Privatization and marketization in long-term residential care in Germany – effects on care and care work

Beatrice Müller, PhD
University of Vechta

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Abstract

Marketization has been a widespread phenomenon in the German long-term and the health care sector since the 1990s. The marketization process has also gained plenty of interest in the academic field. Special attention has been paid to the effects of the logic of competition on non-profit organizations because lines between for-profit and non-profit are blurred. This paper focuses on political-economical changes within the long-term care (LTC) infrastructure in Germany as well as on its concrete effects on working conditions and care practices (employment type and hierarchization; working hours and staffing; time to care and quality of care). This study aims to demonstrate the effects of marketization on all care providers (blurring) and to re-focus the research angle away from the commonalities of non-profit and for-profit and toward the differences and their effects. Further research is needed to demonstrate these differences.

1. Introduction

Care work is body work that is based on a relationship between the care provider and the care receiver. In most capitalist societies, care work—for example, social provisioning, cleaning, cooking, elder care and child rearing—are still mostly unpaid or low paid everyday practices that are mostly done by women in private households. In Germany in 2013, 35% more time was spent on unpaid work than on paid labour (Schwarz/Schwahn 2016).

That amount of unpaid work is not a coincidence but rather a basic condition of capitalism. The capitalist economy is built not only on unequal class relations at a very basic level, but also on a tendency to devalue and externalize elements of care to the private sphere, where it is mostly invisible and unpaid (Müller 2016). The structural devaluation and externalization of care from public to private spheres also affects care work at another level of abstraction in the public and market sphere. However, the concrete organization of care (public or private, collective or individualized/as family

responsibility, etc.) is a question of political struggles and concrete relationship of forces. Nevertheless, Marxist-feminist analysis shows that if care gets commodified, the relational part that is difficult to measure will be externalized, devalued and abjected. A deterioration of working conditions, standardized care and unpaid labour are consequences of the commodification of care (for a value theoretical argument and its consequences in home care, see Müller 2016).

Marketization of LTC has been a widespread phenomenon in the German LTC and the health care sector since the 1990s. The marketization process has also garnered plenty of interest in the academic field. Special attention has been paid to the effects of marketization (here especially the logic of competition) on non-profit organizations. This paper examines political-economical changes within the LTC infrastructure in Germany and the concrete effects on working conditions and care practices. Therefore, I aim to demonstrate, on the one hand, the effects of marketization, especially the increasing market logic that also influences non-profit providers and in general leads to a blurring between non-profit and for-profit organizations (for further explanations on blurring effects, see Armstrong/Panos 2017) and its effects on working and care conditions as also an attempt at the level of the organization to cope with marketization.

On the other hand, besides the overall market tendency that puts pressure on all providers, I propose more research efforts be made in the analysis of differences between non-profit and for-profit providers and related more concretely to work and care conditions (employment type and hierarchization; working hours and staffing; time to care and quality of care) in the long-term residential care (LTRC) sector. This seems to be an important research field because private capital considers the care market a good future investment and therefore plays an increasing role. Its focus is naturally on profits; therefore, for-profit actors push for fewer state regulations (e.g. Rhine Westphalia Institute for Economic Research 2011). The growing participation of for-profit actors changed and will further change the LTC sector. Unfortunately, not much data exist that would allow a comparison between non-profit and for-profit in Germany and its effects on wages, qualification levels, etc. However, the data that do exist allow for some assumptions and demonstrate where further research has to be done.

1.1 Method

This paper is mainly based on literature and document analysis as well as ethnographic interviews and field note data obtained using rapid ethnography.

Interdisciplinary and international teams of 12 to 14 observed LTRC facilities over a week and conducted more than 500 interviews with staff, management, family members and residents in a total of 27 facilities in the context of the ongoing MCRI project "Reimagining Long-term Residential Care: An International Study of Promising Practices," led by Dr. Pat Armstrong and funded by the Social Sciences and Humanities Research Council of Canada–Major Collaborative Research Initiative.

1.2 First insights and understanding of marketization

The paper begins with a work description by a care worker I interviewed in the context of my Ph.D.

"[You] had to start washing the residents at 4.30 a.m. After that you had to position the residents in the bed with their pants and underpants pulled down (to the knees) and they changed the diaper at seven […] and they lie on the diaper, the blanket covers them, then, at best, the residents could doze a little more and at 7am, the next shift came in, and they change the diaper and got the residents out of bed. This shift followed the command d. and out of bed (diaper on and out of bed) […] (B03: 4, translation B.M., Interview PhD)

The care worker who had worked over a long period in residential care described practices that are direct results of the marketization process in Germany. Due to under staffing and a work intensification care is here organized similar to an assembly line (Armstrong 2009 et al., Matuschek et al. 2008, 50).

Marketization is a widely used concept that is understood in various ways. Therefore, marketization is not only considered a "consequent use of managerial-economic and market-based methods and regulation mode with the goal to increase efficiency" (Maurer 2015: 180, translation B.M.), but also a process that involves different societal levels.

For example, Birgit Pfau-Effinger et al. (2008) conceptualize this different processes of marketization as 1) an integration of measures to increase efficiency within the organisation of public services, 2) a decrease of public activities through the outsourcing of parts of public services and the implementation of competition and contract management and 3) a comprehensive privatization of former public services to market providers. Frank Nullmeier provides a slightly different definition that allows us to consider marketization between states as also on an individual level: consequently, Nullmeier (2004) differentiates between: 1) the internal marketization of welfare states by the creation of a welfare market, 2) an external marketization where the welfare states are

competing against each other and 3) a subject related marketization or an education to markethood ("Erziehung zur Marktlichkeit").

A different concept of marketization developed by Anneli Anttonen and Gabrielle Meagher (2013) can be applied to illustrate the marketization process in the German LTC sector and provide the possibility of comparing marketization among different welfare states. This concept involves two dimensions: It focuses on "whether or not market practices and logics (most notably competition) are used in organising services and whether or not private actors, particularly for-profit companies, are involved in providing service" (Anttonen/Meagher 2013: 16).

	Private actors involved	Private actors not involved
Market practices/ competition	1 Outsourcing with competition; customer choice models	2 Importation of private sector practices into the public sector
Non market practices	3 Outsourcing without competition	4 'Traditional' public sector provision

The first form (Cell 1) of marketization plays a central role in Germany today, and I will focus mainly on this form of marketization. The third form (Cell 3) was traditionally important in Germany because before the introduction of long-term care insurance (LTCI), the state cooperated closely with non-profit providers (welfare organizations). Different from the Nordic countries where the concept has been developed, this third form (Cell 3) has been the traditional way to organize LTC in Germany. The first form of outsourcing with competition can be differentiated for Germany between outsourcing with competition to non-profit providers and outsourcing with competition to for-profit providers, which I would rather call privatization.

2. Background: The German welfare state before its transformation

The German conservative welfare state is characterized by social insurance based on the Bismarck model. In that welfare type, comprehensive changes have been made

since the 1980s. These conversions were made against the background of demographic, social and cultural transformations and an emerging new economy at a global scale.
Between 1980 and 1990, the former welfare regime and its emphasis on local autonomy was challenged and transformed. As in many other countries, public administrations were criticized as too expensive, not efficient, or "organized irresponsibility" (Banner 1991: 6). The organizations should instead resemble modern service companies. Reforms like the introduction of a new controlling and regulation mode (NSM) in the social sector as well as health care related reforms and LTC policies were implemented (Theobald 2015: 27).

Within the long-term care sector, the background for a critique was the so-called nursing care crisis: women entered the labour market and public care provision was increasingly needed and demanded, which led to a shortage of nursing homes. The growing demand for public care was discussed as too expensive for the welfare state because care dependents in nursing homes were mostly funded by social assistance.

The introduction of the LTCI in 1995/1996 as the fifth pillar of the German social insurance system had significant consequences not only for the provision of nursing care but for the social sector in general. The goal was to redefine care provision to enable more efficient services that corresponded with the cost-containment and users' free choice goal (Theobald 2012: 65).

Nullmeier describes the law as a "market-purchasing or market-forcing law" ("Marktschaffungsgesetz") (Nullmeier 2002: 273, translation B.M.) because the implemented New Public Management (NPM) strategies were adopted in other sectors as well.

The LTCI law was an outcome of an ongoing 20-year debate and struggle between various political and civic societal actors. The final result was dominated by the (neoliberal) free democratic party (FDP) in alliance with employer associations (Lessenich 2003).

Traditionally, as we saw in the conception of marketization, public care was mainly provided by non-profit organizations called welfare associations (Cell 3), based on the concept of subsidiarity and funded by health insurance funds, social assistance institutions and public subsidization. This close cooperation between the state and welfare organizations was typical for Germany. It has existed since the Weimar Republic and was strengthened after the Second World War (Theobald 2012: 65). Welfare organizations provided care and were compensated by public funds. The focus was clearly based on need.

The introduction of a long-term care coverage as social insurance (instead of a tax-based model) corresponded with the German welfare state tradition. However, the LTCI profoundly changed the regulation mode and the relationship between state, market and welfare organizations (Theobald 2012: 65). At first glance, the results were an expansion of targeted public LTC provisions and therefore seemed to be a continuity in the German welfare provision rather than a classical neoliberal transformation. Therefore, the LTCI didn't seem to break typical regime paths. One example of this continuity is the conservative focus on family care. Accordingly, the LTCI pushed for home care and therefore kept the conservative focus on family care intact (Auth 2017).

Although the LTCI seemed to be a traditionally known instrument, according to Stephan Lessenich it was used as a tool to successfully break with the regime and transformed the entire welfare regulation. The LTCI is therefore seen as "Bismarckian camouflage" or as a "best possible shell" (Jessop) for the restructuring of the German welfare state (Lessenich 2003).

In the next section, the rupture with the regime path and the neoliberal transformation is analysed in greater detail.

3. LTCI and cost-containment

Most importantly to the cost-containment goal, the insurance was built as insurance that doesn't cover all the needs of care dependents but instead pays a lump sum for strictly defined care tasks. This is a significant departure from how the former social insurance system was built: either needs-based as health care insurance or equivalent-based as pension or unemployment insurance (Lessenich 2003: 223).

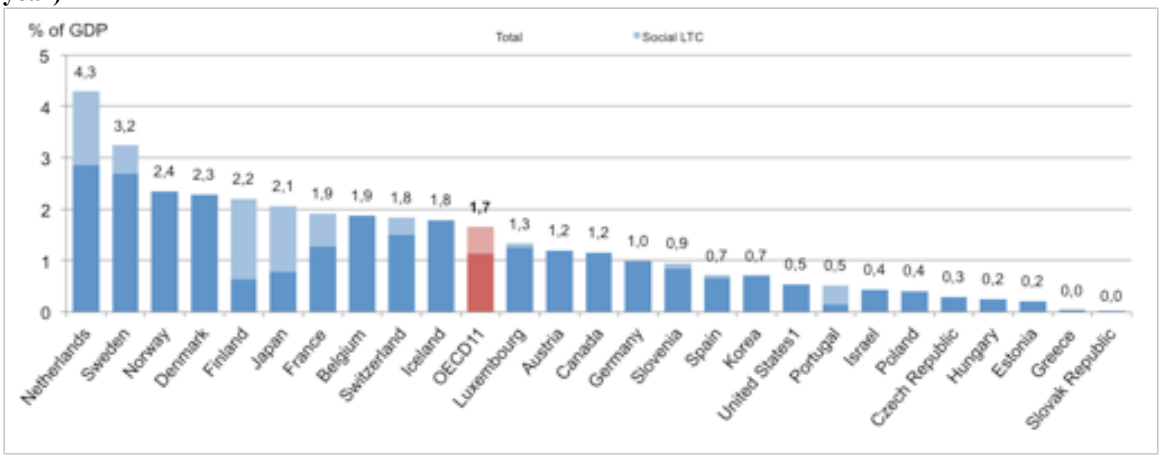
In addition, a significant departure from all other social insurance is how the LTCI is financed. Usually, social insurance in Germany is co-paid by the employee as well as the employer. The LTCI is paid the same, but the employers' share is compensated. Employers negotiated to cut a public holiday as compensation for their share. Therefore, co-payment is, according to Rothgang, only a "fiction" (Rothgang 1994, Lessenich 2003: 225, Naegele 2014). In the context of the debate of the competitiveness of Germany as a business location, this new regulation evolved to a master standard for all social policy decisions that followed: Reforms should be cost neutral, or at least should not increase costs for the employer (Lessenich 2003).

The development of private expenditures illustrates the success of the cost-containment goal. According to Lukas Slotala, the expenditure of private households in

home care increased between 2000 and 2008 around 133%, whereas the expenditure of the LTCI increased only around 15% (Slotala 2011).

The cost containment goal might also be able to explain the very low LTC public expenditure of Germany, which is, with 1.0 percent of GDP, significantly below the OECD average.

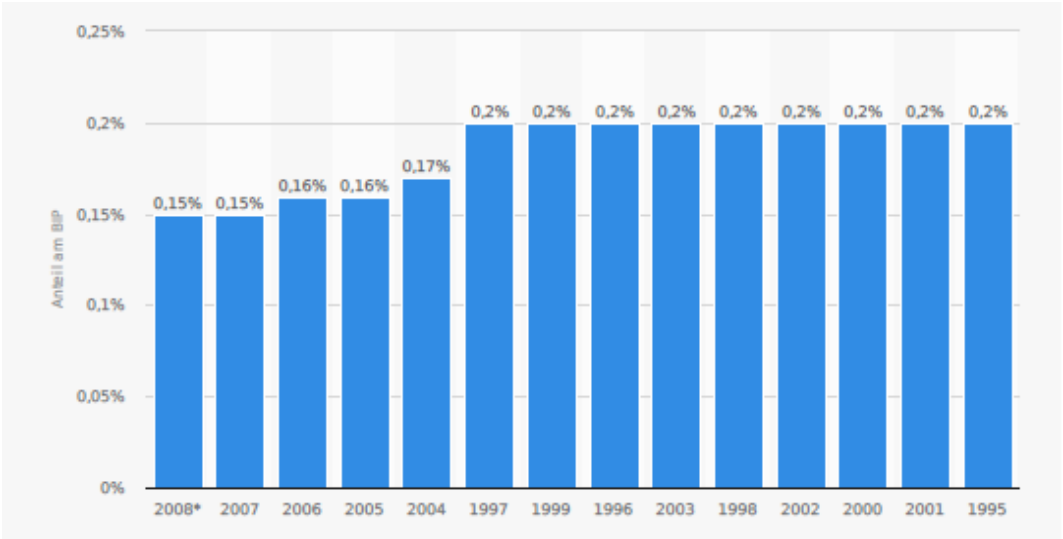
Long-term care public expenditure (health and social components), as share of GDP, 2013 (or nearest year)



Source: *OECD Health Statistics 2015*, http://dx.doi.org/10.1787/health-data-en.

If only social LTC is taken into account, public expenditure in Germany is clearly even lower.

Expenditure for social LTC as share of GDP in Germany (1995-2008)



Source: Eurostat, Statista 2016

4. Competition. Opening of the care market

Another relevant step towards privatization and marketization was the opening up of the care market. Equal terms between non-profit and for-profit providers have been introduced and the practiced cooperation between the state and welfare organizations (non-profit providers) ended. The explicit goal of these changes was to introduce competition, which led to a care market expansion based on private ownership. Outsourcing departments like laundry or cleaning also became a form of privatization. Since the introduction of LTCI, the amount of residential care homes increased from about 4.300 in 1992 (Hielscher et al. 2013) to about 13.600 in 2015 (Federal Statistical Office 2017).

Private providers have a structural advantage because they mostly don't abide by collective wage agreements and provide LTC to a lower price (Economic Research 2011, Geraedts 2016). On the other hand, welfare organizations often use and move funding from another facility that belongs to the same welfare organization (cross-subsidize) and gain money through donations, and therefore might balance the marketization pressure differently (Hielscher et al. 2013).

The following figures clearly demonstrate the steady increase of private ownership:

Development of private ownership in home care

1992[1]	**1999**	**2001**	**2003**	**2007**	**2009**	**2011**	**2013**	**2015**
about 20%	51%	52%	55%	60%	62%	63%	64%	65%

Source: own compilation from Federal Statistical Office (2001-2017) and Rothgang (1997)

Development of private ownership in residential care

1992[2]	**1999**	**2001**	**2003**	**2007**	**2009**	**2011**	**2013**	**2015**
15–20%	35%	36%	37%	39%	40%	40%	41%	42%

Source: own compilation from Federal Statistical Office (2001-2017) and Rothgang (1997)

Competition is intended around prices and quality. The price competition has significant effects and its allowance is a huge difference to other countries that also apply, like Germany, customer-choice models. In Sweden, for example, there is only competition around quality. The intended price competition is especially responsible for a marketization of care that blurs the lines between non-profit and for-profit. Competition around the care price has negative effects on work and care.

[1] Rothgang 1997: 71
[2] Rothgang 1997: 73

4.1 Contract management

The former cooperation between the state and non-profit providers was replaced by contract-management strategies. Before, the relation between the state and the welfare organizations was based on cooperation because welfare organizations were supposed to impact policy development from the perspective of the more vulnerable parts of society. Welfare organizations had an advocacy function (Theobald 2012: 67). The new coordination mode between the state, market and welfare associations is defined in the LTCI law. The care insurance funds, as quasi-public institutions, are responsible for negotiation of the contracts with all care providers that meet the preconditions, such as qualification of staff and cost-efficient services (Theobald 2012:65). Competition around a budget is becoming a characteristic of the welfare/social sector (vgl. Trube/Wohlfahrt 2000: 48). Even if there is no more need for care provision in a region, every provider has to be considered. Therefore, further regional concentration of nursing homes is expected, which will be an additional competitive advantage for nursing home chains (Lennartz 2011: 4).

4.1.1 Negotiation of care packages and care rates

Care insurance funds negotiate with care providers' or care provider organizations' (welfare organizations) prices that are adapted to the individual provider (organizations). In these negotiations, care rates (for residential care) and care package prices (for home care) are discussed and determined. The provider should be oriented at standard market prices. In practice, the provider tries to make sure that the rates or prices are high enough to cover their costs, and at the same time, they need to make sure that prices are not too high to assure a good position in a competitive field.

Expensive staff, for example a so-called non-optimal staff age structure or a collective wage agreement, which increases costs of the provider, were for a long time considered the "problem" of every provider (Oschimansky 2010: 45). In a case law in 2000 (Rechtssprechung), the Federal Social Court (Bundessozialgericht) stated:

> […] who has comparatively speaking high staff costs, needs to cut them down, if he doesn't want to be excluded from the market (Federal Social Court 2000, Point 7, Paragraph 4, translation B.M. cited from Oschimansky 2010).

However, in 2009, a new case law changed this attitude again and explicitly allowed taking collective wage agreements and staff ratio into account (Oschimansky 2010).

Nevertheless there is still the problem that, to make a profit or at least to have a balanced budget, providers need to lower their costs, which they often achieve with low wages and a particular mix of staff that is less expensive. We can therefore diagnose a blurring between for-profit and non-profit because welfare organizations follow the same competition rules. De-skilling and precarity are consequences of these strategies (see section 5).

4.2. Marketization and LTCI – conclusion

The LTC law in Germany led to a substantial limitation of the traditionally strong position of welfare organizations in Germany. NPM measures changed the organizational forms of non-profit care provision and questioned their essential values. The law led to a strengthening of for-profit providers, the regulatory position of the state and to an emphasis on market-oriented principles (Theobald 2012: 67). The regulation type of the state, hierarchy, stays intact because political actors still regulate the nursing care sector. However, another regulation mode is added to this. The mode "competition" led to a marketization of the care sector as a whole but also to privatization (Auth 2017, Theobald 2012). These findings clearly contradict the statement that a post-Fordist or neoliberal transformation goes hand in hand with a decrease of state power. In fact, the state changes its role but its power does not decrease. Private capital actors demand that the state minimizes its regulations to enable further competition (Augurzky 2015).

5. Effects on work and care conditions

In the next part of the paper I analyse the further consequences of the market-purchasing policies. As overall tendency can be demonstrated: on an abstract and a concrete level it becomes apparent that the commodification and marketization of LTC is leading to an externalisation of relational care. At a more concrete level, at least two broad consequences of marketization can be diagnosed:

- *The deterioration of working conditions and partly a de-qualification of care work and*
- *Understaffing and the standardization and taylorization of care*

5.1. The Deterioration of working conditions and partly a de-qualification of care work

Since the introduction of the LTCI, the formal care infrastructure expanded—as we saw—very much based on private ownership. According to this expansion, the formal workforce

increased from approximately 320,000 in 1995 to approximately 1.075.758 in 2015, with a rise in employment rates for both qualified and assistant labour (Federal Statistical Office, 2015; Oschmianski, 2010, Theobald 2012).

The increase is mainly based on atypical and precarious working conditions. Part-time work rose from 54.2 percent in 1995 to 69 percent in 2015 in home care and from 39.1 percent to 63 percent in residential care over the same period. In home-based care, 19.3 percent of the care workers hold a marginal employment contract, which is based on very few hours and lower social security standards. In residential care, 8.5 percent of the workforce are in that category. According to Theobald, often these care workers, who have no (or no recognized) formal training, are marginally employed and therefore belong to that category (Theobald 2012: 69, Federal Statistical Office 2017).

The increase of atypical employment can be explained by price competition and contract management, which I described before. Additionally, marketization led to a hierarchization between employment groups, and relational elements of care became more and more delegated to low paid care workers like, for example, social care aides (dementia carer). Volunteers are also increasingly taking over social care duties. In general marketization led to a deregulation of collective bargaining policy and in that context to an overall pressure on wages especially for less formally trained staff (Dahme/Wohlfahrt 2007, Kühnlein 2007).

5.1.1 Working conditions and differences between non-profit and for-profit

Even if marketization affects all providers in LTC, studies clearly show that non-profit providers charge higher LTC prices than for-profit providers. Private providers charge prices that are on average 5 (large private homes) to 10 (small private homes) percent lower than prices of non-profit organizations (Rhine Westphalia Institute for Economic Research 2011, Geraedts 2016). Even if there is not much research done about the differences between for-profit and non-profit, at least assumptions can be made about these price differences.

International Studies found that higher prices in LTC relate to a higher quality in LTC and vice versa (Geraedts et al. 2016, Comodore et al. 2009). The study of Geraedts et al. (2016) supports these findings for Germany even if the quality differences are not very high. International findings also demonstrate that for-profit mainly correlates with a lower resident nurse or care staff relation (Harrington et al. 2012). In the German context, this

correlation, at least regarding the overall numbers, is not evident (TNS, see 5.2). According to the study of a private employer association, the care worker/resident relations are not fundamentally different between for-profit and non-profit providers. Another survey illustrates a slightly higher staff/resident relation in private facilities (Rhine Westphalia Institute for Economic Research 2011, TNS).

However, the question remains of how lower prices are affordable for private companies. We know that lower prices that provide competitive advantages have to be affordable for the provider. Since staff costs in LTC are the highest cost (70%), often providers attempt to save money at this level. What is not shown in the staff-resident calculations is the specific staff mix, since saving money is often possible by employing lower formally qualified staff, staff with less social security or fewer staff in general, and also by a more efficient use of staff and nursing material and the payment of lower wages (Greß/Stegmüller 2016). All strategies are used by non-profit and for-profit providers. However, since welfare organizations are often oriented to collective wage agreements of the public sector (even if this orientation is decreasing), private providers are able to use the strategy of lower wages more comprehensively to secure lower prices (see, for example, Hielscher et al. 2013). The price dumping of private providers leads to lower care rates/care prices in general. A study that was commissioned by an employer association for LTC illustrated that a 10 percent increase of for-profit providers in a region lowers the price of non-profit providers by about 0.85 € (Rhine Westphalia Institute for Economic Research 2011: 50).

In general, more research has to be done to demonstrate further possible differences between non-profit and for-profit LTC provisions. Data are needed that allow more comprehensive comparison and refer to working conditions, e.g. wages, qualification level, work intensity, etc.

The most recent LTC reform (Pflegestärkungsgesetz III) provided an important change regarding care worker wages that could also enable better research conditions. Since 2017, providers have had to demonstrate that the share of their care rates that were negotiated to pay labour wages are really spent on wages (BMG 2017).

Private capital actors criticize this new regulation. The president of the employer association for nursing care, Thomas Greiner, calls this regulation a “meander to state-nursing.” He further comments that “no company will be able to finance wages based on

performance/output if they have no control of staffing costs. They have no incentives to manage efficiently because staffing cost are a self-balancing item" (Greiner 2016).

It seems to be apparent that private for-profit ownership becomes increasingly important in LTC in Germany, and this will further change how work and care will be provided. Because higher investment possibilities in LTC are expected the care market is of interest for private capital actors and therefore they requests more market purchasing changes in this sector. They demand, for example, a more efficient use of staff in LTRC. They also call for a greater and more unregulated focus on competition where only supply and demand are the regulation mode:

"Without private capital it won't work [the care market expansion B.M.]. Private capital will only be available if adequate interests are paid. Capital searches otherwise for different investment possibilities. Political actors are therefore **advised to keep laws and regulations to a minimum**. For example, regulations on the size of residences or on the number of private bedrooms are unnecessary. It is only important that a sufficient supply of nursing homes is provided because then care dependents and their relatives are **able to choose the facility** that **matches their needs** and is **still affordable** for them. If politics chooses to regulate restrictively, they risk that not all needs are met or only expensive options are available" (Augurzky 2015: 16, translation B.M.).

The unregulated market offers choice. That is the classic neoliberal lesson we learn here. Nevertheless, choice is clearly based on money. The regulation mode that is called for is inequality. Not everybody should get a private bedroom but in this logic it is a choice if a resident lives in a private bedroom or not. This argument doesn't take vulnerability into account. Care dependents have no choice if they need residential care and only a home with double bedrooms is affordable for them. This example clearly demonstrates the problems of market logic in general but especially when it comes to care.

5.2. Understaffing and the standardization and taylorization of care.

Beside the deterioration of working conditions, permanent underfunding and therefore understaffing in residential care homes are apparent. The strictly defined care tasks and the low staffing rate that corresponds with the cost-containment goal led to a taylorization of care. A strict time-task regime is established, especially in home care (Müller 2016). However, some residential care facilities apply—as we saw in the beginning of the paper— – taylorized work organization based on clearly defined tasks. The general results of underfunding are low staffing, low wages and a high workload and time pressure in the daily work organization.

Resident care staff relation:

	2003	2005	2007	2009	2011	2013
Pflegebedürftige* / Pflegefachkraft**	4,67	4,56	4,55	4,74	4,90	4,92
Pflegebedürftige* / Nichtfachkraft**	4,83	4,95	5,03	4,89	4,72	4,92
Pflegebedürftige* / Personal insgesamt**	2,37	2,37	2,39	2,41	2,40	2,46

** Pflegebedürftige insgesamt*
*** Personal in VZÄ überwiegend in Pflege und Betreuung tätig in VZÄ*

Source: Greß/Stegmüller 2016

We see that even if the total amount of care staff increases, according to this calculation, the overall resident care staff relation steadily decreases in time. Therefore, the workload of care staff increases simultaneously. This data doesn't include the increased workload due to an older and sicker resident population and an increased demand to provide high quality care. Additionally, in the context of marketization, requirements for quality management and especially the need for documentation increased significantly. That also led to a labour intensification and took time away from direct resident care. The increased need for quality management also ties care staff to managerial positions (even if this is not recognized in the formal staff calculations), like the position of a quality manager that worsens the resident-care worker relation in practice (Interview, Germany).

A study in 2009 demonstrated that the care worker/resident relation in German LTC facilities is very low. If the interaction between resident and care worker is taken into account, in fact, only one hour per resident per day is provided (resident-related housekeeping included; administrative work excluded,) (Stenger/Kirchen-Peters 2011, Hielscher et al 2013). This number doesn't include social care aides, who have very low formal training and have been paid since 2008 directly by the LTCI. Social care aides (dementia carer) can be employed in a ratio of 1:25 (one social care aide for 25 residents with a special social care need) additionally to meet social care needs especially in the context of dementia (SGB XI).

A very low staffing number that is not calculated systematically and doesn't match the requirements of everyday care needs in residential facilities is criticized by unions, care activists, nursing care associations and also by management of LTRC facilities. They demand the introduction of a resident assessment tool that calculates the staff requirements. The most recent LTCI reform (Pflegestärkungsgesetz II) prescribes the introduction of a resident assessment program like RAI or PLAISIR in 2020 (PSG II).

5.3 Pushing back – attempt to cope with restrictive funding and staffing conditions

In light of these problematic effects of privatization and marketization in Germany, studies show that even if competition in Germany does affect all care providers and for-profit provision has additional problematic effects because it strengthens the competition further, there is still some possibility for agency at the level of all organizations. Lukas Slotala found that management in home care played an important role concerning agency in the light of marketization and privatization. He diagnosed two groups that followed different ways to cope with the pressure of marketization that are not attributed to ownership. In the first group, managers of home care services showed a "proximity to the economic sphere," and the ones in the second group a "distance to the economic sphere." As a result of this attitude, the competition pressure led the first group to a comprehensive application of neoliberal reforms with all the negative effects on working and caring conditions. Providers that represented the other group were not free from this competitive pressure but balanced the transformation and took the goal to provide good care into account (Slotala 2011).

In a case study in the context of the project "Reimagining Long-term Residential Care: An International Study of Promising Practices," led by Dr. Pat Armstrong, we studied an LTRC facility and a managing team that copes with the pressure in a more distant attitude to the economic sphere. However, their scope of agency is rather small, so the creative attempt to cope with restrictive funding and market competition is rather ambivalent. The case example can be used to illustrate a creative coping attempt, but more importantly, it demonstrated the positive results of a higher staffing number and consequently the urgent need for more staff in the LTRC sector in Germany.

The facility is a rural non-profit facility, which is part of a bigger non-profit organization that also includes other LTC facilities such as home care and assisted living. Almost all services are done in-house. Only the heavy laundry and the window cleaning is provided by a different company. When the managing director came into power, he re-integrated former outsourced sectors. A housekeeper at a German site explains the reason for the integration of the former outsourced service/housekeeping department: "The director wanted to have it more personal for the residents" (Fieldnote, Germany).

The staff-resident ratio is considered very good compared to the normal German standard, which can be explained by a specific use of a program in a German jurisdiction. Therefore, the facility has a very specific staff mix.

A good staff resident ratio – apprentice program

The rural non-profit facility employs 190 apprentices (for 90 residents and approximately 60 care workers) in the context of a jurisdiction-specific (German lander-specific) apprenticeship support program. The apprentice program is an answer to a low staffing rate due to the intended competition and the restrictive public financing described above as a means of compensation. This massive employment is possible because the SPD-Green governed Federal State of North-Rhine-Westphalia introduced a funding system that covers the costs of apprentices. This was designed to encourage employers in the elder care sector to offer more training possibilities as a way to counteract the shortage of care workers in the sector. The facility uses the program in an extensive way, which helps the facility avoid understaffing and minimizes the heavy workload. Because there are many apprentices in the morning nursing care, each staff member, including apprentices, cares for of 3–4 residents, which is fewer than the average in Germany (the number is more like 8–10).

Another positive feature is the common shared units. They seem to be especially promising because of the many apprentices: Common shared units are living spaces that resemble a living room with an open plan kitchen for 8–12 residents. In this living space, residents spend most of their day. They dine there, rest on cozy chairs or take part in group activities. The atmosphere in these units is described as very good. Residents are included in meal preparation and other daily activities.

With the apprenticeship program and the common shared units, this facility can avoid classical pressure on work and care. The time for care is much more than the above described average hours per resident/day. The apprentice model is a creative attempt (but very volatile because the program to subsidize wages of apprentices might only be temporary) to cope with restrictions due to marketization but cannot replace a fundamental shift in LTC policies.

The case example is more of a coping strategy then a pushing back, but it leads to a better work and care atmosphere. Moreover, it illustrates that more staff are needed and have to be secured on a national and structural level. However it also became apparent that more qualified staff than not yet trained apprentices is needed. A more comprehensive promising practice would need a transformation not only at the level of the organisation,

but would require a complete shift in welfare state policy. The process of marketization and privatization needs be overcome at a societal level.

6. Conclusion

The paper illustrates the overall process of marketization that influences all care providers (also non-profit providers) and therefore could be described as blurring the lines between non-profit and for-profit. The intended competition around prices leads to a deterioration of working conditions in all LTCR facilities. Beside these commonalities, differences between non-profits and for-profits still exist. For-profit providers offer lower prices and some secure them by paying lower wages (Hielscher et al 2013). Low prices in turn put pressure on all care providers. Their increased participation within the care market is changing the LTC infrastructure constantly, because e.g. private LTC actors push for more market and less regulations in the LTC sphere. This paper proposes that more research has to be done that focuses on the differences between providers (organizations) and their effects on working and caring conditions. Wages, qualification level, staff-resident ratio, nursing material, and care concepts should be taken into consideration.

Connected to the claim to do more research on private for-profit ownership in LTC, the following argument provides a suggestion for change. To transform the problematic LTC infrastructure, a twofold strategy should be applied: 1) Even if there is an abstract tendency in capitalism to externalize care, the concrete structure of care and care work depends on concrete struggles and relationships of forces. It therefore needs a broader movement that struggles at different levels for a comprehensive change of care politics, regulation and the care infrastructure, and a significant push back of marketization and capital accumulation within the care sector (contemporary movements in Germany like the so called “care revolution” and in that context “care at the bottom” are promising examples). Private for-profit ownership in LTC should be re-considered. The example of Norway, where municipal and civic society protest led to a significant push back of for-profit ownership, could therefore be a promising example. 2) In the long run, a more radical perspective should be applied: care should be at the center and society should be structured from a care perspective (Tronto 2013). Because of the structural tendency to externalise care in capitalism, alternatives to this specific mode of production should be considered.

7. Literature

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