

## CHAPTER 2

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# HISTORY OF PROFESSIONAL CARE FOR THE ELDERLY PERSONS

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### ABSTRACT

The history of professional care for the elderly persons is underresearched due to a lack of interest for this mainly female (non-)profession and due to a difficult archival situation. Compared to other fields of the care (general hospital, children, psychiatry...), professional care for elderly persons remains a marginalized field. Focusing on Western Europe, this chapter presents a chronological overview of the last two centuries: by distinguishing three periods—an aspiration of professionalization in the 19th century, a growing institutionalization in the 20th century and the emergence of the fifth risk for the beginning of the 21st century. Being central in the daily care of the older adults, the history of the carers is pivotal if historians want to approach the experience of the elderly persons.

In 2013, almost a million people were employed in nursing homes and ambulant care throughout Germany, mostly related to the care of the elderly. Comparatively, this figure is 25% higher than the number working inside the German automobile industry, a sector often lauded for its role in driving Germany's current thriving economy. And yet, in the public mind, the professional elderly care sector is less audible and visible than its counterpart in the automobile market.

This "silence" also characterizes the history of professional care for the elderly: the topic is rarely addressed, and, if so, only cursorily. Monographs based on detailed research are rare, comprehensive overviews are next to nonexistent. Often considered as a peripheral concern, the men and women<sup>1</sup> who took care of the needs of the elderly in all their facets, are obscured by the religious congregations in the 19th century and behind the medical establishment in the 20th century and in the postmillennium period (Arborio, 2012, p. 17). The limited legitimacy and absence of any appreciation of care for the elderly compared with other forms of care only reinforces this lack of visibility.<sup>2</sup> Another salient factor in their invisibility is the strong overrepresentation of women among those involved in the terrain; the casual workers and occupational care workers. Even if the gender aspect has become an increasingly overriding concern within the social sciences in general, and with historians in particular, the strongly feminized nature of care work probably contributes to making it still largely invisible.<sup>3</sup>

Even those individual historians interested in retracing and reevaluating the history of the professional care for the elderly are often confronted with a significant heuristic problem: in contrast with the physician-patient relationship, the carer-patient relationship does not systematically offer us written sources. Compared with the written histories of mental hospitals furnished by psychiatrists or superintendents, hardly anything has been documented or recorded by administrators or founders of residential homes for the elderly. Historians are obliged to work on normative sources, or on reports of conflictual situations when, for example, the care delivered is considered problematic or not up to standard. More often than not the carer's daily work and life went unnoticed (Jusseume, 2015). This is particularly puzzling, as most contemporary scholars underline the vast discrepancy between national-based normative texts and local practices (Means, Morbey, & Smith, 2002).

Based mainly on secondary literature, this chapter will attempt to retrace the history of professional care for the elderly over the last 200 years in Western Europe. Due to the aforementioned historiographical gaps, the text will largely remain hypothetical in nature. It will offer a picture painted with broad brushstrokes with the hope of encouraging fresh research in this promising field. Three countries will be mainly taken into account: France,

Germany and Great Britain. Even if major differences exist between them, the working hypothesis of this chapter will postulate a common European evolution, where chronologies and categories may differ but where structural changes are common. This choice is also justified by the international character of this book and the scattered nature of historiographical literature, which renders comparative analysis rather difficult at present.<sup>1</sup>

Finally, the focus on professional care for the elderly introduces a bias underlining processes of formalization, neglecting aspects of in-formalization and completely overlooking the issue of nonprofessional carers, which is paramount, especially in relation to care for the elderly (Pfau-Effinger & Geissler, 2005).

The chapter retraces the history of the last 200 years, starting its narrative at a moment when different developments changed the nature of Western European societies: industrialization, urbanization, birth of the nation state, laicization.

## **THE LONG 19TH CENTURY: FROM POOR RELIEF TO PROFESSIONAL ELDERLY CARE?**

### **Institutional Heterogeneity**

For traditional historiography, in the beginning of the 19th century the elderly were taken care of not because of their advanced years, but because they were poor. In the absence of any structured and comprehensive pension system for the general populace, women and men simply worked as long as they were able to do. Afterwards they were taken care of by their families, given that the proportion of the elderly within the general population was much lower in the 19th century than it is today: in 1871, 4.6% of the German population was older than 60; in 2013, this number has almost been multiplied by six and attained 27.1% (Statistisches Bundesamt, 2015; Tölle, 1996).

In a period of burgeoning industrialization and migration, the elderly increasingly lived outside of traditional family circles and lacked the financial wherewithal to fend for themselves. It was precisely this poor and elderly segment of the population that was accepted in institutions devoted to shelter those who could no longer support themselves. Despite the situation in cities such as London, where 15% of women aged 75 and over lived in local alms-houses, the elderly were less impacted upon than other segments of the population, such as the mentally ill or orphans (Cole & Edwards, 2005, p. 233), by what Foucault referred to as the *grand enfermement* or large-scale internment. They were neither considered as

posing a risk to others, as were the mad, nor were they deemed essential for the nation's survival, as were children-in-need.

A typical 19th century setting exemplifying this kind of institution were the so-called workhouses in England and Wales. Based on structures established back in the late 16th century, the workhouse system was overhauled following the introduction of the New Poor Law of 1834 which addressed the issue of the elderly, the sick and mentally ill, as well as children unable to meet their needs. Even if workhouses seemed to shelter an undistinguishable population of marginalized groups, a categorisation was already taking place within the workhouse system. In Birmingham, for example, the elderly were put in the "bedridden wards." In the second half of the 19th century, institutions increasingly abandoned their all-embracing approach—taking care of the marginalized—and instead specialized on one particular segment of the general population. The elderly, however, were the least "attractive" group: the absence of any therapeutic hope, the chronic nature of their ailments and their perceived uselessness at a time of thriving capitalism probably explains this situation. In proportional terms, their percentage inside the workhouses increased during the 19th century (Booth, 1984).

In most workhouses, care-related activities were more custodial in nature than therapeutic. In the second half of the 19th century, the Birmingham authorities were already showing foresight by appointing a nurse to each ward at a time the supervisory staff were less numerous on the ground and also lacking in education (Ritch, 2013, p. 64).

In the European metropolises, those institutions devoted to the poor could offer shelter to quite an impressive number of the needy. The *Assistance Publique* in Paris, for example, had a bed capacity of between 10,000 and 15,000 at their disposal in the second half of the 19th century. In Paris, as in other urban centers, a differentiation was quickly established between a hospital—in principle for the sick irrespective of age—and a *hospice*—in principle for the elderly though not necessarily ill upon admittance (Rossigneux-Méheust, 2013). In provincial cities and in rural areas, the institutions were far smaller and this differentiation process took place at a later date.

In recent years, these gloom-ridden narratives, in which these institutions appear as nothing more than houses for the dying (*mouroirs*, *Siechenhäuser*...), have been partially revised, especially for those in the larger cities. A closer look at these institutions has resulted in the introduction of a fine distinction concerning the dominant and homogeneous image of the "Poor Law dump houses." Even were poverty has been a determining factor for admittance, the institutions for the elderly were not limited exclusively to these social categories. In Brussels, for example, the *Fondation Pachéco* was specifically conceived for women from affluent

backgrounds. Contrary to the strict rules applied in other institutions, under the administration of the *Hospices et Secours de Bruxelles*, residents at the *Fondation Pachéco* had private rooms, which they had the right to individualize, visiting hours were more flexible and so on (Richelle, 2016).

## Professional Elderly Care in the 19th Century?

Speaking of professional care for elderly in the 19th century may appear anachronistic for two reasons. First, if one applies the classical sociological characterisation of a “profession” defined as a process by which an occupation is transformed into a profession through standardised qualifications, exclusion of those considered unqualified, and establishing a monopoly in a certain domain (Freidson, 1970), then it is clear that numerous scholars would argue, that even today let alone two hundred years ago, care for the elderly has yet to achieve this status. Second, even if little is known about those working inside these institutions and their daily practices, it nonetheless seems evident that their chief task was to maintain order and ensure certain levels of hygiene, a far cry from that which would be currently considered as care.

In the 19th century, two institutional structures, namely the church and local authorities, operated the management of institutions caring for the elderly, a path dependence that remains visible to this very day. Even in France with its strong secular tradition, the religious congregations played a decisive role in how care was administered. Although the institutions were under municipal direction, daily care was nonetheless often administered by the nuns.

In the larger cities, the local authorities did attempt, however, to exert some control by nominating physicians as directors. These directors were often accommodated within the precincts of the homes for the elderly and carried out important administrative tasks. Conflicts between directors and Reverend Mothers were not unknown due to various contentious issues. Beside hierarchical and organizational dissensions, discussions about appropriate care were also numerous: the nuns tended to underline the importance of spirituality and charity, while the directors, who were often physicians and members of the urban social milieu, pleaded in favor of a more “professionalized” approach to caring.

The Little Sisters of the Poor [*Les Petites Soeurs des Pauvres*] were one of the most important charitable organizations in Europe of the 19th century. Established in France during the 1840s, the Sisters specialized almost exclusively in caring for the elderly and over time were to manage institutions in Europa, the United States, Australia, China. In the 1920s, they supervised 120 institutions (almost a 10th of all existing ones at

that time) with 20,000 elderly residents under their care in France alone (Langlois, 1981; Polligkeit, 1928). If the religious dimension of their care was their ultimate *raison d'être*, they nevertheless developed a specific expertise in caring for the elderly: a balance between care for the person (food, clothing, taking care of vulnerable bodies) and spiritual assistance (solace and prayer).

The influence of the religious congregations was still palpable, even in the latter half of the 20th century because secularization was far less pronounced in care for the elderly than in other care sectors. Considered as less essential than traditional hospitals where an important lobby, that is, the physicians fought from the late 19th century for a care administered by qualified nurses under their direction, this was not the case for the professional elder care. Less expensive, less assertive on the working conditions (holidays, pension ...), the sisters remained therefore a central actor in the professional elderly care till the 1960s (Feller, 2005, pp. 60–62). Over time they gradually withdrew from direct involvement in care and were increasingly confined to surveillance duties and management roles. The decreasing number of nuns made their daily presence impossible. One task, however, that did remain their prerogative was *care for the dying*. This task was normally reserved for women; the nuns were considered as distinguished experts in looking after the spiritual dimension (Jusseume, 2015).

Besides this relatively homogeneous group of nuns, a second group and a more heterogeneous one was also implicated in elderly care. Largely comprising women from the lower social classes with no specific training in elderly care, they had usually worked beforehand as house-servants and/or factory workers. In addition to these women, those elderly residents, who were considered sufficiently fit to partake in caring duties and in nursing other residents, were also mustered and made a significant contribution. It was this very heterogeneous personnel that administered and carried out the daily chores within the institution, providing essential care, yet also imposing discipline through a series of actions such as enforced isolation and food deprivation (Irmak, 2002, p. 268).

Professional elderly care was characterized throughout the 19th century by a significant numbers of employees quitting the workforce and being subsequently replaced—with the exception, it must be added, of the ever-present religious sisters. This was due to the far from satisfactory working conditions—carers quit to find a better-paid job—and, moreover, to the fact that they were regularly sacked because their work ethic was considered lacking by the authorities managing the elderly homes.

Staff—even if they did not belong to a religious congregation—were submitted to an extremely severe regime. They were obliged to live inside the institution; they often slept in the same dormitory as residents, especially in the 19th century. As most staff were women, they had no choice but to quit

their work on getting married: being a wife and a mother were considered incompatible with the job. A relatively strict dress code introduced a sense of discipline whereby carers did not arouse patients. Some authors would even argue that through these disciplinary measures, carers themselves were forced to undergo a similar process of “mortification” (Goffman) as the patients (Brooks, 2009).

Lay people were often referred to as guards, or *Wärter* in German, as the term *Pfleger* or carer only came into more regular use in the 1920s and 1930s. Compared with the evolution of general nursing in hospitals, professional care for the elderly lagged far behind. Indeed, in most European countries, nursing was to become a recognized profession in the last quarter of the 19th century. In Prussia, for example, the nursing profession was first defined in 1907; this entailed a trainee nurse undergoing one year’s training under the supervision of physicians (Schultheiss, 2001). Even care for the mentally ill had commenced before this (Majerus, 2015). In the general nursing curricula, geriatric care was not a priority, because only few nurses would eventually work in elderly care. This was to change partially after 1918. The consequences of the First World War and the endemic inflation of the interwar period forced new categories of elderly, who were less socially marginalized, into the institutions. Confronted with these affluent newcomers, social disciplining and moral rectification could no longer constitute the sole *raison d’être* for care (Feller, 2005, pp. 57–58).

Carers had to supervise large groups of elderly. In 1865, at the Birmingham workhouse, where conditions were considered particularly good, one carer was responsible for 135 male patients, aided by 13 able-bodied paupers. Fifty years later, in the same institution, 35 female bedridden patients were taken care of by one nurse and three residents. While this statistic might suggest, for Alistair Ritch, an increasing dependency by the inmates on the workhouse, it could also simply reflect how the meaning of “elderly” had changed over the intervening period (Ritch, 2013, pp. 81–82). Levels of care greatly varied according to social criteria. In Paris, for example, Mathilde Rossigneux-Méheust (2015) argues that the poor housed in Bicêtre and Pitié-Salpêtrière Hospitals were merely supervised, the affluent in Sainte-Périne cocooned, and the invalids in La Rouchefoucauld looked after (p. 246). In smaller cities and provincial centers, the carer-patient ratio was generally less significant in numerical terms than in the larger agglomerations. Sometimes, institutions did not even have staff to care for the elderly. In 1914, in Solre-le-Château in northern France a small *hospice des vieux* housed 12 persons, who had to do housework and cook for themselves (Feller, 2005, pp. 51–52).

If the religious congregations assured a certain continuity, the notion of what taking care of the elderly involved and meant in practical terms changed during the 19th century. Undoubtedly, the foremost break

with ways of the past was the spread of Pasteur's ideas: an increasingly overriding preoccupation with hygiene in the normative framework, by which physicians defined the tasks to be undertaken and the measures to be implemented by care personnel. Carers themselves were being disciplined at the same time that they disciplined patients (Murard & Zylberman, 1996). In 1909, in the *Règlement général de l'hospice départemental de Vieillards de la Sarthe*, for example, one reads: "The staff and the patients are to change bed-linen weekly.... The employees of the institution must remain perfectly clean; they must take a bath or a shower once a month at least."<sup>5</sup> Regulations were often linked to corporal behavior. In large hospices such as those in Paris, one task of the personnel was the permanent recategorization of the residents, which manifested itself, *inter alia*, by confining them to designated spaces: dorms for the infirm, rooms for the able-bodied, and infirmaries for the senile (Rossigneux-Méheust, 2013, pp. 208–209). In the 1920s in Hamburg, geriatric care inside an elderly home was thus defined by a physician: "Be empathic with all those who suffer, repeatedly assist them, put things in order, clean those in your charge, patiently accept ingratitude, lovingly care for your ward—and, all this, for long years, that is the onerous task facing the nursing staff."<sup>6</sup>

### THE SHORT 20TH CENTURY: GROWING INSTITUTIONALIZATION?

The first half of the 20th century saw the emerging basis for an institutionalization of specific knowledge related to the elderly and their care. Categories were invented to name these new specialities. "Gerontology" coined by Elie Metchnikoff in 1903 and "geriatrics" by Ignatz Leo Nascher in 1909 proved popular terms and remain in use today. Academic journals, like the *Zeitung für Altersforschung*, were founded in 1938 in Germany. Chairs were created at universities.<sup>7</sup> Medical knowledge, however, was no longer based on what Elise Feller calls *médecine d'hospice* (Feller, 2005, p. 75). Charcot, for example, was still developing his theories on geriatrics while working in a home for the elderly, basing his hypotheses on observations made within such institutions (Lellouch, 1992). In the 20th century, the source of medical knowledge concerning the elderly shifted to the general hospital and to the ever-increasing medical laboratories.

At the same time, specific elderly care institutions were being increasingly established. In Brussels, with its population of close to a 900,000, no less than 31 institutions specifically dedicated to caring for the elderly existed in 1925: private and public institutions, nursing homes for the rich and the poor, institutions specifically offering services to Jews or Catholic women, hospitals for peasants and artists. This impressive heterogeneity, however, should not make one overlook the fact that the number of disposable beds



remained relatively limited. In 1925, around 1,950 bed-places existed for a total population of nearly 900,000 inhabitants (Gronckel, 1925).

Both these evolutions, the emergence of a specific knowledge related to elderly care and the development of specific institutions for this purpose, experienced dramatic growth in the 1960s and 1970s. In most European countries, knowledge related to age became institutionalized. As alarm bells began ringing about rapidly changing demographics, geriatric care became a concern in Western societies (Katz, 1992), and experts were increasingly considered a *conditio sine qua non* [an indispensable condition] in finding a satisfactory solution. This was not, however, a linear process and remains a work in progress. In Germany, a combined *Facharzt für Innere Medizin und Geriatrie* [Specialist for internal medicine and geriatrics] “exists in just in 3 of the 16 federal states (*Bundesländer*), and care for the elderly found itself for a long time in an administrative no-man’s land, being neither part of the “welfare sector” nor of the “health sector.”

Establishing specific institutions for the elderly as the standard institutional response was also linked to a progressive exclusion of this category from general hospitals and asylums, where most elderly were still housed at the beginning of the 20th century (Majerus, 2017; Moses, 2005). The elderly were considered as an onerous charge and, medically speaking, an uninteresting segment of the general population. In psychiatry, for example, where the introduction of neuroleptics in the 1950s seemed to transform psychiatry from a care-oriented to a cure-dispensing institution, the chronic nature of the ailments afflicting elderly patients was an unwelcome reminder of a time when all patients appeared noncurable. Numerous psychiatric hospitals therefore petitioned for the creation of a separate institution to be designated exclusively for elderly (psychiatric) patients. A similar process of marginalization occurred within general hospitals. Medical treatment for acute symptoms became more effective during the latter half of the 20th century, including for the elderly. In most European countries, hospitals were transformed into *acute-only* medical care systems: the elderly were considered “bed-blockers” at a time in which statistics of discharge rates were becoming a new instrument to measure hospital efficiency. Paul Bridgen has demonstrated how the hopes for the elderly built around the establishment of the National Health System in the United Kingdom had been diluted by the introduction of a so-called geriatric bed norm, which limited care for the elderly in general hospitals. Ultimately, this strategy led to an effective freeze of available geriatrics beds in the 1960s as the proportion of elderly in the general population, and the number of hospital beds increased overall (Bridgen, 2001).

If, in the 19th century and at the beginning of the 20th century, it was never quite clear whether the personnel working with the elderly should be considered as domestic staff or as caring staff, this incertitude gradu-

ally changed during the interwar years, when their caring duties became increasingly prominent. After the 1950s, care also became more and more professionalized. This was due to several factors: the religious congregations had gradually withdrawn from daily care duties due to a lack of novitiates, but nonetheless they remained powerful players in professional elderly care not only in Western Europe (Matron, 2014), but even in the Communist Bloc countries such as East Germany, where geriatric care was the only sector in which the religious orders were allowed to remain important stakeholders (Otte, 2013).

The number of caring staff with formal training, however, remained low in the first half of the 20th century. In England, 70% of the elderly care personnel (matrons, wardens, and superintendents) still had no state-recognized qualifications in 1956 (Brooks, 2009, p. 25). After World War Two, however, the continual development of the European Welfare State afforded institutions the necessary financial wherewithal to employ new and better qualified staff-members. In West Germany the *Bundeshilfegesetz* (Federal Aid Law) and the *Heimgesetz* (Nursing Homes Act) set down benchmarks for minimum standards of care. New categories of personnel emerged, like the *aide soignante* [caregiver help] in France, who were not necessarily or exclusively dedicated to caring for the elderly but who did by and large work in the sector.<sup>8</sup> Outpatient care knew new developments: in Germany, the *Hauspflegerin* [home helper], initially envisaged to replace housewives who had taken ill, quickly found her main activities in elderly care (Matron, 2013). In parallel, a specific term for the professional carer for the elderly emerged in the German-speaking realm: *Altenpfleger* [old keeper]. A sign of the significant degree of institutionalization, the first professional associations were founded: in Germany the *Deutscher Berufsverband für Altenpflege* in 1974, in France the *Union française des aides soignants(es)* in 1994.<sup>9</sup> Journals exclusively dedicated to elderly care, such *Altenpflege*, appeared shortly after the Millennium.

This growing professionalization also led to changes in working conditions for personnel. Henceforth, they no longer had to live inside the institutions; their working hours and rosters were modified to their benefit. The aforementioned professional organizations engaged in negotiations, and, where necessary, social disputes to obtain better working conditions. At the same time, new distinctions appeared among the carers. If nuns in the 19th century assumed an array of diverse tasks (cleaning, preparing food, caring duties, transportation, administrative work ...), this changed after the 1960s, where a gradual differentiation inside professional geriatric care took place: At the top of the hierarchy was the qualified nurse while the cleaning lady stood at the bottom, with nursing assistants and other similar professions somewhere in-between. This specialization was function based: who, for instance, had the right to administer an infusion

therapy or inject a patient—but also emblematic in nature. The starched-white uniform increasingly became the distinctive symbol of the educated nurse. From the 1990s onwards, newly-emerging professions responsible for care became more visible: the speech and occupational therapist, the social worker, though the latter had been present since the 1930s (Irmak, 2002, p. 292).

Critique of institutions—and not only those caring for the elderly—started becoming ever more persistent and audible in most European societies from the late 19th century onwards. Poor quality of care as well as the apparent pandemic mistreatment of patients and residents acted as permanent reminders of the insufficient legal and professional standing of those working in elderly care. Investment in training was seen as a tool to ameliorate the profession's image, and combat persistent staff shortages, an issue that to this very day has been a continuous narrative in the sector (Chenoweth & Lapkin, 2018). In Germany, organizations such as Caritas or the *Innere Mission* started giving lectures in their institutions. Beginning in the 1960s, a growing number of technical colleges launched specific courses for those working in the sector. In 1968, forty such schools were in existence, 7 years later the number had doubled, and by 1988 it had tripled to 243 (André, 1993, p. 219).

The first handbooks on care, such as Mary Hodkinson's *Nursing the Elderly* (1966) were published in the latter half of the 20th century. Employed as a matron in a geriatric hospital, she wrote the manual for "pupil nurse, student nurse, or even the trained nurse who lacks experience of the specialized care of old people—by others who have to care for elderly relatives or residents in welfare homes" (p. 43)<sup>10</sup> Focus was on practical gestures, as highlighted in the first five illustrations: "learning to wash, bath, support, learning to dress, learning to feed herself, moving from chair to commode." Caring for the elderly, irrespective of how professionalized the care was and which therapeutic paradigm were dominant, always involved direct physical touch with patients. This intimate handling of patients still remains a structural element in caring for the elderly. Notions of corporeality, shame, embarrassment, norm violations and the frontiers of intimacy were and are still permanently negotiated in all institutional settings where elderly people are managed. All experiences associated with professional elderly care whether physical (moving the elderly ...), corporal (touching their bodies ...) and sensory (body odors ...) remain undoubtedly one of the most fascinating historiographical fields.

Despite such efforts and the profession's rise in social prestige, the difficult working conditions more often than not explains why the professional geriatric care sector suffered permanent staff shortages (Grabe, 2013). Notwithstanding, the number of women and men working in the sector rapidly multiplied in the second half of the 20th century. The precise numbers

are not fully available. As elsewhere in the historiography of this field, the existence of personnel designated to take care of the elderly have not constituted a statistical unit for a long time. The political scientist Günter André (1993) estimates that the numbers working in professional geriatric care in Germany nearly tripled from the early 1960—jumping from 40,000 to 110,000 in the early 1980s, male and female included (p. 215). Over the 20th century, professional elderly care remained, more so than in other care activities, a female prerogative.

### THE 21ST CENTURY: EMERGENCE OF A FIFTH RISK?

The latter half of the 20th century is characterized by so-called *Age of Degenerative and Men-Made Diseases*, to quote the well-known theory originally advanced by Abdel Omran (1971). Chronic diseases play a key role in this third and most recent epidemiological transition. If at the beginning of framing chronic diseases as a central feature in this new period, age-related illnesses in themselves were not directly considered a core concern. Alzheimer's disease and Parkinson's disease served as a game changer in how this transition was perceived. In several European countries, discussions ensued on how to finance care for that elderly segment of the population who no longer seemed to be insured by conventional health insurance systems that were conceived for old age and illness.

While the chronology and the detailed solutions chosen in various European countries differed, several nations introduced the notion of a "fifth risk,"<sup>11</sup> namely, an endangered segment of the population who had to receive appropriate long-term care and had to be covered through a comprehensive enhancement of the traditional social insurance system: the *Soziale Pflegeversicherung* introduced in Germany (1995), the *Prestation spécifique dépendance* (PSD) in France (1996), *Assurance dépendance* in Luxembourg (1999), and the *Zorgverzekerung* in Flanders (2001) to cite but some examples. And yet, this strategy was not taken up universally: the United Kingdom remains attached to its more liberal tradition, where individual responsibility (either through private savings and/or private health insurance) is privileged.

These new regulations altered the entire professional care landscape for the elderly. In Germany, curricula for professional elderly care were modified. In France, the profession of the *aide-soignant* [caregiver] was for the first time legally structured in 2005, and included a clearly defined training régime. However, these diverse strategies to invest in the profession have not proven to be an outright success. Not only in Germany, where a specific profession—*Altenpfleger*—became institutionalized, but also in France, women working in the legally structured professional elderly care sector still endure poorer working conditions than their counterparts in the

nursing profession. For many, working in the sector is still considered as a temporary solution: jobs in other caring institutions are often better paid, considered less difficult and more rewarding (Loffeier, 2015).

Even if elderly care was less impacted upon by the incremental deinstitutionalization that affected hospitals and asylums from the 1960s onwards, a noticeable change has been perceptible over the last 20 years, of a distinct shifting away from nursing care inside institutional settings to sheltered housing or at-home-care. Less personnel intensive and considered as a potential measure to relieve overcrowded nursing institutions, these new care settings appeared as one potential solution to the ever-increasing surging financial costs associated with professional elderly care (Timonen & Rostgaard, 2018). The carers' working conditions have fundamentally been altered (Riedel, 2007). No longer working in a team inside one institution, they are frequently more isolated. In this context of a "new public management," carers are asked to be more flexible, and they are more directly submitted to economic constraints (Gemperle, 2014). This evolution has also produced unfamiliar hierarchical differentiation among caring personnel with the emergence of new staff categories in France and Luxembourg, such as *aide-ménagère* [home helper], *aide à domicile* [home helper], *assistante de vie* [personal assistant], and *aide socio-familial* [social-family helper].<sup>12</sup> If training for these new categories was characterized by a lack of any clear curricula at the outset, the new staff categories went through a similar process of professionalization as the former nonprofessional caring categories.<sup>13</sup> Today, the field of the professional elder care appears as extremely heterogeneous, ranging from highly specialised nurses in biomedicalized settings to nonqualified carers in outpatient care.

## CONCLUSION

The history of the care for the elderly persons remains a historiographical void. A profession mainly practiced by women and leaving only a limited amount of traces probably explains the little interest historians have shown till now for this field. The chapter offers a chronological overview of a potential history of the elderly care, by distinguishing three developments—an aspiration of professionalization in the 19th century, a growing institutionalization in the 20th century and the emergence and official recognition of care dependency as the "fifth risk" for the beginning of the 21st century. Future research should not only try to fill up the institutional gaps but also concentrate on three topics: the care of the elderly outside the walls of the nursing homes, a focus on moments of greater vulnerabilization such as wars or economic crises and a particular attention for the voices of the elderly persons.

## NOTES

1. The absence of a specific noun to designate their occupation illustrates their social invisibility.
2. In the England of the 1960s, the wards for the elderly in general hospitals were considered as the “punishment” wards: few nurses were willing to work there on a voluntary basis (Brooks, 2009).
3. This was one of the starting points for the reflections by the American psychologist Carol Gilligan “on care (Gilligan, 1982). For an overview on this discussion refer to Garrau (2010).
4. For a stimulating view beyond this West Europe bias refer to Hayashi (2015).
5. “*Le personnel et les hospitalisés changent de linge toutes les semaines.... Les employés de l'établissement sont tenus à une parfaite propreté; ils doivent prendre un bain ou une douche au moins tous les mois*” (Cribier & Feller, 2005, p. 103).
6. “*Mit allen Leidenden Mitleid haben, die Pfleglinge immer wieder stützen, ordnen, reinigen, manchen Undank geduldig hinnehmen, für seine Abteilung liebevoll zu sorgen - und das jahrelang, ist die schwere Aufgabe des Pflegepersonals*” (Hartmann, 1925, p. 184).
7. This linear progressive narrative of the 20th century was interrupted by the two World Wars. During World War One the elderly were more affected than other segments of the general population by abnormally high mortality rates due to malnutrition (Majerus, 2005, pp. 72–73; Robert & Winter, 1993). During World War Two, professional care for the elderly worsened dramatically. In Germany, the elderly risked being labelled *unwertes Leben*, unworthy life forms only fit for extermination (Hahn, 2001; Matron, 2013). Even in countries not directly affected by forced euthanasia, care for the elderly declined considerably, inducing higher mortality rates, as was the case in France (Von Buelzingsloewen, 2005).
8. Arborio (2012, p. VIII) estimates that of a total of 350,000 *aides-soignantes* 100,000 work in professional elderly care.
9. In England, nonprofessional carers established *National Council for the Single Woman and her Dependants* in 1965 (today *Carers UK*): (Kramer, 2017).
10. In Germany, three editions of the book (Böger, 1965) were published by the end of the 1970s.
11. The so-called “fifth risk” (care dependency) has been added recently to the other four ones (disease, accidents at work, family and old age) covered traditionally by social security systems.
12. Christelle Avril shows the diversity of the categorisations for these women (cases of men working in these professions are extremely rare): (Avril, 2006).
13. In Luxembourg, Grand Ducal Regulation established specific training for “aide socio-familial” in 1999. cf. Retrieved May 1, 2015, from [http://www.mfi.public.lu/a\\_z/A/AideSocioFamiliale/index.html](http://www.mfi.public.lu/a_z/A/AideSocioFamiliale/index.html)

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