them from '*having to deal with the human dimensions of presenting situations*' and help them deal more quickly with individual situations (Lipsky, 1980, p. 100). Looking at gender roles and inequalities helps to trace how specific cognitive and normative dimensions of policies are appropriated by local governments and street-level bureaucrats in charge of policy implementation.

Since elderly care particularly concerns women, in France as in other countries, we can surmise that the routines, simplifications, stereotypes and stabilised frames attached to elderly care policies have gender implications. A majority of care receivers, informal helpers, or declared and paid care providers are women. Firstly, the majority (57%) of the population in France aged over 65 years old are women (INSEE). Secondly, people living at home are often helped voluntarily by their neighbours or family (relatives, spouses, and children), work mainly carried out by women (Campéon, Le Bihan, & Martin, 2012; Renaut, 2000). Thirdly, 98% of professional givers of home-based care are women (Marquier, 2010).

Adopting a gender perspective leads us to question the place of gender in the routines, simplifications, stereotypes and stabilised frames used by those in charge of policy implementation. Do frontline workers' ideas and practices take into account the inequalities faced by women? Do they change or reproduce the gender order? Our approach focuses on dimensions of implementation that have been relatively neglected in discursive institutionalism and implementation studies: the gendered dimension of

frames and practices of agencies involved in policy implementation. Gender is discursively constructed and it is therefore important to analyse the way organisations and actors participate, through their discourses, in the reproduction of the gender order, whether intentionally or not (Forest & Lombardo, 2012). Analysing gendered dimensions of routines, simplifications, stereotypes and policy frames questions how policy ideas are conveyed, adopted and adapted by actors in charge of public policy implementation in different institutions. This leads us to concentrate on the institutional and organisational context influencing the different actors involved in implementation, to analyse how they define and take into account the interests of the different protagonists, their perceptions of the problems, routines and simplifications they use, and why they act as they do. Our argument is that these perceptions depend on the type of professional cultures they belong to, and that the consequences of these frames and practices also depend on the way work is divided up in street-level organisations.

Methodology

In 2017 and 2018, we carried out a case study in a French *département*, an administrative area with a subnational level of government situated between that of a large city and a region. *Départements* are in charge of the implementation of the APA and the *département* we chose is characterised by its demographical and economic dynamism. This department has devolved its services into 6 territorial units, working in zones with very different social dynamics: while one is a metropolitan area, attracting 9,000 new inhabitants each year, often young households, another is rural, ageing, characterised by demographic loss and poverty, and also experiences much greater difficulty in recruiting administrative staff.

French *départements* do not directly provide the services funded by the APA, but rely on providers, which can be municipalities, associations, for-profit companies, or individual employees. Help plans are mainly used to define the services elderly people should receive, how much the *département* should pay and the user fees. In the *département* we studied, APA administrative work is highly divided and performed by different workers: doctors and nurses make decisions on the level of dependency, which determines a maximum threshold for the allowance, while social and administrative workers make decisions on the kind of service proposed and the amount of the allowance.

We used two main sources: first-hand administrative documents produced for the frontline agents by their superiors, explaining the procedures they should follow, and numerous administrative documents available on the websites of the *département* or at its administrative offices; as well as observations and 33 in-depth interviews. These were conducted with several types of departmental agents: the elected Vice-President and the heads of the administration in charge of delivering the APA in the home; the heads of the 6 territorial units in the *département*; and 24 agents who work in these territorial units. Among these agents, who come from all 6 units, a first group is in charge of the assessment of the level of dependency (doctors and nurses), a second one (the '*évaluateurs*') of the negotiation and administration of help plans (workers with an administrative background or ex-social workers), and a third group of employees with a purely administrative background is responsible for administrative procedures and payment. Among these agents, we interviewed 3 doctors and 4 nurses in the first group,

9 agents in the second group, and 8 in the third one. In French local administration, agents are differentiated according to a scale of status and income: with doctors at the top (*catégorie A*), nurses and members of the second group belonging to a middle category (*catégorie B*), and the third group at the lowest level (*catégorie C*) (Gottschall et al., 2015). Those belonging to the second and third group mostly had working-class backgrounds.

We negotiated access to the different agents from the top of the hierarchy and the director of the units gave us the contact details of the different agents in their unit. We contacted them and chose those who could be present when we visited the units. In the first and second groups, we interviewed 16 agents, who represented 43% of the 37 agents of the *département* in charge of these tasks in the different units. Through crosschecking, we managed to interview as diverse a sample as possible. As in other organisations dedicated to welfare administration, frontline workers in charge of the elderly care allowance are mostly women, and 90% of our informants were women. Our interviews lasted between one and three hours.

We also observed 7 half-day meetings in the different territorial units, during which the decisions taken by the frontline workers were discussed collectively and validated by the group and the unit head. The interviews and observations we carried out helped us to encompass the substantive ideas of those in charge of policy implementation, and to understand the contexts in which their ideas emerge (Schmidt, 2008). We were attentive to discourses, since they commit the speakers to action and also constrain other actors than those who are speaking (ibid). Also, over a period spanning several years, we conducted numerous interviews with experts and private organisations that provide home-based care and domestic work at national and local levels in France.

Discursive frames at the national and département level

Jane Lewis has shown that France is moving toward a relatively less conservative, less gender-based system than other countries, especially when compared with Ireland and Great Britain (Lewis, 1992). Implementation of French elderly care policy is an interesting area of study, since important changes have been enacted at the national level over the last 20 years. But gender issues were not mentioned during the parliamentary debates in the pre-adoption process, or in the design of the APA. This formal policy, however, allowed the *départements* the room to manoeuver to transform the policy.

The APA, a gender-blind national scheme

Before the APA, a specific long-term care allowance ('*Prestation spécifique dépendance*' or *PSD*) granted recipients payments for care during their old age that were partly recovered from their estate after their death. This inheritance clause was criticised, and abolished with the introduction of the APA in 2001. From the PSD to the APA, parliamentary debates concentrated on social justice, but gender did not play a role. In the debates, reports and subsequent laws and decrees, the beneficiaries were always defined as 'elderly persons lacking autonomy', even though the life expectancy of women is higher than that of men, and they are more likely to live alone at the end of their life than their partner. For the Ministry for Employment and solidarity, the APA was to be seen as a new universal and

personalised right, guaranteeing equality. Following in the French tradition of universalism, based on equal formal rights and treatment, the beneficiaries were defined as abstract entities, without any reference to their sex.

The implementation of the APA requires coordination by several agencies. The central government (*l'Etat central)* stipulates eligibility conditions, provides guidelines for funding and implementation, and also co-funds the APA. The *départements* are responsible for assessing the level of dependency, defining help plans, and distributing allowances, which they also co-fund. Central government determines the conditions of eligibility for the APA, and a maximum allowance threshold – calculated in euros – for each level of dependency. The dependency levels are classified according to 6 groups, called GIR 1 to 6 (from most to least dependent), listed in the AGGIR grid, standing for *Autonomie Gerontologique – Groupes Iso-Ressources*. Only people classified as being in the GIR categories 1 to 4 are eligible for the benefit. Invented by geriatricians, this national grid imposes a medical definition and recognition of dependency: dependency is considered a consequence of a physical or mental illness, and identified according to people's ability or inability to do certain types of activities themselves (Ennuyer, 2004). This grid, established at national level, can be considered gender-neutral, and aims only to assess what abstract individuals are able to do themselves, without explicitly considering what help they may benefit from in their surroundings. The level of dependency in itself is not described in terms of service needs, as it is in other countries, but as a psycho-physical situation. In such a perspective, the AGGIR grid concerns a neutral individual, in an abstract world: the grid does not consider whether the person lives alone or as part of a couple, near to or far from their family, isolated in the countryside or in a big city. *A priori*, this evaluation can identify elderly people as dependant, and opens up social entitlements to paid care work even if (female) informal helpers are already doing a lot of unpaid care work for them. It therefore has the power to limit the systematic assignation of women to unpaid care for elderly people, and replace it by paid work.

Nevertheless, the formal national policy also requires that needs be defined, which leads the *département* to devise help plans. Care funded by the APA can be given through direct employment of care workers by the APA beneficiary, by a for-profit or non-profit provider organisation, or by relatives employed and paid as carers, with the exception of spouses. Public authorities rarely provide the services themselves; in most cases, private organisations are paid directly or indirectly by the *départements*, but the central government makes it compulsory to declare paid caregivers. This conveys the idea that home-based care is real work, which should be declared, but at the same time excludes the caregiving activity of spouses from being acknowledged, instead implicitly characterising it not as work but as an expression of love. This underlines the gender-blind and gender-biased dimension of the APA, since men are in many cases older than their spouses and female spouses very often become the primary caregivers, living with the informal care recipient (Bonnet, Cambois, Cases, & Gaymu, 2011). The blindness to the care work done by spouses, therefore, mainly concerns women. It is reinforced in practice at the *département* level.

The coping strategies of the 'départements'

The *départements* are responsible for distributing information about the allowance, assessing the level of dependency and the services needed, defining the 'help plans', and

calculating the user fees, according to national rules. They are obliged to comply with the rules defined by central government, but even if they deny it, they have some room for manoeuvre.

This gap between the visible role of *départements* as state agents, and the invisible reality of decisions made at a departmental level is evident when confronting the discourse of the Vice-President of the department studied with that of one of the street-level bureaucrats. While the first affirmed that: '*The APA is not questioned because the APA is a right*' (interview on 6 February 2018), one of the agents (interviewed on 21 March 2018) explained that the APA '*is not a right, it is a threshold. It is not a right to get 650€/month or 1350€ or 900€ depending on the loss of dependency. We are here to discuss the need and the amount (…). I do not like this idea of "I have a right to". I like to justify the amount*'. Here, street-level bureaucrats take important decisions, which are embedded within the organisational architecture of policy delivery organised at the *département* level. In the ways they define bureaucrats' duties, divide work and power in the organisation, recruit and supervise frontline workers in their duties, and manage the teams responsible for the assessment of dependency and needs, the *départements* also contribute to shaping and transforming policies, although in a less visible way than the formal policies.

One of the major policy transformations at the organisational level has been a result of the APA's success: the rapid increase of welfare recipients has put street-level organisations and bureaucrats under pressure, particularly in a context of limited resources. The *département* studied, like others, has increased the number of agents responsible for APA implementation, but in the units, this was not always considered sufficient. In order to deal with the tension between increasing demand and work resources, and to homogenise practice in order to treat citizens equally and individually, the *départements* have developed assessment sheets, rules and standards to organise their work.

In the *département* studied, the construction of the help plan mentions how many hours of care work should be carried out and which tasks should be realised; but the nature of the workers (qualified or not) is not mentioned. Lump-sum packages for care interventions have been introduced to serve as a reference for the decisions of the '*évaluateurs*', without communicating these directly to the public. The administrative directorate decided to create flat rate care packages for the elderly people classified as GIR 4: 20 hours per month if they needed help for washing and preparing meals, or 13 hours per month if they did not need this specific personal assistance. The '*évaluateurs*' have to determine if this kind of help is needed. They can attribute more or less than these packages, but have to justify it. Through such policies, the *département* plays a role in defining the duration of the different care tasks, which are mainly performed by women as paid helpers, but also tries to reduce the discretionary power of frontline workers. This conveys the idea that the perceived public of the APA policy is above all the elderly; the workers performing the care tasks are not the centre of attention.

In the *département* studied, the application for the APA in each of the 6 territorial units follows an administrative circuit in which three or four different frontline workers play a part. The tasks are strictly divided, separated into three chronological stages: (1) assessing the dependency level (performed by doctors and nurses); (2) assessing the service needs and making help plans (performed by '*évaluateurs*'); and (3) answering the applicant, paying the allowance and checking that the beneficiary used it as

intended. In the *département* studied, the level of dependency is mainly assessed without direct interaction between bureaucrats and applicants, while the evaluation of service needs is performed through direct interaction in applicants' homes. This division and organisation of labour has different advantages.

Firstly, it provides an opportunity to define quickly – within two months – eligibility for the APA, since a French national rule indicates that in the absence of an answer from the administration within 2 months of applying for a social entitlement, the application should be considered accepted. This organisational strategy thereby reduces the number of valid claims.

Secondly, it allows the '*évaluateurs*' who assess needs and negotiate the help plans to go to people's homes already knowing the maximum amount the beneficiaries can be allocated. This routine helps to distance street-level bureaucrats from the ineligible population, prevents them from being subjected to their reactions, and helps them make beneficiaries and their families accept the social statuses and (gender) roles the '*évaluateurs*' attribute them. Consequently, when they visit people's homes, they have the impression they are '*someone who brings a solution to people's difficulties*', as many of them affirmed.

Although not required by the national policy, this division of labour is matched by a division of different professional groups at departmental level: the professional group responsible for assessing the level of dependency is composed of doctors and nurses, while the one responsible for negotiating the help plans (the '*évaluateurs*') is more diverse. It is the professional group to which the street-level actors belong, rather than the territorial unit to which they are attached, that has the greatest impact on the differentiation of practices.

Street-level practices embedded in professional cultures

This professional division has consequences for everyday practices. Doctors and nurses have followed a similar programme of studies, which is highly selective for doctors particularly, giving them the impression of belonging to a certain elite, with nurses operating under their orders. However, the backgrounds of the '*évaluateurs*' are more varied. Two main profiles dominate: those who were trained as social workers before joining the *département*'s services, and those who passed through the administrative recruitment process. Hierarchically, the '*évaluateurs*' answer to their territorial unit director, while the doctors are attached to a central departmental medical unit. As a consequence, doctors regularly meet together at the *département*'s headquarters, unlike the '*évaluateurs*'. With the exception of one unit, in most cases, the '*évaluateurs*' and doctors do not eat together during lunchbreaks, and doctors fight to keep their monopoly on certain tasks, like the opening of letters from the family doctor detailing an APA applicant's health record: the nurses are not authorised to do it in their absence. These different professional groups also have different ways of thinking about both the beneficiaries and their work, which also means that the formal policy frame of gender-blindness is differently appropriated.

The gender-blindness of medical professionals assessing the level of dependency

In the *départment* studied, the dependency assessment is not carried out in the home, as the central government recommends, but is based on three different elements: (1)

telephone calls by the nurse or doctor to people close to the elderly person, (2) analysis of a family questionnaire, completed by the families or professionals, and (3) if possible, a medical questionnaire completed by the family doctor. The central government does not require a questionnaire to be filled in by doctors, but the administrative services of the *département* decided that if they receive the family doctor's questionnaire, the level of dependency does not have to be assessed again in the home. Doctors therefore play a central role in the dependency assessment, and they share a biomedical, gender-blind vision of dependency.

During the first years of APA implementation, family doctors working in the national health system were paid by the *département* to carry out the assessment of dependency levels. Now, the *département* has partly internalised this role and for a number of years, only doctors employed by the *département* have been in charge of the assessment of the dependency level, basing their analysis on the medical questionnaire filled in by the family doctor. They have gradually received more help from and been partially replaced by nurses, who, however, do not have the right to open the medical questionnaire themselves, and can only do it while in the presence of the doctors. As nurses belong to the health profession, they try to continue the work of the doctors and determine any health problems. They complete their reading of the family questionnaire by calling families and providers, but rarely the elderly person. They try to identify the illnesses this person suffers from before confronting their diagnosis with the medical questionnaire opened and read with the doctor. They consider their job well done when the opening of the medical questionnaire does not alter their initial evaluation of dependency.

The family questionnaire is very long and closely related to the AGGIR grid. It aims to determine the activities the applicant can do unaided and the help s/he receives for each of the items. In the medical questionnaire filled in by the family doctor, the doctor has to describe the medical history and disabilities of the applicant. This questionnaire is also quite medically oriented: it establishes a link between illness and the level of dependency. This way of seeing the problem of dependency is coherent with doctors' socialisation and their propensity to reduce social problems to medical problems.

This frame also reinforces the national one, imposing a gender-blind medical definition and recognition of dependency. In the *département* studied, doctors monopolise the definition of dependency, and the different groups concerned (old people, informal caregivers, paid caregivers) are not all asked about their perceptions. However, this way of viewing the elderly as individuals reduced to their biomedical characteristics can be a guarantee of gender neutrality: existing informal care is not taken for granted, whether the applicant is a man or a woman.

Psychological versus administrative approaches in negotiating help plans

For the assessment of needs, the *department* studied sends its '*évaluateurs*' (administrative workers, social workers) to the families' homes in order to define a help plan. Different studies carried out on the APA (Weber, Trabut, & Billaud, 2013) have already shown that help plans are more negotiated than prescribed. According to interviews we carried out, in practice, families have often already begun to pay for services before applying for the APA. The plan can, in that case, help to finance services the family has already engaged, and provides an opportunity to reflect on other alternatives. In all

cases, the street-level bureaucrats leave the family homes with a compromise concerning the help plan. It is about '*trying to find a balance between what people want, their resources and what the département can contribute*' (Interview 27 June 2018). This is the purpose of their home visit: to assess the needs of people according to their personal situation and obtain the consent of families.

Two main types of workers compose the group of '*évaluateurs*': those with a purely administrative culture, and those trained as social work professionals (social welfare advisors, specialised educators, etc.). Their practices are not oriented by the same frames, and their ways of applying procedures and assessing service needs are different. Two main methodologies are used to negotiate the plans: 'syllogism' and 'narrativism' (Weller, 2011). In the 'syllogism' posture, adopted by the workers with an administrative background, the assessor starts from the types of situations described by the *département*, and tries to 'fit' the specific situation of the elderly person into the boxes. In this case, it is a matter of matching existing services already paid for by households, or a desired service, to hourly packages. On the other hand, in the 'narrativist' posture, the decision is based on social work professionals listening to the person's story. In both cases, the discourses we recorded were gender-blind. None of the evaluators were aware that the situations they were examining most often involved caregiving women. None of them mentioned the situation of women helping their parents or parents-in-law who had difficulties combining work and family life, or had reduced their working time to deal with this. Nevertheless, the differences between the frames and methodologies adopted by these different workers can have different consequences for the situations of women doing informal care work. We will present first the social workers' approach, and then the administrative workers' approach.

In interviews, professionals with a social work background explain that it is essential to take into account the specific situation of the elderly people concerned. They emphasise the fact that they listen to the applicant or their family 'telling their story', explaining their own social and medical trajectory. In this phase, they are particularly attentive to situations that they consider to be delicate and difficult to maintain over time, such as when the elderly person begins to live alone in their home with nobody in the immediate entourage who could step in in case of emergency, when the elderly person begins to suffer from a cognitive disorder, or when they feel there is a situation of family conflict in which the elderly person has few resources, or risks abuse. The gender of beneficiaries and paid or unpaid care workers is not mentioned in these discourses, but since women are more inclined in heterosexual couples to live with older men, those who are considered to be fragile implicitly seem more likely to be women, and the examples given mostly involved women.

These street-level bureaucrats use psychological and sociological concepts in order to assess needs, analyse family relations, and prevent caregiver burnout. They are aware of people's need to talk – '*they need to be heard*' – and enjoy spending time with them (interview on 21 March 2018). They regret being pushed into becoming an administration of '*report production*'. In their discourse, they can identify situations that place women in danger, but at the same time, they contribute to the reproduction of dominant gender norms by considering it normal for female spouses to do the unpaid care work. These professionals are also very sensitive to social inequalities, which are often mentioned. They feel proud to help poor households, as it reminds them of their

'*previous job*' (interview on 28 June 2018). They also underline that the care plans are not there to provide domestic care for middle-class elderly people. These '*évaluateurs*' therefore pay special attention to socio-economic inequalities, while not seeing gender inequalities.

On the other hand, street-level bureaucrats trained as purely administrative workers are much more aware of the need to process cases quickly, to spend less time on individuals in order to be able to reduce the waiting time of the beneficiaries, and to see their needs assessed. These bureaucrats are proud to 'not run late'. They begin by asking people about the types of elderly care services already engaged and they have no misgivings in using the simplification proposed by managers in order to define the help plans. These workers use a more syllogistic approach in order to assess needs: they more often begin by considering the flat rate package of hours defined by the management, and make less reference to individual situations.

In both cases, the needs and service assessments are not restricted to home visits, but also include socio-medical team meetings attended by the various professionals as well as the service leader in each territorial unit, who then acts as the referee. In the meetings we attended in the different units, we witnessed a diversity of practices, due in part to the relative weight of the different professional cultures among the participants. If street-level bureaucrats want to propose a help plan that is different to the departmental package, they have to justify the different extra services included, in writing or during these weekly meetings. It is in this context that different standards of justice are discussed, and that different discourses are justified and validated. But what are the outcomes of all these policies and practices?

Rationing gendered services provided to a feminised demand for care

The gender biases of a growing demand

After more than 15 years of APA implementation, the number of beneficiaries has grown significantly. While there were nearly 600,000 APA beneficiaries at a national level in 2002, there were more than 1,200,000 in 2016, despite the fact that the French population aged over 60 has definitely not doubled in the same period. These changes in take-up demonstrate that the *départements* managed to provide the APA to an increasing proportion of elderly people after its introduction. This can be seen in the *département* studied: between 2002 and 2009, the number of APA beneficiaries increased by 67% in general, and between 2013 and 2016, the number of APA beneficiaries living at home increased by 10%. The *département* has thereby been able to treat and create new demands (Leray & L'Hour, 2018). This growth also means that France has introduced alternatives to familialism, and moved from explicit familialism to optional familialism, by providing more funding for the externalisation of care tasks.

Among the APA beneficiaries in the *département*, 70.5% were women and 29.5% men, while only 63.5% of people aged over 75 were women (and 36.5% men).[1] This means that *ceteris paribus*, women have more chance of receiving the APA, even if frontline workers do not purposely differentiate treatment of men and women. This can be explained by

[1]Own calculations based on https://www.insee.fr/fr/statistiques/2011101?geo=DEP-44.

several factors related to beneficiaries' behaviour, and the assessment of dependency by doctors and nurses does not play a role here. Firstly, women have a longer life expectancy than men (Bonnet et al., 2011), so they are more likely to be enrolled on the elderly care scheme. Secondly, when men become dependent first, they are usually first cared for by their spouse at home without the APA, and later with the help of a professional. On the contrary, when the woman becomes dependent first, French men, even with professional help, have more difficulty staying at home with their wife, and quickly seek institutional care for her or, often, for both of them (Daune-Richard, Jönsson, Ring, & Odena, 2012, p. 163). Thirdly, since women are more inclined in heterosexual couples to live with older men, it is more frequent that men become dependent first. Most bereaved spouses are widows. As we have seen, the assessment of dependency and access to the APA is gender neutral, and neither evaluates women and men differently, nor reinforces gender inequalities. Nevertheless, this is not the case for the practices and negotiations around the APA help plan.

When the '*évaluateurs*' insist on 'loving' relations between spouses and do not consider care practices between spouses as work, they are not aware that they are reinforcing existing gender inequalities in the sharing of care responsibilities between men and women. The '*évaluateurs*', and especially those with a social work background, encourage spousal solidarity as an abstract principle; but in reality, it concerns female informal carers much more than male ones, and results in the reproduction of gender inequalities.

Moreover, although APA implementation has adapted to a growing, feminised demand, this does not mean that the demand has been absorbed without difficulties and that the right to the APA has been automatically applied. In the *département* studied, some of the agents consider that the units' workforce is insufficient for the tasks they have to carry out; and during the interviews, all the agents spoke repeatedly about the waiting lists and pressures of the number of demands arriving. Some of the agents affirmed that they were '*alerting their hierarchy*' and that they were '*in the red zone*' in terms of waiting times (interviews on 21st February and 21 March 2018). In some units, they acknowledged that the waiting time between the applicant's first demand and the *département*'s answer could be as long as 6 months, during which time the elderly person's situation could greatly deteriorate. Among the different agents, those with long waiting times were more likely to have a social work background than an administrative background. The different ways of evaluating the cases also impact people's lives, and especially women's lives.

Nevertheless, even if some of the evaluators had long waiting times, they all spoke of interactions with the families as being conflict-free and said that the plans were accepted. Some of them mentioned that '*beautiful things are said during these interviews, like children explaining that it is normal for them to care for their parents, after all that the latter did for them in the past*' (interview on 9 February 2018). The most difficult cases are those in which families already pay for services which are above the threshold of the costs of the help plan: '*it is difficult to go back on a help plan which already functions*' when the *département* cannot pay for it, but then the '*évaluateurs*' refer to the rules and reach consent without difficulty (interview on 9 February 2018). The division and organisation of the work seem to be efficient at reducing contestation, since the number of administrative appeals is very limited, at less than 20 per year (interview on 24 February 2017). After it is allocated,

however, the APA is far from being a solution to gender inequalities, which are perpetuated by the methods of service delivery. These especially concern relatives and care workers.

Relatives are still 'care managers'

When deciding the structure of the help plans, the frames and practices of street-level organisations and bureaucrats impact the relatives of elderly people. The '*évaluateurs*' who have an administrative background are more likely to draw up plans including what people already have as services, or what they say they would like to have, while those who have a social work background are more attentive to social ways of functioning and unexpressed needs. This can bring them to reinforce gender norms by allocating a limited number of care hours when female relatives already do the major part of the care work. But their ways of studying cases can also bring them to detect more easily elderly people's individual situations and/or their caregivers' refusal to recognize the decline in their own capacities. In this sense, some frontline social workers tend to propose help plans that give more paid care hours than would be claimed by the beneficiaries, and try to convince families to accept these hours. The issue is then for them find a way to encourage the families to accept the intervention of a paid care worker in the home, and to progressively increase the number of paid hours of care given. Sensitive to the possibility of 'caregiver burnout', they seek in this way to forestall exhaustion in unpaid family members carrying out care work. From this viewpoint, burnout prevention is often presented as being in the interest of the elderly person, and designed to maintain the care function of the existing family carer as long as possible; the interests of the informal care providers themselves do not seem to be taken into account.

Nevertheless, even when introducing more paid care hours, the APA does not entirely eliminate the burden felt by relatives. Focus groups conducted in the main city of the *département* confirm that women engaged in caring for their dependent parents face many difficulties, even when their parent benefits from an APA help plan (Bigoteau, Chaudet, Dussuet, & Péribois, 2015). The lack of coordination of home care services, medical and hospital services means that the APA still requires them to be '*care managers*' (Campéon et al., 2012; Petite & Weber, 2006).

A casualization of professional caregivers

Before the introduction of the APA, employment conditions for paid home-based caregivers corresponded to gender norms in work; these activities were mostly carried out by women, working part-time and poorly paid (Avril, 2014; Dussuet, 2005). Since the context following the APA's introduction was characterised by an increasing demand for the APA, combined with austerity constraints, the employment conditions of paid caregivers did not change much, even though regulations applying to paid care jobs were modified at the beginning of the 2000s (Clergeau & Dussuet, 2005; Devetter, Jany-Catrice, Ribault, Fraisse, & Gardin, 2008).

In the face of austerity, the *départements* tried to ration the help plans. In the case we studied, the function of the lump-sum package included reducing costs. Without being taken into consideration by the street-level bureaucrats, paid care work time financed by help plans was broken up. For the care package of 20 hours per month including

help for washing and preparing meals, used for some of the GIR 4 population, shorter interventions have had to be planned. Replacing the longer house calls of the past, paid care workers' home visits are now greater in number and last half an hour, with more time spent travelling between beneficiaries' homes. The consequences for the care providers include increased mobility between houses and increased complexity in schedules and the work itself. Here we can clearly identify a process of labour intensification that originates in the terms of the help plans, and which is fuelled by reduced funding per individual (Dussuet, Nirello, & Puissant, 2017). This is a major constraint, making it difficult to establish full-time schedules for employees.

The way the plans are constructed also gives rise to a reduced definition of caregivers' work as relating solely to the period of their activity in the homes of beneficiaries. Part-time jobs are a result of this restrictive definition of working time. Yet when home caregivers perform a part-time 25 hour week, they are, in reality, because of the obligations related to their job (travel, coordination time, training time), working for a time corresponding to an average of 35 hours or a full-time job (Devetter & Barrois, 2012). Home-based caregivers suffer from the introduction of shorter, more numerous home visits, and the intensification of work, with its resulting health risks. This explains why many, especially older employees, prefer to limit their working time, and do not ask to work full-time. Even if they could increase their income, they want above all to be able to keep the job as long as possible in order to accumulate retirement pension rights and do not feel able to withstand the physical and mental demands of a full-time job that would require much more than 35 hours per week.

Conclusion

After 15 years of APA implementation, the gender-blindness present during the adoption process of the APA elderly care allowance endures in the everyday practices and discourses of street-level bureaucrats. However, the implementation of the APA has begun to impact women's resources: France can no longer be described as developing explicit familialism in elderly care, and paid care is better recognised. Care options external to families have been developed through the APA, especially home-based care. Nevertheless, these changes have not transformed gender roles. While care work is today more often carried out by paid workers, it remains a feminised activity. Implementation practices have also contributed to transforming the policy.

The rapid increase in welfare recipients has put both street-level bureaucrats involved in assessing needs and care workers under pressure, particularly in a context of limited resources. Routines, simplifications, stereotypes and frames help them to solve the different problems they face; but according to their professional background, frontline workers in charge of APA implementation do not adopt the same attitude. These elements have consequences for the situation of women particularly.

Frontline workers (doctors and nurses) in charge of the dependency evaluation have a medical understanding of dependency, exaggerating the national medical frame in line with French universalism, which establishes abstract equal rights. This contributes to gender neutrality, which does not take for granted existing informal care. But this real neutrality is compensated by the practices of the '*évaluateurs*', whose gender-blindness is more biased. Street-level bureaucrats in charge of the definition and negotiation of the help

plan take into account existing care practices in beneficiaries' homes. Those with a social work background analyse people's needs very precisely, even if this means encouraging 'spousal solidarity' and reproducing societal gender norms, without recognising the bias of their discourses or acknowledging spousal care activities as being work. But in contrast, their attention to individual situations can bring them to detect undeclared needs and prevent carer burnout. On the other hand, '*évaluateurs*' with a purely administrative background are less likely to rely on gender norms and social interpretations, and more likely to accept the standardisation proposed by the heads of the *département*. While the first group carries out its tasks more slowly, the second has shorter waiting times.

This study underlines the need to take the professional backgrounds of those in charge of implementation seriously: professions chosen by the administration for implementing public policies are not neutral. We show that the types of professionals determine the stereotypes and frames developed in organisations and the routines adopted. Policy frames might not be the same for each group in charge of policy implementation, as the professional cultures they belong to shape these frames. Including gender analysis in implementation studies draws attention to these different frames used by street-level bureaucrats.

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