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MORE AND BETTER JOBS IN HOME-CARE SERVICES

FRANCE

Etude réalisée pour Eurofound

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Contents

Introduction

This country report gives an overview of the labour market policy in community-based care for adults with disabilities in France. The main topics discussed are the context in which community care labour market instruments are implemented, the funding structure, the strategies used to recruit new employees and retain current workers in the sector and the resulting impacts and outcomes. Three case studies were carried out into initiatives in the field of labour market policies in community-based care to support adults with disabilities: Establishment and service supports through work (ESATs), PMR transport service, and Professional accreditation for work experience in community-based care. Annex 1 to this report contains summaries of the three case studies and analyses the main outcomes and success factors.

1 Policy background

Overview of the care sector in France

Care services for adults of working age with disabilities are built on:

- institutional structures that intervene in the housing of people with disabilities;
- community care services at the home of people with disabilities.

It is difficult to specify the share of each of these sectors but it is easy to identify institutional structures providing accommodation to adults of working age with disabilities. Distinguishing community care structures dedicated to providing home care to people of working age with disabilities is more difficult, as most of the structures are not specialised in working exclusively with such people. They also provide help at home for older people with disabilities or for households of various ages without disabilities.

The care offered relies on many systems and structures. Historically, healthcare and social care services have been structured around large national non-profit associations of patients and their families. In France, these associations are sectored by type of care depending on the target users (people with motor disabilities,[1] intellectual disabilities, sensory disabilities or mental health problems, physical rehabilitation centres, senior care).

Services providing care at the home of people with disabilities need a specific agreement from the Préfet (regional representative of the government) and have to fulfil a number of conditions regarding the quality of service, training and qualifications of their staff.

As is the case for all private companies in France, all structures delivering home-care services as well as residential care services (except public employers) are controlled both by Labour Inspection (a government administration verifying that the labour legislation is adhered to) and the DGCCRF (General Director for Fair Trading, Consumer Affairs and Fraud Control, a government organisation in charge of verifying the quality of goods and services provided to the public)[2]. Residential care services are more tightly controlled than home-care services, as they are also visited by inspectors of the Regional Agency for Health (Agences Régionales de Santé) and by regional representatives of the Ministry of Social Cohesion (Directions Régionales de la Jeunesse, des Sports et de la Cohesion Sociale, DRJSCS).[3]

There are many companies involved in home care. According to the National Agency for Personal Services (Agence Nationale des Services à la Personne), 11,600 different companies were providing care at the home of people with disabilities in 2012. Some of these structures are part of one of the national federations of home-care organisations.

The companies sending workers to the home of people with disabilities (Sector 8810A – aide à domicile in the 2010 labour survey) are quite varied, but most have an associative structure. As a whole, 54% of the workers in this sector are employed by non-profit organisations (association loi de 1901), 11% work for a private company (either a limited liability company (SARL) or a simplified stock joint company (SAS)), 7% are employed by the public sector (mainly local authorities), 3% are employed directly by the households they work for and 2% are self-employed. Those employed either by an NGO or private company represent 22% of workers, but the employers' legal status cannot be identified more precisely in the survey. In this survey, there were no employees in the home-care sector working for a cooperative company.

[1] Motor disability means a physical disability that creates mobility impairment (as opposed to hearing and seeing impairments).

[2] http://www.servicesalapersonne.gouv.fr/controle-et-retrait-(93242).cml

[3] Code de la santé publique Livre IV Titre II les Agences régionales de la santé. On the missions of the DRJSCS; see décret n°2009-1540 du 10 décembre 2009 and décret n°2009-1484 du 3 décembre 2009.

Reasons for developing and maintaining community-based care services

The general trend in the last few years in France has been to develop community care services to provide more choices for people with disabilities. This option was strongly supported in the law 'for equal opportunity and rights, participation and citizenship of disabled people' (Loi pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées, 11 February 2005, 102). When given the possibility to choose, people with disabilities most often stay at home. As a result, the number of places in institutions dedicated to people with disabilities aged 20–59 years old represents only 3.2 per 1,000 of the whole population in this age group. This number has not changed in recent years. Meanwhile, there has been an increase in the number of people of working age who are entitled to disability benefits. This means that the number of people with disabilities staying at home is increasing.

The major rationale for developing and maintaining community-based care in France is to preserve autonomy and consequently to keep people with disabilities in their own home for as long as possible. Several opinion surveys show that French people with disabilities prefer to stay at home rather than in a residential care setting (such as Baromètre Prévoyance Dépendance 2011 TNS SOFRES). The fact that home care is cheaper than residential care has not greatly influenced the debate in France.

Type of community care services available

In France, the sector of community-based care, access to healthcare services and various aspects of overall personal support are mainly organised to counteract a loss of autonomy among older people, regardless of the actual origin of the loss of autonomy, be it age or disability.

In addition to institutions and homes that care for many people in one location, scattered housing, mixed real estate developments and assisted living facilities are contemporary alternatives developed to support people who are not independent. Along with these new types of housing, the organisation of care services – associated with the restructuring of healthcare resources – tends to increase the local availability of a community-based service.

Community care services specialised in healthcare are, amongst others:

- home hospital services (hospitalisation à domicile);
- home nursing services (services de soins infirmiers à domicile, SSIAD).

Other services provide care to help keep people with disabilities at home such as:

- helping them get up, washed and dressed in the morning;
- household cleaning, cooking and shopping;
- helping them go for walks and attend leisure activities;
- assisting people with disabilities to travel.

Some adults with mental health problems require specific help in relation to their finances. In this case, a judge can order that they be helped by a professional (mandataire judiciaire) to deal with these issues.

Various organisations provide community-based care services, such as:

- municipal authority services (especially community centres for social action – centres communaux d'action sociale, CCAS);
- local hospital services;
- health insurance companies, which also provide direct care;
- non-profit organisations in the home-care sector;
- private companies in the home-care sector.

Labour market situation

The national survey on labour requirements (Besoins en Main d'Œuvre, BMO) is conducted every year by CREDOC for the National Employment Agency (Pôle Emploi) amongst companies with at least one employee. Those employed directly by a household are not included. Recruitment intentions were particularly high in the care sector in 2012, and more specifically in home-care services (home helpers – aide à domicile and aide-ménagère), with more than 50,000 forecasted recruitments. This accounts for around one-third of the recruitments in the care sector.

Employers in the care sector expected that 66% of the vacancies would be difficult to fulfil in 2012. For the whole economy, this figure was 43%, meaning that finding personnel in the care sector is much more difficult and this had increased compared to 2011 (61% for the care sector and 38% for the whole economy).

The main reasons for the difficulties in finding personnel in the care sector were the lack of candidates (77%), lack of skills, diplomas and motivation (67%) and poor working conditions (45%). For the whole economy the reasons were the lack of candidates (62%) and lack of qualification and motivation (87%). Working conditions were quoted by only 33% of the employers.

PESTLE analysis

The research used the 'PESTLE' model to identify the external factors influencing the development of the labour market. The six dimensions in the PESTLE model are the *political*, *economic*, *social*, *technological*, *legal* and *environmental* dimensions. The PESTLE approach was originally a business-study model used to describe a framework of relevant factors at the macro level, used mainly for analysing the business environment of organisations. It is a means of measuring strengths and weaknesses against external factors and can help organisations develop strategies. In the same way, a PESTLE analysis can also be used for a contextual analysis of sectoral labour markets.

These six dimensions can greatly influence the sectoral labour market, although some are obviously more important than others. In the context of the research into the care sector, particular consideration must be given to the political and economic dimensions, as these have direct effect on the possibility of creating attractive and useful jobs in the community-based care sector. The financial dimension is of special importance in this context since this is not a commercial sector, but one generally financed with public money.

Since the situation in the different countries included in the research is different, the labour market discrepancy model connected to the PESTLE factors can identify where the issues lie in each country. The model provides, in a sense, a common language that describes the challenges faced by the different actors. As previous research has already shown that there is a general shortage of labour in the sector, and in some cases a shortage of jobs, it is to be expected that there are clear discrepancies. The model can swiftly record whether these are qualitative or quantitative, due to a lack of influx into the sector or too great an outflow than can be compensated for, or whether they are triggered by developments in one of the PESTLE dimensions. At the same time, the model offers a structured means of comparison.

Political and legal factors

- Various national federations of associations are lobbying to give political support to the improvement of services for people for disabilities. These federations of associations tend to represent families affected by intellectual disability, such as UNAPEI (National United Associations of Parents of 'Unadapted' Children), and they generally consist of representatives for people with physical impairments, such as APF (Association of Paralysed People of France) or APAJH (Association for Disabled Youths and Adults).
- There has been much debate in France in recent years about the financing of services for older people who have lost their autonomy. In 2011, the Minister of Solidarity and Social

Cohesion organised a debate among representatives of members of parliament, local authorities, associations representing families and people with health problems, trade unionists, civil servants and researchers. Four different groups met regularly and produced reports outlining the situation and proposing reforms. These reports were published in June 2011 by the French publisher of official reports, La Documentation française. These publications provided an opportunity for a larger debate in the French media. This debate includes the creation of services to cover the needs of people with disabilities in each age group.

- New requirements have been introduced for organisations active in the care sector for vulnerable groups (children, elderly people and people with disabilities). The requirements relate to the employment of qualified staff, the provision of training for employees to improve working conditions, the availability of supervision and client satisfaction.
- To cover increased unemployment, the government has tried to develop new jobs in the care sector through the Borloo Plan (2005 and 2009, see Chapter 2).

Economic factors

- In France, the unemployment rate has risen since the economic crisis, from 7.5% in 2008 to 10.5% at the end of 2012.[4] Young people are particularly affected by unemployment, as more than a quarter of people under 25 did not have a job in 2012. At the same time, employers often face recruitment difficulties, as the job demand in specific geographic areas does not always match the offer in terms of skills requirements. As seen above, the national survey on labour requirements provides figures about the recruitment intentions of French employers (reflecting both job creation and staff turnover) and whether or not these are expected to be difficult to fill. Since 2010, around 40% of the recruitment projects are seen as difficult by employers. Difficulties are even higher in the construction sector (more than 50%). In the care sector for disabled people, the demand for care services is considerable, but recruitment difficulties are also very significant, as two-thirds of recruitment projects were considered difficult by employers in 2012. The main reasons for difficulties in finding personnel in the care sector is the lack of candidates (77%), which shows that the sector is not very attractive for young people, even in the context of high unemployment.
- In the context of high unemployment, finding a job becomes harder and harder for people with disabilities. People with minor disabilities who could find employment in more economically favourable times are more likely to apply for a disability allowance. This economic context may contribute to the increase in the number of beneficiaries of a Disabled Adult Allowance or Disability Pension.[5] More people with disabilities are subsidised and can pay for home-care services. The Disabled Adult Allowance (Allocation Adulte Handicapé, AAH) guarantees a minimum income to people aged 20–60 whose incapacity rate is either above 80% or between 50% and 80% and who have a significant long-term restriction to work. There were 915,000 recipients of the AAH in 2010, which accounts for 2.4% of adults aged 20–64. The number of recipients is regularly increasing: between 2001 and 2010, these numbers went up by 24%.[6] During Nicolas Sarkozy's presidency (2007–2012), the AAH increased by 25%. This contributed to the rise in the number of recipients, as this allowance can supplement income for people with disabilities receiving less than the full amount of AAH (Velche, 2012). However, this increase looks set to be a long-term trend. The eligibility criteria based on 'non-employability' were debated, but were then considered impossible to use.

[4] Source: Labour Force Survey, INSEE-national statistical institute.

[5] A report from the senate showed that in some councils (Départements), the commission for people with disabilities' rights and independence (CDAPH) had a higher tendency to allocate the AAH to long-term unemployed people over 50 years old (de Montgolfier, Cazalet and Blanc, 2010).

[6] Source: CAF – Bénéficiaires tous régimes des prestations métropole et DOM.

- Employees or unemployed people who have contributed to the social security insurance (assurance maladie) as workers for at least 12 months are entitled to the disability pension (pension d'invalidité). In 2011, there were 940,100 beneficiaries of the disability pension, which represents 2.3% of working age adults. Between 2001 and 2010, this number increased by 33%.[7]
- Due to the economic crisis, the expenditure of the department councils for the minimum income benefit (RSA) has increased. As a result, subsidies to the community care enterprises providing care to disabled people are under pressure.

Social factors

- Due to the ageing population, the demand for care at home or in institutions (in terms of numbers as well as the period of support needed) is increasing. These care services generally also provide services to people with disabilities of working age.
- Due to harsh working conditions, the degree of sick leave (in terms of number and duration) in the care sector is high.[8]
- The number of people with disabilities wishing to remain at home for as long as possible and to participate in local social life is increasing.

Technological and environmental factors

New medical and technological devices make it more feasible to stay at home longer.
The environmental factor does not seem to have much influence on the labour market in community care.

Recruitment and retention of care workers

Recruitment in the community-based care sector is influenced by the following factors.

- The jobs are often part-time jobs, while most of the staff prefer to work full time to earn more.
- It is not always possible to work the number of hours desired by one employer, yet working for several employers often creates schedule problems.
- The time for transport from one household to another is not always paid as working time.
- These working conditions are creating an unattractive image of the sector. There is no general policy to retain workers in the care sector.

Employment services for adults with disabilities

Several care institutions provide socioprofessional support to improve the employability of people with disabilities. This support includes assistance to work establishments and services, job-seeking services and job-preserving services. These institutions are facing an increase in requests due to the very high unemployment rate among people with disabilities (19% in 2011, which is twice as high as the French average).

[7] Tableau de bord sur l'emploi et le chômage des personnes handicapées, source: DARES-Ministère du Travail.

[8] Two national agencies in charge of monitoring risk reduction at work – INSR (Institut national de recherche et de sécurité pour la prévention des accidents du travail et des maladies professionnelles – National Research Institute for Preventing Work Accidents and Occupational Diseases) and ANACT (Agence Nationale pour l'Amélioration des Conditions de Travail – National Agency for the Improvement of Working Conditions) – agreed on the major risks faced in the home-care sectors. Workers suffer from musculoskeletal disorders that particularly affect their hands, shoulders and backbone due to repetitive gestures and lifting people with disabilities. Because they often have to travel from home to home, visiting several households in a work day, they are more likely to be involved in a road accident. They also are at risk of suffering from stress. See http://www.anact.fr/web/dossiers/mutations-changements-organisationnels/services-a-la-personne?p_thingIdToShow=22719582 and http://www.inrs.fr/accueil/secteurs/commerce-service/service-personne.html.

People recognised as workers with disabilities can benefit from two kinds of professional orientation: a so-called 'ordinary' work environment or a protected work environment. Whether or not a person is disabled is assessed by the Commission for People with Disabilities' Rights and Independence (CDAPH), based on advice from a trans-disciplinary team within MDPHs (Maisons Départementales des Personnes Handicapées – Departmental Centres for People with Disabilities).

Professional orientation in the mainstream labour market

The mission of CAP Emploi, which had 103 offices in 2011, is to help workers with disabilities to find employment. They are financed by the National Employment Agency. In 2011, over 87,500 workers with disabilities received support from CAP Emploi and 67,000 placements were established, 7% of which were with public employers.

Another institution helping people with disabilities to find employment is Handipole. Handipole is a department of the National Employment Agency specialised in assisting people with disabilities. In addition, there are various associations assisting job seekers with disabilities and specialised recruitment services advising companies on employment issues related to people with disabilities.

Professional orientation in the protected work environment

The aim of the ESATs (Etablissements et services d'aide par le travail) is to facilitate integration into the mainstream labour market for people with disabilities. Apart from professional support, they provide medical, social and educational support to people with disabilities in order to help their personal and social development.

ESATs employ workers with disabilities, regardless of the nature of the disability, who are aged over 20. Their status differs from common law employees. Most ESATs are managed by an association and financed in part by the government.

EAs (Entreprises adaptées) are businesses where 80% or more of the employees are disabled. These firms must have a licence from the regional government (Préfet). The employees receive at least the official minimum wage.

Legal obligation for French companies to employ disabled workers

In France, businesses with more than 20 full-time jobs are obliged to employ people with a disability (at least 6% of the workforce). Most companies fail to fulfil this obligation and must pay a financial contribution to the AGEFIPH (Association de Gestion du Fonds pour l'Insertion Professionnelle des personnes handicapées). On average, the percentage of disabled workers per enterprise is 2.7%.

The AGEFIPH plays a central role in helping people with disabilities to find employment by, for example, subsidising the adaption of the workplace, providing a bonus when a person with disabilities is hired and supporting companies to develop a policy for employing disabled workers.

2 Political and legal frameworks

Regulations and policies on recruitment in community care services

There are three major ways of recruiting in community care services. These ways apply to the sector in general and not only for the recruitment of home-care workers for people with disabilities.

- The most common method is that the household directly recruits the person providing the care. Around 57% of the 891 million hours of care provided in personal services in 2010 (excluding childcare) was carried out by workers directly recruited by households (Ould Younes, 2012). 'Directly recruited' means that the household finds the person themselves and arranges the necessary paperwork. The Fédération des Particuliers Employeurs de France supports individual households with the legal obligations (administrative work, collective agreement in the sector, and so on).
- Almost one-third of the hours are carried out by employees who are employed by an organisation (organisme prestataire). The household pays the organisation for the recruitment and the administrative obligations. The use of an organisation is increasing; in 2000 it covered one-sixth of the hours. Most of these organisations are private companies (including mutual health insurances) and non-profit organisations (associations). Some of them are directly run by local authorities (especially by municipal authorities, such as community centres for social action – Centres Communaux d'Action Sociale).
- There is an intermediate solution, called the representative body (organisme mandataire). In this situation, the organisation recruits the employee and the household arranges the administrative work. In this case, the household is the employer. In 2010, this solution covered 9% of the hours and its use is decreasing. All these organisations are private companies.

Universal service employment cheque

The main objectives of the universal service employment cheque (Chèque Emploi Service Universel, CESU), introduced in January 2006, are to promote the development of personal services, to reduce the use of undeclared staff in the domestic sector and to ease the recruitment and employment of domestic care (home care). The CESU was introduced to simplify the administrative work and to secure the payment of wages and social contributions for domestic workers. The cheques can be used for paying staff who are directly recruited or for paying an organisation if the domestic worker is employed by such an organisation. The list of tasks that can be paid for with the cheque has been defined by the Borloo Plan (see below).

Generally, the household using these cheques can get a chequebook from a bank with 20 cheques. Each cheque has two parts: one part to pay the employee and another part to declare their name and social security number of the employee, the number of hours worked and the wage paid. This form has to be sent to the national service in charge of calculating the social charges to be paid by the employer and registering social contributions (health insurance and pension scheme).

Another type of chequebook is the prepaid CESU, which is provided by certain employers of households using personal services, pension providers, non-profit organisations or local authorities.

Recruitment strategies for community care workers

No specific national strategy or policy exists in France for the recruitment or retention of community care workers.

However, the recruitment and retention of community care work is indirectly influenced by two national laws that govern labour in the care sector for people with disabilities: the 11 February 2005 law and the Borloo plan.

11 February 2005 law

The 11 February 2005 law (2005-102) is one of the main laws dealing with the rights of people with disabilities. This law covers a large number of aspects disabled people's lives (care, compensation rights, resources, education, employment, accessibility, citizenship, and participation in social life). There has been no general assessment of the 11 February 2005 law and the impact it has had on the recruitment and retention of employment in community care.

The Borloo plan

The 2005 Borloo plan has two goals: developing more jobs in the care sector and responding to social needs. The plan includes 26 groups of activities that can provide tax reductions to users of these services. These activities are mainly related to traditional home care for older people, which still accounts for over half of the jobs in the care sector, and which also remains very diverse, considering the significantly diverse needs and users.

The Borloo plan has widened the list of activities eligible for tax reductions and that can be paid by a universal service employment cheque (see above).

Under the Borloo plan, the National Agency for Personal Services (Agence Nationale des Services à la Personne, ANSP) was set up. The ANSP is supervised by the Ministry of Labour, Employment, Vocational Training and Social Dialogue and the Ministry of Crafts, Trade and Tourism. The agency:

- coordinates the implementation of actions relating to personal services (the entry of new stakeholders in the sector and the creation new jobs);
- develops and promotes quality services;
- coordinates the increase in the use of universal service employment cheques;
- supports and sets up pilot initiatives related to the promotion of training in the field of home-care services.

There has been no general assessment of the Borloo plan. It is widely considered that a large part of the job creation was due to a legalisation of undeclared workers, which has a positive impact on these workers' access to social rights (social security, national pensions and training). A report from the senate in 2010 pinpoints the slow growth of the share of provider organisations in the number of hours carried out at home in care services, which is a limitation for professionalising the sector (Kergueris, 2012).

3 Structural framework, funding and actors involved

Employment in the care sector

The estimate of the number of jobs in care for people with disabilities is based on the Labour Force Survey.[9] It is difficult to know precisely how many employees work for people with disabilities receiving home care, as part of these hours are paid directly by them and can hardly be differentiated from the general use of care services for older people or people with no disability. The scope of community-based care services is broader than services for people of working age with disabilities. Details on the age of the household members benefiting from the care and their state of health are not included in the survey. Therefore, there are no details for this specific group.

In the context of the Labour Force Survey in France, 410,000 work situations of people aged 15 and above were registered in 2010. Half of these corresponded to employment situations. Every participant was interviewed each quarter and more than 100,000 participants were surveyed in 2010. The results are balanced to adequately represent the population aged 15 and over.

Table 1: Number of employees in services to support people with disabilities by activity code, 2010

NAF code[10]	Company's activity type	Number of employees
8810A	Community support work	261,400
8810C	Support by employment	122,100
8720A	Social housing for adults with mental health problems and intellectual disabilities	54,400
8710C	Medical housing for adults with disabilities and other medical housing	35,000
8810B	Support or care centres without housing for adults with disabilities or elderly people	10,200
8730B	Social housing for people with physical disabilities	7,300
8720B	Social housing for drug addicts	500

Source: 2010 INSEE Labour Force Survey, elaborated by CREDOC.

Community support can be characterised as a feminine sector, as only 4% of workers are men (even though men make up 53% of the general working population). People aged 45–54 carry out 27% of the jobs and account for 28% of all workers. This is probably why employees have been employed for longer in the community care sector than on average.

It is common for workers in the community care sector to have more than one employer, as is the case for 14% of them, which is close to the average for all workers.

More than one-third of the employees work fewer than 25 hours a week and nearly one-quarter are underemployed (they work part time but would like to work more hours), which is much higher than in the general working population.

[9] The Labour Force Survey is organised by the National Statistical Institute, INSEE.

[10] NAF (nomenclature d'activités française) is a numerical indexing code used by the French National Institute for Statistics and Economic Studies (INSEE) to identify French companies.

Table 2: Characteristics of workers and jobs in community support work in France, 2010 (%)

	Community support work	Total working population
Men	4%	53%
Women	96%	47%
Under 35	22%	31%
35–44	25%	27%
45–54	37%	28%
55 and up	16%	14%
Seniority of less than 24 months	30%	19%
Seniority of 24 months and more	70%	81%
Only one employer	86%	85%
Several employers	14%	15%
Stable job status	89%	76%
Insecure job status	11%	24%
Working hours (main employment) < 25 hours per week	35%	10%
Working hours ≥ 25 hours per week	65%	90%
Part time and wants more hours	23%	5%
Other cases	77%	95%
Moderated interviewee numbers	261,000	25,692,000
Interviewees before moderation (number of questionnaires gathered)	2,136	197,293

Source: INSEE 2010 Labour Survey, elaborated by CREDOC.

In the last decade, the number of hours worked in personal services has increased, although there has been a lower growth during the last few years due to the financial crisis, which reduced users' financial means). In 2010 there was a 0.3% increase compared to 2009, with 891 million paid hours for home care. This represents 429,000 full-time equivalents (FTEs) on the basis of a 35-hour week.[11]

It is not possible to make a distinction between home care for older people and people with disabilities of working age. Some of the home-care hours are for people with no disabilities. If the statistics on subsidised support by the French Department Councils (Conseils Généraux) are taken into consideration, among adults with disabilities being helped and living at home, one out of five is under 60 years of age. However, they highlight evolutions between direct employment and service provision. The number of hours by workers employed directly by households decreased in 2011 (–1.2%). On the other hand, the hours provided through service providers have continued to increase (+3%) and now account for 34% of the sector's activities. In 2010, 1.46 million people were working in community care, including one million employed directly by households.

Funding structure

The Department Councils provide financial support to adults with disabilities of working age living at home to pay for home care. The number of adults with disabilities receiving a

[11] Published by DARES (Direction of Animation of Research, Studies and Statistic) in September 2012.

contribution from the Department Council to help them stay at home by paying a home-care worker increased by 64% between 2007 and 2011. There were more than 194,000 beneficiaries in 2011. The support amounted to €1448 million in 2011.

All medical care provided at home is paid for by the social security system (Assurance Maladie). People with disabilities and those with long-term diseases can claim a 100% reimbursement of these costs.

The income of care workers directly employed by households is financed by individuals' incomes, who can claim part of it as fiscal advantages either meant for the general population or specifically targeted towards people with disabilities.

- **Meant for the general population:** The fiscal advantage refers to an income tax discount. Costs for personal service (support, providing meals, and so on) are entitled to a discount of 50% of the sums spent (benefits for this being deducted) on the income tax, up to a maximum of €6,000 per year (€10,000 for people with disabilities). This advantage is limited to households paying income tax (around half of the households in France do not earn enough to pay income tax). Most of the people receiving social benefits because of their poor health conditions are not able to deduce their care expenses from their income tax, as they do not earn enough to pay income tax.
- **Specifically targeted towards people with disabilities, such as an exemption of employer contributions:** Those who hire an employee, either directly or through a service, can benefit from social security and employer contribution exemptions if they receive disability benefit or an additional income from the disability insurance.

The national centre receiving the universal service employment cheque gets a management fee of €0.15 per cheque. This represents an expenditure of €1,567,000. This cost is paid by the National Agency for Personal Services (ANSP).

Organisations, actors and stakeholders involved

Historically, healthcare and social care services have been structured around large national non-profit associations of patients and their families. The care offered relies on a multitude of systems and structures.

Among these third sector employers, national groups of associations for adults and children with disabilities exist, which are either specialised for a certain type of disability – physical (Association of Paralysed People of France, APF) or mental (National United Associations of Parents of 'Unadapted' Children, UNAPEI) – or more general, such as APAJH (Association for Disabled Youths and Adults). These types of associations exist at a subnational level.

The third sector also includes many local associations. As needs arise, the third sector creates various types of establishments (hostels, specialised care homes) as well as residential services, specialised care service, support worker services and more recently, the Health and Social Support Service for adults with disabilities. Users of these services must be referred from the Departmental Centre for People with Disabilities (Maison Départementale des Personnes Handicapées, MDPH).

The main goals of the MDPHs are:

- supporting and informing people with disabilities and their families;
- helping and supporting the design of the life project and counselling;
- implementing decisions of the CDAH (Commission of Rights and Autonomy of Disabled People);
- coordinating within the department.[12]

[12] Article L.146-3 du CASF.

Since its creation in 2006, the National Agency for Personal Services (ANSP) has played an important role in improving the quality of the services in the sector and in inducing the development of staff training.

There are also many other organisations that support and care for people with disabilities (but not exclusively) at community level, such as:

- addiction care, support and prevention centres (CSAPAs) – groupings of specialised centres for addicts (CSSTs) and outpatient treatment centres for alcoholism treatment (CCAAs);
- care and support centres for risk reduction for drug users (CAARUD);
- residential therapeutic centres (CTR);
- therapeutic community centres (CTC);
- therapeutic coordination apartments (ACT);
- home nursing services (SSIAD).

4 Strategies for recruiting and retaining employees

General overview of activities in community care services

Targeting labour reserves

As previously mentioned, there is no specific policy from the National Employment Agency (Pôle Emploi) for recruiting and retaining employees in community care.

The new subsidised contracts for low-skilled young people, called *Emplois d'avenir* (Jobs for the future), offer a higher level of financial support for jobs in the non-profit sector or 'social economy' (Economie Sociale et Solidaire), mainly composed of associations in the care sector. The state finances 75% of the minimum wage during one–three years for jobs in the non-profit sectors, as opposed to a 35% subsidy in the private sector. In the near future, these government-sponsored jobs can be useful for attracting new workers into the care sector. However, since their introduction in France in the 1990s, these types of contracts have not been targeted to support job creation in specific sectors or occupations.

A recent CREDOC study on the conditions for success of these contracts in the social economy underlined the high potential of the home and institutionalised care sector in terms of recruitments (more than 100,000 recruitments every year) due to the high level of demand and the replacement of 600,000 employees who will retire before 2020. The study also showed that these contracts are considered very useful for recruitment by organisations facing financial difficulties due to the fall in public subsidies. However, interviews with employers revealed that the legal constraints and the high expectations of recruiters in terms of educational level and interpersonal skills could make it difficult for low-skilled young people to fulfil these requirements.

In early March 2013, the Ministry of Work announced that 10,000 contracts had been signed since the end of 2012 and that the objective of signing 100,000 contracts in 2013 could be reached. But the ministry also underlined that it is difficult to find employers for those young people who have little work experience and training.

There is no policy in France focusing on specific groups, such as new graduates, vulnerable groups, older workers, men, immigrants, workers and part-time workers, concerning the development of jobs in community care services.

In the context of supporting people who receive the RSA (Revenu de Solidarité Active, a form of minimum income benefit aimed at people who receive low wages), the system aims to inform and favour the professionalisation of employees in order to improve the quality of support and residential services.

An example of this is the Oise Department Council, which has recently put a system in place that offers RSA recipients the opportunity to become a 'friendliness visitor' to support people who suffer from isolation. Since October 2011, 16 recipients have been recruited and the Department Council's goal is to reach 30 people hired in the short term.

Employability by economic activity is intended as a transition to ordinary employment for people in difficulty. It is about putting people in a work situation by means of individualised support of people whose employability is considered low because of their age, lack of qualifications or experience. Particularly through Employability Associations[13] (according to DARES numbers, four Employability Associations out of five were licensed for personal services in 2008), people who are gaining employability by economic activity experience their first 'return to work' in the community care sector, doing tasks to combat individuals' loss of autonomy and ability to perform daily tasks.

[13] Employability Associations (Associations d'Insertion) – non-profit organisations dedicated to bringing people who have not been at work for a long time back to the labour market.

Promoting education and training

The education system for the care sector is mostly structured around two main trades: social assistants and specialised educators. Both of them are called social workers, but the first group is mainly dedicated to providing information to people in need of care services, while the other is directly in charge of delivering help and services.

Social workers usually follow a three-year training programme after the baccalaureate. But the diploma they obtain only corresponds to a two-year training, which does not make these occupations very attractive for potential candidates.

There are some potential barriers for newcomers without experience to obtain a social worker diploma: in theory, schools for social workers are accessible to people with a baccalaureate without professional experience, but in reality, there tends to be a selection in favour of people who have worked for at least one or two years in the sector.

Apart from social workers, home-care assistants (Auxiliaires de Vie Sociale) are low-skilled workers with low salaries and poor-quality, often part-time, jobs with lots of travelling from one client to another. The development of VAE (professional validation by experience) is meant to improve the qualification level of these professionals, but the various obstacles encountered lead to a low success rate – around 2% of candidates acquire this certification).

Improving the situation of current employees

The Borloo plan helped the legalisation of employees in the home-care sector by creating tax reductions for the cost of more tasks and by extending the universal service employment cheque. Reducing the informal economy in the sector provides more social rights, including training possibilities, for employees.

As mentioned above, the quality approval of organisations working in the sector of care for people with disabilities obliges these organisations to organise training for their staff.

Despite the willingness of professionals to be qualified with specific partnerships with training centres (such as AFPA or GRETA), access to qualifying courses remains limited. Support worker qualifications, or even the state diploma in social care worker (Diplôme d'Etat d'Auxiliaire de Vie Sociale, DEAVS), are seldom pursued due to the cost of becoming more qualified. Moreover, increasing qualification levels leads to an increase in salary costs, which organisations whose financial allowances are not greatly reevaluated can barely afford.

As acquiring a qualification is onerous, the personal care services develop support measures by means of targeted and isolated actions, such as the following, which often rely on associations' values, ethics and services.

- **Themed training days:** Educate carers to react to the behavioural problems experienced by some people with disabilities, to understanding the importance of hygiene for people with disabilities, and to support the ageing and future of workers with disabilities.
- **Short preventative training courses:** teach about movements and postures, preventing repetitive strain injuries (RSIs), and stress management at work.
- **Support of workers:** dialogue groups, practice work interviews, and help for professionals working in the care sector who submitted to the stress of dealing with people with various difficulties such as bad health, including terminal illnesses, or extreme poverty.

Improving operational management and labour productivity

The National Agency for Personal Services (ANSP) contributes to the improvement of management in companies in charge of the care sector by providing information on available training for managers in those companies.

Overview of activities focusing on the effects of the financial crisis

- **Ill-suited profiles and turnover:** Because of previously mentioned sociodemographic factors, the care sector represents a considerable pool of jobs. However, many limitations prevent job-seekers from taking up these jobs. This is due to the sector's relative unattractiveness, but also to the lack of national strategy from the National Employment Agency (Pôle Emploi) in favour of local vocational guidance actions. As these jobs do not usually require high-level qualifications, people are drawn towards care work without necessarily evaluating the human predisposition and social skills expected in and inherent to the job. Employers, who often have limited human resources staff, must deal with employees who are ill-suited to the job, which leads to a high turnover level in their teams.
- **The precarious financial balance of personal care organisations:** The personal services sector has been significantly weakened over the past few years. This is due to significant cuts in its main contributors' financial means, including Department Councils, and more generally to deregulation or a lack of coherence in running of the system. The Centre for Strategic Analysis (CAS), which has made projections for the sector for 2016 and 2030, states that 'There will thus be some stress in the coming years because of, on the one hand, government budget tightening, and on the other hand, an increase in collective and individual needs.'

5 Outcomes, results and impact of policies

Effectiveness of current instruments and policies

There is no global assessment of the Borloo plan to develop work in the home-care sector. The number of hours worked in private households (excluding childcare) in full-time equivalents increased from 2005 to 2008, and then stabilised under the effects of the economic crisis. It is generally presumed that some of the jobs created were due to the legalisation of previously undeclared staff in this sector.

As mentioned above, the Labour Requirement Survey shows that the care sector suffers from recruitment difficulties. These difficulties are mainly due to the lack of candidates, the lack of skills, diplomas and motivation, and poor working conditions. The two organisations in charge of improving working conditions and reducing risks highlighted specific health problems in the sector due to repetitive gestures, heavy lifting and numerous journeys from home to home. A survey on the home-care sector for people with disabilities conducted by a research team managed by Florence Weber (2011) underlined these difficulties. It identified the following potential actions to tackle them:

- bringing more young people to the sector, as the average age in the social and care sector is higher than the average age of the general active population;
- developing qualifications for current employees as well as newcomers to improve the working conditions and the image of the sector on a short-time basis;
- improving management in the sector to limit the time spent commuting.

6 Analysis of key trends, issues and policy pointers

This report gives a brief overview of the French labour market policy in community-based care to support adults with disabilities, illustrated by three case studies (see Annex 1).

Partly as a result of the ageing population, causing more demand for care, the costs of the French care system are high and continue to grow. Although specific surveys in France comparing the cost of residential care and home care are lacking, it is generally considered that community-based care is less expensive than institutional care. However, there is no specific survey to asses this assumption. Cost reduction policies are increasing the (already high) level of community-based care and place responsibility at community level. Another rationale for encouraging community-based care is stimulating patients' ability to live and do things independently for as long as possible.

In a context of decreasing public resources, the care sector has to accept the need to make services more professional, ensure the quality of employment in the sector and increase the range of services to meet a broad, increasingly diversified range of demands.

There is a discrepancy in the demand for improving the qualifications of the staff in this sector and the reduction of public subsidies to pay for the services. People with disabilities have important needs, but their ability to pay more for the care they receive is limited.

The National Employment Agency (Pôle Emploi) could play a major role in the development of a recruitment strategy for this sector. Providing training in this field for job-seekers could contribute to attracting more job-seekers in this sector.

Faced with an increase in systematic requests to remain at home, the sector must structure itself when emerging needs are identified by the sector's professionals. Although working conditions have improved in the past 10 years, areas of improvement are regularly identified along the following lines:

- train job-seekers in the care sector;
- secure careers for employees of the branch;
- develop a Provisional Management of Jobs and Skills (GPEC) policy that depends on labour pools;
- improve working conditions by, for example, using new technologies for 'tele-management';
- prevent professional risks in coordination with occupational doctors by the optimal use of domotic advances (home automation).

The working conditions in the sector remain harsh and include frequently imposed part-time work, lack of social recognition, long commutes, occupational exhaustion, professional isolation and multiple employers.

Job creation in the personal services industry has been continuous since the early 1990s, and has even accelerated since the governmental support plans to the sector have been in place. As mentioned, there is a general policy to develop the home-care sector, but it is not focused on disabled people of working age.

Ultimately, over 500,000 jobs have been created in 20 years, with cleaning assistance to elderly people and people with disabilities being the major part of the jobs created (180,000 extra jobs). Growth perspectives are positive for the next 20 years, according to the Centre for Strategic Analysis's forecast. And although job creation has slowed since the 2007–2008 crisis, hiring intention remains high, and difficulties in recruiting reveal a need for better guidance for potential applicants towards this sector, especially job-seekers.

The issues are of a political and financial nature in that they mobilise resources and stakeholders in order to support the development of social, individual and joint responsibility with a view to recognising people with disabilities as citizens with full, normal entitlements. It is under these conditions that it will be possible to increase the quality and numbers of jobs in the care sector for people with disabilities, including for those in the working age group.

The three case studies (see Annex 1), through examples of employment, mobility and vocational qualifications, illustrate France's policy on employment creation and retention in community care.

The examples, based on relatively longstanding systems, address the issues to be dealt with; profound changes due to sociodemographic change and the crisis in public finances, as well as political developments relative to the French situation. On the basis of these detailed examples, it is possible to make various recommendations.

In the case of ESATs, significant change is seen between the historic view of occupational centres (poor assessment of the value of work done) and the current drive for productivity required in its structures to offset the fall in government funding. This development has direct repercussions on employers' expectations of workers with disabilities and can create bias by selecting people according to their degree of productivity in the workplace. In terms of career development and requirements, it will be helpful to build a dual segmentation approach involving organisations and careers:

- one type of ESAT per district, according to the degree of productivity required to maintain the organisation's financial balance;
- a scale of assessment criteria for the careers of workers with disabilities, to better focus ESATs so that an individual's career can develop gradually.

In the case of special transport, the positioning of these services, in addition to universal entitlements, is moving towards use exclusively for people who are not able to use general transport systems, which in France must be totally accessible by 2015. In addition, support services for people with disabilities seeking help but able to use the general public transport system could be offered, on request, for all new journeys made. Stress situations related to handling the unforeseen or non-access to information should thus be reduced to improve the use of general public transport systems.

By boosting the employability of workers with disabilities in upward careers aimed at finding jobs in regular employment environments and by supporting people with reduced mobility in using public transport, two recommendations are made for services for people with disabilities to steer them towards the mainstream labour market. This dynamic, which is at the heart of the 11 February 2005 law, encourages care professionals on a local basis to develop these pathways between ESATs and regular environments.

Professional Validation by Experience (Validation des Acquis de l'Expérience, VAE) is aimed at developing individual careers and providing vocational training. Against a background of crisis, where the opportunities for internal promotion are poor but where demand continues to increase, greater use of the opportunities offered by VAE is encouraged to increase the opportunities for further vocational training in the care sector. To that end, routine support for accredited learning courses and the possibility of gaining accreditation per unit of value in order to support individuals' actions are recommended.

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Annex 1: Case studies

This annex presents the results of the three French case studies on initiatives in the field of labour market policies in community-based care to support adults with disabilities. The three case studies are:

Case study 1: Establishment and service supports through work (ESATs)

Case study 2: PMR transport service

Case study 3: Professional accreditation for experience of working in community-based care

Each case study includes a description of the initiative, definition of the problem, approach and implementation and contextual factors. There then follows an analysis of the outcomes and results of the initiative. Finally, the lessons learnt and factors regarding the sustainability and transferability of the initiative are presented.

Case study 1: Establishment and service supports through work (ESATs)

Description of the initiative

This case study looks at supported employment facilities for adults with disabilities, known as ESATs (Etablissements et Services d'Aide par le Travail).

ESATs exist nationwide and cover 1,345 establishments. They are part of the mechanisms in place to help workers with disabilities to enter employment. Decentralisation Acts have transferred much of the social care for vulnerable individuals (children, people with disabilities, poor people, and dependent older people) to local authorities, but the inclusion of people with disabilities in employment is still the direct responsibility of the national government. Therefore, most of the funding is provided by the Ministry of Health and Social Affairs (Ministère de la Santé et des Affaires sociales). Regardless of whether their managing structures are national or local, ESAT facilities are small-scale establishments. They can therefore be considered as community services.

Overall objectives

The main purpose of ESATs is to include workers with disabilities in employment. However, the facilities also have a social and educational role to play, with a large portion of staff's paid time being devoted to social work. ESAT facilities have two purposes. The first is to employ people with disabilities who are not capable of working in a mainstream company environment or in a supported workshop, but who are nonetheless able to work. The second is to give workers with disabilities the care and support they need to lead fulfilling social and private lives through help and advice from social workers, thus creating jobs in the care sector.

Definition of the problem

Policy background

ESAT facilities fulfil a special role, as they aim to facilitate the integration of people with disabilities into employment, and therefore into society too. The facilities are intended for individuals whose disabilities are recognised by the Local Disability Office (Maison Départementale des Personnes Handicapées) and who are deemed to have professional potential but who, due to their state of health, are unable to work in a regular or disability-friendly company environment (Entreprise Adaptée, a company that operates like a regular company but where 80% of the employees are workers with disabilities).

ESAT facilities receive financial support from the French Ministry of Health. The ministry's representative at the regional level, the Agence Régionale de Santé (Regional Health Agency), is an important partner for these structures, not only on account of its auditing role but also in discussions about the plans drawn up by each ESAT establishment.

ESAT facilities are designed to be open and receptive to their economic and social environment, and they enter into numerous partnership agreements. Some of these partnerships result from their commercial operations. Certain customers decide to use an ESAT facility because they want to show their support for the work they do to promote the inclusion of people with disabilities. ESAT marketing materials often refer to the corporate social responsibility of companies that use their services.

Issue at stake

Workers in ESAT facilities are primarily individuals with intellectual disabilities (72% of workers in 2006), followed by people with mental health problems (19%). Physical disabilities (hearing, visibility, mobility) account for a minority. Recent shifts reveal an increasing percentage of individuals with mental health problems and a falling percentage of individuals with intellectual disabilities. This trend can be related to the sharp fall in the number of places in

medical facilities for people suffering from mental health problems. As a result, for example, the French care sector will require more non-institutional but formalised care for people with disabilities, especially care workers specialised in mental health.

Through their work to integrate workers with disabilities into society, ESAT social workers become part of a network of local partners, through which they find housing solutions, preventive medicine programmes, care and even cultural activities for their workers with disabilities. Thus, the ESAT facilities both provide work for people with disabilities and support them in non-work aspects of life to promote social inclusion for the target group. It also creates jobs in the care sector for disabled people. Jobs are created for social and care workers, as they are the ones who support people with disabilities through non-work aspects of life.

Approach and implementation

Overall approach

ESAT facilities operate in production and services activities. Each ESAT facility has one or more workshops in which workers with disabilities work under the supervision of one or more supervisors. The most common types of activity in these workshops are: processing, packaging and dispatch; renovation and decoration (wallpapering and painting) and joinery; maintenance of parks and gardens; catering; cleaning; agricultural production and processing (vineyards, fruit-growing, poultry farming, preserves and jams); and sewing and tapestry (curtains, clothes, reupholstery). ESAT facilities also have a commercial side, selling their services and produced goods to customers in the private market. The commercial activity of ESAT facilities generates income that is allocated to the purchase of necessary production machines and equipment.

Aim of initiative

The aim of ESAT facilities is to train people with disabilities and recognise their skills at a level and pace that are appropriate to their capabilities. Work, as a vehicle for social inclusion, increases prestige and recognises people with disabilities as members of society. The professionals who contribute to this support system provided by ESAT facilities have relatively stable employment.

Recruitment versus retention

This measure focuses on promoting the social inclusion of people with disabilities; it does not focus specifically on either retention or recruitment. ESATs employ workers with disabilities aged over 20, regardless of the nature of the disability.

Specific target groups

ESAT facilities are intended for individuals whose disability is recognised by the Local Disability Office (Maison Départementale des Personnes Handicapées) and who are considered able to work but who, because of their state of health, are unable to work in a normal working environment or even in a disability-friendly company.

Formal versus non-formal employment

This measure does not focus on shifting non-formal to formal employment.

Project implementation

Programme level

In most cases, ESAT facilities were founded by associations representing disabled people's families. It is a bottom-up procedure. In order to be established, the ESAT needs to have a business plan on how the facility will be organised and run, be validated by the regional representative of the Ministry of Health (Agence Régionale de Santé) and receive the agreement of the regional representative of the state authority (the Préfet).

ESAT facilities are local structures found throughout France, although some regions are better provided for than others, as support for the organisations varies from region to region. The number of places available in each ESAT is set by the French state's regional representative, according to the establishment plan drawn up. Most people with disabilities working in ESAT facilities receive an adult disability benefit (allocation pour adulte handicapé (AAH)), from the French Benefit Office (Caisse d'allocations familiales) funded by the state in accordance with the policy of national solidarity. The ESAT facility then provides the rest of their salary so that they receive between 55% and 110% of the legal minimum wage (in addition to other subsidies and benefits granted by the French government).

In France, the integration of people with disabilities into employment is part of the state's remit. Payment operations are the responsibility of a national agency, the Agence des Services et des Paiements, which receives funding from the Ministry of Health and Social Affairs. Two types of funds are paid by the state to ESAT facilities. The first is the job support benefit, also known as the guarantee of resources to the worker with disabilities (Garantie de Ressources des Travailleurs Handicapés, GRTH). This supports the income of these workers and expenditure on this totalled €1.16 billion in 2011, approximately €4,300 per person per year. The second benefit is the general operating grant (Dotation Globale de Fonctionnement, DGF). This is intended to pay staff for their social and educational work with people with a disability. This came to a total of €1.4 billion in 2011, an average of €4,000,000 per ESAT. Both benefits are state funded and complementary to the AAH.

Project level

The 1,345 ESAT facilities in France provide employment for social workers as well as services for people with disabilities of working age. ESAT facilities employ 29,000 social workers and supervisors, the equivalent of 23,000 full-time jobs, which is approximately 16 full-time equivalent jobs per ESAT facility (2006 figures). ESAT facilities also provide work to 110,000 people with disabilities. These workers are not considered as salaried staff. Instead, they sign a specific contract with the ESAT where they work. Each ESAT facility provides support to an average of about 75 workers with disabilities.

Workers with disabilities who have access to an ESAT facility must be referred by the CDAPH, the commission for the rights and independence of people with disabilities (Commission des droits et de l'autonomie des personnes handicapées), which exists in each Local Disability Office (Maison départementale des personnes handicapées, MDPH).

Monitoring and evaluation

As the vast majority of ESAT facilities are non-profit organisations, their management teams must report regularly to the organisation's chairperson and its board of directors. ESAT facilities are audited by the Regional Health Agency. Their findings are used to reassess the financial support awarded by the French state to ESAT facilities.

Once every four–five years, the Ministry of Health carries out a statistical survey of all social care establishments, including ESAT facilities. This survey is processed by the ministry's statistical department and provides information about the characteristics of the jobs and population group reached by these structures.[14]

Contextual factors

Until 2005, ESAT facilities were called Support Through Work Centres (Centres d'Aide par le Travail, CAT). The first CAT facilities were created in 1954 by local and national non-profit organisations and brought together the families of people with disabilities. Their activities were regulated by various laws.

[14] The most recent survey dates back to 2010 and will be published in 2013.

Over the last 10 years, a number of laws have emphasised the importance of allowing individuals with a disability or long-term health problem access to a social life and to the same rights as people without disabilities or health problems. Incentives designed to encourage inclusion in employment are in keeping with this strong tendency to demand the same dignity and independence for people with disabilities as for any other citizen.

In the last few years, the government has begun to demand that ESAT facilities make efforts to improve their efficiency and profitability to become more self-sustainable. This shift in attitude can also be seen in the public sector and is precisely the philosophy behind the General Review of Public Policies (Révision Générale des Politiques Publiques), which has been aimed at increasing public sector efficiency while keeping its cost to a minimum since 2007. It is also the reason why the general trend in recent years has been to hold ESAT facility operating budgets steady without any increases in line with inflation or additional margins to fund new projects. In order to maintain their staffing levels and have the potential to take on new staff, ESAT facilities are being driven to improve the profitability of their commercial activities in order to make a budget surplus that they can reinvest.

Outcomes and results

Type and numbers of jobs created

According to information sourced from the Ministry of Health's statistical department (the Direction de la Recherche, des Etudes, de l'Evaluation et de la Statistique (DREES)), 54% of staff in ESAT facilities in 2006 were men and 46% women, they were mainly employed on permanent contracts (88%), their employment agreements were covered by the 1951 and 1966 National Collective Labour Agreements, and they had been working for the same ESAT facility for an average of 10 years.

The occupations with the most staff in FTE terms were workshop supervisors (47% of all FTEs), followed by administrative workers and office staff (8%). Educational, teaching and social staff account for approximately 60% of all jobs in ESAT facilities. The average ratio of staff to the number of places was approximately 13 supervisors per 100 places.

In terms of changes, between 2001 and 2006, the number of staff in ESAT facilities increased by approximately 15%, from 25,484 to 29,205. This increase does not necessarily indicate an improvement in the supervisor-to-places ratio, but rather, should be considered alongside increasing growth in the number of places in ESAT structures (116,000 places in 2011). This growth is due to the increasing orientations of MDPH, which since 2005 have been reinforced towards ESATs.

Other relevant outcomes

State funding of ESAT facilities is based on the vocational activities of the facilities and the potential progression of the supported individuals towards employment in a regular working environment. However, the reality of the population group supported means that this move towards the mainstream work environment is more of an ideal scenario, as shown by data published by the IGAS in October 2012:

the average length of time spent in an ESAT facility is 11.5 years, and one-fifth of the people in them have been there for more than 20 years.

only 5% of people leaving an ESAT during the year had employment in a regular, non-supported work environment (IGAS, 2012).

These observations do not call into question the usefulness of ESAT facilities, but rather, show the need for new forms of support facility that work with and strengthen concrete ties with the mainstream work environment, generating real employment opportunities for people in specialised institutions.

Main results

See the previous two sections.

Lessons learnt

Success and fail factors

One of the problems for ESAT facilities is that they compete with one another. The demands made by the French state for an improvement in efficiency could have a detrimental effect by driving ESAT facilities to take on workers with disabilities with a higher level of productivity and to curb the inclusion of individuals who are less efficient in the work environment.

The economic crisis is also making new contract opportunities scarcer and putting pressure on ESAT facilities that are unable to adopt an energetic approach to sales and marketing as a means of maintaining and growing their business in a negative economic environment.

Certain ESAT facilities are finding it hard to adjust to the requirement of improved performance and more professional management. In the future, some of these structures may have trouble surviving financially and state subsidies may no longer be enough to balance the accounts.

Another potential fail factor is the complete reliance on state funding. Given the current economic climate (amongst other things), this could be an obstacle for ESATs.

Sustainability and transferability

ESAT facilities have existed since 1954, so the question of their transferability nationwide within France does not arise. Transfer towards other countries implies the need for strong government support, as the low profitability level of such facilities would prevent most of these structures from existing if they were in direct competition with companies in the private sector.

While transferability does not seem to be an issue, the sustainability of these facilities is less certain. Given the French government's desire to make the facilities more efficient, combined with the increasing number of facilities, it is questionable how long these structures will continue. The government subsidises the workers with disabilities through benefits and funds the ESAT facilities as well.

Conclusions

The impetus for change in ESAT facilities, by boosting the idea of integration into the mainstream environment, has directly influenced the creation of jobs for medical and social workers, intended to promote access to employment and maintain people with disabilities in work.

Additionally, ESAT facilities are developing employment support for workers with disabilities in a regular environment by extending their skills.

Lastly, the availability of workers with disabilities increases host businesses' awareness of dealing with an individual's disability in the work environment, and gives them the chance to analyse and adapt workstations and to educate trainers.

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Case study 2: PMR transport service

Description of the initiative

This case study investigates the introduction and development of special transport services for people with disabilities. These special transport services aim to implement additional means of public transport to meet the demands of people with disabilities. The Grenoble case, through PMR transport (Personnes à Mobilité Réduite – People with Limited Mobility), will be used as an example throughout the case study because it illustrates current issues of accessibility. In addition, this pioneer service is found in a city where general accessibility has been a priority for a number of years in many spheres, such as transport, public areas and the university campus and housing.

Overall objectives

The overall objective is to provide special transport services form a dedicated service for people with limited mobility. These services help people travel from their home to their destination in suitable vehicles. These accessibility solutions are designed to meet needs not covered by existing systems and to adapt to the needs of people with disabilities.

Besides enabling adults with disabilities to live as normal a life as possible (including pursuing an education and career), these special transport services create jobs for drivers with interests and competences in the field of social care. However, creating these jobs is a consequence, not an objective.

Definition of the problem

Policy background

The issue of accessibility is broad in the sense that it does not just concern people with disabilities. Old age, illness, infirmity and reading difficulties and deficiencies can also result in difficulties in accessing particular places or urban areas. Various studies on mobility in modern urban societies (Allemand, Ascher and Levy, 2004, p. 336) have given rise to the notion of the right to movement as the basis of a universal service for mobility for all. Use of the road system, public areas, means of communication and information are integral aspects of mobility.

The freedom to travel without dependence is one of the essential points specified in France's 11 February 2005 law for equal rights and opportunities, participation and citizenship for people with disabilities. Faced with the wide variety of situations in major French towns, the law proposed a common framework and committed towns to implementing specific means to improve accessibility. The law gave a new impulse to integrating people with disabilities into society by providing that the 'chain of travel, which includes buildings, road systems, facilities in public areas, transport systems and moving between them, must be organised to make them accessible to all people who are either disabled or have limited mobility'. The law requires accessibility of the system by February 2015 at the latest.

Role of the social partners

Special transport services are usually provided in major towns by semi-public transport companies, such as Syndicats des Transports d'Ile de France (STIF) for Paris or Syndicat mixte des transports en commun de l'agglomération grenobloise (SMTC) for Grenoble. These semi-public transport companies depend legally and financially on city authorities.

Issue at stake

The features of substitute transport are mainly deduced from the 2005 law and its application directive, as presented in the following list:

substitute transport must suit the needs of people with disabilities or with reduced mobility (article L.1112-4 of French transport law);

the cost of substitute transport for users with disabilities must not be higher than the cost of existing non-accessible public transport (article L.1112-4 of the transport law);

substituting for a public transport service, substitute transport is itself open to all. If it can be organised for users with disabilities or those with limited mobility (as regular or on-demand transport can be), its access must not be restricted to constituents or residents of the locality.

As mentioned above, besides enabling adults with disabilities to live as normal a life as possible, special transport services also create driver jobs, but this is a consequence rather than an objective.

Approach and implementation

Overall approach

The Grenoble case provides a good example of how the measure is implemented and how it operates. Created 32 years ago, Grenoble's PMR service has reduced accessibility problems that people with limited mobility encounter getting from one destination to another in the city and its surrounding areas (population 400,000). In a town where the network is 99% accessible, with low floors and platforms designed for accessibility, difficulties are found mainly on the journey between home and the transport system. There are also difficulties for people with severe disabilities, preventing them from being independent on the general network's transport lines. The PMR service has 11 specialised minibuses that are able to carry up to five people in wheelchairs and are fitted with floor rails enabling the wheelchairs to be secured.

Aim of initiative

By having specialised vehicles and drivers, the transportation needs of people with disabilities can be met, and a gap in their means to social inclusion (including participating in education and the labour market) is remedied, as they can now travel more independently.

Recruitment versus retention

Grenoble's PMR service recruits drivers with interests and competences in the field of social care. There are two main recruiting processes for drivers of adapted transport systems: recruiting voluntary drivers of the public transport system; and posting job offers on transport professional organisations' or city hall's websites. Job retention can be supported by continuing training: drivers are given training concerning disability gestures and postures when starting their new position and along the way to become more specialised. Job retention for the older drivers is a specific issue in this kind of service, as professionals are often recruited based on their level of experience.

Specific target groups

Passengers benefitting from the service are mostly wheelchair users, but also people with other mobility problems. Currently, people are aged between 18 and 65, even though the service is seeing an increasing demand from wheelchair-bound elderly people. The main reasons for travelling are to go to specialist centres or to the workplace from home; the service is in addition to the general system and must be exclusively for people unable to use the general system. Before covering a person, the PMR staff sees whether the journey requested can be made on the general system and, if so, some people can then be redirected to the traditional lines.

Formal versus non-formal employment

This measure does not focus on shifting non-formal to formal employment.

Project implementation

Programme level

The PMR service has 16 driver jobs and about 30 stand-by drivers in the whole network. Employment involves drivers on the lines, with relatively long service in the company (they are not paid more for working for this service than in the general network); they are recruited on the voluntary principle through an interview with the human resources department. There are lots of volunteers and drivers are specially trained and receive first aid training courses and regular training with disability professionals to better appreciate the various disability situations and to understand how to deal with passengers during the journey.

Project level

As they make door-to-door journeys, drivers are not carers – they do not help people enter their home. If needed, PMR passengers can be accompanied by other people, who, when on board, help if necessary with travel before and after the PMR service. These carers are not hired by PMR, but are a part of the human help ascertained and paid for as part of the independence assessment by the MDPH (Maison Départementale des Personnes Handicapées – Local Department for People with Disabilities). For a town that has incurred substantial costs to make its network almost totally accessible, the SMTC does not now want to see its PMR service grow in size before it has optimised the use of the general system as much as possible; the aim is to have all people who are able to do so access the general system from the outset. The dynamic of the substitute transport service must remain a possible response to address any shortcomings.

Monitoring and evaluation

The service had 73 regular passengers and 232 occasional passengers in December 2012, giving a total of 305 passengers. It made 3,754 journeys. The PMR staff mostly consists of men, which reflects general trends in driving staff, and they have generally been employed by the company for many years.

Contextual factors

Development in response to growing needs: People with limited mobility mostly live in regular housing and they increasingly travel and go out. This trend encourages the development of local services within districts, guaranteeing their independence. Whether it concerns access to care, facilities, culture or social life, the most important thing is the notion of a local network. In addition, in terms of attractiveness of the services provided, a snowball effect can be seen. The PMR service is seeing passenger numbers steadily increase as Grenoble has the reputation of being very accessible for people with disabilities, encouraging more of them to move and live there.

A need for reassurance when using the general transport system: The management of the PMR service keeps its service just for people who cannot use the general transport network at all, or who find doing so very difficult. For those who decide to use the general service, the PMR service provides occasional support on the first journeys to boost their confidence on the network in order to free up the PMR service. This support should be coupled with greater awareness from all drivers on the general network to better deal with people with limited mobility on bus and tram lines.

Increased demand is compensating for the decrease in eligibility for medical transport: With a view to cutting costs paid for by social security, the requirements for eligibility and using medical transport vehicles (known as Véhicules Sanitaires Légers, VSLs) for people who have serious health problems have got tougher since 1 April 2011. Substitute transport services also handle limited situations in terms of coverage. In spite of a precise assessment of the consequences of disability, requiring a manual or electric wheelchair or assistance with breathing, with a view to ensuring that the means of transport match the individual's needs, some situations come within the scope of VSL medical transport. The PMR services make many

journeys for medical treatment. But apart from regular medical appointments, PMR services may well have to transport people in an increasingly fragile state of health.

Outcomes and results

Types and numbers of job created

The study on special transport services in the major French cities conducted in May 2007 with 65 transport authorities in major French cities and their surrounding areas shows how dynamic this activity is: together, the 45 services analysed account for more than 1.64 million journeys a year, covering 16 million kilometres by some 450 vehicles. Seven hundred people, 80% of them drivers, work to ensure that the services operate correctly. The services saw passenger numbers grow in 2004 and 2005 and an average increase in the number of journeys of around 8%. In total, the 45 services have 30,000 registered users, or 26 per 10,000 inhabitants. On average, a user's journey lasts 26 minutes over a distance of 10 km. Pre-booking times of about 24 hours are generally required.

This increase in the number of users and journeys in the major French cities was accompanied by a substantial increase in the number of jobs associated with special transport services. Besides drivers and driver-carers (who are specially trained on different types of disability, smooth and preventive driving, handling wheelchairs and the quality of service to meet the requirements and needs of people with disabilities), other types of jobs were also created. For instance, in Paris and its surrounding area, the PAM75 network (Pour Accompagner la Mobilité – the Paris Transport Service) makes more than 300,000 journeys a year for people with limited mobility and has 128 vehicles. Special PAM advisers provide information on PAM75 services and help with the process of registration by going to homes and workplaces on request, logging transport bookings and managing the PAM-PASS card, for example.

Unfortunately, no data are available on the numbers of jobs created.

Other relevant outcomes

The main studies on specialised transport services show that special services are requested by users to go to their place of work: on average, work is the reason for up to 40% of travel on special transport services in major French cities and their surrounding areas (IAU Ile-de-France, 2007).

Main results

See the previous two sections.

Lessons learnt

Success and fail factors

By transporting people with disabilities from their home to their destination in specially adapted vehicles, substitute transport services have introduced dedicated teams of drivers specialising in transport for people with reduced mobility. The drivers are specialists who have all been trained about disability. These drivers make journeys where preventive driving, safety and the relationship with passengers are crucial. The example of Grenoble demonstrates drivers' commitment to the quality of the relationship with the people with disabilities they transport. In addition, recruitment to this department is on the basis of length of service in the transport company of drivers in the general system, as a form of thanks.

No (potential) fail factors were identified.

Sustainability and transferability

Transport services have been developing rapidly since the 1980s and have been reinforced since the 2005 law. These services now exist in most large and medium-sized cities. In addition to the

development of accessible public transport services, adapted transport services bring an added value, as they offer a door-to-door service, provided by dedicated drivers who are aware of disability issues.

Conclusions

The services are intended to be in addition to general systems for people who encounter difficulties getting from home to the nearest public transport terminal, or for people whose state of health does not allow them to travel alone.

Regarding the reasons for travelling, people mostly use these services to get from home to a medical or social facility, to go to work (40%) or to appointments relating to their health (20%).

People with reduced mobility mostly live in regular housing and they increasingly travel and go out. This trend encourages the development of local services, guaranteeing their independence. A survey conducted in 2007 in 65 major French cities and their surrounding areas shows that these services employ 700 people, 80% of whom are drivers.

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Case study 3: Professional accreditation for experience of working in community-based care

Description of the initiative

This case study focuses on accreditation of prior learning (Validation des Acquis de l'Expérience, VAE) for jobs in healthcare and social work. VAE is the fourth path towards certification, after basic training, apprenticeships and in-service training. It allows candidates to obtain a state-recognised qualification by having their practical experience recognised and evaluated, without having to take a long training course.

The VAE scheme is a national policy. The health and social work diplomas are handed out on behalf of the Ministry of Health and Social Affairs. Information provision and the handling of applications regarding the VAE programme are dealt with by the national Services and Payments Agency (Agence des Services et des Paiements, ASP) and the regional departments for youth, sports and social cohesion (DRJSCS). The budget of the ASP's national VAE delegation is €8 million, including €4.5 million for examiners' pay and €3.5 million for the delegation's operating costs, which represents 36 full-time equivalent staff. They are funded by the Ministry of Health and Social Affairs.

Overall objectives

VAE enables individuals with at least three years' work experience to get a professional diploma or qualification. It is open to people who can prove they have a paid job, are self-employed or are voluntary workers (but not to undeclared home helpers).

Definition of the problem

Policy background

The VAE scheme was instituted by the social modernisation law of 17 January 2002. VAE is an individual right laid down in the Labour Code (art. L.900-1 5). It does not impose any conditions of age or educational attainment, only proof of experience as a paid or voluntary worker. Many home-care services for people with disabilities are provided by employees who specialise in help and support for people with disabilities, but who are not professionally qualified. VAE is their opportunity to further their professionalisation by having their experience and skills recognised. This process helps them further their careers and continue working in their sector of activity.

Role of the social partners

Among the actors who can be involved in VAE procedures (besides employees) are:

- Regional Councils, which finance candidates' preparation for VAE;
- job centres, which encourage job-seekers to move towards the recognition of their qualifications (only a minority of candidates for VAE are unemployed, the vast majority are employees);
- training organisations (often linked to the state), which provide logistical support to VAE candidates;
- employers who support their employees in these procedures.

Issue at stake

VAE in the health and social sector is a response to the lack of recognised qualifications of some of the sector's staff, particularly for low-skilled positions. By improving the recognition of qualification, this scheme helps to retain professionals in the sector.

VAE is a way of allowing career development in an area where, due to a lack of prospects, staff tend not to remain in their positions. The turnover in the sector is even more of a problem when it is associated with a recruitment crisis.

Approach and implementation

Overall approach

The VAE is an opportunity for people working in the home-care sector for further professionalisation and to have their professional skills recognised. This process can also help them further their careers and continue working in their sector of activity. The VAE only takes work experience into consideration, which forms the basis for granting certification of an individual's qualification regarding the care of people with disabilities.

Aim of initiative

VAE helps to professionalise people in employment who obtain certification through these means. It provides opportunities to improve their professional status (pay rise, promotion) and improves their chances of evolving, either in the same company or by changing employer. Job-seekers are a minority among people getting a diploma; however, they still improve their employability once they have been certified. VAE applies to all sectors, though the health and care sector represents one-third of all the candidates.

Recruitment versus retention

VAE focuses on retention rather than recruitment.

Specific target groups

VAE is specifically aimed at people who have or have had a job matching a given qualification but who do not have the corresponding qualification or diploma.

Formal versus non-formal employment

VAE is aimed at people already working in the formal sector who wish to stay there.

Project implementation

Programme level

Applying for VAE is an individual initiative. Most candidates are already employed, generally in the social sector. Sometimes the employer may have suggested to an employee that they should submit an application for VAE. Employees are eligible for financial support from the joint body in their professional sector approved to collect contributions within the framework of their company's training budget.[15] They can receive support from this training organisation to finalise the wording of their assessment booklet (see the section below). This aid is limited to 24 hours' consulting work. They can use their individual training entitlement to pay for these hours of consultation. Employees can also request three days' leave to prepare for their oral test. The certification procedure is organised by various ministries, depending on the qualification. Each ministry is responsible for ascertaining that candidates fully meet the requisite conditions of experience to apply for VAE.

Project level

There are several steps in getting a recognised qualification through the VAE.

[15] French companies with at least 10 employees have to pay a contribution to a joint body and approved collector (OPCA) to fund the vocational training of their employees. This contribution ranges from 0.55% of the wages bill for companies with fewer than 10 employees to 1.60% for companies with 20 or more employees. Companies can spend more on the training of their employees. The OPCA are joint bodies run by employee and employer representatives.

- The first step ascertains that candidates meet the required conditions of experience to apply for VAE. Candidates must first fill in an admissibility booklet summarising all their work experience in connection with the relevant qualification or diploma. They must also provide certificates of service substantiating their experience. At national level, nearly 8 out of 10 applications are accepted.
- Candidates then have to fill in a more detailed assessment booklet (called booklet 2), and write down the answers to a series of questions that are specific to each qualification or diploma that can be awarded under the VAE scheme.
- Lastly, candidates take an oral test with three members of an examining board.

The ASP then processes the application on behalf of the Ministry of Health and Social Affairs.

Monitoring and evaluation

At national level, DARES, the statistics office of the Ministry of Labour, publishes an annual assessment of VAE in the various certifying ministries and monitors trends in the number of candidates and their profiles over several years.

The ASP, which manages VAE applications, issues a report every year on its tasks of informing potential candidates, on its processing of applications, on the funding of examining boards and on candidates' outcomes. In 2009 and 2012 it conducted a direct survey of candidates who had successfully completed a VAE process in order to take stock of their opinion on the scheme and its impact on their career.

Contextual factors

The issue of low-skilled jobs in care is often raised. Care employers often recruit among those who have not had the opportunity to train in the area. Some of those involved have not been educated in France and do not have recognised qualifications. VAE is one of the ways of solving these problems.

However, the public finance crisis and the ever-increasing social security debt stand at odds with the measures promoting the improvement of skills in the care sector.

To reduce deficits, one response is to reduce social spending or limit its expansion in the face of growing needs. Skilled positions tend to be replaced by less skilled jobs, limiting the possibilities for promotion and discouraging training due to a lack of growth prospects.

Outcomes and results

Type and numbers of job created

VAE does not directly create jobs. It helps stabilise and professionalise people already employed in the sector. VAE applications were submitted by 17,000 people to the Ministry of Health and Social Affairs in 2011. Two types of diplomas were awarded to approximately 11,000 applicants: the state-recognised nursing auxiliary diploma (diplôme d'Etat d'Aide-soignant, 6,300 candidates), and the state-recognised home-care assistant diploma (diplôme d'Etat d'auxiliaire de vie sociale, 4,800 candidates). These are both level five qualifications (ISCED 3C level). They lead for the most part to jobs in community-based care for adults with disabilities who receive home nursing or nursing in local medical or social institutions. The same goes for the home-care assistant qualification (titre professionnel d'auxiliaire de vie familiale), certified by the Ministry of Employment, which attracts 1,900 candidates a year.

Other relevant outcomes

A survey was conducted by ASP on 9,000 VAE candidates who obtained a diploma in the social sector between October 2006 and April 2009 (De Rincquesen, 2010). The vast majority answered that they were proud of having obtained their diploma. Nearly all successful

candidates (96%) also mentioned positive factors on a personal level. More than 4 out of 10 respondents agreed with the phrase 'It has boosted my self-confidence'.

Main results

VAE is now a well-established national scheme in France. The initial years were more of a period of scaling up of the scheme. The number of candidates has grown for two reasons: a greater number of diplomas can be awarded this way, and the fact that this scheme is now well known by the general public. The number of candidates submitting booklet 2 has fluctuated at national level since 2007 after years of a sustained rise. This trend can undoubtedly be explained in part by the economic crisis. Between 2010 and 2011, the number of diplomas awarded remained stable.

As mentioned above, 17,000 candidates applied for all qualifications and diplomas under the authority of the Ministry of Health and Social Affairs in 2011 and 7,000 (41%) effectively obtained certification. This is a lower percentage than in all the VAEs in all ministries taken together (58%). This can be explained by the following factors.

- As a matter of principle, the Ministry of Health and Social Affairs does not select candidates amongst those who have three years' work experience in the jobs matching the requested certification.
- Most candidates applying to this ministry for certification apply for a rather low level of diploma. Their level of basic educational attainment is often very low and, according to Philippe Boisson, the ASP's national VAE delegate, 'some of them no longer have a culture of writing'. Furthermore, some of the candidates (particularly those providing care in people's homes) have never had schooling in France.
- Candidates working in small associations or employed directly by private individuals in the home help sector seldom benefit from professional support to prepare their VAE application. However, as shown by an ASP statistical survey of the first 92,000 VAE applications conducted in 2010, professional support considerably improves their chances of certification (De Rincquesen, 2010).

Lessons learnt

Success and fail factors

The following factors contribute to the success of the programme.

- It is often in the interest of employers to apply for VAE, especially when the funding of their organisation depends on a certain proportion of their staff having recognised qualifications. VAE costs the company less than conventional vocational training, as companies do not have to bear the costs of employee absences while training.
- The lower their initial level of education, the more successful VAE candidates tend to mention the positive effects of this success.

One of the difficulties is the written nature of the assessment test, which is a barrier to candidates with weak writing skills. A move towards more practical tests, though harder to organise for examiners, would undoubtedly benefit more candidates. Professional support would be more effective if systematically provided, as it considerably improves the success rate.

The annual number of successful applications is still low if considered as a proportion of potential candidates in jobs without the corresponding qualification or diploma. For Ministry of Health and Social Affairs certifications, the number of potential VAE candidates is estimated at 350,000, whereas only 7,000 passed in 2011, which represents 2% of potential VAE candidates. Furthermore, a system that could validate credits over several years would be more of an incentive for candidates. Part of the difficulty is the amount of work needed to complete the process – spreading these tasks over more years could help convince more candidates to try to obtain a qualification.

Lastly, the economic crisis has slowed down the VAE process, as it restricts opportunities for job improvement.

Sustainability and transferability

VAE is well established in France and it still has significant growth potential. Inequalities between regions in VAE applications do not correspond to differences in needs in the social sector (numbers of older people and people with disabilities), but are more of a reflection of levels of priority in the public employment service or in organisations likely to fund support. In the French context, there is no threat of cutting the budget for the VAE scheme. It is not very costly and is often regarded as useful by public bodies.

Transferability of the scheme to other countries presupposes a minimum of information and management resources.

Conclusions

The analysis of Professional Validation by Experience (Validation des Acquis de l'Expérience, VAE) is centred here on how this system is used for home helpers and carers of adults with disabilities. VAE is a fourth route to certification, after basic training, apprenticeships and in-service training. It is possible to obtain a vocational diploma or qualification through at least three years' vocational experience.

This system aims at providing training for those working in the homes of people with disabilities. It does not create jobs in and of itself. However, the system, which is still underused, provides opportunities for improving occupational situations, such as increased earnings and promotion, and for improving prospects of development, either in the same business or with a new employer. Lastly, once job-seekers are certified, they see a significant improvement in their employability.

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Annex 2: Interviewees

Philippe Boisson, Directeur du Pôle VAE et Handicap, Agence de Services et de Paiement (Limoges).

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Case study 1

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Philippe Boisson, Directeur du Pôle VAE et Handicap, Agence de Services et de Paiement (Limoges).

Viviane Condat, Directrice ESAT Ménilmontant, Vice présidente de l'association des directeurs d'ESAT parisiens.

Zélie Legrand, Bureau de la Formation Permanente et de l'Insertion Professionnelle des Jeunes, DARES (service d'études et de statistiques), Ministère du Travail, Paris.

Case study 2

Claudine Hervieu, Head of Human Resources Department, PMR Service, Grenoble, 10 January 2013.

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EF/13/53/EN 5