Work and Life Quality
in New & Growing Jobs

walqing social partnership series 2011.16

"And who cares for the carer?"

Elderly Care Work in Germany

Angelika Kümmerling

Institut Arbeit und Qualifikation (IAQ), Universität Duisburg-Essen

September, 2011

This report is one of 22 sectoral reports carried out on stakeholder policy in 5 sectors and 11 countries for Workpackage 5 of the WALQING Project, SSH-CT-2009-244597, produced for use within the project.

www.walqing.eu

EUROPEAN COMMISSION
European Research Area

Funded under Socio-economic Sciences & Humanities

walqing social partnership series 2011.16

"And who cares for the carer?"
Elderly Care Work in Germany

Angelika Kümmerling
Institut Arbeit und Qualifikation (IAQ), Universität Duisburg-Essen

Duisburg/Essen, September, 2011

This report is one of the outputs resulting from Workpackage 5, “Stakeholder policies and problem assessment”, of the WALQING project, SSH-CT-2009-244597.

www.walqing.eu

The WALQING research is funded by the European Commission’s 7th Framework Programme.

However, this report only reflects the authors’ views. The European Union is not liable for any use that may be made of the information contained therein.

Content

Introduction 1

1 Structure and organisation of the supply of long-term care in Germany 1

2 Economic and employment development in the sector 4

2.1 Structure of home care providers 4

2.2 Employment in the home care sector 6

2.3 Who is working in the elderly care sector? 7

2.4 Education and Training 8

3 General background on the organisations and the interviewees 9

3.1 Union: ver.di 10

3.2 Employer organisation 11

3.3 Professional organisation 12

4 Current developments and estimates 12

4.1 Quality of work/ work characteristics 12

4.2 Shortage of workers? 15

4.3 New and old jobs 16

5 Collective bargaining and social dialogue 17

6 Relationship with other actors and institutions 19

7 Perspectives 19

8 Conclusions 20

9 References 21

List of Tables

Table 1 Characteristics of basic care in the sense of the long-term care insurance ... 3

Table 2 Amount of benefits depending on care category and care supplied, in Euro ... 3

Table 3 Provider structure of home care services ... 5

Table 4 Patients in need of care within home care services according services providers (15 Dec 2009), 2003 share in brackets ... 5

Table 5 Employment in the home care sector by working time (in %) ... 6

Table 6 Qualification level of employees in the long-term care sector ... 8

Table 7 Typical activities of elderly care work ... 14

List of Figures

Figure 1 Development of services (in %) ... 4

Introduction

As it is the case in many European Countries, the German society is ageing. This is due to both an increasing life expectancy and the ongoing demographic change: fewer women are bearing fewer children later in their life than earlier generations (Deutscher Bundestag, 2002). An ageing society faces many challenges. Among these, care issues, in terms of how care and in particular long-term care can be provided and maintained, are of highest priority, as it is mainly the older and oldest generations that are in need of care. Moreover, data show that dependency is increasing exponentially among the elderly, a prospect of highest concern to German society because it is the share of oldest people that is expected to increase in particular during the coming decades.

But it is not only the demographic change that puts a burden on the German care system. Increasingly, women are entering the labour market, working more and longer hours – and will most probably continue to do so. As Germany is relying strongly on informally given (or family) elderly care, traditionally provided by women, this ongoing decomposition of gender roles exerts additional pressure on the care system. Even more so, as Germany recently has made efforts to boost informal/family care instead of further expanding professional home care.

The German system of providing and maintaining elderly care cannot be completely understood without the role that statutory regulations, namely the long-term-care insurance, play. Since its introduction it has been setting the frame for the way care suppliers are to offer their services and what kind of care will be paid for by the insurance to what extent.

1 Structure and organisation of the supply of long-term care in Germany

The care market in Germany is highly regulated – the way care suppliers are to offer their services and the way care is paid for is regulated in several laws. Of highest importance in this regard is the long-term care insurance (LTCI) that has marked a turning point in the health care system. After two decades of discussion and argument, the German government implemented the long-term care insurance act in the years 1995 (home care) and 1996 (residential care) as a fifth pillar of the German Bismarckian social security system. The idea that the possible need for care could be a matter of insurance and a task of the Social welfare state was new until then.

Until the introduction of the long-term care insurance act, there was no comprehensive public system for financing long-term care. Though there were benefits available for ambulatory long-term care based on the Social Health insurance, care services were mainly financed privately (by dependents as well as by relatives of dependents). Those who could not afford the professional care they needed received means-tested social welfare (Busse & Riesberg, 2004). For instance, in 1993, about 80% of West-Germans in-

need of care and 100% of East-German dependents cared for in nursing homes relied on social assistance (Rothgang, et al. 2004, 6). In the whole of Germany in 1993, expenses of social contributions for care in nursing homes amounted to 16.5 billion DM. Home care expenses, paid for by the different health insurance schemes, amounted to 3.29 billion.

Thus, the aim of the introduction of the LTCI was manifold:

- Removing the financial burden of long-term care from the regions (Länder) (because social assistance was a matter of the "Länder")
- Favouring home care over institutional care (this can be seen as the guiding principle behind the LTCI. This principle corresponded to both the wishes of the dependents who prefer(red) to be cared for at home and the plans of the government to reduce costs)
- Expanding home care services
- Opening care services to the market
- Offering (financial) support to informal care-givers.

This insurance is uniform, universal and mandatory for all those already covered under the public health system or who hold a full-cover private health insurance. However, the latter had to acquire a private equivalent. Consequently, the public scheme of long-term care assurance is covering over 70 million people in Germany, and the private insurance system a further 8.5 million people. With that, well about 98% of the German population is covered by the long-term care insurance scheme (private or public) (Rothgang 2004).

It is fair to assume that development of the home care sector as it is is the result of the LTCI, which organises and structures the way care is to be given. This is underlined by the statement of a member of an employer association: "The long-term care insurance basically constitutes elderly care. In the public mind the content of elderly care comprises only those activities that are paid for by the insurance. That care work includes more than sheer washing or feeding does not seem to be part of the common understanding".

Entitled to receive means from the LTCI is everyone, regardless of age, who applied successfully to the Medical Review Board (Medizinischer Dienst). The Medical Review Board decides to what extent a person is in need of care basically by the evaluation of 13 "basic care" dimensions and the amount of time per day a person needs to be cared for.

Table 1 Characteristics of basic care in the sense of the long-term care insurance

Personal hygiene	Feeding	Mobility
Washing	Bite-sized preparation	Help with arising, bedding
Bathing, showering	Feeding	Dressing/ undressing
Dental care		Walking
Combing/shaving		Standing
Urination/ defecation		Climbing stairs
		Leaving home

Source: Robert-Koch-Institut, 2004, 11.

There are three dependency levels that determine the amount of benefits a patient is entitled to receive (see Table 2).

Table 2 Amount of benefits depending on care category and care supplied, in Euro

Care category	Home care		Institutional care
	Cash benefits	In kind benefits	In kind benefits
Care category I (“considerable need of care”)	235	450	1,023
Care category II (“severe need of care”)	440	1,100	1,279
Care category III (“extreme need of care”)	700	1,550	1,550
Special cases		1,918	1,918

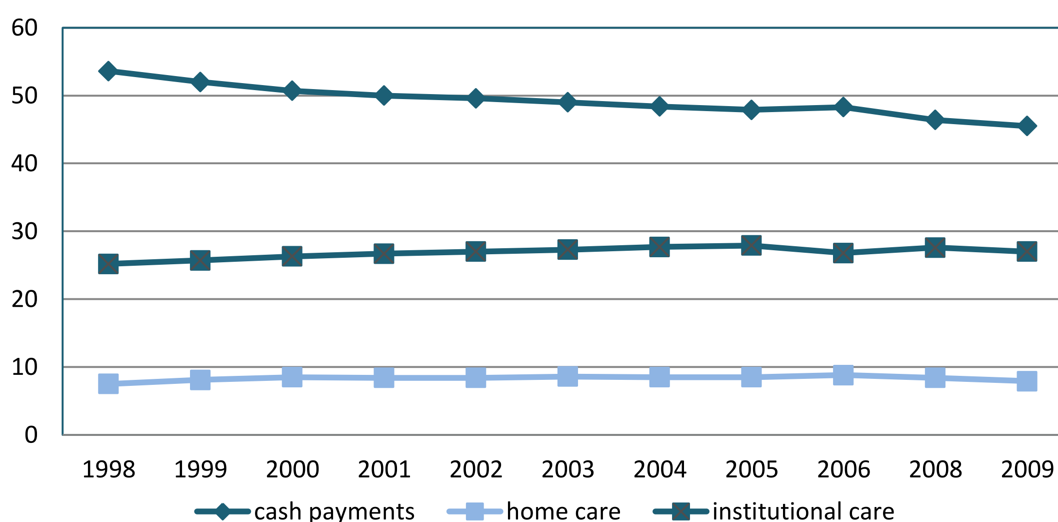
Source: BMG (2009)

Additionally, people can choose between receiving stationary or home care. It is noteworthy that this decision is totally up to the patient and not the insurance. Furthermore, people in home care have a choice between benefits in kind (for home care services), cash payments (for informal provides care), or a combination of both. Cash payments are given directly to the person in need of care – and not to the care-giver. The recipient is supposed to pass the money on to his (informal) carer but is not obliged to.

2 Economic and employment development in the sector

At the end of 2009 about 2.34 million of people in German were in the need of care. 1.62 million of them (69%) were cared for at home, either solely privately by family members (66%) or professionally by home care services or both (34%) (**Fehler! Verweisquelle konnte nicht gefunden werden.**). The dominant type of benefit of the LTCI until today is the cash allowance, although its share has been decreasing since 1998. 31% of those in need of care are receiving stationary care, 8% are relying on home care services, only. The shares are fairly stable over time, although a tendency towards professional care is perceptible (BMG, 2010)

Figure 1 Development of services (in %)



Source: BMG (2010). Statistiken zur Pflegeversicherung. Berlin.

2.1 Structure of home care providers

In the course of the introduction of the care insurance act, the amount of care services had increased significantly. The latest statistics (2009) are counting 12,026 home care services in Germany –, compared to 1995, the numbers have nearly tripled. However, detailed analysis shows a phase of consolidation between 1999 and 2001 with a small reduction of home care service providers (from 10,820 to 10,594), followed again by an increase between 2001 and 2007.

In Germany the market of professional elderly care is shared by three different kinds of providers: private companies, public (municipal) providers and non-profit organisations (such as the Red Cross, ecclesiastical or social welfare providers). Nearly two thirds of home care providers are private companies by now, and 37% are non-profit organisations. The market share of public providers is only marginal. As it is shown in the table below, the share of private providers has grown significantly during the last decade while non-profit organisations and public providers have lost market share.

According to the interview partners working conditions of employees do not systematically vary across different provider types. Nevertheless, the most extreme forms of under-payment and time pressure apparently are likely to be found among private providers (according to union representative and professional organisations).

Table 3 Provider structure of home care services

Provider	1999	2009
Private companies	43.7%	62%
Non-profit organisations	51.4%	37%
Public provider	4.9%	2%

Source: Statistisches Bundesamt (2001, 2009)

The number of patients in need of care that have to be looked after differs markedly according to provider. At non-profit providers, one agency caters on average for 64 people in need, at private providers the number is 35; on the whole home care services provide for 46 patients on average. A detailed description of the provider structure is listed below. The table shows clearly that private providers are mainly concentrated in smaller home care companies, while non-profit providers tend to have larger care units. Public providers seem to have found their niche in the field of middle-sized companies. Over the years there appears to be a tendency for private providers to expand.

Table 4 Patients in need of care within home care services according services providers (15 Dec 2009), 2003 share in brackets

Number of patients cared for	All		Private providers		Non-profit providers		Public providers	
	N	%	n	%	N	%	n	%
1-10	1,058	8.8 (8.5)	890	12.0 (11.5)	153	3.4 (4.7)	15	7.8 (7.1)
11-15	878	7.3 (8.3)	712	9.6 (11.5)	155	3.5 (4.3)	11	5.7 (8.2)
16-20	1,082	9.0 (9.4)	867	11.7 (12.9)	206	4.7 (5.1)	8	4.1 (7.7)
21-25	1,071	8.9 (10.5)	828	11.2 (13.1)	231	5.2 (7.2)	12	6.2 (8.2)
26-35	1,876	15.6 (17.0)	1,310	17.7 (19.6)	527	11.9 (13.6)	38	19.7 (18.0)
36-50	2,186	18.2 (17.9)	1,316	17.8 (16.7)	834	18.8 (19.5)	35	18.1 (20.8)
51-70	1,679	14.0 (13.2)	818	11.1 (8.7)	831	18.7 (19.8)	30	15.5 (15.3)
71-100	1,213	10.1 (9.5)	402	5.4 (4.4)	783	17.7 (16.1)	28	14.5 (10.9)
101-150	709	5.9 (4.1)	201	2.7 (1.4)	498	11.2 (7.6)	10	5.2 (3.3)
>150	274	2.3 (1.6)	53	0.7 (0.4)	216	4.9 (3.3)	6	3.1 (0.5)
Total	*12,026*	*100*	*7,398*	*100*	*4,433*	*100*	*195*	*100*

Source: Statistisches Bundesamt 2005, 2009

2.2 Employment in the home care sector

In 2009, there were roughly 249,000 people (+46% compared to 1999) working in the home care sector, the large majority of them being women (88%; 1999: 85%) (Statistisches Bundesamt cf. www.sozialpolitik-akuell.de). Just about one quarter of employees were full-time employed, the majority was working part-time. Until 2005 the share of full time workers has been dropping steadily, since then the numbers have been consolidated. While the share of workers working “longer” part-time (i.e. more than 50%) has been slowly increasing, the shares of “short” part-timers and also the marginally employed have been more stable over time. This is in contrast to the assessment of union representatives who claim that marginal part-time work in home care has been significantly increasing.

Table 5 Employment in the home care sector by working time (in %)

	1999	2001	2003	2005	2007	2009
Full-time	31.0	30.3	28.6	26.3	26.4	26.8

Part-time (> 50%)	26.7	29.0	30.2	31.8	32.9	33.1
Part-time (50% and shorter)	15.7	16.3	16.3	16.4	15.5	15.0
Marginally employed	21.3	19.7	21.2	22.4	22.5	22.5
Else	5.3	4.7	3.6	3.2	2.7	2.7

Source: own calculations, base Pflegestatistik (2007), c.f. Bücker (2010)

There is no systematic information about working conditions among part-time workers and the marginally employed available. However, there has been evidence that in some cases (establishments belonging to Caritas and the Red Cross) the marginally employed have been experienced wage discrimination[1]. According to ver.di, employers use part-time workers as a means to obtain flexibility. Part-time workers are more inclined to work (non-compensated) overtime and often have bad working times or split shifts (two hours in the morning, two in the evening). Hence, it can be concluded that marginally employed care workers in particular are "vulnerable".

As has been mentioned before, the German care market is highly regulated: it is strictly listed what kind of care is required by a patient (e.g. hygiene, feeding) and, how often and in what time period it is to be provided by the care worker. Each activity is charged for by a pre-defined amount of money by the care insurance scheme (Pflegekasse). Given this regulation, it becomes obvious that the scope for reducing costs is limited. According to ver.di and representatives of Caritas and professional organisations, the main leverage points in order maximize profit are personnel costs. Normally, staff costs in the elderly care sector amount to roughly 70% of total costs - some private providers already managed to lower them to 50%, by

- Employing a disproportional amount of underqualified or untrained staff
- Employing so called mini-jobbers (an employment form of marginal part-time that is exempt from social security payments) who often can be employed at very low hourly wages
- Ignoring the fixed-by-law rate of fully trained personnel (Fachkraftquote) of 50% per establishment – in some private companies the Fachkraftquote is said to be only 35%
- By exerting time pressure (applies to all provider groups)
- And – in particular in the case of nursing homes – by contracting out (laundry, cleaning, kitchen) (applies to all provider groups)

2.3 Who is working in the elderly care sector?

Care, regardless if provided formally or informally, is a female dominated obligation. 88% of employees in elderly care are women (Statistisches Bundesamt, 2009), and data

[1] In Germany, it is the law that full- and part-time workers have to get the same wage rate.

suggest that the typical employee in the elderly care sector is on average older than employees in other professions. This may be due to several reasons:

- High fluctuation of younger employees: it is known from previous studies that the survival rate in care professions is relatively low – in particular it is the young and well-qualified generation that is leaving the care profession (results from the Next-study).
- During recent years the majority of new trainees in elderly care work were not recent school graduates but career changers that had completed vocational retraining or further qualification measures in health care funded by Bundesagentur für Arbeit. In 2000 and 2003 about 48,000 unemployed persons participated in those measures. Approximately three quarters of them were trained to become elderly care workers (IAB-Forum 2005, 44). Graduates of those measures generally are female and, with a mean age of 37 years, comparatively old (IAB 2005).
- Among nurses elderly care is often disregarded and especially young nurses seek employment apart from elderly care. Only when they return from parental leave or family time they turn to elderly care providers as they offer better work-life balance opportunities than stationary care (professional organisation representative). This is because home care providers were among the first to offer part-time jobs to their employees.

Over the last years the share of women working in care professions has been increasing further. It is noticeable that among men both the proportion of workers with no vocational training at all and those with academic degrees is significantly higher than among women (Statistisches Bundesamt 2011). There is also a difference between women and men with regard to working time: Men working in the elderly care profession are more likely to be employed full-time than women, and their share in higher positions is disproportionally high (ver.di interview). According to all interview partners it is unlikely that this uneven gender distribution will lessen any time soon.

2.4 Education and Training

Germany is among the few countries worldwide where elderly care work is an autonomous profession that implies a three year training course. As such it differs in its demands, professional training and work contents from those of nurses. While the training courses of elderly care workers revolves around the wide topic of care, focusing on geriatric medicine and gerontology they are less medically oriented than the training of nurses. As a result there are some tasks (e.g. to administer intravenous injections, to take a blood sample) that elderly care workers are not allowed to perform but that have to be left for nurses. These differences often imply a hierarchy between nurses and elderly care workers and some elderly care workers express a feeling of being disregarded. However, there are currently undertakings to unify training courses between elderly care workers and nurses, so that these differences are likely to be vanishing soon.

Table 6 Qualification level of employees in the long-term care sector

	Home care services
Exam. Elderly care workers	14.9
Exam. Nurses	32.7
Auxiliary workers	21.5
Academic degree (in health care)	0.3
Other care workers	2.7
No health care training	18.0
Unskilled workers	10.0

Source: RKI, 2004, S. 18, 19

Despite the fact that elderly care work in Germany is an autonomous profession, the qualification level in the elderly care sector is disparate. Most employees in the elderly care sector who completed professional training are qualified as nurses or elderly care workers. A remarkable fact is the high share of unskilled workers and people working not in line with their qualification The latter proportion has sextupled between 1996 and 1999 (Kesselheim, 2004, S. 54). On the whole the qualification level of people working in home care services appears to be higher than of those working in nursing homes. The high share of examined nurses employed in the elderly care sector is to be understood in line with the special contents of the education of elderly care workers that includes less training in medical treatments than the training of nurses. In addition, a wave of dismissals of nurses in hospitals occurred in recent years due to restructuring processes, with nurses moving into elderly care (see Chapter 4.1).

Traditionally care for the elderly in Germany was supplied by churches (nuns) and dioceses. West Germany started to establish an own vocational training for elderly care workers in the mid-1960s, since the 1970s there have been own vocational schools that provide the training. However, until recently there was no nationwide standard training within the elderly care profession. Instead the regions regulated the training on their own behalf (IAB, 1995). Although possibilities to undergo training as an elderly care worker reach back to the 1960s and 1970s, the share of untrained workers or workers with an initial training in a different vocational field is traditionally high in the elderly care sector. It was not until August 2003 that Germany managed to standardize the vocational training for elderly care workers. The contents of the training are regulated in the federal law on the care for elderly people. However, the training itself still lies in the responsibility of the Regions, (Gesundheitsberichterstattung des Bundes, 2004, 36 and 39)[2]: According to this regulation, the aim of vocational training is to "qualify (*the apprentices*) for the autonomous support for, care and counselling of elderly people" (Gesundheitsberichterstattung des Bundes 2004, 39)

[2] There is however no uniform regulation with regard to the training contents of the elderly care workers aids.

Trainees are required to have a leaving certificate from secondary school (Realschule or equivalent. Applicants with a lower degree need to have completed an additional training course of at least 2 years (e.g. as an elderly care workers aid). The length of the training to become an elderly care worker is three years (full time), followed by a 6 month qualifying period.

The apprenticeship is divided into theoretical and practical sections. The theoretical training comprises 2100 hours and involves topics such as

- Concepts of elderly care
- Support of elderly with regard to the demands of daily life
- Legal and institutional framework conditions

The practical lessons cover 2,500 hours of which at least 2,000 hours have to be completed within a stationary institution or home care service. The residual hours can be split amongst other institutions (such as psychiatric clinics, hospitals with geriatric treatments). The training concludes with a training certificate (see BMFSFJ, 2003).

3 General background on the organisations and the interviewees

For the purpose of this report, four interviews - two with union representatives, one with a representative of an employer organisation and one with a representative of a professional organisation - have been conducted. Also results from a previous interview with a churchly provider (who wanted to remain anonymous) have been added where appropriate.

3.1 Union: ver.di

Ver.di: Vereinigte Dienstleistungsgewerkschaft; Bundesfachbereich: Gesundheits- und Sozialwesen; Betriebs- und Branchenpolitik – Pflegeeinrichtungen – Bundesverwaltung

Interview partner: Head of the division long-term care establishments, Department Health and Social Service

Our interview partner is working in the department Health and Social Service, she is head of the division long-term care establishments. She has been working at her position since 2003. Before, she was engaged with the long-term care insurance. Before her employment with ver.di she has been working in the field of care herself and has acquired own “care competence”. She has full expertise of the elderly care sector, her main focus, however, is on stationary elderly care.

Ver.di: Fachbereich Soziale Dienste, Wohlfahrt und Kirchen im Landesbezirk NRW
Interview partner: trade union officer

This interview partner is head of the department social services, Welfare and Churches in the region of Nordrhine-Westphalia. He has profound knowledge about current developments in the elderly care sector. He is specialized in the domain of establishments belonging to non-profit organisations, although his main focus is on stationary care.

Ver.di was founded in 2001 when the German Salaried Employees' Union (DAG) merged with four unions of the German Confederation of Trade Unions (DGB) (DPG, HBV, ÖTV, IG Medien). It has currently about 2.1 million members and is one of the largest independent, individual trade unions in the world. As a multi-service trade union it represents people employed in over 1,000 different trades and professions. Ver.di is the second largest union in Germany (first is IG-Metall).

Ver.di is democratically structured and divided into four levels and 13 sectors. In addition, women and special interest groups have their own organisational units and activities. The levels are Bund (national level), Landesbezirke (regional districts) and Bezirke (districts) and local level. The mentioned sectors are similar to those of employers:

- Financial services (sector 1)
- Utilities and disposal (sector 2)
- *Health, social services, welfare and churches (sector 3)*
- Social insurance (sector 4)
- Education, science and research (sector 5)
- Federal Government (*Bund*) and federal States (*Länder*) (sector 6)
- Local Authorities (sector 7)
- The media, art and culture, printing and paper, industrial services and production (sector 8)
- Telecommunications, information technology, data processing (sector 9)
- Postal services, forwarding companies and logistics (sector 10)
- Transport (sector 11)
- Commerce (sector 12)
- Special services (sector 13)

Additionally the sectors are also divided in several subsectors. Sector 3, the sector relevant for the purpose of our report, is divided into 7 Bundesfachgruppen, among those the home care, semi-residential and residential care.

Collective bargaining is the core activity of ver.di. The different sectors establish their own collective bargaining commissions which have the right to cancel collective bargaining agreements, make demands and pronounce on the results of negotiations. These collective bargaining commissions will observe the collective bargaining principles laid down by ver.di at all times. These principles are put forward by a cross-sector collective

bargaining committee, and are passed by the ver.di Trade Union Council. A clearing house exists to ensure there is unity in diversity. This body examines individual collective bargaining agreements for compliance as per their essential pillars with the above mentioned principles. The ver.di National Executive Board (*Bundesvorstand*) is ultimately responsible for collective bargaining demands and agreements (see www.verdi.de).

3.2 Employer organisation

Bundesverband der privaten Anbieter sozialer Dienste (bpa) (employer organisation of private providers of social services)

Interview partner: executive director

The bpa is an employer organisation and was founded 1964. It represents both private home care services and nursing homes (among others with care associated institutions). With more than 6,500 members it is the largest special interest group of private providers of social services in Germany. 3,100 of the members are home care providers. In total they provide for ca. 150,000 patients in Germany and they are responsible for 200,000 work places. Members are typically SME with on average ten employees per home care service.

The bpa is organised in 16 regional groups (Landesgruppen) covering all Bundesländer. It is member in several organisations: The European Confederation of Care Home organisations, der Europäischen Vereinigung privater Heiträgerverbände, dem Bundesverband der Dienstleistungswirtschaft (BDWi), im Kuratorium Deutsche Altershilfe (KDA).

The employer organisation bpa is not able to negotiate collective bargaining.

3.3 Professional organisation

Katholischer Pflegeverband e.V. (Catholic professional organisation)

Interview partner: executive director

The Katholischer Pflegeverband (catholic care organisation) is a professional organisation with approximately 7,000 members. It is the largest Christian professional care organisation in Germany and a result of a fusion of two former organisations (Caritas-Gemeinschaft für Pflege- und Sozialberufe e.V. and Katholischer Pflegeverband e.V.). The objectives of the Katholischer Pflegeverband e.V. are consulting and support of members, lobbying activities, political representation. The recent activities include the improvement of care training, improvement of working conditions, implementing of a Christian coaching that enables care workers to better deal with the demands of their jobs, and also the Katholischer Pflegeverband aims at the establishing of a General Nursing Council.

Our interview partner has a qualification as an examined nurse and has worked several years as head of a division in a hospital (Pflegedienstleitung). In the following years she

studied nursing sciences and Charitas-science (a course that qualifies for working in ecclesiastical and other non-profit organisations). She has worked several years at the association level and is very much informed about the current development in the elderly care sector.

4 Current developments and estimates

4.1 Quality of work/ work characteristics

Care often needs to be provided day-long. Consequently, working in care means working in shifts, and including weekends and holidays. The most typical shift pattern in Germany is a 2 or 3 shift-system. Working time in elderly care is characterised by a low degree of employees' decision latitude but a high demand for overtime (according to dip there were 8 million hours worked overtime in 2001, dip Perspektiven, 2004, S. 1). This is due to an inherent shortage of staff which both mirrors a general shortage of adequate staff and reflects cost pressures that prevent companies from hiring (see below). Moreover, the bulk of work of home care workers concentrates around a normal daily routine, that is in the morning (washing, teeth-brushing, dressing), at noon (feeding, mobilizing) and in the evening (washing, feeding, bedding). Since all patients more or less require attention at the same time, many providers employ part-time workers and marginal part-timers to ensure maintenance.

According to the interview partners there have not been many changes when it comes to the daily work of home carers. The basic contents of home care work have remained the same during the last decade, although time pressure and administration duties have increased markedly (see Table 7). According to all interview partners the basic characteristic of home care work today is high time pressure and work concentration. Employees are working under strong time guidelines that often cannot be fulfilled. Many employees complain that even the time set for driving from patient to patient is so unrealistic that they already are short of time when they arrive at their first client per day. Some providers are even known not to pay for petrol or commuting time, which further lowers the income of care workers. Also, there are strict time regulations for each care activity, and any deviation from the scheme, because the patient has some extra needs etc. imposes further time pressure. According to Caritas and ver.di many elderly care workers experience moral conflicts because they see that they cannot perform the kind of care that they perceive is really needed. There is never time to talk to the patients or to listen to their problems. During their training elderly care workers learn that real care work involves also "relationship building" but the reality has nothing to do with it. Many care workers invest leisure time in order "to do care rightly". High time pressure and the lasting effect of moral conflicts lead to a comparably high burnout rate among elderly care workers. Moreover, the special working conditions of mobile home carers add to a general feeling of being overburdened. Home care work is basically a very lonely and individualistic job. It takes place in the private home of the patient instead of an office or a company. Hence, actual working conditions vary across patients (some have lifting aids or

special beds, some have not etc.) and possibilities to discuss job matters with colleagues are scarce. Workers have to make important decisions regarding the care situation on their own. Other typical working characteristics are high physical and emotional demands which may be reasons for the fact that elderly care workers call more often in sick than workers in other sectors. Moreover, a survey shows that 50% of elderly care workers do not believe that they will be able to work at their job until retirement age (DGB-Index Gute Arbeit).

Table 7 Typical activities of elderly care work

Typical activities of elderly care workers	Examples
Basic care	— Professionally putting bedridden into another bed — Help with dressing and undressing — Help with personal hygiene (washing, combing, teeth brushing, etc.) — Changing diapers — Feeding
Carrying out therapy care following/according to a medical prescription and help in rehabilitation	— Assort and administer medication — Carrying out special treatment such as clysters and irrigations — Changing of bandages — Skin care — Help with physiotherapy
Monitoring the patient's condition with respect to changes Documenting the care giving activities Co-operation and of exchange of information with doctors First aid	
Upkeep/Maintenance of an autonomous lifestyle and providing counselling on daily routines	— Speaking comfort and providing encouragement — Counselling on health care provisions — Counselling on difficult situations in life — Providing information about day-care centres, self-help facilities, and ancillary services (meals on wheels etc.) — Support of inter-personal relationships — Provisions against isolation and increasing solitariness — Intervention in crisis situations — Creating contact to offices and authorities — Help in filling out forms and requests
Terminal care	
Administrative and organisational tasks	— Writing reports — Drawing up accounts of care services rendered

Source: www.dbva.de, 15 August 2006

4.2 Shortage of workers?

Due to changing gender roles, an increase of life expectancy and multimorbidity, many countries face a scarcity of carers – often compensated by migrant workers. Until very recently Germany, in contrast to other European countries, did not face a shortage of nurses/elderly care workers. Relying on migration in order to secure the supply of care needed is only beginning to be an issue within the discussion of the German Health System and is still far from the situation in the UK or Italy (Hasselhorn et al., 2003). Due to structural changes in the hospital sector that were accompanied by a severe reduction in jobs, many nurses were seeking employment in the elderly care sector instead, thus delaying a staff shortage. Indeed, in some cases elderly care workers faced the situation to be replaced by nurses who have broader training and allow for multifaceted operations.

Only recently a shortage of care workers has been claimed for Germany, too: "the market is empty" (professional organisation). This is true for specialised personnel with additional qualifications in particular. While nursing and especially elderly care work due to bad working-conditions and low wages is in general not seen as a very attractive career, some of the newer problems with staff recruiting are home-made. Usually, the demand for elderly care workers was satisfied to a large extent by so called re-trainees (Umschüler), supported by the Agency for Labour. In 2006, the Agency for Labour abandoned the complete funding of the training. The last year of that training was now supposed to be funded by the Regions and the establishment that provides the practical part of the vocational training. This negatively affected the willingness of establishments to take on trainees: increasingly they abstained from of offering practical training in order to reduce costs. As a result there are currently fewer available training positions than at the beginning of the millennium (ver.di interview).

- Moreover, mobile home care services are usually not offering any training positions at all; as a consequence they have to rely on job changers in order to recruit staff. Besides, this may also be a reason why staff in elderly care are usually older than in hospitals.
- Some private schools are demanding tuition fees (between 50 € and 175 €).
- Some, mostly private providers, pay so little that their employees have to rely on supplementary benefits to make a living.
- Other than expected the opening of the German labour market for East-European countries on May 2011 has not resulted in a rush of East-European care workers.

While the demand for elderly care workers is increasing, so are unemployment figures (in 2009 34,200 elderly care workers were registered as unemployed; ver.di personal interview). This phenomenon is due to several reasons. Firstly, many listed unemployed elderly care workers are not seeking a new job within the elderly care sector, for example for health or burnout reasons. Secondly, studies on staffing processes show that open positions are filled late or not at all. In particular there is a problem with regard to qualified personnel and personnel with specialised further qualification (personal interview, ver.di, professional organisation). Moreover, managers within elderly care work report that they receive ample applications but applicants often show a lack of social skills (personal

interview, see also Hieming, 2005).It is expected that this situation will become more severe in the upcoming years.

In recent years, a parallel market for (often illegal and mainly East European female) health care workers has emerged. These workers are offering to provide 24 hours services whilst living with their patients in their residences. They often stay for a three-month period, then return home and take turns with colleagues. Although an estimation of the number and distribution of illegal care worker is by its very nature difficult, it has been estimated that there were about 5,000 foreign illegal care givers in Germany in 2002 (Erdmann, 2002). According to ver.di, illegal carers (or domestic assistants) do not distribute uniformly across Germany, but there are strong regional differences. A new way to place illegal workers appears to be via Internet: a so-called care transfer organisation launches an only temporarily available website where services are offered. Contact partners are only be reached by mobile phone number.

There are several reasons for this rather new trend: As has been said before, to be cared for at home in one’s own private environment as long as possible is a key concern of most people in need of care, since it is regarded as the only way to maintain self-determination. Changing gender roles have led to a higher employment rate of women who are thus not available anymore for unlimited care of elderly relatives. As a result of the cash allowance that is given to compensate informal care, a limited amount of additional means are available for making the German ideal of being cared for at home come true. This and the economic situation in the new member states are the essential driving forces behind the increase in illegal employment in private households. In this context, important EU regulations are the freedom of establishment (article 43) and the freedom to provide services (article 49). Illegal carers are incomparably cheap; according to estimations, salaries for illegal carers are only one tenth of salaries legal carers and lie between 600 and 800 Euro + board and lodging. Additionally, 24 hours care can push back the point in time at which a referral to a nursing home becomes inevitable (neue Caritas, 2006, S. 9).

4.3 New and old jobs

It has been already stated that home care work is defined and by those activities that are paid for by the long term care insurance (see Table 1). Thus, home care is perceived to be a fragmented and sometimes cognitively unchallenging work that also lacks career opportunities. In contrast to this notion, increasing professionalization and rising academic degrees of care workers are seen as one of the major changes that have occurred during the last years (interview professional organisation). During the last decade more and more study courses and alternances have been implemented on universities or universities of applied science. It is assumed that the academisation will have a long-term effect on both working conditions and self-conception of workers.

According to the interview partners there have not been many changes when it comes to the daily work of home carers, the basic features have remained the same during the last decade although time pressure and administration have increased markedly. Recently, new jobs have developed that involves a certain specialisation of the workforce.

- Because of changes in hospital structure residence time of patients has been shortened markedly. Nowadays patients return home much earlier and much of the convalescence is to take place at home. This also applies to older patients who are already depending on elderly care (be it stationary or home care). Since patients returning home from a hospital stay thus are sicker or less healthy than in earlier days, home care workers now must also engage in sick-nursing.
- Counselling and mentoring of relatives. Apart from actual caring activities care workers are increasingly confronted with counselling and advisory duties. In particular family care givers are in need of counselling support. Important topics here for instance, are how to deal with relatives that suffer from diabetes or dementia, but also how to deal with public authorities and administration.
- Dealing with elderly who suffer from dementia or are mentally handicapped. According to a Caritas representative, Germany has only low experience with dementia or older mentally handicapped patients. This is still a result of the Nazi regime where whole age cohorts of mentally handicapped people were killed (also people with dementia). The cohorts of mentally handicapped born after 1945 are only now reaching old age and require special care that cannot easily be given by “normally” trained elderly care workers.
- Dealing with multimorbidity of patients. Relating to increased age the likelihood to develop multiple diseases has risen, too. Specially trained care-givers are necessary to deal with these new demands.
- Experts in palliative care.

There is currently no information available about the prevalence of these new jobs.

5 Collective bargaining and social dialogue

Working conditions in the elderly care sector are not subject to a general collective labour agreement. In total, collective bargaining coverage is extremely low in this sector. There is no employer organisation that is able or prepared to negotiate collective agreements. Hence, labour agreements mainly apply to establishments belonging to public and municipal care providers, additionally non-profit organisations usually have company agreements. According to ver.di there is currently no private provider of home care that relies on a collective agreement.

The actual collective labour agreement in the domain of public providers is the TVÖD. Note that only about 2% of providers belong to this tariff scheme. According to ver.di the average monthly pay for an examined elderly care worker with a public provider is between 1,967.31 € and 2,532.13 € (gross), at 39 hours per week. The basic salary for elderly care worker aids according to the tariff varies between 1,743 € and 2,286 € (WSI Tarifarchiv 2011; http://www.boeckler.de/index_wsi_tarifarchiv.htm).

For a long time most of non-profit organisations adjusted their wages (and working conditions) on the rate system according to the public service. After changes in this rate system were made in 2006, non-profit organisations (such as AWO but also Caritas and

Diakonie as ecclesiastical providers) increasingly tried to withdraw from that scheme and implement their own independent collective agreements with worse working conditions and lower wages. According to ver.di and professional organisations this trend has recently been stopped and non-profit organisations are more and more returning to the public service tariff scheme. Their position is not uniform, however, but differs at regional level; some regions adopt the collective agreements, others do not.

In Germany, ecclesiastical providers have special rights and follow different regulations when it comes to labour agreements (the so called third way). Strictly speaking working contracts that follow those regulations are not collective agreements in a judicial sense because they are not negotiated with unions. Those working contracts are called AVR (Arbeitsvertragsrichtlinien). AVRs are negotiated by committees that are to be equally composed of employers and employees. According to the recent AVR (Caritas) an examined elderly care workers earns between 2,130.51 € and 2,513.47 € (39 hrs/week). According to ver.di some ecclesiastical carriers try to reduce cost by sub-contracting temporary employment agencies. In this way, employers are hired at lower wages, and permanent employees can be replaced by agency workers. According to estimates by ver.di, 10-20,000 employees in Germany are affected by this development.

Private providers are under particular pressure to maximize profit. Private providers assume a minimum rate of return of 7%, and this goal is predominantly achieved by lowering staff costs, that is the cost pressures that private providers are exposed to are passed on to the employees (ver.di interview). Still, salaries vary markedly between employers and also the regions. Although it appears that extreme forms of underpayment and exhausting working conditions are more likely to be found among private employers, there are huge differences. Generally speaking, wages are lower in East-Germany than in West-Germany and higher in urban areas. According to ver.di, some (East-German) providers are known to pay hourly wages of about 4.50 €. To avoid the expansion of these adverse working conditions a minimum wage was imposed in 2010 in the care sector (8.50 € in West-Germany, 7.50 € in East-Germany). According to ver.di the effects of this minimum wage are currently barely perceptible[3].

The rate of unionisation is traditionally low among elderly care workers. According to ver.di only about 7-8% of care workers in home care are members. Even lower is the share of care workers who are organised in professional organsiations (about 6% according to Caritas). There is no information about who the members are. However, it is not expected that they differ systematically from the work force. The interview partners mentioned several reasons for these low organisation rates: First, the vocational self-esteem among elderly care workers is comparatively low, which may lead to a low readiness and willingness to collectively fight for better working conditions. Second, care workers generally express high demands of themselves and strong commitment (see below). According to ver.di representatives care workers are reluctant to go on a strike if they cannot be sure that their patients are meanwhile provided with adequate care.

[3] Note that many employer organisations were against the implementation of a minimum wage.

Currently unions are starting new campaigns in order to enhance the union density among elderly care workers (personal interview, ver.di representatives).

Second, care workers generally express high demands of themselves and strong commitment (see below). According to ver.di representatives care workers are reluctant to go on strike if they cannot be sure that their patients are meanwhile provided with adequate care. Currently unions are starting new campaigns in order to enhance the union density among elderly care workers (personal interview, ver.di representatives). With regard to home care it has also been stated that working conditions are so demanding that workers who are also likely to having reconcile family and work are too exhausted to actively engage in a union or professional organisation.

6 Relationship with other actors and institutions

The interviewees know each other very well either personally or via their respective organisations. Although their basic assessments of the situation of elderly care work(ers) (for instance about staff ratio, working conditions, time pressure and institutional frameworks) are surprisingly similar there is no collaboration of either sides. There are in particular strong resentments between unions and ecclesiastical representatives. According to ver.di ecclesiastical providers are refusing any collaboration with unions. In Germany, Unions and churches have traditionally had a difficult relationship.

7 Perspectives

The health minister has already announced that changes in the domain of elderly care will take place in the near future. Most likely the contribution payments will be increased to compensate for rising numbers of people in need. At the same time further measures to advance and improve the situation of informal (family) caregivers will be implemented. Already now informal caregivers are receiving pension entitlements and they are also insured against accidents. Employed persons who want to care for a relative are entitled to take a 6-month (unpaid) leave. This is fully in contrast to the ongoing and much needed professionalization of care. Germany apparently continues to rely on a mixed strategy of encouraging the use of unpaid family carers (or those working for pocket money) and is on the same time intensifying the training and education of nurses, while ignoring the actual working conditions and realities of professional carers. In the near future, a shortage of qualified elderly care personnel is to be expected, but, according to the interview partners, this is only slowly (if at all) reflecting in better working conditions. One sign for the better is the already mentioned trend of non-profit organisations to return to the public tariff system. On the other hand there are also contradictory indications. For instance, there are attempts to classify aids with a two-year-education as fully examined care workers (a full training course requires 3 years).

So far the opening of the labour market to East-Europe has not brought much relief for the elderly care market. According to professional organisations, working conditions and payments in other countries, namely Austria, are much more attractive for care workers. Instead a trend towards emigration of care workers from Germany to the Nordic countries and Austria has been recently observed.

8 Conclusions

Germany responded to the threat of an ageing and possibly increasingly frail society with the introduction of the Long-Term Care Insurance. At the core of this act lies the wish to decrease costs in attendance of the elderly while optimizing and maintaining quality standards. It can be stated that the introduction of the Long-Term Care Insurance marks a turning point within elderly care resulting in the initiation of a new market. The labour market is still developing, and it is not quite clear yet in which direction it is heading. As for employees, there is evidence towards an ongoing professionalization of staff. This is underlined by the development of a standardized training systems and rising figures of employees that have completed such training as well as growing numbers of academic graduates in the sector. On the other hand, there is also a high percentage of untrained workers and workers stemming from another profession working in elderly care that seems to contradict the described pattern of increasing professionalization. Moreover, this combination of qualified and unqualified workers is an indicator of a high degree of labour division.

As for the provisional structure, it can be stated that the old structure (private, non-profit, and public provider) is basically prevailing, but that there has been a shifting of weights within this structure: Public providers (with collective agreements) increasingly withdraw from the market and presently only play a marginal role, while private providers (with no collective agreement) seem to replace them.

Taken as a whole, the German elderly care market is a market in transition and still hybrid in its characteristics. It faces multiple pressures of strict regulations (fixed by law) on one hand and highly competitive structures on the other. So far the market has reacted mainly in passing the pressures on to its employees by reducing hourly wages, expanding the division of labour and offering poorer working conditions (time pressure). However, as shortages of nurses and elderly care workers are beginning to show, it can be expected that payment and working conditions will have to be change for the better. The question remains, though, who will be mainly paying for these changes: the Long Term Care Insurance (that is, the state) or the patient and his/her relative. This year, the department of health has published that it tends to further increase the contribution rate (now 1.95% of gross salary for individuals with children, resp. 2.20% for individuals without) and on the same time setting more incentives for informal/ family care-givers.

9 References

Bundesministerium für Familie, Senioren, Frauen und Jugend (2006). 7. Familienbericht. Bundesdrucksache.

Busse, R. & Riesberg, A. (2004). *Health care systems in transition*. Germany. Copenhagen.

Isfort, M. (2004). Pflege-Thermometer 2004. Strukturen bremsen ambulante Pflege aus. *dip Perspektiven,* 2, 1-3.

Erdmann, Y. (2002). Pflegedienste ein Pflegefall? Die Auswirkungen der EU-Osterweiterung auf personenbezogene Dienstleistungen des Gesundheitssektors. *Loccumer Protokolle: Die Mobilität von Kapital und Arbeit in der EU-Osterweiterung. Welche Anpassungsmaßnahmen brauchen wir?, 22*, 109-116.

Hasselhorn, H.-M., Tackenberg, P. & Müller, B.H. (Hg.), *Working conditions and intent to leave the profession among nursing staff in Europe*, Stockholm.

Hieming, B.; Jaehrling, K.; Kalina, T.; Vanselow, A.; Weinkopf, C. (2005). *Stellenbesetzungsprozesse im Bereich „einfacher" Dienstleistungen:* Abschlussbericht einer Studie im Auftrag des Bundesministeriums für Wirtschaft und Arbeit. Berlin: Bundesministerium für Wirtschaft und Arbeit. BMWA-Dokumentation, Bd. 550.

Kesselheim, H. (2004). Altenpflege in einem wettbewerbsorientierten System. *Gesundheits- und Sozialpolitik, 3-4*, 53-59.

OECD (2005). *Long term care for older people*. Paris.

Robert-Koch-Institut/ Statistisches Bundesamt (2004). *Schwerpunktbericht zur Gesundheitsberichterstattung des Bundes*. Pflege. Berlin.

Rothgang, H.; Comas-Herrera, A.; Wittenberg R.; Pickard, L. et al. (2004). The mixed economy of long-term care in England, Germany, Italy, and Spain. *ZeS- Arbeitspapier Nr. 3/2004.*

Schulz, E., Leidl, R. & König, H.-H. (2001). Auswirkungen der demographischen Entwicklung auf die Zahl der Pflegefälle. Vorausschätzungen bis 2020 mit Ausblick auf 2050. *DIW – Diskussionspapier 240.*

Statistisches Bundesamt (2005). *Bericht: Pflegestatistik 2003 –2011 Pflege im Rahmen der Pflegeversicherung – Deutschlandergebnisse*. Bonn