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Stream 14: Transformation of long-term care in ageing societies. Causes, patterns and consequences of policy development

Stream convenors: Tine Rostgaard (SFI – The Danish National Centre for Social Research) and Virpi Timonen (Trinity College Dublin)

Universitat de València - ERI POLIBIENESTAR.
Edificio Institutos-Campus de Tarongers. Calle Serpis, 29. 46022. Valencia.
Phone: (+34) 96.162.54.12– C.I.F. Q4618001-D
Email: espanet2011@uv.es

Combining universalism, cost containment and family care-giving:

Long-term care Insurance in Germany

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Universitat de València - ERI POLIBIENESTAR.
Edificio Institutos-Campus de Tarongers. Calle Serpis, 29. 46022. Valencia.
Phone: (+34) 96.162.54.12– C.I.F. Q4618001-D
Email: espanet2011@uv.es

Hildegard Theobald

University of Vechta

Centre for Research on Ageing and Society

Driverstr. 22

49377 Vechta

Germany

hildegard.theobald@uni-vechta.de

Abstract

With the introduction of Long-term Care Insurance (LTCI), Germany established a policy scheme to secure funding and provision of long-term care in a situation of demographic and social changes. Until the mid-1990s, responsibility for providing care to older adults in Germany lay with the family. Only where family members were unable to provide sufficient care did welfare organisations step in - publicly refunded after a means-test within a social assistance framework. LTCI was designed to combine three goals – to provide universal public support in a situation of care-dependency, to control costs related to care provision and to maintain family care-giving. The goals should be achieved first, by the introduction of a new type of universal social rights defining a medium level of public support, secondly by the definition of a cost ceiling related to public expenditure and thirdly by an emphasis on family care embedded in re-organised formal care provision. While the design of the scheme, the funding principles and the re-organised care provision enabled cost containment, LTCI has resulted in unequal outcomes along the dimensions of gender, socio-economic class and ethnicity. In the focus of the paper is the analysis of the interrelationship of the elements of the LTCI – social rights, funding principles and family care – and its impact on the emergence of distinct inequalities visible in difficult situations within informal, family and formal care provision. Inequalities related to care gaps and care burden for distinct social groups question the idea of sustainability, i.e. to provide universal public support which enables the development of a user-oriented and comprehensive care provision without overburdening informal, family carers. Conceptually, the paper is based on approaches developed within the framework of international comparative research on care to analyse policy design, outcomes as well as care provision and funding. Empirically, it includes statistics on the use of different types of benefits and care provision and on the corresponding situation of care users, their families and paid carers.

1. Introduction

With the introduction of Long-term Care Insurance (LTCI) in Germany and the reforms since then, public long-term care support has become considerably restructured. Before the establishment of LTC the responsibility for providing care to Germany's elderly population lay mainly with the family, while based on the principle of subsidiarity

public support was only available after a means-test. Despite the still dominating family-orientation of long-term care provision, with the introduction of the policy scheme the traditional mode of family-orientation were embedded in a newly-defined interplay of state, market and civil society with regard to care provision, funding and regulation (Esping-Andersen 1999; Bettio & Plantenga 2004; Burau, Theobald & Blank 2007).

With LTCI a social-insurance based long-term care scheme was established to grant universal public support in defined situations of care dependency, to construct a sound funding system and thus to secure an adequate and user-oriented care provision. The policy scheme aimed to promote ageing in place in particular based on family care provision. LTCI in Germany was created at the beginning of the 1990s in a situation of welfare state constraints characterised by criticism towards comprehensive public welfare spending and an increasing emphasis on individual responsibilities and market solutions (Landenberger 1994; Meyer 1996). The law on LTCI aimed to combine several goals; i.e. the introduction of universal social rights, the promotion of family care and the expansion of a market-oriented care infrastructure and relate them to cost containment policies; i.e. to contain present and expected future costs (Theobald 2011a,b). Within the German context, sustainable care provision should be enabled by a combination of universal social rights oriented towards family care supported by market-oriented formal care provision embedded in a cost containment strategy.

Prevalent care arrangement patterns emerging within the framework of LTCI still confirm a family-oriented strategy of long-term care provision mainly supported by cash payments. However, a more detailed analysis of current care arrangement reveals considerable differences of the interplay of family care and professional care provision depending on gender, socio-economic class and ethnicity. Furthermore, the unequal care arrangements may be related to care gaps and an overburdening care situation for informal, family carers. The development even questions the goal of LTCI to construct a sustainable policy scheme; i.e. to promote universal and adequate domestic care provision within the family context.

The paper analyses the diverse arrangement patterns within the family-oriented strategy of long-term care provision characterised by a distinct interplay of informal or formal care provision. It proceeds on the assumption that the institutional design of LTCI and its underlying ideas impact significantly on the emerging unequal pattern of formal and informal care arrangements. This concerns in particular institutional designs defining the private-public mix related to social rights, funding principles and regulation of care provision. The paper starts with a conceptual part, where, based on approaches and findings within international comparative research on social care and public policy, significant dimensions of institutional designs are elaborated and combined with conceptional tools for the analysis of policy-making and the interrelationship of care policy design and care arrangement patterns. In the empirical part, the emerging care arrangement patterns, their interrelationship to the design of the policy scheme and its consequences for the establishment of sustainable care arrangements are examined using a two-step design. First, the institutional design of LTCI and its construction during the process of policy-making are outlined to reveal the goals and underlying ideas of LTCI policy. Second, we shall show the impact of the design on care arrangement patterns and the outcomes for different social groups dependent on gender, socio-economic status and ethnicity. In a final conclusion care arrangement patterns and their interrelationship to the policy scheme are assessed towards their strength and above all their weakness to enable the development of sustainable care arrangements on a universal basis.

2. Conceptual Part: Institutional design, policy–making and care arrangement patterns

Institutional policy design and underlying ideas of LTCI build the focus of the empirical analysis and are viewed as a link between processes of policy-making–with policy design as a result–and as the starting point for the development of care arrangement patterns for distinct social groups in society. Decisive for policy design are ideas on the interplay of private, family and public responsibility, which is reflected in the definition of social rights and related benefits, funding principles and the regulation of formal and informal care within a welfare mix of care provision.

- Social rights and related benefits

Based on research four dimensions of institutional designs of benefits, such as eligibility criteria, range of risks covered, level of public support, and types of benefits can be summarised reflecting private, family and public responsibilities (see Theobald 2011). Risks of range covered and related eligibility criteria determine access to public benefits in principle and thus provide a starting point for public responsibility. The risks of range covered, e.g. assistance related to personal or bodily care, household services or social integration and the level of care needs within the areas, serve to define the threshold for public support. Based on this, benefits can either be universally provided or according to economic circumstances–ascertained by means testing–or the family situation (Anttonen, Baldock & Sipilä 2003).

A third definition of public responsibility is related to the level of public support that determines the mix of public funding and private family resources. Here it can be distinguished between institutional designs "guaranteeing minimum standards" i.e. only a minimum level of public support, and designs that "support accustomed living standards" which grant higher levels of public support (Österle 2001). The types of benefits, such as cash benefits, leave arrangements or available services, can be viewed as a fourth definition of the private-public mix (Daly 2002). The different types of benefits reflect the ideas on the mix of formal and informal or family care provision and their interrelationship to the mode of funding.

- Funding principles

The construction of benefits is complemented by funding principles. Here two dimensions can be specified as relevant for the private-public mix. The first dimension includes general regulations related to the amount of public funds available; e.g. the mix of private-public costs may be indirectly determined by a general cost ceiling that limits the public funds available, which may be fixed by law or regulations. The second dimension concerns the calculation of public and private costs. Within a given definition of benefits either all costs may be covered publicly or a certain amount of private costs can be defined. The remaining private costs can be calculated regardless of beneficiaries' family or economic situations or adapted to specific life situations. The

adaptation of private costs reflects ideas on redistribution between different social groups.

- Regulation of formal and informal care within welfare mix of care provision:

Finally, the public-private mix is reflected in ideas on the division of caring activities between the informal family care on one side and formal care services provided by the state, market and civil society organisations on the other. According to the welfare mix approach the interplay of different sectors with regard to care provision, funding and regulation is characteristic for western welfare states. However, western welfare states differ with regard to the significance, organisation and the interplay of the sectors with regard to care provision and their embeddedness in modes of funding and regulation (see Rose & Shiratori 1986: Evers & Wintersberger 1990; Evers & Svetlik 1993; Mishra 1990; Powell 2008). The emphasis on a significant role of all societal sectors – family, state, civil society and more recently even the market - is characteristic for conservative welfare systems (Evers & Olk 1996; Zimmer 2000 for Germany; Powell 2008 in general).

New institutionalist approaches created within public policy research are selected for the analysis of processes of policy-making, i.e. how the dimensions of policy design came about embedded in ideas and related goals. Such approaches analyse the process of policy-making based on the interplay of actors, their ideas or their interests within frameworks of political and social policy institutions. Beland (2009) elaborates on the role of ideas in a situation of social policy change. From his perspective ideational processes are particularly significant in situations of high uncertainty, when existing institutional structures are less likely to determine the behaviour of key political actors (see also Pierson 2004; Brodin 2005 for elder care). Ideas impact on policy-making in several ways and can become political weapons. Ideas help to shape the definition of the problem on the agenda. As economic and social assumptions they guide reform policies and, finally, as a basis of framing processes within public discourse, they may convince policymakers, interests groups and the general population. Ideas become politically influential because they interact with powerful political actors or political

coalitions and are embedded in an institutional framework that create constraints or opportunities for certain actions (Thelen 2004; Beland 2009).

In order to examine the impact of policy designs on care arrangement patterns, concepts created within welfare research will be selected. Within welfare research social policy designs are examined with regard to their impact on outcomes for (potential) beneficiaries and viewed as contributing significantly to the construction of inequality, i.e., of unequal life situations for different societal groups. Until the 1980s the outcomes of policy designs were mainly considered on patterns of socio-economic inequality, but welfare state research has gradually developed since the 1990s to include issues of socio-economic and gender inequality within a common framework. More recently even the issue of ethnical inequality is taken into account based on the concept of intersectionality (see e.g. Korpi & Palme 1998; Esping-Andersen 1999; Korpi 2000; Daly 2000; MacCall 2005).

In the course of the scientific debate, social care was identified as an area where gender, socio-economic and ethnical inequality meet. Care provision as a traditional gendered activity was increasingly illuminated related to divisions of gender, socio-economic and ethnical status within the area, e.g. related to the situation of migrant care workers (see e.g. Ehrenreich & Hochschild 2002; Lutz 2008). Daly's approach (2000) provides a starting-point for the analysis of the interrelationship between different types of inequalities and institutional policy design in the area of social care. In her approach she focuses on the emergence of processes embedded in structures and outcomes. As fundamental process within social care she teases out the construction of care activities across the private-public border defined as formal or informal care activities. The process develops within a framework of the institutional designs of related social policies and their underlying ideas. Outcomes are defined as the (un)equal distribution of resources and opportunities and corresponding stratifications among different social groups. Based on her approach the role of structures, i.e., institutional policy design on construction of care arrangements, related inequalities can be illuminated.

3. Empirical part

3.1 Institutional policy designs and policy-making: Combining universalism, family care and cost containment

The LTCI in Germany aims to combine three fundamental goals: universal access in a situation of long-term care risk; cost containment; and ageing in place embedded in family-oriented support. The long-term care scheme was negotiated within a corporatist framework encompassing the Conservative-Liberal government on the Federal level and politicians of the Social-democratic Party dominating the Council of the Federal States, which must approve the law, as well as other societal actors (for a detailed analysis of processes of policy development see Theobald 2011a). In contrast to previous social assistance support scheme, LTCI aims to provide universal public support. During the process of policy-making, universal social rights were increasingly discussed related to funding risks and cost containment concerns. Cost containment of the expected expenditure became a main goal (Meyer 1996). Both goals–universalism and cost containment–were striven for. First, by introducing a new type of universal social rights, second by defining distinct funding principles, and third by restructuring care provision in a welfare mix approach that maintained family care provision and strengthened market principles.

- Social rights and benefits; Universalism and medium public funding

The new type of universalism within LTCI in Germany falls into three dimensions: definition of the range of risks covered the level of public support and the types of benefits. The dimensions, listed below, are constitutive for the definition of the interplay of public and private responsibilities and thus directly related to cost containment goals.

-- Definition of a considerably high threshold of care needs eligible for public support and a focus on functional impairments.

The determination of the threshold to insurance benefits provides the starting-point for access to public support. The federal law on LTCI clearly defines three levels of care dependency mainly oriented towards functional impairments as thresholds to a distinct level of public support. The need of support with household services only is

not covered by the insurance framework; a minimum of 45 minutes of care provision related to personal hygiene, eating or mobility is required (Care dependency level 1). The orientation of the insurance towards functional impairments was motivated by cost containment efforts. While the comparatively high threshold has been accepted since the introduction, the neglect of psychological or cognitive impairments, in particular related to dementia illness has resulted in an intense societal debate including a wide range of social actors, like the Alzheimer Society or welfare associations. In 2002 and 2008 two reforms were conducted to facilitate access to the policy scheme of people suffering from dementia and to provide more comprehensive support for their informal carers. An additional benefit of €360 p.a. was established with the 2002 reform, which could be used to purchase different types of care services. With the 2008 reform the amount of the additional benefit was increased to €2,400 p.a. and the benefit threshold was lowered (MDK Bayern 2008).

-- *Definition of the level of public support, which leaves a considerable amount of private responsibility.*

The policy scheme provides medium-level public support defined by a lump sum benefit related to the care dependency levels, which must be complemented either by private means or family support. The level of benefits was negotiated in intense debate during the process of policy-making of LTCI. While at the beginning most actors agreed that comprehensive public support was needed, the debate on the high public costs of the German health care insurance and the high public expenditure related to the long-term care policy scheme in the Netherlands led to the definition of a lump sum only on a medium-level of public support (see Meyer 1996). The benefits can be supplemented with social assistance benefits after thorough mean-testing. By granting only medium-level public funding, the long-term care scheme represents a significant departure from traditional health care insurance in Germany. However, public debate on the level of benefits was laid to rest with the introduction of LTCI (Landenberger 1994; Theobald 2011).

-- *Definition of different types of benefits*

The definition of types of benefits was related to cost containment policies, but also to ideas on the existing interplay of family and formal care provision. In the process of policy-making the provision of “in-kind services only”, comparable to the health care insurance schemes, was rejected by almost all actors as not coherent with the existing patterns of care arrangements. The introduction of service benefits was

related to quality concerns and to the need to publicly support costly institutional services. Finally, a mixed system of public benefits related to free choice was introduced with a lower-level cash benefit to acknowledge family care provision but to avoid the "economisation of family care" and higher benefits oriented towards the more costly home-based and residential services (Meyer 1996).

- Funding principles

Social rights and benefits provide public support on a medium level regardless of beneficiaries' family or economic situation. Where service providers are involved in care arrangements, users purchase services based on their benefits and calculated at market-effective prices whatever their socio-economic or family situation. The idea of market-effective prices without subsidisation is motivated by the introduction of care market based on free choice for the users and competition between providers on equal terms. In policy-making phase, the Liberal Party in office with the Christian-democratic Party on the Federal level only accepted a social insurance scheme combined with a strong role of a care market and user demand (Burau, Theobald & Blank 2007). Comprehensive social assistance benefits are only accorded to very low-income users (see above). In order to control the costs of the long-term care scheme, the contribution rate of the insurance is fixed by law and binding for all social long-term care insurances funds. The contributions are defined as the ceiling of expenditure. Thus the insurance contributions and not care needs are used to calculate the public support available. In particular, the Christian-democratic Party emphasised the necessity of cost control related to a universal social insurance scheme (Meyer 1996).

- Regulation of care provision

Care provision was also restructured to contribute to cost containment goals. Characteristic of the German approach is its emphasis on family care within a welfare mix of care provision. While less costly care within the family framework should be maintained by providing a cash benefit, an increasing orientation towards market principles ought to deliver high-quality but cost-efficient care services. While formal care providers are involved in more complex care activities and in control of care quality, social support, daily care work and "keeping an eye out", should be provided

by family members or wider social networks (see also Meyer 1996; Pfau-Effinger, Och & Eichler 2008).

3.2 Care arrangement patterns and inequality

Within the LCTI framework a largely family-oriented care strategy developed embedded in a distinct mode of state regulation, funding and support of formal care provision. Within the family-oriented strategy, different patterns of care arrangements can be distinguished according to gender, socio-economic class and ethnicity. The development of distinct and unequal patterns of care arrangements can be explained by the interplay of LTCI's institutional design on the one hand, and cultural values together with the socio-economic and social situations of the beneficiaries and their informal carers, on the other.

LTCI draws on a combination of cultural values related to provision, funding and care regulation, as well as public support, which corresponds in part to the cultural values within the population. The emphasis on the role of informal, family care as well as free choice between family care and different types of formal care is consistent with German tradition and corresponds to the ideas of beneficiaries (Runde, Giese & Stierle 2003; Alber & Köhler 2004). LTCI transferred public support for long-term care need situations from local-level social assistance frameworks to a national social insurance scheme partly oriented towards a health care insurance scheme based on the idea of comprehensive public responsibility (Evers & Sachße, 2003). By granting only medium public funding, however, the long-term care scheme departs significantly from the German health care tradition (Landenberger, 1994; Theobald, 2011a). The departure is still reflected in attitudes within the population, where a representative survey shows that while public funding is greatly welcomed, 45% of participants wanted a fully-funded solution (Alber & Köhler, 2004).

Despite general agreement within population on long-term care support, care arrangements differ widely and reveal considerable difficulties with the mode of long-term care support as defined by LTCI. Three issues illustrate these differences.

- Choice of type of benefits as a starting-point
- Distinct patterns of care arrangement
- Characteristics of unequal care provision

Based on the principle of free choice of type of benefits, the majority of beneficiaries are cared for at home supported by cash payments only (see table 1). The use of home-based services has–only slightly–increased since the introduction of the insurance. Running counter to the goal of LTCI, the ratio of beneficiaries using institutional services has increased (Federal Statistical Office 1999 - 2011).

Table 1: Benefit use in 2009

Benefits	**In % of beneficiaries**	**In % of population 65+**
Residential services	30.7	3.8
Home-based services/combination cash/services Service use: beneficiaries living at home only	23.7 34.3	3.0
Cash payments only	45.6	4.6
Total	100	11.5
Day care services/additional	1.4	0.2

Source: Federal Statistical Office (2011)

A representative inquiry of 2002 examined in a greater detail the mix of care provision in home-based care arrangements. In 2002 36% of beneficiaries living at home used professional care services within the framework of LTCI (comparable with the figures of 2009 see table 1). 23% of beneficiaries purchased additional private services, which is related to a dual structure of care service use. Beneficiaries who chose cash payments only were mainly cared for by family members, friends or neighbours and only 9% paid additional private support. In contrast, the users of professional care services purchased additional private assistance, often household assistance. Home-based service users typically received a mix of informal and home-based care services (Schneekloth 2006). In several representative inquiries informal carers said they were (very) burdened by informal care provision, and about 60% demanded more comprehensive support (Runde, Giese & Stierle 2003; Schneekloth 2006). High levels of care burdens are assumed as one reason for the increasing use of institutional services (Theobald 2004).

In a representative survey in 2002, participants described the available types of care service offers as inadequate to their needs of unburdening and above all criticised the high costs of unsubsidised care services (Runde, Giese & Stierle 2003). In their interview study Pfau-Effinger, Och and Eichler (2008) related the low level of home-based service use to the fact that care services were oriented to bodily care only and that other daily care tasks were not provided for. Predefined care packages, where the emphasis is on processes of marketisation and the rationalisation of care provision, were also criticised. The findings may explain the dual structure of service use. Professional services and private assistance are combined to create a more comprehensive care support, while most groups among the beneficiaries turn to informal networks for support.

Within the dual structure of care support different care arrangement patterns have emerged for men and women, beneficiaries of different socio-economic classes and ethnical background. Representative statistics on family care-giving indicate changing gendered patterns in care provision. The female share of 73% among main informal carers in 2002 already represented a reduction of the proportion of women carers

following the introduction of LTCI (Schneekloth 2006). The increasing share of male informal carers is mainly based on an increase of spousal care. However, the number of sons acting as a main informal carer also increased, albeit at a low level. The mode of care provision differs significantly between male and female main informal carers. Male carers can be found where care arrangements are shared with other informal and formal carers, particularly with personal care delivery services (Schneekloth & Wahl 2006).

The use of cash payments or professional services provides a first indicator on the impact of the living situation, socio-economic status and ethnicity on the patterns of care arrangements. Within the framework of LTCI, home-based care services are more often used by beneficiaries who live alone with precarious social and family support, or older adults on higher socio-economic strata. They are also more likely to be German nationals than certain migrant populations (Blinkert & Klie 1999; Klie & Blinkert 2002; Heusinger & Klünder 2005; Okken, Spallek& Razum 2008). The distinct care arrangements may indicate a situation of overburdening for some groups of informal carers, but also a lack of care services. For instance, in a 2002 representative study, 14% of care recipients reported a lack of care provision (Schneekloth 2006). In Germany several research projects have been conducted to explain the emerging unequal care arrangement patterns. Projects into the impact of socio-economic class reveal a complex pattern of class-related economic and cultural factors that influence the construction of care arrangements (see Klie & Blinkert 2002; Heusinger & Klünder 2005). Economic factors are related first to the (private) costs for the purchase of care services, which are unfolding within the design of LTCI. Within this framework, the level of care-dependency and the type of care provision determine the amount of public support, while the care recipient's economic situation is not considered (see above). The economic burden related to the purchase of services differs depending on the income situation and excludes beneficiaries with more limited private means.

Second, economic factors are related to opportunity costs when informal carers interrupt or reduce their employment. In 2002, 10% of informal carers had interrupted employment and a further 11% had reduced their working hours in order to meet their

caring responsibilities. Previous to this, fully 51% of main informal carers in employment age were not gainfully employed (Schneekloth 2006). The combination of informal care-giving and employment is strongly influenced by socio-economic class, i.e., women on the lower socio-economic strata are significantly less often employed at the advent of care dependency–as defined within the LTCI framework–and, if employed, more often reduce or interrupt their employment (Runde, Giese & Stierle 2003). The pattern of labour market participation may be furthered by pension credit points related to informal care provision. Pension credit points can be obtained for informal care activities of between 14 and 30 hours a week, but people so employed are generally on low to medium-level incomes and women with lower qualification levels (Schneider & Reyes 2007).

Class differences are also related to cultural factors, which, in turn, are related to parental care (see Heusinger & Klünder, 2005). The role of family members in care provision is emphasised in all socio-economic classes in Germany. Despite an emphasis on the responsibility of the family, the upper middle-classes involve professional home-based services or use residential care services according to care needs. The middle-classes might also call upon paid assistance–purchased mainly on the grey market–to lighten the burden on informal carers. Families at the lower end of the socio-economic scale expect free provision of care and are less willing to move to residential care. Moreover, a migrant background may influence patterns of care arrangements. In an analysis of assessment reports in one German region the Turkish migrant group were more likely to choose cash benefits than the German group (91% to 42%), less likely to use home-based services (9% to 29%), and hardly ever chose institutionalised services (0-1% to 29%) (Okken, Spallek & Razum 2008).

Reports on the high burden of informal carers brought about measures to lighten their load. An additional benefit is available since 2002 related to dementia. The low level of this benefit was widely thought to be one reason for its rare take-up it was increased in 2008 (Sauer & Wißmann 2007; see above). In addition, personal budgets were introduced in a model project, which enabled users to purchase care assistance even outside the strictly regulated care market. Evaluations of the model project found an increase of care hours, which improved the difficult care situation of

beneficiaries who had no stable social or family network. The improvement stems mainly from increased support from neighbours, etc. and from paid care services on lower social security standards (Blinkert & Klie 2006). There is no indication whether or when a personal budget will be introduced in the regular benefit structure. With the 2008 reform, additional benefits–also on a low level–were introduced to facilitate the use of day-care services. More comprehensive services, however, still call for considerable private means. Finally, in 2008 local case/care management services and an individual right to service free of charge were introduced to support beneficiaries by the establishment of their care arrangement (MDK Bayern 2008).

The cost ceiling, i.e. the definition of a limit of public support based on the insurance contributions–restricts the range of reforms (see above on cost ceiling). The reform efforts improved access to information and strengthened public support for service use to some extent. Nonetheless, the reforms have not tackled some of the basic problems of service provision; i.e. the cost structure, and the fact that the high costs are not adapted to beneficiaries' income or family situation, and that emphasis is placed on care packages within a market oriented service system.

Since 2000, a bottom-up solution with more comprehensive care support has emerged, namely the provision of 24-hour service within the family context by migrants from Eastern European countries. According to estimates, about 120,000 migrant carers provide (mainly illegally) 24-hour care in about 60,000 households in Germany. Working on a rotational basis, they cover the needs of about 5% of long-term care beneficiaries living at home (own calculations based on Steffen 2009; Federal Statistical Office 2011). Such care arrangements are mainly sought by severely care-dependent older adults, often those on higher income levels (Neuhaus, Isfort & Weidner 2009; Lutz 2009). Families who employ migrant carers cite the lower costs for care compared to 24-hour formal care provision or residential care, the wish of avoiding nursing-home admission and to relieve the burden on family carers (Neuhaus, Isfort & Weidner 2009). The mainly illegal activity is related to recent societal debates on the regularisation of the activity, in which Christian-democratic and Social-democratic politicians point to the mode of regularisation in Austria. The bottom-up development

does not solve the general unequal care situation, it adds a further dimension to the dual structure of care provision.

4. Conclusion: Dual structure of care provision and sustainability

With the introduction of LTCI, Germany considerably redefined public support related to long-term care needs embedded in an effort to restructure long-term care within the framework of a welfare mix approach. A mainly family-oriented care strategy has emerged within the framework of LTCI, which is however related to different care arrangement patterns depending on gender, socio-economic status and ethnicity. The paper proceeded by the assumption that certain dimensions of institutional design of LTCI impact on the emerging care arrangement patterns, which proved to be mediated by the socio-economic and social situations, as well as via the cultural values of beneficiaries and their informal carers. Following an elaboration on dimensions of institutional design of care policies, the paper examines the development of LTCI's institutional design within the process of policy-making and the impact of the design on care arrangement patterns.

Significant dimensions of institutional design of care policies–the definition of social rights and related benefits, i.e. eligibility criteria, range of risks covered, level and type of benefits, funding principles and the regulations of informal and formal care provision–have been determined based on a literature review. The institutional design of LTCI was negotiated within a corporatist system emphasising ideas of universal support, cost containment and ageing in place embedded in informal, family support. The combination of the ideas led to a comparatively high threshold to LTCI support, a medium-level of public support, private costs that are not adapted to beneficiaries' situations, a cost ceiling within the funding scheme, free choice between cash and in-kind benefits, and emphasis on family care supported by market-oriented formal care provision related to complex care tasks.

The institutional design of LTCI interacts with the socio-economic and social situation, as well with the cultural values of beneficiaries and their informal carers. The result is a dual structure of care arrangement patterns depending on gender, socio-economic and migration status. While beneficiaries with higher socio-economic status, German nationals and male carers more often use a mix of professional care services, additional paid services and informal care, other groups of beneficiaries are still cared for mainly within the family context. The dual structure can be explained by an interaction of institutional design–medium funding and non-adaptation of private costs to the situation of beneficiaries, the emphasis on family care based on cash benefits, and the market orientation of professional service offers–with the different economic and social situations and very diverse ideas on the role of the family within care provision. Reform efforts that have been carried out within the framework of a cost ceiling have not fundamentally changed the dual structure of care provision.

The introduction of LTCI significantly increased public support in a situation of care dependency based on ideas of universalism and family care. Furthermore, LTCI corresponds at least partly to the cultural values in society. However, in the course of the analysis considerable deficits of LTCI became visible concerning the goal of a sustainable care provision for all members in society. Within the German context, sustainability is related to the goal to secure a user-oriented and adequate care provision on a universal basis, to promote ageing in place and to enable cost control. The dual structure of care provision questions these goals of sustainability. Within the dual structure of care provision care gaps and related vulnerable groups have emerged; i.e. a lack of home-based service use in particular for the lower classes in society, overburdened informal carers and even distinct groups in need of care without an adequate support in case they lack family respectively social or economic resources. One consequence of the care gaps is the increasing use of the more costly residential care services counteracting the goals of LTCI. Furthermore, in Germany the idea of comprehensive family care is based on the readiness and time opportunities of female family members to take over comprehensive care tasks. Both, readiness and time opportunities may decline in the future based on value changes in society and social policy changes in particular related to the female employment strategy within the EU (Klie & Blinkert 2002).

References

Alber J.& Köhler U. (2004) *Health and Care in an Enlarged Europe. European Foundation for the Improvement of Working Conditions.* Official Publications of the European Communities, Luxembourg.

Anttonen A., Baldock J. & Sipilä J. Eds. (2003) *The Young, the Old and the State. Social Care Systems in Five Industrial Nations*. Edward Elgar, Cheltenham

Beland D. (2009) Ideas, Institutions and Policy Change. *Journal of European Public Policy* **16** (5), 701-718.

Bettio F. & Plantenga J. (2004) Comparing care regimes in Europe. *Feminist Economics* **10** (1), 85-113.

Blinkert B. & Klie T. (1999) *Pflege im sozialen Wandel*. Vincentz, Hannover.

Blinkert B.& Klie T. (2006) Der Einfluss von Bedarf und Chancen auf Pflegezeiten in häuslichen Pflegearrangements. *Zeitschrift für Gerontologie und Geriatrie 39*, 423-428.

Brodin, H. (2005) Does anybody care? Public and Private Responsibilities in Swedish Eldercare 1940-2000. Doctoral thesis. University of Umea, Umea.

Burau, V, Theobald H. & Blank R. (2007) *Governing Home Care: A Cross-National Comparison*. Edward Elgar, Cheltenham.

Daly, M. (2000). *The gender division of welfare*. University Press, Cambridge.

Daly, M. (2002) Care as a good for social policy. *Journal of Social Policy*, **32** (1) 251-270.

Ehrenreich B. & Hochschild, A.R. (2002) *Global Woman*. New York, Metropolitan Books

Esping-Andersen G (1999) *Social Foundations of Postindustrial Economies*. Oxford University Press, Oxford.

Evers A.& Olk T. Hg. (1996). *Wohlfahrtspluralismus: vom Wohlfahrtsstaat zur Wohlfahrtsgesellschaft*. Westdeutscher Verlag, Opladen.

Evers A & Wintersberger H. Eds. (1990). *Shifts in the Welfare Mix*. Frankfurt/Main, Campus.

Evers A. & Svetlik I. Eds. (1993). *Balancing Pluralism. New Welfare Mixes in the Care for the Elderly*. Aldershot, Avebury.

Evers A. & Sachße C. (2003) Social Care Services for Children and Older People in Germany. In: A. Anttonen, J. Baldock and J. Sipilä. (Eds.) *The Young, the Old*

and the State. Social Care Systems in Five Industrial Nations, pp. 55-80. Edward Elgar, Cheltenham.

Federal Statistical Office (2001, 2003, 2005, 2007, 2009) *Pflegestatistik*. Wiesbaden.

Heusinger J.& Klünder M.(2005) *„Ich lass mir nicht die Butter vom Brot nehmen!" Aushandlungsprozesse in häuslichen Pflegearrangements*. Mabuse- Verlag, Frankfurt/Main.

Klie T. & Blinkert B. (2002) Pflegekulturelle Orientierungen. In: C. Tesch-Römer (Hg.) *Gerontologie und Sozialpolitik*, pp. 197-217. Kohlhammer, Stuttgart.

Korpi W. (2000) Faces of Inequality: Gender, Class, and Patterns of Inequalities in Different Types of Welfare States. *Social Politics* **Summer 2000**, 127-191.

Korpi W & .Palme J. (1998) The Paradox of Redistribution and Strategies of Equality: Welfare State Institutions, Inequality and Poverty in Western Countries. *American Sociological Review* **63** (5), 661-687.

Landenberger M. (1994) Pflegeversicherung als Vorbote eines anderen Sozialstaats. *Zeitschrift für Sozialreform* **40** (3), 314-342.

Lutz H. Ed. (2008) *Migration and domestic work*. Aldershot, Ashgate

Lutz H. (2009). Migrantinnen in der Pflege in deutschen Privathaushalten. In: C. Larsen, A. Joost & S. Heid (Eds.) *Illegale Beschäftigung in Europa. Die Situation in Privathaushalten älterer Personen, pp. 41-52.* Rainer Hampp, München-Mering.

Mc Call L.(2005) The Complexity of Intersectionality. *Signs* **30** (3), 1771-1800.

MDK Bayern Hg. (2008) *Prisma Gesundheit. Die soziale Pflegeversicherung*. ecomed Medizin, Landsberg.

Meyer J. A. (1996) *Der Weg zur Pflegeversicherung*. Mabuse, Frankfurt/Main.

Mishra R (1990) *The Welfare State in Capitalist Society*. HarvesterWheatsheaf, Hemel Hempstead..

Neuhaus A., Isfort M & Weidner F. (2009) *Situation und Bedarfe von Familien mit mittel- und osteuropäischen Haushaltshilfen*. Deutsches Institut für angewandte Pflegeforschung e.v., Köln.

Okken P-K., Spallek J. & Razum O. (2008) Pflege türkischer Migranten. In: U. Bauer & A. Büscher (Hg.) *Soziale Ungleichheit und Pflege,* pp. 396-422. Verlag für Sozialwissenschaften, Wiesbaden.

Österle A. (2001) *Equity choices and long-term care policies in Europe. Allocating Resources and Burdens in Austria, Italy, the Netherlands and the United Kingdom*. Ashgate, Aldershot.

Pfau-Effinger B., Och R. & Eichler M. (2008) Ökonomisierung, Pflegepolitik und Strukturen der Pflege älterer Menschen. In: A. Evers & R.G. Heinze (Hg.) *Sozialpolitik,* pp. 83-98. Verlag für Sozialwissenschaften, Wiesbaden.

Pierson P. (2004) *Politics in Time. History, Institutions and Social Analysis.* Princeton University Press, Princeton.

Powell M. Ed. (2008) *Understanding the Mixed Economy of Welfare*. Policy Press, Bristol.

Rose R & Stiratori R. Eds. (1986) *The Welfare State East and West*. Oxford University Press, Oxford.

Runde P., Giese R. & Stierle C. (2003) *Einstellungen und Verhalten zur häuslichen Pflege und zur Pflegeversicherung unter den Bedingungen des gesellschaftlichen Wandels*. Bericht. Universität Hamburg: Arbeitsstelle Rehabilitations- und Präventionsforschung, Hamburg.

Sauer P. & Wißmann P. (2007) *Niedrigschwellige Hilfen für Familien mit Demenz: Erfahrungen, Beispiele, Perspektiven*. Mabuse-Verlag, Frankfurt/Main.

Schneekloth U. (2006) Entwicklungstrends beim Pflege- und Hilfebedarf in Privathaushalten – Ergebnisse der Infratest-Repräsentativerhebung. In: U. Schneekloth & H.W. Wahl (Hg.). *Selbständigkeit und Hilfebedarf bei älteren Menschen in Privathaushalten,* pp. 57-102. Kohlhammer, Stuttgart.

Schneekloth U. & Wahl H.W. (2006) Möglichkeiten und Grenzen selbständiger Lebensführung in Privathaushalten im Lichte der Ergebnisse von MuG III. In: U. Schneekloth & H.-W. Wahl (Hg.) *Selbständigkeit und Hilfebedarf bei älteren Menschen in Privathaushalten*, pp. 229-242. Kohlhammer, Stuttgart.

Schneider U. & Reyes C. (2007) Mixed Blessings: Long-term Care Benefits in Germany. In: C. Ungerson & S. Yeandle (Eds.). *Cash for Care in Developed Welfare States,* pp. 137-165. Palgrave Macmillan, Houndmills.

Steffen M. (2009) *Branchenbericht: Die Arbeitssituation von Migrantinnen in der Pflege*. Ver.di, Berlin

Thelen K. (2004) *How Institutions Evolve: The Political Economy of Skills in Germany, Britain, the United States, and Japan*. Cambridge University Press, Cambridge.

Theobald H. (2004) Care services for the elderly in Germany. Infrastructure, access and utilisation from the perspective of different user groups. WZB-discussion-paper (SP I 2004 – 302) Berlin, WZB.

Theobald H. (2011a) Multi-level governance and universalism: Austria and Germany compared. *International Journal of Sociology and Social Policy* **31 (** 3 / 4), 209-221.

Theobald H. (2011b) *Expanding and restructuring long-term care service provision: Long-term Care Insurance and New Public Management in Germany*. Paper presented at the Annual ISA RC 19 Conference "Production, Reproduction and Protection in the Welfare State", Seoul, August 25-27, 2011

Zimmer A (2000). Welfare Pluralism and Health Care: The Case of Germany. In: A. Zimmer (Ed.) *The Third Sector in Germany*, pp.95-115. Münsteraner Diskussionspapiere zum Non-profit Sektor Münster, University of Münster.