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Care work policies in France

The pitfalls of austerity and fragmentation[1]

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Introduction

The covid-19 health crisis created a shock on the economy, especially on the care economy already facing a "crisis of care" (Fraser, 2016). Since care policies usually focus on those who need care (notably children, disabled persons or the frail elderly), public resources dedicated to them reflect the extend of the collective responsibility towards vulnerable persons. In the European Union, health and long-term care, as well as childcare or education sectors, have experienced long-term austerity policies, leading to service closures or labour shortages. These policies reduced the scope of collective responsibility towards vulnerable persons, placing a heavier burden on care workers (whether in paid or unpaid work) and weakening the resilience of the care economy to the consequences of the pandemic.

Care workers, who were often overlooked before the covid-19 crisis, suddenly became perceived as "essential" ones, in the frontline or in the second line of the fight against the virus. The health crisis also contributed to shed light on their de-

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teriorating working and employment conditions, thus leading policy makers to pay more attention to them.

This article aims at questioning French public policies and regulations of care work in the wake of the pandemic. Analysing these policies and regulations is not an easy task, because they are segmented, reflecting the fragmentation of the care economy. It is all the more delicate that there is no such a unifying word like *care* in the French language – an extended literature about *care* however facilitates its delineation and characterization (Box 1).

BOX 1
Defining and analyzing care and care work in France

Strictly speaking, care could correspond to the French world "*soin*", which however has a narrower meaning. For instance, whereas "to take care" can be translated into "*prendre soin*", "to care for" or "to care about" necessitate other words, respectively "*s'occuper de*" and "*se soucier de*". When it comes to care policies, the French language does not even refer to a unifying word like care: "childcare policies" correspond to "*politiques de la petite enfance*", "healthcare policies" to "*politiques de santé*" and "long-term care policies" to "*politiques de la dépendance*" – or now "*politiques de l'autonomie*".

In her book about *Care, theories and practices*, Helena Hirata (2021), has explored the (unstable and controversial) definitions and theories of care in the French literature. She showed that care primarily refers to the social relationships between care providers and care beneficiaries as well as to ethical issues. The literature mostly considers human relationships but may extend to relationships between humans and animals or between humans and nature. As care involves social relationships, it is also a matter of social (gender, class, race) inequalities as regards who provides care and who receives it (or who can afford it). These inequalities are central for understanding care work and care employment.

Care work is widely recognized as a very specific one. First, it encompasses a wide range of activities, from domestic unpaid care (often provided in the name of love) to paid care delivered within formal or informal employment. Second, care work is widely recognized as implying responsibilities towards those who are cared for and eventually emotional relationships – care work may be material, mental and affective. Third, it is gendered, since most of care work (and especially unpaid care) is provided by women. Fourth, there is a continuum between paid and unpaid care, that may explain why care work is poorly valued in monetary terms: care competences are often considered as "natural" (and "female") instead of professional (and gender neutral) ones, so that care workers in paid employment generally experience a "wage penalty" – or "care penalty" (England *et al*., 2002; Folbre *et al*., 2021). Finally, care work is essential to the existence and survival of human societies; in other words, it is crucial for the social reproduction (Fraser, 2016).

Care workers operate in a wide range of occupations from separated segments of the care labour market and submitted to differentiated labour regulations. A broad definition of care occupations would embrace all those contributing to make the world "liveable", including cleaners, shopkeepers, cashiers, hairdressers, garbage collectors, gardeners *etc*. This definition incorporates the many "essential workers" whose work appeared so necessary during the pandemic. Considering only those occupations in which professionals are directly responsible for the continuous care of people who need care would lead to an intermediate definition, where care occupations mostly cover childcare, education, healthcare, and long-term care. An even narrower definition would be focusing on care occupations in which works essentially consists in providing care, excluding those in which caring is only a part of another core (often skilled) activity, such as teaching, nursing, curing etc. We will here consider the intermediate definition because it allows embracing all occupations that correspond to a specific care sector or to a specific care policy, whatever the level of formalisation or recognition of the skills or qualifications that workers have to prove or to mobilize at work.

In this article, we will first examine the "care crisis" related to austerity policies already in place prior to the pandemic (1). Then we will delineate the main features of French (fragmented) care policies that contribute to shape care employment (2), before to characterise the (segmented) care labour market, with a focus on childcare and long-term care. Finally, we will analyse the way public policies and regulations handle care work issues in the wake the pandemic (4).

Care crisis and austerity: an adverse context for care policies

Even prior to the covid-19 crisis, scholars were speaking about a global "care crisis" in financialized capitalism. This "care crisis" has many dimensions. On the one hand, it relates to increasing needs for care, notably because of the ageing population, the rise of women's employment or the persistence of massive unemployment and poverty. On the other hand, it refers to the lack of resources dedicated to care and to the care economy, even though these resources are crucial for the social reproduction.

The "crisis of care"

Nancy Fraser (2016) defined the "*crisis of care*" as a crisis of social reproduction and social relationships[2]: "it refers to the pressures from several directions that are

2. See Federici (2024).

currently squeezing a key set of social capacities: those available for birthing and raising children, caring for friends and family members, maintaining households and broader communities, and sustaining connections more generally" (p. 99).

This crisis is, according to her, part of a "general crisis" (economic, political, ecological), and "social depletion" that threatens the very existence and continuation of society. More fundamentally, she considers that the care crisis reflects a contradiction between capital and care, which takes a specific form in the (global, neoliberal) financialized capitalism. Financialized capitalism both fosters women's enrolment in the paid labour force (and the model of a "two-earner family"), and promotes austerity through retrenchments in social care expenditures, thus diminishing the availability of public provisions and care services. For Nancy Fraser (2016), this creates a "care gap" between the supply and the needs for care, that rich societies try to fill by "importing" (female and racialized) migrant workers from poor countries. Migrant women from poor countries thus have to delegate their own care responsibilities to other poorer caregivers, thus contributing to a "global care chain" shifting the care burden to poor countries, and fuelling social, gender, and racial inequalities.

The crisis of care in the sense of Nancy Fraser thus contributes to the polarisation of (and within) societies, opposing those who can pay for care and those who cannot and have no other choice but to become unpaid and/or underpaid caregivers. The author however underlines that this crisis favours the development of social struggles, that for instance aim at reducing inequalities, upholding public provisions (healthcare, housing, energy etc.), supporting the rights of precarious care workers and/or the rights of migrant workers.

The ambivalent European Union care strategy

In the European Union (EU), health, long-term care as well as childcare services have gone through long-term austerity policies prior to the pandemic. Many EU member states (like France) experienced a care crisis taking the form of service closures and labour shortages that made them vulnerable to the shock of the pandemic.

The European Union has developed an ambivalent care strategy. On the one hand, European institutions have promoted ambitious care policies since the late 1990s and early 2000s, notably to foster childcare provision and the reconciliation of work and family life. But on the other hand, they have implemented strict fiscal austerity rules that hampered the implementation of their care targets.

Maria Karamessini (2023) distinguishes four periods in the EU care strategy. From 1997 to 2008, a reconciliation strategy took place within the European Employment Strategy, aiming at accompanying the rise of women's employment

and favouring gender equality. The 2000 Lisbon Strategy and the 2002 Barcelona targets for childcare stimulated the development of Member states' childcare policies. Following the 2008 Great Recession, the European care strategy remained in the background for nearly a decade, due to prevailing austerity policies. Then, according to Maria Karamessini, the 2017 European Pillar of Social Rights (EPSR), the 2019 Work-Life Balance Directive and the European Gender Equality Strategy adopted in March 2020, initiated a "revival" and a "turning point" of EU care policies: instead of focusing on working women, care policies began to also address the gender-unequal division of unpaid care. In the most recent period following the covid-19 crisis, the recognition of the essential character of care favoured the adoption in 2022 of an ambitious European Care Strategy. This strategy aims at investing in the care economy to develop quality, affordable and accessible childcare, educative and long-term care services. It also ambitions to better recognise care work and to favour its redistribution between women and men. As far as care workers are concerned, it ambitions to promote training, improve working conditions and work-life balance for (low-skilled as well as professional) carers, and foster social dialogue and representation.

However, as underlined by Maria Karamessini (2023), there is little cause for optimism: the return to austerity policies, both at the EU and Member State levels, is seriously inhibiting investment in the care economy and lowering the ambitions of future care policies. Five years after the beginning of the health crisis, austerity continue to represent an adverse context for care policies in the EU.

French care policies: a fragmented landscape

French care policies reflect the ambivalences of EU care strategies. Their ambitions are hampered by both austerity and fragmentation.

French care policies are highly segmented. For instance, childcare policies are separated from health or long-term care policies. Yet care policies share some similarities. They rely on various levels of implementation (national, eventually supranational, territorial) and involve a wide range of actors (the State, European institutions, and local authorities at the regional, departmental, and municipal levels) and operators (public or private, in the non-profit as well as in the for-profit sector). Among the common trends are the development of a market-oriented domestic sector (Eydoux, 2025), the diversification (and slow privatization) of service providers as well as the lack of resources to provide care services that meet the needs in quantitative as well as in qualitative terms.

Childcare policies

The case of French family policies that shape the supply and demand for childcare services, is illustrative of these trends.

Marie-Thérèse Letablier (2022) distinguishes several periods and trends in French family and childcare policies. Family policies and institutions have developed and were structured after the second world war, along a dedicated branch of the French Social Security[3]. Important reforms occurred in the 1980s, with the adoption of measures to promote the reconciliation of work and care. In the name of "free choice" for parents, a variety of early childcare provisions and instruments was implemented: collective childcare facilities (mostly *crèches*), but also personal childcare home services as well as childcare allowances for parents who temporarily retire from the labour market to care for their children. French childcare policies thus both supported working and caregiving parents (mothers). However, "free choice" turned out to be a mirage: parents opting for the childcare allowance were in most case mothers experiencing job precariousness, atypical hours, or unemployment (Marc, 2004). Since the early 2000's, changes were introduced to foster gender equality and women's participation to paid employment (through the option of a part-time leave), and to encourage gender equality in parental responsibilities (through a father's leave and shared parental leaves). However, fiscal constraints limited progresses towards gender and social equality, paid parental leaves being too poorly compensated to encourage well-paid parents (and especially fathers) to opt for it.

The supply for collective childcare is multileveled, and its financing is partly decentralized, which implies important territorial inequalities (Letablier, 2022). Collective childcare arrangements are mostly financed by the family branch of the Social Security (53 %), but local authorities also take a large share (40 %) while the state less contributes (7 %). Collective childcare providers display an increasing diversity. Collective childcare services remain in their majority managed by public actors, but the creation of private providers has been encouraged, either traditional ones in the non-profit sector (*crèches associatives*), or new ones in the private for-profit sector (*entreprises de crèches*). As far as personal domestic childcare and parental care are concerned, the "centrepiece" of childcare benefits (Letablier, 2022) is the Early Childhood Care Benefit (Paje). It combines a birth or adoption premium with a basic allowance and a shared childcare allowance (Prepare) for parents (with a minimum past employment record) who want to care for their children,

3. This family branch represented a large share of Social Security expenditures in 1948 (about 40%) during the baby boom; it now counts for a much lower share (about 10%).

or a "free choice" complementary allowance (CMG) for parents who prefer to pay a childminder or a home carer.

Childcare policies and instruments shape the demand for childcare according to parent's income. While parental leave may appear as a liveable solution for precarious parents (in most cases, mothers), collective *crèches* are affordable for middle and low-income parents. The CMG also makes childminders affordable for middle-class parents. Wealthy parents from their part rather receive incentives to hire a home carer at their own home, since it allows them to benefit from income-tax reductions.

According to the French Childcare Survey 2021 (Caenene and Virot, 2023), 56 % of the children below the age of 3 are mainly cared for by their parents, while 20 % benefit from day care provided by a childminder and 18 % are in a collective childcare facility. Since the early 2000's, the share of children receiving day care in a collective childcare structure (+ 9 pp) or at a childminder's home (+ 7 pp) has nearly doubled. Meanwhile, maternal schools[4] slightly reduced their supply for early child education (while they accepted children above the age of 2 in the early 2000s, the threshold is now 3 years). The share of children who are mainly cared for by their parents have reduced by 14 pp. However, there has been a reduction of childcare places since 2017, mostly because those provided by childminders are declining, but also because of the decrease of places in public and associative crèches as well as in maternal school. Only private crèches offer more places, but these are more expensive (HCFEA, 2023). In addition, the quality of collective childcare is now an issue (Bohic *et al*., 2023) because of labour shortages and the reduction of the compulsory staff-to-children ratio in crèches[5].

Long-term care policies

The so-called "autonomy" policy replacing the previous "dependency" policy for the frail elderly, that has recently been integrated in a new (fifth) branch of the French Social Security system, also reflect budgetary constraints and privatization trends.

Olivier Giraud and Blanche Le Bihan (2022) underline a shift in French long-term care policies. Whereas they were, between 1960 and 1970, dedicated to "dependent" elderly, the reference to dependency was gradually abandoned and replaced with a more positive reference to autonomy[6]. The creation in 2001 of the

4. So-called "maternal schools" are French schools for children aged two to six years. Nearly all children aged three to six years attend to these schools in France.
5. Decree of 30 August 2021.
6. Instead of defining vulnerable elderly through medical and functional incapacities, the term autonomy indicates a policy valuing the preservation of some room for the "free choice" of vulnerable persons.

Autonomy Personalized Allowance (APA) materialized this shift, aiming at better considering the needs and resources as well as the expectations of the person and his/her family. However, according to Olivier Giraud and Blanche Le Bihan, it turned to be a mere semantic shift that did not really challenged existing practices; in addition, the APA remained too low to cover the needs for support of the elderly. In 2015, a Law for Adapting the Society to Ageing intended to promote a global and preventive approach of ageing and at recognizing the role of family caregivers (*aidant·es familiaux*). But again, dedicated resources remained too low. During the pandemic, the creation of a new branch of the social security (on 7 August 2020), gathering care for the frail elderly and for persons with disabilities, suggests a turning point towards a better recognition of care needs. However, due to the return to strict austerity policies, resources allocated to this new branch remain uncertain.

Autonomy policies initiated a long-term deinstitutionalization of long-term care, in the sense that they promoted home care (whether formal or informal) rather than collective care for both the frail elderly and persons with disabilities. Replicating the "free choice" argument of childcare policies, they relied on cash for care instruments, such as the APA for the elderly and the Disability Compensation Benefit (PCH) for persons with disabilities, to allow beneficiaries to choose between institutions or homecare, either provided by formal home helpers or by family caregivers (relatives of the beneficiary). As for childcare policies, the choice is largely biased in favour with family caregivers, because of the lack of quality institutions (Residential Homes for Dependent Elderly, EHPAD) and professional services (Giraud and Le Bihan, 2022)[7]. The deinstitutionalization partly relied on the mobilization of home helpers (*aides à domicile*) through a market-oriented rationale that contributed to the devaluation of home help – whereas caring for vulnerable persons requires competences and qualifications (Devetter *et al*., 2015; Eydoux, 2025).

Autonomy policies also initiated a refamilialization of care – whereas previous long-term-care policies were promoting defamilialization from the 1960s to the 1980s (Giraud, Outin, Rist and 2019). They particularly mobilized family caregivers who care for their relatives and coordinate the intervention of professionals. Autonomy policies now aim at better recognizing and supporting these caregivers (through access to training, to job-search support, to pension entitlements or to a

7. According to the Care Household and Care Institutions surveys (Roy, 2023), among those ageing persons above the age of 75, only near to one on ten (9%) live in institutions (EHPAD). Most of them (one on three) are women and their average age is 86. Those who are already in institution below the age of 80 are more often single or widows and socially disadvantaged persons (formerly blue collar or out of employment) than those who are cared for at home. They also more often experience disabilities, notably cognitive and psychic limitations.

right to respite). Yet, the family caregiving relationship is still poorly formalized, and provides caregivers with weak social entitlements (Giraud and Le Bihan, 2022). They may receive a care "indemnity" – representing about half or two-third the minimum wage, depending on their participation to paid employment – and are only entitled to poor pension rights. Under restrictive conditions, they may be formally employed by their dependent relative, paid at least the minimum wage, and gain full social entitlements.

Between informality and professionality: a fragmented care labour market

Care policies largely structure the care labour market, which appears both specific and highly fragmented.

Because of the continuum of care activities, ranging from unpaid work (for love) to informal (paid) activities, and from (deemed) low-skilled jobs to high-skilled occupation, care competences are largely undervalued, if not invisible. Care work being provided for free within the family, it is often considered as relying on natural competences (and female ones), so that its professional dimensions are frequently denied. In skilled occupations as well as in occupations were skills are not formalized or recognized, care workers commonly experience a wage penalty when compared with workers in male-dominated occupations or in other sectors of the economy such as the industrial sector.

Analysing the care labour market fragmentation

Analysing the care labour market though the lenses of labour market segmentation theories allows a better understanding of the fragmentation of care occupations and its consequences.

The labour market for care work is highly fragmented. A first dividing line relates to the sectorisation of care: every care sector displays its own labour market structuration and regulations, so that, for instance, childcare and long-term care workers have differentiated occupations, experiences, qualifications, and training backgrounds.

A second dividing line has to do with the variations in statuses, skill requirements, employment and working conditions. Many of those who provide care to vulnerable persons are (deemed) low-skilled, low-wage workers experiencing job precariousness and physical and mental arduousness. Among them, those whose activity is primarily to provide care at home are the most exposed. However, the care economy also mobilizes skilled (sometimes high-skilled) workers, whose caring activities represent only a part of their core occupation – consisting for instance in nursing, educating,

curing *etc*. A common feature of care labour markets is that care workers are distributed in a wide range of statuses and qualifications, from informal low-skilled (or poorly formalised skilled) activities to highly formalised and skilled occupations.

A third dividing line of care labour markets lies in the stratification of care employment: the distribution of care activities and care jobs is unequal, and there is a clear gender/class/race divide. Informal or poorly formalised activities as well as low-skilled jobs are not only female-dominated but are also often characterized with an over-representation of migrant and working-class workers. Even in many skilled occupations, that are generally more balanced, women remain overrepresented.

Institutionalist theories of labour market segmentation, that originally develop to analyse the structuration of industrial labour markets, are however fruitful for analysing the fragmentation of the care labour markets and its implications for care workers' employment and working conditions.

Peter Doeringer and Michael Piore (1971) pointed out the dual structure of the industrial labour market. In the "primary" labour market, workers are rather protected within firms' "internal labour markets" providing them with job security, training, and career opportunities. By contrast, the "secondary" labour market is competitive, and exposes workers to long-lasting job precariousness. For the authors, this labour market segmentation relates to the diversity of firm's productive models. François Eyraud, David Marsden and Jean-Jacques Silvestre (1990) suggested that (industrial) workers' mobility could be secured not only within firms' internal labour markets but also across firms through "occupational labour markets", through the recognition of workers' qualifications facilitating skills' transferability. Educative and training policies, by ensuring the production of professional qualifications and diplomas, play a crucial role in regulating these occupational labour markets.

Jill Rubery and Colette Fagan (1995) extended the analysis of labour market segmentation to encompass all sectors of the economy, and notably to analyse gender relations at work. They used the notion of occupational segregation to account for the fact that men and women do not work in the same occupations and that gender gaps may vary across countries and over time.

Labour market segmentation: the case of childcare and long-term care

The fragmentation of the care labour market may be analysed through the lenses of labour market segmentation theories, taking for granted that public policies play a structuring role in the care economy and in care sectors.

The case of the childcare labour market well illustrates the gender segregation as well as the occupational fragmentation of care employment. The structuration

of childcare provisions contributes to the construction of a dual labour market for childcare workers (Eydoux, 2005). On the one hand, skilled childcare workers' career and mobility take place in occupational labour markets, where their national diploma sustains career mobility across collective childcare facilities (notably *crèches*). It is notably the case of paediatric nurses (*puéricultrices)*, early childhood educators (*éducatrices de jeunes enfants*), certified childcare assistant (*auxiliaires de puericulture*), and to some extend of *crèche* agents (*agent·es de crèche*). On the other hand, those who are considered as low-skilled workers rather pertain to the external labour market. It is especially the case of domestic workers: registered childminders (*assistantes maternelles*) or home carers (*garde à domicile*), who work at home and and hardly have access to any kind of promotion.

The long-term care labour market displays similar features, combining gender segregation and labour market segmentation. Collective structures (EHPAD) partly rely on qualified professionals, such as coordinating doctors (*médecins coordinateurs*), coordinating nurse (*infirmier·es coordinateurs*), assistant nurse (*aide soignant*·es), whose mobility pertains to an occupational labour market rationale. Domestic workers in contrast – home helpers (*aides à domicile*) and certified social life assistants (*auxiliaires de vie sociale*) – are exposed to job precariousness in the external labour market. They are also exposed to diverging regulations depending on the nature of their employers (either an individual or a public or private organization), which contribute to their job precariousness. Family caregivers from their part remain at the margin of the external labour market, due to their ambivalent status: they may be paid for their work, but hardly in formal employment.

The fragmentation of the care economy tends to mitigate the relevance of the reference to occupational labour markets beside the external one. Whereas the recognition of childcare or elderly care diplomas introduces skill homogeneity and fosters occupational identities, mobility is limited by the variety of (public, private, for profit and non-profit) providers. It is for instance delicate for a paediatric nurse to secure her/his owns wage or social entitlements when moving from a private crèche to a public one. Similarly, being qualified or working in an institution does not mean that working conditions are secured. In the long-term care sector, for instance, regulatory decentralisation, budget containment and the development of performance policies, led to the "industrialization" of care services, to the intensification of work, and to the dissemination of hard-working conditions (Dussuet *et al*., 2017; Giraud and Le Bihan, 2022).

Care policies and care workers in the health crisis

A specific feature of the covid-19 crisis is the centrality of care – either paid or unpaid. During the first stage of the crisis, because of the confinement, many people had to care for their confined relatives, either children, elderly or ill persons. Meanwhile, care workers were at the frontline or the second line of the health crisis. The needs for care continued thorough the following waves of the crisis (epidemic peaks and confinements or other adaptive measures). How did public policies address these needs for care? What were the implications for care workers?

Policies addressing the renewed need for parental care during confinement

In France, the major public investment during the health crisis has been directed toward the protection of the economy and the support to employers, aiming to protect both firms and jobs. Apart from the support to firms with cash-flow difficulties, main instruments were short time working (*activité partielle*) schemes i.e., compensation schemes aiming to allow firms to continue to pay their employees while reducing or interrupting their activity. After placing their employees on short-time work (STW), firms had to fill a demand for compensation to receive an indemnity representing a large share of paid wages[8].

While STW schemes were usually used for male industrial workers to protect firms and employment from temporary reduction of activity (in case of raw material supply interruption or recession for instance), they were extended to nearly all sectors of activities, including service activities during the health crisis. STW also served to support employees who were caring for their children at home so that they compensated for unworked hours due to necessary unpaid care activities.

As a matter of fact, during confinements, protecting employment also necessitated to protect those who had to care for their confined children. Part of the public investment during the health crisis was thus dedicated to parental care. It was at first (from mid-March to the end of May 2020) through paid sick leave (with a compensation up to 90 % of the gross wage), and then (after May 2020) through short-time work (with a compensation up to 70 % of the gross wage). As soon as at the end of March 2020, in private sector firms with more than 10 employees, one employee on four was on sick leave, either for illness, for vulnerability or for childcare reasons (while one on four was on STW, one on four was teleworking, and one on four was work-

8. Successive and differentiated STW schemes and regulations were implemented since March 2020. We will not review these schemes in detail here.

ing on site). After the first confinement, sick leave and STW continued to be used to meet parental care needs in the following waves of the pandemic.

Relying on the Social Security general account (Marc *et al*., 2022), the cost of wage maintenance (sick leave and STW) for parents caring for their children can be estimated at EUR 2.2. billions in 2020 (it was 0 in 2019 and 0.1 billion in 2021). It represents only a small share of total wage maintenance expenditures, which include the main STW scheme for employment protection (EUR 24 billions in 2020 and still 9.5 billions in 2021 vs. 0 in 2019) and total sick leave compensations.

Policies addressing frontline sectors and frontline workers

During the health crisis, public policies addressed care workers differently, depending both on their sector of activity and their professional status. The three care sectors (childcare, healthcare and long-term care) have been the object of separate and differentiated policies.

Healthcare (and, to some extent, long-term care) have been considered as "essential" (or even "vital"), so that policies aimed at maintaining, if not intensifying their activities (Eydoux, 2020). On 23 March, a Law of emergency to face the covid-19 pandemic led to the adoption of a series of ordinances, notably the 25 March ordinance for emergency measures as regards paid leaves, working time and days off, allowing employers of vital sectors to upgrade weekly working-time ceilings, to freely decide the attribution of working-time reduction days or the use of time-saving accounts, or to postpone vacations (when authorized by a firm's collective agreement).

In public hospitals, a decree of 24 March 2020 on overtime and excess hours provided for an administrative authorization to exceed the overtime ceiling up to 20 hours per months and 240 hours per year per civil servant. The confinement and this decree occurred at a time when hospital civil servants were demanding better working conditions and wage revaluations (especially for hospital caregivers, hospital agents and nurses). Far from getting what they were demanding, they were asked to work more while exposed to the virus (due to the lack of masks and protections). They experienced worsening working conditions, but only received a punctual covid premium (decided on April 15), restricted to those working in hospital services dealing with covid patients in the most hit French regions.

Even though healthcare workers were mobilized to care for vulnerable and ill people during the pandemic, and despite the fact they were recognised as essential workers and widely applauded, they received what they perceived as a poor and unequal rewards for their work, which fuelled further demands for rewards and recognition.

From May to July 2020, the government organized a consultation named the "Health Ségur". It notably resulted in a new investment of EUR 19 billions in the Health system, in EUR 8.2 billions for the revaluation of occupations in healthcare institutions and EHPADs, and for new recruitments in public hospitals. However, according to a Senate report, the Ségur "has been a consequent and late stopgap which has produced disappointment and frustration" (Deroche and Jomier, 2022, p. 9).

Blurred boundaries of frontline and second line: the case of home helpers

The case of home helpers in the long-term care sector is illustrative of the blurred boundaries between frontline and second line workers (Bonnet and Primerano, 2022)[9]. Many of them continued to work, to be exposed to the virus without relevant protections, and to see themselves as being in the frontline when caring for vulnerable people who were liable to die when infected by the virus. But their vital work remained overshadowed: generally considered as "second line" workers while they often continued to work on the frontline, home helpers felt they had been overlooked and relegated in the background of public policies.

As soon as in the first confinement, home helpers benefitted from reinforced protection against the loss of income. Whereas the needs for home help did not vanish, part of the demands for care were cancelled, so that some home helpers were exposed to an immediate reduction of activity and loss of income. On 16 March 2020, the Ministry of Labour announced the extension of short-time work to all home helpers. While prior to the confinement, STW was only possible for those employed in an institution, it opened to workers who were mandated by a service structure as well as to those who hired by an individual employer. Individual employers were encouraged to declare and pay all the agreed hours of their home helpers in March, April and May 2020. For non-worked hours, they had to pay at least 80 % of the usual rate and were entitled to a reimbursement of this amount. This scheme was extended up to the end of August 2020. It however provided a weak protection to precarious home helpers whose usual remunerations are generally low and uncertain.

But as frontline workers, they had to wait a later stage of the health crisis for recognition (Bonnet and Primerano, 2022), until President Macron acknowledged in August 2020 that they had been overlooked when the covid-19 Premium was adopted, and announced a dedicated Premium for the 320 000 professionals of

9. Revealing of this invisibility, a report on "second line" essential workers (Amossé *et al.*, 2021) only classified medical professions in the frontline while considering home helpers as second line "essential" workers.

home help. However, the state was willing to limit its financial commitment and asked local authorities (*départements*) to contribute to the financing of the premium and to determine both its amount and conditions of access. In resulted in territorial heterogeneity, fuelling discontent from the part of home helpers who felt they were poorly and unfairly recognised for their mobilization during the pandemic.

The case of childcare and childminders

Contrary to other care services, collective childcare services (*crèches*, Childminders, Houses etc.) have in most cases been closed during the first and third confinement, from 15 March to 3 May 2020, and from 6 to 23 April 2021. A few *crèches* were requisitioned to take care of children whose parents were "essential" frontline workers, many of them in the health or long-term care sectors. Some (available and willing) childcare professionals were thus allowed to continue to work in crèches, often without any protective device against the virus. Other care professionals were put in short-time work or on sick leave (either ordinary or dedicated to care for their children, or precautionary for those vulnerable to covid).

Registered childminders, from their part, were allowed to continue to work and were even encouraged to receive more children at home, but still with poor protections against the virus[10]. However, like home helpers, they became for the first time eligible to short-time work. While they were, at the beginning of the health crisis, exposed to a suspension or a break of their contract from the part of their individual employers, this extension of STW reduced their employment insecurity. However, the definition of their STW scheme and compensation rules was departing from normal rules, reflecting their particular (and precarious) employment status (Box 2).

Childminders have a very specific employment status, even when compared with other workers providing homecare (Barrère-Maurisson and Lemière, 2006; Perseil, 2021). Their labour contract (generally with parents as employers) is regulated partly by the Labour Code and partly by the Social Action and Family Code. Childminders are normally allowed to care for no more than four children below the age of 3 and eight children below the age of 11 (including their own children, except by specific permission). During the confinement, they were allowed to receive up to six children below the age of 3, under the condition that they had no more than 10 children at home (including their own).

10. They were allowed to care for no more than 6 children below the age of three at their home, under the condition that there were no more than 10 children at home, their children included. However, collective structures employing childminders (such as Childminder's Houses) had to close when receiving more than 10 children.

BOX 2
Short time working schemes for childminders

The ordinance No 2020-346 of 27 March 2020 on emergency measures regarding short-time working provided a right to compensation to childminders experiencing a loss of remuneration due to a temporary cessation of activities resulting from the covid-19 crisis.

Contrary to the prescriptions of the Labour Code for other employers, prior administrative authorization was not requested for childminders. The employer had to pay an hourly compensation representing 80 % of the net remuneration set in the labour contract. The net compensation had to be at least equal to the minimum pay stipulated by the Social Action and Family Code (EUR 2.23 per hour; EUR 2.19 in Alsace and Moselle). This compensation was exempted from social contributions. It had to be fully reimbursed to employers by the Urssaf, the administration in charge with the collection of social contributions for the French Social Security and for the Family Allowance systems. Employers had to provide a declaration from their childminder stipulating that compensated hours were not worked.

According to the Labour Code, non-worked hours corresponding to short time had to be compensated up to the contractual duration of work (number of worked hours stipulated in the labour contract), up to a threshold corresponding to the legal duration of work for childminders (45 hours per week). The number of compensated hours had to correspond to the difference between the contractual work duration and the number of hours effectively worked over the period. Every compensated hour had to be considered for the computation of the rights to paid leave.

Employers were free to complete the compensation to maintain the usual pay of their childminder – and the Federation of individual employers (Fepem). At first, the extension of short time working schemes to childminders was designed to compensate for an involuntary reduction of working time. But after the 1st of May 2020, it also replaced the sick leave for childminders who were caring for their own confined children or the precautionary sick leave for vulnerable workers or for workers caring for a vulnerable relative.

Source: https://www.lassmat.fr/mots-cles/chomage-partiel.

Childminders usually sign several labour contracts with different employers at the same time. It may explain why the minimum wage they receive from each employer (3.49 gross hourly wage in May 2023) is below the statutory minimum wage. However, such a definition of their remuneration is not sufficient to bring about income security: in spite of long working days, their monthly wage is often below the full-time minimum wage. As a matter of fact, they are not covered by the legal duration of 35 hours per week: their contract may stipulate up to 45 hours per week, above which their hourly rate is increased by a percentage to be defined by mutual

agreement with their employer[11]. Because of their particular employment status and specific STW scheme, childminders were poorly protected during the pandemic.

Conclusion

Before the health crisis, France as many EU countries already experienced a care crisis, which made their care sectors more vulnerable to the consequences of the pandemic. In France, the care economy is highly fragmented, because of segmented care policies and a much fragmented and polarized care labour market.

At the outset of the health crisis, public policies first developed protective schemes (short-time-working schemes as well as care and sick leaves) for employers and workers, including domestic care workers who were previously excluded from short-time work.

More fundamentally, public policies diversely and unevenly addressed to care workers, depending on care sectors and statuses. While in healthcare, the priority was to intensify the mobilisation of frontline professionals, childcare was not considered a vital sector – except to care for the children of mobilized healthcare professionals. The treatment of long-term care was more ambivalent: despite the fact that many workers were effectively mobilised to care for vulnerable elderly, they were not immediately recognized as first-line workers – and gained a late and uneven access to the Covid Premium.

All in all, public interventions towards care workers during the pandemic remained too little and too late. First, because of the pre-existing austerity and care crisis. In hospitals, the health crisis occurred after years of beds and service closures so that medical teams were in many cases already insufficient and exhausted. Their mobilization during the pandemic hardened their working conditions and many of them expressed their will to leave the profession – or the hospital. Many health professionals expected a significant change after the pandemic, but considered the measures adopted under the Health Ségur as insufficient and frustrating.

In childcare and long-term care, domestic workers (home helpers, childminders) were the most exposed to job precariousness. The extension of short time work demonstrates that policy makers were (for the first time) willing to prevent these workers, who were diversely exposed to a decline of their working time, from experiencing a drop of their monthly income. It was an example of re-regulation aiming

11. Social Action and Family Code (Casf, 2025) and National Collective Agreement for Individual Employers and Domestic Jobs of 15 March 2021 (CCNPEED, 2025). See: https://www.service-public.gouv.fr/particuliers/vosdroits/F838.

to bring these workers closer to core industrial ones benefitting from maintenance schemes securing both their income and their job. However, because of their job precariousness, it was not sufficient to secure them.

Because they became seen as "essential" workers, and recognised themselves as such, many care workers were disappointed with the poor recognition and support they received. The health crisis thus gave way to new social demands, notably from the part of barely unionized workers such as home helpers and childminders[12]. These workers began to express their dissatisfaction and denounce their working conditions through professional organizations or labour unions as well as through social networks (Doumenc, in Doumenc *et al*., 2024).

Home helpers and childminders finally gained some audience from the part of policy makers. A report from two deputies, Bruno Bonnell and François Ruffin (2020) denounced their precariousness and suggested to improve their employment and working conditions. The report notably recommended to secure their working time, upgrade their minimum wage and guarantee that they are effectively paid. It also recommended to take their work arduousness into account and improve their working condition. It concluded that these workers should be granted a status, with real career opportunities. Yet, policy measures remain far below these recommendations, providing for slow and patchy improvements (Eydoux, 2025).

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12. Their unionization rate is estimated at 7% vs. 11% on average in France (Perseil, 2021).

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Abstract

Care work policies in France: the pitfalls of austerity and fragmentation

This article questions French public policies and regulations of (paid and unpaid, formal and informal) care work in the wake of the pandemic. It first examines the "care crisis" already in place prior to the pandemic. Then, it identifies the main features of French (segmented) care policies

and examines care employment through the lenses of labour market segmentation theories, with a focus on childcare and long-term care. Finally, the article analyses public policy responses to the pandemic. It concludes that the segmentation of the care economy and the fragmentation of the care labour market, combined with pervasive austerity, tend to hamper the implementation of ambitious policies beyond patchy progressive measures.
Keywords: Care policies; Employment regulations; Pandemic; France.

Resumo

Políticas de trabalho de cuidado na França: as armadilhas da austeridade e da fragmentação
Este artigo questiona as políticas públicas e as formas de regulação vigentes na França quanto ao trabalho de cuidado (remunerado e não remunerado, formal e informal) após a pandemia. Primeiramente, examina a "crise do cuidado" já existente antes da pandemia. Em seguida, identifica as principais características das políticas francesas de cuidado (segmentadas) e examina o emprego no setor de cuidado sob a óptica das teorias de segmentação do mercado de trabalho, com foco em cuidados infantis e cuidados de longa duração. Por fim, o artigo analisa as respostas das políticas públicas à pandemia. Conclui que a segmentação da economia do cuidado e a fragmentação do mercado de trabalho no setor, combinadas com a austeridade generalizada, tendem a dificultar a implementação de políticas ambiciosas que vão além de medidas progressivas e fragmentadas.
Palavras-chave: Políticas de cuidado; Regulação das relações de emprego; Pandemia; França.

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