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Home care provision in Germany
The state of things and recent developments

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1. Introduction

Internationally, home care provided to frail citizens is on the rise. Against the background of social modernization and demographic change, the services provision to the domicile of care-dependent people has become a major concern of both public policies and researchers investigating the social welfare sector. This report presents findings from a broad review of the overall home care system in Germany and its recent evolution. Emanating from a European project coordinated by a team located at the University Louvain-la-Neuve¹, it assembles information from various sources, including previous research, in order to sketch an encompassing picture of particularities of the German care system to an international audience.

Of course, this is anything but the first undertaking out there, as there are many others English-written publications that contain information about this system and its development.² However, this report not only updates much of what has been written elsewhere but includes elements which often are not considered together when dealing with elderly care. In particular, it links information and data on the wider context of home care with an analysis of structural features and of dynamics of change throughout the care system, including with an eye on how a given society (the German one) meets the challenge of keeping frail people permanently at their homes through temporary professional support. Regarding methodological issues, we draw on data from various official statistics, public reports and documents composed by major stakeholders of the care system, such as studies published on behalf of nonprofit care providers.³

The report begins with charting major societal foundations relevant to current developments in the German care system. Among other things, we look at what is referred to as ‘demographic challenge’ and depict the evolving social arrangement(s) by which Ger-

¹ Major coordinators have been Florence Dagrave and Marthe Nyssens.
² To name but a few: Burau et al. (2007), Ungerson & Yeandle (2007), Doyle & Timonen (2007), Huber et al. (2009), and articles contributed to a recent special issue of the International Journal of Sociology and Social Policy (31, 3-4 2011).
³ Some of these references are cited throughout. Further references are provided in other publications of the authors, equally referred to in what follows.
man society intends to deal with this challenge. Thereafter, we present the institutional framework in which home care provision is embedded in this country. Importantly, our analysis comprises information on issues beyond what is considered in the first instance when Germany is referred to internationally, that is, provision within the confines of *long-term care insurance*. This institution, while forming the core of the care system, is not the only pillar of the latter; rather, further schemes are interlinked with this core – and often it is these interlinkages that are critical when it comes to the challenge of maintaining frail citizens at their homes. The third section elaborates on the socioeconomic framework relevant to home care provision. It explores how actors are coordinated throughout the system, with a particular attention on the role of quasi-market regulations as these regulations are different from approaches known from other parts of the Western world. Again, considering the landscape of international analyses of the German system, our analysis delivers novel insights insofar as it includes data on the infrastructure of this system (providers, patterns of employment, market regulation) and elucidates tensions that arise from this infrastructure. The report also presents the current quality inspection regime and some of its biases. The conclusion will summarize major findings and look out into the future of home care provision in Germany.
2. Societal foundations of the German system of long-term care

As many other countries in the Western world, Germany has seen considerable demographic change over the last decades, with a rapid increase of its senior population. The demographic development is among the factors that have led to the expansion of home care provision in Germany – although other reasons, such as a changing gender model and growing reluctance to foster residential forms of care provision have played a role as well. From the 1980s onwards, reforms to the pension scheme (yielding more entitlements to family carers) and the establishment of the so-called long-term care insurance have boosted the provision of domiciliary care services. While professional provision has grown in importance, families continue being solicited to respond to these increasing needs – in particular daughters, daughters in law and spouses who were playing a pivotal role in the provision of care during the 20th century. While their caring role has now been complemented by professional services, it is obvious that home care in the prevailing (temporary) form continues to depend on family support to a considerable extent. This has an impact on the division of work between men and women and the work-life-balance, which will be discussed below. New actors such as migrant care workers play also a significant role. The following sections will shed light on these societal foundations of the home care system as it exists in contemporary Germany.

Meeting the demographic challenge: the German debate

This section charts major developments in the public debate concerned with elderly care and the social arrangement dealing with demographic change. The growing demand for elderly care is a widely accepted perception across the German polity and mentioned in numerous official (government) reports and documents (for many, see: EPN: 58-73). While there are voices stressing that the improving health status of the elderly may imply a less stronger increase of care needs than one might assume (FMF5: 3), the overarching perception is that the care burden will rise in the decades to come. Obviously, this perception is driven by demographic concerns much more than by an evolving gender regime (ENP: 64).

As shown in Table 1 (next page), the number of people over 65 years of age has achieved a proportion of 20% of the total population. The very old (over 80 years of age), presenting particular care needs, are heading 4 million. Furthermore, as the number of people in residential care remains low, the lions' share of this demographic change will have an impact on the home care system.
Table 1: Contextual data about elderly people

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population of Germany (2008)</td>
<td>40,2 M*</td>
<td>41,8 M*</td>
<td>82,0 M*</td>
</tr>
<tr>
<td>Nb of people over 65 (2008)</td>
<td>6,9 M*</td>
<td>9,6 M*</td>
<td>16,5 M*</td>
</tr>
<tr>
<td>Nb of people over 80 (2008)</td>
<td>1,2 M*</td>
<td>2,7 M*</td>
<td>3,9 M*</td>
</tr>
<tr>
<td>Nb of people aged 65 and more staying in residential care (2007)</td>
<td>142 756</td>
<td>517 009</td>
<td>659 765</td>
</tr>
<tr>
<td>Nb of people aged 80 and more staying in residential care (2007)</td>
<td>74 789</td>
<td>412 811</td>
<td>487 600</td>
</tr>
</tbody>
</table>


As the birth rate is relatively low in Germany, observers expect a net increase of the dependency rate during the following decades. This is often viewed as implying investment in domiciliary care services, but also new efforts for extending informal support. In the public debate, allusions are made towards neighborhood-based mutual aid and volunteer work in the community (FMF5: 29-30). That said, concerns are widespread that in the future the overall level of care provision may be insufficient. This is endorsed by the experience of major personal care needs not being covered by long-term care insurance and the fact that wealthier citizens have begun to resort to (often undeclared) immigrant work to meet these needs (Neuhaus et al. 2009).

Evolving social arrangements: family care and professional services

In Germany, care provided by the family is still understood as a substantial element of the care system. In the official discourse, this orientation resonates with a preference of a large majority of the elderly to live at home as long as possible. The high costs of residential care seem to be less relevant in this discourse (for many, see FMF5: 29). Over several decades now, all relevant stakeholders stress the inconvenience, if not cruelty, of residential care. Most care-dependent people, it is said, could not imagine living in residential care. Thus, given that most commentators in the public sphere do not question the very popular cash-for-care option in the long-term care insurance regime (see
below), the family care model – maybe with a supplement of domiciliary (body-related) professional services – appears deeply engrained in the welfare culture of the country.

However, many of those concerned with elderly care are clearly aware of constraints arising from the changing modes of living throughout German society. In official reports, mention is made of the rising activity rate of women on the labour market and the greater spatial mobility of workers as major challenges to the care system, including regarding costs (see e.g. EPN: 18, 65, 109). Experts and stakeholders of the professional care sector suggest intermediate solutions to cope with this, such as day care or serviced flats. This also seems to be the reading of major political forces, encapsulated in the comments of the Government to the ‘aging report’ published in 2005 (FMF5: 11). Moreover, a recent government initiative (in 2011) envisages to give workers the right of a longer term leave from their job while keeping their employment contract and being paid on a part-time basis – the key idea is that, following this sabbatical, the salary continues to be calculated on a part-time basis while the employee is working full time, over the same period they had been absent before. To some extent, this would be both a confirmation of the change the German labour market model is undergoing regarding the gender dimension (see below) and an attempt to preserve a ‘part-time’ version of the more traditional approach. In the context of increasing needs, German families remain pivotal regarding the provision of care at home. However, both the public debate and the social arrangements underlying the provision of care to frail citizens reflect some change in the way families are involved.

The fact remains that Germany exhibits a traditional family model in which care-dependent people are viewed as having a right to intense support from their relatives. German law obliges children (including children-in-law, but not grandchildren) to support parents in case these are unable to bear the cost-of-living which may include expenses for care; in general, there is an assessment threshold under which they are exempted from this obligation for alimony. The public expectation resonates with provisions in the

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4 Those defending such intermediate solutions seem however in trouble as the wider population rarely resorts to these novel patterns of elderly care. Note that, in such documents, elderly care is defined as one basic element of intergenerational solidarity, besides childcare. In the same report, the reconciliation between professional and private activities is discussed for both varieties of care. The key orientation is what is being referred to as ‘new time policy’, geared towards the reconciliation between any kind of family life and gainful employment for both sexes (FMF5: 6).
social law regarding the obligations of the family to pay for care. Thus, social assistance is awarded to frail senior citizens unless children (couples in which they live) earn more than 100,000 €; means-testing for each case is the rule; expenses for professional care can be claimed back from children if their income exceeds what is necessary for maintaining their social status. Local welfare departments (which have some discretion over the respective decisions) usually leave 2,500 € to a couple (depending on incurred costs for accommodation) plus expenses for their own offspring plus private pension accounts plus part of accumulated assets. That said, welfare departments can claim expenses for social assistance (see below) claim back from heirs if the heritage exceeds 15,340 €.

It holds true that – given a rapidly rising employment rate of women – the direct involvement of relatives is more limited than in the past for greater sections of the population. As (temporary) professional services are more available, the exclusively family-based social arrangement of the 20th century is losing ground. However, the role of the family as major coordinator, if not as a part-time provider, of care does not appear to be contested in principle. Rather, there is a continuous debate about the conditions under which families may be able to take over this responsibility without becoming overburdened.

**The gender issue**

From a comparative perspective, Germany has long been characterized by a relatively low activity rate of women, particularly mothers. There are notable differences within the country, however. Prior to unification, East German women had been in gainful employment much more often than their Western counterparts, due to both the worldview of the communist regime and extended childcare facilities. That said, the Western tradition still has a considerable influence in the reunified Germany. The traditional mainstream model was a division of labour making women raising children at home while men being the ‘breadwinner’ for the whole family (Pfau-Effinger 1993). Major social and legal institutions were endorsing this family model (Burau et al. 2007: 104-112). Schools held classes half-day only even as kindergartens closed around lunch time, with all this being based on the assumption that mothers were available at home. Concerning social protection schemes, the informal work role of women in the family, including care to both children and the elderly, was endorsed by a parental benefit scheme and the generous cash for care option included in the long-term care insurance system (Leitner 2009).
Reforms affecting the care systems have rarely been pursued with an eye on gender equality strictly speaking. However, work-life balance issues have become more prominent in the debate, with reports claiming better opportunities in this respect and with recent government proposals envisage the afore-mentioned ‘care sabbaticals’. Government documents (e.g. FMF5: 6) refer to this issue as a generational challenge, that is, as a topic to be dealt with more generally in terms of the temporal organization of the life course. This refers to a life course during which there should be time slots for both men and women to devote themselves to other things than mere gainful work.

For the rest, reports and policy documents laconically state that elderly care has remained a responsibility of women rather than men. This is put forward in the description of the domestic ‘care regime’ but also in the analysis of the labour market for elderly care (e.g. ENP: 104). While women are nowhere defined as being ‘ideal carers’ experts observe that users may prefer female carers (Neuhaus et al. 2009: 62). Moreover, they note that professional care provides excellent opportunities for women to (re-)enter the labour market, including on a part-time basis (ENP: 21). In the same vein, it is noted that contemporary women wish to stand on their own feet in economic terms, and that this may affect their availability as informal carers in the near future (EPN: 64). However, most documents remain silent on how both sexes can achieve economic independence and complete a full career together.

Having said all this, change is underway concerning both the family model and the related institutional set-up. The activity rate of women, including mothers with younger children, has considerably increased over the last twenty years or so. The prevailing culture of care has evolved accordingly. In any kind of official document, a comment stating that female labour market participation entails a crowding out of the domiciliary care workforce would be very unlikely nowadays. The key concept today is taking measures improving the work-life balance, e.g. through new patterns of work organization.

As noted earlier, the new mainstream is men being in full time employment with partners working part-time or in petty jobs during the early years of their children. However, the traditional gender contract has left its footprints in the current «care regime», including with respect to how women are entering the labour market (Pfau-Effinger 1993). In the 1970s and 1980s, women were attracted by work in the personal service sector not least because the latter offered part-time employment opportunities, that is, the possibility to balance the women’s desire to combine gainful employment and domestic care. Reforms in social protection schemes have consolidated the ancillary economic function of women (since the role of the carer has been acknowledged by reforms e.g. in the
pension system, providing carers with some additional entitlements) while promoting this special version of a double income family.

Table 2: People in the labour market – Employment rates for selected population groups (%).

<table>
<thead>
<tr>
<th></th>
<th>Male (15-64)</th>
<th>Female (15-64)</th>
<th>Older workers (55-64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>71,9</td>
<td>55,8</td>
<td>37,7</td>
</tr>
<tr>
<td>2003</td>
<td>70,9</td>
<td>58,9</td>
<td>39,9</td>
</tr>
<tr>
<td>2008</td>
<td>75,9</td>
<td>65,4</td>
<td>53,8</td>
</tr>
</tbody>
</table>

Source: Europe in figures - Eurostat yearbook 2010: Labour market (tables and graphs)

Table 3: Gender employment gap in Germany*

<table>
<thead>
<tr>
<th></th>
<th>1985</th>
<th>1995</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>37,84</td>
<td>23,54</td>
<td>15,19</td>
</tr>
</tbody>
</table>

Source: OECD Outlook 2008

* The gender employment gap is defined as the difference between male and female employment rates as percentage of the male employment rate.

Available data show both the resilience of the traditional family model in Germany and the fact that this is about to become history as the labour market participation level of German women has definitively caught up with the rate in other industrialized nations (see table 2 and table 3). In most cases though, women provide an extra income and not the main revenue to the household. Also, the new model exhibits a precarious character as lower class women are left with petty jobs and a high poverty risk once they are affected by a family split-up. As the number of children born prior to marriage is rapidly rising, this risk extends to mothers not covered by ‘marital law’. Note that the risk of poverty is also encroached in the characteristics of the postindustrial labour market which does not provide parents with sufficient employment opportunities in accordance with family obligations (stable and reliable work hours, mainly). Solutions to this problem discussed by the media, such as flexible child care facilities, opening day and night, are not only poorly developed but apparently are not welcome by major parts of the population.
More recently, dual full time careers have taken centre stage in the public debate. Reforms of the 2000s have been geared towards extending child care facilities and making parental leave dependent of previous income from gainful employment. Moreover, public employers and big companies have taken initiatives to get hold of the more qualified female workforce through family friendly employment policies (child care at the workplace, flexible working time). In quantitative terms, this movement is still in its infancy, and it remains to be seen whether it will extend to wider sections of the German population.

The role of migration

While being still at the margins of the care system, migrant care workers play a growing role for the provision of care to the frail citizens in Germany. They often appear as semi-formal workers, since many of them live at home with the elderly and assure an 24h support (Larsen et al. 2009). Despite the lack of official data on migrants working in the home care sector (estimations say that 100.000 workers are busy in the field at present), there is a widespread public perception that the level of illegal workers from foreign countries is high. The least one can say is that the expansion of the EU towards Eastern Europe in 1990 had a significant impact on the influx of foreign workers in the home care sector. There is a also number of legal migrant employees, hired by private households for a periods up to 3 months and admitted to this market via a tourist visa. These employees then leave the country for 6 months and can take up again domestic employment for another three months. Moreover, a reform of the immigration act (‘Aufenthaltsgesetz’) in 2005 has permitted foreigners to provide domestic work on a full-time basis over a period of up to 3 years unless EU citizens are available to provide care to a very dependent elderly. This contract includes social insurance coverage, but is rather expensive for employers. In 2010, more than 65 agencies were offering round-the-clock home care ensured by citizens from Eastern Europe. It also appears that undeclared domestic work is tolerated by public institutions in Germany. Inspections are rare, and social workers and care professionals learning about a foreign worker in a dependent elderly’s home would rarely indicate that to the employment authorities.


6 See Flothow (2010).
The German route to ‘defamilialization’

Considering the significant role of the family in the delivery of home care in Germany, the availability of programs and opportunities making the elderly more financially independent from members of their family regarding the provision of care (at home) is a crucial issue. In the international literature concerned with the societal organization of care, the term ‘defamilialization’ is used to define ‘the degree to which individual adults can uphold a socially acceptable standard of living, independently of family relationships, either through paid work or through social security provisions’ (Lister 1997: 173).

In contrast to the highly ‘defamilialised’ care regime of the Nordic countries, the German configuration has long exhibited a combination of subsidiarity (the norm of ensuring care provision publicly but at the lowest organizational level available) and familialization (the norm stipulating high informal contribution to child and elderly care). Institutional arrangements have followed this logic in several respects: they include a universal long-term care scheme featuring highly professionalized medical and para-medical care services in parallel to considerable investment by families providing care and domestic work (Behning 2005, Heusinger 2008). While the basic assumption during the 1970s was that women should take care of the elderly in their family without being paid, the 1980s and 1990s have seen a growing institutional recognition of care work in the family, with new policies providing ‘cash for care’ within the framework of long term care insurance (see below). This has allowed family members, mostly women, to receive a compensation for the investment in the care of the frail elderly. Notably, the ‘defamilialization effect’ of such programs is limited. Moreover, with the introduction of long-term care insurance (at latest), there has been a growing institutionalization of care-related social protection together with a strong gendering of professionalized social service provision. Pfau-Effinger (1993) has referred to this as a new fundamental (albeit unwritten) gender contract assigning productive and reproductive roles to both sexes. Voges (2002) makes a connection between the fact of the sector being ‘womanized’ (including with respect to the role of female immigrants) and the limitations set to professionalization, materializing in working conditions poorer than the ones of many other, men-dominated industries. He concluded that female care workers were leaving their domestic sphere to work in yet another private sphere which implied a certain social reproduction of the gendered ideas associated with healing, caring and helping.

True, the rise in formal (professional) caregivers has endorsed the process of defamilialization after all. Care work has become a buoyant labour market over the last 15 years or so. Highly feminized, it is shaped by modest working conditions including wages and working hours, however. Defamilialization has been boosted by the long-term care in-
surance policy because the latter has boosted a market of home care services. Prior to the introduction of the program, families had less options, with major alternatives being having considerable out of pocket expenses (or resorting to the social assistance) and total withdrawal from gainful employment. With the increasing participation of women on the labour market, the traditional gap with other industrialized countries has been narrowed, as spouses, daughters in law and daughters, or female neighbors, can (and will) no longer assume the entire responsibility.

While the existing societal arrangement contributes to the process of defamilialization, those care services currently available in the German care sector are far from liberating family members from social responsibility. There is choice over having a professional caregiver or asking a member of the family to do the ‘care job’. This also implies that the caregiver is not depending exclusively on his or her family in order to survive economically. That said, the available in-kind services do not cover all needs. In particular, home help is developed poorly (Falk et al. 2011). Moreover, as the time slots awarded by long-term care insurance for professional service provision at home are very short, activities at the ‘social heart’ of care, such as emotional support and company, remain widely left to the private or informal sphere. What is more, the ‘cash for care’ option does after all not foster the autonomy of female caregivers (Leitner 2009). Firstly, it advantages the caree at the expense of the caregiver because the money is awarded to the first and not the later. The caregiver (3/4 of them are daughters or spouses) remains dependent on the caree regarding his or her financial autonomy. Secondly, in many cases the benefits paid are not sufficient to guarantee financial independence, let alone a standard of living comparable to the one achieved through gainful employment. While the period running from the 1970s to the recent times does have seen ‘a shift towards formalization of caring work provided in private households’ (Behning 2005: 82), the ‘cash for care’ option has endorsed private home care provision, with long term care remaining an affair of private households rather than residential provision so that the family remains the key actor in the care regime.
3. The institutional dimension

In the modern welfare state, social service provision has been subject to important institutional regulation under the influence of socio-political concepts. However, this regulation differs with national jurisdictions, in line with cultural traditions. More precisely, distinctive legal provisions shape the way welfare state resources are channeled into social welfare, including the care of frail citizens – mainly through allowances and the funding of service-providing agencies. Importantly, the access to services; as well as the kind of providers involved in formal care; is highly dependent on such provisions. This section provides a detailed overview of this institutional dimension of the German care system. Following a general introduction, we elaborate on the regulation of domiciliary in-kind services, including aspects concerning the infrastructure of care provision (such as the qualification of home care workers). In a second step, we depict the cash allowances scheme.

The legal regulation of elderly care in Germany

Regarding the institutional regulation of care services, Germany has been a pioneer by introducing a long-term care insurance scheme providing earmarked funding to these services. This has led to a regulated market of – mainly paramedical – care to the frail elderly and other dependent people. Around 90 % of the working population pays wage contributions to this insurance (in accordance to their level of income), with employers and employees sharing the burden. The scheme offers choice between in-kind services offered by different types of nonprofit or for-profit providers, a lump-sum direct payment which beneficiaries may use to employ someone or support a relative doing the work (cash for care), or a combination of both. Table 4 (next page) shows that a strong majority of beneficiaries stay at home (using cash allowances or/and domiciliary in-kind services). Though the more costly residential care is chosen by a minority only, the take-up of this option has been slightly increasing over the last ten years. Among home care recipients, most of them prefer cash allowances over the in-kind services or a combination of in-kind services and cash for care.
### Table 4: Type of benefit chosen by beneficiaries of the long-term care insurance, in percentage

<table>
<thead>
<tr>
<th>Type of care</th>
<th>1998</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash allowances for care</td>
<td>55.9</td>
<td>49.9</td>
</tr>
<tr>
<td>Domiciliary in-kind services</td>
<td>7.8</td>
<td>9.3</td>
</tr>
<tr>
<td>Combination of in-kind services and cash</td>
<td>10.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Total home care</td>
<td>73.7</td>
<td>70.2</td>
</tr>
<tr>
<td>Residential Care</td>
<td>26.3</td>
<td>29.8</td>
</tr>
</tbody>
</table>

Source: Rothgang 2010

### Table 5: Number of recipients of care, by type of care

<table>
<thead>
<tr>
<th>Type of care</th>
<th>1999</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing home (vollstationäre Dauerpflege)</td>
<td>554 217</td>
<td>671 080</td>
</tr>
<tr>
<td>Day care centres (Tagespflege)</td>
<td>10 276</td>
<td>23 196</td>
</tr>
<tr>
<td>Short time care (Kurzzeit)</td>
<td>8 545</td>
<td>15 002</td>
</tr>
<tr>
<td>Night care (Nachtpflege)</td>
<td>173</td>
<td>33</td>
</tr>
<tr>
<td>Residential Care* (total)</td>
<td>573 211</td>
<td>709 311</td>
</tr>
<tr>
<td>Domiciliary in-kind services</td>
<td>415 289</td>
<td>504 232</td>
</tr>
<tr>
<td>Cash allowances for care</td>
<td>1 027 591</td>
<td>1 033 286</td>
</tr>
<tr>
<td>Total</td>
<td>2 016 091</td>
<td>2 246 829</td>
</tr>
</tbody>
</table>

Sources: Federal Statistical Office of Germany, Pflegestatistik 2007, Rothgang 2010
[http://www.gbe-bund.de/glossar/Pflegestatistik.html](http://www.gbe-bund.de/glossar/Pflegestatistik.html)

The number of people in residential care should be considered with caution: first, this number takes into account only people classified on the scale of long-term care insurance (within the dependency levels 1-3); secondly, when an elderly moves to a care facility, it is often unknown whether her or his new address has been registered officially.
Table 5 (overleaf) illustrates that the demand for services among the elderly has been growing overall, by 11% between 1999 and 2007. Assessments and other care policies, especially the allocation of social assistance beyond what is granted by long-term care insurance, have so far not been explicitly directed towards heavy cases. Concerning social assistance, such concentration (rationing) would be illegal as a matter of principle. The existing ‘social security statute book’ (‘Sozialgesetzbuch’, SGB) stipulates that any citizen lacking resources needed for subsistence has a right to public welfare for his or her daily living.

In-kind services: Regulation and service provision

There are a number of different programmes through which the German welfare state provides or supports care (services) to frail citizens. While short-term nursing care is provided under the health care insurance scheme, long-term care insurance covers longer periods of both institutional care and home care, with the latter including some bids of personal care (home help). Benefits are capped. Social assistance for care may take over the remainder of expenses related to home care in case the personal income of care-dependent citizens is low. Finally, voluntary municipal programmes may provide some additional support to these citizens. The different ‘pillars’ are depicted in greater detail in what follows.

Types of programmes

- **Health care insurance** (‘Gesetzliche Krankenversicherung’, ‘Sozialgesetzbuch SGB V’): This insurance scheme covers acute medical care including at home, following hospital treatment, for example. The respective service package may comprise some domestic support services (in case of pregnancy, during hospital treatment). After a couple of weeks, however, the lion’s share of this package is devolved upon the long-term care insurance scheme.

- **Long-term care insurance** (‘Gesetzliche Pflegeversicherung’, ‘Sozialgesetzbuch SGB XI’): This scheme embraces a cash-for-care allowance (see below). Regarding formal services, it has a clear focus on nursing care but also contains options for receiving some bids of home help including domestic work and social company (in particular, for people affected by dementia). The care package is capped as a matter of principle, according to the assessed state of need (three dependency levels apply); beneficiaries can (and have to) chose those elements of the care package they want to have covered by long-term care insurance. The
remainder has to be taken over by themselves or by municipal welfare departments. A freely contracted provider will then provide the selected bundle of care services. Importantly, most beneficiaries need support beyond what long-term care insurance funds provide. Table 6 shows that the actual benefits offered by the long-term care insurance embraces a certain range of care services, including advice services and social protection to caregivers. In theory, the care package offered by long-term care insurance (see table 7, next page) comprises household-related support as well. Yet the list of services as actually contracted by the beneficiaries often gives priority to body-related services, the available budget being insufficient to cover domestic services as well. Note however that, since 2009, there is special funding (out of long-term care insurance) available for 'social company services’ (‘Soziale Begleitung’). Senior citizens affected by dementia and their families are entitled to this grants, covering expenses up to 200€ per month; long-term care insurance may also support volunteer groups engaging with lay support to this target group.

<table>
<thead>
<tr>
<th>Table 6: Current benefits covered by the long-term care insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free nursing care courses for relatives and volunteer carers.</td>
</tr>
<tr>
<td>Allowances to pay the cost of modifying your home to accommodate your nursing care needs.</td>
</tr>
<tr>
<td>Nursing aids that facilitate long-term care, such as a special bed.</td>
</tr>
<tr>
<td>Part-time institutional care and short-term care</td>
</tr>
<tr>
<td>Social security insurance for carers</td>
</tr>
<tr>
<td>Direct payment (embracing all kinds of benefits available to a frail/handicapped person; going beyond the benefit basket covered by long-term care insurance)</td>
</tr>
</tbody>
</table>


All sorts of suppliers are put on equal footing concerning this public funding, with the awarded care hours depending on the dependency level assessed by the respective public agencies. Long-term care insurance grants payments according to time units (mainly nursing and body-related care) whatever the status of the provider. Care support benefits paid by the municipalities are purchased by the
latter with selected providers, often on an hourly basis. Prices, including for domestic services, are negotiated between representatives of funders and provider networks, and then generally binding in a given region; this does not apply to services offered by suppliers against private co-payment; these prices are not overseen publicly. Prices are fixed for various baskets of service acts, including eg. helping beneficiaries getting up in the morning, washing, dressing up etc. For instance, in Berlin, a short morning/evening toilette may cost 8.00 €, a comprehensive morning/evening toilette 18.00 €, help to feed someone 10.00 €, etc. (Gerlinger & Röber 2009, p.87).

<table>
<thead>
<tr>
<th>Table 7: Services covered by the long-term care insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal hygiene</strong></td>
</tr>
<tr>
<td><strong>Nutrition</strong></td>
</tr>
<tr>
<td><strong>Mobility</strong></td>
</tr>
<tr>
<td><strong>Household-related support</strong></td>
</tr>
<tr>
<td><strong>Temporal Care</strong></td>
</tr>
<tr>
<td><strong>Various Aids</strong></td>
</tr>
</tbody>
</table>

Source: derived from Alzheimer Europe.

- social assistance for care (‘Hilfe zur Pflege’, ‘Sozialgesetzbuch SGB XII’, § 61). This scheme may grant subsidies required for home care if a frail person is unable to pay for services necessary for subsistence. Usually, this is deemed to be the case when the monthly personal does not exceed 1.000 € including expenses for accommodation and personal assets are lower than 2.600 €. The responsibility of funding lies with local (or regional) welfare departments. There is

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7 These negotiations, taking place at regional level (between associations of providers and funders), have to fix standard care packages (§ 86 SGB XI).
means testing, with all kinds of personal revenue being taken into account (insurance benefits, state pension income, monetary assets etc.). Note (again) that children have to pay for the costs of care for their elderly parents according to their means (see above). In theory, the ‘care support’ benefit should cover all domestic and social company services deemed indispensable by the welfare department that assesses a user’s needs. Compared to the long-term care insurance scheme, there are additional criteria concerning the need assessment as the latter is comprises not only acts of daily living but also acts that occur from time to time but nonetheless are viewed to be indispensable (e.g. the purchase of household items, various errands) (Krahmer 2010). In practice, however, local discretion is considerable. The available data shows that this kind of social assistance has been awarded to nearly 400 000 people in 2008 (see table 8). The scheme has been growing in many places in Germany (below, we provide figures for a middle-sized municipality, see table 9).

<table>
<thead>
<tr>
<th>Table 8: Social Assistance for care (‘Hilfe zur Pflege’) Costs and number of recipients, 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>3,26 billion €</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Table 9: Recipients of social assistance for care (‘Hilfe zur Pflege’) in 2005 and 2008 in a middle-sized municipality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of recipients</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
<tr>
<td>2005 532</td>
</tr>
<tr>
<td>2008 599</td>
</tr>
</tbody>
</table>

Source: Stadt Kassel - Sozialamt 2009. [http://www.stadt-kassel.de/imperia/md/content/cms01/06prokassel/senioren/08.pdf](http://www.stadt-kassel.de/imperia/md/content/cms01/06prokassel/senioren/08.pdf)

- various voluntary municipal programmes: In addition to the afore-mentioned national schemes, there are services provided by municipalities on a voluntary ba-
sis, though very limited in scope. Local authorities may indeed run programmes supporting frail elderly citizens for a number of small-scale social needs, especially meals-in-wheels, leisure activities, counselling etc. Some local programmes geared towards labour market integration embrace wage subsidies to nonprofit ‘home work service pools’ (see below). Municipalities (examples include Tübingen, Stuttgart, Chemnitz) provide special counselling for the elderly and their family regarding available support at local level and general information about old age. In some cases, municipalities grant a small cash allowance (‘kleines Pflegegeld’) to those not eligible to other allowances (up to 205 € per month).

- **special schemes** for those holding the administrative status of being severely disabled (‘Schwerstbehinderte’): Citizens classified as severely disabled are entitled to ‘personal assistance’ which is a benefit borne by the social assistance budget of municipalities. In general, such assistance services are carried out by non-qualified workers, mostly employed by voluntary sector agencies on an hourly basis. Compared to other care-dependent citizens, users receive rather generous assistance services, especially when they are in gainful employment. Indeed, by virtue of the ‘social security statute book’ (§ 1 SGB IX), disabled citizens have to receive public support allowing them to participate in social life. Law stipulates furthermore that they are eligible to workplace-related support services.⁹ The entire array of public support measures may also be organized by the means of a lump-sum direct payment (a personal budget) which beneficiaries may use to employ personal assistants but also other kinds of staff at home, according to their free will.

Note that these different 'pillars' are located at different governmental levels. Historically, the key development concerning the division of work between central/federal level and regional/Land/local level has been the introduction of long-term care insurance as a national programme. This was to some extent replacing the more localized pillars of service supply and has brought more homogeneity in long-term care provision (which, however, has remained nursing-oriented to a large extent). In this field, there are some inequalities between regions/Länder/local authorities but variation is overall

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⁸ General provisions on this can be found in ‘SGB XII’.

⁹ More precisely: § 33 Abs. 8 SGB IX and § 102 Abs. 4 SGB IX.
limited. However, while long-term care insurance is a national programme, leaving little influence to regional or local actors, domestic-work-related programmes and activities, as well as services funded by social assistance and innovations such as ‘home work service pools’ (see below) are much more unequally distributed across Germany.

**Types of providers**

Looking at the type of providers legally allowed to supply home care, one type of provider is largely pre-dominant, that is domiciliary care enterprises (‘ambulante Pflegedienste’). These have are either a for-profit or a nonprofit status. Over the last years, the dominance of nonprofits providers in the field has eroded to the benefit of small forprofit providers, to the point that the latter hold more of half of the market today. Public provider play an (ever more) marginal role (see tables 10 and 11 below).

<table>
<thead>
<tr>
<th>Type of providers</th>
<th>1999</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Providers &amp; beneficiaries</td>
<td>Providers &amp; beneficiaries</td>
</tr>
<tr>
<td>Forprofit</td>
<td>5 504</td>
<td>147 804</td>
</tr>
<tr>
<td>Nonprofit (Freigemeinnützige)</td>
<td>5 103</td>
<td>259 648</td>
</tr>
<tr>
<td>Public provider</td>
<td>213</td>
<td>7 837</td>
</tr>
<tr>
<td>Total</td>
<td>10 820</td>
<td>415 289</td>
</tr>
</tbody>
</table>


In some places, there have been attempts to create ‘home work service pools’ (‘Dienstleistungspools’) at local level, offering cleaning and other household-related services to citizens (of any kind). As of the mid-2000s, 125 pools were estimated to exist throughout the whole country, with two thirds of them holding the status of a for-profit enterprises and the remainder that of a non-profit organization. These agencies have proved viable due to labour market policy-related public subsidies (e.g. 20 % of expenses for wages in one programme established in the ‘Land’ of North-Rhine Westphalia.\(^{10}\) While

\(^{10}\) The ‘Länder’ are the greatest territorial divisions in Germany.
some experts (see Becker 2007) argue that there is a potential for this sector of domestic work to grow (especially for low-cost services), national regulation for this sector does not yet exist. Overall, it has remained a small player in the care system.

Table 11: Beneficiaries and market shares of providers

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipients of in-kind services at home (as funded by long-term care insurance)</td>
<td>363 000</td>
<td>408 000</td>
</tr>
<tr>
<td>Market share for home care†</td>
<td>Public provider</td>
<td>1,9 %</td>
</tr>
<tr>
<td></td>
<td>Nonprofit</td>
<td>62,5 %</td>
</tr>
<tr>
<td></td>
<td>For-profit</td>
<td>35,6 %</td>
</tr>
</tbody>
</table>

†measured in persons cared for.

Legal requirements relevant to formal care provision

If it comes to formal care provision, a number of legal requirements exist that shape the home care system in various ways.

- The typical user of professional care services in Germany are care-dependent citizens receiving benefits within the framework of long-term care insurance. As care allowances are contingent on formal assessments estimating the gravity of impairments and the amount of needed services (calculated in minutes of support), formal care provision is framed institutionally from the very beginning. Assessments are carried out by the ‘medical service department of health care insurance’ (‘Medizinischer Dienst der Krankenkassen’) and (formally) focus on the physical and mental capacities of frail people. They are carried out during visits at home or at a hospital; users (and relatives) are asked about their activities of daily living and how their impairment poses problems to carry out these activities. Following the assessment, a care package is suggested out of which users may chose the most relevant elements (as the entire package cannot be covered by the insurance benefit). Usually, users and their families then negotiate with service providers on the conditions under which these bids of care are delivered and pass a contract with the supplier.

- Moreover, those eligible to additional ‘social assistance for care’ (see above), will be assessed by social workers of the municipality, on the basis of the assessment completed by the ‘Medical service department’ of a given health insurance
fund, but with additional assessment criteria (concerning their personal life, availability of relatives, other forms of informal help etc.).

- Citizens holding the status of a severely disabled person are entitled to the aforementioned personal assistance services. For these individuals, social workers linked to the regional welfare umbrella organisations provide an assessment of the potential beneficiary and then fix the amount of hours needed.

- Regarding the activity of the typical ‘domiciliary care enterprises’, providers are admitted to the market once they have passed a provider contract with long-term care insurance bodies. The undertakings have to obey to some basic spatial and technical requirements and be run by a formally qualified nurse. They must employ at least four workers (among whom 2 have to be full time employees). Usually, domiciliary care enterprises will consist of the following staff: nurses (‘exami- nierte Krankenpfleger’, three years of professional training including on-site apprenticeship); elderly care nurses (‘Altenpfleger’, a specialised profession acquired after two years of professional training, including on-site-apprenticeship); (less frequently) family care workers (‘Familienpfleger’); and more seldom, social workers.

- In the private sector, collective agreements are rare but may serve as a model nonetheless. Wages have long been subject to unilateral decisions in this sector, yet more recently, a minimum wage has been decided at branch level (following governmental pressures). This wage amounts to 8,50h € in the Western part of the country and 7,50 € in the Eastern part; in general, qualified (elderly care) nurses and those at the middle management level are better paid.

Things are a bit different for providers that belong to (greater) nonprofit entities running several care centres (often referred to as ‘Sozialstationen’). They are equally led by a nursing professional or sometimes a social worker, with a similar staff structure otherwise. However, they embrace some lay workers, involved in separated groups of volunteers. Working contracts are regulated by a collective agreement as a rule, modelled on the public sector collective agreement (‘TVöD’) in one way or another. More recently, this agreement gives considerable leeway to local managers as to working time provisions, extra-hour organization and compensation etc. Wages are above the aforementioned minimum wage but de-

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11 These take over (middle) management roles in most cases.
viations are possible. As for employees of ‘home work service pools’, wage and employment conditions have usually been modelled on collective agreements agreed for the public sector. Regarding workers in the ‘personal assistance scheme’ (for disabled people), services are paid for by users on a fee-per-hour basis. Here, no collective agreement applies, nor is there any social security coverage.

- There are also legal requirements concerning the evaluation of providers. As will be explained in greater detail below, the German home care sector is, for some time now, subject to a fine-grained (though highly standardized) quality inspection by the ‘medical service department of health care insurance’ (MDK). This takes place on site, based on written documents and some interviews, and once a year (as foreseen by the law). The focus is set on body-related outcomes. Providers get a mark which is published on the Internet. As to the other sub-sectors (‘personal assistance’; ‘home work service pools’, ‘care support’ paid for by welfare departments), quality inspection takes the form of a general report delivered by the supplier.\footnote{See \url{http://www.pflegenoten.de/Pruefablauf.gkvnet}. The respective legal provision is § 114 ff SGB XI (Pflegeversicherungsgesetz). Below, we will address this question more thoroughly.}

Qualification and training of workers

There is a great diversity of professional qualifications in the field of home care, notwithstanding attempts to standardize training schemes and degrees (Bode et al. 2010). Body-related care work is subject to professional training embracing two or three years, with some period at school and other periods at a work place. Regional initiatives have aimed at enhancing the level of qualification throughout the care sector. For instance, in association with the Federal Employment Agency and local home care providers, the Ministry of Work of the Land of North-Rhine Westphalia has developed a programme to promote the training of geriatric nurses, using money from the European Social Fund (further expenses are covered by the Land).\footnote{Jobless participants continue to receive unemployment benefits during the three years of their education (Ministry of Employment, Health and Social Affairs North Rhine-Westphalia, 2006).}
The employment structure in domiciliary care shows the prevalence of nurses in the sector, health care nurses and nurses specialized in geriatrics (see table 12). This table indicates an increasing professionalization in the sector with a decreasing number of employees without any qualification. However, ever less workers have a degree in 'home help' (family care, as the degree is labeled in Germany).

<table>
<thead>
<tr>
<th>Home care professions</th>
<th>1999</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care nurses</td>
<td>58 129</td>
<td>78 184</td>
</tr>
<tr>
<td>Geriatric nurses</td>
<td>25 453</td>
<td>44 975</td>
</tr>
<tr>
<td>Other care professions</td>
<td>42 646</td>
<td>49 987</td>
</tr>
<tr>
<td>Other qualification</td>
<td>36 268</td>
<td>46 060</td>
</tr>
<tr>
<td>Without qualification</td>
<td>20 850</td>
<td>15 012</td>
</tr>
</tbody>
</table>

Source: Hoffmann 2009.

Note that most available data referring to the domiciliary care sector are reflecting issues relevant to the mere long-term care insurance and exhibit a bias toward body-related care work. Given the German landscape of home care support, it is almost impossible to specify the total number of personal care (home help) workers; moreover, data on administrative and management staff devoted to home care are often not available as figures refer to provider organizations as a whole; data is very seldom organised along temporal measures (hours). That said, some information on quantitative issues can be inferred from a local case study recently conducted in the city of Kassel (Bode et al. 2010).

Choice of provider

Across all sub-sectors, users can select providers on their own, with the exception of ‘care support’ paid for by welfare departments; in the latter case, the rule is that welfare departments have a preferred provider plus some additional suppliers at local level with which local contracts are established. Thus, no public tender scheme applies, nor an assignment or public procurement scheme. The general level of activity of the home
care sector is not directly set by public bodies, but largely follows the available budgets (caps in the long-term care insurance scheme, local social welfare budgets etc.)

With the introduction of long-term care insurance, the (paramedical) core of the German care system has been built around the idea of free choice. The concept is very important in the public debate (e.g. EPN: 65). It refers to both the option for professional support, as opposed to cash for care, and the choice of suppliers, including the list of deliverables contracted with the latter. Case management schemes are endorsed by some stakeholders and politicians, but only as a gate-keeping mechanism prior to independent choices taken by the user. Altogether, the consumer-model appears quite influential, even though one has to bear in mind that the majority of carees are using (rather than consuming) family-based informal support.

*Regulation in practice*

While the bulk of home care services is organised under a national institutional framework, the regulation in practice appears to be less homogeneous than one would expect. First of all, there are some important differences between ‘Länder’ and local authorities. These are concerning: a.) investment funding as available for service suppliers (no clear national regulation); b.) informal support given to traditional (nonprofit) providers (e.g. through giving them access to municipal information sites or making them a preferred provider for ‘care support’ paid for by welfare departments); c.) the role of the for-profit sector altogether (quite important in Eastern Germany, less developed in some Western German regions).

Secondly, regarding differences between legal prescriptions and practices, local case studies have shown that, due to logistical constraints, body-related and domestic activities are not clearly separated from each other. The division of labour among workers with different skills (and qualifications) does often not correspond to the official norms prescribed by collective agreements (among other things). Moreover, formal care packages (under the responsibility of nurses, with a focus on body-related care) are sometimes not respected by both workers and users. The former are concerned about supplementary (spontaneously perceived) needs of the clients while the latter claim extra services beyond what the contract stipulates, menacing otherwise to select a competing supplier (see Geller & Gabriel 2004).

Thirdly, the financing of home care is more complex than one would expect, as long-term care insurance scheme is far from the only source of funding. From the perspective of a provider, the funding is mixed. This mix includes not only a notable share public funding, but also private investment and some bids of volunteer work. Beneficiaries of
long-term care insurance receive allowances they pay to providers. As to nursing covered by health care insurance, the insurance fund awards reimbursements for in-kind services directly to suppliers. Things are similar concerning ‘care support’ under the local social assistance scheme (which rarely exceeds 10 per cent of the providers’ revenue). ‘Personal assistance’ granted to the disabled is awarded on the basis of a case-per-case assessments (under the control of local or regional welfare departments); no general (legal) provisions apply concerning the amount of hours granted. Finally, there are some subsidies stemming from labour market policy programmes. Although they generally play a minor role they have proved significant for many ‘home work service pools’ (as these subsidies have amounted in some cases to 20% of incurred wage costs). Moreover, nonprofit providers have sometimes created social support agencies using the so-called ‘One-Euro-jobs’ (social assistance plus at least one Euro per hour), granted by the labour office as a subsidy, in order to provide elderly citizens with basis support services.

Those suppliers connected with larger nonprofit undertakings (faith-based ‘welfare associations’, ‘Wohlfahrtsverbände’) may get additional subsidies by local church organizations in case they run into deficit. Donations did play a role historically as major nonprofit providers in the care sector emanated from faith-based associations linked to the churches. Today, their financial contribution is minoric. However, some specific activities of the nonprofit sector (home care for the terminate-ill; support for people and families affected by dementia etc.) benefit from donations or lottery funds. Volunteer work is relevant to nonprofit providers. It takes place in groups which are often only loosely connected to the highly professionalized domiciliary care enterprises units. Note that, as far as nonprofit providers are concerned, volunteers have to sit in their boards (or the ones of their umbrella). Others participate in special groups ensuring befriending, social support and leisure activities; however, they would seldom carry out domestic work. Volunteers don’t play a role in the for-profit sector. While most traditional welfare associations still run groups of volunteers in our days, there are concerns about this workforce becoming rare in the future.

Although domestic services are often bought from charladies, domiciliary care enterprises do provide some bids of these on-top services. For this, there is additional funding coming from taxpayers. Users may indeed set off outlays for privately engaged home workers against tax liability.
ciliary care usually try to get resources beyond what long-term care insurance provides; a key strategy has long been the supply of out-patient medical care, funded by health care insurance much more generously than services under the long-term care insurance scheme. Private providers often specialise in distinctive areas of body-related care and tend to leave domestic work services to the nonprofit sector. A number of them have been reported to resort to wage dumping through which they are initially able to outperform the nonprofit sector in terms of 24-h-service provision. Many now offer extra-benefits (not necessarily written down in the care contract) to users in their home (small-scale domestic help alongside a mere para-medical care package); the nonprofit sector has been pressurized to imitate this practice meanwhile (Bode et al. 2010).

**In-cash benefits and informal home care**

The German long-term care insurance scheme includes an important section of cash-for-care benefits (‘Pflegegeld’), granted to carers whatever their relation to the caree. The benefit is lower than the one awarded for professional care. Some beneficiaries also combine a ‘care allowance’ with some bids of in-kind support provided by professionals. Long-term care insurance also pays benefits to fund respite care. Otherwise, direct payments exist for the severely disabled (see above). Concerning eligibility and entitlement criteria, there is no difference between regulations applying to in-kind services and those applicable to beneficiaries of the ‘care allowance’ (as specified above); moreover, eligibility is independent of the civil status of the claimant. The level of funding is decided by government (which is fixing rates for the aforementioned dependency levels, table 13). The medium level of cash paid to the users is according to our calculations of 297 € per month. Formally, the local branch of long-term care insurance, and more recently, one-stop information centres (‘care bases’, ‘Pflegestützpunkte’) have to inform claimants on existing options. In practice, however, domiciliary care suppliers are eager to posit themselves as key information points in order to sell their own services.

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15 The so-called ‘Verhinderungspflege’, according to § 39 SGB XI.

16 This number is derived from the standard amounts paid by dependency levels (see below) and the number of recipients for each dependency level, divided by the number of recipients. Source: Gerlinger & Röber 2009; Federal Ministry of Health, Statistiken zur Pflegeversicherung, 2010, [http://www.bmg.bund.de/DE/Pflege/Statistiken/Pflegeversicherung.html](http://www.bmg.bund.de/DE/Pflege/Statistiken/Pflegeversicherung.html)
Note furthermore, that, as the allowances are passed on to informal care givers, they are in practice rarely taxed as income for the carers (because the relation remains informal, usually within the family). The ‘cash allowance’ of long-term care insurance once paid as such cannot be used to formally employ professionals at home or to purchase services on the free market. Insurance benefits may be used to engage (and co-fund) illegal employment at home. In this case, no social protection applies, of course. Otherwise, no explicit restrictions exist on how the cash for care is spent, but a general clause is stipulating that the beneficiary receives sufficient care.

There is no national data available regarding the take-up according to social class background. However, local research has found that lower strata of the population use to resort much more widely to the cash allowance option (Bauer and Büscher 2008). Apparently, home care arrangements in Germany depend on available economic resources but also on cultural and social capital, including the support of the family and of social networks (Heusinger 2008). The existence of the ‘care allowance’ is common knowledge among Germans. The option is widely used across the whole country. Yet while the ‘care allowance scheme’ is national in kind, take-up is different across regions as is suggested by data on the share of beneficiaries being cared for at home. The lowest take-up of cash for care being Hamburg where 36.6% of people needing care use the cash option, while it reaches up to 54.3% in the Land of Hesse (see table 14).

As noted earlier, information about what happens to illegal workers in private households is rare and pertains, if existing at all, to domestic employment in general (see Larsen et al. 2009).
Table 14: Number of Recipients of home long-term care by Land, in percentage, 2007

<table>
<thead>
<tr>
<th>Land</th>
<th>Total</th>
<th>Residential care</th>
<th>Home care</th>
<th>In-kind services</th>
<th>Cash for care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baden-Württemberg</td>
<td>100</td>
<td>35.4</td>
<td>19.7</td>
<td>44.9</td>
<td></td>
</tr>
<tr>
<td>Bavaria</td>
<td>100</td>
<td>33.2</td>
<td>22.2</td>
<td>44.6</td>
<td></td>
</tr>
<tr>
<td>Berlin</td>
<td>100</td>
<td>28.2</td>
<td>23.8</td>
<td>47.9</td>
<td></td>
</tr>
<tr>
<td>Brandenburg</td>
<td>100</td>
<td>25.1</td>
<td>26.6</td>
<td>48.3</td>
<td></td>
</tr>
<tr>
<td>Bremen</td>
<td>100</td>
<td>29</td>
<td>28.7</td>
<td>42.3</td>
<td></td>
</tr>
<tr>
<td>Hamburg</td>
<td>100</td>
<td>33.8</td>
<td>29.5</td>
<td>36.6</td>
<td></td>
</tr>
<tr>
<td>Hesse</td>
<td>100</td>
<td>25.4</td>
<td>20.3</td>
<td>54.3</td>
<td></td>
</tr>
<tr>
<td>Mecklenburg-Vorpommern</td>
<td>100</td>
<td>29.5</td>
<td>24.3</td>
<td>46.3</td>
<td></td>
</tr>
<tr>
<td>Saarland</td>
<td>100</td>
<td>31.6</td>
<td>19.9</td>
<td>48.5</td>
<td></td>
</tr>
<tr>
<td>Saxony</td>
<td>100</td>
<td>34</td>
<td>25.8</td>
<td>40.2</td>
<td></td>
</tr>
<tr>
<td>Lower Saxony</td>
<td>100</td>
<td>32.7</td>
<td>23.8</td>
<td>44.3</td>
<td></td>
</tr>
<tr>
<td>Saxony-Anhalt</td>
<td>100</td>
<td>29.6</td>
<td>24.3</td>
<td>46.1</td>
<td></td>
</tr>
<tr>
<td>Schleswig-Holstein</td>
<td>100</td>
<td>40.4</td>
<td>20.9</td>
<td>38.8</td>
<td></td>
</tr>
<tr>
<td>Thüringen</td>
<td>100</td>
<td>27.8</td>
<td>23.2</td>
<td>49.1</td>
<td></td>
</tr>
<tr>
<td>North Rhine-Westphalia</td>
<td>100</td>
<td>31.7</td>
<td>22</td>
<td>46.3</td>
<td></td>
</tr>
<tr>
<td>Rhineland-Palatinate</td>
<td>100</td>
<td>28.9</td>
<td>19.5</td>
<td>51.6</td>
<td></td>
</tr>
</tbody>
</table>


Haberkern (2009) notes that – due to the German familialist tradition – women have (as a fact) accepted a particularly high burden when it comes to elderly care. This configuration persists with care support financed by the cash allowance and unpaid domestic work. Statistics show that more than three quarters of those receiving long-term care benefits also resort to informal support from relatives or friends. Accordingly, elderly people lacking (local) family relations or informal networks assuming part of the care risk being not adequately cared for.
According to the existing regulation, the health condition and wellbeing of recipients should be reviewed every 3 or 6 months – otherwise the cash allowance maybe withdrawn (Lundsgaard 2006). There is a ‘quality inspection’ ensured by the ‘medical service departments’ (which are attached to the health care insurance funds). These departments make a yearly home visit to those having opted for the care allowance. They may also decide on taking measures in order to improve a user’s situation at home. However, all these interventions are small-scale, if not superficial.

**Problems with the current institutional framework**

As to the typical patterns of domiciliary care provision, the German care system embraces two poles, one strong and one weak: the strong pole is focusing on body-related home care (nursing covered by health care and long-term care insurance), with a wide-reaching service supply across the entire territory. This pillar is encompassing by international standards, although benefits are capped and insufficient to cover existing needs (Falk et al. 2011). The second, much weaker, pole is home help. Germany has barely seen broader public measures fostering home help. While, in theory, the care package offered by long-term care insurance comprises home help services, the benefit cap makes (care-giving) households giving priority to body-related services.

Home help as provided by unqualified cleaners, however, has been promoted through a number of reforms, revamping tax provisions and social protection schemes that facilitate short hours part-time work. The respective contracts have been labelled «mini-jobs». The incentives for the employee and the employer are tax exemptions (2 %) and lower social security contributions (among others 5 % for pension costs of the salary and 5 % for health insurance instead of respectively about 19.9 % and 15 %). In 2009, 4.9 M workers have been involved in a «minijob», with women representing the bulk of this workforce. Note that while the programme was aimed at legalizing undeclared cleaning work, doubts are widespread as to whether the programme is really attractive to undeclared workers. Regarding home help in general, it is important to note that

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18 There is no particular policy promoting specialized domestic care services (like in Belgium or France), nor is there a strong ‘personal care’ branch at local authority level (like in the UK).

19 Source: Arbeitsagentur: [www.pub.arbeitsagentur.de/hst/services/statistik/deail/b.html](http://www.pub.arbeitsagentur.de/hst/services/statistik/deail/b.html).
those eligible to social assistance are provided with a more generous array of domestic care services. As explained above, these services are contracted by welfare departments on behalf of poor citizens after means-testing. In this area, declared home help is the rule.

Today, the most widespread pattern, however, is domestic work at home being organized informally. This embraces private caregivers (taking up cash-for-care benefits), but also (mostly Eastern European) immigrants who step in on a 24-hours-basis. A growing number of frail (elderly) citizens tend to combine in-kind services and informal domestic work, including foreign workforce (Neuhaus et al. 2009). This mixture corresponds to the (still) limited institutional support to care-dependent citizens, as publicly funded care provision is experienced by many as insufficient to cover all the needs of the frail elderly (Heusinger 2008), but also to a strong familiaristic tradition which makes families and care-dependent citizens reluctant to use more professional (in-kind) services than absolutely necessary.

What does all that mean in terms of accessibility? A couple of observations can be made regarding this question. Firstly, one should look at the degree of universalism of a given care system. Most experts and commentators agree that the long-term care (social security) scheme does only offer ‘part insurance coverage’, with the remainder having to be borne privately. In that sense, long-term care insurance has brought partial universalization. True, the extension of home care (hours and facilities) is a matter of fact. At the same time, one should note that the introduction of long-term care insurance has stopped a tendency prominent in the 1980s that consisted of creating local social support centres (‘Sozialstationen’) offering a whole bundle of care services (including personal care) by means of mixed funding and interorganizational networking (health insurance, tax money by the ‘Länder’, municipal grants, social assistance, volunteer input, initiatives of welfare associations…). Seen from this perspective, the establishment of the existing long-term care insurance scheme has set limits to universalization.

Secondly, service provision under the social assistance (for care) scheme proves unequal in many respects; some (richer) municipalities have managed to run additional programmes while others are very restrictive even when awarding what national law re-

20 This is legally possible for periods up to 3 months; in this case, employers benefit from tax exemptions.
quires as basic ‘care support’. The main reason behind this is a considerable cleavage in the prosperity of local authorities. Thus, while Germany has seen standardization in body-related home care, the support system has remained very fragmented when non-body-related bids of care services are included into the picture. Case management is weak overall, body-related support and personal care are often separated, providers are in a harsh competition with each other and ever less keen to collaborate mutually, municipal policies in favour of care-dependent people are piecemeal overall; domestic work has remained a family affair in the vast majority of cases.

Thirdly, the limits of public funding are salient. Table 15 (next page) shows the expenses incurred for long term care in Germany, home care and institutional care (excluding informal care). It displays the respective contribution of public actors as opposed to the contribution of users. The bulk of public funding comes from long-term care insurance, covering 56.8% of all the costs incurred for long-term care. Out-of-pocket expenses are significant, representing more than 30% of all the costs of residential long term care. In domiciliary care, private payments are less frequent, due to the availability of family members or to non-declared work.

There is data suggesting that many care-dependent citizens purchase professional services privately (Rothgang 2010). However, users will find it difficult to pay for required services if their pension income and personal assets are limited. For greater sections of the population, underprovision is likely to occur, notwithstanding that the bulk of domestic support is still ensured by relatives. True, available data (see ‘Altenbericht’/Federal Ministry of Family Affairs, Senior Citizens, Women and Youth 2006, Hauser 2009) suggest that the economic situation of elderly people in Germany is generally good since most (male) senior citizens have access to multiple sources of income as a pensioner (public pension, work pension, income from renting and interest rates). There are important exceptions to this rule, however. Thus, widows, and women with poor employment records are much worse off. What is more, things will become more complicated in the future. Against the background of recent pension reforms, the income situation of the elderly is likely to worsen. Many with bad (low paid) jobs in their working life will probably fall under the poverty line. Their only source of income will then be minimum benefit at the level of social assistance (‘Grundsicherung’).
<table>
<thead>
<tr>
<th>Source of funding</th>
<th>Million euro</th>
<th>% of public/private spending</th>
<th>% of all spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public LTCI*</td>
<td>17860</td>
<td>82.6</td>
<td>56.8</td>
</tr>
<tr>
<td>Private mandatory LTCI*</td>
<td>550</td>
<td>2.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Social assistance</td>
<td>2610</td>
<td>12.1</td>
<td>8.3</td>
</tr>
<tr>
<td>Welfare for war victims</td>
<td>590</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>Public funding (total)</td>
<td>21610</td>
<td>100</td>
<td>68.7</td>
</tr>
<tr>
<td>Nursing home care</td>
<td>7660</td>
<td></td>
<td>24.4</td>
</tr>
<tr>
<td>Home care</td>
<td>2180</td>
<td></td>
<td>6.9</td>
</tr>
<tr>
<td>Out-of-pocket private funding (total)</td>
<td>9840</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31450</strong></td>
<td></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Rothgang 2010.
* Cash allowances are included.

That said, low income earners are slightly better off, given the availability of ‘support to care’ services (‘Hilfe zur Pflege’, see above). There seem to be, secondly, two realities for unfortunate frail citizens: those who are very poor will, once they make a claim, see their needs in terms of personal care/domestic work covered to some extent, with social assistance stepping in; however, those holding some assets and a modest pension may impoverish following a state of increasing frailty, as the threshold above which they are entitled to social assistance is quite low and since many are reluctant to resort to social assistance as there will be a claim-back from their heirs.

Fourthly, users confront a turbulent and often opaque home care market. While numerous nonprofit providers are reported to be in trouble because they are bound to collective agreements on wages and working conditions, private providers have sometimes to cope with barriers when stepping into a local market. A number of nonprofit and many small private providers have gone bankrupt over the last 15 years. Thus, there is insecurity regarding the performance potential of a given provider.

In addition, working conditions are problematic in many sections of the home care sector. With the exception of (middle) managers, most workers are on part-time contracts
(see table 16), often with a split up of shifts. Untypical employment has been on the rise over the last decade. Many employees are working 12 days in a row, with some spare days thereafter. Research findings display scattered working time schedules for care staff, together with a high level of work stress (Geller & Gabriel 2004, Oschmiansky 2010). The same holds for workers involved in the ‘personal assistance scheme’ for disabled people as they are usually engaged alongside the flexible demands of their employers (the disabled). According to a recent local study (Bode et al. 2010), major service providers report a turnover between 5 and 10 % a year.\textsuperscript{21} Hence, the current care market is shaped by a considerable degree of disorganization.

<table>
<thead>
<tr>
<th>Table 16: Type of employment in domiciliary care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Full time</td>
</tr>
<tr>
<td>Part-time</td>
</tr>
<tr>
<td>Petty job ('Minijob')</td>
</tr>
<tr>
<td>Interns</td>
</tr>
<tr>
<td>Voluntary service (Zivildienst)</td>
</tr>
</tbody>
</table>

Source: Hoffmann 2009.

Finally, the German care support system has remained bread-winner-oriented to a considerable degree, although this is due to a large number of influences, with some of them going beyond the regulation of the care system itself. As men usually earn more money than women on the labour market, a (part-time) withdrawal of men from waged labour would have a stronger impact on a family’s income. Cultural attitudes especially among lower class citizens endorse the traditional model furthermore. Indeed, lower class citizens tend to prefer the ‘care allowance’ over professional services and benefit

\textsuperscript{21} National data is not available on this issue. One enquiry from 2001 seems to confirm the idea of a high turnover rate among employees among providers of home care. On average, a third of the staff has been changing the job over a period of 24 months (Roth 2001).
more from it in relative terms. That said, Germany has overall seen a tendency of elderly care becoming more professionalized over the last twenty years which implies a better access to formal home care after all.

**A special issue: Integrated care**

Although integrated service facilities have been a major issue among experts concerned with the provision of elderly care, the medicalized sections of the care system have long been given priority by public policies and in the institutional design of the care system altogether. That said, transitions in the care trajectory, such as hospital discharge, have been awarded growing attention by recent care reforms. Moreover, a number of experimental integrated care projects have been instigated during the last decade, with geriatric specialists, hospitals and general practitioners as major partners. They have received special funding because many consider them innovative. However, while the need for integrated care is a key issue in reports and political document (e.g. ENP: 150-153), the rationale underlying recent care policies consists of experimenting novel arrangements while conserving established structures. Thus, Germany is a country in which the fragmentation of service provision remains the rule rather than the exception.

In the more recent public and scientific debate about personal care provision, major supply-side stakeholders have argued that home help may become ensured by immigrant workers in the future in combination with care services provided by salaried professionals (Neuhaus et al. 2009). There is, then, a propensity of considering elderly care as a mix of highly professionalized nursing services, on the one hand, and low-paid work in the individual households within a more or less precarious framework, on the other. A further rationale prominent in this debate is the combination of professional care services and volunteer work, as mentioned earlier. The introduction of small-scale funding for attendance and company for senior citizens affected by dementia in 2002 was propagated by praising concepts for the promotion of volunteerism in this area (FMF5: 30). The latest revamp of this policy in 2008, however, seemed to focus more on the part-time employment of moderately qualified workers.
4. The socioeconomic dimension

This section is dealing with key socioeconomic dimensions of the German home care system. Socioeconomic analysis makes much sense in this field against the background of ‘social care going market’ (Bode 2010) for some time now, worldwide. The most important aspects of such an analysis include: the marketization of care, that is, the prevalence of a welfare market with hybrid structures of care provision, alongside a value system stressing the willingness of users to make proper decisions regarding their needs; then, furthermore, the diversification in the organization and governance of the care system; and, finally, the patterns of employment throughout this system (which has already been considered above to some extent).

The marketization of care

Over the last two decades, the German care system has seen a clear movement towards the marketization of home care. This movement has various facets. To begin with, as both the ‘care allowance’ and in-kind-benefits of the long-term care insurances have long remained frozen (before being up-rated a bit more recently), the share of the cost left to users has increased since the inception of the scheme. As services have to be bought on various sorts of markets, this is a first lever of marketization. To some extent, this has given an impulse to voluntary private care insurance which is reported to be flourishing for some time now.

What is more, with the introduction of long-term care insurance, commercial providers have been admitted to a field hitherto dominated by the nonprofit sector. True, the old big nonprofit elephants have survived by adapting their management policies to the ones introduced by the small-scale newcomers. In addition, municipalities have still some influence on the shaping of a local market, as they may privilege the (nonprofit) old players by a number of policies (support to innovation, contracting for ‘care support’ services under the social assistance scheme etc.). Furthermore, commercial providers have overall played the rules of the game as established prior to their existence, especially regarding the leading role of experienced professionals who have often taken out their qualification in the public or nonprofit sector and are sympathetic with basic standards of quality-sensitive service provision. They have at times imitated nonprofits, strong in combining different kinds of care support, in offering more holistic services to those (few) who desire them (e.g. the organization of pastoral services).

That said, the commercial providers have rapidly taken over half of the market and have exerted strong pressures on wage schemes and on patterns of work organization in the
nonprofit sector. The new competition has invited users to behave as volatile customers, demanding extra-services beyond what has been fixed in the care contract and the care package as assessed by the competent authority. Furthermore, recent reforms have brought a quasi-star-rate benchmarking of care services performance, expressed by ‘schools marks’ which are publicly accessible. While this is not directly linked to market regulations, it endorses regulatory ideas according to which consumer will get information in order to make ‘good choices’, to ‘vote by the feet’ and engage in a logics of entry and exit.

In many respects, this movement towards marketization has been approved by the wider public and most stakeholders of the care system. The increasing role of for-profit agencies in home care has been an explicit objective of care reforms in the 1990s and is currently not challenged by any of the care system’s stakeholder in the public sphere. Although doubts can be raised (see Bode et al. 2011), it is widely assumed that this involvement, like provider competition in general, will enhance quality and diversity in the sector. Most importantly, the increase in the care capacity of the sector has being imputed to the admission of commercial providers to the sector as of the mid-1990s (e.g. EPN: 129). However, fifteen years after the introduction of open competition between providers22 in Germany, reports and public documents do rarely engage with the question as to whether competition among providers is a lever for reducing the costs of care. Maybe given the long tradition of a welfare mix in the German care sector, the involvement of further (this time commercial) players has not provoked a more long-standing, severe critique among traditional stakeholders of the care system (nonprofit providers, local politicians).

A welfare market exhibiting hybrid structures

In the light of what has been stated earlier regarding the role of the family in the provision and coordination of care at home, it is obvious that other actors have become much more important over the last two decades or so. More than ever, then, the German care sector can be viewed as being emblematic for the concept of ‘welfare plural-

22 Competition between insurers has long been a non-issue in the German debate as long-term care insurance has been constructed as a multi-pillar system in which all funds offer the same type of services under the same conditions.
ism’ involving of a great variety of actors in the provision of person-related services. The existence of market regulations alongside statutory oversight and public funding implies that home care is provided under a hybrid regulatory framework. Hence the German care system exhibits several rationales impinging on those concerned with managing and providing services.

As noted above, market regulations come into play for any kind of organized care outside the family sphere. This becomes crucial especially where beneficiaries receive direct payments to be used to ‘buy’ services with (mostly) independent providers (whether commercial or nonprofit). This is obvious in Germany – unless the cash for care option is taken. Given the contemporary provider landscape in which nonprofit and commercial providers coexist, the market rationale does play an important role in this country.

However, the implication of actors from civil society remains crucial in Germany. The involvement of nonprofit organizations seems to provide a ‘ray of hope’ for those affected by a lack of resources for elderly care provision. While the philanthropic input in elderly care is marginal after all, the overall institutional set-up of the care system remains strongly influenced by an institutionalized dialogue between public authorities and (networks of) the nonprofit sector. In Germany, the involvement of organized civil society has rarely been discussed in terms of user participation or democratic governance, including when it comes to the topic of ‘modernization’. However, there is a strong emphasis on a better collaboration between established local ‘actors’ involved in the care system (EPN: 186). This concept addresses the participation of (elected) representatives or managers of civil society organizations in the shaping of the local care system.

That said, most stakeholders of the care system including from the nonprofit sector adhere to a highly standardized system of professionalized care, with some bits of home help. The major institutional lever for this, long-term care insurance, as well as policies directed towards the improvement of service quality, are widely endorsed by the sector. This general orientation has no class bias – although there are concerns over an increasing number of poor senior citizens unable to pay for formal care (EPN: 103) –, nor does it appear gendered in one way or another.

Accordingly, when it comes to the question what typical stakeholders see as the best way to care for frail senior citizens at present, the mainstream opinion in Germany is that hybrid structures have their merits. This first of all applies to the funding scheme which combines quasi-universal entitlements with the idea that they should not extend to more than basic services, initiated by professionalized assessments and overseen by administrative quality checks. By the same token, the prevailing concept includes an important role left to what might be referred to as ‘informal governance’, featuring (at
least) a clear (coordinating) role of families and considerable practical efforts by the latter, too. There seems to exist then a latent consensus within the polity about the necessity of (middle class) users to complement benefits granted by long-term care insurance by private resources, be it with their own savings or be it by drawing on family support (EPN: 37). Poorer households are expected to apply for social assistance (after having spent down their personal assets). This as well is consistent with the idea of hybridity as a mainstream welfare state technology in Germany, as long-term care insurance is viewed to be complemented, if necessary, by a social assistance scheme which provides full coverage in domiciliary provision to those who have spent down their fortune (or never had one) and renounce on any inheritance after the end of their days.

Moreover, whereas donations are rarely alluded to in the public debate (in contrast to other related fields of elderly care, such as hospice care), volunteer work is welcome. Many see volunteers as a panacea to the alleged shortage of informal and formal care in the future (e.g. FMF5: 30, 36). At discourse level, moreover, many observers and politicians currently argue that greying Germany will not be able to do without (more) volunteer support to the frail elderly in the near future. In the same vein, there are voices promoting non-professional care work at home. While the prospect of additional volunteer inputs in the future is likely to be unrealistic, prevailing norms about ‘good service provision’ are hybrid in that particular sense as well. Indeed, the German care system draws on both a highly professionalized, mostly well-educated workforce (geriatric and health care nurses) on the one hand, and a mixture of informal work, undeclared employment and petty jobs, on the other. Informal care has always been particularly salient, and this has been underpinned by the architecture of the long-term care insurance scheme. More recently, the German government has enacted a law introducing ‘long-term care sabbaticals’, urging employers to accept that part-time workers leave for a two years’ care period while maintaining their monthly pay, and then return to the employer taking-up a full-time work arrangement. We can see here that family-based care is still heavily endorsed by public policies. At the same time, Germany has hardly been affected by a movement by which pre-existing levels of formal care were replaced by more informal ones (as observed in other, eg. Anglo-Saxon countries); rather, the professional sector has seen an expansion overall.

Hybridity is also an issue regarding the provider landscape. Meanwhile, the relative share of the different actors in providing care (families, public, non profit and for profit) seems to be rather stable, yet it has to be emphasized that the private sector was completely absent from the field prior to the mid 1990s. Very recently (2010-2011), there is a debate about whether to extend this pluralism to the field of care insurance. Part of the government in office intends to introduce additional asset-based (commercial) insurance pillar, this time (probably) on a competitive basis, similar to what has happened in the
field of retirement provision. This would imply public subsidies for those investing in privately funded saving plans devoted to long term care provision. The main reason given for this is a lack of coverage by the existing long-term care insurance (and not a lack of choice in the insurance system). The government in office has made a pledge in this direction.

The user on the market

Before any market contact, users of the German home care system have to deal with gatekeepers assessing their needs. This is the role of a quasi-public body associated with health care insurance (‘Medizinischer Dienst der Krankenkassen’, MDK), a monopolistic assessment agency. This agency however does not really intervene in the choice of providers made by the user. That said, the assessment reflects the way care needs are ‘channeled’ through the institutional set-up of the market. Far and wide, it is shaped by a medicalized approach although there has been a growing concern over the assessment standards being insufficient to map the state of needs of a frail person, given that somatic and body-related criteria were prevailing in the assessment (EPN: 170/171). Recently, a national expert commission (‘Beirat zur Überprüfung des Pflegebedürftigkeitsbegriffs’) has published new guidelines which considerably enlarge the assessment criteria towards areas such as cognitive capacities, coping with impairments or ability to participate in social life. So far, these recommendations have not been transposed in national law, though.

Beyond this ‘pre-market entry’ through assessments, the information available to users has been an important issue in the recent public debate. Conceptually, the provision of ‘unbiased’ information was a key rationale instilled the institutional regulation of the market. As care-insurance bodies hardly played that role, local or regional initiatives were started to improve the process of ‘client information’. For example, the ‘Land’ of NRW took steps to make counseling services available across its territory (EPN: 187). The latest care reform in 2008 took the same direction and obliged the ‘public partners’ involved in the administration of the care system (long-term care insurance funds, wel-

23 Note that assessments are slightly different for those eligible to social assistance but that the rationale underlying this is derived from the general approach to ‘welfare to the non-working poor’. This particularity has thus far been a non-issue in the public debate on the care system in Germany.
fare departments of municipalities) to create ‘one stop counseling points’ (‘Pflegestützpunkte’) at the level of urban agglomerations and rural districts. This agency, based on kick-off funding from the state, received a remit to provide basic information to users and relatives, but not to oversee the process of care provision, including by different suppliers.

The decision-making capacity of the user has remained a key topic, though. Arguments put forward in favor of improved ‘consumer information’ included the observation of underuse of special care services (respite care, temporary residential provision, etc.) (Neuhaus et al. 2009: 26) and the existence of a ‘provider jungle’ taking shape in urban agglomerations (EPN: 144). However, formal choice options are considerable when it comes to the selection of a provider under the long-term care insurance scheme. In a middle-sized town (of 100,000 inhabitants), there may easily be 20-25 competing providers, for-profit and non-profit (rarely public). However, given the wide-reaching regulation of the service package and the streamlining of the provider market, true choice of services is limited. Informally, however, users may negotiate services different from the official care package – in that respect, choice is greater than it seems.

**Tensions between rationales**

Regarding the rationales prominent in the German care system, there are clear tensions concerning what the rationales of the welfare mix as depicted thus far imply altogether. Welfare state responsibility for elderly care is widely acknowledged, yet the cap on benefits leaves observers with many open questions, given that most of them know about the reluctance of elderly Germans to resort to social assistance (and to renounce on inheritance). Tensions are also touching gender issues, such as opportunities for women to enter the labour market, which is ever more proclaimed by the political and economic elites of the country. Labour market integration of women (meanwhile) is a mainstream policy objective in contemporary Germany, yet care policies still draw on the idea of ‘someone being at home’. True, informal carers are retirees in an increasing number of cases (as is noted by some observers). As the mainstream policy goes towards postponing the age of retirement, however, this tension is anything but resolved. As to the welfare market in elderly care, the discourse stressing freedom of choice opposes concerns over little transparency in this market and over the fact that professional care is becoming ever more taylorised so that few opportunities exist for suppliers to make a difference. They may however pay lower-than-average wages for those they employ.

To this, one could add tensions related to the fact that long-term care insurance does barely cover personal care needs (home help, company etc.). The latter seems to justi-
fy, in the eyes of many, the recruitment of immigrants as a low-paid, temporary workforce. Yet, at the same time, there are concerns over the impact of wage dumping entailed by home helps provided by immigrants. In this debate, there is a lot of ambiguity when it comes to the distinction between personal and nursing care, and the expectations regarding the quality of both.

The overall increasing pressure on quality performance, including the management of health care trajectories and the transmission of information across the domiciliary sector, brings further sorts of tensions. Demands for quality assurance sit uneasy with a discourse stressing competition and the consumer-centeredness of the care system, as suppliers are urged to neglect quality wherever this is not detected by users, and to invest in marketing instead of better quality. At the end of the day, the typical political stakeholder will claim all: full labour market participation of men and women, on the one hand, and a high level of informal engagement (volunteering) on the other; competitive supply of professional services on the one hand, and smooth transitions, integrated services and universal quality of care, on the other; and, last but not least, an unchanged proportion of societal resources devoted to elderly care on one side, and the universal respect of human dignity for an increasing number of people, on the other.

**Approaches to employment in the German home care market**

Until recently, the provision of professional elderly care has barely been explicitly discussed in the context of labour market policies in Germany. Importantly, as personal care is not seen in this country as an autonomous professional field – but as a small appendage to body-centered service provision – labour market policies, and the public debate about them, have rarely addressed home help to the frail elderly as an area where jobs could be created on a larger scale, including for disadvantaged workers.

There are, however, some exceptions to this rule. First of all, the creation of service-pool enterprises has been understood for some time as a policy to replace undeclared work by formal jobs, especially for low-skilled (mostly female) workers. Regional labour market policies, for instance in North Rhine-Westfalia (NRW), have been drafted with this objective in mind. The Land’s Green paper on elderly care in 2005 (EPN: 377) refers to these pools implicitly, however only in a small subsection, towards the end of the report.

Secondly, a training policy initiative has been launched since 2008 offering long-term unemployed citizens the opportunity to complete a short-term training course (160 hours plus internship over two weeks) teaching skills for the attendance and company of elderly persons affected by dementia. This has been was funded by long-term care insur-
ance. While the program, concerning more than 15,000 workers by 2010, was focused on residential care settings in the first instance, an increasing number of domiciliary care providers have been recruiting people from this new workforce meanwhile. If policies of that kind are welcome by some stakeholders in the nonprofit sector (Neuhaus et al. 2009: 98), the fact remains that the bulk of professional care work in Germany is generally viewed as being incumbent on skilled personnel (nurses or geriatric nurses having completed a three or to years’ professional education).

Since wages are low and (scattered) part-time employment is widespread throughout the domiciliary care sector, however, many observers refer to the care labour market as a precarious one. Trade unions draw attention to this from time to time in the public media while official reports (EPN: 149, 313ff) would stress the high psychological and physical burden of care work, rather than the precarious character of the occupation as such. Regarding low wages, meanwhile deemed a serious obstacle for the development of the sector’s workforce, employer organizations, responding to an initiative taken by the German government, have very recently agreed on the introduction of a minimum wage. Given that salaries paid to care workers are among the lowest throughout the country, trade unions, major political parties and the mass media had all claimed a national policy initiative in that direction. Employers, including from the nonprofit sector, had initially been reluctant to follow this initiative, arguing that their income from long-term care insurance and other sources were insufficient to award higher wages. Yet, they have finally accepted the new minimum wage entailing limited pay rise (up to 7,50 € per hour in the East and 8,50 € in the West).

**The quality dimension**

Quality dimension is an important aspect in both the institutional and socioeconomic configuration in which home care is provided. Although much of what will be set out in what follows relates to the institutional set-up of the home care sector, we will deal with this aspect in a brief chapter standing on its own. After presenting the system of evaluation used in the German care sector.

*The inspection regime of the home care market*

The National Association of Health Care Insurance (MDS), a semipublic body assembling the regional medical service departments of health care insurance (MDK), is responsible for the external evaluation of both care needs (of potential beneficiaries of long-term care insurance) and quality performance (see figure 1). Running on-site inspections in domiciliary and residential care organizations, it serves as a key watchdog
agency in the German care system. Regarding the respect of the prevailing quality norms, providers entering the market have first off all to meet a number of basic criteria, among which the employment of qualified nurses and the opening of a public venue (obligation of means). Secondly, regional satellites of the Medical Service Department (MDK) have a remit to conduct on-site inspections at least once a year (geared towards an 'obligations of results'). Note that these inspections are highly standardized and address body-related care acts in the first instance.

Figure 1: Evaluation system of the public LTCI scheme

Home care providers are obliged to participate in this evaluation. The respective law stipulates that the inspection can be based on random enquiries, surveys, auditing or comparative studies. The inspection procedure embraces a comprehensive on-site inspections of the care process, an analysis of the provider’s care procedure documents, interviews with staff and care recipients feeding into a survey, with all this leading to a final grade awarded to the inspected provider (this grade being modeled on the German school mark scale, starting with 1.0 for the best result and going down to 6.0 for the worst). In particular, the inspection considers the carees’ physical condition (particularly

\[24\] SGB XI § 80.
the body-related state of health) and the traceability of ‘technical’ processes in care service provision (see figure 2).

Figure 2: Example for the evaluation of one provider

Inspections feed into a benchmarking process with a detailed report and a ‘star rating’ for each provider. The overall result is a grade (‘Pflegenote’) modeled on school marks which is published on the website of the regional association of the health insurance.²⁵

²⁵ http://www.pflegenoten.de/Pruefblaufl.gkvnet.
Legally, individual inspections of provider should be performed yearly. The inspections are conducted by the MDK that completes a national report on the entire care system.\textsuperscript{26} By the end of last inspection period (2010), a total of 175 examiners had been involved, mostly health professionals (145 care workers and 22 doctors).

*Problems with quality assessments*

Notwithstanding the sophisticated inspection regime, transparency over actual quality remains limited. Thus, informational asymmetry remains a key phenomenon in the market of care for frail citizens. First of all, the records produced by the workers during their visits are very much routinized, with caregivers often being reluctant to note anomalies or special events. Moreover, one-shot on-site evaluation is being criticized for providing accidental outcomes as regards interviews with managers, workers or carees. Given that the aforementioned records are produced somehow 'mechanically' and focus on body-related outputs mainly, both care outcomes and the sustainability of service provision are not awarded much attention. In addition, Germans thus far are not accustomed to select care providers on the basis of an internet-based benchmark-system (which is not easily accessible for an average beneficiary).

Remember that the MDK services are also obliged to visit households receiving the sole cash allowance (cash for care). These visits take place once a year and are meant to ensure that basic requirements of private caregiving are met. Again, this will not but modestly provide information about the quality of service. Furthermore, professional home help is rarely subject to a formal evaluation procedure as the emphasis of the latter lies on body-related care acts. In theory, housekeeping-acts may be considered too but they do not play a role in the actual evaluation process. Finally, the issue of 'work quality', though a critical factor when it comes to sustainable service, is widely neglected. Recently the national federation of trade unions, drawing on surveys of care workers, has alerted the public about poor working conditions. Thus, while some outputs are evaluated, the interest in input structures is very low. Concerning the quality of employment, the care sector exhibits a dual reality: with a large number of qualified

\textsuperscript{26} Overall, the report of the MDK offers the most comprehensive source of information about the care infrastructure in Germany with an extensive survey of home care beneficiaries and audits of home care providers.
nurses and elderly care nurses (‘Krankenpflegerinnen’, ‘Altenpflegerinnen’), Germany has got a fairly professionalized system, with a long(er) tradition of collective agreements and formal training. In this field, managerial tasks and recognition of skills and seniority have evolved extensively by international standards (but not up to what is known from the Nordic countries). At the same time, an increasing share of home care workers does not belong to this group. Low wages and high job-turnover become prevalent here. The small sub-sector of domestic home support has never seen a serious movement towards professionalism, nor have specialized organizations developed (on a greater scale) within which a profession of personal care work could have taken shape; in the latter area, then, the quality of employment is almost a non-issue.

These limits to quality performance control may be seen as a particular problem because, in the German care system, evaluations are geared towards offering (alleged) consumers on the care markets information about the services on offer. They are not deemed to inform public purchasing bodies and their commissioning policies. The more recent evolution towards marketization and greater job differentiation, together with exacerbated stress at work, sets the sector under growing pressure.

Regarding the quality of care, then, the glass again is half-full and half-empty: recent attempts to inspect domiciliary care providers more thoroughly (quasi-star-rating; enormous requirements in terms of work documentation) have brought new incentives to providers to deliver ‘good care’; however good care is understood as being represented by body-related (paramedical) outcomes in the first instance; social company and domestic support do barely play a role in this quality assessment; and, what is more, the standardized managerialist quality inspection regime sits uneasy with the competitive character of the supply side, leaving providers with very unequal capacities to ensure ‘good quality’.
5. **Conclusion**

Home care is a booming industry in contemporary Germany. More than 10,000 care enterprises are busy in this sector as the number of workers is increasing steadily. While it can be certainly referred to as a new branch of the German welfare state, it exhibits distinctive characteristics in that it is evolving as a fully fledged welfare market and differs from what is known from other parts of the health care and social sector. Its recent development is shaped by both attempts to refine the regulatory framework (particularly concerning quality inspection) and dynamics typical of market-based social interaction. Despite considerable efforts, fragmentation, poor coordination, variety in quality, and problems with transparency and market access are all obvious in the current configuration.

Germany has thus seen the paradox of strong investment in home care on the one hand and a more laissez-faire approach to the steering of the overall system, on the other. Case management, holistic service supply, a homogeneous infrastructure of provision, and a clear-cut professional order are all missing links in this system. Moreover, while entitlements are considerable when compared to the past, a lot of lacunas persist in terms of coverage. Finally, the country hesitates when it comes to the development of changing cultural approach regarding frail (elderly) citizens. The idea of ‘family care’ continues to be a reference point for public policies, as witnessed by the recent initiative to create a ‘care leave’ scheme through which caregivers can withdraw from the labour market for up to two years. Together with limits set to a ‘true’ career in the professional care market (with a growing number of precarious jobs in the sector), this particular option will extend the cash-for-care bias of the overall institutional framework shaping the German care system.

That said, once set the foundations of a new branch of the welfare state, this branch may evolve with the maturing of the actors, with experiences made in the welfare market, and with a better awareness of problems and issues. Regarding the development of a thoroughly modern care system, everything seems to be set in Germany. Future will tell if the system’s response to the demographic challenge will be a more universal and integrated approach, or if social inequality will grow with regard to the access to decent home care provision.
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