Care Work in Europe
*Current understandings and future directions*

**Workpackage 9**

**Work with elderly people**
*A Case Study of Sweden, Spain and England with additional material from Hungary*

**Consolidated Report**

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Chapter One: Introduction
This report is part of the second stage of a research study Care Work in Europe: Current Understandings and Future Directions. It is one of three cross-national studies of particular forms of care work and focuses on residential and domiciliary services for elderly people: the other two are concerned with centre-based services for children under 6 and services for adults with severe disabilities. The main aim is to provide in-depth studies of understandings of care work in theory and practice – although it is also recognised that the term ‘care work’ is problematic and contentious.

This study compares three countries: Sweden, England and Spain (in particular, Catalonia). The study is based on interviews with practitioners (in the public and private sectors, in home care and residential care and in tow contrasting types of area), local and national (or regional) policy makers and trainers. The main findings are also presented from a parallel study undertaken in Hungary.

Chapter Two: The Three National Contexts
The three countries involved have contrasting demographic and economic profiles, and also vary in terms of models of social care based on different ideas about the role of women, families and the state in particular in relation to care and employment. Sweden, for example, emphasises women’s role in the labour market and the State’s responsibility for care; Spain, by contrast, emphasises the family’s responsibility for care. There have also been marked differences in the development of services for old people, with Sweden and Spain at extremes in terms of when public services were developed (Sweden far earlier than Spain) and the current levels of provision (Sweden far more than Spain).

But there are also elements in common in English and Swedish trends, some of which are also apparent (though less extensive) in the more recent developments in Spain, for example: the increasing standardisation of care services, through national standards and better and/or more education and training; a growing discourse about quality in care services; increased targeting of publicly-financed services on elderly people with high levels of need, with greater and more complex demands on home care workers; and a trend towards more formal education and training for care workers – even though none of the three countries is yet aspiring to a basic education for care workers beyond upper secondary level and many workers do not have this level.

Chapter Three: The Workers
Sweden has the most highly trained workforce. The main occupation is the auxiliary nurse, educated at an upper secondary level, and the intention is that this should be the standard qualification for all workers with elderly people – but for various reasons this is far from being implemented. The English workforce is more fragmented with different home help and residential care occupations, and has a lower level of educational qualification and training: many workers have none and the target is for all workers to achieve a secondary level qualification. In Catalonia, many domiciliary carers are called ‘family workers’: they focus on both the elderly individual and her family, devoting some of their time to training and supporting the family members. This attention to the family reflects the emphasis in Spain on the primary role of the family in providing care.
The workforce in all three countries is overwhelmingly female, with an average age around 40 and few have school-age or younger children. Salaries are relatively low, but highest in Sweden. In Sweden most work in the public sector. But in England and Spain most work in the private sector; in England, most services, and therefore most workers, are in the for-profit part of this sector. Workers tend to enter the field at a later age, rather than straight after completing their education. Home care in Sweden was originally built around untrained women who had been housewives; now with a greater emphasis on qualifications, workers increasingly choose to train for the work before entering the field.

There are few men in elder care work, but those that are often enter after some major life event has provoked a change of employment direction.

Chapter Four : Training and Education
There are different ideas about appropriate knowledge and how to acquire it, ranging from the experience gained from caring for relatives, through competency-based skills to a more academic orientation with a stronger theoretical component. A non-academic tradition has been maintained longer in social care for the elderly than in other comparable professions.

Sweden is moving from personal experience as a basis for the work (initially as a housewife, more recently employment experience) to an academic education. In the 1960s, the work became more hierarchical, with the introduction of social care managers. Since then, the educational levels of both managers and practitioners has increased, but the educational gap between the two groups has widened. For those practitioners who have not gained a qualification as auxiliary nurse, local authorities are providing various forms of training.

Education and training in England is less developed, but moves are now underway to increase levels of training; national standards require providers to move to at least half their staff being trained, though the minimum training level required is set at a low level (a secondary level qualification). A competency-based model is in use, focused on outcomes in the workplace based on specific skills and knowledge that have been identified as needed for a particular occupation.

Spain has a range of largely low (secondary) level training, divided between occupational and professional courses. Occupational courses have been developed for unemployed people and as continuous training for care workers already employed. The professional courses are at a medium level and they do not allow a direct access to higher level professional training, except within the same professional field if special examinations are succeeded. Like England, training therefore is occupationally focused.

There is an issue in all three countries of whether and how practitioners can gain career progression without having to leave care work. In all three countries, too, the work is increasingly complex and demanding and more and more health oriented.

Chapter Five: What is Social Care?
‘Social care’ is used in England and Sweden to describe care work with older people. But apart from being a term used to label a particular policy field and collection of services (i.e. an administrative concept), the concept has not been much developed in policy and practice. Its meaning can be rather unclear although reflection on the concept has begun in Sweden associated with a process of academisation of education.
Social care is also defined in terms of what it is not, but this becomes more problematic as the borders blur between care, social work and health. In England, there is a close relationship between social care and social work (both are defined in legislation as ‘social care’ work), but the relationship is more problematic in Sweden, where social care and social work are seen by many as having clearly different orientations. Similarly in Spain, social care and social work are very different in legislation and in reality, though they are associated in the media.

In all countries, however, there is a close relationship between social care and health. In Sweden, for example, social care work has evolved into a complex activity including an important health element, with social and health care of elderly people now both being the responsibility of local authorities. Closer relations can also lead to more conflict.

A third important border is between formal and informal care. In Spain the relationship is ‘complementary’: the family is the primary source of care with care workers offering a more specialised role and support to families. In Sweden the relationship is more ‘supplementary’: informal and formal carers supplement each other rather than restricting formal care to more specialised help. The Swedish workers in the case study are more in favour than their English and Spanish counterparts of formal services taking on the major part of care work, seeing the main responsibility as societal rather than familial. The relationship between formal and informal services may also change over time, if elderly people get access to good services which provides them with a real choice between formal and informal care.

While a number of difficulties can arise in relations between workers and relatives, the workers are mainly sympathetic to the situation of relatives and consider working with relatives as an important part of their jobs.

Work with old people involves complex relations between the person giving the care and the person receiving it. It is also shaped by carers’ views about how old people are or should be. Four main views emerged: old people as often dependent but also potentially independent (care services emphasise enabling old people to be as independent as possible); old people as resources, with valuable experience and knowledge; the importance of dignity; and old people as burdensome.

**Chapter Six: Necessary skills for a care worker**

Care work is often spoken about in terms of relationships, with English care workers talking about the importance of communication and social skills; empathy, intuition and understanding; awareness of need; listening; patience; responsibility; sense of timing; personal experience and engendering trust. Spanish trainers speak of current training placing more emphasis on tasks than emotional relations. In both cases, the necessary skills for the work are often understood as innate personal qualities – a carer either has them or does not.

Swedish care workers identified six areas of necessary knowledge: medical competence; care knowledge (e.g. medication, psychology, conflict management); empathy; social competence; practical knowledge; and experience-based knowledge. Experience-based knowledge is a term often used without defining what kind of experiences might be necessary for care work with old people.

Relationship-based work raises a number of dilemmas: between being task-oriented and client-oriented; drawing boundaries between the care receiver and care giver (complicated because the care receiver often has more power in the relationship than is sometimes
recognised); between management/administration and time spent on the direct meeting between care giver and recipient; and insufficiency of time to develop a good relationship.

Chapter Seven: What is social care work in praxis?
Most workers felt the public image of their work was not good and that many people neither understood nor valued what they did – yet care workers themselves usually think the work they do is important, and some workers felt that there were signs of improvement in their social standing. Reasons given for the low status of the work included its association with low qualifications, the invisibility of the work and lack of promotion opportunities. It is also suggested that it may be linked to low social valuation of old people, so that working with them is seen as ‘care work without any result’ which is treated as work of low priority.

Care workers see little in their work that is inherently gendered, though old people themselves may have strong preferences regarding who provides care, especially personal hygiene.

In England the division between paid work and family life is blurred for many female care workers, whilst in Sweden the division is stricter. This seems to reflect ideological and policy differences between the two countries.

Few practitioners had experience of caring for older people from minority ethnic groups. However the issue is not just how workers behave towards old people from such backgrounds, but the behaviour and attitude of some elderly white people to workers from minority ethnic groups. Some Spanish informants spoke of complicated relations with migrant workers, for example arising from different qualifications and lack of papers.

With the practice of care work part of an increasingly broad and complex network of services for older people, increasing attention is given to coordination and leadership. In Sweden, the social care manager is a key position which has been developing as since the 1960s: leadership has become a core area of knowledge for this profession, which is differentiated from social work. In England and in Spain, by contrast, social workers are accorded an important coordination role.

Abuse and neglect of elderly people has become an increasing issue, leading to more attention being paid to risk management.

Chapter Eight: Work Environment
A particular feature of home help work is negotiating work in someone else’s home, which can be a complex and sensitive issue. Many Swedish workers stress the importance of the working team, even in the more isolated work of the home help. Work teams also exist in England and in Spain, but seem less developed in home help services.

As with other forms of care work, elder care practitioners seem very satisfied with the work itself: they like what they do and they like old people. The downside is poor pay (especially in England and Spain), stress arising from the demands of the work (physical and psychological) and shortage of time.

Chapter Nine: Recruiting the workforce
Getting and keeping a sufficient workforce is a problem in the three countries. In England and in Spain, poor pay and conditions are recognised as major causes of staffing problems. Possible solutions being proposed in England include a more differentiated workforce, with
new, more flexible and better paid types of care worker. Emphasis is also placed in Spain on a
general improvement in levels of training and qualification required for work with elderly
people. Without this, some think, good care workers will be lost to other occupational fields.

Sweden has been moving away from its original source of workers: middle-aged women
without young children at home and with low levels of education. New sources of recruitment
are sought, as well as new sources of knowledge – moving from ‘housewifely’ and other life
experience to academic education. The official aim therefore is to tackle recruitment by
increasing the standing of the work through formal education and broadening the recruitment
base. However, locally high value continues to be placed on life experience.

It is generally agreed that more male workers are needed.

**Chapter Ten: Future directions**
The report finishes by offering conclusions about the current situation of and possible future
directions for care work with elderly people. It considers the implications of the different
models of social care, highlighting how the Swedish model (in contrast to England and Spain)
is based on the expectation of dual breadwinner families, social support for working parents
and clear boundaries between work and family. The relationship between gender, employment
and family life is, however, dynamic, and England and Spain are currently experiencing major
changes. These changes will have implications for the role of women and families in
providing care and for the future care workforce. Care work will need to predict and
accommodate new career trajectories, and routes into the field, or risk increasingly severe
shortages in a world where women are better educated, have more employment opportunities,
expect a continuous employment career and are prepared to defer or abandon having children.

A number of dilemmas are highlighted: the status of the work; recruitment and retention;
education, training and the future structure of the workforce; and support and coordination.
More attention needs to be paid to: conceptualising and theorising the work, for example
exploring in depth existing concepts such as ‘social care’ and new concepts such as ‘elder
pedagogy’; and evaluation of practice, for example through developing methods for critical
analysis and reflection such as pedagogical documentation.

Eldercare services are increasingly targeted and more is expected of families, in contrast to
services for children, where public responsibility is already universal or growing. Family care
and formal care work should not be thought of as ‘either/or’. Old people do not necessarily
prefer relatives to provide all their care. Care workers may ‘free up’ family members to give
more time to other aspects of care, for example talking with their relatives. What is required
by older people themselves is not static, nor are their expectations.

Demographic trends and changes in the care workforce point to increased costs in the field of
care work with elderly people. But ‘care work without any result’ is not a private or public
priority. If costs are placed too much on individuals and families, this may create incentives to
find certain kinds of ‘low cost’ solutions. Public authorities, faced by rising costs, may seek to
keep a lid on costs by ever greater targeting of services. The future direction of work in this
field, therefore, is unclear. The supply of labour needs to be considered in relation to the
evolution of the work and emerging understandings of the work, as well as the value attached
by societies to older people.
CHAPTER ONE : INTRODUCTION

1.1 Introducing ‘Care Work in Europe’

This report covers the first part of the second stage of a research study, Care Work in Europe: Current Understandings and Future Directions. The work is funded by the European Union as part of its Fifth Framework Programme and involves research partners in six partner countries: Denmark, Hungary, Netherlands, Spain, Sweden and the United Kingdom. The overall objective is to contribute to the development of good quality employment in caring services that are responsive to the needs of rapidly changing societies and their citizens. More specific objectives include: describing and analysing the current care workforce; comparing different understandings of care work and different approaches to the structure and practice of care work; identifying conditions necessary for the development of employment that is both of good quality and sufficient to meet growing demand; and contributing to the development of innovative approaches, both in care work and cross-national research.

The project runs for 39 months, starting in September 2001, and it has three stages. The first stage, completed in 2002, involved mapping, surveying and reviewing: mapping care services and the care workforce; surveying demand, supply and use of care services; and reviewing recent literature on quality, job satisfaction and gender issues in the care workforce. For each part, national reports were prepared by all six research partners followed by consolidated reports based on these national reports. These consolidated reports have also reviewed other literature, particularly cross-national work spanning the whole of the EU but also central and Eastern Europe, and statistical sources. National and consolidated reports, including an overview report on Stage One, and summaries of consolidated reports are available on the project website at www.ioe.ac.uk/ctwu/carework.htm (all in English, with summaries available in the languages of other partner countries, as well as Russian).

The third stage, scheduled to begin in Spring 2004 will look at innovative developments in care work, as well as undertake dissemination of the project’s findings. The heart of the project, however, is the second stage. This consists of three cross-national case studies to investigate in depth particular forms of care work: centre-based work with children under 6 years, the subject of this report; residential and domiciliary services for elderly people; and younger adults with severe disabilities. The second stage is completed by a fourth piece of work, which involves the development of methods for the cross-national study of practice.

The main objectives of the three case studies are to provide in-depth studies of understandings of caring work in theory and practice. Within these broad objectives, the three case studies address a number of particular questions:

- How is care work understood?
- What are the important changes in society that shape/influence services and thus care work?
- What are the important theories that shape/influence practice?
- Is there a critical discourse going on or do practitioners/trainers/decision makers work without considering underlying principles/theories?
- How well does the training prepare for the work?
- What is the prestige of care work like?
- What is the quality of care work like?
- What opportunities are there for development and/or sharing experience?
• Are there issues that arise across groups of policy makers, trainers, practitioners?
• Are there issues that arise across groups or settings?
• What is very important in the relationship between the carer and the child, adult?

1.2 The problem with ‘care work’
Although this research study carries the title of ‘care work’, the research team have recognised from the beginning that the term is problematic and contentious. For example, it has been long apparent that the concept ‘care work’ is of limited relevance when considering services for young children. Other concepts such as ‘education’ or ‘pedagogy’ are often seen as more appropriate for describing these services, while workers are often described as ‘pedagogues’ or ‘teachers’ rather than ‘carers’. But the same issue arises with respect to work with young people and adults of all ages. Turning to the subject group of this report – elderly people – one of the project’s Danish research partners has recently written a book (commissioned by the Danish government) on the concept and practice of ’elder pedagogy’ (Hansen, 2003). While in the same country our earlier work in this study has shown how pedagogues, professionals who practice pedagogy, play an important part in services for children, young people and younger adults with disabilities, and can also be found working with elderly people (van Ewijk, Lammersen, Hens and Moss, 2002).

This is not to deny that children and adults need care, however defined. But care may be viewed as inseparably linked to another concept, forming part of a broader, holistic concept – for example, pedagogy discussed further below. Where this is the case, ’care’ may not be considered to merit a distinct policy or occupational field.

The terms ’care work’ and ’care workers’ are not therefore self-evident. However, although we treat the concepts of ’care work’ and ’care services’ as contestable, to be questioned throughout the study, we have had to adopt a pragmatic approach. To conduct the research, we needed an initial definition of what services and occupations fall within a ‘care work domain’, which is our subject of study. Our definition has focused on three groups of services:

• childcare and out-of-school care (including schooling for children below compulsory school age);
• child and youth residential and foster care; and
• care for adults with disabilities, including elderly people.

This case study, therefore, takes us deeper into one part of a large area of provision and work.

1.3 The research process
Each part of Stage One involved working across all six partner countries. The parts of Stage Two are more selective, in that each focuses only on three countries to enable more in-depth study. The selection of countries for each case study partly reflected the interests and expertise of research partners. But we have also sought for each case a spread of countries differing on important dimensions. In this case of services for older people, the three countries are Sweden (the lead partner), Spain (or more precisely Catalonia) and the United Kingdom (or more precisely England)¹. As we shall see in the next chapter, these countries provide examples of different models of care, in particular where the relationship between the individual, family and state differ considerably.

¹ In recent years, all three countries have experienced processes of devolution from central government: Sweden to municipalities, Spain to regions or autonomous communities and the United Kingdom to its constituent nations. We have focused here on the current main level of policy making in the three countries studied.
In addition to the three countries covered by the EU-funded programme of work, a fourth partner, Hungary, undertook a parallel study, using their own national resources. Although outside the main study and not included in the cross-national analysis, the results of this work are relevant and provide an important perspective on how work with elderly people is developing in a country which has recently gone through the transition from a Communist to a capitalist regime. An overview of the main findings and conclusions from the Hungarian study has been added towards the end of most chapters.

The work discussed in the current report generally follows a design agreed for all three case studies. The main component of this design was to conduct around 25 in-depth interviews per country with practitioners, trainers and policy officers in two or three contrasting local authority (municipality) areas, one in a major city, the other chosen because it included more rural areas; in addition interviews were to be conducted with policy makers at national or regional level (depending where competence for policy making was located). These interviews would ask informants about their perspectives on care work practice and wider issues such as the way care services are being delivered and should be delivered, and the supply of labour for care work, both issues of substantial concern in Europe and documented in Stage One of the project. Interviews were to be analysed by the researchers in each participating country, on the basis of which national reports were to be prepared. This would enable a cross-national analysis to be undertaken by the lead partner for each case study, from which a consolidated report would be written.

For this case study, the consolidated report is written by the Swedish lead partner, on the basis of three national reports:

- National report from Spain written by Anna Escobedo, Esther Fernández, Maria Lluisa Marrugat and Natàlia Lladó
- National report from UK written by Claire Cameron and Judith Phillips
- National report from Sweden written by Petra Norén and Stina Johansson

The work in Hungary was undertaken by Andrea Racz and Zsofia Hajos

1.3.1 Preparations and sample selection

As a three country case study, the research process began with the lead partner familiarising herself by visiting each country. During a one week study tour in June 2002 the lead partner visited care services for elderly people in England and Catalonia. The locations for the visits were Stoke-on Trent (England) and Barcelona (Catalonia), and both residential services and home care services were studied. In England, particular attention was paid to intermediate care services, that is services that enable older people to continue living at home or provide care after illness and treatment (for example, a residential rehabilitation service providing intensive therapy during a stay of a few weeks). During this week a preparatory meeting was held in Barcelona where the design of the study was discussed.

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2 ‘Informants’ was the term chosen to best reflect those who gave us information through interviews. This term was chosen to reflect the expertise of the person being interviewed and to reflect a relationship with the researcher of information exchange rather than dependency. The research team is aware that in some European countries the term has had historic associations with surveillance of the behaviour of nationals and that is not intended in our use of the term.
Sample selection involved choosing geographical areas, settings and individuals based on a common set of criteria. As a general principle, it was agreed that partners choose typical settings and workers, representing the mainstream situation in their country: the object of the case study has therefore been the usual rather than the particularly innovative or otherwise atypical. In each case country, practitioners in ‘typical’ types of services were selected from (a) a major city; and (b) a local authority including substantial rural areas.

The original intention was to interview 16 practitioners in each country, divided between home and residential care services and, in turn, between public and private sector employers. This division does not mirror the real proportion in the three countries. In our study, the private sector is under-represented in England and over-represented in Sweden. Practitioners who were typical of the workforce in terms of age were sampled. At least one male worker in each area was sought for, which also gives overrepresentation of men in some areas (data from Part One suggested that male workers accounted for a small proportion – between 5 and 10 percent - of workers in services for elderly people in all countries). To summarize, this selection mirrors both typical current and as we hope future directed understandings of care work for the elderly people in the three countries.

In the end we interviewed the target number of practitioners in England, and rather more in Sweden and one less in Catalonia (Table 1). In Sweden, two practitioners divided their time between direct care work in the home help service and acting as co-ordinators, which did not involve direct contact with old people but rather working on schedules, maintaining contact with home assessors and other administrative duties. Similarly one of the seven Catalan home help workers was the head of staff at a service run as a cooperative. We provide more information about these practitioners, including their background and their work in Chapter Three.

<table>
<thead>
<tr>
<th></th>
<th>Sweden</th>
<th>England (UK)</th>
<th>Catalonia (Spain)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public sector</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home care</td>
<td>6</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Residential care</td>
<td>10</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Private sector</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Care</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Residential care</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

In addition to these practitioners, interviews were planned in each country with eight further people, divided between national/regional and local levels, and working in policy and/or education and training. Overall, interviews were conducted with the target number in England and with one more in Catalonia (where a home help worker was replaced by an policy maker from the regional government who was expert on elderly care in rural areas) and one less in Sweden (Table 2).

In the parallel Hungarian study, 16 practitioners were interviewed. Most worked in residential and home care, but (unlike the other three countries) three were leaders of day centers. Two had management positions. Trainers and local and national policy makers were also interviewed.
Table 2: Number and position of policy makers and trainers interviewed

<table>
<thead>
<tr>
<th></th>
<th>Sweden</th>
<th>England (UK)</th>
<th>Catalonia (Spain)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central/national/regional government</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Local government</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Employers’ organization</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Trade union</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Trainers</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

1.3.2 Instrument development
A range of research instruments were developed:

- Interview guides (See Appendix A1)
- Self-completion practitioner questionnaires (See Appendix A2)
- Guidelines for a “tour” of each centres
- Document analysis (key documents were listed for analysis)
- Photographs to be taken at each site (optional).

Separate interview guides were developed for practitioners, policy makers and trainers. These focus on common issues concerning care work with elderly people. But each guide has some specific questions related to the particular circumstances and job of the informants.

The self-completion questionnaire complemented the interview with practitioners. Its purpose was to collect relevant factual information about the informant herself and about the centre the informant worked in (such as the size of the centre, number of residents, number of staff, etc.), as well as some standardized information about the job itself, satisfaction with the job and opinions about the purpose of the work. Some questions on attitude to informal care, unique to elder care, and repeating an earlier study in Sweden, were added (Johansson and Anderson, 1993).

The focus on practice was expanded by adding data on the practice environment. The practitioners in residential care services were asked to show the interviewer around the setting (i.e. to take us on a “tour”) and to explain what is done in each part of the centre, how and why. The aim was to understand the service better, what it was like to work in this physical environment and to assess how the environment might assist her/his work. The conversation during this tour was recorded, and photographs were taken of the care workers and the working settings to assist the cross-national research team’s understanding of the different environments. We also asked for floor plans of institutions visited, along with any written information about the service, such as brochures outlining aims and principles.

The intention was to make this case study on elder care comparable with the case study on work with children under 6 years, which was already underway. The same general approach was adopted, not only to design and sampling but also with respect to the research instruments. Thus it was found very fruitful to use as many of the same questions as possible, although making some adaptations where necessary for example in this case adding some
extra contextual questions to give more emphasis to the national picture. The focus on national context was expanded by including national policymakers as informants.

### 1.3.3 Analysis

The interviews were all tape-recorded and transcribed. The main work of initial analysis was undertaken by each national partner, and formed the basis for national reports. As part of this initial analysis, the transcribed interview material was coded using the programme Nudist Nvivo 1.3, according to an agreed set of codes developed by the cross-national team at a meeting in Umeå in January 2003. This programme greatly facilitates the mechanical task of marking up interview transcripts in the first place, and secondly, the grouping by topic codes of those interview extracts that could be relevant for the qualitative analysis of the sample.

National reports formed the basis for the cross-national analysis conducted by the lead partner as the basis for this consolidated report. In addition, though, selected extracts of interview transcripts from each country were translated for the lead partner to enable her to conduct some primary analysis for the consolidated report.

Some critical remarks should be added concerning the preparation of the consolidated report. Leading a cross-national project presents several challenges since the researcher is from a particular national background and has been socialised into a particular way of thinking. The meaning of words can, all too easily, get distorted or lost in the translation process, which is a necessary part of a comparative research project. Words also arise out of, as well as within, a social context and knowledge of this context is necessary in order to understand fully their meaning. Understanding another context is further complicated because much in that context may seem natural to a researcher living there; but what seems self evident to that researcher may be missed or misinterpreted by a researcher from another country.

Problems associated with the comparative nature of the project became quickly apparent, for example in the formulation and construction of the questions that were to be used. For instance, in a Swedish context, the question “*How do your family and friends view your job?*” is problematic. To ask this question in a country in which a woman’s labour market participation and wages are taken for granted and accepted as necessary for the family’s economic well being is quite different than asking it in a country such as Spain, in which the male breadwinner is the norm. It would be impossible for a Swedish man to question the fact that a woman has a job or to suggest that this infringes on the time she can spend on her family, and be taken seriously.

Another example of a question that is problematic, but in another way, regards access to a garden and the possibility to spend time outside. In the north of Sweden, access to a garden is only possible for a few months each year due to the climate, and spending time outside is associated with extreme cold and icy conditions for a substantial part of the year. This is very different to the situation in Spain. These differing contexts will give the question different meaning and shape different answers, which it may be difficult for the researcher to fully understand.

In the end, the former question, about the views of friends and family members concerning women’s employment, was not included in the Swedish study. The latter question, about a garden and being outside, was included, but resulted in some difficulty interpreting the responses.
A further example, which gave rise to many discussions in the project, concerns the relationship between employment (in this case care work) and family life. Growing up and living in a country, such as Sweden, that has long placed a high premium on gender equality in the labour market, influences the response of researchers and informants to this issue. A Swede is inclined to have great faith in the public caring systems and their ability to reduce difficulties in combining family life and working life. It is even possible that these difficulties have been underestimated in Sweden since they are seldom brought up by respondents.

The low profile of this issue in Swedish interviews gave rise to many discussions in the project. Given a specific order of society, how much space is there to discuss problematic situations? Does a woman living in a country with a well organised child care system have the same ‘right’ to complain about problems combining family and working life as a woman living in a country that lacks such service? In any case, we can be quite sure that there are different ways of talking about family situations in the different countries, which is apparent in Chapter 7 (see especially sections 7.4 and 7.5). In other words, there is reason to maintain a sceptical attitude towards the rhetoric regarding relationships between home and work.

These examples, which naturally coloured discussions regarding the construction of the questions and the interpretation of answers, are presented in order to illustrate how various external conditions and contexts influenced the research. Such problems run through this report, which is written from a Swedish perspective. We have attempted to address these problems, which are inherent in cross-national work, in several ways – although we cannot claim they have been fully resolved. The research team met on several occasions. Drafts of this report were sent to the researchers in the different countries to enable them to comment on the lead researcher’s perspectives and interpretations. While to give the reader the opportunity to make his/her own interpretation beyond the written text, we have added some of the photos taken during the tour (to be found in Chapter 8).

1.4 The rest of this report

The rest of this report consists of nine chapters, together with an Appendix. Chapter Two locates the three case study countries in relation to models of social care policy and provision, then reviews the post-war development of policy in the field of elder care. Chapter Three outlines the structure of the workforce in elder care in the three countries, and profiles the practitioners both generally and those interviewed for this study, including their routes into care work. Chapter Four looks at the related areas of education and training. Chapter Five explores what the meanings attached to ‘social care’, a term often used to cover work with elderly people, including an examination of how social care relates to other policy fields as well as informal care. Chapter Six develops this theme of the nature of the work by considering what knowledge and skills are thought necessary for work with elderly people. Chapter Seven looks at a variety of influences on social care work, including images of the work, gender and family. Chapter Eight covers the work environment and job satisfaction, while Chapter Nine deals with issues around the recruitment of the workforce. The concluding Chapter Ten offers some conclusions about the current situation and possible future directions.

The Appendix contains the interview guides drawn up for practitioners, trainers and policy makers; and the self-completion practitioner questionnaire.
CHAPTER TWO : THE THREE NATIONAL CONTEXTS

The three countries in this case study differ considerably in many ways likely to be relevant to policy, provision and practice in work with elderly people. In this chapter we explore some of these differences first in relation to their different welfare ideologies, conceptualised as models of social care, then in relation to the development of policy over recent decades. First, however, we have summarised some key demographic and economic indicators in Table 3.

Table 3: Key demographic and economic indicators for the three case study countries, 2000

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Spain</th>
<th>Sweden</th>
<th>United Kingdom</th>
<th>Hungary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>39,466,000</td>
<td>8,858,000</td>
<td>59,501,000</td>
<td>10,024,000</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>1.2</td>
<td>1.5</td>
<td>1.6</td>
<td>1.2</td>
</tr>
<tr>
<td>Population 75 and over as % of total population(a)</td>
<td>11.1%</td>
<td>13.8%</td>
<td>10.4%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Per capita GDP using PPPs&lt;sup&gt;3&lt;/sup&gt;</td>
<td>$21,000</td>
<td>$25,600</td>
<td>$25,400</td>
<td>$13,200</td>
</tr>
<tr>
<td>Female labour force participation</td>
<td>51%</td>
<td>75%</td>
<td>68%</td>
<td>53%</td>
</tr>
<tr>
<td>Employed women working part time</td>
<td>17%</td>
<td>21%</td>
<td>41%</td>
<td>5%</td>
</tr>
<tr>
<td>Care workers (ISCO 88 513)(a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>245,300</td>
<td>194,200</td>
<td>453,100</td>
<td>No Information</td>
</tr>
<tr>
<td>Part time</td>
<td>71,400</td>
<td>216,400</td>
<td>696,000</td>
<td></td>
</tr>
<tr>
<td>Unemployment rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>10%</td>
<td>6%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Women</td>
<td>20%</td>
<td>5%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Tax receipts as % of GDP (1999)</td>
<td>34%</td>
<td>52%</td>
<td>37%</td>
<td>39%</td>
</tr>
<tr>
<td>Services for elderly people (65+)(b)</td>
<td>1999</td>
<td>2000</td>
<td>2000</td>
<td></td>
</tr>
<tr>
<td>Home care</td>
<td>No information</td>
<td>8%</td>
<td>8%</td>
<td>?2.5%</td>
</tr>
<tr>
<td>Residential care</td>
<td>3%</td>
<td>8%</td>
<td>?3%</td>
<td>?2.5%</td>
</tr>
</tbody>
</table>

Source: OECD, 2001, except (a) Escobedo, Fernandez, Moreno and Moss, 2002; and (b) Moss and Cameron, 2002. See also Escobedo et al. (2002) for definition and discussion of ‘care workers’.

Compared to Sweden and the UK, Spain has lower fertility, per capita GDP and female labour force participation and substantially higher unemployment (though on the last three economic

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<sup>3</sup> Purchasing Power Parities (PPPs) are the rate of currency conversion which eliminates the differences in price levels between countries. They are used to compare the volume of GDP in different countries. PPPs are obtained by evaluating the costs of basket of goods and services between countries. PPPs are given in national currency units per US dollar.
and employment indicators, Catalonia will be above average for Spain). The UK (in which country, England accounts for about 85 per cent of the total population) stands out for high part-time employment among women, while Sweden has a far higher level of taxation than either Spain or the UK and a larger proportion of persons aged over 75. Sweden has a high proportion of care workers in relation to population, with rather more working part time than full time, though the part-time employment rate among this group of workers is even higher in the UK; the proportion of care workers in Spain is lower than the UK and most work full time. As we shall see later (in Chapter 3), most women employed part time in Sweden work relatively long hours, i.e. between 20 and 34 hours a week.

2.1 Three models of social care
Comparative research into social care services is an under-developed field. There still remains much conceptual ambiguity and even the identification of the services is difficult. That is one of the conclusions from a European study in 14 countries made by the Finnish social researchers Anttonen and Sipilä (1996). They also conclude that a clear distinction between health care and education services is required, to delineate clear borders with care services. Anttonen and Sipilä used international materials to compare the volumes of institutional care and home help services provided for elderly people as well as children’s day care and pre-school services, in Scandinavia and in the EU member states in the late 1980s. In addition they looked at the connections between women’s gainful employment and social care services, finding at the national level that the two are indeed very closely related.

Two distinct models of social care services emerged from their analysis of service volumes and state policies; two, possibly three, other models remain more tentative. These models seem to offer very different options and opportunities as regards women’s gainful employment and care solutions outside the family. The Scandinavian welfare state has been built to support the wage employment of every adult, and consequently Scandinavian countries offer women the opportunity to enter the labour market. The public sector has taken the responsibility for doing this. By contrast, in Southern Europe in particular, women’s chances of gainful employment depend on their ability to come up with private solutions. These contrasting models show very different levels of public provision of services, whether for children or adults, generally extensive in Scandinavia, generally meagre in Southern Europe. Many studies, in addition Anttonen and Sipilä, have documented these extremes (Daly and Lewis, 2000; EC Childcare Network, 1996; Esping-Andersen, 1999; Pacolet, Bouten, Lanoye & Versieck, 1999; Rostgaard and Fridberg (1998).

Two of the countries involved in our study belong to the distinct models identified by Anttonen and Sipilä: Sweden (Scandinavian) and Spain (Southern European). Our third country, England, belongs to a less distinct model. Over the last 25 years it has moved from being closer to the Scandinavian welfare state to being inscribed with what Esping-Andersson (1990, 1999) has described as a liberal welfare regime, characterised by targeted public policies focused on low income groups; flat-rate, means-tested benefits; and a strong move from public to private provision, promoting market solutions. In spite of major differences between England and Spain, there is a trend to move towards liberal welfare regime features in elder care also in Spain.

Within these different welfare ideologies, but also influenced by gender politics, economic developments and other factors, the three countries compared in this study have developed their care services in three different ways. The strands of ideology are also reflected in differing views about gender, citizenship rights and the division of responsibility for care
between individuals, families, markets and society. Present caring ideology in each case can be better understood when set against the history of change in welfare solutions. The following presentation of these changes is arranged in a chronological order. The different historical development in the three countries contextualise the words and institutions and make them impossible to interpret without losing their colour and flavour. We have chosen to present the occupations by their national professional titles. Also the different kinds of services are presented in national terms.

2.2 Legislation and the evolution of social policy

2.2.1 Up to the 1950s
In England, the primary responsibility for care of older people was very much grounded in the family. This was reflected in the National Assistance Act 1948, which established the welfare state and continued the then dominant social policy premise of a male breadwinner/female homemaker model, in which men earned an income and women cared for family members, whether children or adults, and disregarding the fact that for most working class women, paid labour was a reality (Lewis, 1992; Crompton, 1999). The emphasis on informal care by families has continued, despite the changing nature of family relationships in England. In the 1950s there were fears that state intervention would erode the willingness of families to care for elderly relatives; today the role of the state is seen as supporting informal carers.

Until the advent of the post-war welfare state, institutional care of older people was under the aegis of the Poor Law and organised very locally. The main tenet of this legislation was that only the destitute and socially isolated could be eligible for such assistance, and therefore using these services incurred great social stigma. In 1948 the Poor Law was abolished and responsibility for residential care institutions transferred to local authorities. Residential care therefore has a long, but residual, role in England’s care services.

By contrast, home help services were developed during and after the Second World War when reasonably fit older people were unable to cope with the austere conditions associated with rationing. Such help included cleaning, shopping, collecting pensions and laundry on weekly visits and was greatly appreciated (Sinclair, I. Gibbs, I. and Hicks, L. (2000) The Management and Effectiveness of the Home Care Service, Social Work Research and Development Group, The University of York). But throughout the post-war period, this was a low status, forgotten service. It was unregulated, manual work, undertaken by home helps and cleaners mainly employed, until recently, by local authority departments.

Until the middle of the 20th century, the transition in Sweden from poor law relief to a more differentiated policy field of social care caused shifts and negotiations around two frontlines: health care and family-based care. In the early 20th century, in residential care there was a political wish to reach a balance between health care and social support. Föreståndarinnan (Matrons) at old peoples homes had two separate tasks to manage: household tasks and nursing tasks. Household tasks were to keep their homes orderly and hygienic, to ensure food was well prepared and menus well balanced, to supervise and control staff, to manage finances, accounts and inventories, to check fire precautions, and to represent the home in relations with the outside world. Nursing tasks were to organise care and treatment, to distribute medicines and give injections, to call for doctors when needed, and to keep relatives informed.
During the first period of the 20th century, emphasis was placed on keeping the elderly residents busy and treating them in a friendly manner. The staff should perform their duties with love (Trydegård, 1996). Separating the social and medical tasks made it clear that they both existed. But it also made it clear that they could be in conflict when time was lacking or when one of these areas of competence was more highly valued than the other.

Care for elderly people in Sweden therefore has a long-standing tradition: the post-war years, however, saw it firmly entrenched in the welfare state. It emerged in the public service sector throughout the Nordic area following the Second World War, in particular through the growth of home help services providing *offentlig omsorg* (community care). This was a response in the post-war years to the demographic problems related to a growing proportion of elderly people in the population. But the ideology underpinning a policy to keep older people at home for as long as possible, and so postpone admission to institutional care, was a response to the criticism of institutions for older people made in the 1950s by the Swedish author Ivar Lo-Johanssons (1952). For a long period, therefore, the public services expanded with *hemsamariter* (paid home helpers, this being the term used before 1976) as the base for the elderly care. This both met the service needs of the elderly and provided women with job opportunities.

One consequence of this expansion was the appearance in the public sector services of a large number of assistant staff. Subordinate help staff in care work, in particular *hemsamariter* (home helpers) and *undersköterskor* (auxiliary nurses), emerged in Swedish statistics in 1962. This was long before they were visible in statistics in Finland and Norway. The explanation, according to Wærness (1989), is that Sweden was the first Nordic country where these low-educated workers got proper employment terms and where they first organised themselves into trade unions. As we shall see, also in contrast with other Nordic countries, Sweden has developed other specific features in its care workforce, including the development of hierarchies and professional opportunities.

The antecedents of social services in Spain are to be found in provision made by the Catholic Church: as in England and Sweden, there is a long historical tradition of involvement by charitable organisations in the provision of institutions for the poor, welfare and social work. The development of modern public social services has its origins in Catalonia during the Second Republic (1931-36) and was related to the development of political decentralisation at that time with social services defined as a regional competence. In 1932, the first Spanish school of social work was created in Barcelona, by the Catalan Catholic Church with the support of the regional government (*Generalitat de Catalunya*). This development process was interrupted first by the civil war (1936-39), then by the Franco dictatorship (1939-75).

During the first part of the Franco dictatorship only a few social assistance resources were developed, and these had a high ideological profile and very limited coverage. Besides them, the Catholic Church continued to play an important role.

### 2.2.2 The 1960s

In England attempts were made within social work to develop ‘community care’ throughout the 1960s, some time after similar developments in Sweden. If successful, this would have had an impact on the work of home helps. In the event, responsibility for home helps was transferred to unitary social services departments in 1970, and the distinction between social work (professional) and care work by home helps or care assistants (manual) remained. Social work with older people was also of low status and undertaken by unqualified assistants.
However the relationship between social work and care work has remained important, as developments within the former have tended to impact on the organisation and work roles of the latter.

As a result of the introduction of state grants in 1964 in Sweden, other work with elderly people, such as cleaning, also came to the fore. However, the personal contact was still at the centre of things. But at the same time, the importance of staff management, which could bring about contacts between the right people, was formulated in connection with the new economic conditions (Szebehely, 1995). A hierarchy was put in place in what was then called the *hemsamaritgrupp* (home helpers group). Staff management is symptomatic of an organisation that emphasises the profession rather than an interest in the tasks involved in the work. This is also where we find the historical explanation for leadership having such a central position in many *sociala omsorgsutbildningar* (social care education programmes) in Sweden today.

During the 1960s, Sweden introduced the possibility of payment to relatives caring for a family member, as well as to non-related carers. There are several schemes. Under the most favourable one, a person can become a *anhörigvårdare* (a relative employed to provide care), and is then paid the same salary as an *undersköterska* (auxiliary nurse): under this scheme, the community retains a role both as a funder of care and as an employer of the carer.

In Spain, a modern public social security system first began to develop in the early 1960s. Within this social security system also appeared the first public social service for pensioners – a non-universal home help service based on a contributory system (*el servicio asistencial al pensionista*). This service was provided by women without any training or qualification, and with a low basic education. However, they became a stable group of public employees: after the democratic transition and the return to decentralised government, they were transferred from the central state to the *Generalitat de Catalunya*.

### 2.2.3 The 1970s

In England in the 1970s the concept of care was developed along ‘community’ lines with the focus on increasing and supporting community resources and networks to assist older people, for example through mobilising voluntary organisations. Hence, developments such as ‘patch-based work’ with formal care being organised around local communities became fashionable with ‘care’ being seen as a collective responsibility. Community care went alongside a policy of deinstitutionalisation and an emphasis on ‘keeping older people at home for as long as possible’. Such moves however, put increasing financial pressure on community care services, such as home helps.

In Sweden, a reinforcement of the role of *arbetsledare* (supervisor) became an important issue in the 1970s (Szebehely, 1995). More and better trained *arbetsledare* (supervisors) with increased authority, it was argued, could pave the way for a more rational organisation of the home help service. The rules for government grants were, for this reason, changed. They now included funding for services provided outside the homes of the elderly, e.g. chiropody, distributing meals and bathing services. The ‘housewife competence’ of *hemsamaritens* (home helpers), which had been sufficient until then, had to be supplemented with other knowledge.

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4 The question of whether managers receive basic training within *sociala omsorgsutbildningar* (the social care programme) or whether a manager is something one becomes after taking supplementary training was one of the most hotly contested debates of recent years.
The next step in the reinforcement of professionalisation in the Swedish hemvård (the term for home help service before 1982) was the provision of a theoretical structure to the work content. This occurred during the 1970s, but above all during the 1980s, when a social pedagogical orientation set the tone. Activation, social rehabilitation and assistance in helping oneself became the key concepts of the work. Hemtjänst⁵ (home help, the term used after 1982) was to be activating, and it was expected that educational and rehabilitative tasks would largely replace household work. The new approach was introduced on the grounds that it would offer time savings in comparison with the former more traditional model, and that it would facilitate personnel recruitment (Szebehely, 1995). Efforts were concentrated on the formal training of the staff.

The 1978 Spanish Constitution defined a new consensus based on democratic and social rights, the acknowledgement of the different historical nations within Spain (Catalonia, the Basque Country, Galicia and Andalucía) and the principle of decentralisation. The state was organised into 17 Communidades Autónomas (autonomous communities), with self-governing institutions including parliaments. So, in Spain, there is not unitary state legislation about Social Services: there are seventeen different Social Services Laws, and the competencies are distributed between Autonomous governments and municipalities. In theory, Social Services are a right for all, but without guarantees. In practice it depends on the different budgets. There are major differences – cultural, economic and social – between the Autonomous Communities, which contribute to different developments in social services across Spain.

2.2.4 The 1980s
Throughout the 1980s the need for restructuring became clear in England because of the ineffectiveness and inefficiency of services (see for example, English Department of Health, 1981a, b, 1989; Audit Commission, 1986). The ‘at home if at all possible’ objective was severely tested through the failure of joint working between health and social care agencies intended to keep people at home. If an emphasis on community care was a major theme of 1970s, the privatisation of care was promoted in the late 1980s, driven by the ideological commitment of the then Conservative administration. This applied across the board to home care as well as residential care, with local authorities shifting away from direct provision of services towards using private services, culminating in a requirement by government that local authorities mostly use these services. One consequence was a rapid rise in social security expenditure to pay for people to live in private residential homes, which was accompanied by an explosive growth of private, for-profit homes.

In Sweden important legislation came into force. Both the Social Services Act and the Health Care Act strengthened the autonomy of the client/patient and their right to influence the services. These new directions could be contradictory to the emerging professional interests of the care workers when elderly people wanted to be helped in their households rather than activated and rehabilitated.

The health system was reformed and universalised in Spain in 1986. This new model of primary health care included the possibility of domiciliary nurse care. The Catalan programme Vida als anys, also started in 1986, opened the way to the development of socio-health (atención sociosanitaria) care. It was the first time in Spain that a programme of care for elderly people has been co-funded and co-ordinated both from health and welfare authorities. It is a first step forward a more systematic and rational care system for frail

⁵ Hemvård changed name to hemtjänst with the introduction of the Socialtjänstlagen, the new Social Services Act 1982.
elderly persons with chronic diseases and for terminally ill persons. The only municipality in Spain which has a co-ordination between health primary care and social care for their inhabitants is also in Catalonia.

2.2.5 The 1990s
In England the NHS and Community Care Act (1990) reflected continuing changes in policy, towards the commodification of care and the provision of welfare services by the private sector. Local authority social services departments were to become the ‘lead agency’ responsible for assessing need for social care and organising its delivery by means of ‘care management’. A distinction was established between ‘purchasers’, who hold purse strings, and ‘providers’ of care services. A ‘mixed economy’ of social care services took further shape, though with most services provided through the independent and private sectors. While the independent or voluntary sector had long held an important role in providing residential and day services for older people, the radical shift in policy through the 1980s and 1990s was the specific encouragement of the private, for-profit sector: care services for elderly people became big business.

Separating purchasing and providing was also an effective way of rationing, targeting and gate keeping resources, controlled by local authority managers whose concerns were to keep within allocated budgets. The growth in charging and means testing for domiciliary services in the 1990s was one of the results of this approach. Another was to rein back public expenditure on residential services, that had spiralled in the 1980s when government had funded residential care for anyone who wanted it (subject to a means test). Now public funding was dependent on assessment processes by local authorities, one condition of which was that it was not possible to enable elderly people to live at home with a ‘care package’.

In Sweden ‘the revolution of freedom of choice’ in the 1990s has put the rights of the citizen in focus in a clearer way than ever before. Other changes have, however, had the opposite effect. Cutbacks in funding combined with a growing number of people over 85 years of age (the age group most likely to need services) have contributed to a situation where social care services have been increasingly concentrated on those with the greatest need for care, in other words more services for fewer people (a similar trend is apparent in England). The Ädel reform of 1992 has resulted in the hemtjänst (home help service) becoming a multi-professional activity. At the same time as cost-cutting measures have been implemented, there has been a shift towards more medically-orientated care (again, a similar trend is apparent in England). Medically-orientated tasks have come to overshadow the social ones, partly because of the transfer of the former health responsibilities of county councils to the municipalities, who are also responsible for home care; and partly because of the increased targeting of services on those in greatest need, who often also have poor health. As in England, the purchasing and providing of care services were increasingly separated, because “care-packages” were becoming too costly and the assessment process appeared to be at fault.

From mid-90s onwards, Spanish elderly social policy has been moving towards liberal welfare regime features and practices. Public social services have always been only for the poorest, and recently there have been cutbacks in these services resulting in even more targeting of these services on people with the most needs. The establishment of agreements with private providers for the provision of public services is developing, especially in the sector of residential services, in such way that the elderly care sector is becoming an important business sector nowadays, with the participation of insurance, banks and building companies in the market.
2.2.6 The current decade

In England, the mixed economy of care has been reinforced by a modernisation agenda which includes the concept of ‘Best Value’, where the expectation on local authorities is to bring a criterion of competitiveness to considering which service providers to use and to demand quality and efficiency improvements. At the same time a National Service Framework for Older People was introduced in 2002. This aims to provide high quality care and treatment, regardless of age, to treat older people as individuals, with respect and dignity, to provide a fair distribution of resources for older people, and to ease the financial burden of long-term residential care (English Department of Health, 2002). The main themes for the delivery of this policy are better co-ordination or partnership, specialist posts aimed at both treatment and prevention, and enhancing independence for older people.

In April 2002 a new system of standards in long-term care was introduced which was brought into existence by the English Department of Health (2000) Care Standards Act 2000. This also established four new national bodies, with responsibility for regulating and steering care work. They were explained by one of the policy informants in these terms:

(There is the) National Care Standards Commission (NCSC), which is regulating organisations as opposed to the General Social Care Council (GSCC) (which is) regulating people. You have TOPSS (Training Strategy Organisation for the Social Care Sector), which has a role in setting national occupational standards, you have the Social Care Institute of Excellence (SCIE), which is supposed to be looking at what works best and sort of locking that in ... We are here to provide high quality services to a particular standard, and that standard has been set out by the national minimum standards of the Secretary of State.

Alongside these organisations there is also the Social Services Inspectorate (SSI). A policy informant described this body as

the professional arm of the Department of Health that leads on social care, so the Department of Health has responsibility for the NHS and health services and directly manages it. And it has responsibility for policy advice and guidance for social care but the delivery of social care is the responsibility of local government. So it has a policy giving [responsibility]. It sets the policy, the legislation and gives guidance and the Inspectorate has two functions really, it inspects the quality of social care services provided by local councils and it also has an arrangement where it is the link between local government and central government for social care so we have inspectors in each region who manage the day to day business with each council. Our main function these days is to assess the overall performance of councils which result in a star rating being allocated to them for social services.

It is envisaged that in 2004, the NCSC and the SSI will be combined into a single organisation. At present there are practical difficulties in getting the new organisations running. There are great variations in the interpretation of standards that have to be reconciled, while the sheer number of care workers to be registered under the GSCC’s remit number around one million. There are also difficulties persuading owners and managers that
quality will be improved by regulation of residential care homes. There has been a “cooling” in enforcing care standards in England.

Through the 1990s and into the 2000s, there has been increased policy attention to closer working relations between social services and health authorities. This recognises that many elderly people requiring services have closely linked social and health needs. But it is also driven by a concern that many hospital beds are taken up by so-called ‘bed blockers’ - old people who, with appropriate ‘care packages’, could be discharged back to their homes. One consequence has been jointly funded services, including rehabilitation schemes (part of intermediate care) to help hospital patients prepare for a return home.

Such has been the growth of the private sector in England since the 1980s that by 2002 less than a fifth (18 per cent) of residential homes for elderly people were in the public sector. The remainder were divided between the voluntary (private non-profit) sector (33 per cent) and the private, for-profit sector (49 per cent). However the number of places in these homes has been falling for some years, with the private sector blaming this mainly on the level of fees that local authorities are prepared to pay for those people they support, together with the costs required to meet increased national standards.

The current decade has also seen the introduction, in 2002, of ‘cash for care’. Under this policy development, elderly people may opt for direct payments with which to purchase their own services, mainly through the proliferating private businesses offering home care, either to local authorities or to private individuals. Another trend in England in the beginning of the 21st century is the development of primary care trusts and the merger of health and social care in many local authorities.

In Sweden, the current ideology, unlike England’s, is not in favour of nationally determined and regulated standards, but to go instead even further down the decentralisation path. There is a government study of the issue, and one of the main suggestions will be that municipalities are given greater powers to decide which public services their residents should have the right to receive (Svegfors, 2003). At the same time the care work can be characterised by a shortage of staff, a recruitment crisis, and various educational projects including more ‘academisation’.

As we have seen, care services for elderly people have developed later in Spain (as in other Southern European countries). The family has been expected to take responsibility. In 1997, a general law was passed which regulated the whole health system. This has been followed, in 2001, by the transfer of responsibility for health care in Spain from central government to the last autonomous communities that had not assumed it yet. Catalonia has had responsibility for health care from 1981, and other competences, including social services and education, have also been devolved for some time. Most care work with elderly people is now located within social services, but some is also within health. Further programmes and services are located in between, in a grey area called socio-health care (atención sociosanitaria).

Since the transition to democracy, and the accompanying process of decentralisation, Catalonia has been a pioneer region within Spain in the field of elderly care, including for example the first school for family workers (treballadores familiars).

From the mid-90s, there has been a debate on a national system to support those with long-term care needs and to support informal care. However after nearly 10 years of discussion, no
agreement has been reached nor any proposal agreed and implemented. The main discussion is about public funding of such a system and private participation. Private companies (in the health and insurance sector) have done some marketing studies and have started to offer some private packages; however, these are still too expensive to have any significant impact. Thus Spain has a private sector interested in developing the care business, but not yet any legislation, tax incentives nor public social security schemes to address this major issue. Care is still far from being the fourth pillar of the Spanish welfare state. However various proposals are still debated, and in the next round of the social partners negotiations on future directions for the Spanish social security system, in autumn 2003, the proposed law on dependency is on the agenda.

Some regions have experimental programmes to provide economic support to families caring for elderly relatives. In Catalonia, for example, the programme Viure en família (Living in the Family) has existed since 1992, offering a maximum of €240 per month to families living with and caring for a dependent elderly relative, provided that total annual family income is under €36,061. This is not a universal right but a programme subject to budget availability, thus the payment is not guaranteed and depends on the number of claims: as the budget is very limited many are turned down.

2. 3 Hungary

Hungary has a low fertility rate and a relatively low proportion of people aged 75 and over. Women’s employment rates are similar to Spain, and lower than Sweden and the UK, but nearly all employment is full time. It has the lowest per capita GDP of the countries covered in this report, but a tax take similar to Spain and the UK – and far below Sweden.

A recent overview of elder care services prior to transition in the countries of Central and Eastern Europe and within the former Soviet Union concluded:

> Families, women, and informal community networks provided the elderly with long-term assistance when they became frail…Few nonmedical community-based services were available to assist the elderly…The types of in-home assistance for the elderly available in other European nations were largely absent…Long-term residential institutions were the main resource available to the elderly when their families could not care for them…[Since transition] roughly the same [0.8 percent] are residing in residential institutions as 10 years ago…Over the past 10 years community-based social services have developed very slowly in Central and Eastern Europe and the former Soviet Union (Tobis, 2000, pp.10, 22, 23, 33)

Reflecting this general situation, levels of service for elderly people in Hungary are substantially lower than in Sweden and England, but (at least for residential care) comparable to Spain (Moss and Cameron, 2002). Hungary, however, did enter transition with more community-based services than most other countries in the former Soviet block.

Key recent legislation is the Social Act of 1993, which defines responsibility for providing social services, including those for elderly people. This legislation has oriented Hungary towards common practices in Western Europe, as well as conforming to the requirements of the European Union. However, a legacy remains from the previous regime, including some large institutions providing residential care; for example, one of several residential homes visited by the research team was for 250 residents, while many complaints were made by
informants about the bad physical state of buildings. The government has launched a programme to improve institutions, including plans to renovate 240.

Three other recent developments are important. First, since 1990 there has been a process of decentralization from national to local governments, and this has included responsibility for many services including elder care; this has contributed to financial problems in services as many local authorities lack adequate funds. Second, central government retains a regulatory function, and this now includes a system of regulation for elder care services, introduced in 1999. Finally, the Social Act 1993 enables local authorities to make contracts with private organisations to provide services, and government policy encourages a more mixed economy of provision. However, most provision continues to be made by the public sector, which now means local authorities, for example two thirds of residential care services with the remainder from the church and voluntary bodies.

### 2.4 Concluding comments

The three countries covered by the main case study differ in levels of provision and providers. Sweden, overall, has the highest level of publicly-funded provision, followed by the UK with Spain lagging some way behind (Table 3). While most Swedish services continue to be provided by local authorities, the private sector is more important in the UK and Spain, with UK provision increasingly dominated by private for-profit providers.

The development process described here has also differed in the three countries, even though there are some similarities in the origins of care work. In particular the mix between state, market and family has differed, both between countries and at different times. For instance, Sweden has gone from a large publicly financed care sector up until the 1970s, to a sector consisting of a greater mix of publicly and privately financed programmes including a larger portion of voluntary work and participation by close relatives: this development has been pronounced from the 1990s onwards. Despite more private provision and funding, commitment to publicly organised and financed solutions is still a Swedish/Scandinavian phenomenon. By contrast, from the 1980s onwards England has shown a strong turn towards private, for-profit providers. It has also begun to develop a direct payments or cash-for-care policy, whereby elderly people will have increasing opportunities to organise and pay for their own care services.

Developments in Sweden and England have been underpinned by two different welfare ideologies. Sweden has had a positive view of the state as provider and liberator of women, while the UK has been more sceptical towards the role of the state, in part due to the view of the family as private and not an appropriate object for public intervention. The Swedish model has been based on welfare as a universal entitlement while England has a means tested tradition that targets low income groups. But adjusting to a harsher economic reality has meant Swedish elder care has, in this respect, moved closer to England: means testing has become a more pronounced feature of the Swedish system, and the notion of general welfare has come to be severely circumscribed. Economic resources, however, are not the main criteria for means testing, rather it is the applicant’s health and social network which are the important factors in the decision of whether to offer public services.

Spain stands out in an important way due to the Franco regime’s long duration (1939-1975) and the preceding civil war (1936-1939). These contributed to a considerable delay in developing welfare state involvement in the care of older people. Compared to both the UK and Sweden, the Spanish welfare state has expected, and continues to expect, the family to
play a far greater part in elder care. This is in line with the model of Anttonen and Sipilä discussed at the start of the chapter.

But there are, as we shall see also in the following chapters, elements in common in English and Swedish trends described above, some of which are also apparent in the more recent developments in Spain:

- The increasing standardisation of care services, either through national standards or through professionalisation / academisation with better and longer education and training.
- A growing discourse about quality in care services, which has also been made visible through different kinds of solutions.
- Increased targeting of publicly-financed services on elderly people with high levels of need, with increased and more complex demands on home care workers.
CHAPTER THREE: THE WORKERS

In this chapter we will profile the care workers we interviewed, as well as considering their routes of entry into, and motivations for doing, care work, and their caring responsibilities outside work. Later, in Chapter 7, we shall consider how family work and care work interrelate. We will also show that understanding care work draws to a varied extent on experience within families, and that for most of our English informants, for example, work and home are seen as ‘the same’. In all countries this experiential definition of care work is a product of a particular social era: when expectations of women in the educational system and in the labour market were not high. In two of the countries, England and Spain, expectations of women within families are still clear – the norm is the home-based mothers. In one of the countries, Sweden, the expectations of women are to be a double worker, both wage-earner and mother, which was the vision of Alva Myrdal in the book she wrote together with Viola Klein in 1957 called Women’s two roles.

But before looking at the care workers in our study, we provide an overview of the structure of the care workforce in the three countries, as well as the main forms of training for the work.

3.1 The structure of the workforce

Of our three case study countries, Sweden has the most highly trained workforce. The occupations that perform most of the care work are personliga assistenter (personal assistants), undersköterskor (auxiliary nurses), sjukvårdsbiträden (health care support workers) and vårdbiträden (nursing assistants). A number of other occupations border on to these front-line professions, principally hemtjänstassistent, områdeschef or biståndsbedömare (middle managers), sjuksköterskor (nurses), sjukgymnaster (physiotherapists) and arbetsterapeuter (occupational therapists): these occupations, however, constitute only a small part of the total workforce in care for the elderly. Of all these occupations, personliga assistenter (personal assistants), vårdbiträden (nursing assistants) and hemtjänstassistent or biståndsbedömare have a social focus in their work, while the other occupations listed have a health focus.

We have already mentioned, and will discuss again later, the attention that has been paid to developing a cadre of hemtjänstassistent or biståndsbedömare (middle managers), who now receive a 3 to 3½ year education for this role. Amongst those actually doing ‘frontline’ care work, the main occupation is auxiliary nurse (undersköterska), with a qualification involving three years study at an upper secondary level. Auxiliary nurses, with a basic medical training, can work in many kinds of services, and can consequently be both vårdbiträde i öppen vård (a home helper) and undersköterska/vårdbiträde (a worker in residential services).

The intention in Sweden is to make the auxiliary nurse a standard qualification for all workers with elderly people, which underlines a shift towards a more medical focus in the Swedish elderly care. However, this official policy has not been possible to implement. One problem is that the young people do not chose omvårdnadsprogrammet (the health care programme). Many of the courses are not full or, in some places, are even totally empty. Another problem is that this programme has many drop-outs: only about half of those who enter the programme

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6 Biståndsbedömare and områdeschef are terms used after 1990; hemtjänstassistent is the term used previously.
will reach the final examination. A third problem is that many of those who achieve the qualification choose to work in other occupations or to follow another education.

In practice, therefore, there are a substantial number of workers who have not trained as an auxiliary nurse. The development in the front line care work will in the long run need to include other solutions. Given these circumstances, municipalities need to be creative to find attractive forms of training for those who want to enter the care work arena. The structure of alternative training for care workers is therefore difficult to describe, as it differs between municipalities and because it is in constant state of change.

In England, there are ‘home helps’ or ‘home carers’ who provide domiciliary services and ‘care assistants’ who work in residential services (in all countries, there may also be trained nurses working in some residential services which provide for elderly people with high needs, but they constitute a small proportion of the total staff). As we shall discuss in the next chapter, many of these workers have no training at all or only a very low level of ‘competency-based’ training often equivalent to a qualification that might be acquired at the end of compulsory schooling.

In Spain, there is a similar distinction between domiciliary and residential workers, although within these broad groups are various sub-groups defined in terms of their training and qualifications. Cuidador/a is a general term used for all care workers in eldercare, but it is also sometimes used to refer to a non-qualified carer. Other terms for non-qualified workers include asistenta/e familiar (a home assistant, usually working in the informal grey market); auxiliar de geriatría (geriatric assistant) and auxiliar de gerontología (gerontology assistant). At the other end of the training spectrum are occupational groups with professional training: auxiliar de enfermería (nurse assistant) and técnico en atención sociosanitaria (technician in socio-health care). In between, with vocational training, is found the auxiliar de ayuda a domicilio (home helper) (see section 4.3 for fuller description of the training of these various occupations).

A second group of vocationally trained domiciliary workers domiciliary workers are called treballadores familiars (family workers). This term originates in France and is the translation of travailleuse familiale, the profession on which Catalonia has founded the model of their home helpers. These family workers focus on the capacities of individuals and families, and, when relatives are available, they devote some of their time to training and supporting the family members. One aim is to provide some guidance so that the families know that what they are doing is beneficial for the old person. This attention to the family reflects the emphasis in Spain on the primary role of the family in providing care. But more and more, and especially with elderly people, they are doing a supplementary role, when the family is not available or does not exist.

3.2 Profile of care workers

3.2.1 The general picture
According to SCB [Statistics Sweden], the two most common occupational groups in the whole Swedish labour force in 2002 were ‘auxiliary nurses/medical care workers’ (undersköterskor / sjukvårdsbiträden) and ‘home helper/personal assistants’ (vårdbiträden / personliga assistenter) (in addition to auxiliary nurses, medical care workers, home helps and personal assistants, these groups include various other occupations including family day
carers (familjedagvårdare), dental nurses (tandsköterskor) and other care workers). Women have always dominated nursing and care, and they constitute about 95 and 90 per cent, respectively, of these two occupational groups. The women are in general somewhat older than their male colleagues. Nearly half (45 per cent) of the women are aged 40 to 54 years, whereas nearly half (46 per cent) of the men are to be found in the 25 to 39 age group (Statistics Sweden 2002).

The same statistical source (SCB) records that the majority of women in the occupational groups of auxiliary nurses (undersköterskor) and home helpers (vårdbiträden i öppen vård) work part time (see also Table 3). However, this set of statistics do no distinguish between short and long hours part-time work, which may explain the difference between these statistics and the questionnaire answers from our informants (see 3.2.2.), in which the majority stated that they worked full time7.

No official information on ethnicity is available in Sweden, as it is not considered ethical to collect such information. Also information about educational level is lacking. Public employment is dominant. In 2000, 90 per cent of the two main occupational groups of carers (see above) were employed by the public sector or by companies owned by the county councils.

The salaries are low. The average full-time monthly salary in 2000 for public employees was SEK16,200 (€1760 at 1€ = 9,2 SEK) for women and SEK 16,500 (€1795) for men. In private employment the comparative figures were SEK16,500 (€1795) for women and SEK17,300 (€1880) for men. During spring 2003 a strike for better payment took place, but the payment is still low compared to other sectors.

Analysis of the care workforce in the United Kingdom, using the Labour Force Survey (LFS) for 1997 to 1999, found that workers in the category ‘care assistants/attendants’ (which includes residential and home care workers with elderly people) were nearly all female (91 per cent), and that nearly two thirds (61 per cent) of them were aged 35 or over with an average age of 39 years. They were nearly all ethnically white. Just 6 per cent came from a minority ethnic background, although in both cases there are large local variations in the figure, with minority ethnic populations heavily concentrated in a number of major cities and other urban locations.

Levels of education in the national workforce were low. The average age of leaving full–time education was 16 years (i.e. the end of compulsory schooling, before upper secondary, further or higher education). Only 31 percent had an educational qualification at upper secondary level or higher and 20 percent had no educational qualification at all.

Just over half (55 percent) worked part time (i.e. less than 30 hours per week), and nearly two-thirds (62 per cent) work in the private for-profit sector. Pay was low, but higher for the minority not working in the for-profit sector (who would also be more likely to have enhanced occupational benefits such as occupational pensions). ‘Care assistants/attendants’ in the public or private non-profit sector earned £5.19 per hour (€1265 per month for a full-time worker assuming a 40 hour week and 4.3 weeks per month: €1=£0.70) compared to just £4.08

7 In Sweden, 74 per cent of women and 79 per cent of men are active in the labour market. 48 per cent of women work full-time (more than 35 hours a week). 72 per cent of men work full time. 22 per cent of women work long hours part-time (20-34 hours a week) and 5 per cent of men. Only four per cent of women work short hours part-time (1-19 hours a week) and 2 per cent of men (Statistics Sweden, 2002)
in the private for-profit sector (€995). By comparison all women workers earned £8.56 and £7.79 per hour respectively. Care workers therefore lagged far behind the female workforce, let alone the male workforce.

English policy informants confirmed this general national picture. They said that social care workers were around 50 years of age, were mostly women and mostly had low levels of qualifications.

3.2.2 The care workers in the study
Of the 23 care workers interviewed in the Swedish part of the study, five of the informants are men. At just over a fifth of the total, men in the study are over-represented compared to the overall care workforce.

The average age of the women is 45 years with an age distribution of between 28 and 62 years. The age of the four men for whom there was information averages 38 years, with an age distribution from 30 to 48. The women have worked in care for the elderly for an average of 15 years and have been employed at their current workplace – whether a residential home or home help district - for 7 years. As regards the men, the corresponding figures are 10 years and 6 years, respectively. These figures are in line with those in the SCB statistics referred to above, emphasising the fact that women in care occupations in Sweden are, on average, in middle age and are on average a few years older than their male colleagues.

As already noted, contrary to the national workforce picture, most Swedish workers in the study, say they work full time: 4 worked long part-time hours (i.e. 20-34 hours per week) and 2 work shorter part-time hours. As noted in Chapter 1, two of the home help workers divide their time between direct care work and a co-ordination role.

The Swedish informants are also somewhat different to the overall workforce in another way. A quarter work in the private sector, in consequence of the selection process, compared to about 10 per cent nationwide. These private sector workers are employed by for-profit companies operating in a quasi-market, mostly supplying municipalities with services.

All the Swedish care workers except 3 have received some sort of care and/or nursing training, either as an auxiliary nurse with basic medical training (10 informants) or a home helper qualification (8). Of those without such training, one has a university-level education in another field, while two people give nine-year compulsory school (grundskola) as the highest form of education they have completed. Many of the informants also have other qualifications, e.g. in childcare, masseur/masseuse training and in other programmes unrelated to care at upper-secondary school level.

As regards the family circumstances among the Swedish practitioners, we can see that the men have different family responsibilities to the women. Three of the men live alone, with one of them having had a child who has now moved out. One man is living with a partner and has children at home. However, 15 of the 17 women are married or living with a partner. Most women have also had children – 14 out of the 16 for whom we have information – though only 6 (2 living alone) currently have children living with them.

Altogether 16 English care workers were interviewed, 12 women and four men. As for Sweden, men are over-represented compared to the national workforce. Thirteen of the care
workers are white British, two white Irish and one was Black African. The residential and home care workers are between the ages of 36 and 52 years.

All except one of the women workers in England are married or living with a partner. Nine have had children, but only four currently have children living at home. One has an elderly relative living with her and three have elderly relatives living nearby who require regular help.

The four British male care workers have distinctive and varied profiles: the female workers have much more consistent characteristics. All of the men are employed in the urban authority. Two are younger than the average for women, while one is nearing retirement age. One, the eldest informant, is of Black African origin, the other three are ethnically white, although two are of Irish descent. Three of the four men have children, although these are not living with the informants at the time of interview, either because they are adult, or due to a previous divorce.

Over half the informants (56 percent) work in the public sector. This is considerably more than the national workforce, where only just over a third work in the public and private non-profit sectors combined (Simon, Owen, Moss and Cameron, 2003; Owen, p.c.). The seven informants employed in the private sector work for for-profit organisations.

Similar to the national workforce average, all the female care workers in the English study have left school at the minimum age of 16 years, and levels of qualification are low. Six of the 12 women have attained a vocational qualification while at work. Two of the four male informants have a university education and other professional training such as nursing and teaching, and the other two have vocational qualifications in care work. Thus in total, eight care workers have a vocational qualification for care work; two have university degrees (one of which was in an unrelated subject); and one has nursing and teaching qualifications as well as his university degree. Two have no qualifications at all and only three have academic or vocational qualifications at an upper secondary level or higher.

Altogether 15 care workers were interviewed in Spain (Catalonia) - 12 women and 3 men. Three women and one male family worker are immigrants from Latin America, however all of them also have Spanish nationality and have lived in Catalonia for more than 10 years, having older children also living nearby. More than half of the interviewed are older than 40 years; only two nurse assistants in residential care are under 30 years of age.

Only four of the 15 Spanish carers are directly employed by the public sector. The rest are employed by private non-profit organisations (4 family workers and 2 residential carers) or by for-profit companies (4 residential carers).

All the care workers have some qualification (as family workers or nurse assistants) or some occupational or continuous training (see 4.3 for a description of the various training possibilities, mostly at a relatively low, post-16 level). Two of them have studied or are studying at university: one residential carer has a University degree as psychologist (and was in fact combining her role as carer and developing for some hours a week a new role as psychologist within her workplace), while one of the male family workers had started a University course of social education (after a previous working experience in a traditional food market with his parents, he had found his vocation in working with people and wanted to develop it with more training). The fact all of the workers have some training reflects the fact that people more engaged in their work were more likely to agree to be interviewed.
Nine of the 15 care workers have children, but few have young children. In six cases the children still lived at home with their parents, but in only three cases are the children of school age or younger. None of them reported having elderly dependent relatives.

3.3 Routes into care work and/or motivation to do care work
There are many routes into current occupations, some typically involving a linear career entered into after school or further/higher education, and followed without break or changing tack. Other routes involve coming to an occupation later in life, perhaps as a result of some life event, or because of mounting dissatisfaction with an existing career or the growing attractions of a new course of employment. In the case of our informants, we can discern three main routes into their current care work.

3.3.1 Late entrance
In England, routes into care work were different for the female majority and the male minority. From the interviews we learn that it is unusual for women to start working with elderly people soon after leaving school. The exception was one care worker who attended school in the Middle East, went on to do a shorthand and typing course, then returned to England and began working as a care assistant in a residential home, and subsequently in a hospital before moving to her present position. But more typically, the pattern was to leave school at the minimum age of 15 or 16, and go to work in a job that required no or low qualifications such as in a factory, post office, or as a hairdresser. All but two of the informants then had children, and this interrupted their employment.

Most of the English informants therefore did not start out working with elderly people. Rather, they found their way into it later in adult life. One set of reasons involved motherhood. The role of motherhood was significant in that most of the informants had had children in their early twenties, and in several cases this new status put pay to plans for training as a nurse. Motherhood usually provided a period when informants were not employed full time, but could manage to do part-time hours: care work was something that could be undertaken on this basis with working hours that could be fitted in around family commitments.

I used to work as a home help...I chose that type of work because it fitted in with my family at the time, because you could sort of like, um, just do mornings and that sort of thing.

I think (going into the work) basically that I like the hours; it fits around the family, as I done evenings and weekends and I could pick up work during the day when the family was at school. So that worked out very nicely.

Other reasons for later entry into care work among the English care workers were to do with previous jobs. Some, when mothers of young children, had sought work they could fit around mothering duties. Women might have sought an alternative to a job they did not like. Or they may have been attracted to care work because it offered aspects of work that they had found they liked in previous jobs. For example, one residential care worker found that working in the lingerie department of a large shop was more to her liking than factory work, because it involved meeting people. Similarly, for another residential care worker the rewarding aspects of her work in a post office were meeting elderly people and helping them with their pensions. She said:
Male workers were also late entrants into care work, but came to it with a background of higher levels of education and of employment in higher status or better paid jobs. The change to care work was often precipitated by some crisis, personal, financial or a combination. One male worker, for instance, changed job following his business going bankrupt and a divorce; another had been a casino manager in Israel and sought new work on his return to England; while a third man, previously an accountant, had sought a life change in his 50s.

Six of the English care workers, three men and three women, reported being ‘failed nurses’. For one reason or another nursing was not available or was not the right choice for them. Three male care workers had tried nursing auxiliary work as a first choice when moving into work with elderly people, and made the shift into care work because they did not like the medical model or they saw in care work a greater freedom of approach or more opportunities for progression into management. Similarly, three female care workers had wanted to be a nurse when they left school, but were unable to realise this ambition either because they didn’t have enough or any educational qualifications, or because they got married and had children or both. They had entered care work because they had failed in their first choice, nursing, and care work ‘fitted’ better with family responsibilities. In other words, both female and male care workers saw themselves as having a disposition for nursing, but the organisation of that occupation did not suit them for different reasons.

As already discussed in Chapter 2, Swedish home care has historically been built up around the competence of a housewife. But times change. Care work is no longer a career track for women who want to combine paid and unpaid care work: in particular, motherhood is not an entrance into work with elderly people. Instead, two different routes for entering the caring arena can be found in Sweden right now:

a) Via unemployment and having to accept any job available on the market. Another example is a person who had worked on a family farm but started to work in elder care when the farm was closed down, preferring this to work in a factory or shop.

b) Via the need to change job, including people who had previously worked in a hospital and wanted a change from the stressful work and unsatisfactory work schedules.

Many of the informants had changed job several times during the period when their children were small, sometimes due to unemployment, sometimes due to a wish to work with elderly persons. Many of the informants did not plan a career for work with old people but had occasionally ended up there because of staff shortages in the area. The reasons for staying in the field can vary. For this residential care worker the working hours suited her:

Well, it started with, it was quite a long time ago when I needed a job and I started to work in home help and I thought that was quite fun and then I studied to become a dental nurse, but since then I’ve also worked with young people and children with autism, mental retardation, but in that area the working hours are
so odd, lots of evenings and that, so I thought to myself that it’s better to work with old people, you can work daytime and that, it’s more sort of, well these are the hours I prefer.

What the Swedish data indicates is that recruitment strategies have changed since the early days of elder care services. In particular higher demands are now set in terms of education, so that workers increasingly choose to train for the work before entering the field. Thus, as we have already seen, all the Swedish care workers interviewed, apart from three, have received some sort of nursing or care training, either for home help work or to work as an auxiliary nurse with the competence to give basic medical aid.

Care work with elderly people was often entered later in life in Spain and, as in England, related to family circumstances. Work with elderly people is one of the available options for adult women with caring experience, who want to return to the labour market after having had children, especially in the event of divorce. Two of the Spanish residential carers were divorced and explained how this profession had helped them to regain their personal autonomy and self-esteem. While the co-ordinator of the family worker non-profit cooperative reported various cases of divorced women in her organisation, and explained that home help work was seen as especially suited to divorced women as it allowed them different combinations of part-time working and fitted with school hours.

3.3.2 An occupation in between

As already noted many of the care workers have tried other occupations before they entered the arena of elderly care. This is a pattern for both female and male care workers. We have also seen one route of male workers – into care work later in life after some major crisis or other life event has provoked a change of employment direction. In Spain, male care workers suggested another trajectory, with care work as a transitory occupation that was left when better paid jobs turned up in other sectors. This male worker in a residential home had seen other male workers follow this path:

I am the only male assistant. There were three, but they left, they went to factories, it’s normal. If you ask young men of 19, 20 or even 30 years old, they’re all the same, they are in front of a machine cutting pieces, they get paid 140,000 pesetas, so they don’t stay here. It is normal.

This male carer is not the only informant who is uncertain whether he or she will stay in the occupation for the rest of their working lives. This uncertainty and the possible transitory nature of care work reflects what is a central issue in Spain: the high incidence of low pay and precarious / atypical work. This helps to explain labour shortages and high staff turnover in low status jobs, even though there is still a low employment rate and high unemployment. Good care workers may be forced to leave the sector to work, for example, in shops because of low pay, especially if full-time jobs are not available. In many occupations - education, health or social work, but also care - jobs are better paid in the public than in the private sector. Moreover part-time jobs are not necessarily family friendly, as part-time working hours may be spread over the course of the day. In the short run, for example in home help services, even ‘informal self-employment’ allows higher payment than formal employment.

3.3.3 Immigrant workers

In England, migrant labour has played some role in the history of post-war care work. In particular, trained nurses have been recruited from many countries to work in hospitals – from
Caribbean workers in the 1950s and 1960s to staff from Europe, Africa and Asia today. Some of these staff will have gone on to work, as nurses, in elder care settings outside hospitals, or even to open their own homes. While there is active and officially sanctioned recruitment of migrant labour for nursing (and other professional jobs working in services for children and adults where staff shortages exist), this does not apply to care work in general, which is regarded as a low skilled occupation and not, therefore, permitted to recruit staff from overseas.

A different pattern of migrant labour is apparent in Spain, where migrant labour, mostly from Latin America, and often without nursing or other specialist education, is coming in search of work, both in the formal and informal economy (as domestic labour also often providing care for children or older people). Migrant labour, therefore, is a significant factor in the current development of the care workforce; as we have seen, several care workers in our study came from Latin America. As we shall see later, ethnicity has become a big issue in the Spanish context.

For the moment, we can observe that, though migration is one route into care work in Catalonia, care work and migrants share low status, as this trainer vividly explains.

_We take advantage of the fact that carers from other countries are people with needs and that’s their way in, but we offer them poor conditions. Many immigrants are here due to care for the elderly, but at what price. This issue is not highlighted at all. When you compare care work to other professions you can find the most outrageous things. I’m obviously very lucky because of hospital regulations. I think that to get the work you have to survive certain places and situations but this violates human rights, it’s as clear as that._

### 3.4 Hungary

Work in social care has developed from the health care system, and until 1960 the most common qualification was called an ‘old people’s home nurse’. Subsequently, as the social care system was increasingly differentiated, training with a more social orientation has been introduced. Now the main types of workers in residential and domiciliary care are [szociális gondozó](social care worker) and [ápoló és gondozó](nursing and care worker), the former mostly working as home helps and in day care centres, the latter being mostly found in residential homes and other institutions. There is also a [szociális asszisztens](social assistant), found in day care centres and residential institutions, complementing the work of the other workers.

In the care sector overall (including child welfare and adults with disabilities as well as elder care), most of the workforce (93 per cent) are women. More than three-quarters (80 per cent) have either basic or secondary level education, with two thirds of those with the lowest (basic) level of education being employed in homes for elderly and disabled people. Care workers who completed secondary level education are most often found in home care services and children’s services; there are more staff with higher level education in child protection and management of services. Among the practitioners interviewed, most have secondary or upper secondary education. Three have a tertiary education, but below university level; all three were managers.

Pay is rather low, despite a pay rise in June 2002 that substantially increased the salaries of public sector workers. For example, the average monthly wage for the practitioners
interviewed in this study is HUF 87,262, ranging from HUF 58,200 for a home helper to HUF 135,500 for the head of a mental health team. This compares with average gross earnings in Hungary in 2002 of HUF 122,453. Part-time work is uncommon in Hungary, and all the practitioners in the study worked 40 hours a week; all but two had permanent contracts.

The 14 ‘frontline’ practitioners (i.e. working directly with old people), all women, were in their 30s and 40s, ranging from 30 to 54 and with a median age of 43, similar to the Swedish female care workers; the two other informants, in management positions, including the one male worker, were under 30. Five of the 16 were single (including the three who were under 30 years of age). Four of the practitioner respondents have no care responsibilities of their own; of the remainder, 7 currently or recently cared for elderly relatives or friends, and 5 care for their own children.

The practitioners had come into elder care work via several different routes, but most had entered the field some time after finishing their education. Of the 16, two had always worked with older people. At the other extreme, five had previously worked in occupations unconnected with care work, mainly in the private sector, three in the commercial field and two in administrative positions. The move to elder care was linked, in three cases, to family reasons. The remaining workers came into elder care work either from health care work, moving because they did not like the environment in hospitals and found it unconducive to providing good care for patients, or (a distinctive feature of Hungary) from childcare work. In this latter case, the move into elder care was necessitated by the closure of the nursery or kindergarten where the worker had been previously employed. One example is a care worker in a residential home who previously worked with young children for 22 years. When her kindergarten was closed, she was employed in a day care centre for elderly people before a brief return to childcare work, which she left because of the bad working conditions. In 1999 she took up her present job in a residential home. These workers found much in common between their work in childcare and eldercare, and reported that their previous childcare experience helped them a lot in their work with elderly people.

One consequence of many practitioners coming from a health or childcare background was that 9 of the 14 practitioners working directly with elderly people had health or childcare qualification. All but two had also completed a social care training, mostly as social care work workers, nurse and care workers or social assistants.

### 3.5 Concluding comments

Elder care work in the three case study countries has its roots in *husmorsarbete* (housewives’ work) and the competency that is associated with it. As care activities develop in formal services, the emphasis on training and professionalisation increases. This will take place in a variety of ways and for a variety of reasons, as we will see in Chapter 4. A common denominator is that work becomes more diversified.

What none of these three countries has, however, is a ‘core’ profession - with a high level basic education and an accompanying body of theory and practice - working directly with older people in either domiciliary or residential care work. Professional groups – therapists, nurses, doctors, social workers – do work with older people. But the main workforce engaged in everyday care work with old people is not professionalised, consisting instead of a range of occupations, some with no training still, others with low to medium levels of training. Pay and status are low.
A characteristic of care work is that much of it is provided by part-time employees, in particular in countries like England and Sweden which have a tradition of widespread part-time employment. A reason for this is that it allows care workers to also fulfil their obligations to their own families. The consequences of this, for example how family-friendly this proves in practice, will depend on the context within which the part-time work is carried out and how the work itself is organised. We will return to this subject in Chapter 7.

Instability in the occupation and a lack of clear career paths are also characteristics of elder care work. When *husmödrarna* (housewives) have disappeared, as they have in Sweden, there are no effective strategies for recruiting personnel. The mismatch between political strategies and movement on the labour market is a serious problem for Sweden.

A late start with care of elderly is characteristic for all of the countries included in the study, resulting in a workforce with diverse previous experience and qualifications. Is this pattern - of late entrance into care work combined with a diversified experience and qualifications – inevitable? What are the implications – both good and not so good - of elder care being a sort of melting pot for different experiences? How can many and different routes into care work be combined with a development of elder care into a highly professional occupation with a high status in society?

The workforce is also highly gendered; it remains very largely ‘women’s work’. But there are marked differences between the few male workers and the female majority. The men in the study are on average younger than their female colleagues. Add to this a more diverse background and different routes into the work and the profile that emerges for male workers differs from that of traditional (i.e. female) care workers. The potential for change associated with an increase in the number of men as care workers is still an unknown factor. But first more men need to be attracted to the work, which may call for various changes not least different recruitment strategies.
CHAPTER FOUR: TRAINING AND EDUCATION OF CARE WORKERS

What is the purpose and content of the education and training of care workers? What knowledge does the work require and how is this best acquired? To whom is the training addressed? If we look at the history we will find the same picture: the knowledge base for care work has in all the three countries developed along the same lines. Life experience, rather than any prior educational qualification, has been a normal condition for entrance to the work field. Personal experience as a source for knowledge is traditionally put in contradiction to other forms of knowledge, for example academic knowledge. So, too, it has been in the discussion of care work and the caring professions in all the three countries, which have been late in their ‘academisation’ process. In Sweden, for example, a non-academic tradition has been maintained longer in social care for the elderly than in other comparable professions – the basic qualification for working with pre-school children is, for instance, now a teaching degree.

One example of the traditional opinion is expressed by a Spanish care worker employed in a private setting. She hesitates when asked about ‘education’ for work with old persons, and contrasts it with ‘training’:

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\text{With elderly people it is something that’s also very difficult to change because they have habits which they have had all of their lives.}
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\[
\text{Q: Is there or isn’t there an educational task?}
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\text{Educational or non-educational, I’m not quite sure. I would say that it’s not really very educational, because the type of things that we do are care or activities, sometimes, yes, there is some training, but more than education I think it is training.}
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The English material also indicates some doubts about more formal education of care workers, most of whom are not familiar with learning and qualification procedures. One of the national training informants provided his perspective on what training for care work with older people was about, in response to a question about curriculum. He recognised the difficulties that formal learning may pose for an adult in a low status job, and arising from attempts to match learning to the occupation as practised. He said there was

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\text{a core which is generally made up of value, communication, health and safety and all these issues, there’s then quite a broad range of choice that people are able to construct the qualification that best matches the functions of their sort of employment. So in doing that we, I think we freed education up to address educational problems, ...(for example) how do you get this person who doesn’t think much of themselves, doesn’t think they can read very much, doesn’t think they can ever get a qualification, how do you get them from that position to the position where they do have a qualification? ... So how can we construct a}
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8 The distinction between ‘education’ and ‘training’ is not easy to make. ‘Education’ might refer to school, college or university-based courses and qualifications, including initial or basic qualifications; and ‘training’ to those based on the workplace and ‘learning by doing’, including competence-based qualifications, with an emphasis on a rather practical way of transferring knowledge. While we have tried to keep to this broad distinction, the distinction is not always clear cut and is further complicated in that many courses may have elements of both education and training as just defined.
programme that will help someone become somewhat more understanding of what it's like to be an older person who has lost the sort of circumstance of control that they experienced? How can we get them to get into that to the point where they can listen and work with someone individually?

In the rest of this chapter we look more deeply into approaches to the education and training of care workers in our three case study countries, including the tension between experiential and other forms of knowledge and between a drive to higher levels of qualification and a concern with cutting off a lot of potential recruits to care work.

4.1 Sweden

England, as we shall see, has opted for a ‘competency based’ model of training, with a strong basis in the workplace. In its national policy, Sweden has gone from a personal experience base to an academic education – although, as we shall again see, local administrators who employ care workers still give high value to personal experience. Initially in the 1950s, uppmuntrande besöken (inspirational visits) were seen as the principal point of the work in social care. Women had at this point acquired a wide-ranging ‘housewifely’ competence in their own homes; they were financially supported through marriage, but they were also ready to increase their independence in the family by means of the extra income provided by employment. When it came to competence, politicians and administrators looked for what a housewife had normally developed through experience of working with her own children and caring for her own or her husband’s parents. The influential Stockholm city commissioner Hjalmar Mehr expressed this clearly, when he said in 1951 that:

_The source we want to draw on here are the middle-aged and older housewives who are able to take some hours off and who will be content with relatively modest remuneration... but who are interested in the task and who can derive benefit from the relatively modest income that goes with it._

Changes in home care took place in the 1960s with consequences for education and training. As we have already noted, as a result of the introduction of state grants in Sweden in 1964, the importance of staff management was recognised. A hierarchy was put in place and the management work with old persons was separated from the frontline work. Following these changes, the educational level of the home helpers and managers has been constantly raised. A tradition has developed of educating leaders in social care services, with longer and longer educational programmes for these managers. But it is also important to notice the increasing educational gap between the managers and the frontline care workers, many of whom have had little or no education or training beyond school. The low status of working with old people is related to frontline work still being undertaken by workers with low qualifications. Training programmes, however, have emerged for the frontline workers. But in contrast to the UK, where the training for care workers has a strong workplace orientation, Swedish training has been more ‘classroom’ and theoretically oriented.

During the 1980s, the sociala servicelinjen (social service programme) was developed as an upper secondary school programme with a particular focus on social care. It was transformed during the 1990s into the omvårdnadsprogrammet (health care programme), the social service programme being combined with the earlier health care support worker (local educator) programme. The _omvårdnadsprogrammet_ is undertaken in upper secondary schools with young people aged 16 to 19 years (though there are also courses aimed at mature students. As mentioned in section 3.2, this training is preparation for professional work in health and
medical care, along with social care; specialisations are offered in nursing and social care including auxiliary nurse education. Most of the people who follow this course of study will eventually work in care for the elderly.

Further specialisation is available through optional courses. These courses currently are not, however, primarily focused on care for the elderly.

The Svenska Kommunförbundet (Swedish Association of Municipalities) highlights in its document Aktuellt om äldreomsorgen 2001 (Current Information about Care for the Elderly 2001) that qualified staff are one of the most important conditions for being able to guarantee good nursing and care for the elderly. Yet despite this recognition, and developments in training, only 60 per cent of basic personnel today have had care and nursing training at upper secondary or equivalent level. This percentage does not include Komvux (municipal adult education) or job-based training which play an important role given the lack of basic education among many entrants to the field: looking at the people that were recruited new to the field between 1995 and 1999, about 55 per cent did not have prior care or nursing qualifications.

There are some interesting recent signs of change in the training of auxiliary nurses and other staff in care for the elderly. In Stockholm, staff in the field of elder care are now offered training with a different underlying ideology compared to the usual nature of further training in this area. Normally, further training is intended to lead to a professional career, in which people wanting to progress must move away from doing actual care work and end up in positions such as supervisors, teachers and researchers. To stay and improve one’s skills and knowledge relating to care work as such, and to be trained to be a specialist in practical nursing and care work, as is now happening in Stockholm, signifies an innovation in basic thinking as far as this type of training is concerned. Another new development has been the introduction in 1998 of kvalificerade yrkesutbildningar (qualified vocational training programmes) or KY. This is post-upper secondary school training organised by municipalities, training companies and universities on an occupational basis that takes place in co-operation with workplaces.

The training of middle managers in Sweden is also in transition. Within social work programmes there are today specialisations towards care for elderly and disabled people and towards social pedagogy.

There are many reasons to believe that medicinsk omvårdnad (the medical care) of elderly will increasingly take place in the home in the future. Several municipalities in Sweden provide training for specialist nurses on the care of elderly people. The trend is towards complex omvårdnad av långvarig karaktär (long-term care) and/or care in the final stages of life. This kind of care places special demands on workers, for example in the use of technical equipment and specialist competency in the medical field.

This brief overview of developments in Sweden shows the important role played by the state in the early creation not only of a welfare policy, but also of an accompanying educational policy. But its interests have often contradicted the wishes of the professions regarding the content, length and organisation of training programmes, as well as regarding continuing education and licensing. The state has been unwilling to provide more training than it has

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9 In the middle of 1960s this connection between welfare policy and educational policy weakened. Possibly this link is on its way to being re-created in Sweden in the late 1990s.
deemed necessary from its political perspective on welfare. In this context, it has been difficult for occupational groups employed within the welfare state to steer their professional projects in a direction that falls outside the state’s objectives (Evertsson, 2002).

4.2 England
Training for care work with elderly people in England (and in the UK in general) is, according to the interviews, undeveloped, although changes are occurring at present. One reason for this is government’s recognition of how little training most members of the workforce have in any form of social care. A government White Paper in 1998 drew attention to the low level of training in the social care workforce, 80 percent of whom had no recognised qualifications or training. It also announced a new national training strategy to improve training levels across all social care staff (English Department of Health, 1998).

Historically, as in Sweden, care work was seen as manual work based on domestic and familial experience and for which women were ‘naturally’ suited. Few care workers had any kind of academic or vocational qualification. Those with academic qualifications looked to a career in social work or nursing rather than care work. Similarly there has been almost no career structure in care work with elderly people, so progression through acquiring qualifications was difficult – the only option was to go into management of home care or residential care.

In the mid 1980s, a very specific approach to training emerged, which went beyond personal experience while avoiding academisation. National Vocational Qualifications (NVQs, and SNVQs in Scotland) were introduced as a way of rationalising vocational education into a single progressive framework. This ‘competence-based’ system was a radical shift away from traditional forms of learning towards ‘outcomes’ in the workplace in terms of the functions a competent worker should be able to carry out and the knowledge that they draw on in order to perform competently in different circumstances. They were intended to provide a guarantee of competence to do a job based on nationally agreed occupational standards, defined in great detail, and assessed primarily in the workplace (Hevey, D. and Curtis, A. (1996) Training to work in the Early Years in G. Pugh Contemporary Issues in the Early Years: Working collaboratively for Children, London: Paul Chapman Publishing/NCB, second edition): the emphasis therefore was on equipping people for an occupation rather than educating them for a profession. Each NVQ is made up of modules or ‘units of competence’ which represent skills and knowledge in areas of work related to a particular occupation. These modules can be built up over a period of time at the pace of the candidate.

The NVQ system has five levels, each of which can be equated to a level of qualification in the education system. NVQ level 3, for example, is equivalent to the main upper secondary qualification, NVQ level 5 to a higher education first degree. Government minimum standards require that half of staff must have at least NVQ Level 2 - by 2005 in the case of residential services and by 2008 for domiciliary care (English Department of Health, 2003a, b). NVQ Level 2 is, in effect, the lowest level of qualification available in this system and equivalent to the main secondary school qualification for 16 year olds.

It is envisaged that the NVQ system will replace and unify existing diverse qualifications and forms of training, so that in time NVQ level 2 and 3 (secondary and upper secondary level qualifications) will become the standard qualifications for work with elderly people. These qualifications are supplemented by other systems, such as the ‘modern apprenticeship’ and the ‘key skills’ programme, which are designed to enable poorly educated workers to prepare for
the demands of NVQ. In addition to these national programmes, there are workplace-based and employer-led training programmes around specific subjects, such as dementia or depression, or specific skills in diagnosis and treatment. These are available to care workers according to local funding and availability.

4.3 Spain

Presently there are three levels of training among workers in services for elderly people:

Non qualified:
- Home assistants, with no specific qualification (usually in the informal grey market, e.g. employed privately to provide care to an elderly relative of the employer).
- Carers in institutional settings, with no specific qualification.

Occupational training recognised by Spanish Labour authorities (provided as occupational training for unemployed people or as continuous training for employed carers):
- Certificado de profesionalidad de auxiliar de ayuda a domicilio: 445 hours of occupational training for home help workers.
- Training for Treballadores familiars (family workers): about 700 hours of occupational training.
- Training for auxiliares de geriatría o gerontología (workers in residential care for elderly people).

Professional training recognised by educational authorities:
- Training for Cuidados auxiliares de enfermería (Nursing care assistant): about 1400 hours of medium level post-16 professional training.

For people with the last two qualifications, there is a possibility to access a higher-level technician training: but only after passing a specific examination and only in the same field of community, social or cultural services. There is, therefore, no direct progression from being a medium-level technician to a higher-level technician in the field of community, social or cultural services. This reflects the fragmentation in Spain of work across what we have termed the ‘care work domain’.

In their training, Spanish practitioners get some influences from life history work Emphasis is placed on the importance of not working on the basis of disabilities, but rather foregrounding capacities, of stimulation and simulative entertainment rather than the ‘distractive entertainment’ that is perhaps the stereotype that we usually have. There is pedagogic work, being able to work with the capacities that old people still maintain. “Self help” is an important concept, although the family perspective makes the autonomy perspective sometimes problematic. One person says:

I think that there are elements that we should take into account. We all believe that we should make proposals for re-autonomisation, of working on autonomy, not only the physical but also the mental, and in this sense I think that it is very important to be able to encourage the autonomy to occur by learning to depend on the rest. Working with autonomy from interdependency, we aren’t autonomous at all, we are self sufficient. But if they learn to depend on other
people, they don’t become autonomous. They are scared to learn to be dependent, rather they depend on other people to live.

Another possibility is to take a course to learn more about dementia and its consequences for the families and next-of-kin. One of the informants says:

With Alzheimer’s cases, the final stage is the worst for the families. Overall, it is a case of giving them emotional support and helping them to understand the illness. We anticipate the losses, an old person with Alzheimer’s doesn’t simply lose his memory, it is an evolving process. We keep giving them emotional and psychological support if it is necessary. Even on a good day, if the mother doesn’t recognise her own daughter, of course, the daughter is depressed, she doesn’t know what to do, more than anything we work at this level, we give emotional and psychological support to the families. We also provide a lot of training on how the illness evolves, because they have these feelings of loss because they feel useless. As there is a high level of depression among elderly people, we give them information, and apart from giving information, we help to form a relationship between them, not only with the resident, but also with the families. It’s not that we end up being a therapy group, but it seems that when they share experiences it gives them emotional support, they become stronger, it’s more solid in my experience, and it hasn’t just happened to me.

Courses are also offered on other subjects, including work with the mentally ill persons and terminal care.

Spanish informants give a contradictory picture of education in social care work. Some regard training as too extensive, taking into account that working conditions are often very bad in practice. Others take a different view. A university trainer has a more visionary view on education, in this case with respect to work with dementia patients.

Perhaps the newest thing or the innovation was in saying that we can only stimulate the capacities that are still maintained, therefore sometimes we are stimulating nothing. So we must see that if someone has 5 capabilities and another has 2 for example, sometimes perhaps what we see is that they are missing 3 capabilities and we don’t focus on the fact that they still have 2. This perhaps is precisely what is new and what we keep working on, it’s the only way to be able to initiate a new educational response of self help, in which the elderly person can have the role in his own life project, and he can realistically follow a process. I believe it could be an educational process that the elderly person should be able to take with him to the end.

Another Spanish trainer did notice a number of changes in the level of training. Nowadays it is more theoretical than before, and there are perhaps more people doing the initial training. The training has also become more diversified.

The people, who wanted to train to be carers didn’t have the level that we have now, they didn’t want to enter into this field. I think that they keep opening more doors and there are many more people interested and many more young people in vocational training. I said before that the majority we had were older than 25 years, but in the last few years it is noticeable that there are lots of young people
in training with a higher level of education. You can see that it’s a profession that they enjoy. As much as we talk about theories, I think that you can see dozens of these experts putting the theoretical methods into practice on a daily basis. For example, we have recently stressed the importance of communication, we think that how we treat the person is important to be able to know what they feel. I think that we have run the programme along these lines, we have kept changing the level of the expert, we have to introduce this determined theme, we have kept on improving.

In Spain, professional training (either at a medium post-16 level, or at a higher post-18 degree level) is not prestigious. Even though the aim of education policy is to make this type of training more prestigious, the fact is that, except for some industrial branches, it has been traditionally associated with poor training and with not leading to well-paid jobs. This explains the interest of professional groups for a training that leads to a university degree (the qualification, for example, for teachers specialising in work with young children). A drawback of this qualification, however, is that its focus is on theory rather than practice. The contradiction between the demand for higher qualifications, which would require more theoretical studies, and a more qualified practitioner is also discussed in Spain.

4.4 Hungary
There are four levels of training in Hungary for people working in the various branches of social care, but most workers in elder care are trained in the lower two levels, i.e. below the tertiary level. Admission to train for the qualification szociális ápoló és gondozó (social care and nursing) requires only 8 years of elementary schooling and training mainly takes place in vocational secondary schools. Training for the qualification szociális gondozó és szervező (social care and organising) requires completion of secondary schooling including the exams taken at the end of this stage of education. Most people training for these qualifications are also working, and in the case of the szociális gondozó és szervező are usually middle managers. Since the late 1980s, higher education courses have been developed for social workers and managers.

Measures have been planned and tried out to enable progression from upper secondary to tertiary levels of training, for students from the former who have obtained sufficient credits and taken an examination.

4.5 Concluding comments
In these last three chapters, we have reviewed the situation in elder care in our three case study countries, in particular the development of policy and the workforce. There are some striking differences. Services for elderly people are perhaps most developed in Sweden. While levels of home help provision are similar in Sweden and England, Sweden has more residential services. Both countries have more developed and extensive services than Spain where policy development began later and there is a higher expectation on families to provide care (for comparisons of service levels, see Moss and Cameron, 2002). Most services in Sweden continue to be provided by local authorities, while most in England are provided privately, mostly by ‘for profit’ providers. Though both countries are seeking to establish a common minimum level of qualification for all care workers with elderly people, this level is higher in Sweden than in England. Sweden looks to extending a more academic-based initial education, while England places more emphasis on a competency-based vocational training. Much of the training, in Spain, is also vocational rather than academic, and at a low level.
But there are also elements in common in English and Swedish trends, some of which are also apparent in the more recent developments in Spain. Some of these have already been reviewed, including the increased standardisation of services, a growing discourse about quality and increased targeting. Another development is the trend towards more formal education and training for care workers – even though none of the three countries is yet aspiring to a basic education for care workers beyond upper secondary level and many workers do not have this level. There are many reasons for the trend. Formal education is an important part of a profession’s struggle for a higher status in society. Highly valued professions, such as doctors, lawyers, veterinarians, all have a long formal education to go through before they can work in their fields. To prolong the formal education is often an important step for a profession in order to reach higher status and to get permission to do more qualified work tasks.

Sweden has a long-established interest in staff management and leadership. The development of services has been associated with a widening gap in training and status between managers and those who do the actual care work: more educated or trained personnel become separated from the frontline work with clients. More generally, in all countries, there is an issue of whether and how practitioners can gain career progression without necessarily having to abandon care work for management. This calls for a hierarchy with visible career steps which practitioners can take and that a career should be possible pursuing either a vertical or horizontal direction, for example, through ‘senior practitioner’ posts.

One Swedish trainer introduced this discussion, reflecting about further training of auxiliary nurses to do more specialist functions. Usually, further training leads to career moves, in which people become distanced from the actual care work and end up in positions such as supervisors, teachers and researchers. This trainer wanted further training to lead to continuing, but more specialist, care work.

Many of these home helpers and auxiliary nurses long to profile themselves and become more skilful in their field. The way I see it is that there is an unsatisfied demand for competence development in many people, a whole profession ready to take on much more responsibility in the duties that they are given compared with the opportunities they have today.

There are different ideas about appropriate knowledge and how to acquire it, ranging from the experience gained from caring for relatives, through competency-based skills to a more academic orientation with a stronger theoretical component. A non-academic tradition has been maintained longer in social care for the elderly than in other comparable professions, such as nurses, occupational therapists and physiotherapists. Low levels of training are linked to low status for frontline work with elderly people.

Increasing demands are made of workers. The elderly people with whom they work have increasing needs as a consequence of the higher proportion of persons over the age of 85 and the emphasis on care in the home. In the same process, the care of elderly people has become more and more health oriented which leads to an increasing demand for qualifications involving a nursing element. The other side of the coin is that the social aspects of care work become more difficult to maintain.
CHAPTER FIVE : WHAT IS SOCIAL CARE?

An area of work and its accompanying knowledge must be identifiable and definable through some essential quality. In two of our three countries, England and Sweden, the term ‘social care’ is used to describe care work with older people. In this chapter, we start by trying to get an understanding of what this term means. How could you describe the distinctive quality of social care? That will be, of course, something that is culturally understood. If a Swede, for example, talks about nursing he or she will mean a field including some medical knowledge. If the same person talks about physiotherapy she or he will probably mean a field which includes knowledge about movements, occupational therapy will include knowledge about activities, and so on. But without at least one such significant or essential marker in the field under discussion, you could not talk about nursing, physiotherapy or occupational therapy. How could you understand such an essential marker in social care? What is its special and distinctive quality? Could you find something specific in common between the three countries involved in this case study, some shared way of talking about social care? Do different contexts develop different discourses, with different understandings of social care?

We also consider the concept of care work or social care from another perspective. How does it relate to other fields of work and care? How far is it distinctive from or synonymous with social work, health and informal care?

5.1 Finding the distinctive quality of social care

In this section we are going to give some examples of the way social care is talked about and understood. What do informants say they are doing when they do social care in the three countries? The analysis will be done partly from the way of organising care work, and partly from its content.

In cross-national comparative research on welfare states, ‘social care’ has been defined in a very particular way. Here it has been used as a concept that transcends many boundaries: formal and informal care, paid and unpaid, public and private – and children and adults. Another EC-funded project defines social care as

"assistance that is provided in order to help children or adult people with the activities of their daily lives and it can be provided either as paid or as unpaid work, by professionals or non-professionals and it can take place as well in the public as in the private sphere. In particular, it is distinctive to social care that it transcends the conceptual dichotomies between the public and the private, the professional and the non-professional, the paid and the unpaid (Kröger 2001: 4)."

Understood in this way, social care is a transcendent concept. Care is a distinct practice that “transcends the conceptual dichotomies”. The dualism between paid and unpaid work dissolves (Ungerson, 1997). Social care can be either work done by family members, usually women, or by workers acting as substitute family members, again usually women. ‘Care work’, from this perspective, is the commodification of the work of housewives, mothers, and other family members, so that it is done instead by paid workers.

At a policy level, ‘social care’ has also come to serve as an umbrella term that covers a wide range of services: the term “‘social care services’ has European-wide acceptance as referring to non-cash care services provided by social workers and other professional groups for user groups such as children and families, elderly people and people with disabilities”
In this administrative usage, ‘social care’ can become an administrative label for whatever services fall within the welfare system. This is very much the case in England, where ‘social care’ as a term or label has been used to cover all non-health services for children, young people and adults coming within the remit of the Department of Health, i.e. the welfare system. A search of the Department’s website, or those of government agencies with a ‘social care’ remit, reveals no actual definition of the term. This is reflected in the English case study, where there is a sense of confusion, or at least a lack of clarity, about the meaning of ‘social care’. Many practitioners were unable to respond when asked their understanding of ‘social care’. Often informants ended up defining the concept in terms of its boundaries with other fields or to administrative components.

In Sweden, the term social omsorg (social care) is also used and has also emerged from administrative thinking. Historically, it was decided which work should go into the sector of social care and which should go into other welfare sectors. Only care for disabled people, including those who are elderly, is counted as social care in Sweden, while services for children, young people and other adults are in other fields: for example, foster care or work with adults goes to social work, while childcare goes to the educational system. Used in this way ‘social care’ is largely an administrative concept.

However, its meaning has been further discussed. In care for elderly people nowadays, there are many tasks that make up the staff member’s duties. The Swedish sociologist Franssén (1997) takes the view that social omsorg, omvårdnad och medicinsk vård (social care, nursing and medical care) are central concepts this work. They are, in Sweden, sometimes used synonymously, above all in everyday language, but they can also be distinguished and given different meanings. They describe different aspects of work in caring for elderly people.

In her study, Franssén describes different dimensions of the work in two wards that are similar to residential homes with special services. She divides the work into direct and indirect nursing relationships with the old people. The indirect work is that which the staff carry out regardless of which old person it is; it can, for example, be a matter of taking care of the laundry, or of carrying out administrative duties, such as making schedules and arranging meetings. The direct work is of a more complex nature as it involves tasks that are carried out in interaction with the old person and represents direct nursing. Furthermore, there is a difference between routine-based nursing and more spontaneous, “here and now” interaction with the old person. Morning routines, dressing and showering are examples of routine tasks. An example of a spontaneous task is fetching a glass of water or satisfying wishes the old person expresses in other ways. The social care aspect in the work has to do with “caring”, she says, being attentive to the mental and social needs of the old people in order to make the old people feel secure. Warmth, empathy, and being able to listen and provide consolation are some of the emotional aspects that she highlights as important qualities in the social care of old people.

In Sweden, reflection over the concept of social care and its knowledge base has started, in connection with the process of academisation of training and education, which includes training programmes in social care (elderly care and care for young adults with disabilities) moving increasingly into the universities. The reflection over core and peripheral knowledge can help understand the formation of social care work, and should now be done with the help of social theory. But just as important as knowing the core knowledge for a field is to know what are the borderlines with other areas of knowledge.
5.2 The borderlines between social care and other areas

Borderlines between occupations and different areas of knowledge are always under negotiation and often in tension. A notable feature of the understandings offered by informants about social care concerned boundaries. How does social care relate to other fields? Is it possible to distinguish a discrete area of social care, distinctive from other areas of policy and practice, but also distinct from informal care?

So, for example, the distinctive space for ‘social care’ was often defined in the English material by what it was not—*not* health care, *not* social work (although some thought it was social work), *not* family work (although some help given by kin could be very similar or the same, such as taking an elderly person out), and *not* leisure activities. In terms of increasing the visibility and recognition of the work, it would appear that social care has a long road to travel even within its own workforce before there is clarity about its remit, principles and purposes.

Or, to take the example of Sweden, in practice the way Swedish workers talk about social care does not follow the theoretical lines. Judging from practitioners’ answers to the question of what *omsorg* (social care) means, it soon became clear that the staff do not always use that concept to describe their activities. They often use instead the concept *omvårdnad* (nursing). This reflects how, in Sweden, the borderline between nursing and social care has become a major issue during the 1990s. Some people think social care and nursing are the same thing; whereas others distinguish between, on the one hand, social care and nursing and, on the other hand, between nursing and medical care.

In other words, there is no simple definition of what social care consists of and there are different ways of describing one’s work. The nursing and social care concepts are related to a holistic perspective, that the whole person is considered and not just whatever part is unhealthy. The medical perspective and the medical care concept represent hospitals, bandaging and probes. It is not actually what the workers caring for elderly people do that has led to modifications in their tasks, but changes in the amount of care required.

There are three main borders to be aware of for a social care worker, borders which help to define and determine care work with older people. These borders may involve conflict and protection, or negotiation and cooperation—or both: in Sweden, at least, the protection of these borderlines has often been quite burdened by contradictions (Forsgärde Westman & Nygren, 2000). They may be differentiated or indistinct. There is the border with social work with its emphasis, at least in Sweden, on delinquency and deviant behaviour. There is the border with health care, with its negative effects of medicalisation or hospitalisation (Trydegård, 2000). And there is the border with informal care performed unpaid by family members or voluntary organisations (Trydegård, 1996; Johansson, 2001). We consider each of these borders now in more detail.

5.2.1 Social care and social work

The relation between social work and care work has remained important in England, as developments within the former have tended to impact on the organisation and work roles of the latter. One of the ways in which the care workers are promoted is to enter the social work profession, and care work was often seen as giving social workers experience of working with older people prior to joining a social work course.
In Sweden the relationship between the two fields has become more complicated than before, following a change in social work education during the 1990s more or less forced through by the National Board of Higher Education (Högskoleverket). At some Swedish universities, the vocational training of middle managers in elder care and care for younger disabled adults (i.e. the ‘social care’ field in Sweden) became an academic training within socionomprogrammet (the educational programme for social workers). This brought together two very different approaches. Prior to this reform, social workers mainly worked with delinquents or poor people with the normalisation principle in mind. Social care workers, on the other hand, knowing that working with old or disabled persons did not involve curing or reversing the life course, were guided by the idea of keeping intact as many capabilities as possible. Life quality, not liberation from symptoms, was defined as the goal for work with older people.

These two contradictory principles have caused discussions within academia on how the education for social workers should be organised. What kind of joint or unifying knowledge should underpin a social workers’ basic education? The tensions have resulted in unsuccessful attempts to integrate the two educational goals, ending in some cases with total disintegration. One cause of conflict is the fear of status loss if social workers start to include older people in their client group. Also in the UK the status issue has been discussed. In the 1990s a debate questioned whether this linkage of care work and social work diminished the status of social work. Anyhow these debates say something about the low societal status of old people.

In Sweden, care for older people has become an important issue for the future of social work, and may lead to negotiations about the future boundary between the two fields of knowledge. During 2003, a review of sociala omsorgsprogrammet (the degree programme in social care) is to be carried out. The aim is to analyse the descriptions of objectives in the degree regulations for the socionomprogrammet (the educational programme for social workers) and the sociala omsorgsprogrammet (the degree programme in social care). The length of both programmes is also being reviewed. The review will address some key questions. Should the programmes be combined into one comprehensive degree programme all over Sweden as it already is at some of the universities? Can an improved link be established between the contents of the programmes and the needs of the labour market? (Högskoleverket, 2003)

The contradictory orientations of social care and social work have already caused boundary conflicts within social work departments, as well as stimulating fruitful discussions about what these areas of work are. This tension is less apparent in England: the boundary between social care and social work was not so clearly marked and tense. Indeed, for many of the informants that boundary was non-existent, unlike in Sweden. This is reflected in the English Department of Health (2000) Care Standards Act 2000 (s.55), legislation that defines a group of four occupations as ‘social care’ workers: (1) social workers; (2) people who work in residential establishments providing care; (3) managers of those establishments; and (4) domiciliary care workers who work in people’s homes. The Act therefore attempts to define social care through the occupational roles of people involved in delivering it, without attempting any definition of the concept and what qualities define social care. Something very broad and vague - like personal care to any person provided by a person - actually comes pretty close to what most people’s thinking about the meaning of ‘social care’ would come up with.

Some English informants related social care to social work, arguing that social care has a broader application than social work but comes from the same starting point. It might include
employment, the social economic context. That in turn feeds into social need, and in part meets social need. Social care might for some informants be a compound; it is not an element.

In Spain, ‘social’ means all which is not related to health services, and social care means helping people in practical aspects of everyday life. In this sense, a range of occupations – such as social workers, home helpers or other care workers and social educators - are all social workers in a broad sense. In practice, however, these occupations have very different roles. A social worker, in a public institution, has the responsibility for assessment of needs and provision of services in a context of very limited budgets and resources. Home helpers or other care workers can work in very different contexts: public or private organisations, providing practical help. Social work includes clear dimensions of social class and work with marginalized groups, and consequently social work theory seems to be more closely connected to underprivileged groups than to the average population (in this respect, it corresponds to Swedish and English understandings of social work). The reverse of this is that care workers are employed in both public and private services, and can meet all types of population.

A Spanish trainer described this association of marginalisation with social work.

Yes, I suppose so, because many of the people who they care for are ethnic gypsies. A family worker never knows if they are going to go to work in an upper class area, or if they are going to go to work in a deprived area. In these areas they can come across people from gypsy origins or with different economic backgrounds, this can be expected, it is more related to the field of social work, this has already been introduced.

In the same way as many Swedish care workers argue about the boundaries between social work and social care, the Spanish informants answered that the theories of social work were not sufficient for work with older persons. Care work has another dimension not linked to delinquency or marginalisation, expressed by these three Spanish trainers:

Each sector of the population has a set of very specific characteristics, which are not so general. Within theoretical subjects but theoretical...what happens in social work is that when you work you might end up doing something other than what you've studied. I say social work but I could say social education, or psychology. They specialise in working with the elderly but end up working with children.

Not going with the rules and the techniques in your hand, but using these rules and these techniques to accompany more sentimental parts. I don’t want to say sentimentalism but it is a more human part, because social work is a profession dedicated totally to humans, and sometimes we seem to be anti-humanist.

This profession needs more than just knowledge, all professions need that, but I think that in the field of social work what I am about to say is valid. I think this profession needs more because it’s linked to very intimate elements of the human being. In the case of the care worker, we are talking about a level of attention that’s a lot more direct, a level of assistance that is a lot more direct...
than in other social fields. Thus, the information offered has to be coherent and the training has to be coherent.

In fact the work of the family worker in Spain may be closely linked to social work. Publicly provided services – both social and family work – are for poor people. Other older people in Spain use private services.

The councils are always giving more of these services to people in lower classes, because in my experience you go to houses with a very low economic level and others in a normal situation. However, it’s true to say that normally we go to elderly people who have very low pensions and very low income and they need these services. In these cases, what the council does is, depending on the person’s situation or their income, to pay for a part of the cost of the service.

5.2.2 Social care and health care

In many interviews health care has been mentioned as sometimes synonymous with social care, but sometimes as a perspective that ignores important social aspects of ageing. Many care workers in Swedish social care services tell about a shift in the borderline with health in the wake of the 1992 reform (Ädel-reformen). This reform removed formal organisational boundaries between social and health care for the elderly, which previously existed due to services being split between different levels of government. The health care services for old persons were moved from the county councils to the municipalities, where social care was already located. But by the same process, a hierarchical conflict arose between the two areas of work and knowledge: within the Swedish system today, there is a fight between two fields of knowledge – one more socially oriented, the other more health-oriented – though neither is dominant.

In Sweden social care work has been transformed from a quite down-to-earth type of work to a complex activity including an important health element. The organisation of medical care for older people living at home has been tightened up. More people nowadays receive treatment in their own homes due to medical staff being available around the clock. This is carried out with increased medical competence, better technical equipment, etc. The distriktssköterska (district nurse or the municipal nurse when the municipality is in charge) plays an important role. She evaluates the condition of the patient, co-ordinates and instructs assistant nurses and contacts doctors to arrange house calls. She also receives instructions from county medical care specialists. Co-operation with the municipal home help service is also important.

Following the 1992 reform, the services provided by municipalities have become multi-professional. In municipal care, there are middle managers, nurses, physiotherapists, occupational therapists, auxiliary nurses, home helpers and others working side by side. However, at the same time, new organisational barriers have been established – amongst other reasons, due to the strengthened organisation of professions. During the 1990s, the boundaries between health care and social care have been the most important to control in Swedish elder care. Generally speaking, it can be said that sjuksköterskor (nurses) have a stronger position than previously due to the establishment of a MAS - medicinski ansvarig sjuksköterska (nurse in charge of medicine).

Managing the operations / activities has become a more multifaceted task. It is no longer a question of just leading the work of subordinate staff but now also the work of equally
important professionals, each with advanced qualifications, e.g. nurses, physiotherapists and occupational therapists. The result is that the *hemtjänstassistent* or *områdeschef* (middle manager) is no longer the obvious team leader for the care team, which may instead be led by a nurse, an occupational therapist or a physiotherapist. There can indeed be competition for this role from other professions, often with a health perspective in their training.

One English policy informant pointed out that once you define social care broadly, applying the term to cover large parts of people’s lives, then the boundary with health care “is still a bit like an amoeba, I think it pushes in that direction and then comes back”. As in other areas, such as mental health and learning disabilities, the ‘blurring’ borders between social care and health are forcing reconsideration of the relationship between health and social care (although, unlike Sweden, this is further complicated in England by health being part of a National Health Service while social care is the responsibility of local authorities). This is leading to new forms of partnership and organisation, providing a closer relationship between health and social care, and to active consideration of new types of occupation. An English Minister, speaking in October 2002 referred to these possibilities:

> [Recent legislation has] allowed health and social services to work more closely together through at least 160 partnerships delivering services now worth £2 billion a year. These services are breaking down barriers between services so that people who are elderly or have mental health problems do not have to deal with two different – sometimes competing – systems... Care trusts provide another means to this end...I think you all know the complexity of modern social problems requires more specialised skills not just the traditional mix of social work skills. So I am today asking the General Social Care Council, training organisations and local government to work with us to develop new types of social care professionals. People who can work in the community, combining the skills of the therapist and the home help (Milburn, 2002: 5, 2).

These developments, together with joint appointments between health and social care agencies, will challenge boundaries between health and social care in the future. In the meantime, there are still some obstacles to social care workers assuming wider responsibilities. Some restrictions were mentioned on the activities of English home helps, such as cutting toenails, on the grounds of it being a risky operation only suitable for health personnel. To the care recipient it makes no sense.

5.2.3 Social care and informal care

In our study, different opinions were expressed in all three countries about who should care for older people, including the respective role of families and formal care services. Returning to Anttonen and Sipilä (1996), who found that there are major differences between different European countries in social care services, what they discuss is the specific ways to increase the autonomy of both care providers and care receivers. The Scandinavian countries offer women the opportunity to enter the labour market. In southern Europe in particular, women’s chances of gainful employment depend on their ability to come up with private solutions. This, of course, will influence the way formal and informal care work will be co-ordinated and this is apparent if we compare the relationship between the two forms of care work in Sweden and Spain.

The most ‘clear’ relation between formal and informal care is reported from Spain. Here the family is regarded as the primary source of care, with care workers offering more specialised
care. The role of care work, therefore, is to support informal care work in families as far as possible. No discussions about any boundaries are reported. The ambition is to educate family members and also the older persons themselves to take an active role in their own or the family life project. This educational role is described here by a male family worker.

*I think that it is more educational than the tasks like hygiene or caring for a person, because it’s like I say: we go for 1 or 2 hours a week and the rest is up to the family. So we need the people to help us and co-operate with us, we tell them “listen. I see that he has a bad chest. You have to give him a little water” because, of course, I go and I give him a glass of water, but the rest of the day he has to continue drinking. They have to be orientated in the sense of if he had this with a fever I would call the doctor, because he could have a chest infection. So we are connected a little, in all of these aspects we end up being a part of the family, because with the years you become more... You meet the children, the grandchildren too. You have to be with them, each of the family members has their own problems, their own life and the poor elderly person is always dependent on his children, if they can come to see him or not, even if it’s only once a week.*

The work with families is described by a Spanish worker at a residential home as a matter of giving the family emotional support and helping them to understand the illness. In the case of people with Alzheimer’s, the final stage is the worst for the families. The care workers anticipate the loss and keep giving them emotional and psychological support if it is necessary. They also provide a lot of training on how the illness evolves. As there is a high level of depression among elderly people, care workers supply information, and help to form a relationship not only with the residents, but also with the families. When experiences are shared they become stronger. At lunch and dinner time the carers are there because they have to be, but almost all the residents have a family member who comes every day to feed them and walk with them. The integration and involvement is experienced as very good, and in 95 percent of cases it is the children who are involved.

In Spain, the socio-health (atención sociosanitaria) perspective is developing. But ‘care work’ is still seen as very close to informal work done in the family, and therefore is often associated with unpaid and unqualified ‘emotional’ work:

*I think that care work here is very seldom seen as a job. Care work, because of our Mediterranean tradition, because of a low standard of social welfare, is the type of job that still forms a part of the social view as a job that is carried out by families (basically by women who are at the centre of the family). It is even understood and perceived below the logic of self-production and tasks that are, from a gender perspective, natural, inherent in the role of the female, rather than a professional job.*

Education or health is clearly given more consideration and economic value in Spain than care work, which is given very little economic value and is associated with the informal sphere.

These Spanish examples are characteristic of what Noelker and Bass (1989) describe as a ‘complementary’ link between formal and informal care. Complementarity is defined as the
informal system doing the most unpredictable non-uniform and non-technical tasks while the formal system handles specialised and predictable tasks.

This perhaps is precisely what is new and what we keep working on, it’s the only way to be able to initiate a new educational response of self help, in which the elderly person has the role in his own life project, and he can realistically follow a process. I believe it is an educational process that the elderly person should be able to take with him to the end.

This type of co-ordination can be compared to the more ‘supplementary’ style found, for example, in Sweden (Johansson and Åhlfeldt 1993). The supplementary link, to use the definition of Noelker and Bass (1989), means that the informal system uses formal services to supplement their efforts, and vice versa, rather than restricting formal services to more specialised help.

5.2.4. Attitudes towards the responsibility to provide care

There is evidence that, in some countries at least, elderly people view formal services favourably, preferring them in certain circumstances to informal services from family and friends. A Norwegian study shows how elderly Norwegians were clearly more aware of public health and services in the 1990s than they were in the late 1960s, and that a growing number of them prefer public rather than family help. A majority would now choose to turn to the public services when they need assistance, even if their children live close by. Children or other informal helpers were preferred over public services only when short-term assistance was needed (Daatland, 1990, Daatland & Herolfson 2003 a,b). A Swedish study of the cultural values of elderly mothers and of intergenerational relations revealed the same pattern. Geographical proximity and the number of children were the most important factors in explaining whether they would turn to children when they need daily care (Hammarström, 1991). It has also been argued that there is a widespread preference for formal services among elderly people in England (Daatland and Herolfson, 2003a,b).

How did the practitioners in our study view this issue of the respective roles of society and family? The response to questions on this subject - the relationship between formal and informal care - on the self-completion questionnaire shows Swedish practitioner informants to be more positively in favour than their English counterparts of formal services taking on the major part of care work for frail family members. This was not to say that relatives should do nothing, but rather to see the main responsibility being societal rather than familial (see Tables 4a and 4b). This reflects Swedish legislation, in which there is no legally binding regulation concerning care and nursing by adult relatives. It is the society’s responsibility.

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<thead>
<tr>
<th>Close family members (spouses, adult children) should always be prepared to carry out practical tasks to help frail family members with their daily lives.</th>
<th>Do not agree</th>
<th>Uncertain/ don’t know</th>
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Close family members (spouses, adult children) should always be prepared to provide emotional support and friendship to frail family members in their daily lives.

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Close family members (spouses, adult children) should always be prepared to carry out practical tasks to help frail family members with their daily lives but formal care services should do the majority of this work.

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Close family members (spouses, adult children) should always be prepared to provide emotional support and friendship to frail family members in their daily lives, but formal care services should do the majority of this work.

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Table 4b. Statements about who should provide care for older people by care workers: Sweden (N=21)

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<tbody>
<tr>
<td>Close family members should always be prepared to carry out practical tasks to help frail family members with their daily lives</td>
<td>10</td>
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<td>8</td>
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<tr>
<td>Close family members should always be prepared to provide emotional support and friendship to frail family members in their daily lives</td>
<td>8</td>
<td>3</td>
<td>10</td>
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<tr>
<td>Close family members should always be prepared to carry out practical tasks to help frail family members with their daily lives, but the formal care services should do the majority of this work</td>
<td>2</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Close family members should always be prepared to provide emotional support and friendship to frail family members in their daily lives, but the formal care services should do the majority of this work</td>
<td>4</td>
<td>1</td>
<td>16</td>
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5.3. Working with relatives

There were themes under this heading that crossed all three countries, emphasising the growing importance of this aspect of care work for practitioners. We have, for instance, already seen the importance placed on working with families in Spain, reflecting a view that families have primary responsibility for the care of elderly people.

The Swedish discussion on relations and co-ordination of care work has, up until recently, been focused mainly on the workplace organisation: the triadic relation between care worker,
care recipient and the middle manager is found to be important (Johansson and Anderson, 1993; Johansson, 2001; Sellerberg, 1973). Methods for working with relatives are, however, now under development and the issue is looked upon very seriously. The matter of relatives and how the staff work with them came up in response to several different questions in the interviews.

All staff in the Swedish study have experience of working with relatives and think that this is a part of their work. In the answers in the questionnaire, 14 out of 21 informants stated that it was a part of the work to have a meeting with the relatives in order to discuss care issues. Six informants stated that meeting the relatives is not included in their work. However, all of them meet the relatives in some way, whether it is planned or not. In many places, get-togethers for relatives are arranged once or twice a year, while other places have relatives’ associations. There are a number of different associations, many of which are especially for relatives of people with dementia-related illnesses.

In England, too, working with relatives was clearly part of care workers’ understanding of the work. All the care worker informants organized or attended meetings with relatives, although these mostly occurred less frequently than monthly. The main topics for these meetings were the elderly person’s health, arrangements for care and other services, and welfare and well-being. In residential care, where there were key worker systems in place, informants said more of a relationship developed.

Yes, oh key residents, yeah. There are three families that I have. One of the ladies has just got a son and a daughter-in-law. The son comes. He is very good. We have a chat on what she needs and that, and if she is okay. He or she comes and finds me and says, “How’s mum? How’s mum been today?” you know, just that sort of thing. The other family, um, they are extremely good. Their mother couldn’t want for absolutely anything. But they can’t cope with caring for them themselves.

A system of key workers or kontaktmannaskap (contact persons), with one staff member responsible for making appointments etc. for a resident, is also found in Sweden. This system will be described further in the next chapter.

In home care, the dynamics of the relationship with relatives are slightly different. Whereas in residential care, the old person is physically removed to an institution, where there are hierarchies of power and authority largely controlling the daily life of residents, in home care the physical site of care work is less clearly controlled by the care worker and their employing agency. In some cases, the elderly person’s home might also be the relatives’ childhood home. Almost certainly the home will be more physically and socially familiar to relatives than to care workers when they first start their work, although in some cases relatives live far away and have infrequent contact. Moreover, home care workers cannot rely on the authority of the institution in the same way as residential care workers: they work in a more autonomous manner.

Informants stressed the variability and individuality of relatives’ involvement in caring for elders. The main role for home care workers was to liaise, update and inform relatives, but also to request help from them at times. As this home helper explained, care workers are the pivot or liaison point between identifying and supplying needs:
I inform the children that this is the situation, this is your parents so if you can come to help out. So at least you serve as a liaison officer or a colleague between the person you're caring for and their relatives. Some relatives really appreciate it, instead of keeping quiet say it's none of my business. It is your business, you have come to the situation and you have to try to resolve it so it is your business.

5.3.1. Continuity
Workers think that it is important if relatives can give them a background description of what the old person’s life used to be like. The levenadsberättelsen (life story), as it is known in certain services, is a means of support in getting to know the old person and is naturally an area where the relatives can be of considerable assistance. Here an auxiliary nurse in a Swedish residential home discusses the important contribution relatives can make to her work:

Q.: What do you think the role of the relatives for this kind of residential unit for people with dementia?

Above all sort of to... to give us staff something to base things on. Since I might not be able to ask the person who lives here those things, it’s up to family members to give us some background... They are the ones with the background information. But just the fact that somebody comes for a visit makes such a big difference for the residents. Even if they forget all about it in 10 minutes, they’re so happy at the time. So I think most of all it’s that.

The role and responsibility of the relatives is, according to this person, in part to give the care workers a basis for their work, supplying the background knowledge they need about the old person. In addition, it is also about coming to see the old person. The worker quoted here is clear about the distribution of work. She states that it is not the job of the relatives to take care of their old family member should he or she become troublesome. The staff should not unload difficult situations on to the relatives. Other staff talk in a similar vein. They discuss the situation and responsibility of the relatives and underline that the relatives should not be saddled with additional work relating to the elderly person. Statements such as “They do as much as they’re able to” or that it may be difficult to see the changes that mum or dad go through because of illness are things that the staff bring up.

5.3.2. Distant relatives
The staff point out that it varies a lot from case to case whether the relatives come and visit and, therefore, how often the staff meet the relatives. Many staff members are sympathetic to the fact that some relatives do not come for visits that often and they base their understanding on the arguments such as those given above. The fact that many relatives do not live nearby either is another reason why not all old people receive visits or help from relatives. Sometimes there may be things in the past that the staff do not know about concerning the relationship between the relatives and a resident, which could explain why some old people do not receive any visits from their relatives. The fact that some staff in residential homes only work weekdays and not at weekends is put forward as positive both for the residents and their relatives. This way they know there is always a member of the regular staff to get hold of if there is something about which they are concerned.
Some residential carer staff welcome relatives helping out with practical chores. Staff in special housing in particular emphasise this. It is often the same workers who think that you cannot ask too much of the relatives that welcome their help if they are able to and want to give it. There is no conflict between these two points of view. Cleaning the flats and cupboards, taking old people for walks and keeping them company are all tasks that the staff are happy to see the relatives help out with. Again nobody mentions more intimate tasks like, for example, hygiene and showers.

All the home help staff point out that family members and relatives have a lot to do, that they work a lot and often live in a different place to their parents. The care workers accept that the relatives are in a difficult situation and point out that you cannot dump work on them that the staff have a duty to perform. However, in many cases, the staff welcome more help from the family members if it is possible and consider that family members do have certain responsibilities, for example to purchase clothes and cleaning equipment.

5.3.3. Ignorant relatives
But it is not all plain sailing. Some of the staff members indicate that problems can occur in the contact with relatives. Most frequently the problems are because the relatives do not understand the nature of the illness or the situation the old person is in. They do not always realise just how ill the old people are and the disappointment brought on by the their parents’ condition is then often taken out on the staff. Family members can ask questions like: “Why isn’t my mother dressed?”; or “Dad says that he hasn’t eaten at all today, is that right?”. When these questions are asked, it is common for the family members not to have a good understanding of the old person’s condition.

Residential care staff think that, when problems occur and family members complain about the care and nursing, it has a lot to do with their own bad conscience about not being able to do more for their elderly relative. Worries express themselves in forms that the staff sometimes experience as complaints and a lack of understanding about the old person’s illness. Some workers, such as this Swedish residential home worker, also say that some relatives have peculiar expectations on the residential home, seeing it as some kind of sanatorium, and believe that their mother or father will soon be discharged, healthier and younger than before.

Q.: But have you noticed any problems with family members?

There can be, many family members make very high demands and I think that it is a way of easing their own anxiety that maybe if they complain a lot then Mum will get all the help she needs. If I’m at it all the time, then I think that, well, if you feel inadequate then you might try to get somebody else to do all the things that you don’t have the strength or chance to do and this leads to many complaints, things come out that way instead, so they might say: “I see that there are buttons missing on my mother’s blouse”, well that sort of thing, that sort of totally unreasonable request and very odd opinions about stuff. I think it all comes down to a way of shifting responsibility for Mum on to someone else.

Q.: How do you mean that they have strange expectations?

The fact that this is a residential home, they come here when they are old and many people think this is some kind of sanatorium and that their mother aged 85
will soon be well again. They wonder when mum will be back to her old self and it doesn’t really work that way.

Much of what is brought up in the above extract concerns both special housing and home help. However, as the home help service works with old people who live in their own homes, the situation concerning relatives and contact with relatives can appear different. The care workers in the large city area point out that above all the relatives do not understand the time-related pressure that the staff are often under and the consequences this situation has for the work. The problems originate, according to the staff, from not always knowing what the home help service is actually there for and what tasks the staff have. In the urban part of the other municipality, home helpers also brought up the fact that the nature of the service has changed a lot over the course of the last decade and that relatives and old people for this reason may have an unclear image of what the objectives of the service actually are. Here two home helpers discuss this apparent lack of understanding

Q.: Do you ever have problems regarding contact with family members?
I don’t suppose they really know what we do and...

They don’t know what things are like here and ask “Why hasn’t mum’s place been cleaned for several weeks?” They ring up and complain and it’s hard to explain that we don’t have any staff.

Yes, they don’t care about that. Things are supposed be done anyway because it says so in the decision and these things can get blown out of all proportion sometimes with loads of bickering about little things and that and you find yourself thinking that there are worse things...

Q.: Such as for example...

Well, I mean cleaning and such like, I sort of think it’s worse if people get left on their own. Sometimes you read about it in the paper, that they don’t get any food or are forgotten about in that sense and I sort of think that doing the cleaning I mean, as children to the old people you just have to chip in a bit every now and then if they notice that it hasn’t been done, they can just ring up and ask why. They don’t need to be unpleasant, some are from the beginning. You can just ring and ask a bit about why things have turned out a certain way, there has to be a reason, sometimes there have been many different people and then things can get a bit messy or when a lot of people are ill or when there are a lot of substitutes.

The problems originate in part from lack of time. Another problem that the staff experience is when family members cannot see the ‘big picture’ and there is a lot of fuss made about apparently small omissions. Worse things can happen than not having had the cleaning done for a few weeks, e.g. when food has not been delivered or somebody is forgotten about. The fact that the relatives do not know that the service has an organisational problem means the help assessors should keep the relatives better informed.

The staff members in the villages outside the town do not highlight any problematic situations concerning relations with family members. Indeed, they emphasise that the co-operation often works very well, with the work divided between the home help service and the old person’s
children. Not all of the old people have a family member they can be in contact with; but if there are family members, the staff are very keen to establish contact with them in order to facilitate the work.

5.3.4. Tension, conflict and the need for co-ordination

One informant raised the importance of trust between relatives and care workers. She said: “you are looking after their prize”. For her, trust was about being given responsibility for looking after members of the family and about being entrusted with the family finances. The relationship was about

being trustworthy with them whether it's that you've got money of theirs. Whether it's the caring of the residents you know. They have to trust you as well and I would hope that people who came here would do that. You have as much of an association with them as you do with the resident because you've got to tell them things about what's going on, that's very important. I mean where I worked before you didn't really say too much to the residents' families about them and I thought that was wrong.

But the relationships between relatives and care workers can have their tensions and conflicts. It emerged that family members can be experienced by workers as a nuisance, as more of a problem than a help especially when there are differences of opinion about an elderly relative and how best to care for her or him. One worker, for example, talks of the importance of letting old people do as much as possible without help. He describes how some family members do not find it dignified for their mother or father to get themselves messy and for that reason want them to be helped when it comes to, for example, drinking and eating. He draws attention to the fact that family members and staff may have differing sets of values and that these values are not always compatible.

Another issue raised was that of relatives resenting the relationship that workers establish with clients over time.

I mean you get the families what I wouldn’t say dislike you - but you just always know, because mum sees you or dad sees you all week, and they don’t see family once a month, and then when cos they come in all they hear about is the carer, the carer this, the carer that, and the family...

Despite such potential tensions, this informant stressed the importance of having a relationship with relatives, especially when ‘things go wrong’.

In general I would say we get on very well. You can build the relationship. And also I think that is very important that you have their support, because when something goes wrong or you need them at any time, they are always there and they are always willing to come. Well, you get the odd one, but the majority are willing to come.

The possibility of disagreements with relatives foregrounds the importance of having a third party through which issues could be aired, solutions found and workers protected. Managers were the first port of call when disagreements arose about the type or quality of care. Managers would hold a meeting with the relatives, sometimes including the care worker, and would ‘work until we get it right’ in the words of a home care worker. Complaints procedures
were mentioned by two informants as a possible avenue for relatives, and two more said it was important to document the events in the life of a resident in case of conflicts.

But in fact, few informants reported experience of having to deal with disagreements with relatives. One residential care worker said:

*We have not had many problems at all. I think some families when they say, “Do you have to use that hoist on the bed?” when he can’t weight bear anymore, we have to say, “Well it is health and safety, you know.” And no, they don’t like it, but they do get concerned about them sort of things. But apart from that we very rarely have any problems. They all know that we do the best for them.*

Two other residential care workers did mention some cases of conflict with relatives. One was about the issue of possessions. Getting relatives to mark clothing could be an area of disagreement. But sometimes the service shrank or destroyed items of clothing in the laundry or damaged personal possessions such as glasses. The second was about an incident of a relative abusing a resident, where the manager had to discuss the events with relatives and restrict the contact with the resident.

This section has been very detailed. The reason is that the meeting between formal and informal care can be seen as crucial in the future directions of elder care work. You can call the job, as in Spain, working with families and have the family as the focus. Or, as in Sweden and England, you can call it work with an individual, with some relatives involved. Either way, it will be the same actors involved in the process.

5.4 The view of old people and its expressions

In the literature there has been a discussion on caring attitudes towards the cared for. One attitude that plays an important part in theories of caring is responsivity or receptivity, to always relate individually to the care recipient. Another is to assume a dual perspective, to see things from the point of view of both the carer and the care-recipient (see, for example, Tronto, 1993).

Much of the theory on caring has been developed with caring for children in mind, which creates a need for a further discussion on what care for elderly people means in practice. One issue is that the relation is built around an asymmetric encounter, where one person needs help with something he or she is unable to do. The construction of this meeting can be different in different national contexts and at different periods of time. One dimension concerns how much individuality or autonomy the care organisation will accept. How much regulation is there of the care receivers? Another issue, related to the former, is how the care workers talk about the care recipients. Do they talk about them as persons? Or do they talk about them as problems? to bring into the discussion one of the points raised by Noddings (1984).

The discussion by Wærness (1980) about the asymmetrical relation between the care worker and the care recipient is regarded in Scandinavia as a classic theoretical work about social care. A person who takes care of another person has to give more than she or he can expect to get in return. That is the definition of an asymmetric relation. Wærness also analyses the different social status of the two participants in the relation. It is the recipient of care, she contends, who has the lower status. But this has been criticised because it is not sensitive to the class relationship between the parties in the caring relationship.
One such critical discussion takes its starting point from the fact that Wærness does not fully take into consideration that care-giving work constitutes social interaction. A Swedish researcher in social welfare analysed how elderly people and home helpers perceive and interpret each other; what they expect of their mutual relationship; how they influence each other’s actions in their emotional interaction; and how the old person’s family group and the home helper’s work team influence their relationship (Ingvad, 2003) ¹⁰. He found that the home helpers and the old people perceive their relationship as instrumental, friendly, emotional, insecure (recipients), laborious or charged with conflict (home helpers). What the old person and the home helper expect of their emotional relationship is linked to social needs such as respect, acknowledgement and appreciation from the other. These aims influence the experiences and actions of the two parties and, thereby, the care-giving work. Commonly the home helper subordinates herself to the old person or adapts to the recipient, e.g. by listening and adjusting to the old person.

To care for an old person has one meaning if you have an individual in mind and another if, as in Spain, you view a family as the unit to work with. A local trainer in Spain puts it like this:

Sometimes you forget that this person isn’t a unit, that this person belongs to a family, if they have one, or to some other people of reference. Sometimes it’s used very little in this area. Perhaps it is used more in the field of social work, on a professional level as well as in practice. Every social worker has to elaborate, report and agree with the rest of the team. Sometimes we forget some protocols, in these protocols all the attention is on the family. So I would say that sometimes in some areas this is forgotten.

Even in Spain, though, it is possible to see the individual without the family. The same trainer admits that sometimes,

well, it is forgotten that this person belongs to a family. We look after the person a lot and we look after them so much that sometimes with our style of care, we are prejudiced against the family. Therefore, we don’t understand that our work has to be based on the fact that even though this person is admitted into an institution, there is still a family unit, this person belongs to that family. Whether their values are good or bad for him, it is his family, so it is here, perhaps, where we falter a little.

This discussion of whether or not the individual is seen as part of a family raises the issue of different understandings, constructions or views of older people, and how these may change over time and vary between places. A change in terms of the view or image of old people has been going on for several decades in Sweden. In the 1970s, changes were introduced in social legislation. The *Socialtjänstlagen* (Social Services Act), which was formally implemented in 1982, had its fundamental concepts tested in practice long before it came into force. It was part of a process that began in the 1970s, which involved discussion about attitudes towards older people, and which raised awareness about the ideological dimensions of language and the ability of discourses to produce policy and practice. This was of great importance in terms

¹⁰ The empirical investigations, analysed with qualitative methodology, comprised thematically structured in-depth interviews with 48 home-helpers in six work groups, and 40 case studies of assistance cases, based on interviews with the old person (25 cases) and participant observation of the parties (15 cases).
of the view of old people and the care they were entitled to. A local trainer recollected that process it this way:

> When they changed the Social Services Act in the middle of the 1970s, when personal integrity, the right to self-determination and that kind of thing came into the picture, of course it changed the way people work and how people are looked upon and hopefully gives those who live in an institution a home too. To be able to see their home in the institution as their personal home and not as an institution... But there was a long, long journey, a lot of work to change the views of people (ålderdomshemsföreståndarinna) that worked in the institution. I worked then as a Matron at an old people's home myself. I can tell you that it wasn’t that easy to get the staff to rethink their way of looking at things. I mean it’s not just rewriting the law and then everything changes just like that. (emphasis added)

We consider below some important views about how older people are or should be which emerged from the interviews.

5.4.1 Dependence – independence

The driving philosophy in England has been the idea that elderly people should be ‘independent’. Also in Sweden the idea is that old people should “be able to live active lives and have influence in society and on their everyday life, to grow old in security and with maintained independence, to be met with respect and have access to nursing and care” (The Swedish National Action Plan adopted May 2001).

In Spain the concept of dependency is found in the dominant discourses. In the Spanish context, the term has multiple connotations. But in social welfare it refers to the need for care that people who are unable to do things for themselves require every day. The Spanish national report makes reference to a definition proposed by the European Commission (1998): “they are dependent people who, for reasons connected with the lack of or loss of physical, mental or intellectual ability, have the need for assistance and/or help which is important for them to be able to carry out their daily activities” (Defender of the People, 2000:63).

The concepts of dependence and independence are complex and need further and deeper investigation. For example, despite the official Swedish policy emphasis on independence, Ingvad’s study (2003) shows that the Swedish emotional relationship of the vårdbiträden (home help) with the old people was characterised by, among other things, emotional dependence – but of the care-giver on the care-receiver, not vice versa. It feels unsatisfying to the worker when she cannot do a good job, when she does not have enough time for the recipient. It is important for the carer that the old person is satisfied with the care provided. This type of dependency is different to that which is normally discussed in the caring literature and which is related to the care recipient. To be dependent on the client’s evaluation is also strange from the professional point of view. Professions normally struggle to be independent of their clients.

Ingvad’s study (ibid.) points to the importance of symmetry in relations – perhaps some degree of mutual dependency or inter-dependency? A crucial factor in constructive interaction seems to be agreements in which expectations and wishes concerning the care work and the relationship are regulated by fairly equal influence for both parties. When the interaction is
constructive, the old person and the home-helper feel that the character of their relationship is friendly.

Where there is asymmetry, where the care recipient is in some senses treated as the dependent party due to the fact that he or she has lost one or more functions, how is this expressed in the caring relation? In England, infantilised conversations between care-givers and elderly people were observed during the tours of residential homes, suggesting old people were in fact sometimes seen as dependants, rather like dependent children, and/or a lack of ease in communicating with people who have physical or mental difficulties in communication. What other expressions might be visible?

5.4.2 Old people as resources

A positive view of old people arising from possibilities to learn from their experiences and historical knowledge is mentioned in both the English and Spanish interviews. This comment comes from a Spanish care worker in a private residential home.

*It's about dealing with old people who have experienced more in life than you. I should explain to you what the relationship with them is like. They are grateful people. It's a pleasant relationship because they are able to have conversations with you whereas the majority are not able to. And they are conversations about things that have happened in their lives and that you haven't experienced because you weren't born then for a start. I like to learn things about my grandparents' era in this way because you can't have a conversation with children except about what they want to talk about, which is limited, but not so much perhaps with grandparents. The grandparent has lived more than you and knows more and that is what is truly gratifying about working with older people, and I like it.*

Another carer, this time in England, talks about “people with a lot to offer, respect for their history, an ability to let one into the past”. In such cases, old people are looked upon as a resource, their passing away as a loss.

In the Spanish material you can also find in the attitudes towards work a joy in having opportunities to help older people: “everyday you help them to ‘be better’ or emotionally they have a quality of life that is much better than being alone in their home and not being able to clean themselves because of course there is a difference between a resident, an old person and a grandparent”.

5.4.3 The issue of dignity

When it comes to the issue of dignity the way of talking about such a quality varies in the different countries. What does it mean? And how is it expressed in everyday care work? In the English context respect and dignity are among of the cornerstones for a good care for elderly people formulated in the *National Service Framework for Older People* introduced in 2002. The stated aim is to provide high quality care and treatment, regardless of age, to treat older people as individuals, with respect and dignity, to provide a fair distribution of resources for older people, and the ease the financial burden of long term residential care (English Department of Health, 2002). The main themes for the delivery of this policy are better co-ordination or partnership, specialist posts aimed at both treatment and prevention, and enhancing independence for older people.
Among the policy makers interviewed, a concept such as dignity was felt to belong to the “more modern values that have become the government's values around promoting choice and dignity, self-determination and independence”. It was also said that these values were “around dignity, respect, appreciating peoples’ privacy and their right to choice, about helping to empower and enable people ... about a respect for treating somebody how you would want to be treated yourself...Just looking after their personal welfare really”. In the English context the word “dignity” is mentioned together with such words as “meeting the wishes”, “privacy”, “independence” (workers in the private sector), to which should be added “respect”, “informed choices” “friendship”, “developing new skills and knowledge”, “meet individual needs” (workers in the public sector).

There is an interesting feature of the way that English informants talk on this subject. Mention, for example, of “respect for their right to privacy while having bodily care” or of not having locked doors for dementia patients is made as if it is not a human right to privacy in intimate situations or to have the control over when the door to your own home should be locked or not. In other words talk of ‘dignity’ sometimes implies that undignified treatment and absence of rights have become the norm.

Dignity is also talked about as important for care work in the Spanish context. An elderly person does not want to show that they cannot do certain things. A person wants to feel useful. He or she wants to have the maximum degree of autonomy possible. There is also personal quality, that is to say we ourselves have to aim to give quality to a person's life. Here the word ‘dignity’ is loaded with connotations like “capable”, “useful”, “autonomous” and “quality of life”. The old persons, in a dignified old age, have the right to be included in society.

In Sweden the word ‘dignity’ (värdighet) is not used frequently in everyday speech. ‘Dignity’ is only mentioned specifically in the Swedish report to describe funding a solution to a dilemma in a situation that embarrasses both the care recipient and the care giver11. Here the discussion of dignity is limited to thinking about how to handle ‘taboo’ tasks. For example, to be helped with intimate hygiene by somebody other than a family member can be a way to maintain dignity for all parties.

The way of describing their work indicates, however, that the ambition of the care workers is to bring about a quality that could be called dignity. One typical way for a Swedish care worker to describe their work is found in this interview extract:

Q.: Whom and what inspire you in your daily work?

My humanistic view, my caring ideology and my colleagues...Caring ideology is all our joint thoughts. This is their home and a place where they should feel both safety, love and solicitude. All these things connected to a home... it is our mission to protect it like that. Our humanistic view is to never forget that they are individuals beyond their disease. We shall not only notice their illness but the individual. Dementia changes the personality...many times in a way that

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11 In earlier Swedish studies, it is possible to observe that the main types of care that relatives do not undertake concern hygiene and the body (Johansson and Åhlfeldt, 1993). This may be a practical issue, as this care requires regular and frequent contact on the part of the family member, which can be hard to achieve if he or she does not live in the same place as the person needing care. In many cases, however, it is possible that this may be a question of maintaining dignity for both parties.
relatives will not recognise the person. Even then we must see the human being. They deserve our respect! They should not be treated like children even if they sometimes behave like if they were.

Nor does the rare use of the word ‘dignity’ mean that the Swedish practitioners who were interviewed offered no critical views of the work. Criticisms expressed in the course of interviews might be interpreted as a concern about the potential loss of dignity in the caring services. For example, several people stated that there were serious flaws in how premises are designed: too many old people live in the same group living unit; in one place there are two living rooms, which can be confusing for the old people; the toilets are not built for the needs of modern care, they are too cramped to take all the aids needed; the work situation for the staff suffers.

The economic aspects are something that many people brought up. One informant told of wanting a spot for a very small garden for the elderly residents of a group housing unit where they could grow some vegetables and plant flowers, which would be something for both the old people and the staff to do. However this idea was dismissed: “There’s no point, it’s not worth it” and other negative opinions such as who is supposed to look after it when the staff do not have time. Many people said that it is unacceptable that all places for elderly people do not have access to a patio. The best thing would be for all housing to be at ground level so that the old people can walk in and out as they please.

The fact that financial issues in Sweden have such a significant bearing is disturbing for the staff. Several people wanted local politicians to come down and see for themselves the reality that they, as staff, face. This would, the carers thought, serve the purpose of making them better understand the work and thereby prevent further financial cuts. One informant stated that it is impossible to cut one’s way out of trouble and that the municipalities, instead of cutting back, should invest more in their own nursing homes and thereby save money in the long run. Old people are going to need a lot of help in the future so it is a good idea to start preparing for the time to come, says that informant.

Another person was of the opinion that the decisions that concern elder care should be brought down to staff level. Too much restructuring has taken place within the organisation and the staff do not have the energy to get involved in it any more. They miss not being able to participate actively in decisions that concern them and think that if they were allowed to take part at an early stage they would certainly be able to contribute with ways to save money for the municipality. Just being told one day that a certain amount of money needs to be saved in three months’ time does not help them since they have no insight into the budget of their place of work. One person pointed out that a possible solution would be to give the staff better access to information about economic issues. This way they would be able to help with planning and also help the municipality avoid further cutbacks.

Participation is one of the key words in the Swedish National Action Plan for Elderly Care. For example, everyone who receives services and care in the City of Stockholm has the chance to influence what form these take. The Stadsdelsnämnderna (district councils), into which the city is divided, have, in co-operation with pensioners’ organisations, developed methods and structures to ensure user influence. Each district council has appointed a local pensioners’ council as an advisory body. The council’s task is to give the old people influence and insight into the general questions that affect their living conditions and circumstances in the district. Council members and deputies are nominated by local organisations membership
of which is open to all pensioners. The view here is of the older person as an active citizen, participating in political processes.

5.4.4 Old persons as burdensome
Some caring relations are conflictual and burdensome. How do the care workers understand the situation? Which solutions do they choose? We turn again to the recently published study by Ingvad (2003) to offer a starting point.

In emotional conflicts, psychological constructions play an important role in the home helper’s perceptions of the care situation. A silent process takes place in the interaction between the care receiver and the home helper, as they negotiate with each other and adjust to each other. The interaction can become charged with conflict when the old person and the home helper do not succeed in adapting to the mutual expectations of the encounter. The old person and the home helper can make themselves super-ordinate or sub-ordinate to each other, or establish a more equal relationship, or in more extreme cases, use power in an escalating conflict.

In such conflicts the home helper may act more impersonally and show less care in the work. The old person may express confirmatory feelings for the home helper, representing in various ways who the home helper is and what she stands for. The old person may also aim for liberation from dependence, for example by exercising influence and control or to assert her integrity vis-à-vis the home helper. But the home helper expects that the old person, through his or her dependence on help, will show feelings of intimacy and emotional dependence. The home helpers therefore seem, to a large extent, to wish that the elderly have a relationship of dependence on them. But the old people have a desire to be viewed by home helpers as the sort of person they perceive themselves to be. The care recipients to a large extent want the emotional relationship with the home helper to be equal.

English home care and residential care workers spoke of their ability to support elderly peoples’ wishes to remain at home, and their ability to relieve some of the ‘burden’ of caring borne by relatives. One worker also referred to the benefits of a formal service for intimate tasks such as personal care:

Yes, because therefore it doesn’t all land on their shoulders. Nine times out of ten they will still see their daughters or whoever during the course of the day, but the mornings…and some clients don’t like personal care to be done by family members. It is better if it is on somebody else’s...

One problem discussed in the English interviews was how to deal with “difficult” clients. Sometimes this may be a result of a deliberate or accidental failure of communication. A worker in intermediate care said that clients who have been sent to them “under false pretences” can be difficult to work with. They think they have been sent to convalesce after a hospital stay and find that instead they are expected to reanimate their bodies and minds in preparation for independent living again. Two care workers drew attention to the importance of professionalism in dealing with ‘grumpy’ or ‘difficult’ clients: this involved positive greetings despite a lack of responsiveness in kind. One said: “You have to do the job with that person, even if you are not that keen on that person, as best as you can”.

Also in the Spanish material you can find a discussion about how to handle difficult situations.
Yes, yes, we talk about the cases because in the home work it is very good, I can tell you as it is creative, but you feel very alone and you carry a lot of burden. In the residential home, we work as a group and you don’t carry things as a burden, you always talk with the others about the old people, you off load the work, but in the home work, however, you carry a lot of baggage and you need someone.

One common way to work with difficult clients is to visit the client in pairs, sometimes known as ‘doubling up’.

The special needs of elderly people, such as those with dementia and multiple disabilities, were frequently encountered. Behaviour such as wandering at night, confusing identities, and failing to recognise regular carer workers were all reported. Caring for people with dementia is now so common that it is part of the regular work of home and residential care workers. One English home care worker described this area of work:

Yes we have had people with dementia that we’ve been in to and those people get more visits and everything is recorded. The out of hours [team] would get a ring from, we then, those people then have the same carers and the carer would ring up, I’ve got to such and such a body, he’s not in, his front door’s wide open, I’m going to go and find him. And 9 times out of 10 they knew where he was. They bring him back. But we monitor it all and when it reached a stage where this gentleman wasn’t safe to be left on his own then we got together with the family and showed them what had happened and it was agreed that this gentleman should then go into residential care because we could no longer meet his needs.

In one residential home, the staff group’s approach to a user being both deaf and blind was to learn palm writing. This had been a rewarding experience for all concerned, particularly as the man was very appreciative of their efforts, as the extract shows:

Q: Has that created any particular problems or opportunities for you?

Um, it has been very... I mean I am not brilliant at it, but Harry, the gentleman himself, is wonderful. He is a really wonderful man. Because we have had another lady come in who was able, who was supposed to be able to do that, but she...we couldn’t get through to her very well at all with it. Um, but Harry, he is just an exceptional man. He really is good. And he has fitted in well, and we all have...all the staff have learnt how to use it.

5.5 Hungary
Social care also proves difficult to define from the interviews in Hungary. It is seen as a complex task that includes providing physical care, maintaining and improving physical and mental health and (especially for day care centres, not covered in the main case study) helping to provide free time activities. In residential care, there is a strong focus on health and the description of daily work has much in common with hospitals; this is reflected in the many workers with health care qualifications. Home care workers aim to help elderly people remain in their own homes as long as possible, as well as giving attention to those without family and friends; they provide a connection between the old person and the outside world.
The division of work between social care workers and nurses is much debated. Care workers are supposed to be more concerned with mental health, but very often this is not the case. In practice, the two kinds of work may overlap or be interwoven and, when this occurs, care workers are often put in a subordinate role.

There is clearly a strong relation between care and health. But this is not so with social work, which is accorded a very secondary role in care of elderly people.

With relatively low levels of formal service provision, as in Spain, families are expected to take a major role in the care of elderly people. Among practitioners, in all cases work with relatives is considered important, and the practitioners are all in regular contact, mostly on at least a weekly basis. In residential homes, for example, all the workers interviewed believe the family is very important for the elderly person and consider it their job to help maintain family relations as far as they can and to involve family members in the care work. Home care workers mostly believe that family members provide as much help as they can, though on some occasions home helps feel they are treated as servants.

Overall, practitioners are most clearly agreed that family members should provide elderly people with emotional support. Thirteen agreed without qualification that this was a family responsibility, compared to 9 who were similarly agreed that family members should provide care.

5.6 Concluding comments
There are different images or understandings of older people, and these may influence understandings of care work and how it is practiced. The area of independence/dependence/interdependence is important, complex and meriting more attention. How could independence/dependence/interdependence be understood given that one person needs help with something he or she is unable to? This is the central issue when discussing the philosophy of care work.

It is important to understand the different dimensions of asymmetry in the relation between care giver and care receiver. Individual autonomy as a quality should be balanced with the wish to avoid harm and/or indifference. Quality of life becomes an important concept to analyse in relation to the desire to keep as many bodily functions intact within reasonable individual efforts. Autonomy and quality of life should be permeated by dignity, respect and safety, clearly emphasized by the informants. The philosophy of caring also includes theorising over the power relation between the care giver and the care receiver. The ideal is a relationship as equal as possible to enable responsivity and receptivity. This opens for questions about what kind of knowledge and skills are necessary and desirable for doing care work. It also opens for questions about the work environment, as a bad environment creates a climate not fruitful for a caring relation.

The relationship between formal and informal care is central. Generally, care workers agree that “the family has to be here next to us. We are doing our job and the family is doing its.” But this relationship is evolving and what is the ‘family job’ and what is the ‘service job’ varies between countries: at one extreme, the family is viewed as central with formal services offering specialised help, while at the other extreme formal services share responsibility or even have the main responsibility. Sometimes the division between family obligations and the obligations of the care services are explicitly formulated, for example the family obligations
are to provide company for the old person, to motivate him or her and to give them love in a way that a professional care worker can never do.

Despite some important academic work, the concept of ‘social care’ has not been much developed in the fields of policy and practice. It is often used as a label for a collection of services that are administratively and/or legally connected, and the range and variety of the services so labelled can vary between countries and over time. ‘Social care’ is also often defined in terms of its relation to other fields. This may mean conceptualising it in terms of what it is not. Or it may mean that it is increasingly difficult to distinguish care from other fields such as nursing: as the borders between ‘social care’ and other fields, such as health and social work, are increasingly questioned and blurred, care work becomes increasingly broad and complex. Issues are raised about relations with other areas of knowledge and with other occupations - both here and now in relation to team work and leadership, and in the future in relation to the possibility of new occupational structures.
CHAPTER SIX : NECESSARY SKILLS FOR A CARE WORKER

In the Spanish national report three requirements for care work were mentioned: knowledge, skills and attitudes. In the Swedish material knowledge, competence and qualifications are distinguished. In this chapter we look in more detail at what our informants said about what knowledge and skills a care worker needs to bring to her work with older people.

6.1 Knowledge, skills and competencies

Care work is often spoken about in terms of relationships, involving a high degree of ‘emotional labour’ (see for example, James, 1992). English carers, for example, often talk about a good relationship with older people being characterised by trust and respect, and treating people as you would want to be treated yourself. Other features of a good relationship mentioned by English informants included ‘being honest’, ‘being there for them’, making sure ‘that they are happy…that they are doing what they want and they are achieving what they want to achieve’, ‘understanding them’, ‘being confident in me [and] being able to talk to me’, and ‘knowing I will listen’.

In a good relationship the resident or client was ‘not rushed around’: instead, time was taken with them so their wishes were known and could be respected. Interaction was said to be important. A good relationship was also one where you looked forward to seeing that client, because of the positive response the worker would get: “they are going to have a smile on their face when you enter the room, and it does give you a boost”. This comment recognised the interdependence of care work – that care work is about responsiveness as well as attention to the details of another’s situation.

The importance of relationships and these views about what constitutes a good relationship were reflected in English informants’ comments about the knowledge and skills needed to do a good job. These included: communication/social skills; empathy/ intuition/ understanding; awareness of need; listening; patience; responsibility; sense of timing; personal experience; engendering trust.

Similar qualities are mentioned by Spanish care workers. When describing the main knowledge and skills needed to do care work with old people, patience is mentioned as most important in the Spanish report. The capacity to listen is also important. Compassion, love and sympathy for old people are needed to be able to do care work; practical knowledge is useful; and emotional skills should not be taken for granted. Each house is a different world. Respect for the person and a generosity when valuing others is needed.

In the Spanish report there is a discussion about the care workers’ lack of knowledge about emotional relations between the carer and the person cared for. One opinion among trainers is that the current Spanish training programmes are better organised in terms of tasks and the problems old people have. But the programmes offer very little as regards the foundation of bonding and the emotional links that are established between the carer and the person cared for. The work has much deeper social dimensions than are articulated in current training.

In both cases – England and Spain – it is striking how the necessary skills for doing care work are often understood in terms of innate personal qualities that the carer, as an individual, has or has not: for example, patience, empathy, honesty, capacity to listen. More knowledge is requested about relationships, and especially problematic relations.
Six different themes about necessary skills were identified in the interviews with Swedish care workers, offering a mix of disciplinary knowledge, practical skills, relational capabilities and life experiences. These practitioners consider it important to have knowledge and competence in the following areas:

- **Medical competence** – involving specific knowledge about illnesses in order to understand the behaviour of the old people, e.g. dementia/Alzheimer's disease
- **Care knowledge** – involving a number of areas including medication, psychology, assessing the state of elderly people (i.e. having a feel for their state of health), conflict management, pain
- **Empathetic ability** – how to be sensitive to older persons, having a big heart, understanding old people both physically and mentally, being able to listen and communicate, being able to forge trust between staff and old people.
- **Social competence** – patience, humour, fantasy, ingenuity, sensitivity, ability to listen and communicate, flexibility, calmness, self-assurance, knowledge of the old person’s previous life
- **Experience-based knowledge** – common sense, experience from having looked after a family, being a good judge of character
- **Practical knowledge** – lifting techniques, cleaning, cooking, washing

This last area – practical knowledge - raises the question: knowledge to benefit whom? One type of knowledge is to protect the carers: to know how to look after themselves physically, to know how to move people around, in bed, in the bath. To know how to look after themselves make the carers better equipped to care for others. Caring for the carers indirectly influences the situation for the client.

These results are similar to those reported in a Swedish study about social care work in the home help service, where Ellström and Ekholm (2001) identified various competence requirements - social, practical, medical, emotional and personality-related - for these services. A sense of the range of competences that care workers feel they need can be discerned in this extract from an interview with an **undersköterska** (auxiliary nurse):

> It’s really important to know as much as possible about different types of dementia illnesses, because only then will you understand why a person acts in this or that way. You need loads and loads of empathy. It’s almost the be-all and end-all. Another type of knowledge that is important to have is to know as much about the person in his or her healthy state. We have something called a ‘life story’. That’s a kind of form that we give the family members when it’s been decided that a person is going to move here. They take that home and are asked to write as much as possible about the person in question. His life up to now, the number of brothers and sisters, what the parents did. It’s almost more important to know what the parents did than what they have worked with themselves. Because that has often faded away. But they remember the parents. If there was a farm, then they remember, know the names of the cows in the barn and that
kind of thing, but what they worked with themselves only 20 years ago may have entirely disappeared.

Obviously normal medical knowledge too, because other things do come up, so it’s not just the dementia illness, other things affect them too... of course it’s important. Yes I think so. Then you need a big helping of patience. You also need a big helping of fantasy. That’s the most important thing.

This worker just quoted is unusual in one respect: she is one of the few that explicitly highlights how important it is to have solid knowledge about the life situation, that is how the care receiver lived before the onset of illness. Her opinion is that such knowledge is important in understanding the old person and in order to be able to talk about times gone by.

For other institutions and services, the importance of a kontaktmannaskap (contact person system) is emphasised. This might involve the contact person being responsible for the old person’s shower and personal hygiene, keeping track of their doctor’s appointments, etc. By being the contact person for one or more old people, and thus having the main responsibility for these people, it is possible to develop a special relationship.

Another care worker, a home helper, stresses common sense as most vital knowledge.

*We are a bit middle-aged in the groups here, there are some younger people but it works, if you have your own family and that, then you can see what needs doing and I think that’s an advantage.*

These Swedish interview extracts quoted above shed light on the complex structure of care for the elderly, consisting as it does of a number of different dimensions. Social care work is constituted from many different tasks, which leads the staff to highlight different knowledge aspects. The vårdbiträde (home helper) emphasises the importance of experience-based knowledge, that how much help is given needs playing by ear. Being able to sense and see what you need to do in the old person’s home is, in other words, an important skill in the home help service. Several people talk about being aware of not taking over chores from the old people, having the patience to wait and let old people do things for themselves.

There is a certain difference between how Swedish vårdbiträd (home helpers) and undersköterskor (auxiliary nurses) perceive the area of knowledge and competence. Both occupational groups stress that more knowledge and further education in the dementia field are very important as many people suffer from this illness today. Social competence and empathetic ability are self-evident competence areas for both groups. The undersköterskor draw attention to medical knowledge in a different way from the vårdbiträd. They also stress knowledge about illness in general as very important, along with being able to take care of the dispensing of medicines in a proper manner. The vårdbiträd agree that knowledge about dementia and general care are important: but they emphasise experience-based knowledge, derived from common sense and experience in family life, to a greater extent.

Personal flexibility and having ‘life’ experience of household work are things they consider important. Indeed, being flexible is something that very many informants highlight, saying that it is a personal quality you must have. One person compares it to role-playing, that you constantly need to be able to read how the old person is doing in order to satisfy this person’s needs in the best way possible.
One Swedish male care worker is sceptical about the whole debate on education and training in care for the elderly. He thinks it lacks subtlety and that, instead, it is about the attitude the people have towards their work. This man envisages a distribution of work, which involves the basic staff looking after/helping the old people, leaving other personnel to supply the necessary medical knowledge. It would be sufficient with one or a couple of undersköterskor (auxiliary nurses) on a ward as the work is more about having patience and carrying out practical tasks.

Finally, in the Swedish context the term bemötenande is mentioned in relation to knowledge and skills. This could be understood as ‘care ethics’, a concept that has been developed in recent years especially within feminist scholarship (e.g. Tronto, 1993; Sevenhuijsen, 1999).

6.2 Some dilemmas of relational work

A session of care work can, in theory, be task oriented or client oriented; the focus, in theory, can be on completing certain predetermined tasks (perhaps set down in a ‘care package’) or on the relationship with the old person and their general state of well-being. But the context of care work with old people makes it difficult, in practice, to separate the two orientations in practice. It is impossible, if a good quality of care work is to be maintained, to enter a person’s home without noticing the person living there. It is also, by the same reasoning, impossible to help a person with intimate tasks without any personal communication.

In England, much care work with elderly people is now supposedly task oriented, involving the delivery of a set of costed tasks set out in ‘care packages’, on the basis of assessments by ‘care managers’ who are usually social workers. The English report argued that, in practice, “building up a relationship with elderly clients happened during the task-ruled home care session”. Talking about families or telling life histories are important elements in the praxis of care work.

It is important to draw boundaries around the relationship and the care worker has to decide what is an appropriate boundary. One English care worker puts it this way: “You just have to remember to draw that line at some point. There is only a certain amount you tell them”. Drawing boundaries is about preserving a professional identity, which requires not revealing personal details, and retaining some emotional ‘distance’ between the client and the worker. It is a common practice across the welfare professions and failure to do so may result in professional censure as well as stress arising from difficulties in keeping work and home life separate. The latter is brought up especially in the English material and will be discussed in the section in Chapter 7.

There are risks associated with the vårdbiträde (home help) receiving confirmation for her work from the recipient alone, including becoming dependent as discussed in the previous chapter. It is therefore important that the relationship between the vårdbiträde and the old person contains a balance between intimacy and distance. Feedback from the management concerning the work of the vårdbiträde can clarify the goals of the care work and give confirmation that she is doing a good job. The organisation has an important part to play in countering and dealing with destructive processes in the care work, for example, some of the psychological constructions that can arise in conflicts between the old person and the home helper (Ingvad, 2003).
Problems can also arise if there is insufficient time to develop a good relationship. Informants in the English interviews spoke of time, or rather lack of time, being a cause of bad relationships. Shortage of time led to impatience that, in turn, caused bad relationships due to “tell[ing] them what to do instead of asking them”. Time pressures clashed with the principles of trying not to ‘take over’, and adhering to the principle that the ‘client has still got to have her own rights’. Time pressures were caused by organisational problems such as staff sickness, as well as high workloads.

The same point was made by Swedish care workers. Lack of time is reported to be the most significant cause of stress among the care workers (see Table 5). Stress destroys the capacity for empathy, one of the core skills for doing care work. The subject of stress is discussed further in Chapter 8.

### Table 5. What causes stress according to Swedish care workers

<table>
<thead>
<tr>
<th>What causes stress?</th>
<th>Yes</th>
<th>No answer</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time</td>
<td>17</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>Psychological demands</td>
<td>11</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>Low salary</td>
<td>8</td>
<td>1</td>
<td>21</td>
</tr>
</tbody>
</table>

**6.3 Hungary**

Practitioners generally agreed that empathy is the most important attribute required by elder care workers. They said it was necessary for care workers to be able to put themselves in the position of old people, so they can understand their situation. Tolerance, also highly valued, is based on empathy. It was felt to be important to accept people as they are, since they cannot and should not change; the care worker should adapt to the elderly person. Care work is easier if workers have good communication skills, which helps them express themselves and understand others. Being a good listener to others’ problems and a good observer are both important.

To do the work well, care workers said it was important to have a vocation: to love the work and the people they work with. Sensitivity also improved the work, a quality expressed in various ways: as social responsiveness, maternal care, and compassion.

Practical experience is necessary, as too are respect, patience and being relaxed: care work is not for nervous people! Perseverance and stamina, both physical and mental, were also raised; a care worker needs to be fit.

These qualities come from various sources. Professional knowledge, from training, is important, for example knowledge about health; care workers, it was generally agreed, need to be qualified. But some are innate or acquired through life experience, others through experience gained on the job. Some workers felt age was important; elderly people were more likely to trust workers with greater experience.

Trainers shared the practitioners’ views about skills and aptitudes that were important for the work: empathy, tolerance, acceptance of others, patience, good communication skills, vocation. They also mentioned self-knowledge, knowledge of human character, team spirit, conflict-solving abilities and the ability to satisfy needs. They argued for a psychological aptitude test before entering training, to ensure the selection for training of people with the necessary skills and aptitudes. Care workers need to be trained and the task of training is
threefold: the transfer of universal human values; theoretical knowledge; and practical experience.

6.4 Concluding comments
While certain specific types of knowledge are discussed, much of the discussion around care work among most of the frontline care workers refers to particular personal qualities, many concerned with the ability to establish good relations. Patience, a capacity to listen, responsiveness, flexibility are the necessary skills for doing care work according to them. This view of the necessary personal capacities for doing care work leads some workers to emphasise the importance of the life experience brought to the work and the value of ‘common sense’. What is noticeably missing is any reference to reflective practice, the capacity to think critically about the work, or indeed any reference to the value of theoretical knowledge.

This may also reflect the fact that many carers have come to the work later in life, after previous jobs and with first-hand experience of caring in their own families. But as expectations of the work change, especially the need for more and prior education, these views of what knowledge and skills are needed may also change. In Sweden, for example, there is a move to initial education being taken after compulsory schooling and to entry into the work at an earlier stage of the life course: the workforce is noticeable better trained than its English counterpart. Swedish care workers also mentioned medical knowledge, such as the necessity to understand the behaviour of old people, care knowledge including medication and conflict management. In the Swedish context, motherhood, as we shall see, is not a prelude to entering care work, but a role to be managed alongside a continuing employment career.

What kind of experience will be the best preparation for care work with old people? It might be questioned whether having small children at the same time as working with old people is the best preparation for this kind of job. Experience that is closer to the elderly person’s daily life might be more adequate; it might enable the worker to have knowledge about the elderly person’s present and earlier life situation and the capability to share the memory of at least some important life events. This points towards the ideal of a care worker not more than, perhaps, one generation away from a care receiver. This ‘ideal’ care worker has the period when her children were small just as a memory – something that can be shared with the care receiver, maybe together with talk about grand children. Perhaps, late entrance into work with old people, which as we saw in Chapter 3 is common, should be defended rather than criticised as out of date.

Another ideal could be that the caring role should be formed from the needs of the old people, not from the needs of the care workers.

The issue of immigrant workers, introduced in Chapter 3, intersects with a tension in discussions about knowledge and education in care work. If the work is seen as needing more education and professionalisation, then this will tend to exclude immigrant workers (unless they have transferable qualifications) and, more generally, it will close elder care off as a means of entry to the labour market for people with low qualifications. On the other hand, if more emphasis is placed on meeting labour shortages and using care work as a vehicle for welfare to work schemes, then this could reinforce the view of the work as of low status and innately suited to women, impeding attempts to improve levels of education and professionalism.
CHAPTER SEVEN: WHAT IS SOCIAL CARE WORK IN PRAXIS?

In this chapter we consider some other influences on care work with elderly people and its practice. We consider how the work is valued, by society at large as well as care workers. Does society’s valuation affect care workers and their view of the job they do? We also look at three dimensions of workforce diversity – gender, ethnicity and family life. Do men and women differ in the work they do, and if so why? How do workers respond to working with old people from different ethnic groups, and how do old people respond to minority ethnic workers? To what degree are employment work and family life inter-twined, especially when both involve large measures of caring? Finally, as care work becomes part of increasingly complex care arrangements, involving other services and occupations, how are issues of coordination managed?

7.1 The importance and images of care work

We return to the question of how care work is understood, looking at it here from some different perspectives. Care work is a complex activity, difficult to place in any box. We have already noted an extreme vagueness among English informants about the meaning of ‘social care’. This recurred when commenting on the content of social care. It was identified as ‘everyday care’, for example “talking to (elderly people) basically, and trying to get them involved in different aspects” such as attending day centres. Its meaning could also be defined by not being health care: “I have an image of what is social care as opposed to health care then, it’s about freeing people to do things for themselves, it’s about supporting them to do that in a holistic sort of way”.

Promoting independence is a current ideology in care services: “To me social care is looking after people and to help them maintain as much independence as they can”. The personal relationship was emphasised, to meet the needs of vulnerable people to maintain their independence. To help them function as best they can, in the circumstances in which they find themselves, different types of services are needed.

Social care is then for many English care workers extremely vague both as concept and practice. It can absorb almost any activity:

*It could be anything. It could be taking granny out, you know, as in socialising and taking them out.*

*[It’s] activities that enable people to function to their best ability within a community environment, to live in their own homes, to live within the community safety with a high level of self-esteem. Activating old people and make them visible. That’s movement, keeping the bodies moving, it’s keeping their minds occupied and thinking about something instead of both of them sitting in their flats stagnating.*

This lack of clarity about what social care is and what it means in care work with elderly people was complemented by the informants’ perspectives on the image their work holds in wider society. The image, most workers felt, was not good, with many people not understanding and valuing what the work was. Only a few English informants thought that the prestige and appreciation society gave to care work was equal to its importance. Although several informants said the image of care work had got better in recent years, far more typical was the comment “No, I don’t think it is as good as it should be, no, no”.
In considering the continuing low status of work with older people, the language used by English informants to speak about each other is itself revealing. The term ‘girls’ was often used to describe women workers who are typically in their forties and fifties. It is highly unlikely they would have used ‘girls’ to describe adult women in highly paid jobs or in positions of authority or, indeed, in their other roles as mothers and grandmothers: it is reserved for female children and adult women in low paid work. It is a diminutive, low status version of womanhood – and used by care workers themselves to speak of other care workers.12

In Sweden, most people interviewed thought society’s view of care work and in particular work in care for the elderly, is still not very high. They felt that most people think it is a low status profession, something which is reflected in the low pay and the negative images they get from the media and society as a whole. The images of care for the elderly shown by the mass media are considered by the workers to be very distorted, unfair and misrepresented.

One Swedish woman, a home help, stated that society’s attitude towards care work affects how she views her work in the home help service. “Am I just going to be an auxiliary nurse all my life?”, she says, which speaks of the low status that work in care for the elderly holds today. She looks at her work as not including especially skilled tasks. She makes comparisons between working as an auxiliary nurse in hospitals and in residential homes. She feels that it is not as stimulating to work in the home help service, but it suits her family situation at the moment. She has two young children at home and she wants to be able to spend a lot of time with them.

The Spanish material reflects some uncertainty about the social status of care work with older people. Many care workers drew an important distinction. They felt that caring work is highly valued by recipients and their families. But it is poorly valued in society: “They don’t pay as much as they should”. The value of the work does not show in the salaries, which are low. Moreover, many care workers do not find themselves respected. They feel they are often regarded as servants and as lacking any professional knowledge of their own.

In Spain, as in Sweden and England, working with elderly people is not a field in which youngsters want to work. In the Schools of Social Work, the subject of elderly people is not obligatory, and few students choose it. But the paradox is that, at present, this is the field which offers more jobs. The same is so for nurses.

However both English and Spanish informants felt there were signs that a change is on the way, that work with elderly people is being upgraded, becoming better known and appreciated. Evidence of this, cited by English care workers, included the introduction of national standards and expectations that staff will undertake training. However, this has yet to show itself in significantly improved conditions in the workplace, in particular pay.

This perception of low social status does not necessarily affect the value that care workers themselves attach to their work: society’s status and image of the work is completely at odds with their own view of the importance of the work. All the English care workers interviewed

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12 In Swedish, the term ‘girls’ (flickor) also has a diminutive association. The Swedish sociologist Gerd Lindgren has used the book title Doktorer, systrar, flickor, om informell makt (Doctors, sisters, girls, on informal power) to illustrate a hierarchy consisting of doctors, nurses and auxiliary nurses.
thought that the service they provided was important. Home care and intermediate care workers spoke of their ability to support elderly people’s wishes to remain at home, and their ability to relieve some of the ‘burden’ of caring borne by relatives. As already noted, workers referred to the benefits of a formal service for intimate tasks such as personal care: “some clients don’t like personal care to be done by family members”.

For English residential workers, the importance of their service was to provide a network of contacts and relationships for people who may have been lonely in the community or to offer a new lease of life to people who could not manage on their own:

> Many of them don’t have a family or close relatives. They couldn’t cope at home. They have given up. After a few weeks they suddenly start to blossom and they meet up with other people that become. It extends what they didn’t think they were able to do, they can do, and they are able to do that again with just the assistants.

Another theme in the material is that formal care unburdens the relatives from heavy caring obligations. All English informants thought the work was important for society, because without their services, families and communities would have to look after elderly people themselves or “where would these poor people go?” Most thought that their work was getting to be more accepted, but some thought they were still treated harshly by wider society. Some of them had a feeling “that people probably think that care workers are just sort of skivvies that do housework”.

7.2 “The care work without any result”?

Explanations by informants for why their work has such low social status varied, including the association of care work with no or low qualifications, invisibility due to lack of publicity, and the lack of promotion opportunities in the work. Historical reasons were proposed by some. An English informant explained the low status of care work in terms of its historic association with the workhouse and the stigma that went with that residual approach to help from the community.

Other explanations have been offered in academic studies. Some have implicated the relationship between gender and care work. It is argued, for example, that care work is devalued because it is done by women and because it is viewed as ‘only’ requiring certain qualities and experiences that all women have. Care work, in short, is essentially women’s work (for further discussion, see Johansson and Cameron, 2002).

Others have sought explanations from the standing of the ‘cared for’ and how society constructs priorities. Old people’s health and care are not given high priority. Wæreness (1980) understands this valuation through classifying what she defines as care work into three categories. In the first category she counts care work that can be related to growth or some outcome – a result. Work with children who are going to be grown ups and assume responsibility for themselves is one example. Another is adults who can rapidly go back to employment after illness or injury. The organisation of the acute wards in hospitals will be the ideal arrangement for taking care of those patients, with high costs and the need for a highly qualified staff. In the second category Wæreness counts care for people that aims to maintain the status quo, for example treatment of people with disabilities or chronic illnesses. In the third category she puts care work that is tied to decline. The clearest example of this is care work for dying persons.
Wærness states that care work characterised by maintaining the status quo or by decline will be expected to take place in the private sphere. But as such care takes time and the resources in families are insufficient, institutions are often needed. Wærness finds that these institutions often have difficulty in recruiting staff and therefore have to recruit workers with little or no education, who may look upon the work as casual.

The situation in Sweden today – probably replicated in other countries - provides an example of Wærness’ contention. Working with old people is not what youngsters have in their minds when they think of their future careers. For a social worker, higher value is placed on work with young people; working with drug addicts or alcoholics has an especially high status. Within health-related professions, work with middle aged and people who are still employed will be more prestigious than working with old people. Elder care offers job opportunities for many members of these professions – but, for example, only a few students in physiotherapy mention geriatric care as the first choice for work after graduation (Öhman, 2001). Most students in physiotherapy, especially the men, want to work within sports medicine.

Faced by such evidence, Wærness’s concept, Den resultatlösa omsorgen (Care work without any result), has come to be a challenge to make this work, seldom mentioned in scientific journals or reports, visible.

At the same time, it is possible to see that the value attached to care services changes over time, not only because of changing social conditions but if care services become more widely available and gain a good reputation for their standards. We saw in Stage One of this project how this has occurred in Scandinavia with respect to services for young children (Moss and Cameron, 2002). But the same applies to services for elderly people; the importance of this work is now well established in Scandinavia, and it has been possible to show how public recognition of the work has also changed over time (see section 5.2.4).

However it needs to be added that whereas services for young children have moved to being universally available, at least in countries like Sweden, the same is not true of services for older people. Indeed, as already noted, far from being universalised, there has been a tendency in Sweden to concentrate publicly-provided services on a diminishing minority of elderly people with high levels of need.

7.3 Gendered expectations
Care for the elderly has a history of being a female area of work in which traditionally female tasks are emphasised. The Swedish ethnologist Bergh (1995) has investigated the gender division of labour and attitudes towards this among staff in the Swedish home help service and in sjukhem (nursing homes). He concludes that there are differences when it comes to work distribution between men and women in care for elderly people and that this work distribution is most apparent in the home help service. So when the practice of a profession takes place in a private home, it results in a greater difference in the tasks done by women and men. In a nursing home, the distribution of tasks by gender is not as obvious, as the work there is not as influenced by gender as the work in people’s homes.

One explanation that has been put forward looks to traditional work distribution and expectations among older people - but also among the staff. When it comes to home help work, it is possible, to a large extent, for the old person to decide what gets done on a particular day. Views on male and female home helpers’ ability to carry out work in the home
are strongly influenced by ideas about gender. This may, so the argument goes, act as a powerful influence, affecting what the home help workers are asked to do by elderly people in their homes.

In the Swedish interviews for this study, questions were asked about whether there is a difference between what tasks are carried out by men and women. The most striking thing in the material is not, however, that the tasks are that different, although some people do express that view. What is most pronounced is that workers say that there are strong preferences from the old people themselves regarding who takes care of their personal hygiene, either a male or a female member of staff. By contrast, care workers say that they do not place nearly so much importance on gender (though part of the reason may be that it can be thought of as politically incorrect to distinguish between male and female workers).

It is perhaps obvious that personal hygiene, body work, is the issue that makes elder care as a gendered system of special interest. The interviews dealt with this issue. A scenario question was asked:

An old lady does not want to be showered because she does not want to show her naked body. What do you do, how do you react?

The answers delivered by Swedish care workers were, to a large extent, about making sure the old person receives help from the person by whom she or he wishes to be helped (if there are preferences). One way of doing that is simply to let the shower wait for another day. Maybe the old person is not feeling very well that day or has something else that is taking up a lot of their energy. Another way can be to change the member of staff that helps with hygiene on that day. Many people thought that the problem was just about the relationship with a particular member of staff and that is why a change would be made.

In England, responses to the same scenario also indicated a sensitivity to old people’s preferences. There was a need for male as well as female carers in order to offer choice to users/clients/residents about the gender of the carer involved with intimate care tasks. One residential home had a ‘gender specific policy’ in which residents were bathed by workers of their own gender; moreover (and reflecting high concerns about risk and its management in England), no one was allowed to bathe by themselves for ‘safety reasons’.

Other than this, nearly all the informants said they would try and offer a carer of the same gender if the elderly person wished this. In one case there were no male workers, but the informant thought she might try to enlist a male relative if that was wanted. Ten of the informants said they would try to persuade a user to have a bath, sometimes over repeated visits, reassuring them that they had ‘seen it all before’ and promising them they would ‘feel better’ for it afterwards. If persuasion failed most informants said they would offer to give the person a strip wash. One care worker said he would say “do you mind if I clean your head, face, armpits?” Two said they would respect the clients’ wishes, inform their manager and leave it at that, and one of these workers raised the issue of age difference as a further barrier to finding an acceptable person to help with bathing. She said some of the clients found a significant age difference, such as a generational difference, to be embarrassing. Other strategies were to make use of call system located near a bath, and to arrange a large bath towel next to the bath so the user did not have to be alone, but his or her modesty was protected.
In Spain, another gendered pattern can be seen in response to questions about male care workers, who are still a rarity. Men are talked about as useful in situations when physical strength is perceived to be needed, an attitude experienced by this male worker in a residential home.

*Q.*: Do you think that it is a problem that most of the workers are women?

*No, I think that it’s a problem that there are so few men.*

*Q.*: Why?

*Because sometimes your colleagues say, ‘hey, Sergio. I’m not very strong’. I have some strength, but I’m not a man who is one metre eighty tall and weighs 80 kilos. But sometimes you realise that they are calling you to ask for help with something. On the first floor, there is an aggressive Alzheimer case, well yes, I can shower him much better than my colleagues, simply because I raise my voice and Eric doesn’t hit me because he seems to have a little more respect for me. I’ve also overheard my colleagues talking, for example there is a fairly strong man who is schizophrenic, and one day they said that it’s better to send Sergio because he seems to have more respect talking to a man.*

Care work here is discussed in terms of what men and women with experience of traditional gender roles, such as physical strength, can contribute, not in terms of any special kind of knowledge needed to improve care work. The ‘traditional’ man is wanted to add an extra dimension to care for the old persons. How realistic will it be so find such men?

### 7.4 Women’s gainful employment, family life and social care services

Women are the main caregivers in paid and unpaid care work: care work practice might, therefore, be enmeshed with the care demands of family life. This was very apparent in England. Care workers spoke of a blurred, indistinct division between paid work and family life, including unpaid care of relatives. Very often, it seems, caring is a ‘habit of mind’ or a life-style that shapes the person’s outlook on life and perception of their skills and habits. Blurring and overlap between home and work can take a practical form, such as for those workers for whom part-time care work enabled them to fit employment around family responsibilities, or for those who live with or near elderly parents and whose daily routine involves caring for them. Blurring can also take the form of beliefs about life and work being united. The extended family can for some care workers become an ideal. The worker’s life is family life, and work is drawn into the area of family. Family life and care work have similar values and patterns.

The knowledge and skills of the English care workers were often used as a resource by wider family members. This is another example of an overlap between paid work and family life. The care workers are often asked for advice, particularly about the health of and benefits for elderly relatives. These processes give the care workers a special status within families. The care workers are in a sense positioned at the centre of a web of contacts, bridging the private world of the family faced with a care problem and the public world of services. They can informally assess the problem, they are likely to know what is available locally and can bring in services to relatives where they are needed.
The Swedish material shows a very different pattern: work and family life have come to be strictly divided. There is a long tradition of dual breadwinner families, and this has been accompanied by a strong societal supply of childcare and other care services. This means that at least two generations of women now have the experience of combining paid work and family life, which has in turn affected the way of organising the boundaries between family life and working life. At the same time, the Swedish trade unions have also worked hard to create a clear borderline, as well as to remove an attitude of care and nursing work as a vocation. This traditional attitude leads, it is felt, to an acceptance of care work as something performed for purposes not possible to negotiate in terms of payment and work organisation.

Part of this work for change has been an argument that care workers should not create close relations with the older people with whom they are working. This ideology towards care work was specifically developed during the 1980s (Szebehely, 1995). In this decade, the educational level of the vårdbiträden (home helpers) was raised and teamwork became standard procedure. Decisions about old persons were to be taken within the framework of the team. There was an attempt to avoid overly personal relations with the elderly. During this period, too, efforts were made to make the work more attractive and to increase its status. Home helpers were given greater influence over their work and the idea of autonomous groups became widespread (ibid.).

Arguments against this so called ‘professionalisation process’ have been raised. The creation of a distance between the vårdbiträde (home helper) and the care receiver is seen as being at odds with important elements in the theory of caring (Wærness, 1995). Current elder care in Sweden is not guided by such ideology, and there are signs that care workers are unwilling to keep such a distance (Ingvad, 2003).

To conclude: in England, the division between work and family life for many female care workers is blurred while in Sweden the division is stricter. A simple conclusion would be that the pattern found corresponds well with what you could expect from the analysis of Anttonen and Sipilä (1996). The Scandinavian model, with a large public care sector, can help women workers to balance the contradictory expectations from the two arenas of employment and family: it is underpinned by a strong ideological commitment to high labour market participation by women and an expectation that women will keep employment and family life separate. In other countries, like England, far more responsibility falls on women, and their families, to find ways to manage these two arenas, through for example ‘flexible’ working hours and reliance on relatives to provide childcare: employment fits around family life and is much less readily separated off. As in the example above where trade union rhetoric was found contradictory to work place praxis, the official way of talking about the relation family-work obligations also can be contradictory to the way single persons experience and handle this relation in daily life.

### 7.5 Work organisation and family life

In England, the co-ordination of employment and family life sometimes becomes problematic: the demands of care work are often unpredictable and the care worker can be called to work at short notice. Those with management responsibilities could be telephoned at home at any time. Such interruptions at home sometimes created problems in family life, when the family has decided to do something else or if the telephone rings at uncomfortable times. One part-time worker with senior responsibilities said:
My senior or team leader role can be a bit of a nuisance at times if the girls phone up and I am doing something, as in dishing tea up. Because we have a set time that we do our tea in the evening. I mean they can phone me up at six o’clock in the morning, and my husband will moan because he has been woken up.

Three informants said they had cut their hours in order to ease such difficulties at home. One of them said:

Q: And does your work create any problems in your family, either practically or emotionally or...?

Not so much now. It used to, because of the hours I had to put in, the phone calls I get out of hours.

Q: So when you are at home you can be rung up?

Yeah. I am on call twenty-four hours a day, seven days a week.

Q: And what kind of problems did that cause?

Um, it is when you want to go somewhere and your husband’s all ready to go and you say you can’t go. Or, you know, it is seven o’clock in the morning, on a Sunday morning, and everybody wants to lie in and my phone is ringing. It is like that.

Q: It is disruptive?

Yeah.

A second said she realised she would have to give up senior responsibilities when her daughter began answering the phone for her.

When my daughter sat there with a pen and pad and said, ‘good afternoon, can I help you?’ Right your carer hasn’t turned up, OK I’ll ring you back in 5 minutes and I’ll let you know what’s going on.’ And she puts the phone down and then she goes looking through paperwork and then she rings up and says ‘you know, I’ve had a word with the carer she’s just delayed, she’ll be with you shortly.’

Another five workers, two male and three female, said their wives and husbands just accepted the long shifts and the weekend work entirely. One husband went fishing while the informant worked weekends, knowing they would have time together the next weekend, while for the other it was ‘part of the deal’ when they met. One female worker said the work was only possible because her children were almost adult. She thought the shift work would not be possible for someone with younger children.

[It’s] the time of the shifts. If you had a child at home and they had to go to school you wouldn’t be there to take them to school and get them ready for school and you wouldn’t be there to pick them up or be there when they came up so.
The Spanish material similarly shows work obligations often interfere with obligations towards family members. On the other hand, as we have already noted, work with elderly people is one of the available options for adult women with caring experience, who want to return to the labour market after having had children, especially in the event of divorce.

In contrast to Sweden and England, a Spanish person can have financial obligations towards their parents, which makes the dependency between the generations more than just the moral obligations to care for their daily life. Solutions may have perverse consequences, shifting the cost of caring indirectly on to the health system, as this care worker explains:

> For example, my mother is ill and I work. What can I do with my job? The answer is to take leave. The doctors tell me this. Many people take leave to care for a relative. It isn’t just a fictitious sick leave due to depression; the doctors sign people off when they’ve been told they can’t work because they have a sick relative. What else can they do? If the socio-healthcare co-ordination is not arranged based on a very clear picture, we are kidding ourselves because the healthcare system is paying for the carer. This is the reality. This is the picture. When the healthcare system allows the leave, what can I do, I have no way of disagreeing. If you can’t work any longer you go to the doctor, you tell them that you can’t and it’s true. You can’t, how do you do it, work, family, etc. Or you stick with it and maybe in the long term the leave will be much longer.

In Sweden, many of the practitioners interviewed work on a flexitime basis, i.e. the staff decide their working hours themselves as long as they meet certain conditions, such as doing a particular number of weekends or evening shifts. Many informants considered this to be a major advantage of working in care for the elderly.

Other Swedes emphasised the family as a source of support at difficult times and after particular events that take place during the workday, e.g. if they have watched a person dying or had a hard day in some other way.

> Q.: Do you think it’s hard to combine this care work with family life in particular?

> No, well sometimes when something is weighing you down at work. At times like that, they notice at home that there is something going on there. Sometimes you have watched over somebody who’s dying. It’s different how much you connect to people. It’s inevitable. Of course, sure, things like that or if sometimes you get really pissed off too. But apart from that, I leave work at my workplace actually.

In the extract above, the woman describes how the work may occasionally be hard to totally leave behind when you leave for the day. The relationships with the old people, certain special old people and how they are doing can affect how members of staff feel. One reason that the work is trying and affects family life is due to what might be called ‘the meeting’ (mötet).

### 7.6 Working with people from minority backgrounds

Informants were asked what experiences they had had of working with old people from minority ethnic backgrounds. Ethnicity was only discussed in a few Swedish interviews. Most people interviewed had no or little experience of working with or caring for someone with a different background than a Swedish one.
Eleven of the 16 English care workers had no such experience (reflecting, in part, the high concentration of minority ethnic groups in just a few areas in England, as well perhaps as the relatively young age of some ethnic communities). One had experience of working with Asian co-workers as night staff. She disapproved of this, saying the workers concerned did not have sufficient English language skills to understand users’ requests, and during the night there were no other staff members to help out.

Even workers with experience of working with elderly people from minority ethnic groups (all from the urban location) said they had cared for only a few. Issues raised about care work with people from minority ethnic backgrounds were sensitivity to body language, communication and language, religion, culture and diet.

In all the three countries there were minority ethnic care workers, even if there are considerable national variations in which groups they were drawn from and the migration history of those groups. In Sweden there is a long tradition of immigrants from Finland working in social care services and health care, while large-scale immigration from other cultures is quite a new phenomenon. The two other countries compared have a much longer tradition with immigrant workers.

The issue is not just how workers behave towards old people from minority ethnic backgrounds, but also the attitude and behaviour of elderly white people to workers from minority ethnic groups. The one black worker among the English group interviewed, when asked about the way care work is valued, recalled an incident when he was racially insulted while at work:

> he said ‘you black bastard, you must think twice before you attend to me’. It doesn't bother me. It doesn't make any difference. The following day he apologised. I said ‘my friend I'll teach you a lesson today. You see the two of us can go and stand in there in the snow, you know what? The snow will fall on me because I'm different in colour, it will not fall on you’. He looked at me. I said ‘Yes. Life is one, the colour is zero, the end is we shall all die. Not that I want to die but one day we shall all leave this world and so what is the problem?’ So we have become good friends nowadays.

This particular care worker was resilient: he was mature in years, had professional education in two areas (nursing and teaching) and was a lay preacher. He had intellectual, religious and moral strengths which enabled him to deal with personal insults. But this was not always the case. Here a Swedish carer in a residential care talks about how an old lady has been very rude towards a member of staff with dark skin. This lady had a disparaging attitude and was aggressive in her manner. This has had an insulting effect on the affected member of staff and caused disturbance in the whole group.

> Well yes, they become shy, oh yes, and we have those who are different towards people with dark skin, huge problems...

Q.: The old people are prejudiced, you mean?

> Yes, but of course, they are fairly ill so you don't ... if they have been subjected to something before, when they were healthy, unfortunately we don't know that.
Q.: No, but it happens too then that they react against men and against people who are coloured?

I was thinking, we have a lady here who has been on bad terms with and very, very rude to girls with dark skins who work here, that girl doesn’t work here anymore, but she was rude (pause) about “blacks” (speaks quietly) oh yes, oh yes. “You can, you can wipe the floor down here instead,” when we were going to help her out of bed, “You can do it.” I mean she was one of those...

Q.: She considered that person as somebody of a different value?

Mm absolutely, yes! Sure. And she was very angry, we were not allowed to help her and that meant that...

Q.: So how did this girl react?

Well, she took it well and we have actually sort of tried to talk to another girl that started to work here later, you know in order to let her know in advance and not be bothered and that kind of thing. But she did get very, very hurt and well she’s been nasty to other people too, so that, but you do understand, that even the one that said that it doesn’t matter, you could tell that she was upset.

From Spain there are also some reports about complicated relations, even if the language often is not a problem, since many immigrants come from Latin America and speak Spanish as their mother tongue: “No, we haven’t had any problems. Our language is the same; even culturally there aren’t that many differences when caring for the residents.” One problem is the care worker who is an illegal immigrant without any papers. People with no papers cannot be hired because homes and other services have to adhere to certain regulations. Staff have to be on the payroll and payable.

We don’t work with them if people don’t have a contract. They might be very enthusiastic and well prepared but they’re of no use to us, we can't use this group of people.

This group has no professionalism at all, they arrive in the country looking for work, you offer them something but if they find something slightly better they disappear overnight without any sense of commitment whatsoever.

However immigrant workers without papers are often found doing care work in the informal market, being directly hired either by families or else by private residential homes for elderly people which operate outside the regulations. At the same time, some legal immigrants have qualifications from their own country that are not recognised in Spain. In such cases, trained nurses have to work as geriatrics assistants, as is the case with one of the informants. Some informants, such as this trainer, also talk about socio-cultural problems.

I mean problems concerning different ethnic values. I mean that there is an old person’s vision here and in other places which can shock those people; finding out that here people are much older and with unexpected problems, or even how disabled people are viewed in one place or the other. This is what you find and I
think that it’s a tremendous experience.

Although there was evidence of an awareness that special consideration was required for users/clients/residents who may come from minority ethnic backgrounds, there was no evidence of informants in general having trained to deal with insults directed at themselves or their colleagues. Nor was there an informed understanding of why it might be that so few people from minority ethnic backgrounds were using their services. Instead, in England at least, there was a common belief that ‘Asian families look after their own’ (research evidence, however, suggests otherwise, e.g. Atkins and Rollings, 1993).

7.7 Co-ordination and leadership
In all three case study countries, a range of services are now available for older people: the practice of care work is part of this larger picture. In Sweden home help can be combined with many other services and activities such as home health care, alarm systems, meals-on-wheels, daytime activities, short-term care, and transport services. A similar range of services can be found in England and Spain – though to a lesser extent in Spain and sometimes still only as pilot programmes. But as the number of professional groups within the health and welfare sectors have increased and become more specialised, there is an increasingly important issue: how this multiplicity of services is coordinated to ensure old people get their needs met. We can expect that the co-operation and the co-ordination between the different groups varies between the countries, and that how this happens in practice may say something about what is important in social care work and about the content of the daily care work.

As we have already seen in Chapter 2, the 1964 reform in Sweden gave a new importance to staff management, one reason being the perceived need to bring about contacts between the right people (Szebehely, 1995). More and better-trained supervisors with increased authority were established from that time with the mission to become the leaders – for social guidance and standard setting - within social care organisations. Leadership became a core area of knowledge for this newly formed profession of the middle manager. The role of the supervisor was professionalised in the sense that it was distanced from the recipient, with more administration and standardised services, while the possibilities for elderly people to influence matters were diminished. The role of the middle manager has since then shifted and become more complex.

One factor that makes a very clear difference between Sweden and other countries in the study is the role of the biståndsbedömare or hemtjänstassistent (middle manager) in the social care organisation. During several years there has been a special 3 to 3½ year education (social omsorgsutbildning) for this position, an education now proposed to be integrated in the social work education (socionomutbildningen) (see section 5.2.1). The biståndsbedömare or hemtjänstassistent makes an assessment of needs, and is delegated by the social welfare committee to decide on what kind of help and assistance the old person will receive, how much and how often. This middle manager in social care is not described as a social worker, indeed not much need is felt to seek advice from a social worker outside the organisation: indeed, social care workers are wary of social workers, associating them with work with marginalized and deviant groups. Responses to the questionnaire by Swedish care workers point to the importance of collaboration with physiotherapists and occupational therapists.

In England, by contrast, care workers accord social workers the most important role in coordinating services for older people. This probably reflects the key task of social workers, renamed ‘care manager’ in the 1990s, in assessing, costing and organising the delivery of
’care packages’ for older people. District nurses are also frequently mentioned. Can we say that English care work is more grounded in a social orientation, while the Swedish is more grounded in a health orientation? Or are there other factors behind the difference in coordination and leadership patterns?

The importance of coordination is increasingly recognised in Spain, as this trainer reports in her interview:

If I want to compete as a social worker with somebody from nursing, a thing that for whatever reason has happened in the centres at some point, I won’t be caring properly for that person because there will be no collaboration. This is where I’ve felt a change because the carers are better prepared in the field and they’ve been able to modify their attitudes, and in doing so they’ve changed the theories learnt because they’ve realised that times are changing and that the stuff they’ve learnt has been useful as a basis, but now it’s time to formulate new ideas… It’s a form of recycling, so to speak, and I’ve seen it a lot. I’ve also seen caring attitudes among lower grade professionals who realise that their professional aim is not simply washing and feeding but, even if this seems old-fashioned, that the person cared for is a biological, social and spiritual being, and if we want to provide such a level of care, we obviously have to modify ideas and attitudes.

At the same time, lack of resources and the involvement of different levels of government can militate against older peoples’ needs being met.

There would be technical help given by the family programme, but the councils also provide technical help, and if we want to complicate the benefits more, we can include the health system. They give you the health system, for example in Barcelona, under the programme “health at home”, they give you a nurse, a medic and a social assistant. This was established in the poorer areas because the doctors didn’t want to go to the houses. But in the good areas it didn’t make sense, they had to go to the doctor. If the citizen enters the system, they have a doctor, nurse and a family worker goes and evaluates what’s necessary. But if I need a family worker, an orthopaedic bed, tele-assistant etc., you have to go to social services for primary care. One is the Catalan government and the other is the local administration. I go to the council and I tell the lady that I need this, but the council has to prioritise the requests for resources. The health system is a right and I don’t understand this, I don’t understand why we have to wait. Here it isn’t a question of whomever needs this gets it, you have to evaluate the case, the economic questions and prioritise. When many cases come here they continue without anything, and they have to turn to private resources.

In the Spanish national report there are some indications that the co-ordination of care services will be improved. But this Spanish regional policy maker, at least, reflects a current state of uncertainty about how this may come about.

At the moment, honestly, I don’t know. Since the social services have been producing a study, there has been the idea of co-ordination; this idea will have to be followed through because if they are going to ask for it, it is felt necessary but I think that at the moment they are still doing the study, I don’t know if there
will be more assistance or more co-ordination. I can’t tell you because I don’t know, I have asked but it’s difficult with the social benefits that are given at government level directly to the citizen. Betting on direct help to the citizen would be a mistake for me except if they established a good system. With a badly introduced system, the money would be wasted; the money would be wasted if you didn’t know what to buy. For example: we give you X amount of money to go to the theatre, but there isn’t a theatre, or you don’t know where the theatre is or which theatre it is. I see it as being a little disorganised.

7.8 Abuse and neglect

The discourse of risk and risk management has encompassed care work practice as much as other aspects of society. We have already given examples: care workers not being allowed to undertake certain tasks, such as cutting nails, and strict regulations about lifting. Here we consider another aspect of risk.

Abuse and neglect of elderly people whether in their own homes or in residential care has recently become a policy issue in England. Government Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse states that: “In recent years several serious incidents have demonstrated the need for immediate action to ensure that vulnerable adults, who are at risk of abuse, receive protection and support” (English Department of Health (2000) Care Standards Act 2000). Local authorities are responsible for ensuring that incidents of abuse and neglect are prevented so far as is possible and that there are effective interagency procedures to deal with incidents if and when they occur.

The Guidance recognizes that “the circumstances in which harm and exploitation occur are known to be extremely diverse, as is the membership of the at-risk group” (ibid.: para.1.2). For example, it states that “vulnerable adult(s) may be abused by a wide range of people including relatives and family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit vulnerable people and strangers” (ibid.: para.2.10). There may also be a power and control dimension to the abuse. Similarly, abuse and neglect can take place in any location: “It may occur when a vulnerable adult lives alone or with a relative; it may also occur within nursing, residential or day care settings, in hospitals, custodial situations, support services into people’s own homes, and other places previously assumed safe, or in public places” (ibid.: 2.14).

As a consequence of this Guidance, practice procedures in the field of abuse and neglect of elderly people have had greater visibility than previously and the responses from informants reflected this. All said they would report suspicions of abuse or neglect to a manager and either they or their manager would report it to the local authority Social Services Department who would investigate further. They also indicated that a culture of suspicion of possible abuse by care workers existed. New workers were advised to report immediately any marks.

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13 Abuse and neglect of children has been a policy issue since the early 1970s.
14 Government departments issue guidance to local authorities as a method of setting out central government policy on a selected issue. Local authorities (and Social Services Departments within local authorities) act under the general guidance of the Secretary of State (government minister). Guidance does not have the full force of statute, but should be complied with unless local circumstances indicate exceptional reasons that justify a variation.
they made on elderly people while lifting or moving them, as a precaution against accusations.

An English policy informant who had responsibility for ‘adult protection’ at a national level said that elderly people were vulnerable to abuse and neglect in their own homes as well as in care services, but that evidence of the extent of the problem was difficult to document:

*There's no evidence that there's a sort of massive amount of sexual abuse going on and things like that but there is a feeling that there's a certain level of abuse going on that we don't know enough about, or anything about, particularly around financial abuse and emotional abuse.*

This policy informant thought there would continue to be a need for robust recruitment measures in elderly people’s services as well as in children’s services to protect users from unscrupulous people or abusers entering the employment of care services. Two measures involve checks of new recruits against data bases: the Criminal Records Bureau and a Protection of Vulnerable Adults List, which is a nationally available list of those people who have been convicted of an offence against adults and should not be employed in care services.

In Sweden this has also been a political issue since Sarah Wägnerts, an undersköterska (auxiliary nurse), unmasked neglect of an old woman at Polhemsgården, a centre for old people with dementia in the municipality of Solna. After this scandal a new regulation was written in the Act of Social Services (2001:453), the so-called ‘Lex Sarah’. It requires persons employed in social care for elderly and handicapped people to report serious cases of abuse or neglect to the social welfare committee of their municipality or, if employed in a private enterprise, to the responsible person about serious cases of neglect or abuse. This regulation aims to strengthen the protection of the care recipients. The County Administration Board is the supervising authority. Since then several cases of neglect and abuse of elderly care recipients have been reported.

Several informants in the Swedish study discussed various actual cases of old people who have been poorly treated, and said that often only part of the truth comes out. Newspaper reports about what a boring time old people have and that staff steal from and neglect old people give a partial picture. Stealing goes on throughout society, so why should it not happen in residential care homes, one male worker asked. Another male care worker, from a residential home with special services, reflected that when you work close to each other, as you do in housing and care for the elderly, it can happen that you lose your temper. Of course this should not lead to neglect and bad treatment but he thinks that relatives and other people do not always understand what it is like working with old people suffering from dementia.

*Yes, there are such an incredible number of places that provide care for old people, so it would be very odd if there were never any bad conditions and bad treatment and...Well I’m sure you watched that programme where they followed up on that case in Gislaved*15. Did you see that programme?

**Q.** No, I don’t know if I saw that programme.

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15 Two care workers physically abused an old woman with dementia. The son of the old woman had placed a tape recorder in her bedroom and the record was broadcast out over Sweden.
OK, but you’ve heard about it, haven’t you? I didn’t watch it myself but I heard people talking about somebody that really tried to put these problems into... But when I first heard about it, it did sound bloody awful, but then you also got the idea that there was something else. That there was abuse in the background, but I don’t know if that has been established so I suppose it was a case of somebody who...There was somebody who lost their temper and I think that’s a bit like when you lose your temper with your own beloved young child. I mean how reasonable are people who blurt out loads of stuff.

By this, he means that a slanted and unfair image of care work and care workers was being presented in the media. Something else must have happened prior to the critical situation of mistreatment that occurred in Gislaved. Furthermore, he thought that journalists have managed to create a dark and negative image16.

As in England, it has also been reported in Sweden that some persons entering employment in home care services have a criminal background and have stolen money and valuable goods from old persons with dementia. A demand has recently arisen for checks through the Criminal Records Bureau of new recruits in the same way as when recruiting childcare workers. Research by Swedish researchers shows that knowledge about abuse and neglect of old people is an important issue (see for example Tornstam, 1989, 1994; Eriksson, 2001).

7.9 Hungary
Most practitioners consider that they can reconcile their work and family lives; only 2 find this hard to do. The support of family members – partners and relatives – and friends is important.

Practitioners generally would welcome more male workers, especially in home care and residential care. The reasons for this are strongly gendered. The need was seen as less important in day care centres, as these services are regarded typically as a service for women; male workers would be helpful in working with men in home care or institutions. Informants talk about needing male workers because of their physical strength (e.g. in lifting or bathing) and their assumed ability to perform tasks around the home such as chopping wood or gardening. Female care workers thought that a combination of men’s breadwinning role and low wages in the care work make it unlikely that many men would enter the field.

There was a widespread view – not only from practitioners but also trainers and policy makers – that elder care work has low social status and recognition. It was felt that many people equated care work with work performed by domestic servants, while the work itself and the courses for training care workers were not widely known. Although the recent substantial pay rise has contributed to practitioner’s self esteem, the poor financial situation of the elder care sector was seen as linked to its low social standing. This was not just a matter of low pay, but also the poor physical condition of many institutions and other work environments.

7.10 Concluding comments
This study gives support for Wærn’s theory that persons from whom you cannot expect any improvement in health or social abilities (‘care work without any result’) are also low valued in society. Fewer resources will be spent on them. As a consequence this will also bring low status to the work with those persons. In all three countries elder care work is reported as a

16 There is a discussion going on in Sweden about how the low status of social care and social care workers makes it impossible for them to protect themselves from unfounded accusations.
low status sector. A further reason that some think may affect the social standing of the work is an emerging public awareness of abuse and neglect of elderly people: in the case of abuse of children in institutions, this has tarnished the workforce – could the same happen with elder care workers?

Gender is closely implicated in the work. Most workers are women, and old people may often have strong views about whether men or women should provide them with care – or at least more intimate forms of care. Workers themselves, however, downplay the importance of gender in the work. Because gender and care in the family are so closely related, paid and unpaid work may become enmeshed in various ways and the combination of both types of work may prove harder – but this is more likely in a country, like England, where there is a weaker tradition of women’s employment, gender equality and state policies premised on a dual breadwinner family. The wider policy context is therefore relevant to the experience and quality of employment.

Working with ethnically diverse communities will bring new challenges to work with elderly people, though so far these challenges may have received limited attention for various reasons, including the younger age profile of many groups and the concentration of these populations in relatively few areas. The issue of working with ethnic diversity cuts two ways: how the workforce relate to an increasingly diverse elderly population, but also how a majority indigenous population of care receivers relate to an increasingly ethnically diverse workforce.

The increasing diversity and complexity of services places a premium on coordination and leadership and a position in organisations with responsibility for these tasks. The orientation of such a position – towards social work, health, social care – is an issue.
CHAPTER EIGHT : WORK ENVIRONMENT

From the national reports you can understand that the work environments for home care and residential care workers differ. Not only do individual workplaces and working groups vary, but there are also variations between occupational groups and between countries. All English residential care homes have to meet certain national standards on the physical environment. Despite this, the issue of light and lighting was raised in study tours of some residential care homes. In nearly all residential homes, especially purpose-built ones, internal corridors were used, with only artificial lighting. These were often dark, and sometimes lights were kept turned off except when in use, or light switches were inconveniently placed for residents emerging from their rooms. In some cases corridors were a considerable length, and had to be negotiated by frail users with walking aids, with few opportunities to pause and rest on the way.

This was one example of tension between the needs of the workplace environment (e.g. for wide clear corridors for pushing wheeled trolleys and minimising risk of falls) and that of the living environment, where pictures on the walls and chairs or benches for resting would add interest and support to users. In contrast to that you can find the Swedish residential homes, which are not regulated by any national standards, are all very light - and just the same.

8.1 Working in an other person’s home
Home care workers have to negotiate working in someone else’s home. They may have to use specialist equipment or they may have to visit in pairs, sometimes known as ‘doubling up’, in order to lift a heavier person. Many ordinary homes have small rooms, and many elderly people have a lot of furniture. There may be times when furniture has to be moved in order to access the client. The policy for what can be negotiated and how can vary between the countries.

The main principle governing working in another’s home according to English informants was that of respect for the client and their history in the home. Two examples of problematic negotiations were mentioned. One was to accept different people’s standards of cleanliness, another had to do with moving furniture. The issue of risk was, once again, also involved.

In certain circumstances care workers request the involvement of home care managers. For example, in the public sector service in the rural area, home care workers were not permitted to move furniture on their own accord and, if this was needed, the manager would visit and negotiate with the client. This was described, by a home helper, as “a very delicate process. Because at the end of the day that is their home and that has probably been like that for thirty odd years”. If conflicts continued, the manager would do a risk assessment, which would also be done if there were trailing electrical wires or old electrical appliances, or if any other aspect of the home posed a risk to care workers, such as dark entrances or approaches, as is common in very rural areas.

The Swedish material also referred to differences of interest, or at least of view, between care recipients and the staff. Problems might occur when an old person did not want to re-arrange their furniture in order to accommodate the needs of the care workers. Workers describe how, in the end, they may have to move the furniture against the will of an old person and at the same time they feel powerless about their wishes.
Sitting room. Residential care. Sweden

Corridor. Residential care. Sweden

Public sector. Residential care. England

The staff members in the large city gave many descriptions of situations they have experienced in which they found it difficult to carry out their work in a satisfactory manner. The reasons are often because of where the furniture is placed and a home’s untidiness. Another problem with the homes of the care recipients is that the equipment that they need often takes up too much room. The bathrooms are small and the beds are in the wrong place or the old people sleep on futons, making it difficult for the staff and the old person to use the equipment the way they are supposed to.

### 8.2 Work conditions

#### 8.2.1 Work contracts

All but one of the English informants had a permanent contract of employment. On average, informants worked 35 hours, with a range from 20 to 60 hours per week, the latter being a care worker who lived on the premises. In addition, several of the informants said they regularly worked unpaid hours, or extra paid hours as ‘relief managers’.

In Sweden, all the people that answered the question were permanent employees. The Swedish female care workers worked, for the most part, full time with the exception of two women who worked so-called long part-time hours (more than 35 hours a week according to the people in question). Most of the people that worked full time stated that their working hours are approximately 37 hours per week, and, with the exception of two people, they also worked weekends and evenings. The men all worked full time.

All the Spanish residential carers interviewed had a permanent working contract, which is not very representative of the sector. But only the two family workers directly hired by a municipality had a permanent contract; the rest had temporary contracts and one of the male family worker was self-employed.

#### 8.2.2 Supervision and ongoing training

Most English informants said they received supervision from somebody, such as a manager or training supervisor, at least every 3 to 6 months, and four said they were supervised monthly. Home care workers had contacts with colleagues less often than residential care workers. All but one of the residential care workers saw colleagues on a daily basis, while this was the case for only half the home care workers. Residential and intermediate care workers also had more frequent contact with hospitals and medical centres, and with other residential homes, than home care workers had with other home carers.

Nearly all the care workers had regular access to journals, books and other materials, with only two saying they ‘never’ had access to materials for professional development. Nine of the care workers had participated in ongoing training in the previous 12 months, and employers had paid for this in all cases. Most care work informants were satisfied with the development opportunities available through training and staff meetings.

In Sweden it is the middle manager—termed the *hemtjänstassistent* or *biståndsbedömare* or *områdeschef*—who supervises the home helpers in their daily work. In addition, nearly all care workers participated in ongoing training, most often three to four times a year or according to demand, although fewer participated in conferences. Most of the informants had access to some written materials in their workplace: most frequently journals, but also books and other written materials such as policies and procedures. Satisfaction with training was generally good.
The Spanish care workers have a stated amount of staff training per year, which is regulated in some cases within the framework of social partners agreements, and in other cases employment promotion schemes. The implementation of new regulations on health risk prevention at work is contributing to an extension of continuous training about health prevention issues. One local family worker illustrates the subjects of such training.

*We mostly do courses on senile dementia; we’ve been to many. It isn’t just that, we’ve been asking for mental health courses for a long time because this is completely unknown to us. I think they told us that this year we would have them, once we finish the probation period. It’s just that there are only those courses on senility and we’ve been to so many.*

*We had a physiotherapist who would teach us how to move, how to lift the person, and we’d do some exercise. Then we had a psychologist.*

Some of the Spanish informants complained that they have to follow the courses partly in their spare time.

### 8.2.3 Work teams

Many Swedish care workers in residential homes consider that the working team is of vital importance for how happy you are in your work. Most people also think that their staff group is stable, i.e. there is a group of regular members of staff working together. There is a sense of security connected to the fact that you know each other. This sense of security means that you can “hand over” your elderly people to the next staff group, and know that they will be provided with good care and nursing by that following group.

But at the same time, many Swedish workers say that their services are understaffed, that more personnel are needed to cover the current needs. It is also a common occurrence that there are fewer personnel available to work over the weekends and as a result the staff cannot find the time to assist residents to take showers or to organise activities for the residents. There are substitute workers in all the units, hourly paid employees who work weekends and when the regular staff members are absent. During and around summer in particular, it is difficult to find these substitute workers and some say the problem is also that they do not have the authorisation to give out medicines. Consequently the regular personnel have to work more inconvenient hours, e.g. evenings. Home help service also experience difficulty in finding substitutes for summer and holiday periods.

Two Swedish staff members gave examples of what happens when there is an extra person who works a few hours a day, during which time this person is responsible for the kitchen. This person can, for instance, be someone who is doing work practice or who is off sick much of the time and for that reason cannot carry out the heavy tasks of working directly with old people. They say that it gives them a sense of security to have that extra person around because then they know that they can leave the residents, in the kitchen or elsewhere, and not worry about them hurting themselves or other people.

Not everyone though shares this view. Some care workers discussed whether they think the institution in which they work is under-staffed and think that having more people on the staff does not necessarily guarantee more efficient work. They are, on the contrary, of the opinion that this can result in more running about and that people, to a greater extent, think that other
people are going to do certain things - and in that way nothing gets done. They feel that you work better together if there are not that many people and that the planning, too, ends up better that way. However, at the same time, it is nice that there is a person who works four hours extra as it gives the regular staff a chance to do other things with the elderly people.

Swedish *värdbiträdén* (home helpers) also emphasise the importance of having a team to turn to in their work, in spite of the fact that this profession is often described as involving working alone. Besides, for some old people, two people are needed to assist the old person. This may be due to the need for heavy lifting or when a person is totally confined to bed. In those cases, you need two people in order to provide personal hygiene. Two people are also needed when responding to alarms in an old person’s home, when you do not know what has happened and it may be a case of a fall or even the old person dying in their home.

In the home help service, they complain about the team’s premises or the lack of them. One home help group lost their space in a building due to municipal reorganisation. Instead of their old premises, they now borrow a room in the village school for the hours they have meetings every week. The problem is, in their opinion, that they do not have a natural meeting place any more, there is nowhere to keep files and other documents. Another home help group stated that there are too many people in the group and consequently it is hard to get to know everyone. In addition, their premises are too small. They feel cramped when they have lunch and different working teams have different rooms, which does not create an open atmosphere and sense of community. Several people (both in the home help service and special housing) stated that the people who have worked a long time do not always have any energy for getting involved in important work-related issues.

Work teams also exist in the English elder care services, especially in the intermediate care services.

*Yes, yes. It’s, um, there are only five carers work here, so we are a small group so we tend to do it as an ongoing situation. We can also back each other up if somebody is reluctant to make you a cup of tea, we can all make sure that we encourage a skill, or this person to make a cup of tea, rather than one do it and one not do it.*

In responding to requests to ‘talk about’ the care that is needed, the emphasis was on formal systems of communication through care plans to ensure consistent delivery of care tasks, care tasks which had sometimes been specified by another expert (e.g., a doctor), as well as more informal exchanges with colleagues. There were no responses in terms of staff discussion or reflections on the meaning or the impact of the care service.

The work team, however, seems to be less developed in the English home care services. Many of the informants had worked with violent old persons or with persons with social problems. These experiences indicate that violent behaviour and other social problems, such as alcohol use, are common and can occur right from the start of care work jobs. In these situations a well functioning team should be very helpful. They also indicate that relatively little training and instruction is given to new or experienced workers about strategies to deal with these social problems, and that workers can be left to resolve problems or find their own ways of working with them. This highlights the complexity of care work with elderly people: it is or can be about delicate negotiations with individuals and about multi-agency work to try and ensure that appropriate help is available. The area of work that seems less developed is that of
working as a team *within* the home care and residential care services to diffuse the impact of violent behaviour on care workers.

In Spain teamwork was well developed in family work before it was out-sourced from local authorities to external private providers, that are now sub-contracted by the public sector. Now, in a framework of more market oriented home help services, there is much less time and opportunity for team work and this has been experienced as an important loss by family workers. Within the framework of residential care there is some team working - but not much time or space. The best experience of team work was reported by carers from a non-profit residential home, the worst by carers from a large publicly managed home. In the latter case, informants did not feel listened to as front-line workers, but were just expected to follow hierarchical directives without question.

8.2.4 The space for care work

A number of workers were dissatisfied with the accommodation available for old people in residential services. Most residents’ private rooms are of a suitable size and the dining room and communal areas are as well. But the older people using these services today have a greater need for nursing than a few years ago and this causes problems. The staff find that the toilets are not designed to cater for the greater need for help among current residents. It is hard to fit walking frames and wheelchair into those areas. The limited space in the toilets also causes difficulties because it makes it hard for the staff to assist people going to the toilet as you sometimes need to have two people and then it ends up getting even more cramped.

In addition, the premises are often on the wrong floor. Many old people would like to have access to their own patio, so they could go outside on their own to a safe area. Several homes have good balconies where the residents can spend time, weather permitting, but several places lack a good patio for the old people. Around the large Swedish city, the streets are hilly. This means that most old people are not able to go for walks. Then there are considerable differences in individuals’ health among old people sharing a residential service: some people are in a lot worse state than others and this can make the old people who are not so ill feel confused and depressed.

In the Spanish material you can find the issue of space for care work discussed from another, rather unexpected perspective, in the context of different standards between public and private care. A policy maker observed that there are also contradictions in the current situation.

*The majority of people who use residential care, don’t use public residential care. It seems that public residential homes are reserved for people of less means, they are the ones who use them. However, these services are usually of a better quality than the private residential homes where you have to pay. This represents a serious contradiction. The group that sets the values are people from middle class backgrounds (professionals, scholars, etc.), who have no access to good services. Therefore, they don’t create the need for professionals within the social work environment, such as having a psychologist or a relaxation space for the carers…although that exists in the public sector. Most relatives of service users who are in public institutions are not taken into account when a scale of values has to be built.*

Spanish care workers were mainly ‘quite’ satisfied with the working space. Nobody, however, was totally satisfied.
4-bedroom. Hungary

Activities Club for the elderly. Hungary

Common bathroom. Hungary
8.2.5 Stress
A recent Swedish study of care work (Michelsen et.al., 1999) found many examples of symptoms which indicate that persons working in caring occupations are often under considerable pressure, and experience many stressful situations. Stressful work conditions were related to illness and sick leave, but also staff turnover. Some were organisationally induced, arising from restructuring and down-sizing of care work in Sweden. In the work itself, low staffing levels, time pressure, high work demands and too short in-patient care were some of the difficulties. In the daily work with old people there are many examples of split work tasks, high demands, complaints from care recipients and their relatives, the experience of lacking competence and fear of making mistakes.

Stress is also an issue among the workers we interviewed. It is something that all of them experience, in all cases to a greater or lesser extent. The questionnaires that the Swedish personnel completed as part of the interviews reveal that most of them view their work as being stressful. Only three people out of 21 answered that they do not consider their work to be stressful.

As we have already discussed, lack of time was the most frequently cited cause of stress at work: 17 out of 21 informants mentioned this (see Table 5 in section 6.2). Eleven people stated that psychological demands are an additional stress factor, while eight and seven respectively mentioned low pay and heavy workloads. In addition to these answers to the self-completion questionnaires, workers talked in the interviews about the stress they experienced at work. Situations mentioned as stressful include: failing to achieve what you are supposed to, such as helping the residents; worrying that you have ordered the wrong thing for the kitchen or supplies; or when only a few people have authorisation to distribute medicine and they must ensure that everyone gets their medicines. Being under-staffed also causes stress, as it is hard to find the time to do your work in a satisfactory manner. It can also be stressful to work with someone with whom you do not usually work in that you are not used to the other person’s pace and way of working. During the day, different periods vary in their level of stressfulness, e.g. mornings and evenings are more stressful than lunch and dinner. Many people need help at the same time with their morning routines and when they are about to go to bed.

Four of the informants who work in residential homes in the more rural local authority also work in the home help service. The work in the home help service is viewed positively; the workers enjoy the change of scenery and feel they can meet old people with more energy however much help they need. Some people mention that stressful situations can occur due to the fact that time has to be found for both types of work – residential and domiciliary. When they come back, after working as a home help, it can sometimes be hard to know what the other workers in the residential home are doing, how far they have got in the planning of that day. So working this way can somewhat disturb the work of the residential home.

However, most of these four think that there is no pressure caused by lack of time. They do what they have to do and then return to their regular duties. There are also positive benefits with working in both ways. The home help work is a sort of visiting service, so that the workers actually know the old people in question if and when they later move into the residential home. One drawback mentioned is that the old people using the home help service see many different members of staff, thus staff continuity can be hard to achieve.
The Swedish staff highlighted the question of inadequate investment to improve staff conditions. For example, they wish that it was possible for them to receive work clothes and work shoes. In the home help service, there is a lot of walking involved, as staff often walk between homes. Sometimes they travel by bus when there are longer distances to travel. However, staff members have sometimes to pay themselves for their bus passes, which is considered to be a mean act on the part of the organisation. In the large city, the staff find that the districts in which they work are too big, which means that long distances have to be travelled: this causes tiredness and sore legs.

There are also some problems associated with work in the homes of old people. It may be difficult to carry out your tasks because of the furnishings and the lack of appropriate cleaning equipment. Many people on the staff say that the elderly people sleep on futons and this creates problems for the staff when it comes to making beds and cleaning.

Swedish workers mentioned that regular coffee breaks are hard to organise due to the nature of the work. Sometimes, there is little time for lunch. One reason is that it is hard to plan breaks when you do not really know how long the work at each pensioner’s place will take, which in turn depends on how the old person is doing on a particular day. There is also too little time allocated for getting from one person to another. The help assessors have not, according to one informant, understood that it takes time to travel between the old people.

The management of this service is considered to be disorganised, with the staff having to bear the brunt of this in the sense that they do not have sufficient time for breaks. Frustrations like that create stress. This points to the importance of good management: an open and sensitive director is a very important factor as regards general comfort and well-being at the workplace. More generally, the quality of the working conditions, and to an extent the level of stress, depends on whether there is a clear structure and plan for the running of the place, according to the Swedish workers.

One interpretation of the Swedish complaints is that the ambitions of the care workers are too high in relation to the resources available.

English informants reported high levels of physical and mental demands at work. On the self-completion questionnaires, 13 out of 15 stated that care work was either ‘very demanding’ or ‘quite demanding’ physically, while 14 out of 15 reported that the work was either very or quite mentally demanding. Only one of the informants, working in a private sector home care service, did not consider her work to be stressful, although one other both indicated a cause of stress in his work, but then said he did not consider his work to be stressful. Main causes of stress at work – as in Sweden - included lack of time, low salary and psychological demands. Altogether 60 causes of stress were mentioned by these14 informants.

Few benefits were received in addition to salary. The most commonly mentioned was clothes for work, and mileage allowances for those working in home care to travel between clients. Two informants mentioned pension schemes under ‘other financial benefits’ but it is not known whether this was an option or an automatic employment benefit for other informants.

Care work with older people is heavy work and complex work: it can be physically and mentally (and emotionally) demanding. In the Spanish interviews, we hear of staff who have been chronically ill because of slipped disc, pulled muscles and other back problems. The back problems can be related, among other things, to inadequate beds that make it difficult to
move old people. It is important to work with belts when moving people, and if belts are not used there is a risk that both the patient and the care worker are hurt. Walking a lot can also tire the care workers.

8.2.6 Work schedules
Most Swedish staff were pleased with the arrangement of their work schedules and their possibilities for influencing it. Most of them work every third weekend and some every other weekend. The possibility to influence your schedule is said to be of vital importance in the home help service, in that you can decide for yourself what your work should be like or at least be able to influence its structure. When stress arises in this area, it is connected to the fact that there is often a shortage of staff. This means that the workers in post have to take on a lot more extra work and this reduces the time devoted to each individual old person. The home help service could use more employees.

Even if employees and trade unions are satisfied with individual work schedules that seem to meet everyone’s own preferences, social researchers have criticised the system. On the negative side, it is argued, there is a tendency that women in female dominated workplaces work more than would normally be expected. They choose to work at times when their families do not need them at home. Tullberg (2003), for example, argues that the societal need is to get more work from women without changing the work conditions for men.

In England, responsibility for developing work schedules was evenly divided between a hierarchical approach (‘my boss’) and a consensus approach (‘my boss, me and my colleagues together’). Overall, satisfaction with work schedules was high.

8.3 Satisfaction with working conditions
Tables 6 to 8 summarise the answers of care workers in the three countries to self-completion questions on work satisfaction. The small numbers and unrepresentativeness of the sample should be borne in mind. What comes across clearly is the generally high levels of overall satisfaction with the work, as well as most specific items such as the physical and social environment, work planning and level of independence. Dissatisfaction is strongest around pay and other benefits, although in the latter case dissatisfaction is more often expressed in Spain and England than in Sweden. This analysis, based on the self-completion questionnaires, is consistent with interview responses: care workers find the work stimulating, but low valued.

<table>
<thead>
<tr>
<th>Table 6 : Level of job satisfaction among care workers: Spain (N=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of satisfaction</strong></td>
</tr>
<tr>
<td>General job satisfaction</td>
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<tr>
<td>Physical environment</td>
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<td>Social environment</td>
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<tr>
<td>Pay</td>
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<tr>
<td>Other benefits</td>
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<td>Work planning</td>
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<td>Level of independence</td>
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Table 7: Level of job satisfaction among care workers: England (N=16)

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>1 (Not satisfied)</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 (Fully satisfied)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General job satisfaction</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Physical environment</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Social environment</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Pay</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other benefits</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Work planning</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Level of independence</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>2</td>
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</tbody>
</table>

Table 8: Level of job satisfaction among care workers: Sweden (N=21)

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>1 (Not satisfied)</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 (Fully satisfied)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General job satisfaction</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
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<td>0</td>
<td>3</td>
<td>2</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Social environment</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Pay</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Other benefits</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Work planning</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>9</td>
<td>7</td>
</tr>
</tbody>
</table>

8.4 Hungary

Residential care workers work shifts of 8 to 12 hours, while home helpers work an 8 hour day, either from 7.30 to 15.30 or 8.00 to 16.00. Work schedules are organised by superiors (6 cases) or jointly – by the worker, her colleagues and her manager (8 cases). Practitioners are mostly satisfied on this count, as indeed they are with their colleagues and the approach of management.

There are, however, strong sources of dissatisfaction. Low social status and pay have already been mentioned. Home help workers refer to: work overload (too many old people to care for properly, many of whom are very frail or seriously ill, and especially not enough time to give to the relational and affective side of the work); the distances between their visits (which they mostly have to walk); and the poor working environment (because of the poor condition of the housing of many elderly people). For workers in residential care, problems include the poor state of many buildings and work overload. The sources of stress most frequently mentioned among all 16 practitioners are: the responsibility of the work (7); workload (8); and low salaries (7). Half rate their work, without qualification, as mentally exhausting. There is a great demand from care workers for stress and workload to be addressed, but only a few workplaces do so.
Since 2001, all qualified workers are required to undertake further training; this covers a range of possible activities including attending professional conferences, workshops and other group activities and training courses (there is a requirement to attend at least one within a 5 year period). Workers with diplomas may also take a special examination in one of 7 social care topics covering the whole range of social welfare clients, including ‘Social Care for the Elderly’. Further training and special exams can offer professional advancement and material benefits, and are also thought to have increased professional self-respect.

Most practitioners (11) were very satisfied with professional training opportunities available to them, and 12 had participated in courses during the academic year 2001-2. There was less satisfaction with the availability of books and conferences. Another source of support is professional meetings, attended by 14 of the 16 practitioners, mostly on a monthly basis.

8.5 Concluding comments
One of the many complexities of elder care work is that much of it takes place in other people’s homes. The need to interfere in the home – for example, in the sense of re-arranging furniture - in order to do the work, as well as the possibility of different standards illustrates the sensitivities involved. Attention once again focuses on relationships and the need for negotiation.

Home help work is also potentially more isolated than residential care. However even here, and perhaps most so in Sweden, workers may be part of a team, and feeling part of a supportive team appears to be an important condition for job satisfaction whatever the type of work. The team creates a space for social support but also a potential for exchange of information and for discussion of and reflection on practice. This last function of teams raises the question of what time and what methods are available for such reflective practice, and indeed whether this potential role of teams is recognised and implemented.

As with other forms of care work, elder care practitioners seem very satisfied with the work itself: they like what they do and they like old people. The downside is poor pay (especially in England and Spain) and stress arising from the demands of the work (physical and psychological) – and shortage of time.
CHAPTER NINE : RECRUITING THE WORKFORCE

One conclusion of Stage One of the research was that there is evidence of workforce shortages in all partner countries, either currently or predicted: even in Spain some shortages are experienced in elder care services. Various approaches have been suggested or implemented to tackle these shortages: e.g improving levels of education and professionalism; improving recruitment strategies, in particular from under-represented groups; improving employment conditions; extending the working lives of the existing workforce; media campaigns to improve care work’s public image. In this chapter we consider how policy makers saw the issue of recruitment and retention, and strategies for ensuring an adequate supply of care workers.

9.1 Recruitment strategies

9.1.1 England – better payments and flexible jobs

In England, staff recruitment was described as a major issue by policy makers and trainers, though few of the care workers themselves thought that this was the case. Informants were more concerned about how to attract people into care services than about problems that made staff leave. Low pay was a major theme. The salaries were not felt to be commensurate with the level of responsibility held.

As well as low pay, there were some comments about other problems with conditions, including examples of the reduction or removal of previous benefits. In some cases this may have arisen from privatisation, since private sector care workers usually have worse pay and conditions than their public sector counterparts: home helps previously paid by local authorities have found themselves re-employed on worse terms by private agencies when local authorities have reduced or closed altogether their own directly provided services.

But there are also pressures in the public sector. A public sector home care worker said that her employer, a local authority, had downgraded the pay for weekend and evening work for new recruits, though existing workers still got the same extra pay for out of hours work. This had had two adverse consequences. First, “a lot of the girls won’t work Saturday and Sunday, and this is where our biggest struggle is”. Second, it had created difficulties for workers’ relations: “working beside someone who is doing exactly the same job and they are getting double time and you are only getting normal rate of pay”.

We have already seen in Chapter 5 how government in England has been reflecting on the need for new ‘hybrid’ workers, combining skills from a range of occupations such as various forms of therapy and home helping. Similar thoughts, about new types of worker, were expressed by informants. One national policy maker (but echoed by other policy makers) argued that pay had to be increased to boost recruitment - but that improved pay was likely to be tied to creating more ‘flexible’ and differentiated jobs. For example, an ‘intensive home care service’ was likely to be developed, which would be able to pay more to certain workers doing more complex home care tasks. There were also likely to be developments of ‘semi-professional’ care worker roles which would involve working across traditional health and social care boundaries, creating more work opportunities, and which again might attract higher pay. In terms of future recruitment strategies, this informant was arguing that it would not be enough in the future to rely on an ‘army’ of low-paid low-skilled care workers. Instead, there would need to be much more differentiation within the workforce, in terms of skills required, the range of employers, occupational roles and rates of pay.
Skill mix was another idea raised by an English policy maker. In the face of recruitment difficulties, “a lot of the thinking that’s going on for the future has been about how do you make the best use of everybody, the skill mixes that you need, how do you try and attract people in, a number of different things”. Alongside salaries, other aspects of recruitment strategies were improving access to affordable housing for care workers in areas of the country where house prices were out of reach, and improving the image and therefore the status of social care.

9.1.2 Sweden – from life experience to more formal training
Recruiting and training personnel is also in Sweden an important political question today, as the need for nursing and care is increasing at the same time as a changing population structure17. Reforms have led to old people spending shorter periods in hospital care and many people with high care needs being cared for in ordinary housing accommodation. At the same time, the municipalities, which are in charge of care for elderly people, have prioritised providing help and support to those with the greatest needs. This means that fewer old people today than 15 years ago receive help from the municipalities - but that the ones that do receive help are provided with more frequent or more extensive services.

This development naturally has consequences for the staff in care for the elderly in different ways. An interesting question, given this trend, has to do with what knowledge and competence it is thought care workers need to have today when caring for elderly people. Another is where the workforce will come from in the future.

From a historical point of view, as we have seen, middle-aged women without young children at home have been the recruitment base for care for elderly people in Sweden. As the middle-aged housewives have disappeared, new recruitment strategies have been developed. The current view in Sweden is that somewhat older people, both women and men, should make a contribution in the future care for elderly people.

A common aim, also, is for all workers to have undersköterske (auxiliary nurse) training. But this, as we discussed in Chapter 3, is easier said than done. As a local policy maker observed,

> although we require an auxiliary nurse qualification, given the way things are at present, we can’t get people like that, there aren’t enough of them. That also means that we have, well perhaps, 20 per cent of the staff lacking auxiliary nurse training.

In some cases, the more rural municipality for example, co-operation with the job centre has been successful in recruiting redundant workers, for example, people who have held different kinds of office positions, where, due to far-reaching rationalisation, many people have been laid off.

Despite the emphasis in Swedish national policy on formal training, when it comes to the recruitment of both female and male care workers life experience retains a high value among local administrators. As a local policy maker puts it,

> we would prefer the ones who have gained a bit of experience in life, as it’s just as easy for them to work in care for the elderly as it is for an eighteen-year-old, so it’s great for us to catch the slightly older ones who might have received

17 SCB’s homepage www.scb.se Population statistics.
other vocational training in their past and want go in for care work. It has worked out really well

One could draw the conclusion that in Sweden the same strategy is being used as before. Formal education levels are high. But life experience is still highly valued by employers as a basis for working with old people. Life experience, however, is no longer based on housework and motherhood, but on experience from working life: experience gained through domestic work, looking after a family, is not a project for modern women. It is, also, often possible for care workers to share experience from working life with both female and male care recipients.

Quite a lot of people have been recruited to auxiliary nursing through appealing to unemployed persons, for example construction workers and carpenters amongst men during a long period of low activity in house construction. Another local policy maker observes that we have experienced, you see, that a person who is not that young, who encounters a pensioner, gets on a bit more easily than if it is a really young girl or boy that turns up. Well of course that can work too, but generally speaking it is easier to set up a dialogue and an exchange of ideas if the person is not a spring chicken. That’s our experience...They [young people] are more likely to move, I mean they do want to try different things and that’s of course totally natural. But now I’m sounding like I’m totally disinterested in them. Obviously we take them on too, as we have to, in order to manage this, but we also recruit older people and we are very positive about that, in contrast to many other employers, who talk about only wanting young people so we ca be very grateful if we get older too.

9.1.3 Spain – formal qualifications must be kept high

The Spanish informants say that professional care for elderly people is very important. It is an indicator of the level of social development that has been achieved. Generating employment and personal services redistributes wealth in order to improve the quality of life for elderly people. They describe an evolution in the carer’s mentality, from just focusing on physical needs (personal hygiene, getting old people up and putting them to bed) to a more social concept of care. This new orientation means helping old people to maintain their mobility and as high a level of awareness as possible, so that person can do what they have always done for as long as possible.

Emphasis is placed on the need to improve and maintain levels of training and qualification. A higher level of qualification influences the potential for recruiting care workers, but also is a safeguard against losing workers. In the Spanish material there is a discussion about a hierarchy within the caring sector. As a residential home care worker put it, good workers don’t stay in a geriatric home. Those ones go to a clinic, to medical college, to a hospital, or to another geriatrics home where the pay is better.

So good care workers go from work requiring low formal training to work on a higher level of formal training. To stop the drain of good care workers, the formal qualification levels for care work with elderly people have to be improved - but associated with improved pay levels that currently are far below average earnings. The trade union representative interviewed suggested that improving pay levels was the most urgent issue presently in Spain, more so
than the discussion about levels of qualification, as other jobs with low levels of qualification had much better pay and working conditions. However, in the long run formal qualifications also play an important role. Spanish trade unions do, anyhow, focus more on pay and working conditions than on qualifications; within a paradigm of equality, their view is that low qualified jobs deserve fair pay and fair working conditions.

9.2 Recruitment of male care workers
In both England and Sweden care workers agreed that more men should work with elderly people. There is no agreement with the view that men always must be cared for by men and women by women. Rather the argument is about extending choice: “if you do get a gentleman come in...some of them do not want women carers, especially if they are bachelors. Um, that would be nice to have a male carer”. In the English interviews, there are also examples of care workers talking about opportunities to extend the range of conversational topics when talking with older men, if more male carers were employed. Football was an example mentioned. In the Swedish material, some informants give examples of tasks that they think male care workers could help with, for example looking after technical equipment, such as televisions and videos, which would be a help to many widows living at home.

In discussions about the need for diversity, including the need to recruit men into care work, one English policy informant widened the debate to other diversity characteristics such as ethnicity and posed the problem of masculinity inhibiting men from thinking of themselves as care workers:

I mean I think there has in the past been a shortage of other groups you know, of black, minority ethnic workers although that’s changed as well and it's changing but I don’t have all the answers there about attracting men. I mean I think a lot of men still consider it, probably even some of my friends you know, I mean it's never been said to my face I have to say that, but I think it's still considered a slightly sort of unmanly thing to do.

He went on to stress that the workforce and the work itself need a mix of people, and that children who were the future workforce should see diversity in workforces:

We need really, we need a mix. You know children need to know that teachers, nurses, social works, home care workers, you know can be either men or women, black or white you know.

As a part of a Swedish project a few years ago called Män i vården (‘Men in care’), attempts were made to attract men who had previously worked in the office field, as it was impossible to find new jobs in that area. The were offered five months probation in care and were promised that if that worked out to everybody’s satisfaction, they would be given auxiliary nurse training.

In the Spanish report, a cultural problem in recruiting men as care workers is raised: a widespread tradition of hiding the naked body even from close family members. A female residential care worker sees this as a major issue when it comes to caring for today’s older generation, though not necessarily remaining so in the future.

As a carer, and with the current generation of old people, it’s difficult for a man to do personal hygiene for a 90 year old woman whose husband only got to see
her with the lights off. To have a man come and take her clothes off now and shower her, goodness me! It’s difficult for the ladies. This will change as the population gets older, it won’t be the same then.

The Spanish informants say that if you are going to recruit men the stimulus has to be vocational.

9.3 Recruitment of minority ethnic workers
England has a diverse minority ethnic population, highly concentrated in a relatively small number of urban areas. While new migrants still arrive, mainly seeking asylum, much of this population originates from immigration in the 1950s and 1960s, mainly from former colonies. Issues around ethnicity have been the subject of much study and debate. That services need to be responsive to ethnic diversity among old people themselves and to develop a more ethnically mixed workforce is recognised by English policy makers, both nationally and locally (at least in local authorities which have substantial minority ethnic populations).

The need for an ethnically diverse workforce was also very apparent to a policy informant in the large English multi-ethnic urban local authority, where some recruitment initiatives to increase the employment of minority ethnic workers were reported as well as some important difference between minority ethnic groups:

In terms of home care there have been initiatives to recruit more home carers from black and minority ethnic groups so that our services are obviously more responsive to their needs. I think the underlying issue there is about how much as a department we try and change our mainstream services and to what extent we purchase services from [other] providers...I think, you know, there’s a tendency that our service, our mainstream service, has just become services for white people. Our external [non-local authority] services, or some of them, have organised around black and minority ethnic communities. I think the issue is that some of the providers are also kind of community advocates as well, so there’s an issue there, and there’s also an issue about how much about how less organised, less represented communities make their voices heard, you know, and it’s a very difficult area I think and we’re doing a lot of learning on it.

The question here is how to become more responsive in practice, how to turn a rhetoric about the need for diversity into actual practice.

In Spain, the issue is more complex, or at least different. Migrant workers are a more recent phenomenon, entering the country legally and illegally. Some come from Africa, but most from Latin America and speak Spanish. But while the language will not cause any problems for these migrants, there may be socio-cultural problems, as this trainer acknowledges:

Yes, socio-cultural problems. I mean problems concerning different ethnic values. I mean there is an old person’s vision here and in other places which can shock those people; finding out that here people are much older and with unexpected problems, or even how disabled people are viewed in one place or the other.

There are also other obstacles to recruitment of migrant workers. These include whether they have valid papers, finding accommodation and recognition of qualifications. For example,
many migrants have qualifications that are not recognised in Spain, so have to take jobs at a lower level than in their country of origin. In both countries, raising the qualification levels needed for care work may exclude some potential workers from minority ethnic groups.

9.4 Concluding comments
Finding and retaining enough people to do the work is an issue in England and Sweden, less so at present in Spain where services are not so developed and levels of employment lower. The case study suggests different national responses, or at least different emphases. In England, poor pay and conditions are recognised as major causes of staffing problems: possible solutions being proposed include a more differentiated workforce, including new, more flexible and better paid types of care worker. Another specific problem for recruitment in parts of England is the price of housing, which increasingly excludes low paid service workers. Income inequalities therefore may create unbalanced communities, in which the devaluation of care work comes to have adverse consequences not only for care workers themselves but also for the wider community.

Since the 1940s, Sweden has moved away from its original source of workers: middle-aged women without young children at home and with low levels of education. New sources of recruitment are sought, as well as new sources of knowledge – from ‘housewifely’ and other life experience to academic education. The official aim, therefore, is to tackle recruitment by increasing the standing of the work through formal education and broadening the recruitment base. However, locally high value continues to be placed on life experience, which is no longer defined as ‘housewifely’ experience but as experience gained from working life.

Emphasis is also placed in Spain on improving levels of training and qualification required for work with elderly people. Without this, some think, good care workers will be lost to other occupational fields.

Two sources for recruitment into the work are more men and more minority ethnic workers. As matters stand, it appears that the former may prove harder to achieve than the latter. While there is widespread agreement that more men are needed in care work with elderly people, so far there are no examples of sustained and successful strategies for achieving this end.

In the material you can find arguments for questioning the idea of a life-long career within elder care. Specialisation at too early a stage in life might lead to unintended consequences, such as missed opportunities to use life experience as a source of empathy in the work, and maybe in the longer run an early exit from the work.
10.1 The three models

The borderlines and relationships between home and work and between family and state is important for care work in the three countries involved in our study. In Chapter 2, we introduced the concept of different models of social care in Europe. Two of our three case study countries exemplify extremes on the spectrum of models; the third is less distinct. Sweden exemplified a Scandinavian model, organised to encourage paid employment and to facilitate women’s entry into the labour market. In Spain, exemplifying the southern Europe model, the struggle to manage both family and working life is left to the individual or family to resolve. The UK model is less clear cut and subject to change: since 1997, for example, the state has become more interventionist in supporting maternal employment, yet still relies heavily on employers, markets and families. This schema (and similar ones that have emerged from other analyses of welfare states) are important for understanding various national differences revealed in this study, in particular: the provision of services for eldercare and the position of the workforce; views about responsibility for providing eldercare; and the relationship between gender, employment and family life, especially in the care workforces, which in all three countries have in common being highly gendered.

The three countries studied have services at different levels of development, as well as different provider mixes. Sweden typifies the Scandinavian model in having high levels of formal provision, a high proportion of which is publicly funded and organised. The public sector retains substantial popular confidence and support as a vehicle through which solutions to social problems are sought and often found. In Spain, by contrast, services are less well developed, rely far more on private providers and responsibility for financial and practical help for elderly relatives is primarily with families. The UK falls somewhere in between. Levels of service are quite high, if lower overall than in Sweden, but in recent years the public sector has contracted, to be replaced as the dominant provider by a large for-profit sector, providing services that are both publicly and privately funded. But however provided, in all three cases publicly-funded provision is increasingly targeted on ‘high need’ and / or lower income groups. Much care, in its broadest sense, is left to the individual or her family to provide personally or arrange and pay for.

As a direct result of targeting by need, publicly-supported care work, whether domiciliary or residential, is making increasing demands on the workforce. The work is growing more complex, with an expanding health element, and this process will continue as numbers of very old people (i.e. over 85 years of age) continue to grow. In these circumstances, it will be more and more important to find solutions including both social care and health care.

More attention is being given to training – although what knowledge is needed and what methods are best suited remain contentious issues, and levels of qualification remain relatively low. In terms of training, pay and other employment conditions, Sweden is ahead of the UK and Spain. This is associated with a more regulated labour market, which includes a rejection of solutions that fall outside collective agreements and contracts. The labour market in care work in England has, by contrast, been deregulated through privatisation; unionisation is mainly confined to a decreasing number of public sector workers, whose conditions of employment are, in any case, vulnerable to being reduced. The Spanish workforce is experiencing some of the same processes.
Reflecting different welfare regimes, and their underlying values and assumptions, care workers in different countries express different views about who should care for older people, including the respective role of families and formal care services. Swedish carers are most in favour of formal services taking on the major part of care work for frail family members, viewing the responsibility as more societal than familial. However care workers in all three countries seem to view the relationship of formal and informal care as a matter of ‘and/also’, not ‘either/or’. They are not judgmental about the amount of care provided by relatives, appreciating the many reasons why this may be limited.

The relationship between gender, employment and family life in the three case study countries is framed in very different policy contexts. Sweden has universal state provided childcare services and strong leave entitlements for parents, combined with the possibility of working part time. Individual or family responsibility for elderly family members is not a part of the Swedish social welfare legislation. There is, however, a strong expectation that every individual should actively participate in working life.

In marked contrast, Spain lacks the strong social infrastructure of support for working parents, and expectations (for women) focus on taking responsibility for family members rather than participation in the labour market. The labour market is dominated by full-time employment, but also is marked by insecurity, including high levels of unemployment and non-permanent employment. Poor infrastructure combined with a strong expectation of care being a family responsibility necessitate that the choice to work outside the house must be successfully negotiated within the family. There are some similarities with England, for example weak support for working parents, although differences in the labour market (notably far more part-time working) have enabled more women in England to negotiate and manage a combination of employment with family care obligations.

One consequence of these national differences is seen in the way that the boundary between family and work is articulated by the care workers in this study. In Sweden the dual-breadwinner family is expected and supported, and a strict boundary between work and family life encouraged: care work has to follow the same rules as other occupations in labour market. Swedish informants played down difficulties in the relationship between employment and family life, to an extent which surprised the English and Spanish researchers. To what degree this reflects an actually lower level of friction between work and family life or socialisation into a certain way of understanding and describing a social reality is impossible to say based on the data alone. In England, by contrast, the material shows an overlap between family life and working life with the division between work and non-work blurred: work is seen as having to ‘fit round’ family responsibilities, at least for women.

The relationship between gender, employment and family life is highly dynamic. Countries like England and Spain are in the throes of major changes in women’s lives affecting their educational, employment and care careers, changes that began in Sweden several decades earlier. These changes will have implications for the role of women and families in providing care for elderly relatives and for the future care workforce. The routes whereby the current generation of English or Spanish women care workers have come into care work, often relatively late in life and closely linked to motherhood (and to divorce in the case of Spain), are very likely to change. Care work will need to predict and accommodate new career trajectories, and routes into the field, or risk increasingly severe shortages in a world where women are better educated, have more employment opportunities, expect a continuous employment career and are prepared to defer or abandon having children.
10.2 Some dilemmas to be solved
We now turn to a number of complex issues of great importance for the future care of elderly people. Many of these issues confront all countries, whatever the national model of social care or welfare regime.

10.2.1 The status of the work
• Care work remains highly gendered and retains a low status in society. Part of the problem arises from the image of old people as valueless and burdensome and of care work as being without result. Part of it arises from the continuing assumption that care work is something that women are naturally capable of doing based on their role as carers in family life.

• Care work among old people is to a great extent invisible work, at least from the perspective of society.

• Radical changes are needed in order to make the work visible and to increase its status.

10.2.2 Recruitment and retention
• Governments policies are recognising that recruitment and retention of care workers require intervention if chronic shortages are to be avoided. The good news is that, in all three countries, there is a high degree of satisfaction among practitioners with care work itself and with the working environment and they value the work they do highly. The bad news is that there is considerable dissatisfaction with how the work is valued, both in terms of pay and conditions, and in terms of status.

• With other employment opportunities opening up, even for women with low qualifications, the current equation – high job satisfaction, low pay – cannot be taken for granted. There are other reasons why the current situation is problematic. Care work with older people is often, especially in England and Spain, chosen to simplify a certain life situation. The needs of the care worker might overshadow the care recipients.

• Changes in the level of training and in the workforce itself may have implications for future recruitment. As long as the work has required low levels of education and a strong reliance on assumed innate gender qualities and life experience, it has been a way into the labour market for lower educated women – a means of social inclusion. But this role may come increasingly into conflict with expectations of a better educated workforce, especially where, as in Sweden, the aim is to require all entrants to have a basic education. Workplace and competency based training may appear a way round this, but raises the question of what knowledge is needed for the work and of how the worker is conceptualised, for example as a technician or a reflective practitioner.

• One of the most serious challenges is to find persons willing to work in elder care in the future. This means responding to changes in women’s lives, including education and employment, revaluing what has been a low status field, funding improved pay and training and finding ways to retain staff who want to develop a career without abandoning care work. But it also means finding new, previously untapped sources of care workers to replace the housewives who have been transformed into wage-earners and professionals. Possibilities include men, minority ethnic groups and younger people.
Male care workers remain few and far between. Despite a general feeling that more men workers would be welcome, there are no signs that recruiting men is anywhere a priority or has been the subject of a sustained and successful programme. Routes into the work and expectations differ between male and female care workers.

Minority ethnic workers are found in all the three countries, although their origins and histories of migration are very different: from former colonies in England and Spain, to asylum seeking in Sweden. For recent migrants, an important issue is whether they have qualifications that are recognised in their new domicile; otherwise they may drop to the bottom of the care work hierarchy, filling shortages in the poorest paid and least skilled work. For various reasons, including young age profiles, minority ethnic groups may still be under represented as recipients of care services, but their growing numbers will create new challenges for care workers offering a service to an increasingly diverse clientele. At the same time, minority ethnic care workers may themselves suffer racist behaviour from old people who may be less familiar with and adaptable to an ethnically diverse society. Given the concentration of minority ethnic populations, many ‘white indigenous’ care workers may have little experience of working with colleagues or old people from minority groups. This raises issues about how questions of diversity should be dealt with in training – as a specialist option or a general subject?

Young people are not choosing to enter work with elderly people, at least not in substantial numbers. If a more ‘age balanced’ workforce is desirable, both to improve future recruitment prospects but also to create a more diverse workforce, it is not clear how this can be achieved. How might young people be convinced that working with elderly people is a career worth considering and following?

But are young people the right persons to work in elder care services? When discussing the role of life experience, which type of experience could be useful for the work in elderly care? One argument is that the closer in age the care worker is to the care receiver, the closer is the understanding due to shared memories. This argument questions the recruitment of at least very young people to the work. The issue of age requires more investigation and discussion.

10.2.3 Education and training

The work is getting more complex. Mention has already been made of the increasing demands on workers arising from the care of older and frailer care receivers. Another development which points towards the care worker’s job becoming ever more complex and skilled is the increasing salience of the relationship between care workers and old people’s families and between formal and informal care. This involves issues of communication, emotional relationships and coordination.

Levels of training and education remain low for care work with elderly people. There is, however, an increasing recognition, not least by policy makers, of the need to raise the level of education and training among care workers. Strategies differ. In England, policy views care work as a technical exercise involving the delivery of discrete tasks defined in individual care packages, which requires largely manual and managerial labour and training, the management of risk and training focused on acquiring specified occupational competencies. In Sweden, on the contrary, policy sees care work as a field where more theoretical knowledge and higher levels of formal training areas required - but local administrators prefer staff with life experience independent of which formal education the person has.
There is a tension between experiential, vocational and academic knowledge, and therefore of how and where education and training should take place, which is yet to be resolved – which are most appropriate, what is the proper contribution of each, are some inappropriate to care work. This is related to the obscurity surrounding the meaning of the concept of ‘social care’, over and beyond its use as a label to describe a set of services or its definition in terms of what it is not. In short, current understandings of care work with elderly people can too readily be reduced to a set of personal qualities that are either inherent in the individual or derived from family and work experiences: or, put another way, care work can be seen as family work transferred to the public sphere. Underlying this issue of knowledge and education is the need for more attention to be paid to: (a) conceptualising and theorising the work, for example exploring in depth existing concepts such as ‘social care’ and new concepts such as ‘elder pedagogy’; and (b) more routine and rigorous evaluation of practice, for example through developing methods for critical analysis and reflection such as pedagogical documentation.

There is a need for creative thinking regarding content, length, and training programmes, where concepts like life-long learning, cross-occupational careers and life experience as sources for knowledge should be reflected.

Underpinning the question of education and training is the question of the future structure of the workforce. Changes in the structure of social care work may be expected – but what form will they take? Sweden is building on its existing occupations, seeking to increase the general level of qualification, in particular making the auxiliary nurse training standard. England is behind in levels of education, and seeking to increase qualification through vocational training. However, more wide-ranging possibilities are being considered: for example increasing differentiation of the workforce, with a new higher qualified and more ‘flexible’ worker forming part of a new hierarchy, and new types of ‘hybrid’ occupation combining care, nursing and therapy.

**10.2.4 Support and coordination**

There is a growing recognition that care workers need an infrastructure of support to survive and flourish. This will mean increasing attention and time paid to team working, supervision, continuous training and development, reflective practice, work conditions and to identifying and ameliorating the diverse sources of stress including a perceived lack of time. It will also mean recognising the complex, demanding and unpredictable nature of the work.

Co-ordination of care work for elderly people has become and will continue to be an important issue. Boundaries between health care, social work, informal care and social care will be constantly questioned and re-negotiated. One important issue is the structural relationship between health and social services, which have been, or still are, often divided between different types and levels of administration. New structures or other forms of partnership, which bring health and social care ever closer, have already begun to emerge and this process will continue. Sweden, with its strong tradition of social care management and the bringing together of health and social care within municipalities, is ahead of England and Spain at the moment, though major changes are taking place now in England.
• Coordination and management raise the issue of the relationship between those actually doing the care work and those who manage and coordinate them. At present, there seem to be strong pressures leading to the gap between these parts of the workforce widening and the relationship becoming more hierarchical. What are the consequences and is this desirable? Is it possible to increase the status and influence of practitioners in relation to managers?

• Standardisation of care work tasks is going on in the three countries, but through different processes. In England there are strong regulatory systems, including national standards and systems of regulation. In Sweden, with its more de-centralised system, increasingly strong systems of formal education are the main process. At a time of such standardisation, is it possible to create local spaces for experimental and innovative thinking and practice?

10.3 An uncertain future
There is a substantial, and increasing, emphasis in the provision of care for older people on individuals and their families assuming more responsibility, with public provision increasingly targeted on old people deemed to have ‘high need’. This is in contrast to services for children, where public responsibility is already universal or growing. What are the implications for the social status and employment conditions of care workers where there is a split between publicly-supported services for a minority, while the majority are left to make their own care arrangements?

But it is also apparent that old people do not automatically prefer care from relatives. They may be far more discriminating in what they want from whom. They may, for example, prefer to receive intimate care from care workers rather than from family members. Or, indeed, where services are well developed, they may prefer to receive most routine care from formal services. But, family care and formal care work should not be thought of as ‘either/or’.

Routine care undertaken by a care worker does not mean that family members no longer have a contribution to make. Care workers may ‘free up’ family members to give more time to other aspects of care, for example talking with their relatives. Moreover what is required by older people themselves is not static, nor are their expectations: the next generation of old people receiving care, born in 1940s, are expected to articulate their autonomy even more clearly than the present generation of care recipients.

More and better education and training; improved pay and conditions; an improved infrastructure of support; more time for reflective practice – all this, together with an increased population of highly dependent older people, point to increased costs in the field of care work with elderly people. These costs may be desirable in terms of improving the work and the quality of employment, but they may also be necessary simply to ensure an adequate supply of workers. This creates several dilemmas. ‘Care work without any result’ is not a private or public priority. If costs are placed too much on private individuals and families, this may create incentives to find certain kinds of ‘low cost’ solutions, such as migrant labour. Public authorities, faced by rising costs, may seek to keep a lid on costs by ever greater targeting of services. The future direction of work in this field, therefore, is unclear. The supply of labour needs to be considered in relation to the evolution of the work and emerging understandings of the work, as well as the value attached by societies to older people.
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APPENDIX A

RESEARCH INSTRUMENTS
APPENDIX A1

INTERVIEW GUIDES

Interview guide for workers in elderly care

Introduction:
Participants will already have had a letter introducing the project and completed a questionnaire. They should be given a chance to ask questions about the project and their role in it. So, we suggest the following routine after the interviewer gets to the centre:

- Introducing briefly oneself, the Institute (CIREM, …..), and the project
- Confidentiality assurance
- Using the tape recorder/taking photographs
- Answering questions
- Practitioner taking researcher on tours of their service/unit/group (including taking photographs) (residential care only)
- Interviewing the practitioner
- Collecting available documents for later analysis
Tour / observation plan
Elderly care

Date_________________ Time of the tour____________________

The objectives for the tour are to collect information about two aspects of care work: (A) on the work itself and the ethos of elderly care and elderly care centers and (B) the external environment.

A. The work itself and the ethos of elderly care (to ask the person guiding the tour)

- Please tell me a little about a normal / ordinary work day in this elderly care centre (times for when the elderly are to get up and go to bed, what kind of activities they have during the day, meals and coffee brakes for the elderly and the staff).
- Do the people living in the residential / or having home help come from the local area? Do their relatives live close by?
- About the work itself, how is it to work in this elderly care center / home help organisation? What is good, not so good or even bad in this elderly care center / home help organisation?
- What influences how you do your job / why do you do your job in the way you do?
- What is the ethos of the elderly care center / home help center? Do you agree?

B. The external environment

Location and area of the building / elderly care center

Town center
Rundown area (slum)
Suburb
Housing estate
Block of flats
Detached houses
Near shopping area
Near community centre
Parks and gardens, etc.
   Trees and plants
      Full of houses, lots of roads
      Quality of neighboring buildings
      Access to the building/center
      Generally quiet area
      Generally busy area

Anything else:
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
Quality of the building / elderly care center

Old building, without reconstruction
Reconstructed old building
New building
Size of the building
Adopted building to be a elderly care center or not
Center is not a separate building but part of another (e.g. one floor, one flat, etc.)

Anything else:

The garden of the center

Size
Arrangement
Flowers, trees, bushes, etc. Lots of them or not
Well protected and quiet
Not quiet, and poorly protected
Accessibility to the garden
Tables and chairs for recreation and relaxation

Anything else:

Public areas / rooms

Quality of the rooms (in general)
Run down
Needing some repair
Good, suitable condition

A. Equipment/accessories in public areas / rooms
Quality of furniture
Amount of furniture
Space for workers
Space for the elderly
Places to meet visitors
Provisions for special needs and special equipment
Personal belongings

Activities
For example books, papers, journals, audio books, TV, games and cards, Internet
Quality
Condition
Cleanness
Types
Amount
Arrangement (on shelves, in boxes, easily accessible, etc.)
Number of group rooms

**Light, fresh air**
- Lamps
- Windows

**Arrangements within the rooms**
- Space / arrangement for eating
- Space / arrangement for serving food
- Space / arrangement for washing hands
- Space arrangements for cleaning the rooms

**Decoration**
- For example aesthetics, paintings, flowers etc
  - None or very little
  - Well balanced
  - Overcrowded

Anything else:
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

**Safety**
- Safety and adjustment in general (bathrooms, public and private rooms)
- Equipment for special needs (bathrooms, public and private rooms)

**Privacy**
- Number of separate public rooms, for example to use for visits
- Shared bedrooms
- Personal belongings

**Workers personal space**
- Dressing room / area
- Meeting room / area
- Room / area for rest / recreation
- Size
- Furniture
- Equipment

Are there some difficulties in doing care work in these environments (equipment, size of rooms etc)?

Anything else:
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………
Personal opinion:

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Interview Questions

Tell me why you chose this work?

a) What is your motivation (personal or family reasons) to work with elderly?
b) Is the work only a job or is it considered a lifelong career?
c) Did you have similar work before taking the present job? Did you have another job at all?
d) What are the skills that make you good at the job, in your opinion?

How can you reconcile your role in the family and your job?

a) Have you got to do care work in your family as well? If yes, for whom (children, relatives)?
b) Do family members and relatives turn to you for advice in caring for others?
c) Does your work create any problems in your family?
d) What do your family members and relatives think about your work?

How is your work valued in society?

a) Do you think the work you do is important? If yes, for whom (her-/himself, clients, relatives, society)?
b) What do you think is society’s view of care work?
c) Do you think the prestige and appreciation of care work by society is good or not? Why do you think that is so?
d) Have you noticed any changes in how social care is understood in society?

What are the social care aspects/elements of your work?

a) How would you describe the care you provide?
b) Do you discuss with colleagues what kind of care is needed, what you are able to provide and any problems in providing care?
c) What do you understand by the term ‘social care’?
d) Has your opinion on what ‘social care’ means changed during your career?

What is your relationship with the relatives of the clients or residents?

a) What are your responsibilities with relatives?
b) What do the relatives and the clients or residents do together?
c) What is the role of the relatives? What do you think it should be?
d) Would you call the contribution of the relatives care / care work?
e) What do you do if there is a disagreement with relatives about the care you provide?

For all these get examples

What is your relationship with the elderly/clients or residents?

a) What makes a relationship with the elderly a good one? Or a bad one?
b) The elderly of today are not a homogeneous group; do you have any experience of elderly with social problems? (Alcohol, violence etc.)
(For care workers in home help) What is it like to work in someone else’s home? Do you have to take anything in particular into consideration?
   a) How do you / do you negotiate with elderly about what is to be done?
   b) Are there ever conflicts about what is to be done?

Do you have experience of working with people from minority backgrounds or people with special needs?
   a) If it is different, in what way?
   b) What kind of difficulties can occur and why? (language, relation with relatives, special needs as for example special diet etc)

If you were concerned that a resident or client was being neglected or had been abused, what action would you take?

Now I’d like to ask you about how you might react to situations that might occur at work. There are no right or wrong answers, we are just interested in what care workers might do.

a. An elderly user/client refuses to be helped with having a bath, saying she/he is to shy to show her/his naked body.
   What might you do? What action would you take?

b. At the dinner table you witness a colleague treating a user/client badly.
   What might you do? What action would you take?

   a. A client/user who finds it difficult to move around is sitting in a chair holding a letter, visibly upset.
   What might you do? How might you react?

   b. She/he tells you that a cousin in another town has a life threatening disease and she/he would like to see them.
   What might you do? How might you react?

   c. It is the end of your shift/allocated time, and the person is still upset, tearful and wanting to talk.
   What might you do? How might you react?

Thank you for your thoughts on these sensitive matters.

How satisfied are you with your work conditions?

a) Do you know about the regulations/standards of your work? How do they affect your work? Give examples.

b) Who gives you support in your work? Who inspires you in your work?
c Is the center/service flexible enough to meet new needs of the staff? (work schedule, environment, personal space, time for rest and opportunities for professional development)
d Is the center/service flexible enough to meet the needs of the elderly / the relatives? If yes, how? What is done? If no, why not?

**How easy or difficult is it to realize (carry through) your own ideas and initiatives?**

a) Have you got ideas to improve your work or conditions of your work?
b) Do you receive support in realizing your ideas?
c) Is the center a flexible partner to consider new ideas/initiatives from staff?
d) Do you know of new initiatives, innovations existing elsewhere? What? What are the new or innovative elements?
e) What are the consequences of innovations for care work?

**What schools did you go to, in order to get your diploma/degree to work with elderly and how well do you think your schooling/training prepared you for the work?**

a) What kind of training or preparation have you had for your job – in other jobs or in life or in formal education?
b) What do you think about training for work with elderly people, what kind of training do you think is best, why, how do you think it helps or hinders the work.
c) What kind of knowledge is important in order to do a good job?
d) From what you know about training for work with elderly people, are there any problems with it? Are there any changes you would like to see?
e) If you have done any qualifications for work with elderly people, do you have any comments on the balance of theory and practice in the courses available?
f) Have you changed your views on this at all over the years? Why?

**What further training options or opportunities for professional developments are available to you?**

a) What kind of training or courses is available? What are they about?
b) Are these easily accessible? Are these suitable to your needs?
c) Is there a chance for promotion or career development in the center?
d) Would your work (tasks, salary, responsibility) change if you were to participate in further training?
e) Do you think further training is a good idea? Why? Why not? What gets in the way of doing training?

**What do you consider to be the greatest challenge in your work and profession?**

a) Is there a high turn over of staff? Does it create a problem? What are the effects on your work?
b) Do you think it is a problem that most care workers are women? What kinds of problems does it present? Why would there be a need for more men?
If you had a choice, would you change your job and workplace or would you continue in your present job?

a) If you would NOT continue in your present job, why? Is the job very demanding? Do you feel tired or low very often? What kind of a job would you like to get?

b) If you would continue in your present job, why? Have you always wanted to work in the elderly care sector or are there some other reasons? What?

What advice would you give someone just beginning care work?

Do you have any comments, suggestions?
Interview guide for local trainers

Introduction
It is important to get acquainted with the person to be interviewed. She or he will already have had a letter or phone call introducing the research project and its partners. However, they should also have an opportunity to ask questions about the project.

- Introducing oneself and the project
- Answering any questions
- Confidentiality
- Collecting documents for later analysis

Background:
Tell me how you came to have this job (cover educational and employment background, why chose it, what hoped to get out of it, explore any striking differences or similarities between past and present jobs)?

Description of own work:

To what extent is care work with elderly people your area of expertise?
What theoretical and practical knowledge of the field in the past and at present?
Who or what inspires you in your teaching?

System of training offered – courses, qualifications, links with HE/FE/other training organisations, use of practice placements (DOCS?)

Impact of policy reforms, e.g., introduction of national standards on content and/or methods of teaching or on number or type of students coming forward and their success.

What freedom to choose the content, methods of teaching? What is regulated and what is not regulated?

Understandings of the work (for trainers within local authorities)

How do you understand the term social care?

What values and principles are important for students to be equipped to do care work with elderly people?

What is the role of theory in the teaching you do? What kinds of theories are useful or important?

Have you noticed any changes over time in the use of theory or the values attached to the work?

Do you know how theories (or values) about working with older people are used when translated into practice?
Trainer’s opinion about the training

What is the balance in the curriculum between health care/nursing, social care/social welfare, social pedagogy and home economics? Are any other subjects covered in the curriculum?

Does the training prepare students for work with relatives and families, and for work with other professionals? Is it adequate? (Do you think it should?)

Is students’ personal development form any part of training? Do you think it should be?

How are diversity issues, such as gender, ethnicity and disability addressed on the courses?

Are the present forms of training relevant to jobs in elderly care? What kinds of jobs do they do or go on to do?

What changes to training or to the jobs would you like to see?

How flexible is the training – can it adapt to new policy or practice needs as they arise?

How flexible are the occupations available to students – can they adapt to new policy and practice needs?

What further ongoing training needs for care workers are important? How are they met, if at all?

Trainer’s opinion about the students

How would you describe the students in terms of their educational backgrounds, age, ethnicity, gender, motivation?

Have there been any recent changes in the supply of students? What?

Have there been any recent changes in students’ expectations about the kinds of knowledge they should be learning or their views about the work or their professional ethics?

Is there an adequate supply of students? Do you think anything can be done to encourage more people to train to work with elderly people?

What proportion of students abandon their studies during training? Do you know what the reasons for dropping out are?

Views about care work

What purposes or roles do you think care work with elderly people currently serve? Are these right? Do you think families should do more for elderly relatives or should more or other kinds of services be developed?

How important is formal care for elderly people to society (for female and male relatives, elders, the economy)?
What is and should be the status of care work with elderly people? What are the most important factors in achieving any changes?

How important is it to have male care workers or care workers from different minority ethnic groups? How important is the age of care workers when working with elderly people?

The future
If you were faced with a challenge to substantially upgrade the level of training that those people working with elderly people receive, and the numbers of people working with elderly people were to substantially increase at the same time, how would you go about it? What structure of training would be best and what content of training would you advise?

Any further comments?
Questions for national figures in training

Introduction
It is important to get acquainted with the person to be interviewed. She or he will already have had a letter or phone call introducing the research project and its partners. However, they should also have an opportunity to ask questions about the project.

- Introducing oneself and the project
- Answering any questions
- Confidentiality
- Collecting documents for later analysis

Background:
Tell me how you came to have this job (cover educational and employment background, why chose it, what hoped to get out of it, explore any striking differences or similarities between past and present jobs)?

Description of own work:
To what extent is care work with elderly people your area of expertise?
What theoretical and practical knowledge of the field in the past and at present?
Who or what inspires you in your work?

Policy
What recent policy reforms have had an impact on care work with elderly people?
What has been or will be the impact of these policy reforms, e.g., introduction of national standards on:
Quality of care services
Recruitment and retention of care workforce
Status of care work with elderly people
Employment conditions of care workforce
The backgrounds of people who elect to work with elderly people (gender, ethnicity, age)

Values and principles
How do you understand the term social care?
What values and principles are important to be equipped to do care work with elderly people?
Have you noticed any changes over time in the values and principles attached to care work?

Training today
What subjects are covered in the curriculum for training courses for care work with elderly people? Would you like to see any changes to subjects covered?

What is the role of theory in training for care work with elderly people?
Does training prepare students for work with relatives and families, and for work with other professionals? Is it adequate? (Do you think it should?)

Does students’ personal development form any part of training? Do you think it should?

How are diversity issues, such as gender, ethnicity and disability addressed in training?

Are the present forms of training relevant to jobs in elderly care?

What changes to training would you like to see?

How flexible is training – can it adapt to new policy or practice needs as they arise?

What further ongoing training needs for care workers are important? How are they met, if at all?

**Views about care work**

What purposes or roles do you think care work with elderly people currently serve? Are these right? Do you think families should do more for elderly relatives or should more or other kinds of services be developed?

How important is formal care for elderly people to society (for female and male relatives, elders, the economy)?

What is and should be the status of care work with elderly people? What are the most important factors in achieving any changes?

How important is it to have male care workers or care workers from different minority ethnic groups? How important is the age of care workers when working with elderly people?

**The future**

If you were faced with a challenge to substantially upgrade the level of training that those people working with elderly people receive, and the numbers of people working with elderly people were to substantially increase at the same time, how would you go about it? What structure of training would be best and what content of training would you advise?

Any further comments?
Interview guide for national policy makers

Introduction
It is important to get acquainted with the person to be interviewed. She or he will already have had a letter or phone call introducing the research project and its partners. However, they should also have an opportunity to ask questions about the project.

- Introducing oneself and the project
- Answering any questions
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- Collecting documents for later analysis

Background:
Tell me how you came to have this job (cover educational and employment background, why chose it, what hoped to get out of it, explore any striking differences or similarities between past and present jobs)?

Description of own work:
To what extent is care work with elderly people your area of expertise?

What theoretical and practical knowledge of the field in the past and at present?

Who or what inspires you in your work?

Policy
What recent policy reforms have had an impact on care work with elderly people?

What has been or will be the impact of these policy reforms, e.g., introduction of national standards on:
- Quality of care services
- Recruitment and retention of care workforce
- Diversity in the workforce (gender, ethnicity, age)
- Status of care work with elderly people
- Employment conditions of care workforce
- The extent to which the workforce is trained, and the kinds of training seen as relevant

How are the standards being monitored nationally and locally? How will or can standards be changed in the light of experience and monitoring?

How do you see the relationship between policy and training in care work?

How do you see policy developing in care work – how has it arrived at this point and what directions will policy take in next few years (e.g., direct payments, pensions problems, people living longer with disabling conditions, improving health and political power of older people, citizenship and lifelong learning principles)

Are there any policy parallels between care work with elderly people and childcare work or care work with adolescents in residential or foster care? Are there channels of communication between the policy areas?
**Values and principles**
How do you understand the term social care?

What values and principles are important to be equipped to do care work with elderly people?

Have you noticed any changes over time in the values and principles attached to care work?

**Views about care work**
What purposes or roles do you think care work with elderly people currently serve? Are these right? Do you think families should do more for elderly relatives or should more or other kinds of services be developed?

How important is formal care for elderly people to society (for female and male relatives, elders, the economy)?

What kind of formal care do you think is best for older people? Do you think the current choices (home care, residential care, nursing care, hospitals) are sufficient, or should other forms of care be developed? If so, what?

What is and should be the status of care work with elderly people? What are the most important factors in achieving any changes?

How important is it to have male care workers or care workers from different minority ethnic groups? How important is the age of care workers when working with elderly people?

**The future**

If you were faced with a challenge to substantially upgrade the level of training that those people working with elderly people receive, and the numbers of people working with elderly people were to substantially increase at the same time, how would you go about it? What policies would best promote this, and what structures would need to be in place?