

November 2013

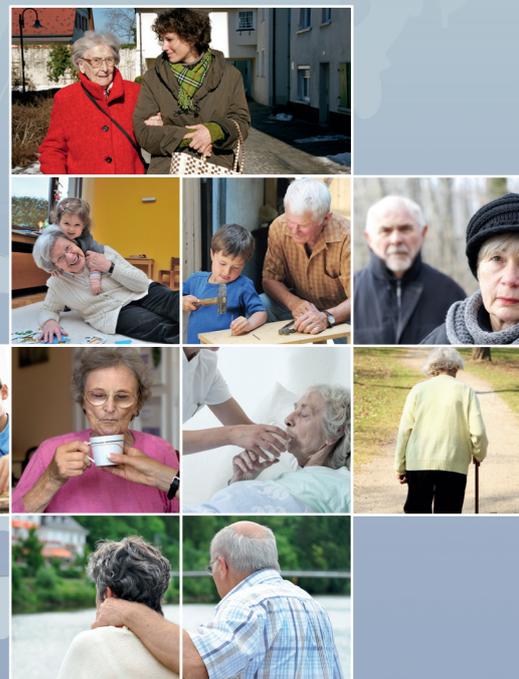
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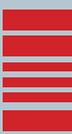
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On the Highroad – The Scandinavian Path to a Care System for Today

A Comparison between Five
Nordic Countries and Germany





Expert Report Commissioned by the Politics and
Society Forum and the Economics and
Social Policy unit of the Friedrich-Ebert-Stiftung

On the Highroad – The Scandinavian Path to a Care System for Today

A Comparison between Five
Nordic Countries and Germany

(Abridged Version)

Cornelia Heintze

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This expert report was published by the Economic and Social Policy unit and the Politics and Society Forum of the Friedrich-Ebert-Stiftung. The opinions and conclusions contained in it are strictly those of the author.

Impressum: © Friedrich-Ebert-Stiftung | Publisher: Economics and Social Policy Unit of the Friedrich-Ebert-Stiftung, Godesberger Allee 149, 53175 Bonn | Fax 0228 883 9202 | www.fes.de/wiso
Design: pellens.de | Cover photo: Fotolia | Printer: bub Bonner Universitäts-Buchdruckerei | ISBN: 978-3-86498-704-5 |

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List of abbreviations

AT	Austria
BE	Belgium
BGBL	Bundesgesetzblatt (Federal Law Gazette)
BMAS	Bundesministerium für Arbeit und Soziales (Federal Ministry of Labour and Social Affairs)
BT-Drs.	Bundestag-Drucksache (Bundestag printed matter)
Destatis	Federal Statistical Office
DK	Denmark
DKK	Danish krone
ES	Spain
FI	Finland
FR	France
GG	Basic Law
GR	Greece
ISK	Icelandic krone
N.S.	Not specified
N.D.	No data
MISSOC	Mutual Information System on Social Protection in the Member States of the EU and the European Economic Area
mtl.	Monthly
NL	Netherlands
NO	Norway
NOK	Norwegian krone
OECD	Organisation of Economic Cooperation and Development
PR	Press release
PPP	Purchasing Power Parity (US dollars)
PT	Portugal
SE	Sweden
SEK	Swedish krone
SGB	Social Security Code
SI	Slovenia
SK	Slovakia

1. Introduction and Summary

The numbers speak for themselves. According to a calculation by the German Institute for Economic Research (DIW) the number of people in need of care will reach almost 5 million by 2050; in other words, it will more than double. Even today polls in Germany show that every second person is worried about needing care in their old age. And many men and women are asking themselves: what shall I do if my own parents need care? These worries and fears point to an administrative failure: quite clearly our society is not ready to handle a sharp increase in the number of people needing care.

Current reforms, such as the introduction of family caregiver leave, so-called »Riester care« and the envisaged marginal improvements for dementia sufferers fall short because they are based on a problematic basic assumption. They assume that in future further care work will be carried out by daughters, daughters-in-law, granddaughters and wives – privately, without remuneration and often giving up their own careers and economic independence. This perpetuates a model for the future whose societal conditions are already being eroded today: the number of »available« daughters, daughters-in-law and granddaughters is falling, while the number of those who need to be taken care of is growing; women are not only increasingly gravitating to the labour market, but they want to remain there; and families often live apart, in different places. Furthermore, responsibility for care is increasingly falling on men, either because they live alone or because they deliberately choose to take on this responsibility.

While worlds of work, gender roles and family arrangements are changing, the current reform efforts cling on to the outdated model of a large family living together under one roof with a male breadwinner, oblivious to actual economic

and socio-cultural developments. The problem is obvious: a care system »created« for a different societal reality is overburdening caregivers, putting a strain on families and driving them into a legal grey area if they want to bring in professional help (the current buzzword here is »circular migration«). A societal debate is long overdue on what kind of care system is needed that would be in keeping with the circumstances and resources of caregivers and would enable those requiring care to live independent, dignified lives. »On the Highroad – the Scandinavian path to a care system for today« is our contribution to this debate.

On behalf of the Friedrich-Ebert-Stiftung political scientist Dr Cornelia Heintze has compared the care and day-to-day assistance provided to the elderly in Germany and Scandinavia (Denmark, Iceland, Norway and Sweden), as well as Finland. In the present expert report she analyses the differences between the German and the Scandinavian systems and shows what ways of thinking and basic decisions have shaped the relevant systems. It is a fruitful comparison because it indicates the key choices now facing the German care system.

The Future of the Care System: Family-based or Services-based?

Modifying Gösta Esping-Andersen's typology of welfare states, the author distinguishes between two basic varieties of care system: the »family-based care system« and the »services-based care system«.

Germany (like, for example, Austria, Italy and Switzerland) has a »conservative welfare state«, according to Esping-Andersen. This means that it is based in the first instance, in accordance with

the principle of subsidiarity, on »family solidarity« and only in the second instance on the solidarity of the whole of society, in other words, on social support. Such a model assumes the existence of the traditional division of labour within the family, however: one partner, usually the man, is the breadwinner, while – as a rule – the woman takes on caring duties either unpaid or in exchange for a token of appreciation (care allowance). The »family-based care system« is in keeping with the conservative welfare state and its characteristics include the primacy of informal over professional care; a low level of public financial support; a narrow conception of care; and a fragmented, complicated structure with poorly accessible benefits and services (a hybrid structure of non-profit, private-sector and public providers). It is highly susceptible to the development of a »grey care market«, in particular in the area of 24-hour care. The »family-based model«, according to Dr Heintze, corresponds to »a policy that is more interested in maintaining the highest possible proportion of family care than in creating a high-quality care infrastructure that is easily accessible to all«. In short, it is a policy aimed primarily at keeping care costs low.

Denmark, Finland, Iceland, Norway and Sweden, according to Esping-Andersen, are »social democratic welfare states«. This type is characterised by comprehensive welfare state provision based on equality and offering a basis for the at least approximately equal labour market participation of men and women. These characteristics are reflected in the structure of care. The features of the »services-based care system« include: primacy of formal care; a medium to high level of public financing (needs-driven); a broad conception of care; a high level of professionalisation; and a high quality municipal care infrastructure. The services-based system is aimed primarily at supporting and further developing the professional care system.

What can Germany learn from the »Scandinavian way«? In this expert report the author makes a detailed presentation of notable and hitherto little discussed connections and circumstances which should help to clear away some of

the many myths that plague the care debate in Germany and to steer it in a new direction.

Advocates of the current care system often reject the Scandinavian way on the basis of two arguments: first, it is not desirable because it is not in keeping with the German welfare state tradition and second, it is not affordable. However, this line of argumentation fails to take account of a number of important points.

Key Insights from the Export Report

High full-time equivalent women's employment goes hand-in-hand with high birth rates. For a long time, the dominant dogma – and not only among conservatives – has been that one price to be paid for women's emancipation is a low birth rate. An increase in the birth rate is possible, from this perspective, only if the process of establishing gender equality – in the first instance, women's employment – is put on hold. On closer examination, however, this assumption proves to be outdated, because it applies only to economically underdeveloped societies. Taking the example of Scandinavia, however, we find that in economically highly developed societies the opposite is the case. There, too, birth rates fell dramatically – even more than in West Germany – at the beginning of the 1980s but in contrast to Germany a reversal of the trend occurred due to a massive expansion of public care infrastructure directed towards children and the elderly in equal measure. The numbers show that the birth rate rises to the extent that a society is able to free itself from traditional gender roles. Where child care and care of the elderly are strongly »familialised« we find the lowest birth rates. This shows that investments in a good child and elderly care infrastructure generate a »demographic dividend« by improving the ratio between those in need of care and caregivers for the future.

Private provision of care by women is expensive. It is a common misconception that women who provide care privately and without pay »cost« nothing in the literal sense of the word – an extensive public care system, by contrast, is un-

affordable. This is misleading. If well educated women – or men – leave the labour market in order to provide care without pay the national economy thereby loses considerable human capital. Investments in a good public child and elderly care system, by contrast, takes the pressure off social security budgets and increases the number of well-qualified workers. Where care is regarded as a public task and a public good well-paid, qualified jobs are created in the care sector that contribute to economic growth. In this way, the national economy gets onto a higher employment path (the »high road«). In Germany the opposite is occurring: low investment in the care system is leading to a »low road«. The author describes what is driving the downward spiral in Germany and how it can be stopped. She also explains why Germans are reluctant to see the care sector as a factor in value creation rather than purely as a cost factor: the traditional fixation on exports leads to a fatal undervaluation of services oriented towards the domestic market which are in society's interest.

Germany is in a care trap. The author describes another phenomenon that could hinder a re-think: people who provide a high degree of care for relatives over a long period without support damage their own wellbeing. They get into a spiral of more and more permanent strain at growing risk to their health. Statistically, they come to need care at an earlier stage, their number of »good years« in old age falls, and instead – in stark contrast to Scandinavia – a large part of those final years are plagued by chronic illness.

Christina Schildmann
Politics and Society Forum

Dr Heintze's diagnosis is that Germany is caught in a care trap.

Acceptance of professional care depends on the quality of care, not (only) on cultural preferences. The dominant idea in Germany is that neither people in need of care nor their relatives desire a high-quality professionalisation of care. For socio-cultural reasons Germans prefer to be taken care of by their relatives. However, such preferences do not necessarily reflect only cultural influences, but even more a lack of confidence in the German care market, whose provisions are regarded as unaffordable and not particularly humane (the current buzzword is »Minutenpflege«: care provided for a fixed number of minutes or »care on the clock«). In this situation, care within the family inevitably appears to be the better option. This attitude is the price and the consequence of a »partly cover system« which, as the author shows, has also been increasingly commercialised in recent years.

Societies that are able to learn, according to Dr Cornelia Heintze, are characterised by their use of societal change to improve quality of life and wellbeing instead of to halt it, thereby descending into a downward spiral. She demonstrates how much the »family-based care system« is coming under pressure in the face of demographic change and indeed accelerating it. She also shows the added value for society of a high-quality public care infrastructure.

The following text is an abridged version of an extensive expert report available online at: www.fes.de/forum/pug/inhalt/publikationen.php.

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2. How Demographic Change, Women's Employment and the Basic Orientation of the Care System Are Linked

European societies are ageing societies. The proportion of elderly people in the total population has increased in recent decades and will increase further in the foreseeable future. In Germany the proportion of people over 65 years of age in the total population increased by around one-third between 1994 and 2009, but much less in the Scandinavian countries. The different dynamics mean that Germany today has the highest rate of ageing in Europe, at 20.6 per cent (2010), second only to Japan (23.1 per cent) in the OECD.¹ The Scandinavian countries, by contrast, are predominantly below the EU average, with proportions of 12.2 per cent in Iceland, 15 per cent in Norway and 16.6 per cent in Denmark. Finland (17.6 per cent as against 17.4 per cent in the EU27) is more or less at the EU average. Only Sweden, with 18.3 per cent, has an above-average rate.

Behind Germany's particularly pronounced ageing dynamic lies the combined effects of a low birth rate over many years and a lack of positive net migration. Up to the beginning of the 1980s the birth rate in the Scandinavian countries was falling, sometimes (for example, Norway) even more sharply than in West Germany.² While in Scandinavia this trend was subsequently reversed, however, in Germany the birth rate not only continued at a low level but fell further. Figure 1 shows that this was not inevitable. Of the 13 countries concerned more than half (Denmark, Germany, Finland, the Netherlands, Norway,

Austria and Sweden) had comparably low birth rates in 1980 between around 1.6 and 1.7 births per woman. Birth rates were far higher in southern Europe and also in France. From the mid-1980s the pattern of development was reversed. In a kind of pincer movement two groups of countries with similar birth rates crystallised. Germany and Austria now formed part of the circle of southern and eastern European countries. The southern European countries – the same applies, with some delay, to the new EU member states from central and eastern Europe – experienced a dramatic fall in their birth rates. In 1980 they headed the field, but now they were bringing up the rear. In contrast to the plunging birth rates in southern and central and eastern Europe and the continuing low level in German-speaking countries the Scandinavian countries managed a remarkable recovery. As a result, all Nordic countries on average achieved values over 1.7 (Denmark and Finland: 1.79; Sweden: 1.73; Norway: 1.86; Iceland: 2.05) in the decade in question (1999–2009). Belgium and the Netherlands experienced a similar development. The values now being achieved not only provide for the stability of the population – the stability criterion lies at around 2.1 – but also ensure that these societies will not be subject to adjustment stress due to more rapid growth in the proportion of older people than they are able to cope with, mentally, economically and infrastructurally.³

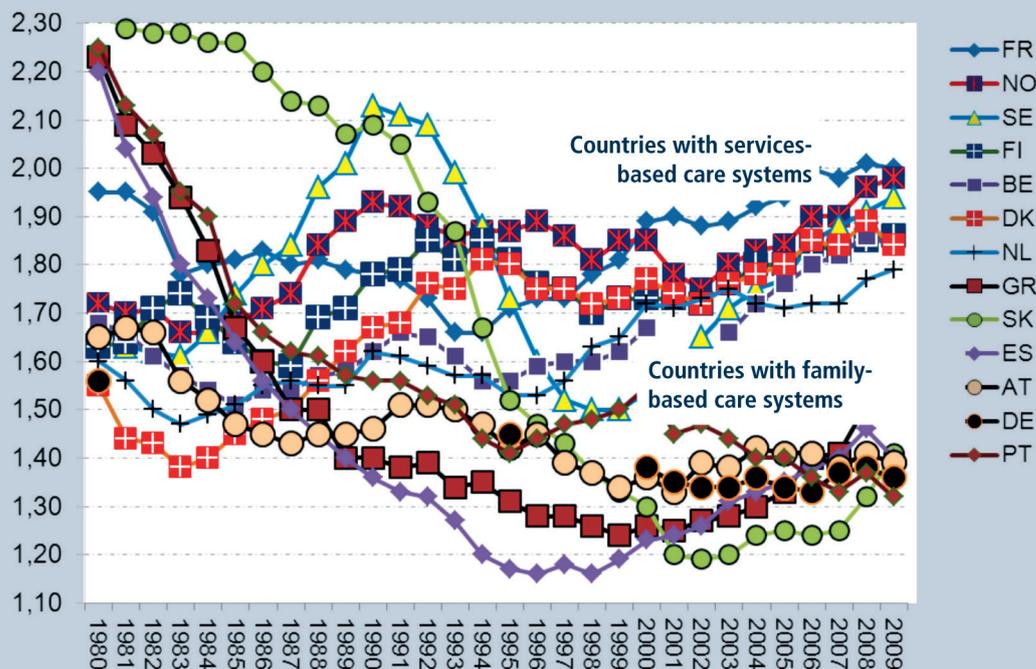
1 Followed in third place by Italy (20.3 per cent). Data source: OECD Labour Force and Demographic Database, 2010.

2 In 1970 the birth rate in West Germany was 2.03 in contrast to 1.95 in Denmark, 1.92 in Sweden and 1.83 in Finland. In the ensuing period, however, birth rates fell in both the Scandinavian countries and West Germany. This was especially pronounced in Norway, where the birth rate plunged by one-third from 2.5 in 1970 to 1.72 by 1980.

3 A high birth rate in itself is neither positive nor negative. On a global scale the average birth rate is much too high. The environmental consequences are dramatic, in relation to both the stability of the global climate and exploitation of nature in general. The decisive question concerns distribution. In less developed countries the birth rates are far above the stability criterion, reflecting their underdevelopment and lack of or ineffective family planning. In highly developed countries, by contrast, low birth rates are not a problem as long as they do not put too much strain on society's capacity to adapt. From this standpoint birth rates in the range of 1.6 to 1.9 arrangements more favourable than birth rates between 1.3 and 1.6.

Figure 1:

Connection between birth rate and care system: European countries by comparison



Source: Eurostat, Table »demo_find-Fruchtbarkeitsziffern« updated on 4.5.2011; author's analysis.

When we look at the causes of contrary developments two interwoven factors emerge. The first concerns women's employment. In economically more developed societies the birth rate declines particularly strongly and, as a consequence, the share of the elderly rises disproportionately where the society is strongly oriented towards traditional gender roles and low women's employment. In traditional societies low women's employment and high birth rates are statistically correlated, while in highly developed societies – in contrast to conservative models of the family – a low rate of women's employment goes together with low birth rates. The Scandinavian countries combine

high – by international comparison – birth rates with the highest levels of women's employment, while the southern European countries and the central and eastern European transition countries exhibit the opposite pattern. This connection was investigated in 23 EU countries plus Norway and Iceland between 1999 and 2010.⁴ The correlation was significant: a good 40 per cent of the variance in the birth rates is due to the level of women's employment.⁵

Although in Germany the female employment rate during the period in question rose significantly, from 57.4 per cent (1999) to 66.1 per cent (2010) full-time equivalent employment

4 Austria, Belgium, Bulgaria, Czech Republic, Germany, Denmark, Estonia, Spain, Finland, France, Greece, Hungary, Iceland, Ireland, Lithuania, Netherlands, Norway, Portugal and Slovenia.

5 Author's calculations on the basis of Eurostat data: Table »demo_find-Fruchtbarkeitsziffern« updated on 4.5.2011 and Table »Erwerbstätigkeit – Jahresdurchschnitte [lfsi_emp_a] updated on 18.4.2011. A correlation of 0.65 was identified. The coefficient of determination is 0.427. The finding is significant at the <0.01 level. Significant results are those that are statistically secured against the possibility of a purely coincidental correlation. There is a significant result only at a P-value of less than 0.05. In our case the regression analysis yielded the value of 0.00126766.

barely increased at all. Full-time equivalent employment of women in the Scandinavian countries in 2007 was between 61.9 per cent in Sweden and 63.9 per cent in Finland, while in Germany it was only 48.2 per cent (Lehndorff et al. 2010: 15, Table B). These differences cannot be explained by women's working-time preferences. The working-time preferences of men and women – according to surveys – have converged strongly throughout Europe. Both men and women want full participation in working life in the form of short full-time work or long part-time work (Gleichstellungsgutachten 2011: 27; Wanger 2011). The convergence of gender-specific working-time preferences in the Scandinavian countries corresponds to a convergence of working-time structures. Regular full-time work (35 to 39 hours a week) and short full-time working (30 to 34 hours) are most frequently chosen and by both men and women. Around two-thirds of women in Denmark, Finland and Norway and up to 72 per cent of men (Norway) worked in this middle range in 2007. Things were different in Germany. There, on one hand, there is a strong gender gap and, on the other hand, a polarisation of women's working time. On one side, more than a quarter of working women find themselves subjected to male-oriented working-time patterns (weekly working time of more than 40 hours), while on the other side, more than a fifth of women as against only 4 per cent of men work short hours part-time, regularly fewer than 19 hours a week.⁶ So-called »minijobs« play only a marginal role in Scandinavia, regardless of gender, in contrast to Germany. While working-time preferences and actual working time are aligned in the Scandinavian countries, developments in Germany indicate a growing discrepancy.⁷

At this point the second important factor comes into play. It concerns the adequacy of women's labour market integration. Women with good qualifications want to practice their profession to the extent that they become economically independent. Adaptive societies support this process. On one hand, by abolishing incentive structures that hinder the growing desire for employment (such as spousal joint tax declarations); on the other hand, by professionalising carer and child raising activities – which traditionally have been undertaken by women within the family – and transferring them to a public infrastructure in such a way that a social contract emerges that creates a new balance between the sexes, as well as between the family and the state. The building of a public infrastructure for care thus concerns not only child care but also the domestic and institutional⁸ care of the elderly. Where high-quality public infrastructure exists for both child care and care of the elderly women's working and family lives, and increasingly also those of men, can be reconciled satisfactorily. At the same time, jobs are emerging that are attractive to the extent that care and assistance have been professionalised. Empirically, it appears that countries that have developed care and assistance as something to be financed and provided publically have birth rates above 1.7; countries with familialised care and assistance, by contrast, are marked by lower birth rates and, with few exceptions, only partial labour market integration of women. A further element of this picture is that inactivity among women due to family responsibilities is a significant phenomenon in Germany, with over 9 per cent as against 2 per cent in the Scandinavian countries.⁹

6 Data source: OECD Labour Force Statistics 2010; author's analysis.

7 Not surprisingly, half of women working part-time, according to Wanger (2011), now want to work longer working hours.

8 Insofar as domestic care in Germany involves professional care services the German statistics refer to »ambulatory care« (analogous to outpatient care in the health care system). In English, however, this is known as »home care«. Institutional care in homes, in turn, is designated »stationary« and »institutional care« following the health care system. In the present report »ambulatory« and »home«, as well as »stationary« and »institutional« are used synonymously.

9 Denmark has the lowest level of inactivity in the EU, at 1.4 per cent. Eurostat, PM 185/2010, 7.12.2010.

The positive effects of a public care economy oriented towards people's needs throughout their lives are manifold. The better reconciliation of family and working life is one aspect. The promotion of real gender equality is another. A third aspect concerns the growth model. When previously unremunerated care activities carried out, as a rule, by women in families and social networks are put on a professional basis in the employment system income and economic growth arise without an additional consumption of natural resources. From an environmental standpoint increased consumption and increased production of social services are thus desirable. A link with rising life expectancy also suggests itself. On one hand, rising life expectancy is a blessing; on the other hand, it goes together with an increase in chronic illnesses, imposing more demands on good care and early sickness prevention. If this is neglected because preventive health is not a priority life expectancy may rise but not the number of healthy years. If the number of healthy years falls and the years of life with health impairment increase this acts as a cost-driver on the health system, although the quality of life of those concerned is not better, but worse. Countries that consider care of the elderly as a task primarily for families and social networks are at a disadvantage here. The combination of rising life expectancy and a falling proportion of healthy years means for caregiving relatives that they be-

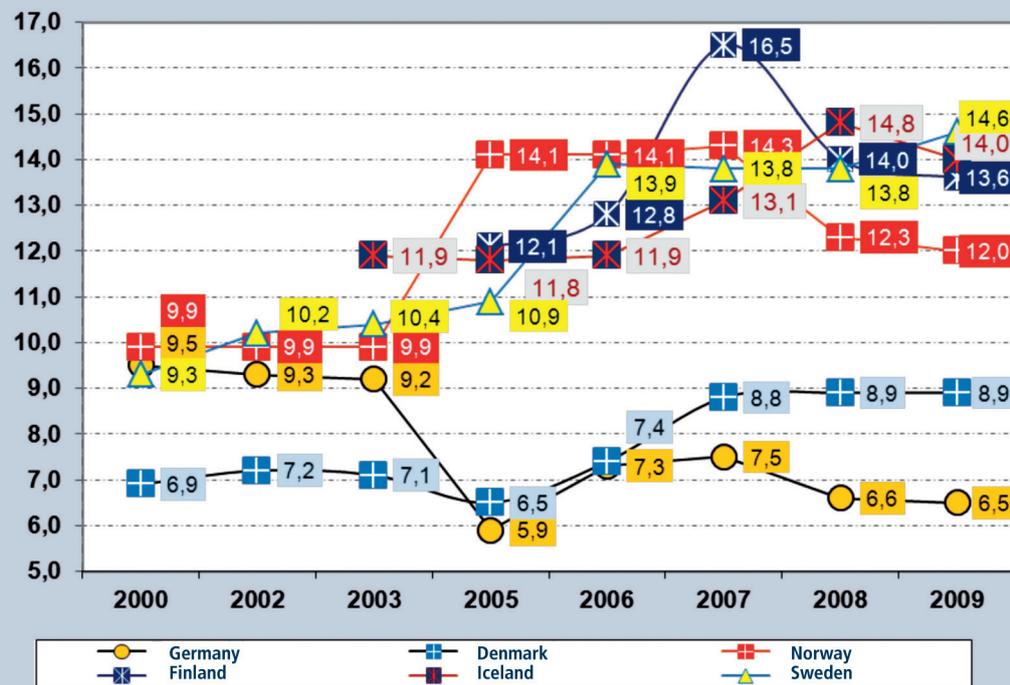
come caught in a spiral of permanent strain with growing health risks to themselves.¹⁰ In the German debate on population ageing this aspect is paid too little attention. It is very important, however, because data indicate that Germany finds itself in the trap described here. People who reached the age of 65 in 2009 could expect to live another 19.3 years. In Iceland, Sweden, Norway and Finland it was a little more (Iceland and Sweden: 19.8; Finland and Norway: 19.6) and in Denmark a little less (18.2).¹¹ However, while in Germany the bulk of these years would probably be marked by chronic illness in the Scandinavian countries the reverse was true, for both women and men. Figure 2 presents the number of healthy years of 65 year-old women. In 2000 Germany, Denmark and Sweden were pretty much on a par, with a little over 9 healthy years. Finnish women were some way behind with 6.9 years. This has now reversed. In all Scandinavian countries there has been progress with regard to women's health, while in Germany it has gone into reverse. The pattern is similar among men. While in Germany from 2000 to 2009 the number of healthy years fell from 10 to 6.4 (-31.8 per cent) Scandinavian men came a step closer to a healthy old age. The increases were between a rise of just over 50 per cent in Sweden (from 9.4 to 13.6 years) and a rise of just over 29 per cent in Finland (from 5.8 to 8.1 years).

10 The Siemens health insurance fund has investigated this issue. The result is that caregiving relatives become ill themselves much more frequently and develop medication dependencies. They are a good 50 per cent above the average with regard to chronic and serious illnesses. Even more serious than the physical burden is the psychological burden. The frequency of depression is three times the norm. Nevertheless, many caregivers find it hard to admit that they are under stress. They become caught in a negative spiral that is halted only when they suffer a breakdown. From *Frankfurter Rundschau* No. 23, 28.1.2011: 2.

11 See Eurostat: »Life expectancy by age and gender« [demo_mlexpec] updated on 4.5.2011.

Figure 2:

Expected healthy years of 65 year-olds: women



Legend: Before 2005 in Germany women who became 65 years of age in the relevant year could expect a good 9 more years of good health.

Source: Eurostat, structural health indicators [hlth_hlye], updated on 14.3.2011; author's figure.

The changes with regard to healthy years of life that older people can expect are of considerable importance in this context. That is, if the number of healthy years that older people can expect grows to the same extent as their overall life expectancy, then the advent of the risk of long-term medical care shifts with rising life expectancy. However, with the advent of a development of the kind indicated for Germany by the data in Figure 2 the period during which older people will be chronically ill and in need of care lengthens. Our analysis leads to the following thesis: economically highly developed countries that actively pursue gender equality by providing an easily accessible services-based care and assistance infrastructure for all at both the beginning and the end of life, which effectively relieves and supports the family, will achieve higher birth rates than countries that pass on this task mainly

to families and primarily to women. At the same time, women's employment is higher because first, women's careers are hindered less and second, the care economy itself contributes to job creation. Because jobs arising from the professionalisation of care activities do not entail further exploitation of natural resources increased consumption of such social services forms part of a growth strategy oriented towards socially and environmentally sustainable value creation. For society this gives rise to added value that, besides serving to promote gender equality, also helps the elderly to remain in good health. The affordability of this approach is shown by all countries that have freed themselves from prioritising family-based care. This includes, besides the five Nordic-Scandinavian countries, Belgium and the Netherlands among continental European welfare states.

3. Care Systems Are Predominantly Welfare State–Oriented, But Not Consistently

»We need a new model of society, like in Scandinavia. Care there belongs to the community, people have the backing of a municipal infrastructure and a commitment on the part of society. Ideas of neighbourliness thrive and day-care centres for the elderly have opening hours that are in line with working hours. There is a quite different kind of cohesion there.« (Jürgen Gohde, chair of the Curatorium for German Geriatric Care, cited after Windmann 2011: 129)

By and large, national care systems¹² follow the relevant basic forms of welfare state. Esping-Andersen's typology of welfare states (1990, 1999, 2000), to which reference is commonly made, distinguishes between three or four different types. The Scandinavian countries are characterised by a comprehensive welfare state. It is egalitarian and offers a basis for labour market participation for both men and women, which is converging in any case. Germany, in accordance with this typology, belongs with the other western central European countries (Austria, Switzerland, France, Belgium and the Netherlands) among the conservative corporatist welfare states. These welfare states are conservative in several ways. First, they have conserved the corporate state pattern in the form of a pronounced status orientation. In the German-speaking countries their characteristic school system serves to perpetuate this system with its early selection. Second, they are based on the family breadwinner model. The focus is not on individuals with rights of their own, but on the family with a breadwin-

ner and a partner who may make a little extra money. Reciprocal obligations of support, which have long been obsolete in Scandinavia, keep family dependencies going. Third, the conservative welfare state, at least in the German-speaking area, binds the organisation of social security systems to the preservation of status orientation. In the case of sickness insurance, accordingly, there are statutory health insurance funds primarily for employees, private funds for the self-employed and high earners, and subsidised funds for civil servants, as well as pension funds for particular occupational groups, such as the artists' social insurance fund. Financing and governance of these social insurance systems are public. Provision of services, by contrast, is based on a hybrid structure composed of non-profit-making, private commercial and public providers.

Reality tends to be more complex than models. There are also hybrid systems whose elements are derived from different system contexts. Care is a good example of this. In theory, quite different arrangements are conceivable between the family, the market, the state and social networks. This ranges from family-based charitable approaches through mixed market–state models to purely state service provision. What kinds of arrangements prevail and how they develop depend on many factors that we cannot detail here. Table 1 attempts to make sense of the status quo. It is based on the view that two issues are key to drawing distinctions within the EU and the OECD: first, the question of whether care provision is formal or informal, provided rather by

12 For more details on arrangements for care and assistance for the elderly in Europe and the OECD see Hammer/Österle 2004; Skuban 2004; BMASK 2005; Beadle-Brown/Kozma 2007; Brandt 2009; Haberkern/Brandt 2010; OECD 2011a and the MISSOC information system on social security benefits and services.

members of one's own family or by professionals; and second, the question of the level of public financing in proportion to the country's economic strength. If one takes this dual criterion as a rule of thumb two basic types emerge that can be more finely articulated in subtypes along the lines of the basic forms of welfare state. The basic types are the family-based system with low to medium public financing and a services-based system with medium to high public financing. In the family-based system informal care by family members and social networks has priority over professional care; in the services-based system the opposite is the case. Policy depends on the prevailing basic type. The family-based basic type is accompanied by a policy that is more interested in maintaining

the highest possible proportion of family care than in creating a high-quality care infrastructure that is accessible to all. In the services-based system, by contrast, policy is oriented primarily towards supporting and further developing professional care, with the limitation that care policy in the market-state subtype (variant S-2) refers primarily to public provision. Both in this case and the other it is conceivable that further development will involve steps that may result in a transformation of the system – for example, because the established system comes under such pressure due to its significant failures that a policy that takes an alternative approach can obtain majority support.

Table 1:

Care of the elderly: a system comparison

Basic system	Family-based care system (priority given to informal care; low public financing)		Services-based care system (priority given to formal care; medium to high public financing)		
	F-1	F-2	S-1	S-2	S-3
Variants	Extended family; weak regulation of public care provision	tight regulation of public care provision	Market-state hybrid system; tight regulation	Comprehensive density of services; hybrid provider structure	Universal public system; high service integration
Countries	Italy, Spain, Greece, Portugal, Poland, Slovakia, Czech Republic, South Korea	Germany, Austria, (Slovenia) ¹	Ireland, New Zealand, United Kingdom, Australia (Switzerland) ¹	Belgium, Netherlands	Denmark, Finland, Iceland, Norway, Sweden
Definition of care	Narrow definition of care; no »holistic« approach		Narrow definition of care	More extensive definition of care	
Professionalisation	Low	Low to medium	Varies	High	
Professional care	Insignificant	Fairly significant	Very significant	Very significant	Very significant
Access	Beset by hurdles	Difficult (fragnen- ted structures)	Difficult (polarised structures)	Low threshold	Low threshold
»Grey care market«	Very important	Medium importance	Medium importance	Low importance	Low importance
Public financing²	<0.8 % of GDP	>0.8 to <1.2 % of GDP	0.8 to <1.4 % of GDP	>1.4 to over 3 % of GDP	>1.8 to approaching 4 % of GDP
Public governance	Weak	Control of expenditure	Control of expenditure	Management based on needs	Management based on needs

Notes:

- 1 Categorising Slovenia and Switzerland is not unambiguous. In Slovenia the system is predominantly public and based on benefits in kind, but public financing is barely medium. Switzerland has a similar level of care expenditure to Finland (>2% of GDP) but with 60% private financing. Furthermore, the system is family-based.
- 2 In the case of the F-1 countries Spain (0.6% of GDP) and in the case of the F-2 countries Austria (1.1% of GDP) have the highest proportions of public financing. The Austrian system, in contrast to the German system, is tax-financed. In the market-state group New Zealand is the most public sector oriented (public provision accounts for 1.3% of GDP, private provision only 0.1%). In the S-2 group the Netherlands is at the same level as the core Scandinavian countries.

Source: Author's design.

One might expect that the care systems of countries with conservative-corporatist social insurance systems would follow the same logic as their health systems. What applies to medicine in the health system would apply analogously to care in the care system and, at the same time, for the basis for interlinking the two systems. In fact, conservative welfare states are categorised under different basic types when it comes to care provision. While Belgium and the Netherlands provide care on a professional basis and in accordance with need, professionalisation in Germany and Austria is comparatively low. The German-speaking countries share with southern and central and eastern European countries a high degree of familialisation and informal service provision. The family-based system has two subtypes, the services-based system has three. In these subtypes characteristics come to the fore that are derived from their basic welfare state orientation. For example, familialised care in the southern European countries is based on the extended family or the »clan« (Hammer/Österle 2004: 46), while in the German-speaking countries the core family plays this role. Core family versus extended family is not the only thing that distinguishes the German-speaking countries from the southern and central and eastern European ones. Another key difference is that in Germany professional care provision is strictly regulated, in keeping with the narrow performance-based definition of care. The aim is not the specific needs of people requiring care, as in the Scandinavian countries, but keeping down public expenditure. The southern European countries do not have public governance systems that determine different levels of care need and link them to entitlement to financial benefits and benefits in kind in accordance with strict bureaucratic regulation. Governance there is weak and financing is mixed, comprising private spending on care and public assistance. Besides the Scandinavian countries and some other from continental Europe individual »Anglo-Saxon« countries also belong to the services-based basic type. Care arrangements that would justify the term »system« exist there only to a limited extent, however. In the United

Kingdom the National Health Service (NHS) provides for medical care; as in the Scandinavian countries it is provided free of charge. Care, which is unconnected to the NHS, is a municipal responsibility and organised differently in individual regions, most of which demand high co-payments. A market logic applies to instances not covered by the universalist provisions of the NHS and when access criteria are not met with regard to municipal benefits.

Why individual central European countries, like the Scandinavian countries, have established care systems based on professionalised service provision, while care arrangements in German-speaking countries are still anchored in the family cannot be discussed in more detail here. I will confine myself to remarking on a point that seems central to me. In the Benelux countries, as in the Scandinavian countries, care and medicine are on a much more equal footing in the health system than in Germany, where there is still a hierarchical gap between male-dominated medicine and female-dominated care, which is subordinate to medicine (»care as the handmaiden of medicine«). The German health system is medicine-centred and suffused with doctors' status interests. Doctors' representatives and policy that is biased in their favour still contrive to hinder the academicisation of care. It is even worse with regard to care of the elderly because health policy and family policy clash. Health-policy logic calls for professionalisation, but because of the subordination of care to medicine it limits it to a medical definition of care. The family-policy logic calls for familialisation. The goal here is, on one hand, to provide some support for family care which is an extremely cheap option for society, thereby stabilising it, and on the other hand, to keep the qualifications of care workers at a level in keeping with their low pay. In F-2 countries (see Table 1) we thus find the abovementioned, interdependent characteristics: (I) a narrow conception of care; (II) a slow rate of professionalisation; (III) high access barriers to good care due to fragmented and opaque provision structures with significant differences in quality; (IV) a strong presence of commercial providers, including a

gateway to the grey care market, through which relatives arrange affordable care; and (V) governance oriented towards keeping public expenditure low.

3.1 Germany: A Narrow Conception of Care Promotes Familialisation in a Core Social Security System

The challenge of ensuring that the needs of the elderly for assistance are met with statutory entitlements to the provision of social benefits and services was faced only in the 1990s with the creation of a care insurance system in the Eleventh Book of the Social Code (SGB XI 1994).¹³ On 1 January 1995 care insurance was created as the fifth pillar of the social insurance system. It is an adjunct to statutory and to private health insurance. Anyone who has statutory health insurance is automatically covered by social care insurance and anyone with private health insurance must take out private care insurance. Expenditure on social care insurance is financed through contributions, with employees and employers paying half each. On reaching the age of 23, people without children pay a supplement of 0.25 contribution rate points (§55 III). Private care insurance companies charge a premium that is independent of the policy-holder's income. If the private policy-holder is employed he or she receives a subsidy from his or her employer in the amount that would be due if they were members of the social care insurance scheme. Social care insurance operates on a pay-as-you-go basis; private care insurance uses the projected unit cost method, under which old-age accruals are made to cover future care needs. If the risk of needing care materialises and ambulatory services are required the principle of benefits in kind applies in relation to social care insurance; in relation to private care insurance the cost reimbursement

principle shall apply. In summary: in creating the care insurance system the authorities missed a chance to establish a system operating on the basis of uniform principles. The errors made in the construction of financing patients, setting up a private system of full health cover alongside statutory health insurance that operates in accordance with a contrary logic was thus passed on to the care insurance system.

Two things were recognised with the creation of a care insurance system. First, the number of those needing care is growing sharply as Germany's population ages rapidly. A particular problem here is the number of people in need of critical care, whose care and support can scarcely be provided by relatives. Second, family structures have changed, which, in parallel with the growing need for care, has reduced the reservoir of potential caregiving relatives. The effects of several processes are cumulative: the number of children in families is lower, as a consequence of lower birth rates over the long term, and the number of childless elderly people is growing. Furthermore, where there are children changes occurring in the world of work mean that those children often work far from where their parents live. Unless they sacrifice their careers they can thus care for their parents only sporadically.

Care insurance is not old-age insurance. Benefits and services are directed towards all persons, regardless of age, who are in need of care within the meaning of the law. However, four out of five people in need of care are over the age of 65¹⁴ and above the age of 70 the risk of needing care rises disproportionately with each passing year. In the case of 80-85 year-olds it is a good 20 per cent and for those aged 90-95 it stands at over 60 per cent. In terms of gender significantly more women than men need care. According to §14 I SGB XI, people in need of care are those who »due to a physical, mental or emotional ailment or disability require help in considerable or

13 In 1995 the Law on ambulatory care came into force, followed in 1996 by the Law on stationary care. The most recent development dates from 2008. The Law on the further structural development of care insurance (Pflege-Weiterentwicklungsgesetz, BGBl. No. 20 of 30.5.2008: 873) makes improvements, among others through the introduction of a legal entitlement to advice on nursing care, improved services for dementia sufferers and the creation of care support centres, when a Land decides to establish them.

14 The proportion has increased slightly over the past decade. At the end of 1999 79.9 per cent and at the end of 2009 83 per cent of those in need of care were 65 years of age and above.

substantial measure for routine and regularly recurring tasks in the course of daily life for a duration of at least six months«. The Medical Services of Health Funds (Medizinischen Dienst der Kassen – MDK) decide whether someone is in need of care. Three levels of care (SGB XI §15) and three main services are distinguished. The levels of care are defined as follows:

- *Level of care I (considerable need of care)*: This entails a need for daily care for at least two tasks in one or more areas of basic care (personal hygiene, nutrition or mobility). In addition, domestic help must also be required several times a week. This must amount to time spent each week averaging at least 90 minutes a day. More than half of this must go on basic care.
- *Level of care II (severe need of care)*: In contrast to level I, care is needed in this instance for an average of at least 3 hours a day, including 2 hours for basic care.
- *Level of care III (extreme need of care)*: The help needed in this instance is so great that it must be provided at all times. This means a daily average of at least 5 hours, including 4 hours for basic care.¹⁵

People with significant disabilities affecting their everyday life (§45a SGB XI), but who do not meet the criteria for categorisation under care level I can also receive care services. This is referred to as »care level 0«. This represents a kind of cushion for those whose care needs are not properly taken into account because of the narrow definition of care in Germany. This includes people with mild dementia or otherwise diminished ability to look after themselves. In this group physical abilities in the areas of »personal hygiene, nutrition and

mobility« are often not impaired at all, but the ability to take care of their day-to-day affairs and to maintain social contacts are affected. Requirements with regard to good care and support in this instance are sometimes much greater than in the case of those who come under care levels I to III. The behaviour of people with significant disabilities affecting their everyday lives is erratic. They can endanger themselves and others and behave uncooperatively or aggressively. This imposes a heavy burden on caregiving relatives. Although the problem has long been known policymakers have failed to find a solution. The additional attendance allowance (100 to 200 euros a month) that can be granted under §45b SGB XI since 1 July 2008 is little more than a token.¹⁶

A person recognised as in need of care receives benefits in cash and/or in kind. The system is multi-level. The lowest financial benefits are paid to informal caregivers through the attendance allowance. This represents a kind of token of appreciation below subsistence level (from 1 January 2012 it was 235 euros a month for care level I and 700 euros a month for care level III). However, the rates paid directly by funds for ambulatory care services are not adequate. Since 1 January 2012 the rates are 450 euros a month for care level I, 1,100 euros a month for care level II and 1,550 euros a month for care level III (in cases of hardship a maximum of 1,918 euros a month). Very narrow time periods for individual tasks are used as the basis for this. Care services calculate this »care on the clock« (*Minutenpflege*) punctiliously, taking into account that care workers will provide unpaid »shadow« care to make up for what they cannot manage in the time laid down.¹⁷

15 Source: German Ministry of Health (Bundesgesundheitsministerium): available at: <http://www.bmg.bund.de/>Pflege>Wer ist pflegebedürftig>Die Pflegestufen> (accessed on 11.7.2011).

16 The Law on the reorientation of care (Pflege-Neuausrichtung-Gesetz – PNG) introduced for parliamentary debate by the CDU-CSU/FDP coalition government in spring 2012 makes no fundamental changes. The need for social assistance of people with incipient or advanced dementia is not systematically included in the care system as a separate category of services alongside basic care and domestic help and is funded accordingly. Only modest increases in benefit rates are planned. With regard to care level 0, the relevant sum of 25 euros a month is purely symbolic; in the case of care level I a supplementary payment for benefits in kind of up to 225 euros a month and for care level II of 150 euros a month is foreseen. Source: German Ministry of Health (as of 29.5.2012).

17 Investigative journalist Markus Breitschdel worked undercover in the care sector several times during the period in question. In mid-September 2011 he published a book entitled *Washed, Fed, Another Tick in a Box: The Degrading Daily Routine of Mobile Care (Gewaschen, gefüttert, abgehakt. Der unmenschliche Alltag in der mobilen Pflege*, Berlin). It describes how he did up to 20 hours a week unpaid overtime as a care worker contracted to do 30 hours a week. The system works on this basis, mercilessly exploiting the compassion of care workers who do unpaid overtime to try to ameliorate this »degrading daily routine«. Cited after an interview by the author of the book with the Leipzig Volkszeitung (»Compassion is exploited«) on 16.9.2011: 2.

The cost shortfall is greatest in the case of 24-hour care. This is nowhere near covered by the care insurance rates, opening the door for the emergence of a grey care market. In the case of stationary care, care insurance pays a lump sum for basic care, social assistance and medical treatment. At least 25 per cent of the fees of residential homes must be paid by the person insured or their family, including the cost of board and lodging; they generally fall outside the scope of care insurance. Because of the limited coverage of costs this is referred to as a core insurance system or colloquially as a »partial cover insurance« (»teil-Kasko«, which properly refers only to car insurance).¹⁸ If neither the person in need of care nor their relatives are in a financial position to bear the costs not covered by care insurance municipalities are obliged to make up the difference.¹⁹

People in need care can choose between the following forms of principal services:

- (I) care by relatives who receive attendance allowance for it;
- (II) care by ambulatory care services;
- (III) stationary care in a home.

Categories (I) and (II) can be combined. There are also short-time care services, partial stationary services, care support services and subsidies for measures to improve the home environment (for details, see BGM 2010 and BMAS 2011: 108 - 110). In the case of institutional care, care insurance (as of 2012) pays monthly lump sums of 1,023 euros (care level I), 1,279 euros (care level II) and 1,550 euros (care level III, in cases of hardship: up to 1,918 euros).

Every care system is based on a particular philosophy and a particular conception of care. The German system with its narrow definition of care excludes people whose problems are due to social isolation, incipient dementia,²⁰ occasional senile dementia or a limited ability to look after themselves on a daily basis. This exclusion is in line with the subsidiary approach of the family-based system. The aim is to minimise the circle of those able to claim professional services as an alternative to family care and thus a higher level of cost privatisation.²¹ Care aimed at basic functions can be fully rationalised in terms of »care on the clock« (*Minutenpflege*). This is scarcely possible in the case of care, psychological and social support services for people with reduced ability to look after themselves on a day-to-day basis. In Germany, because of the ageing and individualisation of society the number of people for whom the care system provides for no statutory services available nationwide²² is growing, thereby increasingly pushing the familialised system up against its limits. Against this background there have long been calls for a widening of the narrow conception of care of SGB XI. An advisory council set up in 2006 by the German Ministry of Health (BGM) proposed a new conception of care and a new assessment instrument in 2007. A field test was carried out successfully in October 2008 (see Windeler et al. 2009). A person's independence is to be taken as the measure of their care needs. Persons in need of care are thus those »whose independence with regard to everyday activities, dealing with illness and organising important areas of life is hampered either permanently or

18 »Care insurance is not full insurance that bears all costs related to the need for care. With its range of services it helps people in need of care and their relatives to bear the personal and financial burden of care needs« (Third Report on the Development of Care Insurance: 12).

19 Surveys indicate that one in households affected by care needs pays additionally for private care. Where municipalities have to step in they try to recover the money from relatives.

20 Dementia begins insidiously and develops progressively, affecting the elderly almost exclusively. At present around 1.2 million people in Germany over the age of 65 suffer from dementia, 7 per cent of this age group. Given ongoing demographic change we can expect a considerable increase in the number of dementia sufferers. Even today more than two-thirds of all care home residents suffer from dementia (SVR 2009: 487).

21 A joint study by the Helmholtz Centre in Munich and the Erlangen University Clinic shows that care by relatives accounts for 80 per cent of the cost of social provision for dementia sufferers living at home. Services provided by relatives were calculated at market hourly rates. Cited after the Press information of the Helmholtz Centre Munich of 23.8.2011. Original publication: Schwarzkopf, L. et al., Costs of Care for Dementia Patients in Community Setting: An Analysis for Mild and Moderate Disease Stage, Value in Health (2011): doi:10.1016/j.jval.2011.04.005.

22 It is true that in most cities there are day centres for the elderly, social groups for senior citizens and so on, in contrast to Scandinavia this is not provided by municipalities on a statutory basis but often no a voluntary basis by members of religious communities and welfare associations. This varies from place to place.

temporarily for health reasons« (cited after SVR 2009: 482). This conception would have far-reaching consequences for assessment. It would no longer have to determine whether a person can dress, wash and so on independently. If independence becomes the focus the issue is to determine whether someone is in a position without outside help to carry out daily activities necessary for personal hygiene, cope with their psychological problems and maintain social contacts. Care closely related to bodily tasks would undergo a psychosocial extension on the basis of such an approach that could address many of the criticisms made of the German care system. Several years have already gone by since the proposal was presented without any prospect of its implementation. Given the basic principles of the German care system (see Tables 1 and 2) this is scarcely surprising. If there was a real change in the conception of care, not just a rhetorical one, it would have consequences: for the number of those in need of care (it would increase sharply); for public financing (it would have to increase from the current 0.9 per cent of GDP to 2 per cent or more); and for the education of care personnel (it would have to be supplemented by psychological and social pedagogical components). This is not likely to be forthcoming from the current German government.

The great significance of family care by relatives in the German system is readily explained by people's preferences. However, this is only half true. There is indeed a preference for care by family members in Germany,²³ but this preference is not independent of the prevailing circumstances. A survey conducted by Eurobarometer throughout Europe in autumn 2007 shows that Germans had a negative view of the availability of afford-

able care matched only in the southern and eastern European countries. Doubts about the quality of care in the familialised system are also more pronounced than in services-based systems. According to Dittman (2008: 3f.): »In the current Eurobarometer survey only 13 per cent of Danes said that they or close family members could not afford stationary care services; ambulatory care was beyond the reach of only 4 per cent of Danes. ... In Germany stationary and ambulatory care are more often considered unaffordable than the EU average. A total of 55 per cent of Germans regard ambulatory services as too expensive. The finding for care homes in Germany is even more dramatic: around 75 per cent of Germans regard stationary care as unaffordable! Such a negative evaluation is not to be found in any other country with a comparable type of welfare.« The evaluation of quality is relatively good only with regard to ambulatory care. Stationary services are evaluated as »quite bad« or »very bad« by 35 per cent of eastern Germans and 42 per cent of western Germans. Only in eastern European countries and in Greece and Italy is the evaluation more negative. The preference for family care should be seen against this background: if provision is characterised not by transparent structures but by fragmented structures;²⁴ if financing is such that only certain population groups can afford good care; and if the quality of institutional care is perceived as poor people in need of care are likely to turn to their own families. Relatives, too, regard themselves as duty bound primarily because they have no trust in the quality of, in particular, homes. If the financing conditions improved and a high-quality care infrastructure with low-threshold services was available this would have an affect on preferences.

23 In the Scandinavian countries 70 to 80 per cent of people favour formal care via community services as against between one-third and just under 40 per cent in Germany. Source: European Foundation for the Improvement of Living and Working Conditions 2004, cited after Local Authorities (2006: 41) and OASIS Project (Old Age and Autonomy: The Role of Service Systems and Intergenerational Family Solidarity), cited after Deutsches Zentrum für Altersfragen, Informationsdienst Altersfragen, Heft 4/2003: 2ff. (July/August).

24 People who need assistance are often at the mercy of fragmented structures. In order to shed light in this jungle since 1.1.2009 (§ 7a SGB XI) there has been an entitlement »to individual advice and assistance«. Implementation is sorely lacking, however. Neutral advice is not available nationwide. The main reason is that the care support centres optional under state law (§ 92c SGB XI) have been established very slowly. A total of 60 million euros were made available in 2008 in order to set up the 1,200 support centres with a subsidy of 50,000 euros at the most by 30.6.2011. Only around 310 support points have materialised, 135 of them in Rhineland-Palatinate. The meagre result was predictable because funds and service providers that are commercial competitors can scarcely be expected to cooperate in providing independent advice. An investigation of 16 support centres by the foundation Warentest showed that only one in three support centres gave good advice (available at: <http://www.test.de/themen/gesundheit-kosmetik/test/Pflegestuetzpunkte-Nur-jeder-dritte-beraet-gut-4149337-4149364/>; 26.7.2011).

Nevertheless, in all German *Länder* care of those in need of it exclusively by relatives has fallen over the past decade.²⁵ In 1999 the figure was 51 per cent across Germany and in 10 *Länder* over the 50 per cent threshold. With regard to care level I a good 60 per cent family care was achieved across Germany. Only Hamburg was below the 50 per cent mark. A decade later family care dominates at all levels of care only in Hesse and with regard to care level I three *Länder* (Hamburg, Saxony and Schleswig-Holstein) are now below the 50 per cent threshold. In care levels II and III formal care now dominates, sometimes in combination with family care. The percentage declines amount to 5.4 per cent, with significant differences by care level and *Länder*. With regard to care level I the values range between -0.7 percentage points in Berlin and 9.7 percentage points in Lower Saxony. In the case of care levels II and III the spread widens, from -1.8 percentage points in Hamburg and -16.2 percentage points in Saxony-Anhalt. Traditional family care is increasingly looking like an »obsolescent model« (Trilling/Klie 2003: 119). The creeping erosion is exacerbated by the decline of the ideological underpinning of familialised care. Windmann (2011: 128) cites a Hamburg University study commissioned by AOK. According to it, in 1997 58.8 per cent of Germans regarded care by relatives as a moral duty; in 2009 the figure was only 45 per cent.

3.2 Scandinavian Countries: Universalistic System with a Broad Conception of Care and Service Provision by Municipalities

In Scandinavia the period from the late 1960s to the mid-1990s saw dynamic expansion of the care economy, from child care to care for the elderly. This took the form of a »convoy«, with Swe-

den leading for a long time, but overtaken in recent years by Denmark, Norway and to some extent also Iceland. The system-building phase was followed by a period of development in line with perceived needs, during which adjustments were made to system management, private providers were permitted and users' rights, for example, concerning choice, with variations in the level of ambition. By international comparison the farthest developed are the care systems of the Scandinavian core countries and Iceland. Finland lags behind somewhat.

If one looks for the shared characteristics of Scandinavian elderly care systems²⁶ the following stand out:

- **Legal framework:** In all Nordic countries the primary responsibility for providing care and assistance for children, young people, adults, the disabled and the elderly lies with the municipalities. The benefits and services of the municipal care economy are regulated in laws on health and social services, which tend to encompass – oriented towards the life course of individuals – the whole spectrum of health care and social services. In Iceland there is also special comprehensive legislation concerning the geriatric, social and other concerns of the elderly (Law No. 125 of 1999 as amended by Law No. 153 of 2010). Finnish legislation is comparatively poorly integrated. On the other hand, Finland's welfare state is most strongly anchored²⁷ in the constitution and legal changes are in progress aimed at expanding the system.
- **The significance of formal and informal care:** By international comparison the Scandinavian countries lead the way in relation to formal care. This is in keeping with the preferences of the population, who regard the state as primarily responsible. In the case of the OASIS

25 Author's evaluation of data on *Länder*. Source: Persons in need of care (number). Characteristics: year, region, levels of care, type of support; available at: <http://www.gbe-bund.de/> »„Pflegebedürftige Region“.

26 This presentation is based on the relevant laws and official government documents. For the sources see the Bibliography (Primary Sources). For more details see the long version of this study.

27 While the Swedish constitution contains only a general reference to state responsibility for the well-being of its citizens, the Finnish constitution of 1999 specifies it with a comprehensive catalogue of social rights. State action towards their realisation is laid down. On social and health services (§ 19 II) it is laid down that the state must ensure for everyone »adequate social and health services and promote the health of the population«.

project, for example, Norway represented the Scandinavian group. Three out of four elderly people regarded the state as responsible; in Germany the number was only one in three.²⁸

- **Definition of care:** There is an extended conception of care that focuses on people's autonomy. The elderly are supposed to receive support in their desire to lead an autonomous life; they have a right to a dignified old age. Elderly care systems are oriented towards this goal, with various tiered measures, ranging from traditional care through social measures to pedagogical and physiotherapeutic activation. Levels of care like those in Germany do not exist; however, assessment must reveal minimum needs so that people can avail themselves of services. Municipalities decide on where the thresholds lie within the framework of assessments.
- **Local planning and service provision:** Responsibility for local/regional planning, such as of service provision, lies with the municipalities or levels of local government. Domestic services are the responsibility of local authorities and trusteeship of homes generally lies with district councils. Municipalities are free to decide whether they will provide services themselves or contract them out. In connection to the establishment of rights of choice Sweden permitted private providers at the beginning of the 1990s, while Denmark did so at the beginning of the 2000s. They are subject to local government supervision.
- **Regulation of family care:** Scandinavian care systems are also services-based in the sense that they value care given by family members or friends in cases of recognised need as an alternative to formal service provision. Informal caregivers do not receive attendance allowance

as a token of appreciation, as in Germany, but – with the exception of Finland – wage replacement benefits. It is in keeping with the strongly employment orientation of the Scandinavian welfare states that this can even include the temporary creation of substitute jobs. In that case, caregiving relatives are contracted by the municipality in return for payment.²⁹ In Denmark, Sweden and Norway this is practiced in some municipalities.

- **Quality of care and the qualifications of care personnel:** There is general training in care. The qualifications of care workers have been successively academicised since the end of the 1970s.³⁰ As a consequence, »care« has gained in prestige as an academic discipline and care standards were defined and applied early on, whereby medical, care and psychosocial perspectives are considered on an equal footing. Assistance is provided mainly as part of an integrated system of care and day-to-day support. The evaluation, monitoring and further development of standards is done by special institutions at national level.
- **User participation:** The participation of the recipients of services and their relatives is considered to be very important. District councils are supposed to ensure that *»the users of facilities (...) are given an opportunity to impact on the planning and use of the facilities. The municipal council shall lay down written guidelines for such user involvement.«* The issues in respect of which recipients are regarded as having a say concern daily routines, meals and social life in the home.³¹
- **Financing:** With certain exceptions (Finland) the basic principle is that long-term care services are free of charge. The cost is borne by municipalities. Municipal resources thus determine the

28 Cited after German Centre of Gerontology (Deutsches Zentrum für Altersfragen) (ed.), Informationsdienst Altersfragen, Issue 4/2003 (July/August), figures, pp. 2ff. OASIS stands for »Old Age and Autonomy: The Role of Service Systems and Intergenerational Family Solidarity«.

29 In Denmark Section 118 of the Social Services Act contains a similar authorisation. The relative who is to be cared for must be suffering from severe physical or mental incapacities or from a chronic illness. In that care the creation of a substitute job with the municipality is possible for a maximum of six months, on condition that the scope of care corresponds to a full-time job and those involved inform the relevant care scheme.

30 See Heintze (2007), pp. 278ff.

31 See Denmark's Social Services Act, Part III, Chapter 5. There are analogous regulations in the other countries.

scope and quality of the system. In Scandinavia there are always complaints about inadequate funding – perhaps justifiably in relation to the established standards. By German standards, however, the financial resources available are very good overall. Municipal income tax plays a significant part in this. Furthermore, there is a financial equalisation system with subsidies from the state. For certain services – exceptional or temporary services – local authorities can levy income-related fees.³² The principle that services shall be free-of-charge – this is also the case in Germany – does not apply to accommodation and food. People living in sheltered housing or with a room in a care home have to pay board and lodging from their pensions. Those in need are eligible for financial support or are entitled to reduced rates. Relatives do not have to contribute to uncovered costs, as in Germany.³³

Looking in more detail at how Finland lags behind we can observe that the Scandinavian systems are based on the idea of providing individuals with the state support services they need in the sense of »helping people to help themselves« in order to enable them to live self-determined lives as long as possible. For many old people it is enough if they go or are taken to municipal day centres for the elderly where they can eat together with other old people and participate in certain activities. If permanent care and domestic support are needed a few hours a week might be enough, not necessarily 24-hour care. Between an occasional pick-up service – to day centres for the elderly, the local library and so on – and a 24-hour service many gradations and individual

arrangements are possible. Assessment criteria are applied for this purpose, although they differ from local authority to local authority. There is no legal standard along the lines of the German levels of care. The individualised approach is widely implemented in Iceland and the core Scandinavian countries. The Finnish system, by contrast, is less developed with regard to »orientation towards individual needs«, »life-course orientation« and »quality control«. Efforts are under way to close the development gap by means of a quality offensive³⁴ and a stronger orientation towards individual domestic support. Since autumn 2009 work has been ongoing on reorganising the legal foundations. In future, individual needs will be examined by means of an assessment that looks at a number of aspects and the local authorities will be obliged to provide assistants for elderly people in need of care and support.³⁵

Finland also exhibits considerable differences with regard to the predominance of benefits in kind. While in Denmark and Iceland cash benefits play no role and play only a modest one in Sweden, in Finland things are different. Pensioners can obtain a pensioners' care allowance (Eläkkeensaajien hoitotuki) of between 57.55 euros a month and a maximum of 302.96 euros a month and a special pensioners' housing allowance (Eläkkeensaajien asumistuki).³⁶ The Finnish care allowance has a different function from the German care allowance; it serves not to compensate informal care, but to subsidise the increased financial burden that comes with taking on care responsibilities. If there is informal care caregivers receive benefits in the amount laid down by

32 In Denmark private co-payments cover around 10 per cent of municipal spending on care (Statistical Yearbook 2011, figure 1 and table 140; no page references). In Sweden the maximum monthly contribution to costs for general care services was 1,712 SEK in 2009, around 192 euros. For medical care services under the Law on health services the maximum annual contribution to costs was 900 SEK (around 101 euros).

33 Contributions to costs have to be assessed in such a way that elderly people are left with sufficient from their pensions to cover accommodation and food. In 2009, in Sweden at least 4,832 SEK a month (around 542 euros) had to be left for daily needs.

34 Within the framework of the KASTE programme 2008–2011 (National Framework for High-Quality Services for Older People).

35 The Finnish Ministry of Social Affairs and Health: »A law to ensure the right of older persons to care according to their needs«, PM No. 68/2011 of 9.3.2011. There is no information on the state of implementation. The parliamentary election of 17 April 2011 resulted in a change of government. In accordance with the model, not unusual in Finland, of so-called rainbow coalitions a six-party coalition was formed headed by former finance minister Jyrki Katainen of the conservative National Coalition Party (the so-called »Six-Pack«). It ranges from the Conservatives to the Left-wing Alliance.

36 In the other Scandinavian countries, as in Germany, there are housing benefits or comparable systems not targeted specifically on the elderly.

the local authorities, but at least 336.41 euros a month. Informal caregivers enter into a contract with the local authorities for this purpose. In Norway, too, higher expenditure due to care can be subsidised. The annual sums come to a minimum of 7,452 NOK (around 950 euros) up to a maximum of 13,356 NOK (around 4,749 euros). Informal caregivers receive 13,356 NOK (around 1,700 euros) a month. In the case of particular burdens additional allowances can be granted.³⁷

Comparing the Scandinavian countries each country has its own profile. Denmark's profile is, among other things, characterised by a relatively strict regulation of users' rights and providers' obligations. Municipal councils not only have to lay down and publish quality standards, but also have to ensure that they are met. Similarly, they are obliged to implement preventive home visits. Every resident 75 years of age or above who lives alone without outside help shall receive each year at least two offers of a preventive home visit. Citizens can accept or decline these offers. The underlying principle is that no one should be forgotten or lost. The elderly are also guaranteed that the waiting time for access to care homes, care apartments and other forms of housing for the elderly shall be kept to a minimum. Since 1 January 2009 there has been a guaranteed waiting time of a maximum 2 months.³⁸ Sweden's profile is characterised by the availability of two care-management paths, a municipal and a private one. Municipal management is by far the most prevalent; private management bundles service provision by private providers with family care. Swedish care policy underwent a critical period in the 1990s. Previously, generous domestic

assistance was cut back on cost grounds so that temporarily – second half of the 1990s³⁹ – there was a certain shift in the direction of informal care arrangements. The restrictive approach to authorisation – it was subsequently relaxed again⁴⁰ – damaged the previous high level of trust in the quality and reliability of municipal social services. By contrast, Danish policy is distinguished by a high level of reliability. Currently, Swedish policy is making an effort, on one hand, to score points by extending municipal services beyond the regular system⁴¹ and, on the other hand, aims to involve the market more by means of vouchers issued by local authorities for the purchase of services from private providers. A law to this effect came into force in January 2009.

In Iceland the ageing of the population is far less advanced than in all comparable countries. Nevertheless, the small island republic already has a highly developed elderly care system with its own character. Four features stand out. First, municipalities, the relevant ministries (social and health ministry) and a national council for the affairs of the elderly participate in monitoring compliance. Second, there is mixed financing from public funds, municipalities and income-related fees; care services are not free of charge, as in the other Scandinavian countries. Third, all-inclusive care is not provided for in Iceland; those who need 24-hour care have to exchange their domestic surroundings for a sheltered apartment or a room in a care home. Fourth, Iceland has special legislation in the form of the Law on the affairs of the elderly of 1999 as amended in 2010 (*Lög um málefni aldraðra*).⁴²

37 Information for 2011 after MISSOC, updated in January 2011.

38 See: <http://english.sm.dk/social-issues/Elderly-people/home-care-services/Sider/Start.aspx> > Residential accommodation; accessed on 22 July 2010.

39 Ministry of Health and Social Affairs, 7.7.2009 updated on 15.9.2010; see: <http://www.sweden.gov.se/sb/d/12073/a/129494> (20.8.2011).

40 The proportion of home-help recipients, as a consequence, again approached the level seen in the first half of the 1990s. See Socialstyrelsen (2008), p. 6.

41 Since 2006 local authorities have been legally empowered to offer elderly people who are not considered to be in need of care practical help with window cleaning, spring cleaning and so on without assessment. The aim is to reduce the elderly's increased risk of accident and injury. Local authorities can levy fees for services within the framework of their specific costs. According to the information of the Ministry of Health and Social Affairs many local authorities, however, offer these services free or at very low cost (Ministry of Health and Social Affairs, 7 July 2009, updated on 15.9.2010; available at: <http://www.sweden.gov.se/sb/d/2061>.)

42 Here the elderly are defined (Article 2) as persons over 67 years of age.

In Sweden, Denmark and Finland the latest developments are characterised by the introduction of elements of competition alongside enhanced rights with regard to choice for users (see OECD 2011b: 304ff.). Sweden already bid farewell to a municipal monopoly on care at the beginning of the 1990s and permitted private commercial providers. Denmark followed a decade later; since 2003 the principle of free choice has applied. The elderly can take advantage of the care services of their local authorities or those of a private provider. As in Sweden, they can switch to another local authority and are not obliged to remain with a chosen provider, but may change from time to time. The empirical data (see below) show that people vary greatly in the use they make of this option to switch depending on the type of service. When it comes to institutions the municipal monopoly remains and also in the case of personal care private providers have only a small share of the market at present. Things are different in relation to practical support services.

Despite considerable differences in detail there are broad similarities in Scandinavia. Between Germany and the Scandinavian countries, however, differences predominate. Common to all the six countries under comparison is that the care system is predominantly oriented towards domestic care, which accords with the needs of the elderly themselves. The ways of achieving this end in the family-based German system, however, differ from those of the services-based Scandinavian systems. People without physical disabilities, but with reduced ability to cope with everyday tasks are fully entitled to services in Scandinavia (only

partly in Finland), while in Germany they are dependent on support from relatives or social networks. The predominance of domestic care in Scandinavia does not arise from an orientation on the part of care systems there towards the family but towards needs and control from a single source. Besides domestic services day care institutions also play an important role. They ensure meals, social participation and health monitoring also of elderly people who are not yet in need of care.

Table 2 contrasts the most important characteristics of Germany and Denmark as Scandinavian reference country. Key to this are the following principles: »solidarity principle versus the subsidiarity principle« and »needs orientation versus spending orientation«. With regard to the solidarity principle all members of a community take responsibility for one another, in the sense of institutional rather than voluntary solidarity. Institutional solidarity refers to authorities entrusted with the regulation of community affairs. This is the state with its various actors, including municipalities and social insurance bodies. With regard to the subsidiarity principle, by contrast, the state is at the end of the chain. Its services are complementary and subordinate, because in the first instance care is regarded as something to be provided and financed privately by the family and/or social networks. In combination with a governance logic interested less in individual needs than in keeping down public spending this leads to a narrow conception of care and to measures aimed at stabilising the role of the family as much as possible as the primary national care service.

Table 2:

German old-age care system in comparison with the Scandinavian old-age care systems on the example of Denmark

	Germany	Denmark
Basic principles	<ul style="list-style-type: none"> • Protection within the framework of the traditional social insurance logic (mandatory and private funds); care insurance as »partial cover insurance« • Emphasis on the subsidiarity principle (primacy of family and private provision) • expenditure orientation 	<ul style="list-style-type: none"> • State as the authority responsible for financing and providing services for all citizens (»universal resident provision principle«) • Emphasis on the principle of institutional solidarity • Needs orientation
Most important legal bases	<ul style="list-style-type: none"> • SGB XI (care insurance), SGB XII • Care-home laws of individual <i>Bundesländer</i> 	<ul style="list-style-type: none"> • Law on social services • Law on homes for the elderly and the disabled
Definition of »in need of care« and the range of services	<ul style="list-style-type: none"> • Legally watertight definition of »in need of care« aimed at controlling spending • Narrow definition of services (basic care + housekeeping) 	<ul style="list-style-type: none"> • Provision of services in accordance with individual needs • Close linking of eligibility, daily support and care
Eligibility requirements	<ul style="list-style-type: none"> • Membership of care insurance fund • Five years' minimum insurance period • Definition of »in need of care« within the meaning of §14 SGB XI 	<ul style="list-style-type: none"> • Resident of the municipality • Individual needs • Individual ruling of the local authority
Forms of benefits and services	<ul style="list-style-type: none"> • Attendance allowance for informal care • Financial benefits and benefits in kind on the domestic front • Flat benefits in the case of stationary care 	<ul style="list-style-type: none"> • Principle of benefits in kind • Caregiving relatives can obtain substitute jobs with the local authority in the case of full-time care (time limited)
Only care and + daily assistance	<ul style="list-style-type: none"> • Limited within the framework of care level 0 in the case of dementia sufferers; in principle, however, there is no legal entitlement 	<ul style="list-style-type: none"> • Yes
Controlling bodies	<ul style="list-style-type: none"> • Legal framework: federal government and <i>Länder</i> • Local needs planning: municipalities • Services management: system of self-administration on the part of funds and service providers 	<ul style="list-style-type: none"> • Legal framework: central government • Operational control: local government (municipalities)
Prevention	<ul style="list-style-type: none"> • Legal entitlement, but in practice not applied • Preventive approaches are in danger of being downgraded • Incentive structures go against preventive approaches 	<ul style="list-style-type: none"> • A practical approach characterises the definitions of assistance and care, including multidisciplinary occupational structures
Freedom of choice	<ul style="list-style-type: none"> • Yes 	<ul style="list-style-type: none"> • Yes (since 2002/2003)
Service providers	<ul style="list-style-type: none"> • Non-profit and commercial providers dominate • Municipalities have marginalised themselves 	<ul style="list-style-type: none"> • Primary: municipal services and institutions • Private providers (non-profit or commercial) play a bigger role in domestic services
Pattern of responsibilities	<ul style="list-style-type: none"> • Fragmented 	<ul style="list-style-type: none"> • Integrated
Financing of care services	<ul style="list-style-type: none"> • Social contributions (social care insurance) • Insurance premiums (private care insurance) 	<ul style="list-style-type: none"> • Tax financing • Fees for temporary services

Source: Author's presentation.

4. Formal Care and Day-to-day Support: Recipients of Benefits and Services, Forms of Benefits and Services and the Importance of Public Financing

There are still no internationally harmonised care statistics and, given the very different conceptions of care, they are not to be expected any time soon. The data evaluated in this and the following sections come from national statistics. They thus reflect different national systems and perspectives. This imposes certain restrictions on comparability, although it also has the advantage of not minimising differences but of bringing them to the fore.

In Germany care statistics are still a relatively new phenomenon. The first survey took place in 1999. Since then, every two years, with reference dates of 15 December (domestic services) and 31 December (stationary services) the number of institutions, of employees in the relevant occupations and of residents/patients in care is counted.⁴³ The care statistics are complemented by less detailed, but annually available statistics within the framework of federal public health reporting, and by the business statistics of social and private care insurance funds. Information on the current and capital expenditure of municipalities is provided by the accounting results of municipal budgets published by the Federal Statistical Office. There are no consolidated overall statistics that bring together the services/benefits and financing aspects of all public and private actors. It is no different in the Scandinavian countries. However, services are covered there by register-based statistics. The municipalities as the bodies responsible for services and benefits provide data on every age cohort by gender, form of service or benefit, duration of service/benefit provision (hours or number of visits) and sometimes other features

(in Iceland, for example, type of household). The financing side emerges from the accounting results of municipalities.

In accordance with the brief of this report the empirical analysis concentrates on formal care and assistance benefits and services for the elderly in a cross-sectional view on the basis of various features (region, age, gender), as well as longitudinally in order to clarify developments. The key findings, going into more detail in selected instances, are presented in what follows.⁴⁴

4.1 Empirical Comparison of Provision in Terms of Scope and Density

»Old age« as a period of life can be marked off in different ways. At the level of the individual ageing is a dynamic process not connected to external dates. Similarly, from a medical and labour economics perspective, however, the period between 60 and 75 years of age can be used. During this period health limitations arise increasingly and the proportion of the population needing daily assistance occasionally or permanently grows sharply. This is also the period in which people cease working. It therefore makes sense to define old age as the period of life after retirement. Despite the in practice increasingly smooth transition a statutory retirement age is usually laid down. In the majority of OECD countries it stands at 65 years of age, with a trend towards an increase to 67. My data analysis is oriented within this framework.

43 The legal basis is SGB XI (§ 109 para 1) in conjunction with the statistics regulation on attendance allowance of 24.11.1999, BGBl. I S. 2282.

44 Detailed data can be found in the long version of this study. See Tables 5 to 12 there.

Germany

At the end of 2009 2.34 million people were in need of care within the meaning of the Law on care insurance (SGB XI). This corresponds to a growth of 16 per cent on 1999. In 1999, people above 65 years of age represented 80 per cent of those in need of care and in 2009 the figure was 83 per cent. Of those receiving professional services nine out of ten are over 65 years of age. In the period under examination the age group 65 years of age or over rose by just under 27 per cent to 16.9 million and the age group 75 years of age or over by just under 26 per cent to 7.3 million. The number of recipients of formal services of the same age rose more sharply by around one-third: in 1999 around 1.6 million people in need of care aged 65 or over received just under 900,000 professional services; 10 years later 1.9 million people in need of care received 1.2 million professional services. The age group 75 years of age or over developed in parallel with this. Both people 75 years of age or over and the larger group of people 65 years of age or over the growth in ambulatory care services increased more than that of stationary services. Before people in need of care decide to enter a home full time, the options related to part-time residential care in case of need are exercised. The number of users of this form of service grew by 216 per cent between 1999 and 2009 (65 years of age or over) and 219 per cent (75 years of age or over), respectively; in other words, they tripled.

In the official German statistics the care rate describes the proportion of people in need of care in the respective population group at year end, regardless of whether provision is formal or informal. In relation to the overall population the proportion of people in need of care increased from 2.5 per cent (1999-2003) to 2.9 per cent, with the

care rate among women, at 3.76, nearly double that of men, at 1.92 per cent (Destatis 2011b: 8, Table 2.1). More than two-thirds of people in need of care (2009 = 1.62 million = 69.3 per cent) receive care at home; just under 31 per cent are in care homes full time. Domestic care is provided mainly by relatives. In 2009 1.065 million people in need of care (46 per cent of the 2.338 million people in need of care of all age groups) were cared for solely by relatives (recipients of attendance allowance in accordance with §37 SGB XI). Professional outpatient services were used by 550,200 people in need of care (2007: 504,200), partly complementing family care.⁴⁵

Regionally there is a clear north-south and east-west divide with regard to the official care rate. The highest care rate of 3.72 in 2009 was that of Mecklenburg-Western Pomerania, followed by other eastern Länder (Brandenburg, Thuringia, Saxony-Anhalt) with rates of 3.42. The lowest care rates are in the south in Baden-Württemberg (2.29) and Bavaria (2.55). The Destatis care statistics, with regard to the elderly, concern the age groups 75- 85 years of age, 85 to 90 years of age and the over 90s. With regard to these age groups the regional pattern generally remains the same. If one looks only at those from among people in need of care over 65 years of age who receive formal services and compare them to the overall population of the same age one arrives at a domestic care rate for 2009 of around 3 per cent.⁴⁶ The institutional (stationary) care rate rose from a little under 4 per cent in 1999 to 4.12 per cent in 2009. Taking outpatient and stationary care rates together, in 1999 just under 900,000 elderly people over 65 years of age (= 6.72 per cent of the corresponding population) received formal care services in outpatient or stationary form. The number of these recipients of services rose from just under 1 million (2003) to

45 As a result of the reform of 2008 the incentive to make use of outpatient benefits in kind or the services of part-time inpatient care in parallel with attendance allowance grew. The main reason is that the level of attendance allowance is no longer a restriction on using services. Thus one obstacle to making use of professional services on a complementary basis has fallen away.

46 Below 3 per cent if the reference dates of the German care statistics corresponding to the population as of 31.12 of the relevant year are used to arrive at the care rate and around 3 per cent if the population as of 1.1 of the relevant year is used. In the calculations of the author the population data of 1.1 are used as the basis because on this reference date Eurostat data are available differentiated by gender and age.

1.2 in 2009. This corresponds to a formal care rate of a little over 7 per cent. Among those 75 years of age or over the care rate is around double that.

Denmark:

Strong Shifts between Types of Services

In longitudinal terms the municipal reforms of 2007 represent a break. Statistics go up to 2007 and from 2007 begin anew with a number of different characteristics. Basically, we can distinguish between medical care services, personal care and practical daily assistance. The two latter categories are captured statistically under »home help«. »Home« in this instance means not only the original home but also care apartments. For the period 2007 to 2010, also taking into account older sets of data, the following findings are considered to be essential:

- The population over 65 years of age rose by 8.2 per cent; the number of users of home help services rose by 9 per cent, however (2007: 238,000; 2010: 260,000). Care services and practical assistance services underwent a different development. The group of those who received care services alone or in combination with practical help went down from 82,500 to 80,200 (-2.8 per cent). By contrast, the number of users of practical daily assistance rose by 15.4 per cent to 179,600 in 2010.
- The number of residents of care homes and other forms of assisted housing remained almost constant at around 5 per cent of the relevant population. Traditional care homes became significantly less popular (-28.8 per cent). The trend is in the direction of forms of housing somewhere between one's own home and a care home. Their proportion rose from just under 73 per cent (2007) to a good 81 per cent (2010).

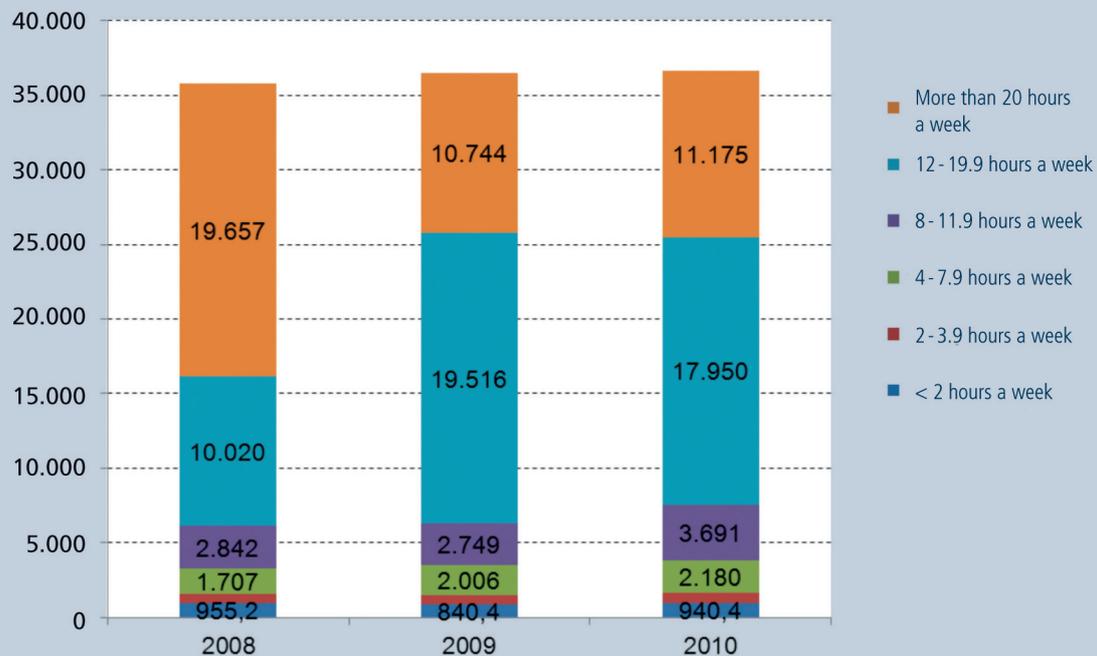
- Despite certain fluctuations around one-quarter of those aged 65 or over received assistance services on a permanent basis. The rate of those under 80 years of age fell slightly, while the rate of those over 80 years of age rose. Among those over 80 years of age two-thirds received care and/or daily assistance in 2007 rising to three-quarters in 2010. As already mentioned, granting benefits and services in Denmark does not require a need for daily minimum care; services for less than two hours a week are also possible. Figure 3 shows the distribution of residential nursing facilities. Most residents receive support services of 12 hours a week and more. The group of those receiving more than 20 hours a week fell. In 2008 they made up 55 per cent, but in 2010 only around 30 per cent. The need for care and assistance among those over 75 years of age rose sharply. This is reflected in a sharp increase in services. Those living without care and receiving no domestic assistance were positively besieged. After the instrument of preventive home visits became a municipal task in 2002 the number of users first rose, then came to hover around the level at the end of the 1990s. Each year significantly over 120,000 people or one-third of the relevant population use the services offered to them.

The latest innovation in the Danish care system is the introduction of a guaranteed waiting period for care accommodation of a maximum two months. The waiting time statistics show that the statutory guarantee was upheld by two-thirds of municipalities in the initial year and by three-quarters of them in the following year (2010).⁴⁷

47 Statistics Denmark, data set with Code AED16; author's calculation.

Figure 3:

Residents of nursing homes above 65 years of age by amount of time (hours a week) home-help services are received in Denmark: 2007 - 2010



Explanatory note: The statistics are based on data for 35,798 residents in 2008, 36,538 residents in 2009 and 36,671 residents in 2010.

Source: Statistics Denmark, data with Code AED05 (Number of recipients of permanent home help – nursing dwellings – by region, sex, type of benefits, hours per week, age and time); author's calculations.

Finland

Compared with Denmark, services in Finland are at a much more modest level.⁴⁸ Among people over 75 years of age the differences are particularly grave. In Denmark around two-thirds of inhabitants of this age are involved in the public service system. A small part of them live in care homes and sheltered housing; the bulk of them receive regular services or preventive home visits. By contrast, as of the end of 2009 in Finland only just under 22 per cent of people 75 years of age or over received formal care services. By comparison, in Germany the figure was 14 per cent.

Among both people 65 years of age or over and people 75 years of age or over the number of those receiving home care rose more than the relevant population. If one looks at developments since 1999 the rate of those receiving home care is fairly stable relative to the relevant population (Statistical Report 25/2010: 17). With regard to people over 75 years of age there was a slight increase to 11.6 per cent (2009), the target being 13-14 per cent. It obviously fell short. Regionally, figures range from 9.0 to 15.3 per cent; looking at local authorities in more detail the gap is even wider.⁴⁹ It was not the larger cities that managed to achieve the target range but the smaller dis-

⁴⁸ The data derive from the statistical reports of the National Institute for Health and Welfare (THL) (2010) and from information from the Ministry of Health.

⁴⁹ Statistics with Code Tr16_10- (Table 1 = Liitetaulukko 1. Kotihoidon laskennan piirissä olevat asiakkaat ja säännöllisen kotihoidon asiakkaat 30.11.2009); author's calculation.

tricts. There is also a large gap with regard to 24-hour care. The national average is 6 per cent for recipients of regular home care around the clock; the rate varies regionally between 3.3 and 22.2 per cent.

From 2000 to 2009 (reference date: 31 December) there was a constant increase in the proportion of sheltered housing at the expense of ordinary old people's homes and care homes (Statistical Report 25/2010: 17, Figure 1). In 2000 the rate of care home residents in the over 75 years of age group stood at over 5 per cent and that of residents of sheltered housing at under 2 per cent. In 2006 the two rates stood at around 4 per cent and in 2009 the rate of residents of sheltered housing exceeded that of care homes by 1.6 per cent. Over 70 per cent of residents were women.

Iceland

It must be borne in mind that home help services come within the scope of the Law on municipal social services; long-term care, geriatric services and care in the home come within the scope of the Law on elderly affairs. For the decade 2000-2010 the findings are as follows:

- The number of service recipients grew more (by 31.6 per cent) than the number of elderly people in the population (17.8 per cent). The proportion of women – 63 per cent – is much more pronounced than in comparable countries.⁵⁰
- Regardless of gender the increases in the uptake of services disproportionately concern single households. Data by »type of household« have been collected since 2004. From 2004 to 2010 the number of service recipients rose by 21.4 per cent overall. Among single men the increase was twice as high (42.4 per cent); among single women it was a little over the average (+28.2 per cent).
- Cutbacks in services and benefits provided due to the financial and economic crisis cannot be detected to date. The number of recipients of

services and benefits did not fall; nor did the quantity of hours per household. Although in 2009 this was below the levels of 2008 and 2007, it was above the levels in 2005 and 2006. This is an interim result. Only after a number of years will it become clear whether austerity policy led to statistically significant cuts in services for the elderly or not.

In Iceland there was also a shift towards home services and places in day care centres. The proportion of care home residents fell across all age groups. In the age group 70 to 74 years of age around 4 per cent lived in a care home in the first half of the 1990s, while in recent years it has been only 2.5 per cent. Among those 85 to 89 years of age around 37 per cent lived in care homes in the first half of the 1990s, whereas currently the figure is only around 25 per cent. Across all age groups the rate of those living in care homes fell from 10.7 per cent in 1993 to 7.5 per cent in 2010.

Norway

The Norwegian statistics differ from those in the other Scandinavian countries. Definitions differ and even the age group »the elderly« is differently demarcated, referring to those over the age of 67. I thus examined the available data for the period 1996–2010 concerning municipal domestic care services and daily assistance for this part of the population. The results were as follows:

- Although the population over 67 years of age in the period 1996-2010 grew by less than 1 per cent the number of those receiving home help and home nursing services alone or in combination rose by almost 25 per cent. This also includes younger cohorts, however. For 2010 provisional data are available on the age structure and the average weekly number of hours.⁵¹ The result: just under 80 per cent of recipients of benefits and services are aged over 50 and a little less than two-thirds are aged over 67. With regard to the age group 67-89

⁵⁰ Iceland Statistics, Table »Elderly households receiving municipal home-help service by type, sex«.

⁵¹ Statistics Norway, Table »Average numbers of assigned hours per week for users of home help and home nursing. Age and need for assistance. 2010«.

- the average number of weekly hours is below five, rising to 5.3 hours for those aged 90 or over.
- Since 2007 the number of old people taking up municipal home services is below the number a decade previously both absolutely and relative to the corresponding population. At the peak (2002) around one-fifth of the elderly population were recipients of benefits and services. According to the still provisional data for 2010 it is now only 17.3 per cent. Among those 80 years of age or over there has been a parallel development. The user rate of this age group went up to 40 per cent from 1998 to 2002 and then went back down again to 34 per cent today. The situation is different for the very elderly. Here the number of users has risen; one in two people in this age group receive home services.
 - Within Scandinavia Norway leads the way with regard to the scope of municipal services for the elderly, together with Denmark and Iceland (see Table 4). The rates of elderly and old people receiving home or institutional services are comparatively high. The gains observed in Denmark and Iceland with regard to home care at the expense of institutional provision and by general assistance services at the expense of what in Norway is known as »home nursing« and in Denmark as »personal care« are not discernible, however. The care home rate remains stable at 10-11 per cent of the relevant population.

Sweden

Municipal social services for elderly citizens are referred to collectively as »*Äldreomsorg*« (elderly care). Regular and temporary home help come into this category, as do meals on wheels, transport services and the installation of emergency alarm systems in the home. Our analysis covers the period 2000-2009. The most important findings are as follows:

- **Home help services:** The number of recipients of benefits and services over 65 years of age grew more sharply than the population of this age. As of 30 June 2008 152,854 people over 65 years of age who live in regular homes received municipal home help services (*Hemtjänst i ordinärt boende*) and as of 1 October 2009 the number was 177,332. The benefits and services recipient rate rose from 7.9 per cent (2000) to 10.8 per cent (2009). A parallel development took place among those over 80 years of age. Their rate rose to 22.5 per cent. This was a return to the level of 1993, with 23 per cent⁵² receiving home help on a permanent basis. Women's share of this was around two-thirds (Statistical Yearbook 2011: 449, Table 19.15).
- **Regional differences:** In Sweden's central districts (especially Jamtland, Dalarna and Västernorrland) and a few areas in the south, such as Kalmar, the municipal home help rates are over 11 to 16 per cent. In most southern districts, as well as in Norbotten in the extreme north, by contrast, only 5 to 10 per cent is achieved (Statistical Yearbook 2011: 441, Figure 19.3). Three-quarters of local authorities are in the mid-range or deviate by a maximum of 2 percentage points upwards or downwards. Among people over 80 years of age there are 20 local authorities in which there are rates of 30 per cent or more and at the other end of the scale there are 31 local authorities with rates between 13 and 16 per cent.⁵³ These numbers show that a low proportion of the elderly receiving municipal care does not necessarily mean that a particular local authority has a low proportion of people who are entitled to benefits and services. It can also mean that the share of private provision is disproportionately high.
- **Sheltered housing:** As in other Scandinavian countries – with the exception of Norway – home care and assistance are gaining ground at the expense of care in special facilities. In the period 2005-2009 the number of residents

52 Data for 1993 from: Socialstyrelsen 2008: 6.

53 Author's calculations based on data for all Swedish local authorities (Table »Antal personer 65- år i ordinärt boende som var beviljade hemtjänst den 30 juni 2008 fördelade efter ålder och kön. Kommunvis fördelning«).

among all age groups fell not only in relation to the relevant population but also absolutely. With regard to municipally managed institutions women make up 70 per cent of residents, with their share growing from age group to age group. Among people aged 65 to 74 women are still in a minority, whereas among the over 90s they account for 80 per cent of residents.⁵⁴

4.2 The Importance of Public Financing: A Brief Overview

In nominal terms spending on benefits and services by care insurance funds in Germany between 1999 and 2010 grew a little more than the number of elderly people; taking inflation into account,⁵⁵ however, real spending growth lagged significantly behind the growth in the number of people 65 years of age or over. Including the accounting results of municipalities – data are available up to 2008 – this finding is heightened because the chronically underfinanced municipalities cut their net spending on assistance for care and municipal institutions for the elderly by almost one-third in the period 2002-2008 alone. The result is that in 2002 1,360 euros of current resources were spent per inhabitant over 65 years of age, falling in 2008 to only 1,210 euros. The share of GDP spent by public authorities rose only if one looks solely at care insurance (1999: 0.77 per cent; 2010: 0.82 per cent), as a result of which the benefits and services improvements that came into force with the Long-term Care Further Development Act of 2008 ceased to work to correct previous decreases.⁵⁶

In the Scandinavian countries public spending per inhabitant aged 65 or over is many times higher than in Germany.⁵⁷ The shares of GDP (see Tables 2 and 3) are also of different orders of magnitude. Given the wider scope and benefit and service density this is not surprising. However, processes of mutual or unilateral convergence could be imagined: Germany could reduce the distance it has fallen behind, while the Scandinavian countries could fall behind due to restrictive spending policies. Comparative analyses of spending development over a decade or so (see Table 3) provide no evidence of this. Although Germany has been ageing much more dramatically than the Scandinavian countries growth in per capita spending, at 2.9 per cent, remains far below the Scandinavian level; the increase in GDP share is also lower. Spending per inhabitant in Denmark in 1999 was a good 460 euros above that of Germany; in 2010, however, the figure was around 788 euros. In relation to Sweden the tendency is the same. In 2006 the net per capita costs of Swedish local authorities (not including the disabled) was around 803 euros higher than that of the German social care insurance funds for all age groups (including the disabled); by 2010 the difference had risen to around 874 euros.

If one looks at spending only on people over 65 years of age the divergence increases. At the end of the 1990s Denmark and Norway notionally spent more than 3,000 euros more than Germany per inhabitant over 65 years of age. In 2010 the difference between Germany and Denmark and Sweden was over 5,000 euros and with Norway over 9,000 euros. The Norwegian data, however, are reduced to the level of Denmark if

54 Register as of 30.6.2008, Table 7 (Antal personer 65– år som bodde permanent i särskilt boende den 30 juni 2008 fördelade efter ålder och kön.); author's calculations.

55 Author's calculation based on: Eurostat, Table »HVPI – Overall index – annual average inflation rate« [tsieb060]; HVPI = Rate of change of the annual average of the harmonised consumer price index.

56 By including spending on investment and administration (including care home supervision) it comes to around 0.9 percentage points of GDP. Public and private expenditure together would yield a GDP share in the order of 1.1 to 1.3.

57 For comparison, in 2009 Germany had 19.3 times as many people aged 65 or over than Denmark (DE: 16.9 million; DK: 875,500), but the social care insurance funds spent only around 3.5 times as much in financial benefits and benefits in kind (DE: 19.3 billion euros; DK: around 5.6 billion euros).

Table 3:

Current public expenditure on care 1999-2009/2010 comparing Germany and the Scandinavian countries: annual expenditure by inhabitant (€)¹ and share of GDP (%)

	1999	2001	2003	2005	2006	2007	2008	2009	2010	Annual change (%)
Germany (care insurance: all age groups)²										
Population aged over 65 (1 January)	13.1	13.7	14.4	15.4	15.9	16.3	16.5	16.7	16.9	2.7
Spending as a % of GDP	0.77	0.76	0.77	0.76	0.74	0.72	0.73	0.81	0.82	0.5
Spending per inhabitant	189.5	19.9	201.6	205.8	207.9	212.0	221.4	235.7	249.7	2.9
Informal care	66.3	63.2	63.2	62.3	61.7	62.3	65.7	69.4	72.7	0.9
Formal care	123.1	131.5	138.4	143.5	146.3	149.5	155.7	166.1	177.1	4.0
Spending per inhabitant 65+	1,189	1,170	1,152	1,105	1,081	1,070	1,102	1,154	1,209	0.2
Informal care	416.3	379.7	361.5	334.5	320.7	314.7	326.9	340.1	352.0	-1.4
Formal care	772.9	790.1	790.9	770.5	759.9	755.2	774.9	814.2	857.3	1.0
Denmark (including disabled)										
Population aged over 65 ('000) (1 January)	790.5	791.9	798.4	812.5	823.0	834.7	853.0	875.5	902.9	1.3
Spending as a % of GDP	2.14	2.14	2.27	2.27	2.25	2.20	2.23	2.48	2.47	1.4
Spending per inhabitant	652.4	711.9	786.7	863.0	903.4	913.4	945.8	1,018	1,038	5,4
Care and assistance	604.8	666.7	721.0	794.0	835.1	840.2	856.9	908.9	906.5	4,5
Prevention	N.A.	N.A.	30.1	36.3	38.4	57.3	73.2	92.3	116.8	42.0
Care homes	47.6	45.2	35.6	32.7	29.9	15.8	15.7	17.1	14.7	-6.3
Spending per inhabitant 65+	4,385	4,808	5,305	5,747	5,958	5,960	6,071	6,410	6,357	4,1
Care and assistance	4,065	4,503	4,862	5,288	5,507	5,483	5,501	5,722	5,552	3.3
Prevention	0.0	0.0	203.2	241.7	253.4	374.1	470.1	581.1	715.4	36.9
Care homes	320.1	305.3	239.9	217.9	197.3	103.4	100.4	107.6	90.2	-6.5
Norway (long-term care: all age groups)										
Population aged over 65 ('000) (1 January)	688.0	678.8	673.6	677.7	682.5	685.6	693.3	704.8	722.7	0.5
Spending as a % of GDP	2.05	2.03	2.37	2.20	2.14	2.18	2.20	2.55		2.5
Spending per inhabitant	726	879	1,056	1,183	1,266	1,345	1,484	1,575		11,7
Institutional	501.6	594.9	699.7	755.6	800,2	834,6	919,3	976,4		9,5
Home	224.5	284.1	356.5	427.1	465.6	510.0	564.2	598.6		16.7
Spending per inhabitant 65+	4,692	5,831	7,138	8,039	8,606	9,181	10,137	10,725		12.9
Institutional	3,241	3,946	4,729	5,136	5,441	5,698	6,282	6,649		10.5
Home	1,451	1,885	2,409	2,903	3,166	3,483	3,855	4,076		18.1
Sweden (Elderly plus disabled; elderly not including the disabled): data for 2010 are provisional										
Population aged over 65 ('000) (1 January)	1,538	1,531	1,534	1,554	1,565	1,584	1,608	1,645	1,691	0.9
Spending as a % of GDP					2.8	2.8	2.9	3.0	2.9	
Spending per inhabitant (elderly and disabled)	945	1,065	1,211	1,271	1,317	1,373	1,445	1,459	1,495	5.3
Spending per inhabitant (elderly)					1,011	1,043	1,094	1,103	1,124	2.8
Spending per inhabitant 65+					6,425	6,611	6,867	6,824	6,832	1.6

Notes:

1 Euro conversion rate as of 10 June 2011.

2 Spending per inhabitant 65+ shows the notional spending per inhabitant 65+.

Source: Bibliography, Primary Sources.

the different purchasing power is taken into account.⁵⁸ The finding remains that there has been divergent development between Germany and the Scandinavian countries. Adjusting for various distortions due to methodological differences would not change this.

The basic tendency observable in Table 3 also remains if we bring Finland into the picture.⁵⁹ In 1999 Germany's per capita spending was 64 euros below that of Finland, but in 2009 it was 217.4 euros below it. With regard to notional spending per person over 65 the difference rose from 500 euros (1999) to 1,475 euros (2009). In the case of Finland it has to be taken into account that the country has built a Scandinavian type of welfare state only since the mid-1960s. Only in this context did a primarily publicly financed elderly care system develop. In 1980 only 34.74 euros per inhabitant was spent on benefits in kind for elderly care; by 1990 the amount had more than quadrupled (to 134.38 euros). This dynamic spending growth continued until recently; annual gross per capita spending on inhabitants over 65 years of age more than doubled from 1,000 euros (1990) to 2,290 euros (2009), with net spending around 20 per cent lower, however.

4.3 Summary

Table 4 presents the proportions of the generations 65+, 75+ and 80+ who received formal home services on the basis of full or partial public funding in 2009 in the countries under comparison and what proportions were looked after in care homes, assisted apartments or other sheltered

housing. As can be seen, the rate of what from a German standpoint are those in stationary care does not vary seriously between Germany, Denmark, Finland and Sweden. In Iceland it is twice as high, however, and in Norway almost two and a half times. By contrast, Germany is worlds apart from the level at which Scandinavian welfare states assist the elderly to remain in their own homes as long as possible. Germany has a good 19 times as many inhabitants over 65 years of age as Denmark. However, the number of those who, in accordance with the narrow German definition of care, were categorised as in need of care in 2009 is only around seven times higher than the number of those who receive constant home help in Denmark. The difference is least in relation to Finland and in the mid-range in relation to Sweden.

With regard to public spending the key finding is not that Germany allocates much less public funding to the care and assistance of the elderly per inhabitant or notionally per inhabitant over 65 years of age than the Scandinavian countries under examination. The decisive thing is rather that there is a creeping erosion of the fundamental pillars of the family-based system, in the absence of the prospect of a real increase in public resources directed towards a services-based system in public hands. Per capita spending is rising only nominally. If one takes into account general rates of price increases and the withdrawal of municipalities from the provision of services for the elderly notional spending per inhabitant over 65 years of age fell. The difference from the Scandinavian countries was not reduced but grew.

58 In 2007 Norwegian purchasing power per inhabitant was 53,477 PPP as against 35,961 PPP in Denmark (+ 48.7 Prozent), 35,961 PPP in Sweden, 34,700 PPP in Finland and 34,391 PPP in Germany. Data from Eurostat [Table code: THJO].

59 The same applies with regard to Iceland up to its rapid collapse. Developments since 2008 have been shaped by domestic inflation and a massive loss of external value (three-quarters) on the part of the Icelandic krone. Against this background we can scarcely say anything with any certainty.

Table 4:

Formal assistance and care provision for people over 65 years of age comparing Germany and the Scandinavian countries in 2009: care rates and public expenditure

	DE	DK ¹	FI	IS	NO	SE ²
Data on benefits and services: recipients of benefits and services as a % of the relevant population						
Age group: 65 years of age or over						
Home help and care (core services of the relevant system)	3.0	(30.4)	6.4	20.1	17.7	10.8 (12.5)
Residents of care homes, care apartments and sheltered housing	4.2	(4.8)		8.4	10.3	4.8 (5.8)
Overall proportion of the population in formal care (not including general old-age homes)	7.2	30.4 ¹		28.5	28	16.6
Age group: 75 years of age or over (DK, NO, SE 80 years of age or over); IS: data for 2010						
Preventive home visits		32.7				
Home help and care (core service)	6.0		11.6	35.3	34.5	22.5
24-hour service			6			
Other services (FI: social care)			1.5			
Residents of care homes, care apartments and sheltered housing	8.5		8.8	14.9		
Total recipients of benefits and services	14.5	75.2 ¹	21.9	50.2		
Public spending (euros per inhabitant 65 years of age or over)³						
Informal care: financial benefit	340			0.0		
Prevention measures		581				
Home care (under the relevant system); DE including technical help	224	5,722		(613)	4,076	
Institutional care (benefits in cash or in kind)	592	108		(541)	6,649	
Total benefits in cash or in kind ⁴	1,154	6,410	2,290	(1,154)	10,725	6,824

Notes:

- 1 Data in brackets: because residents of sheltered housing are at the same time users of home help they were counted twice. Spending on institutional care refers to net costs.
- 2 The rates in brackets include private arrangements (family care, private service providers).
- 3 Not including administrative spending. In the case of Germany also includes financial support for family care and spending by the social care insurance funds on the disabled and recipients of benefits and services under 65 years of age; in the case of DK, IS, SE and NO spending is given at the conversion rates of 11 June 2011. In the case of Iceland the euro amounts are strongly affected by the massive loss of external value of the Icelandic krone in the wake of the financial crisis and thus are put in brackets.
- 4 In the case of Denmark it includes spending on preventive home visits and elderly disabled people, but does not include financial benefits (they do not exist in Denmark).

Source: Bibliography, Primary Sources.

5. Support Structures of Formal Care and Employment Paths between the High Road and the Low Road

5.1 Support Structures: Private Sector versus Municipal Responsibility

By contrast to the strong public responsibility that exists in the Scandinavian countries, despite opening up to private providers, in Germany the majority opt for freedom of choice, which is offered by mixed support structures. With regard to care this argument misses the point. Although there is a large number of care providers the tendency increasingly is for their business models to be shaped by commercial motives. The private commercial realm was able to increase its market share – share of recipients of benefits and services – from 1999 to 2009 in ambulatory care by almost one-third and in stationary care by over 38 per cent. The involvement of non-profit organisations in both outpatient and stationary care diminished, relatively speaking. Public providers play only a marginal role in ambulatory care (share below 2 per cent) and in the case of institutional care, because of the withdrawal of the municipalities, not only did the share of public care fall from 11 per cent in 1999 to 6.5 per cent in 2009, but the number of beds decreased (1999: 59,800; 2009: 55,000)⁶⁰ A provision structure has developed that completely ignores the desire of many elderly people to be admitted to a municipal institution rather than a private commercial or a politically and ecclesiastically motivated provider.

Developments in the *Länder* have largely paralleled those at the federal level. Differences in the initial conditions thus need to be considered:

- **Ambulatory care:** In 1999 non-profit providers clearly dominated. In six *Länder* they achieved market shares of over 60 (Thuringia: 61 per cent) to over 80 per cent (Baden-Württemberg: 84 per cent). In the subsequent decade the number of *Länder* with non-profit providers with market shares of over 60 per cent halved. The development of private commercial providers went in the other direction. In 1999 in the city-states of Berlin and Hamburg alone they achieved market shares of over 50 per cent. A decade later they are dominant in eight *Länder* (including in all eastern German *Länder*). It is because of the low starting level that their position in southern Germany remains limited, despite the above-average growth there. Public providers play a role only in Baden-Württemberg and Hesse. Contrary to the national trend their market share in Baden-Württemberg has risen from 3.8 to 4.3 per cent and in Hesse from 7 to 7.5 per cent. Only in these two *Länder* did a small part of the loss of market share on the part of church and non-profit providers not go to commercial providers.
- **Stationary care:** Stationary care is also characterised by the fact that the growing volume of provision is being overwhelmingly absorbed by private commercial providers. In 1999 they achieved shares of care provision of over 30 per cent in only four *Länder* (Berlin, Hesse, Lower Saxony, Schleswig-Holstein). A decade later they are above the 30 per cent mark in 10 *Länder*; they dominate the market in Berlin, Lower Saxony and Schleswig-Holstein. The

⁶⁰ More precise data may be found in the long version of this study (see Tables 17 to 19).

number of Länder in which church provision dominates has been reduced to two (Saarland and North Rhine-Westphalia). Public providers were serious players in at least six Länder in 1999 (Bavaria, Baden-Württemberg, Hamburg, Saxony, Thuringia, Mecklenburg-Western Pomerania) with over 15 per cent. In two other Länder (Berlin, Schleswig-Holstein) they were at a little over 10 per cent. Public provision is not nationwide, but does exist in half of all Länder. The municipalities have relinquished their control function in this respect. In 2009 only in three Länder did public providers still have a market share of over 10 per cent (Thuringia, Baden-Württemberg, Bavaria).

Private service provision has tended to increase in the Scandinavian countries, too. However, there is no comprehensive privatisation trend. In Norway, for example, statistics show the private share since 2001. There has been no gain in market share on the part of private providers (non-profit and commercial) since then (2001: 10.7 per cent; 2010: 10.8 per cent).⁶¹ In Finland, too, where private providers have traditionally had a stronger position than in the other Nordic countries there is no comprehensive privatisation trend. In the case of care homes although in recent years the municipal share has fallen slightly to 86.6 per cent (reference date: 31 December 2009) it has risen slightly in the growing market segment of sheltered housing with 24-hour service (2008: 43.7 per cent; 2009: 47.2 per cent). While in Germany both outpatient and stationary care is on the path of growing commercialisation the Scandinavian countries are characterised by a range of developments. Regionally, too, inferences cannot be made about other regions from, for example, the situation in and around Helsinki. From a regional perspective,⁶² the share of private providers in care home provision was below 5 per cent in eight out of the 19 Finnish provinces; in eight others it was between 5 and below 10 per cent. Only in three provinces did they achieve a share of over 10 per cent of provision. The high-

est private share has been achieved by Uusimaa in southern Finland, with a good 39 per cent. Analysis by local authority provides a similar finding, without indicating a clear link between geographic location and/or size of municipality. For example, the two largest Finnish cities – Helsinki (around 580,000 inhabitants) and Espoo (around 242,000) – are in Uusimaa. Helsinki has a private market share of around 55 per cent, Espoo of only around 5 per cent. The spread is also considerable with regard to sheltered housing with 24-hour service. Here, however, there is a connection with the size of the local authority: we find above average private shares primarily in large and medium-sized towns; in smaller local authorities municipal institutions dominate.

Of particular interest are developments in Denmark and Sweden since the municipal monopoly was abolished. In the institutional domain, in 2010 in Denmark only 1.1 per cent of the 44,883 care home residents over 65 years of age had private providers. Extrapolating from the trend established in the wake of the opening up of the market in 2002, it took a decade or more for private providers to achieve significant shares of care provision. In the domestic domain things were otherwise. With regard to practical services private providers now (2010) have a market share of 25 per cent. In the case of care and support activities proper, by contrast, there has been impressive growth. Given the low starting level the share rose fairly modestly from 2007 to 2010, however, from 3.9 to 5.6 provision. In Sweden, too, where the opening up of the market occurred a decade earlier, private providers have gained only limited ground. It is possible to draw conclusions about domestic care only indirectly, however, because the Swedish statistics do not distinguish providers, but only forms of management (municipal versus private). Private service provision is based on financial benefits paid to caregiving relatives or private service providers. On the reference date of 1 October 2009 86.2 per cent of long-term home help recipients made use

61 Statistics Norway, Table »Institutions for the aged and disabled. 1996-2010«, updated 12.7.2011.

62 Liitetaulukko 1. Vanhainkotien ja vastaavien yksiköiden asiakkaat 31.12.2008 maakunnittain ja kunnittain (»Clients in residential homes for older people and other similar units on 31 December 2008, by region and municipality«); author's evaluation.

of municipal arrangements and only 13.8 per cent made use of private arrangements. In the case of recipients of temporary services the private rate was even lower (10.4 per cent). The on average low importance of private service provision conceals large regional differences, however. In eight of the 21 Swedish regions (among others in Västra Götalands, Jönköping and Örebro) there is practically a municipal monopoly, with over 95 per cent. In eight other regions the private share is between 6 and below 14 per cent, with over 15 per cent in the five remaining regions. The privatisation of elderly care is concentrated in the Stockholm region and neighbouring Uppsala. In greater Stockholm the private share is three times the national average, at 42 per cent. Findings are similar in relation to care homes and sheltered housing. Here the share of private providers – with regard to residents – is 16.5 per cent across the country, but 43.6 per cent in the Stockholm region.

5.2 Employment Paths: High Road versus Low Road

Historically, care tasks have always been a woman's domain. In Germany almost 80 per cent of the burden of informal care in families falls on women⁶⁴ and in the formal realm women make up a comparable proportion of those employed in it. In the Scandinavian countries, too, care work has a female face, whether in the family or in the care sector. There the similarities end, however. In the Scandinavian countries the care sector offers many times more jobs per 1,000 inhabitants than in Germany. This is despite the fact that the proportion of older people in the

population is lower and the on average better state of health of the generation over 65 years of age (see Figure 2). These jobs do not offer particularly generous wages, but decent earnings and working conditions. Add to that a comparatively high level of professionalisation with full-time employment as the norm and a living wage, even for the low qualified and part-time workers. While the Scandinavian route takes the »high road«⁶⁵ German policy has set a course that entails that the care sector has been forced into the low wage domain with part-time working as the rule and a comparatively low level of professionalisation. A problematic conception of productivity (see Reuter/Zinn 2001: 465f.) has a role in this, as has the low valuation of activities outside what Germany's export-oriented economy defines as proper to it.

Let us look at some of the key findings of the empirical evaluation.⁶⁶

Employment Development

The importance of Scandinavian elderly care with regard to employment is greater than might be expected with reference to the wider scope of formal services. In the domestic realm the virtual absence of unpaid »shadow care« and in the institutional realm work with better personnel ratios than are usual in German care homes come into play. The three Scandinavian core countries were used for a closer comparison. In the municipal sector alone there are three to four times as many employees per 1,000 elderly people than in Germany (regulated area of care insurance). As Table 5 shows, the difference with regard to full-time equivalent employees is greater than in the case of head count. Behind this stands an ambiv-

63 Source: Serviges officiella statistik 2010: Äldre och personer med funktionsnedsättning – regiform m.m. för Vissa insatser år 2009, Socialstyrelsen, March 2010, Table 1 and 2 (pp. 24-37).

64 These women are mainly in a family relationship – wives, daughters, daughters-in-law or granddaughters – with the person receiving the care. Where women are not available men are increasingly taking on caregiving roles.

65 The High Road represents a positive relationship between high needs-oriented service quality and high professionalism with comparatively good working and wage conditions (see Bosch/Lehndorff 2005).

66 Taken from the German care statistics and health care reporting we evaluated the data on employees in ambulatory and stationary care by occupation and type of employment relationship. The evaluation of the Scandinavian countries is based on statistics on employment by economic branch and the primarily on statistics on the development of municipal employment (local authorities and counties) by wages, fields of activity and region. For details see the long version of this study.

alent development. Purely quantitatively the German care sector registered a strong increase in employee numbers since 1999 of 46 per cent (ambulatory) and 41 per cent (stationary). The total number of employees grew from 624,700 (1999) to 890,300 (2009) and employment density per 1,000 elderly people from 47.8 (1999) to the value given in Table 5 of 53.2 per cent. To a large extent this growth was fed by the strong increase in part-time employment, including a strong increase in marginal employment in the western *Länder*; the full-time employment rate fell from 43 to 31 per cent. Part-time employment dominates in all *Länder*. In the case of ambulatory services it has almost reached the 80-per cent mark (Baden-Württemberg, Bavaria, Lower Saxony, Schleswig-Holstein) and also in care homes part-time rates are generally around 60 per cent. Employment has also risen in the Scandinavian countries. To some extent density ratios increased once again, rising, for example, in Norway from 140 notional full-time employees per 1,000 elderly people in 1999 to 198 in 2010. However, there has been no expansion of full-time employment.⁶⁷

Occupational Structure and Level of Professionalisation

From 1999 to 2007 in Germany there was a trend towards occupations with higher qualifications. Since then, however, this has gone into reverse. While the proportion of care workers in ambulatory services rose from 49.4 to 57.1 per cent it then fell again to 54.5 per cent. Developments in care homes parallel this (1999: 31 per cent; 2007: 36 per cent; 2009: 34 per cent). Whether this is to be interpreted as mere consolidation or a break in the professionalisation trend will become evident over the next few years. Many providers, at any rate, rely increasingly on cheap labour. Because occupations with higher qualifications have a

much higher rate of full-time employees than occupations with lower qualifications, however, the conclusion suggests itself that the marginalisation of regular full-time work in favour of atypical employment will not leave the qualification structure unscathed. If atypical employment continues to expand we cannot expect progress with regard to professionalisation. In the Scandinavian countries things have developed differently. In Denmark the qualification level remained stable, but shifted from care workers to educators and physiotherapists. In Norway employment has concentrated more on highly qualified occupations than in Germany and in recent years this has increased; in 2005 care workers made up 66.4 per cent and in 2010 68.7 per cent. When evaluating this development the fact that care occupations in Germany are at a lower level of professionalisation than in the Scandinavian countries must be taken into consideration.⁶⁸ While accredited care staff (»nurses«) in Scandinavia have an upper secondary education (ISCED 3) with a subsequent short course of study of three to four years German technical colleges require only intermediate school-leaving qualifications, and in the case of carers of the elderly even only a *Hauptschulabschluss* (basic school-leaving qualification).⁶⁹ Scandinavia has been implementing the qualificatory upgrading of previously semi-professional care and therapy occupations since the 1970s (see Heintze 2007: 278ff.). This ties in with the expansion of women's employment and dual equality: equality by reducing discrimination against women in the employment system and equality by raising the levels of care and therapeutic occupations, to the effect that medicine and care are at the same level. As in the Netherlands a general care training has been established. German policy has been reluctant, even dismissive with regard to the academicisation of traditional care and health occupations.

67 In Denmark full-time is the rule, with nine out of ten employees in the public sector working full time, and just under eight out of ten in the private sector. In Sweden full-time working plays a much smaller role. In the period under examination the proportion of full-time employment grew, however (2000: 38 per cent; 2005: 44.9 per cent).

68 On the development pension funds care training paths in Germany and other energy efficiency countries see Dielmann (1998), Robert Bosch Stiftung (2000), Rennen-Allhoff (2000), Rennen-Allhoff et al. (2000), Lamers/Lau (2002), Kümmerling (2009) und Schön (2011).

69 As a consequence registered German carers of the elderly are not employed as »nurses« in Denmark, Finland or Sweden, but as social or care assistants.

Although there are courses of study for nursing care, with few exceptions this concerns new occupations still with very low numbers of employees and not the qualificational upgrading of established occupations with a longer tradition.

Job Satisfaction

The »Nurses Early Exit Study« (NEXT) provided comparative European figures on the basis of organisational analyses and surveys carried out between autumn 2002 and autumn 2004 in 11 European countries.⁷⁰ In Germany those questioned indicated a comparatively low level of satisfaction with their working conditions and, as a consequence, a relatively high willingness to

quit. In Germany 46 per cent job satisfaction was achieved on average in comparison to 85 per cent in Norway (highest value) and 64 per cent in Finland. The spread in relation to the German care homes investigated ranged from 20 per cent and 80 per cent satisfaction. A quarter of care homes showed one-third satisfaction with colleagues and a quarter at the other end of the scale showed satisfaction of over 60 per cent. This polarisation is typical of the low road. The image of care as an occupation and career prospects were also evaluated negatively by those questioned (DBFK 2009; Schmidt et al. 2011; special analysis by the DGB-Index »Gute Arbeit«⁷¹). More recent studies came up with similar results.

Table 5:

Density of employment (by 1,000 inhabitants over 65 years of age; Norway: 67) in 2009: Germany and the core Scandinavian countries

	DE	DK ¹	NO	SE ^{1,2}
Full-time and part-time employees	53.2	144.2		164
Home (ambulatory) care	16.1	70.8		
Institutional (stationary) care	37.1	73.4		
Full-time equivalent employees	37.6	119.5	198	
Home (ambulatory) care	10.6			
Institutional (stationary) care	27.1			

Explanatory note:

Included are employees of the respective national care systems. The calculation of density ratios was done with regard to Germany, Denmark and Sweden on the basis of population figures as of 1 January. The Norwegian figures, by contrast, derive from official statistics (year-end population data).

Notes:

- 1 Not including the private sector or private arrangements.
- 2 The data on Sweden refer to 2005 (SALAR 2007).

Source: Germany: <http://gbe-bund.de/> (data accessed on 5.7.2011); Denmark: Tables »Earnings for local government employees by sex, components, occupation« (Code LON 42) and »Staff in measures for elderly people, full-time employees by function, region and time« (Code RES10); author's evaluation.

70 Cited from: »Die NEXT-Studie – Relevanz der Ergebnisse für Deutschland«, presentation at the 36th delegate assembly of the Berufsverband für Pflegeberufe (DBfK) on 30 April 2005 in Berlin. For this and further information materials see www.next-study.net.

71 »Sonderauswertung des DGB-Index »Gute Arbeit« – Kranken- und Altenpfleger beklagen schlechte Arbeitsbedingungen« [survey: carers for the sick and the elderly complain of poor working conditions], available at: <http://presse.verdi.de/aktuelle-themen/Pflegedienste> (6.5.2010).

Remuneration

Employees in the care sector are engaged in very responsible and frequently onerous activity. Pay varies. Data from wage structure surveys are not available for Germany.⁷² The conclusion that emerges from surveys and a multitude of individual findings, however, is that fewer than one-third of those caring for the elderly receive gross monthly wages of more than 2,000 euros, while one-third of those working full time receive less than 1,500 euros. In 2010 a minimum wage of 8.50 euros per hour in western Germany and 7.50 euros in eastern Germany was introduced.⁷³ In fact, minimum wages are supposed to protect care assistants against further wage dumping. The indications are, however, that even registered carers often receive only the minimum wage. According to *Lohnspiegel* Care surveys⁷⁴ a significant portion of employers do not keep to the minimum wage provisions. It fits with this that monitoring is laxly regulated and statistics are not even kept on it.⁷⁵ The services provided by those employed in the care sector in the Scandinavian countries contrast with the situation in Germany. It emerges from the evaluation of municipal services statistics in Denmark that the level is consistently higher and that in the previous decade nominal wage rises were clearly above the rate of price increases. Even the hourly wages of low to medium qualified workers are above the level of care workers in Germany. German elderly care workers which are employed as assistants in Danish elderly care homes can count on an hourly

wage of 16 to 17 euros or a monthly wage without supplementary payments (shift allowances and so on) of 2,600 to 2,800 euros (plus shift allowances; based on a 37-hour working week).⁷⁶ Figure 4 presents the development of total gross hourly wages for personal care workers, by lower quartile, upper quartile and median from 1999 to 2009. We can gather from this that after substantial wage increases in 2009 hourly wages of a median 25 euros in domestic care to 28 euros in institutional care can be obtained. Allowances based on, for example, shift services are included, along with Christmas bonuses, holiday pay and so on. In Norway wages are higher. This is qualified by the per capita higher GDP and the higher average income. Care assistants earned on average 31,600 NOK (around 4,016 euros) a month in the health care system there in 2010 and care workers received a monthly wage of 34,600 NOK (around 4,398 euros).⁷⁷ Wages are similarly high in municipal social services. Home helpers receive a lower wage, however, averaging 28,000 NOK a month (around 3,559 euros).⁷⁸ On Sweden data are available only up to 2005 (SALAR 2007: 63, Table 29). According to them workers in municipal care services in 2005 received monthly wages of between 1,982 euros (care assistants) and 2,540 euros (care workers) at current exchange rates. Finland had the lowest income level within Scandinavia. The median in the public sector lay at 2,772 euros a month gross in 2010.⁷⁹ Nationwide, there has been a care minimum wage of 2,100.39 euros since 1 January 2010.

72 The data of the German Federal Statistical Office include public sector collective agreements. Because hardly any ambulatory services are provided publicly and the public sector also plays a minor role home care (see above) these data are not indicative for the sector as a whole. This is even more so because church providers are less and less taking their bearings from public service agreements.

73 The minimum wage applies only to care workers who provide basic services in accordance with SGB XI, but not to those providing household services and dementia carers.

74 See: www.konfliktfeld-Pflege.de/ > Arbeitsrecht > Lohnspiegel Pflege 2011 (13.9.2011).

75 See in this connection the answers given by the federal government to an inquiry by the Greens. Source: BT-Drs. 17/4133 v. 7.12.2010 (Antwort der Bundesregierung auf die Kleine Anfrage der Abgeordneten Beate Müller-Gemmeke, Elisabeth Scharfenberg, Birgit Bender, weiterer Abgeordneter und der Fraktion Bündnis 90/DIE GRÜNEN, Drs. 17/3590: Arbeitsbedingungen in der Pflegebranche und Kontrolle des Pflegemindestlohns).

76 Currently (18.9.2011) Jobhunter.de offers one of the usual starter packages. It includes a 26-week Danish language course including free accommodation, board and 80 euros per day, followed by a permanent position in a care home (full time, 37 hours a week, wages: 2,600 euros gross + shift allowances).

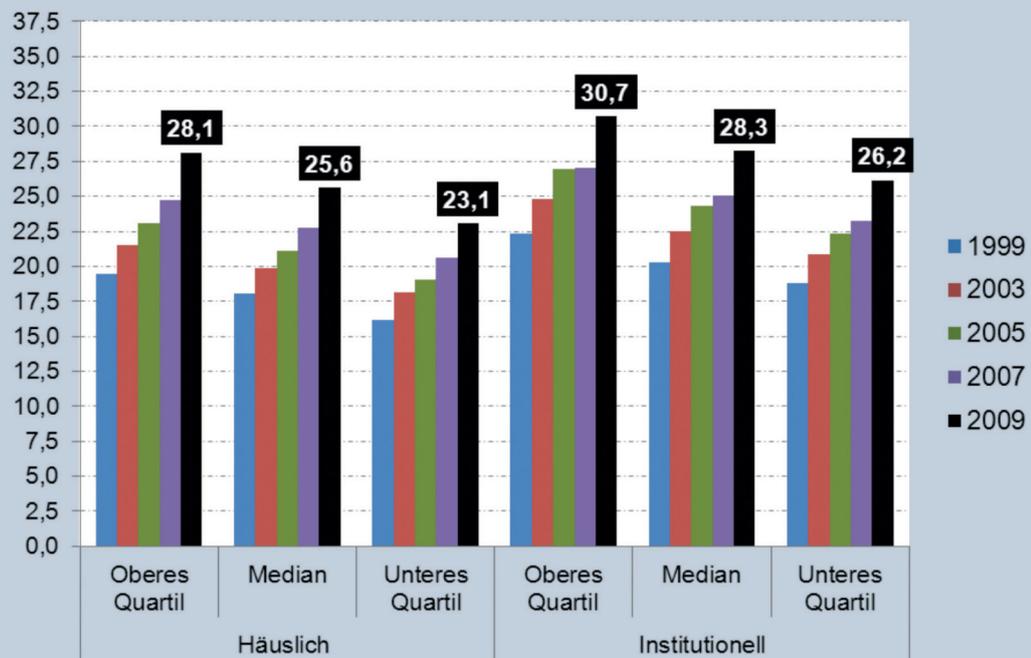
77 Statistics Norway, Table »Average monthly earnings for full-time employees in human health activities, per 1 December 2009 and 2010, by occupation. NOK and percentage change«, 3.9.2010.

78 Statistics Norway, Table »Average monthly earnings for full-time employees – municipalities and county per 1 December 2009 and 2010, by industry. NOK and percentage change«, available at: http://www.ssb.no/lonnkomm_en/tab-2011-03-16-03-en.html (15.9.2011).

79 Data from: Centre for Economic Development, Transport and Environment (no date): Foreign Nurses' Guide to Finnish Working Life 2010: 15.

Figure 4:

Development of hourly wages (gross) of care workers in the Danish municipal home-help service: 1999-2009



Explanation: Conversion into euros was based on the exchange rate of 10 June 2011; hourly rates include collectively agreed special benefits.
Source: Statistics Denmark, Table »Earnings for local government employees by sex, components, occupation« (Code LON42); author's evaluation.

6. Summary

Undoubtedly, a highly developed public infrastructure for care and assistance is of enormous benefit to society. The fact that it can form part of a growth and innovation strategy that creates high quality employment opportunities without additional strain on the environment is largely unrecognised in Germany, however. The Scandinavian countries examined in detail here prove that export success and a high quality public care infrastructure can go well together. However, this requires that it be based on social needs. The partial-cover mentality of care insurance and the commercialisation of provider structures run counter to this. A fundamental contradiction emerges: on one hand, the social binding force of traditional family models has declined markedly; on the other hand, the economic and social structures founded on it remain in place. There is no services policy that takes account of the changes in family models. Instead, there is a divided agenda in accordance with which modernisation is pursued only to the extent that it does not cost anything and thus contributes to cementing existing conditions, not to transforming them.

It is also a hindrance that services policy in Germany is one-sidedly market oriented. Whether the related activities are of use to society or not does not really count. Policy places a high value on service domains that can be considered a kind of appendage of the export-oriented production sector. Domestic market related services are valued less. The large discrepancy between wages paid in manufacturing and those paid in (private) services is a result of this.

The marginalisation of the care sector in the realm of low wages falls within this context. In order to understand the logic of the process underlying this the interaction of care policy, financial policy and labour market policy must be understood. The governance of care service pro-

vision in Germany is not quality-oriented in accordance with social need, but in the direction of keeping down public spending. A definition of care limited to physical handicaps has the function here of keeping down the proportion of people in need of care under the law, while hindering the acquisition of professional high qualifications by care workers and assistants is intended to ensure that demands for higher pay do not even emerge. The fact that informal care provided by relatives is not subject to wage replacement payments, as is the tendency in the Scandinavian countries, but only a token of appreciation known as attendance allowance boils down to the fact that in a family-based care system, as in Germany, caregiving relatives are assigned the role of a cheap care service. It is overwhelmingly women who privately bear the costs of what tax and contribution payers are spared.

Demographic change puts family-based systems under much more pressure than services-based systems because (see Section 2) constantly low birth rates are one of the unintended consequences of the lack of a broad care infrastructure. There are several ways of reacting to that. A progressive solution would be a paradigm change towards governance based on needs and quality. However, this is not on the political agenda. This would require that financial policy aimed (once again) at a higher government spending ratio. In fact, the policy of reducing the government spending ratio was not even interrupted short term in response to the financial crisis. If there is no political will to provide a financial framework required for high quality care another »way out« is labour market policy. Here the labour market reforms of Agenda 10 come into play. One of its substantive and even achieved aims (see among others Kalina/Weinkopf 2010) was the expansion of the low wage sector. It was argued that better

employment opportunities would be created for the low qualified (see Fels et al. 1999). While the employment situation of the low qualified and the long-term unemployed has not improved (see Heintze 2010b) people with good occupational training were marginalised in the expanding low wage sector. The negative spiral of the low road was thus set in motion. In the case of care this labour market policy encountered a branch that, due to low contribution rates and increasingly private commercial structures, did not have the necessary resources to counteract it. Wage dumping is difficult in the public sector because of the comparatively high level of coverage by collective agreements. According to the collective bargaining agreement for civil servants 2011 care assistants currently receive between 1,753 and 1,996 euros a month gross and registered employees between 2,050 and 2,352 euros. Care workers with municipal employers bound by collective agreements thus receive wages above the minimum wage, if they work full time. In the past non-profit providers oriented themselves to public service tariffs. Under increased cost pressure, however, a development got under way or accelerated in accordance with which wage dumping became increasingly common even among church providers. Marginalisation of the care sector in the low wage sector received extra momentum from the withdrawal of the municipalities

from the running of care homes. The massive shift of provider structures (see Section 5.1) in the direction of private commercial providers fits in here. Because of widespread lack of collective agreement coverage wage dumping became particularly easy in the private commercial sector. A segment of this is directed towards people in need of care in the higher income brackets. Here the staff are generally paid normally. At the other end of the scale are care homes in which health-endangering care is provided and employees are massively exploited. Here are concentrated the employers that do not even comply with the minimum wage provisions.

In the author's opinion, without a paradigm change in care policy and its financing it will not be possible to break the negative spiral in both quality and achievability of good care and social assistance, as well as in the working conditions of those active in the care sector. Much more engagement on the part of the municipalities as service providers is needed here, as well as reforms of occupational care training oriented towards higher qualifications. Scandinavian countries have ideas and good political praxis at their disposal for future-oriented reforms. They show that a care and assistance system oriented towards society's needs, which at the same time offers good quality services and working conditions, is a matter of political will.

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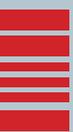
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