

Research Paper

**Conditions and Challenges of Germany's Long-term Care Insurance:
Care Policies and Inequalities
based on Gender, Socio-economic Class and Ethnicity**

Hildegard THEOBALD

University of Vechta

Abstract

With the introduction of the Long-term Care Insurance in Germany, a universal coverage scheme was established on the national level. Despite the universalistic orientation and clearly-defined care rights of this law, unequal care arrangements have emerged depending on gender, socio-economic class, living situation and ethnicity. The emergent care patterns are explained based on a conceptual approach to the impact of care policy designs on the construction of formal and informal care work as determined by life situations. Assessments and the use of types of benefits, care arrangement patterns, informal care-giving and the emergence of migrant carers within the family context provide the empirical basis for the analysis. The findings show that universal coverage on a medium level and the offer of cash benefits and services interact with social, economic and cultural factors of the life situations of beneficiaries and informal carers, and result in the unequal patterns of care arrangements.

Key words: Long-term Care Insurance, Universalism, Cash benefit, Inequalities, Germany

1. Introduction

Following a drawn-out debate in 1995/96, Long-Term Care Insurance (LTCI) was introduced in Germany on a national level to guarantee universal public support in a situation of care dependency. Before the introduction of LTCI the risk of care dependency was covered only after means-testing, in accordance with the Federal law on Social Assistance dating from the 1960s. A serious shortcoming in this law was that the middle classes, above all, were left without social protection in a situation of care dependency. It often resulted either in an increasing dependency on the care and/or economic support of their children, or in a situation of impoverishment due to the high private costs of residential care. Increasing social assistance costs at municipal levels,

however, provided the main incentive for the establishment of the new pillar within the German social insurance system (Ostner, 1998; Campell and Morgan, 2005).

The introduction of the LTCI in Germany and the Federal Care Allowance System in Austria in 2003 marked a starting-point for the establishment of universal long-term care schemes in further continental European countries, such as Luxembourg or Flanders and even further afield in Japan and, more recently, in Spain and South Korea (See Theobald and Kern, 2009). The new long-term care schemes re-defined public responsibility, the role of informal family care and the interplay with the market. Common features that define the new schemes include universalism, clearly defined risk situations and benefits, a re-organisation of public funding systems and an expansion of care service provision mainly related to the introduction of care markets. A more detailed comparison reveals major differences between the long-term care schemes, which concern the type of benefits available, e.g. the provision of care services and/or cash benefits, the level of support and the (re)organisation of national-regional-local interplay with regard to the policy process and implementation. In contrast to Germany, politicians in Japan, for example, voted for services only as type of benefit to promote the expansion of a care infrastructure and to avoid an emphasis on the mainly female informal care provision.

Since the introduction of the LTCI in Germany intense research activities – statistics, quantitative and qualitative studies – on the (changing) situation of the beneficiaries, informal and formal care have revealed strengths but also significant weaknesses in the institutional design of the insurance and the mode of its implementation. On one hand, the insurance led to a marked increase of the population covered in a situation of care dependency, even including the middle-classes. It is also related to an expansion of home-based and residential service provision and changes with regard to the quality of care services. On the other hand, in contrast, significant deficits have become visible related mainly to a lack of comprehensive care service support for older female adults living on their own and to burdened family carers due to the reliance on mainly female family care. A detailed analysis of the deficits brings about different outcomes for different social groups, depending on the intersection of gender, socio-economic class and ethnicity.

Research shows that despite the idea of universalism, the LTCI is related to a wide range of unequal resource allocations from the perspective of the beneficiaries and the informal family carers. The patterns, the related societal processes and their interrelationship to the care policies, are the focus of this article. It starts with the premise that different dimensions of the institutional set up of LTCI – such as eligibility criteria, levels of support, types of benefits and central, regional, local interplay – and their interaction with the social, economic and cultural factors of the life situations of different social groups causes the development of the group-oriented unequal patterns of care provision.

In the following, in the second section the outline of significant features of the German LTCI and a conceptual-theoretical framework for the impact of care policies on the development of care arrangements and outcomes provides a background for the empirical analysis. In the third section, the assumption will be scrutinized empirically on the basis of statistics and research studies. The empirical part discusses assessments, eligibility criteria and the use of different types of benefits, care arrangement patterns, the situation of informal carers and the emergence of migrant carers within the family context. In the final concessionary section, I summarise the findings of the analysis and, based on this, discuss the on-going efforts to reform the LTCI.

2. Background

(1) Basic Features of the Long-term Care Insurance

The LTCI in Germany aims to provide universal and need-related public support in situations of care dependency. In order to achieve this goal, eligibility criteria, care needs and corresponding types and levels of benefits are clearly defined within a national law. The law defines three levels of increasing care dependency and assigns them to three types of support – cash benefits, home-based care services and residential care services (cf. table 1).

Beneficiaries are able to choose between the use of cash payments to organise care provision privately or home-based care services and, in principle, also with relation to institutional care provision. In addition, eligibility criteria and benefits are determined for further support services, such as day centres, short-term care or low-threshold services.

The insurance re-defined the role of the state, family and the market with regard to funding and care provision and is based on four main principles.

Table 1. Care dependency: Levels and Benefits

Types of benefits	Care dependency levels		
	Considerable (I)	Substantial (II)	Most substantial (III)
Cash payments (per month.)			
July 2008	€215.00	€420.00	€675.00
January 2010	€225.00	€430.00	€685.00
January 2012	€235.00	€440.00	€700.00
Care services: home based (per month)			
July 2008	€420.00	€980.00	€1,470.00
January 2010	€440.00	€1,040.00	€1,510.00
January 2012	€450.00	€1,100.00	€1,550.00
(extraordinary high need of care)			(€1,918.00)
Care services: residential (per month)			
July 2008	€1,023.00	€1,279.00	€1,470.00
			(€1,750.00)
January 2010	No increase	No increase	€1,510.00
			(€1,825.00)
January 2012	No increase	No increase	€1,550.00
(extraordinary high need of care)			(€1,918.00)

Source: MDK Bayern (2008).

(a) *Universalism and medium support*

Within the framework of the LTCI the whole population is insured, albeit divided between the social LTCI (approx. 90% of the population) and mandatory private insurance (approx. 10%). The benefits are meant to cover basic care needs and have to be complemented, either with informal family care, private economic means or with means-tested social security assistance. The insurance benefits are strictly related to the level of care dependency, i.e. the economic and family situation of the beneficiaries are not taken into account.

(b) *Priority of domestic care*

The law aims at maintaining domestic care by supporting either informal care or home-based care provision. Cash payments are intended to strengthen informal care, in particular from the family or wider social networks. Home-based care services are intended to provide expertise or unburden family carers, but not to substitute informal family care. Domestic care should be given priority in order to delay the use of residential care services for as long as possible.

(c) Care market: Demand as basis for an expansion of care services

The care services on offer before the introduction of LCTI were strongly underdeveloped – both quantitatively and qualitatively. It was widely expected that the introduction of the insurance and an opening-up of a care market for non-profit and for-profit care providers on equal terms would give impulses to a quantitative and qualitative development of the care infrastructure. The development of care services was to be driven by users' demands.

(d) National-regional-local interplay

By national law eligibility criteria and benefits are clearly defined to secure equal universal support, while a wide range of actors on regional and local levels are responsible for the implementation. The main responsibility for defining the mode of cooperation between the further social and political actors according to regional conditions was assigned to the Federal States (Bundesländer).

With the establishment of the LTCI, former state-supported structures were not abolished but significantly redefined. Now, the Federal Law of Social assistance steps in after a means-test when the individual or the family are unable to provide the complementary care provision not covered by the insurance. The law also comes into force in situations where care needs fall below the LTCI threshold, or when domestic assistance only is required, which is not granted by LTCI. Laws and regulations related to the elder assistance system entail the establishment of local social services, e.g. transport services by municipalities to promote social integration for older adults. Considerable room for discretion has resulted in wide differences in local service structures, which have even been reduced since the introduction of the insurance (Bönker *et al.*, 2009).

(2) Conceptual Part: Social Policy Design and the Issue of Equality

Since the 1980s gendered welfare state research has criticised the orientation of (international comparative) welfare state research on socio-economic class, the related issue of social inequality and the neglect of the impact on gender inequalities. Based on feminist criticism, research gradually arrived at a consensus that different types of inequalities and their intersection are socially constructed and must therefore be taken into account in any comprehensive analysis of welfare state policies and outcomes (See e.g. Esping-Andersen, 1999; Daly, 2000; Korpi, 2000).

In the course of the scientific debate, social care was identified as an area where gender, social and – increasingly, even ethnic – inequality meet. Research into the concept of “social care” has revealed the widespread care activity of women and its relationship to gender (in)equality. Since the 1990s, the inclusion of care work provided by home helpers or migrant workers in US research prove that social care is also related

to socio-economic class and ethnicity (cf. Graham, 1991). In Europe, the increasing influx of migrant carers has fostered a debate on the emergence of new divisions based on ethnicity in the female-dominated activity (See e.g. Ehrenreich and Hochschild, 2002; Lutz, 2008).

While at the beginning of the debate the intersection of different inequalities were analysed from the perspective of informal carers or paid carers within the family context, the unequal situation of the care recipients has gradually come to the fore (See Theobald, 1998; Burau *et al*, 2007). Both the impact of social policy designs on the situation of care users and informal carers and their interrelationship, as well as the underlying processes are the focus of this article. I start with the assumption that institutional designs of care policies impact decisively on the emerging patterns of inequality related to care provision from the perspectives of the informal carers and the care recipients. Second, the impact of institutional designs is mediated by factors of life situations related to gender, socio-economic class and ethnicity that set construction processes of care arrangements in train and result in corresponding patterns of arrangements. The article goes on to examine institutional designs, the processes and the outcomes from the perspective of the care users and informal carers in greater detail.

Daly's conceptual approach (Daly, 2000) offers a starting-point for the analysis of the impact of care policies on the intersection of gender and socio-economic inequalities within the area of elder care. In her approach she distinguishes between structures, societal processes and outcomes. Structures are defined as institutional designs of social policies, e.g. the risks covered and the construction of entitlements. As one fundamental process she teases out the construction of formal and informal care activities across the private-public border. Outcomes are defined as the distribution of resources and the corresponding stratifications from the perspective of the carers and care recipients. The basic concepts of structure, processes and outcome will be elaborated according to the specificity of the area of elder care.

Based on findings within elder care research four dimensions of care policy designs – eligibility criteria, levels of support, types of benefits and central, regional, local interplay – can be defined as being decisive for the process of construction of formal and informal care activities and their relationship to emerging patterns of inequalities (Theobald, 2008). Eligibility criteria generally determine access to benefits. The range of care risks covered, e.g. basic nursing care, household services, institutional care, and the level of care needs, serve to define eligibility criteria. In some countries, further eligibility criteria may also include economic circumstances – ascertained by means testing – or the family situation (Anttonen *et al*, 2003).

Österle defines goals determining the level of support and related them to policy outcomes (Österle, 2001). The first goal of care policies “guaranteeing minimum standards” aims to prevent care recipients falling into poverty and provides only a minimum level of public support. The second goal “supporting living standards” grants

a higher level of public support to prevent older adults from big drops in their individual living standards. The third goal, “reducing vertical and horizontal inequality,” takes vertical differences in income or horizontal differences between the care recipients and the healthy into account.

The new definition of public responsibility for financing care support since the 1990s corresponds to the increasing establishment of a mix of different types of benefits, mainly cash benefits, care services or leave schemes. Daly and Lewis (2000) describe the new balance between cash transfers and services as a major trend in the area of social care, where the mixture differs between and within welfare states. As a result, the boundary between formal care (provided by public, voluntary or commercial organisations) and informal care (by family members, relatives, friends and neighbours) has become an area of conflict, re-negotiation and newly-developed forms of cooperation. The shift from service provision to cash benefits is justified with the promotion of more choice for the service users, an acknowledgement of informal care provision (carried out mainly by women) and the goal of cost-efficiency, i.e. with the aim of lowering costs (Ungerson, 1997; Daly and Lewis, 1998).

Recent research in the area of elder care has revealed the impact of the type of benefits – cash benefits or care services – on the situation for both informal and paid carers within the family context, as well as for care recipients. In a range of western countries, the provision of cash payments for informal family care has led to an increasing inequality among women based on socio-economic class or migrant background (See e.g. Burau *et al*, 2007). In addition, the provision of unregulated cash benefits proves to be related to the emergence of migrant carers within the family framework, e.g. in Italy, Austria or Germany (Ungerson, 2005; Simonazzi, 2009, Theobald, 2009).

Traditionally, elder care policies were developed and implemented at local levels, but the increasing public responsibility within the areas is related to the development of country-specific interplay between central and local relations (Anttonen *et al*, 2003). Thus, political institutions in the field of elder care policies stretch simultaneously across local, regional and national levels. The devolution in some countries of the executive power and responsibility to the municipalities or regions was intended to enable local authorities to adapt care services to the individual needs and to the risk structure in the local area (Glendinning, 1998). Despite the advantages, this emphasis on local level responsibility raises the question of equity and citizenship. For example in Sweden, social care rights are defined in greater detail at local levels, which results in very different support structures on the municipal level (Rauch, 2005). Glendinning (1998) argues that the devolution of responsibility makes the overarching regulatory frameworks even more important if elderly people are to have equal access to citizenship-based services.

According to Daly's framework, structures, i.e. care policy designs, cause societal processes. Societal processes, i.e. the construction of formal and informal care work, strongly influence outcomes and thus the available care resources and stratifications among care recipients and carers (Daly, 2000). The processes and outcomes, however, are not only influenced by policy designs but are also mediated by resources of the care recipients and of the informal carers, respectively. Despite public support, in all western European countries families provide the bulk of care provision. Thus, elder care arrangements mostly include both formal care services and informal family care. Three dimensions of social care are relevant for the analysis of the construction of care activities across the formal-informal borders: the definition of the type of care work as formal or informal, the costs of social care, and its embeddedness in a normative framework of family and public responsibilities (Daly and Lewis, 1998). Thus, the impact of care policy designs on the construction of formal and informal care is mediated by available family and social informal support and private economic means embedded in norms on public and private responsibilities.

Against the conceptual background the design of Germany's LTCI can be described as providing a medium level of support based on the principle of universalism, which has to be complemented by family or further private resources. Cash benefits and care services are offered related to the principle of freedom of choice for the beneficiaries. There is an emphasis on clearly-defined eligibility criteria and benefits on the national level, which together with implementation on the regional or local levels are intended to secure legal certainty and equitable care throughout the country in situations of care-dependency. In the following empirical sections the impact of the institutional designs on the development of care arrangements will be analysed. Above all, I examine assessments and access to benefits, the construction and mix of formal and informal care in different life situations and the corresponding outcomes for different social groups.

3. Empirical Part

(1) Benefits and Assessments: The Impact of Gender, Socio-economic Class and Ethnicity

The introduction of LTCI based on the principle of universalism led to a significant increase in the number of beneficiaries (who had hitherto received benefits according to the Federal Law on Social Assistance), from approx. 563,000 in 1994 to approx. 2.5 million care dependent people receiving LTCI benefits in 2007 (Eisen and Mager, 1999; Statistisches Bundesamt, 2009). In 2007, 11.3% of adults 65 years or older received benefits, whereof 2.8% chose home-based care services, 4.2% cash payments and

further 4.0% institutional care services (Statistisches Bundesamt, 2009). In addition, according to a representative survey in 2002 approx. 3 million citizens aged 70 years or older stood in need of some form of assistance with housekeeping, of which approx. 2% received benefits according to the Federal Law on Social Assistance (approx. 0.5% of adults 70+) (Schneekloth, 2006).

Since the introduction of LTCI a (falling) majority of beneficiaries has preferred cash benefits to home-based care services; from 82% in 1995 to 68% in 2005 (Evers, 1997; Statistisches Bundesamt, 2007). Overall, from 1999-2005 we find an increase of beneficiaries living in residential care from 27.7% to 31.8% and receiving home-based care services from 21.3% to 22.2%. While the use of home-based care was still increasing in 2007 (to 22.4%), the proportion of beneficiaries using residential care fell slightly to 31.6% (Statistisches Bundesamt, 2001, 2003, 2005, 2007, 2009). The take-up rates of long-term care benefits and the type of benefit selected differ markedly between different groups in society based on the criteria age, gender, socio-economic class and ethnicity.

The take-up rates of benefits are commensurate with gender and age and the corresponding health status. The risk of care dependency is strongly related to age, thus in 2007 54% of the beneficiaries were 80 years and older. In addition, in the same year, 68% of the beneficiaries were women (Statistisches Bundesamt, 2009). The interrelationship of care dependency and age and gender can be explained by the health status – with a poorer health status in older age and health differences between men and women. The higher level of care-dependency among women is not a German phenomenon. A study in 12 European countries clearly confirmed the development of a specific profile of morbidity related to a higher risk of care dependency (Stiehr and Spindler, 2006).

The gender-oriented patterns of family status and living-situation in old age are also correlated to gendered patterns of benefit use; above all to cash benefits and institutionalised care. While men more often opt for cash benefits – 54.9% for men versus 41.7% for women in 2007 – women are more likely to “choose” residential care services, 33.7% versus 21.9% (Statistisches Bundesamt, 2009). Above all, women in old age living on their own move more often into residential care facilities if they reach a high level of care dependency. In contrast, men are more likely to be cohabiting and are more often cared for by wives or partners (Theobald, 2004; See section below on care arrangements)

Besides gender and age, adherence to certain socio-economic classes and ethnic groups impact significantly on both the take-up rates and the selected types of benefits, as well as on the results of assessment procedures. In general, due to their poorer health status, citizens on lower-socio-economic strata are more often care-dependent (Theobald, 2004; Borchert and Rothgang, 2008). In 2006, the proportion of care-dependent members of the social long-term care insurances doubled the proportion

within the framework of the private long-term care insurances (Bundesministerium für Gesundheit, 2007). In Germany, compared to the social long-term care insurances, private long-term care insurances typically insure people from the higher socio-economic strata.

The differences are not caused by a more favourable assessment procedure for applicants of the social long-term care insurances. Within the framework of the social long-term care insurances applications are more often rejected than within the framework of the private long-term care insurances (Bundesministerium für Gesundheit, 2007). Furthermore, beneficiaries within the framework of the private insurances are more often assigned to higher levels of care dependency; i.e. to care dependency level two instead of one with regard to home-based care and to care-dependency level three compared to level two with regard to residential care. There is no convincing explanation for the differences. While the eligibility criteria are comparable in both frameworks, assessments for the private insurances are carried out by private firms and those for the social insurance by the medical departments of the health insurance funds. One explanation may be the positive economic situation of the private insurances related to a surplus between contributions and expenditure and, by contrast, the difficult economic situation of the social long-term care insurances related to a deficit. Furthermore, studies in daily care provision found that members of the lower socio-economic classes more often opt for cash payments instead of services, while members of the (upper) middle-classes tend to use more home-based or institutional services (Blinkert and Klie, 1999; Heusinger and Klünder, 2005 for a detailed explanation See section 3.3 below).

Labour migrants recruited from the 1950s to the beginning of the 1970s onwards are increasingly reaching age groups with higher risks of care dependency (Baykara-Krumme and Hoff, 2006). Above all qualitative studies reveal features of different patterns of service use in migrant groups (for further details see section 3.3. below). An analysis of the assessment reports in one region, where applicants with a Turkish migrant background are compared to German applicants proved the role of migrant status on the results of the assessments and the types of benefits selected (See Okken *et al*, 2008). First, the analysis showed that the applications of the migrant group are more often rejected and that they are more often assigned to care dependency level one only. Second, the Turkish migrant group voted more often for cash benefits than the German group (91% to 42%) and less often for home-based services (9% to 29%), and hardly ever for institutionalised services (1% to 29%). The significant group differences are partially related to the group-specific impact of age and gender. In the German group, gender and old age is related to an increasing use of home-based and institutional services (See above). This impact could not be found for the migrant group (for a detailed explanation see section 3.3 below).

The patterns of rejections and assignments related to socio-economic class and ethnicity call for further investigation into the assessment process within both social and private long-term care insurances. The use of different types of benefits – with regard to gender, socio-economic class and ethnicity – will be explained further by a more detailed analysis of the development of care arrangement patterns and the situation of informal carers.

(2) Patterns of Care Arrangements: Family Care, Public and Private Services

The German law on LTCI focuses on the priority of domestic care and especially aims to support and maintain informal family care (See above section 2.1). The general patterns of care provision confirm the family-oriented care strategy. A representative inquiry in 2002 revealed that 92% of the beneficiaries living at home were receiving support from family members, while only 38% were using publicly supported home-based care services. In addition to the take-up rates, the amount of care provision also differed significantly. While publicly financed care services – depending on the level of care dependency – delivered between 0.5 to 1.8 hours a day, informal family care amounted to 5 hours a day on average (Schneekloth, 2006; Schneekloth and Wahl, 2006).

While households with the heaviest care burdens draw on public services more often, the majority of highly-burdened households organise support privately either on the basis of family or social networks or by using private services (Runde *et al*, 2003). Public home-based services are mainly used for the provision of basic nursing care (Statistisches Bundesamt, 2009). In a representative inquiry in 2002, 23% of the long-term care insurance beneficiaries purchased private services and 11% received support from voluntary workers, e.g. visiting services. However, approx., 42% of informal carers stated that they were very burdened by care provision and about 60% demanded more comprehensive support (Runde *et al*, 2003).

Cash benefits are mainly used to pay a nominal sum for informal care, in particular to children or neighbours or, more rarely, used to buy domestic services on a grey market. Related to spousal care cash payments are viewed as a part of the household income (Evers, 1997; Heusinger and Klünder, 2005). Private services are more often purchased by recipients of public services to complement professional care services, while only 9% among the cash benefits recipients used private services in 2002 (Schneekloth, 2006). In a qualitative study, informal carers receiving cash payments complained about the low level of payments, which was, however, not followed by a reduction of informal care. Cash payments or pension points that could be granted in certain defined care situations only rarely offer an incentive for family carers to reduce or interrupt employment (for a more detailed explanation See section 3.3). Cash payments only provide an incentive to carry out informal care-giving for informal carers

in difficult life situations, for example, unemployed neighbours (Heusinger and Klünder, 2005; Schneider and Reyes, 2007).

A representative inquiry in 2002 into the attitudes related to the mix of informal and formal care provision outlined a trend towards the recommendation of professional services. 30% of informal carers and care recipients recommended informal family care only, while 39% recommended a mix of informal care and professional services. A further 20% voted for assisted living facilities and 4% for institutionalised services. Even among the recipients of cash payments about 60% recommended a mix of formal and informal care provision. Here, clear differences can be detected between care recipients and informal family carers, with care recipients preferring more informal, family care provision only (Runde *et al*, 2003). The general patterns of formal and informal care provision outlined here differ significantly depending on gender, family status, socio-economic class and ethnicity, which will be explained from the perspective of informal care provision – a decisive element in the family-oriented care system in Germany.

(3) Informal Care Provision: Inequalities Related to Gender, Living Situation, Socio-economic Class and Ethnicity

Informal care provision is still a female dominated area. In a representative survey 15% of women and 8% of men aged 40-85 years report that they provide long-term care in private households. The gendered pattern changes when the family status of the informal carers and the age group is considered. While the gender difference declines for the older age-groups, mainly due to the spousal care, it increases with regard to parental care for the age-group 40-54 years. With 51% of all care relations care for the parents is the most dominant care support, while 18% of the informal carers provide care for a partner (Künemund, 2006).

Representative statistics on informal family care for LTCI beneficiaries only found changing gender patterns in care provision. The female share among main informal carers was 73% in 2002, and thus already a reduction compared with a female share of 83% in 1991 (Schneekloth, 2006). 60% of the main carers were 55 years or older with an average age of 59 years and were either partners (28%) or daughters/daughters-in-law (32%) of the care recipient. While the inroads made by men is mainly related to care of a spouse even the proportion of sons acting as a main informal carer increased between 1991 and 2002 from 3% to 10%. Since the introduction of LTCI, care provision for the parents and the spouse or partner is seen less as a social duty, but based on more positive feelings or reciprocity (Runde *et al*, 2003). Even the mode of care provision differs significantly between male and female main informal carers. Male carers can be found sharing care arrangements with other informal and formal carers, in particular care services which usually take care of bodily needs. The increase of sons as

informal carers can be explained either by male unemployment but also by the impact of the long-term care insurance and the availability of publicly supported care services (Schneekloth and Wahl, 2006).

In addition to gender, the living situation, socio-economic status and ethnicity influence care arrangement patterns. The use of different types of benefits – either cash payments or services – can be viewed as an initial indicator. Care services are more often used by beneficiaries who live on their own with precarious social and family support, older adults on higher socio-economic strata and are more likely to be German nationals than migrant populations (Blinkert and Klie, 1999; Klie and Blinkert, 2002; Heusinger and Klünder, 2005; Baykara-Krumme and Hoff, 2006; Okken *et al*, 2008). The differences will be explained by group-specific social, family, economic and cultural resources. The care arrangements are not related to a balanced care situation, where one type of support is substituted for another. On the contrary, it may indicate a lack of care provision and an overburdening situation for some groups of informal carers. In a representative study in 2002 14% of care recipients reported a lack of care services and a further 12% a shortage of domestic support (Schneekloth, 2006).

The introduction of the LTCI has increased the number of care recipients who can remain in their own homes; while 40.9% of insurance beneficiaries were living in their children's households in 1997 this figure had dropped to 35.1% in 2002 (Runde *et al*, 2003) Despite changing living situations, representative statistics confirm a situation of intense contact and support between children and parents who often live near one another (Künemund 2006). In a situation of precarious family or social support, however, living alone often equates with inadequate or lack of care provision because publicly provided home-based care is not able to compensate for the lack of informal care provision where high levels of care-dependency exist (Blinkert and Klie 2006). Long-term care statistics reveal that especially older women living on their own with a high level of care dependency more often move to residential care facilities (Theobald, 2004).

An indicator for the impact of socio-economic class on care provision is the group-related use of cash benefits and care services, where the (upper) middle-class opt significantly more often for services instead of cash payments. Several research 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 (Blinkert and Klie, 1999; Klie and Blinkert, 2002; Heusinger and Klünder, 2005).

Economic factors are related firstly to the (private) costs for the purchase of care services, which are developing embedded in the design of the long-term care insurance. Within the framework of the long-term care insurance, the level of care-dependency and the type of care provision determine the amount of public support, while the economic situation of the care recipient is not considered. Only below a certain income threshold are beneficiaries eligible for additional social support within the framework of social

assistance. The economic burden related to the purchase of services differs depending on the income situation. Statistics show that the use of privately paid home-based services is related to the income of the beneficiaries. In a representative study on average 8% of the beneficiaries stated that they buy privately home-based care services; this proportion rises to 18.6% for beneficiaries with an income of €2500 or more. Only 4.9% of all beneficiaries, however, have an income of €2500 or more (Runde *et al*, 2003). In the main, beneficiaries either complement the granted services with informal, family care or they reduce the level of support; only 5% receive social assistance benefits in addition (Runde *et al*, 2003; Bundesministerium für Gesundheit, 2007).

Secondly, 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. Fully 51% of the main informal carers in employment age had not been gainfully employed before (Schneekloth, 2006). The combination of informal care-giving and employment is strongly influenced by socio-economic class, i.e. both the employment status before the advent of care dependency and the impact of informal care provision. For example, while 44.9% of blue-collar workers had not been gainfully employed at the advent of care dependency, the comparable figure for high-qualified white-collar workers is 27.1% and 20% for high-qualified self-employed workers. Furthermore, only 32.2% of the employed blue-collar workers continued in employment without any changes compared to 45.0% of the high-qualified self-employed workers (Runde *et al*, 2003).

The class differences are also related to cultural factors, which, in turn, are related to parental care (See Heusinger and Klünder, 2005). While the role of the family members in care provision is emphasised in all socio-economic classes in Germany, expectations differ widely as to what care tasks should be conducted by offspring differ. Despite an emphasis on the responsibility of the family, the upper middle-classes, in particular, would not expect their offspring to take over all care tasks. The use of professional home-based services and, under certain circumstances, the move to residential care, is accepted. Also, in the (lower) middle-classes paid assistance might be called upon to unburden informal carers (mainly offspring), but assistance is more likely to be sought in grey market services. Families at the lower end of the socio-economic scale expect free provision of care and are more unwilling to accept a move to residential care. Cultural factors also affect access to information on public support. The complex public support structure in Germany – related to a care market with a wide range of providers and with care provided within the framework of the LTCl, but also at municipal levels – impedes service use, in particular for lower socio-economic classes. It may be related to a highly burdened situation of the informal carer, dependent on available further family and social support.

As already indicated in the analysis of the take-up rates of cash benefits or services, ethnicity or migrant background strongly influence patterns of care arrangements (See section 3.1 above). The differences can be explained by a combination of economic, social and cultural factors. An analysis of a representative study of the living situation of migrants without German citizenship indicates discrimination in several respects (Baykara-Krumme and Hoff, 2006). Life situations are characterised by lower incomes, lower educational levels, below-average housing standards, and, although only slightly, poorer states of health. The family situation is comparable to the situation of the control group of German citizens characterised by dense intergenerational contacts, but with two differences. First, the proportion of the elderly, mainly the female widows, living with offspring is much higher than in the German sample. Second, on average the number of offspring in each family is higher than in the German sample.

A qualitative study on the long-term care situation in Turkish migrant families revealed a strong emphasis on family responsibility even related to daughters (in laws), which is based on cultural ideas and socio-structural resources (See Lorenz-Meyer and Grotheer, 2000). While home-based care was generally accepted, institutionalised care was seen as something that should be avoided. Existing home-based care services and residential care facilities in particular are only rarely adapted to the cultural ideas of different migrant groups. In a situation of limited availability of culturally-sensitive care services, the provision of a cash payment to support family care tends to strengthen the care-giving responsibilities of the daughters (in laws). The traditional assignment of care responsibilities to the daughters (in laws) will create increasing conflict with the more employment-oriented younger generation in the near future.

(4) The Emergence of 24-hour Care within the Family Context

The basic principle of Germany's LTCI, namely to grant universal support on a medium level, left a care gap that must be closed, either by informal care, privately paid services or, after a means-test, with social assistance benefit. As figures on take-up rates of cash benefits and hours of care provided by family members reveal, the care gap is mainly closed by family members and social networks. Moreover, apart from the professional care services, a grey market for domestic or care services has emerged.

On the grey care market two different types of care arrangements can be distinguished. In a first pattern, assistance, mainly with household tasks, is provided by older German women, housewives or migrants either already living in Germany or recently arrived workers. The domestic workers do not live in but serve a number of households for whom they work on an hourly basis (Gather *et al*, 2002). A grey market for household tasks in Germany is widespread especially in the (upper) middle-classes, but recently older adults have begun to buy more and more this type of service (Hank, 1998; Enste *et al*, 2009) As a second pattern, the increasing demand for more

comprehensive care service provision has resulted in the emergence of 24-hour care arrangements provided by a live-in migrant worker.

According to estimates, about 100,000 migrant carers provide 24-hour care on a rotational basis in about 50,000 households in Germany and concerns about 3-4% of long-term care beneficiaries. Investigations into the situation of care users reveal the relationship between a certain care and social situation (See Lutz, 2009; Neuhaus *et al*, 2009). 24-hour care arrangements are used mainly by severely care-dependent older adults with a high level of functional or cognitive impairment and a comprehensive need of surveillance, basic nursing care and household services. The arrangements are typically used by older adults on higher income levels who live alone with limited family support or care provision from offspring (Lutz, 2009; Neuhaus *et al*, 2009).

Families who pay migrant carers in Germany cite the lower costs for care compared to 24-hour formal care provision or residential care, i.e. professional care service providers would calculate €3000-5000 per month. In contrast, a 24-hour carer organised by an agency costs between €1200 and €2400. The costs are mainly covered by the care users themselves. In a study, about half of the care users report they are able to pay for the costs without any economic constraints and a further 26% with acceptable economic constraints (Neuhaus *et al*, 2009).

Other reasons for the attractiveness of such care arrangements are wishes to avoid nursing-home admission and to relieve the burden on family carers. Migrant workers typically provide both domestic services and care activities, while about half of the care recipients use additional professional services. Despite this, the use of professional care services has fallen (Neuhaus *et al*, 2009). In a representative inquiry in 2002, about 44% of the recipients of long-term care benefit or their family carers already considered it "acceptable in principle" for them to employ a migrant carer, and 2.4% stated that they already employed a migrant carer (Runde *et al*, 2003).

Many of the migrant workers come from the most recent EU-member states in Eastern Europe and arrive on short-term or tourist visas to offer their services on a rotational pattern (Finotelli, 2008). The limited right of cross-border service provision within the EU is widely used, which offers the legal possibility to provide service in another EU-country for up to six months a year. In 2002, on a temporary basis (that became permanent in 2005) a legal care worker recruitment scheme was implemented to legally hire out domestic carers to families with care dependent members. The regulations correspond to regular working-conditions in Germany, e.g. 38.5 hours a week are defined as a fulltime-job, German labour laws and social security standards have to be followed and the activities concern domestic work only. According to the authority responsible for the placement 3,032 domestic workers were employed on this basis in 2007. The monthly costs lie between €1500 and €2000 a month, comparable to the costs for a migrant carer via the agencies. Empirical research reveals that users view the regulations as too bureaucratic and as not corresponding to their own needs.

Qualitative studies reveal that in reality, users often fail to comply with working-time regulations and controls on the part of the responsible authorities are rare (Lutz, 2009).

4. Conclusion: Conditions, Challenges and Reform Efforts

Long-term Care Insurance (LTCI) was introduced in Germany in 1995/96 to provide universal coverage in situations of care dependency. According to the German social insurance tradition, social rights, i.e. care needs and corresponding benefits – were clearly defined within the law on the national level. Despite the principle of universalism and the strict definition of social rights on a national level, the law resulted in unequal assessment results and unequal care situations for beneficiaries and informal carers, depending on gender, living situation and family status, as well as on socio-economic class and ethnicity. Using Daly's basic concept on structure, processes and outcomes as a starting-point, a conceptual framework was created to examine the impact of care policy designs on the outcomes (Daly, 2000). In the conceptual part, the structure, i.e. decisive dimensions of care policy designs are defined, such as eligibility criteria, levels of support, types of benefits and central, regional, and local interplay. The empirical part clarifies the factors of the life situations that impact on the process of construction of formal and informal care arrangements. The findings reveal care resources and stratifications in group-related care arrangement patterns.

The principle of universalism based on public funding on a medium level, which requires further resources (economic, social or family resources) and the non-adaptation of the level of public support to the income or family situation, build the starting point for the construction of the unequal care arrangements. Moreover, cultural factors – normative values, as well as access to information – influence the care strategies in different life situations. The findings show a significant impact of gender on the processes and outcomes, which, however, have to be differentiated for different groups based on socio-economic status, living situation and migrant background.

Both care dependency and informal care-giving are gendered phenomenon. Women are more often exposed to the risk of care dependency themselves, while at the same time they carry out the bulk of informal family care. Moreover, the care situation, as well as patterns of care provision differ significantly between women and men. Due to their living situations, men are more often cared for by their partners, while women are more often dependent on care from their offspring or on formal care provision. In particular, in a situation of high care dependency, professional home-based care cannot compensate for a lack of informal family care and women move more often than men into residential care facilities. Despite the female dominance in informal care provision, men are increasingly taking over spousal care-giving and – less significantly – parental

care. Compared to women, informal male carers are far more likely to be embedded in a network of further informal and formal care provision.

On the basis of a different economic life situation and normative values, socio-economic class and migrant background interfere with the general gendered pattern. Owing to the combination of high private costs for complementary care services and the low labour market participation rates of women with a low or medium vocational training, beneficiaries in the lower socio-economic strata opt more often for cash payments instead of home-based services. The availability of a cash payment and the normative values "to provide long-term care" without any costs strengthen the informal care strategy. In Germany, the living situation of labour migrants in old age is characterised by a low income level, a low level of vocational training and a strong emphasis on family care responsibility, and thus resemble the living situation of the members of lower socio-economic strata. Moreover, home-based and, in particular, residential care services are only rarely adapted to the needs of the migrant population. Economic, social and normative factors therefore strengthen the preference for cash payments. The opening-up of a care market related to a wide range of service providers, the uncoordinated offer of local services and information policies impede the use of supporting services. The low level of service uptake often results in an overburdened care situation, depending on further family and social resources.

Since the introduction of the LTCI several reform efforts have been undertaken to improve the service use, diversify the care infrastructure and increase the amount, i.e. the hours of care provision for older adults with low levels of family or social support.

- In 2002, the Complementary Nursing Act was drawn up to relieve the informal carers of beneficiaries with dementia and simultaneously to give more space to create new elements in the care infrastructure. According to the law, beneficiaries suffering from dementia may apply for an additional benefit of up to €460 per annum to alleviate the burden of the informal carers. "Payable" low-threshold offers that unburden family carers ought to be created based on co-operation between professional carers and voluntary workers. The benefits are only rarely used: in 2006 17.5% of eligible beneficiaries have applied for the additional benefit (Sauer and Wißmann, 2007). In order to increase the take-up rates, the amount was increased with the reform of 2008 to €1200 and €2400 per annum in very difficult cases and access to this benefit was facilitated.
- Semi-residential care services have been established to unburden family carers. With 1% among the beneficiaries using short-term care and 1.5% attending a day care centre, semi-residential care services are only rarely used (Statistisches Bundesamt, 2009). The private costs related to service use have been put forward as one argument for the negligible use. Since the reform in 2008, an additional benefit can be granted for the use of day care facilities in certain situations, i.e. if it is necessary to maintain domestic care due to the need of supervision, when the care situation deteriorates

rapidly or to enable (part-time) employment of the family carer. The last point can be seen as an acknowledgement of changing labour market strategy, which requires that women be continuously employed during the life course. On the other hand, two unpaid leave schemes were introduced with the most recent reform in 2008. One scheme grants an unpaid ten days leave to organise or adapt care arrangements. A second scheme allows an interruption of employment or the take-up of part-time work on an unpaid basis for up to six months, which again promotes female informal care work.

- A care budget was introduced between 2004-2008 based on a model-project. Participants received the amount of money for home-based care services as a personal budget, i.e. a cash payment, to purchase freely different legal care or domestic services in addition to registered professional care service offers. The aim of the personal budget is to give beneficiaries more leeway to decide on different types of support, thus strengthening their positions as customers. The evaluation of the project shows that beneficiaries buy more assistance via legal, but low-price services, such as domestic workers, meals on wheels, etc. Related to this type of paid assistance, the available paid caring time increased from an average of one hour to ten hours per week (Blinkert and Klie, 2006; Klie, 2007).
- The bottom-up strategy of the German middle-classes to employ (often) illegally migrant carers can be interpreted as a further strategy to create more flexible and "payable" care provision (See above). The development inspired a political debate on the regularisation of migrant carers working within the family context. At the centre of the public debate are the low costs of the care provision for the families and the fact that migrant workers benefit too, owing to wage differentials between the countries.
- In big cities such as Berlin, related to home-based services, culturally sensitive care offers have been established. Here, mainly self-employed nurses with migrant backgrounds offer home-based care services (Theobald, 2004). The employment of carers with a migrant background can be viewed as a further strategy to create more culturally sensitive care services.
- The establishment of a sound information structure aims to support an adequate service use. The reform of the LTCI in 2008 entails the development of "Pflegestützpunkte" (local single information points), to provide adequate and accessible information services and case and care management services at one local office. Since 2009, there is an individual right to information, even including free continuous case management services for all (potential) LTCI beneficiaries.

The reform efforts to increase service use, to provide the insured with more paid care time, to diversify the care infrastructure or to improve information services have been conducted under the premise of cost-containment. From the perspective of the care users and informal carers only a limited success can be ascertained, whereby the effects

of the most recent reform in 2008 have not yet been evaluated. From the perspective of the paid carers, however, the strategies aim to limit the costs of care provision and to create more “payable” care services, which is often related to precarious working situations for carers who provide low-paid, partly illegal, up to 24-hour care. Despite the strategies, the now more “affordable” paid care services are more likely to be oriented towards the life-situations of the middle-classes and offer no solution to the burdened informal carers of lower socio-economic or migrant backgrounds.

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