Long-term care and intermediary structures for frail older people: a comparative view on access, use and outcomes in Germany and Switzerland

Konstantin Kehl & Rahel Strohmeier Navarro Smith
Department of Social Work, Zurich University of Applied Sciences (ZHAW), Switzerland

Paper presented at the 3rd Transforming Care Conference, Milan, 2017
Thematic Panel 23 on "Innovation and social investment in LTC"
Preliminary draft – please do not quote or circulate

Abstract: In recent years, eldercare has become more diverse and pluralistic. It not only includes residential care, home care and familial care, but a broad range of services in-between, such as respite care, day and night care, temporary (short-term) stays in nursing homes, and local infrastructure services conveying informal support. In both investigated countries, the role of intermediary structures is highly debated and affected by recent social policy reforms. Based on the literature, policy reports and official documents, the authors analyse different strategies, concepts and definitions of intermediary structures and discuss their access, use, and outcomes from a comparative perspective. In both countries, they can be seen as a social innovation and can be ascribed to the social investment turn in public policy, albeit within different institutional frameworks and with varying functions for the welfare state and long-term (LTC) care in particular.

1. Introduction

Ageing populations and the effects of the demographic development on care needs will be a fundamental challenge for Western democracies and social policymakers in the next decades. They will need to find answers to the question of how support and high-quality care for the elderly may be ensured in times of societal change and increasing public budget constraints. At first sight, Switzerland and Germany are comparatively well prepared to cope with the demographic challenges. In the Alpine country, long-term care (LTC) is a part of the health insurance system and social policy reforms have recently adjusted the financing of care and introduced additional services between residential, home and familial (informal) care – *intermediary structures* such as respite care, day care, and temporary stays in nursing homes. In Germany, an informal grand coalition of Christian democrats and social democrats established a specialized LTC insurance in 1995 to cover the social risk of being in need of care, equally funded by employers and employees in the Bismarck tradition. It has been a central aim to privilege outpatient and informal care in contrast to inpatient services by means of cash-for-care benefits. In addition, policymakers set up a whole range of intermediary structures complementing residential care, home care and informal (family) care.

However, the rapid increase of people in need of care and assistance in old age – a trend accompanied by a decrease of family caregiving because of changed family structures, labour mobility and female employment – will lead to additional costs if the preferred answer is to simply "scale up" professional (inpatient) care arrangements. Therefore, the role of intermediary structures is highly debated and affected by recent social policy reforms in both investigated countries. They are designed to better prepare people to accept responsibilities for caring a near and dear person at home or to come to terms with (costly and therefore often limited) outpatient care accompanied by professionals. Intermediary structures can, thus, be ascribed to the social investment turn in public policy – a political strategy that seeks to prevent societal problems from arising in the first place by encouraging prevention as well as self-help and self-organizing potentials instead of searching for solutions in retrospect – but serve different functions within different institutional frameworks.

How can intermediary structures be further analysed and what are fruitful approaches to address this newer form of LTC provision with its specific context and characteristics in Germany and in Switzerland? By comparing the two countries in the context of their welfare history and architecture, we seek to answer this question and shed more light on LTC innovations.

2. Theoretical approaches

Intermediary structures for frail elder people have to be interpreted within the country-specific welfare traditions of the investigated countries. According to Esping-Andersen's landmark typology of welfare regimes (1990, 1999 and 2002), the German welfare system is generally considered as a pioneer country with a strong focus on social insurance systems and families, whereas the Swiss case represents a latecomer which has only caught up during the 1990s (Obinger and Wagschal 2000). Today, both countries can be broadly assigned to the corporatist regime which is characterised by social policies conceived in a meritocratic way, with contributory schemes (still) reproducing the socio-economic status that families achieve through the position of the breadwinner on the labour market. Despite considerable policy change in terms of programmes supporting the reconciliation of work and family life and appreciating the merit of household work, families are the prevailing social agency and therefore strongly supported in their caring role in these welfare environments – which can also be described as an "active subsidiarity" (Kazepov 2010, 57). Does the introduction of intermediary structures enhance this "active subsidiarity" or does it shift care responsibilities from the state towards families, communities and the market (Strohmeier Navarro Smith 2010; Saraceno 2008), or contribute to lock-in traditional care arrangements? Which overall social policy paradigm forms the basis of intermediary structures?

In the provision of LTC for frail older people, families have always been of great importance and still play a crucial role in Western industrialised societies. However, public provision is expected to be – more or less – subsidiary to familial care (Strohmeier Navarro Smith 2010). In general, old-age dependency as a social risk can still be seen as less decommodified in comparison to other social risks such as accidents, sickness, old age or unemployment with a longer development in the history of the different welfare states in Europe (Strohmeier Navarro Smith 2010, 2012). The more autonomous sub-national levels are in defining LTC provision, and the less coercive national laws are, the more probable it is that regional variation will occur in the delivery of LTC (Strohmeier Navarro Smith 2010). As a consequence, access can generally be jeopardised by both the (re)familialisation and regional variation of LTC delivery. Older people in need without people to rely on trouble sooner and their health condition worsens faster than that of persons with a wider private social network. In the case of insufficient, seamless or low quality public service provision, family members and informal caregivers might feel obliged to provide care or to intervene and compensate for the missing or lacking provision of public care.

In addition, pluralism among LTC policies, with new forms of cooperation arising between different societal sectors, has become the often-stated explicit goal of LTC policies, containing new and old expectations towards family care (Pfau-Effinger 2008; Saraceno 2008; Ungerson and Yeandle 2007). As a consequence, boundaries between "public" and "private" care provision have shifted and become more blurred. The crucial question, however, remains whether the new forms of "mixed care economies" (Saraceno 2008) imply a retrenchment of the welfare state in the policy area of LTC, postulating more selective access to LTC provision for older people in need, and to what extent families are discharged or supported in the liabilities to their older relatives (Strohmeier Navarro Smith 2010).

Since there is no national legislation, our hypothesis for the public provision of intermediary structures in Switzerland is that they are more common and more widely spread within regions in which families already have a lower responsibility for their frail relatives compared to regions with lower user-rates for residential and home care services (Werner et. al. 2016). The latter could be interpreted as an argument for path-dependent developments of LTC services in general. However, an argument against

path dependency and in favour of social innovation could be that recently publicly funded research projects have been executed (Werner et. al. 2016; Köppel 2015; Bischofsberger et. al. 2014) addressing specific and new forms of LTC care services beyond professional (residential and home) care and "traditional familial care". These research projects were often initiated by parliamentary request and were summarised in a policy report written by the Federal Council (Bundesrat, 2014). In this report, intermediary structures are presented as a triple-win solution for the caring relatives (reduction of the care burden), for the frail elderly (longer stay at home) and for the state (to postpone nursing home entries). Intermediary structures are seen as one piece among others like the improvement of the general conditions for informal care such as the regulation of short-term absences at the workplace or the introduction of care leave or monetary benefits for informal care provision.

A newer argument which was brought into discussion is the reconcilability between familial duties and work (Bundesrat 2014): More than half of all women and men in Switzerland have to deal with care needs of their relatives during the middle life span when they are between 50 and 64 years old. 17.5% of informal care givers indicate that they would like to organise their working life differently if care for their relatives would be organised in a better way. If working conditions are not flexible enough or in case there is a higher need for care during a longer time period, relatives often have to opt for their provision of informal care or for keep on working or – if possible – reduce their workload. In case they decide against gainful employment, they run the risk of lower income and even have to come up for gaps in their personal social protection that is strictly connected with labour market activity. Furthermore, it has been pointed out that a household with two adults is more and more dependent on two incomes in order to have a decent living (Bundesrat 2014).

To make a long story short: not only social, but also economic arguments have been introduced into the political discussion regarding the organisation and enhancement of the provision of informal familial care in Switzerland. From a critical point of view, one could state that in the report of the Federal Council crucial topics such as the division of the care tasks between (working) men and women are not discussed. As other studies have showed, gender regimes strongly influence the provision of unpaid, informal, familial care (Razavi 2007). Two thirds of informal care in Switzerland is provided by women, one third by men (Perrig-Chiello/Höpflinger/Schnegg 2010). With reference to the intermediary structures, the question arises whether this new form of services helps to enhance a more balanced division of informal care provision or if such structures even strengthen the current informal care regimes.

In Germany, the argument goes in a slightly different direction. When the LTC insurance was established in the mid 1990s, a central aim was to privilege outpatient and informal familial care at the expense of professional inpatient services in nursing homes. Since then, people in need of care (as determined by a medical review board) can choose between in-kind benefits and cash-for-care payments (or a combination of both) in order to activate family and non-family caregivers in their home environment. Intermediary structures in-between inpatient and outpatient care were introduced in order to support informal caregivers by means of legal entitlements to respite care, day and night care, as well as temporary (short-term) stays in nursing homes (see section 3). However, the most important instrument in order to de-institutionalize care was (and still is) lump-sum cash benefits. The rationale behind it "is based on the idea that the state (public authorities) contributes a certain amount of resources to the costs of care, and it implies an individual and family responsibility for covering any other costs" (Da Roit and Le Bihan 2010, 298). In fact, the system produces strong incentives for informal familial care since the LTC insurance only covers a limited amount of the costs for care while cash benefits, at the same time, serve as additional family income due to a lack of direct compensation test (which means that they are given to the care recipients without assessing whether and how much care is given to them). From a household-economic perspective, it leads to the situation that those members of the family (or household, respectively) with the lowest (possible) income and (potential) opportunity costs with regard to labour market participation have to bear the burden of care

(Schneider, 2006). Since women had lower educational assets at their disposal for a long time, the German LTC insurance – by trend – reproduced the classic division of labour.

Times are changing and women considerably benefitted from the 1960s and 1970s educational expansion in Germany, pushed forward by social democrats and the women's movement. As a result, they possess much better labour opportunities today compared to their mothers (and grandmothers) and are less willing to function as the "natural resource" of care. This trend has been accompanied by considerably changed family structures due to less children (or even childlessness) and an increase in short-term love relationships instead of formal marriage, thus reducing the familial reservoir of potential caregivers even more. Consequently, the cash-for-care system continuously lost ground during the last two decades and it turns out to be a major challenge to sustain the level of informal care within the existing LTC structure since the share of LTC insurance beneficiaries opting for cash benefits declined from 56.3% to 43.9% between 1997 and 2012 only (Kehl 2016a).

Since this trend renders the political goal of strengthening informal care almost unachievable, even though it would contribute to the financial sustainability and a more encompassing approach to care, capability-oriented policy approaches aiming at the mobilization of alternative resources within the social proximity of the affected elderly (i.e. in neighbourhoods and wider communities) have been intensively discussed in the country. Such approaches would not only contribute to reduce costs, but would also increase quality of life and the public legitimacy of LTC policies since we know from surveys that people in need of care prefer to stay at home as long as possible (ibid.). Apart from care leave opportunities, additional intermediary structures such as local support centres for caregivers and new forms of community-based living providing care and assistance in case of need are part of these policy approaches. They react to the insight that monetary incentive policies to encourage informal care are limited by cost-utility considerations and intrinsic motivations (Kehl and Stahlschmidt 2016).

As a result, one could argue that intermediary structures in Germany are rather thought to unlock path-dependencies in that they add to the mobilization of substitutes for traditional (family) resources. However, in so doing they may also stabilize existing care regimes or foster care immigration. Given the existence of cash-for-care benefits, there are still strong incentives for conventional care arrangements in the family context (or sourcing out care to low-wage earners) that are then simply flanked by (better) infrastructure.

Taking into account these different theoretical approaches, the authors would like to elaborate on the history and actual organisation of intermediary structures for frail older people in a country-specific context. Three major questions for our following analysis arise:

- How do intermediary structures have to be located within the current LTC model of the two investigated countries?
- Does the introduction of new forms of LTC services go along the welfare tradition and the arrangements for informal care in the investigated countries (path dependency), and/or what aspects concerning social innovation can be identified?
- Can intermediary structures be ascribed to the social investment turn in public policy and what functions within which institutional frameworks do they serve?

Based on the literature, policy reports and official records and documents, the authors will analyse the different strategies, concepts and definitions of intermediary structures and discuss their access, use and outcomes in the Swiss and German case from a comparative perspective. We will present some very first results of our analysis, focussing on the third question, the functions and institutional frameworks of intermediary structures in Germany and Switzerland and discussing the questions, whether intermediary structures can be interpreted as social investment turn in public policies; what are the implications and consequences of such an interpretation?

3. State of the art: intermediary structures in Switzerland and Germany

In the Swiss LTC system, intermediary structures are to be found primarily in terms of so-called day and night care structures *(Tages- und Nachtstrukturen)*, but also special (partly publicly subsidized) apartments for the elderly with care services (Werner et. al 2016, Bundesrat 2014, Bischofsberger 2014). Day and night care structures provide support to family caregivers by putting them in the position to retreat from caring obligations for a limited time. Specialized staff (e.g. qualified nurses) guarantees care and assistance to elder people with need in care and mentally disabled people. There are about 400 of these facilities in Switzerland, of which two thirds are part of residential foster care homes. However, so far only some per cent of the people concerned make use of them: while there are approximately 330'000 caregivers in Switzerland, only 4'300 people use the services of day and night care structures per year. Yet they are using them on a very regular basis (three times a week) and care recipients are characterized by rather low demands compared to the population average (Werner et al. 2016; Köppel 2015).

The reasons for the low usage rates can be found in serious variations of fees as well as in the "image" of day and night care structures. Although the health insurance covers the largest part of the health-related costs for day and night care arrangements, and users have to contribute only 20% (max. 21.60 Francs per day; not including 10% for general contribution for health related costs and the franchise of the basic health insurance, such as contributions for not-health related costs i.e. for the stay, for meals and other services), prices vary on a range between 40 and 140 Francs per day and 50 and 215 Francs per night. This may lead to fundamental uncertainties regarding the quality of care and effective cost-benefit ratios, and for some people is simply not affordable. But maybe the bigger problem lies in information deficits, emotional factors and "image" barriers: as we know from surveys, people dislike the "nursing home smell" of some of the structures, and caregivers do not feel comfortable when they send their relatives away to a third-party institution (ibid.). For many, caregiving is a psychological and physiological burden, but at the same time they perceive it enriching to be the one who is providing necessary assistance (Walker et al. 1995; Roth et al. 2009).

Table 1: Landscape and features of intermediary structures in Switzerland and Germany

<table>
<tr><th></th><th>Inpatient (residential) care</th><th>Respite/short-term care</th><th>Day and night care</th><th>Outpatient (ambulant) care</th><th>Infrastructures for informal assistance</th></tr>
<tr><td>Formality</td><td colspan="4">Formal (professional staff)</td><td>Informal (laymen)</td></tr>
<tr><td>Care needs</td><td>High</td><td colspan="3">Medium</td><td>Low</td></tr>
<tr><td>Governance & Financing</td><td colspan="4">National (social insurance schemes) and regional (Switzerland: cantonal care models/Germany: state implementation)</td><td>Regional/local differences</td></tr>
</table>

In Germany, the LTC insurance accounts for almost half of the total costs if a person needs care (the maintaining part has to be covered privately or, in case of financial impecuniousness, by social welfare arrangements of the municipalities). Regarding intermediary structures, there is a comparable day and night care system (*Tages- und Nachtpflege)* as in Switzerland as part of the LTC insurance. People in need of care who receive care from a family member or neighbour in their home environment are legally entitled to use respective services and spend 50% of the insurance benefits for the purpose of day and night care. Additionally, they can use short-term and respite care in a nursing home (e.g. in the case of vacation) up to four weeks per year. In both cases, the insurance covers the cost for care but not those for meals and accommodation.

What is more, there is a network of several hundred local support and reception centres – so-called "care bases" *(Pflegestützpunkte)* and "social stations" *(Sozialstationen)* which are run by the major welfare associations (providing professional care services) and some municipalities (partly in a cooperative framework) and benefit from public funding. The local centres allow informal caregivers to get informed advice and find additional help in terms of low-threshold and neighbourhood/civil

society support complementing to their own caregiving effort or professional services. Following the concept of case management and integrated care, they were intended to become a focal point for caregivers and to interconnect different forms of support (welfare mix). Starting with burning ambition, the idea of local centres did not become one of the sustaining innovations of care policy, as we will see later. However, in combination with the social insurance coverage and the right to take a care leave (without earnings replacement) they fulfil an important intermediary function in the overall care architecture. In addition, there are model programmes of the federal government and on the state level to develop infrastructures of shared apartments and support for community-based living. It has been shown that such approaches – which have partly been introduced and funded by innovative non-profit organizations – contribute to health, informal care provision and well-being/quality of life indicators of their residents (Kehl and Then 2013).

4. Access, use and outcomes from a comparative perspective

In the following paragraphs, the authors will analyse the institutional framework in which intermediary structures – especially day and night care structures – are located in the investigated countries and explore on possible first explanations, which will have to be further tested in a next step of our investigation.

In Switzerland, there is no national law which clearly defines the access to a day or night care structure. In theory, everybody can use such care structures. But in reality, the access is restricted due to financial and ideological burdens. Concerning the financial aspect, the regulation in the national act for the compulsory health insurance, financed by premiums and introduced 1996, plays a crucial role. It only regulates health-related care costs for health care services, which have been prescribed by a physician. The newer national regulation for the financing of health care from 2011 furthermore states that beneficiaries of health care only have to pay a maximum of 20% of the health-related care costs (not including 10% of further user-payment and a possible franchise up to 2'500 CHF). The cantons or municipalities have to cover the rest of the health-related costs that have not been paid by the health insurance. For non-medical care services, there is only means-tested financing which is also regulated by a national law. In practise, the differentiation between health-related and non-medical care services is very difficult. In addition, cantons and municipalities still have a strong say whether they provide further financial incentives in order to enable elderly people to remain as long as possible in their own homes and only move to a nursing home when familial and ambulant care services come to their limits. Day and night structures can be interpreted as a further possibility in the public care chain in order to prevent from longer stays in nursing homes or in hospitals. However, recent research based on expert interviews shows very high inhibition thresholds to overcome for caring relatives or they simple do not realise their own need of support. Only in the second place, high costs, missing orientation towards more specific target groups or towards the needs of the caring relatives such as insufficient accessibility are mentioned. And only in the third place, lacking coordination within the whole offer of different care services is notified (Bischofsberger et al. 2014).

With reference to the use of day and night care structures, there is high regional variation to be observed: In the French speaking part of Switzerland, there are 27 beneficiaries per 1'000 inhabitants aged over 80 years in the canton of Fribourg, whereas in the German speaking part, there is no such a public service at all offered in the canton of Glarus. In the canton of Obwalden, there are 8 beneficiaries per 1'000 inhabitants aged over 80 (Werner et al. 2016).

The same pattern applies for the number of daily visits: In the French speaking part, there are 6'000 visits per 1'000 inhabitants aged over 80 years in the vanton of Vaud, whereas in the German speaking part, there are only 3'000 visits per 1'000 inhabitants aged over 80 in the canton of Basel-Stadt (Werner et al. 2016). As has been mentioned before, user rates for day and night care structures in Switzerland are in general rather low. The reasons for the low or non-use is currently under investigation, taking into account both the different perspectives of the users and their relatives on the

demand side, and different views concerning the services provided and their financial schemes on the supply side.

Regarding outcomes, there is high regional variation concerning the general provision of day and night care structures between the cantons: In the French speaking part, there are 17.1 places for day care per 1'000 inhabitants aged more than 80 years in the canton of Vaud. Whereas in the German speaking part there is no such offer in the canton of Glarus, as has already been mentioned above, and the smallest number is mentioned for the canton of St. Gallen with 2.4 places for day care per 1'000 inhabitants over 80 (Werner et al. 2016). Only 9% of the day and night care structures are public, will say they are owned and run by the municipalities. In three cantons, day and night care structures do not receive any public funding. 6% of the day and night care structures are private for-profit organisations (Werner et al. 2016).

In light of interpretation, it should be mentioned that data is still very limited when it comes to the description of access, use and outcomes of day and night care structures and urgently needs to be completed by further investigations. Only 15 out of 26 cantons have been included in the mentioned study (Werner et. al 2016). What is more, the data needs to be further analysed in a broader context, for instance taking into account user-rates for residential and home care in order to reconstruct the different care models for frail older persons in the single cantons. On this basis, the function of Swiss intermediary structures can be further analysed, checking whether they have been recently introduced or reshaped, what main goals they pursue, whether their introduction is to be seen as a path-dependent development or rather stands for a social innovation. And last but not least, we have to ask whether LTC provision for frail elderly people becomes more decommodified or even (re-)familiarised by the introduction of day and night care structures.

Table 2: Access, use and outcomes of day and night care structures compared

	Switzerland	Germany
Access	No national law or regulation; Limited through financing schemes and due to ideological burden	Universal access; National law (LTC insurance) and nationwide quasi-market with major service providers
Use	High regional variation	Increased between 1997 and 2016; Low regional variation
Outcomes	High regional variation of public provision	Low regional variation

In contrast to Switzerland, intermediary structures are more regulated on a national level through the LTC insurance scheme in Germany (even though implementation may be delegated to the states and municipalities, which are forced to guarantee a certain degree of social services). Day and night care structures are part of the nationwide legal framework and embedded into a regulated quasi-market dominated by major for-profit and non-profit service providers (such as the church-related *Caritas* and *Diakonie* with about half a million employees each) running foster care homes with a comprehensive portfolio of respite care, day and night care, and temporary care settings. Due to considerable investments into inpatient care and retirement homes after the establishment of the LTC insurance and a now average utilization of below 90%, there are even incentives for the organizations to fill up their vacancies by the provision of flexible temporary care services. As regards to the "care bases" initiated by the federal government in 2008, they did not make it to become one of the sustaining innovations of care policy because of a serious reduction of their competences (e.g. in terms of medical assessment and application) during the policy formulation process. Together with their counterparts of "social stations", they are, however, important concerning the provision of consultancy and advice – which approved care recipients and their relatives are legally entitled to use (wherever possible).

As mentioned above, usage rates of the German LTC insurance have changed a lot during the last two decades, especially with respect to cash-for-care benefits. The other side of the coin is that intermediary structures have to cope with growing demand. Between 1997 and 2016, the share of day and night care services in total LTC usage days increased from 0.3 to 2.8%, the share of respite/short time care from 0.3 to 0.8%, and the share of special "vacation care" (*Urlaubspflege*) from 0.2 to 4.5%. This development can be explained by the fact that fewer caregivers feel in the position to care (alone) on a 24-7 basis (and, instead, need assistance more often) and care arrangements increasingly mix up in that they involve more and more people – like non-family members or men in general – only contributing a small amount of time (Kehl 2016a).

In contrast to Switzerland, regional variations score rather low and can at best be explained with general differences between the states; with highest care needs in the East-German and rather rural states of Mecklenburg-Vorpommern and Brandenburg (51% of the cohort aged 85 to 89) compared to a much lower rate (34%) in wealthy Bavaria (Statistisches Bundesamt 2017). While this can be traced back to the national LTC legislation and quasi-market, regional variation becomes obvious where there is no such umbrella framework. Regarding the "care base" infrastructure, for example, the power of decision over their implementation was given from the national to the state level during the process of policy formulation. Compared to the expectations, only a small number has been established (with some states even preventing their introduction) and the usage by caregivers might be, sharp-tongued, interpreted as an "underachiever" (Kehl 2016b).

Nevertheless do intermediary structures serve an important function and have to be interpreted in context and with future developments in mind. Institutional care in Germany seems to develop toward care for the oldest, hospices and high-class retirement homes, whereas different forms of living with available (outpatient) care and support in case of need are on the increase. The latter is in line with the wishes and demands of the elderly and supported by intermediary services.

5. Intermediary structures as evidence for a social investment turn in LTC policy

Social investment strategies in public policy attracted attention among scholars all over the world. Starting from the well-known differentiation between a liberal, a social-democratic and a conservative welfare model (Esping-Andersen 1990), new paradigms have emerged out of the programmatic renewal of social democracy after the 1970s economic crises, the 1980s dominance of neo-liberal/neo-conservative governments, and 1990s privatisation policies. They served the ground for a new welfare principle between social-democratic redistribution, the liberal focus on individual responsibility on markets and conservative familialism mediated by the fusion of concepts such as solidarity, personal responsibility and civil society.

The resulting notion of a social investment state as described by Esping-Andersen (2002) and Hemereijck (2013) aiming at empowering people through a life-course perspective (Giddens 1994) via prevention and investments towards education and work–life balance approaches seriously affected social policy. Respective strategies describe a specific social policy strategy which seeks to prevent societal problems from arising in the first place ("prepare") instead of searching for solutions in retrospect ("repair") through a combination of conventional redistribution and social insurance programmes with the encouragement of individual self-help, self-organization, and co-production of welfare by citizens within their immediate social environment. The latter refers to families, informal networks outside the household, and civic networks. Social investment policies have been introduced in order to enable people to make informed life decisions and to draw on welfare programmes solely if there is no alternative. In Giddens' words: "The welfare state grew up as a mode of protecting against misfortunes that 'happen' to people – certainly so far as social security is concerned it essentially picks up the pieces after mishaps have occured. Positive welfare, by contrast, places much greater emphasis on the mobilizing of life-political measures, aimed [...] at connecting autonomy with personal and collective responsibilities" (ibid. 18).

The term investment refers to the fact that governments increasingly fund programmes in the hope of building the material as well as immaterial foundations of wealth in education, labour markets, and social policy. They try to remove barriers for immigrants in the school system, try to build better educational systems, and introduce flexible work-time models that allow for holding a job while being engaged in childcare or support for senior relatives (Hemerijck, 2013; Morel, Palier & Palme, 2012). In Jenson's (2012, 61f.) words: "The announced goals of the social investment perspective are to increase social inclusion and minimise the intergenerational transfer of poverty as well as to ensure that the population is well-prepared for the likely employment conditions (less job security; more precarious forms of contracts) of contemporary economies. Doing so will supposedly allow individuals and families to maintain responsibility for their wellbeing via market incomes and intra-family exchanges, as well as lessen the threats to welfare regimes and their programmes coming from ageing societies and family transformations. Rather than advocating the minimalist state dear to neoliberals, proponents of the social investment perspective assign the state a key role in fostering these outcomes." The element of choice is of special importance.

Table 3: Distribution of formal (professional) and informal care

	Switzerland	**Germany**
Total formal (professional) care (% of people aged 65 and over with care needs)	47	17.8
Inpatient (in residential homes)	15.8	6.0
Outpatient (at home)	31.1	11.8
Total informal care (% of people aged 65 and over with care needs)	53	82.2
Intensity of informal care provided (median weekly hours)	5.7	6.9

Source: Rodrigues and Nies (2013), p. 201.

Intermediary structures in care can be ascribed to the social investment turn in both countries since they aim at supporting informal caregivers in the family and non-family sphere to perform their tasks, but they seem to serve different functions within different institutional frameworks.

Generally, different social factors favour and restrain the use of professional and informal care resources within the family and social networks. According to our assumption, these factors lead to a situation in which intermediary structures as instruments of a social investment strategy serve different functions in the Swiss and the German socio-political context. In both countries, traditional family obligations are important for the care regime but subject to serious erosion. In answering to this trend, Switzerland's intermediary structures seek to support a system of strong professionalism, whereas in Germany a more serious demographic shift towards old people and a lower level of individual wealth has given way to the impression that professional care cannot be the only (desired) and commonly affordable answer. Instead, it has led to a political claim to strengthen the welfare mix and activate informal and preventative resources. These can be found in the local proximity of the affected, i.e. in the immediate neighbourhoods, urban districts and wider civil society.

According to the literature, the Swiss care regime is a service-based one in which the comprehensive availability of professional services and legal entitlements open up choices between a familialism with strong professional support on the one hand and final de-familialisation with more reduced family obligations on the other. In contrast, the German care system heavily stems from the family since the LTC insurance covers professional care to a limited degree (Haberkern & Szydlik 2008; Saraceno & Keck 2010).

Data on the distribution of informal and professional care in the two countries (see Table 3) strongly support the differentiation: while in Switzerland formal and informal support are almost on a par with each other (accounting for 47 and 53% of people aged 65 and over with care needs), the situation is very different in Germany. Here, not even every fifth person in need of care receives professional care

services, and the higher share of people giving care in an informal context is yet characterized by higher intensity. All in all, only around 2% of the Swiss parents aged 65 and older receive care from their children, but 5% of the German parents (Haberkern and Szydlik 2009).

Table 4: Relevant social indicators

	Switzerland			**Germany**		
	2005	**2015**		**2005**	**2015**	
Total employment rate (% of working age population)	77.2	80.2	*+3.9%*	65.5	74.0	*+13.0%*
Women's employment rate (% of working age population)	70.4	76.0	*+8.0%*	59.6	69.9	*+17.3%*
Total part-time employment rate (% of employment)	25.1	26.8	*+6.8%*	21.5	22.4	*+4.2%*
Women's part-time employment rate (% of employment)	45.7	45.0	*-1.6%*	38.8	37.4	*-3.7%*
GDP per capita, current prices (USD)	54,959.24	80,602.69	*+46.7%*	34,769.26	40,952.42	*+17.8%*
GDP based on PPP per capita (CID)	45,313.06	58,647.20	*+29.4%*	34,020.45	46,973.92	*+38.1%*
Working age population (% of people aged 15 to 64)	68.0	67.5*	*-0.7%*	66.9	65.6	*-2.0%*
Elderly population (% of people aged 65 and over)	15.9	17.6*	*+10.7%*	19.2	21.3*	*+10.9%*
Total fertility rate (children/woman)	1.4	1.5	*+7.1%*	1.3	1.5	*+15.4*

*Sources: OECD, IMF (PPP = purchasing-power-parity; * = 2013 data)*

However, in both countries decreasing family resources have to be substituted. On both sides of Lake Constance and the Rhine, women form the main caregiver potential and opportunity costs are decisive for informal care. Thus, female labour participation should be an indicator for the family caregiver potential. As Table 4 shows, women's employment rates increased between 2005 and 2015, although a bit stronger in the German case (which can, however, be traced back to cyclical effects after the mid 2000's economic crisis and successful solutions to the financial crisis thereafter). Much higher women's part-time employment rates somehow compensate for stronger overall participation in Switzerland. As Haberkern et al. (2013) report on SHARE data, family obligation norms are a bit more pronounced in Germany, while in the Swiss society the effective division of labour (concerning housework, earning money, and raising children) is more gendered (traditional). In the end, Switzerland and Germany seem to be more or less comparable regarding labour conditions on caregiving; in both countries, general and female employment are on the increase and therefore the conditions for family caregiving are getting worse. This will have considerable consequences for the societal costs of care. For example, we know from prior studies that the availability of informal care in the home environment has no impact on the likelihood but – significantly – on the length of stays in inpatient foster care homes (Weaver and Weaver 2014).

In this context, intermediary structures are thought to have the potential to support existing arrangements of care in different ways. In the service-oriented Switzerland, intermediary day and night care structures are tied to institutional (inpatient) care facilities to a considerable degree and their function or role can be interpreted as a "gateway" through which people in need just have to enter the professional system. This might be due to the fact that the economic wealth of the Swiss is higher than compared to the Germans (measured by the GDP in real purchasing power, as Table 4 shows). One can assume that Swiss relatives and the society as a whole is better suited to pay the price of formal care (be it in addition to informal care, be it in an exclusive fashion). In contrast, German intermediary structures are designed to support the informal sphere of caring and assisting, too, since not only economic resources are scarce but also public perceptions of problem solving capacities are seriously

impaired by the fact that the population is more biased towards senior citizens (people aged 65 and older) than in Switzerland (21.3% vs. 17.6%).

Cultural factors complement the drawn image: in Switzerland, 22.9% of the people think that the state is responsible for care while this holds for only 14.3% in Germany (Haberkern and Szydlik 2009), where the LTC insurance was just intended for lending caregivers a helping hand from the beginning. Market-based solutions have a difficult status in the German welfare architecture and eldercare in particular (as portrayed, for example, by the low share of people concluding a private supplementary insurance contract for the risk of care) since social services – if not located in the family – are paid by the state and traditionally provided by non-profit welfare associations. Many of the local support centres mentioned above are run by non-profit welfare organisations, too, or by joint ventures between them and the municipalities. In turn, Swiss people might be even more "statist" (at least if we buy into the figures presented above) but, at the same time, have less reserved attitudes regarding private–professional solutions. Another explanatory factor could be the strong discourse on the welfare mix, co-production schemes and the role of civil society in Germany promoting non-professional solutions to care and new forms of community-based living.

It is worth noting that intermediary structures in both countries intend to support self-help and self-organizing potentials, the reconciliation of work and family life, as well as welfare choice, but may serve different functions in the LTC architecture and lead to different results. In Switzerland, they add on a fragmented federalist system and seem to accentuate regional inequalities in the provision of care. The German system, in contrast, is much more homogeneous due to the integration of intermediary structures in the LTC insurance but invites to question whether it can really contribute to a more balanced division of labour under the conditions of a cash-for-care system privileging traditional care arrangements and the absence of a care leave with earnings replacement.

6. Conclusion

Even though using similar terminology, our preliminary analysis substantiates the suspicion that intermediary structures in Switzerland and Germany are not only different with regards to their position in the legal framework but server different functions in the welfare architecture and with respect to the notion of social innovation and the social investment turn in public policy. While in Germany day and night care structures are part of the LTC insurance on a national level, the Swiss federalist landscape is much more fragmented exhibiting different outcomes for the elderly and their relatives. While this somehow reflects the different welfare cultures in the different parts of the country (a statist/social-democratic approach in the French-speaking *Romandie* and a more liberal approach in the German-speaking part of the country), it seems to strengthen professional care on the one hand and to manifest traditional (gender) care regimes on the other. In contrast, the German discussion goes in a slightly different direction. Whereas day and night care structures are part of the LTC insurance coverage since 1995, which – under the condition of a cash-for-care benefit system privileging familial and female care due to household-economic considerations – rather manifest the division of labour, innovative intermediary elements such as "care bases", "social stations" and new forms of community-based living have been introduced in recent years. In combination with different care leave models promoting the reconciliation of work and family life, they aim at complementing the welfare mix in terms of alternative (neighbourhood and community/civil society-based) sources of care and low-threshold assistance. While such a strategy seeks to further "privatize" care obligations by way of broadening the informal resource base of care – and is, thus, in line with the social investment paradigm of encouraging individual self-help and co-production, but invites to question whether it can contribute to a more balanced division of labour – the Swiss intermediary structures rather support state- or market-based (professional) solutions. With this, intermediary structures refer to the prevailing welfare cultures of a strong professionalism in Switzerland and family-based care in Germany. They are, thus, drivers of a path-dependent policy development (incremental change) in line with the social investment idea of investing into the choice of clients and their relatives.

References

Bischofberger, I.; Jähnke, A.; Rudin, M. and Stutz, H. (2014). *Betreuungszulagen und Entlastungsangebote für betreuende und pflegende Angehörige. Schweizweite Bestandesaufnahme.* Im Auftrag des Bundesamtes für Gesundheit BAG. Zürich/Bern.

Bundesrat (2014). *Unterstützung von betreuenden und pflegenden Angehörigen, Situationsanalyse und Handlungsbedarf für die Schweiz. Bericht des Bundesrates*. Bern.

Da Roit, B. and Le Bihan, B. (2010). Similar and Yet So Different: Cash-for-Care in Six European Countries' Long-Term Care Policies, *The Milbank Quarterly* 88, 286–309.

Esping-Andersen, G. (1990). *The Three Worlds of Welfare Capitalism*. Cambridge.

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

Esping-Andersen, G. (2002). *Why We Need a New Welfare State*. Oxford and New York.

Giddens, A. (1994). *Beyond Left and Right: The Future of Radical Politics*. Cambridge.

Haberkern, K., and Szydlik, M. (2008). Pflege der Eltern: Ein europäischer Vergleich, *Kölner Zeitschrift für Soziologie und Sozialpsychologie* 60, 82–105.

Haberkern, K., and Szydlik, M. (2009). State care provision, societal opinion and children's care of older parents in 11 European countries. *Ageing & Society* 30, 299–323.

Haberkern, K., Schmid, T., and Szydlik, M. (2013). Gender differences in intergenerational care in European welfare states. *Ageing & Society* 35, 298–320.

Hemereijck, A. (2013). *Changing Welfare States*, Oxford.

Jenson, J. (2012). Redesigning citizenship regimes after neoliberalism: moving towards social investment. *Towards a social investment welfare state? Ideas, policies and challenges* (Eds. Morel, N., Palier, B., and Palme, J.). Bristol, 61–87.

Kazepov, Y. (2010). Rescaling Social Policies towards Multilevel Governance in Europe: Some Reflections on Processes at Stake and Actors Involved. *Rescaling Social Policies: Towards Multilevel Governance in Europe* (Ed. Kazepov, Y.), Farham/Burlington, 35-75.

Kehl, K. (2016a). Nach dem Pflegestärkungsgesetz II: Eine alternative Interpretation der Probleme und ein Plädoyer für potenzialorientierte Reformen, *Zeitschrift für Sozialreform – Journal of Social Policy Research* 62, 49–78.

Kehl, K. (2016b). *Sozialinvestive Pflegepolitik in Deutschland: Familiäre und zivilgesellschaftliche Potenziale im Abseits wohlfahrtsstaatlichen Handelns*. Wiesbaden.

Kehl, K. and Then, V. (2013). Community and Civil Society Returns of Multi-generation Cohousing in Germany, *Journal of Civil Society* 9, 41–57.

Kehl, K. and Stahlschmidt, S. (2016). The Limits of Monetizing and Paying for Volunteering in Eldercare: A Behavioral-Economic Approach, *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations* 27, 768-789.

Köppel, R. (2015). *Erfolgreiche Praktiken von Tagesstätten*. Rikon.

Morel, N., Palier, B., and Palme, J. (2012). *Towards a social investment welfare state? Ideas, policies and challenges*. Bristol.

Obinger, H. (2000). Vom Nachzügler zum Vorbild? *Der gezügelte Wohlfahrtsstaat. Sozialpolitik in reichen Industrienationen.* (Eds.: Obinger, H. and Wagschal, U.). Frankfurt/New York, 245-282.

Obinger, H. and Wagschal, U. (2000). Ökonomie, Institutionen und Politik: Determinanten der gebremsten Sozialstaatlichkeit im Überblick. *Der gezügelte Wohlfahrtsstaat. Sozialpolitik in reichen Industrienationen.* (Eds.: Obinger, H. and Wagschal, U.). Frankfurt/New York, 365-390.Perrig-Chiello, P.; Höpflinger, F. and Schnegg, B. (2010). SwissAgeCare2010. Pflegende Angehörige von älteren Menschen in der Schweiz. http://www.upload.sitessystem.ch

Pfau-Effinger, B. (2008). Erosion of the bounderies between formal and informal work in Europe. Keynote speech at the International Conference "Transforming Care". SFI Copenhagen. 26.-28. Juli 2008. http://ww.sfi.dk

Razavi, S. (2007). *The Political and Social Economy of Care in a Develpment Context. Conceptual Issues, Research Questions and Policy Option*s. UNRISD. http://www.unrisd.org

Rodrigues, R., and Nies, H. (2013). Making Sense of Differences: The Mixed Economy of Funding and Delivering Long-Term Care. *Long-Term Care in Europe* (Eds.: Leichsenring, K., Billings, J., and Nies, H.). Basingstoke and New York, 191-212.

Roth, D. L., Perkins, M., Wadley, V. G., Temple, E. M., and Haley, W. E. (2009): Family caregiving and emotional strain: associations with quality of life in a large national sample of middle-aged and older adults. *Quality of Life Research* 18, 679–688.

Saraceno, C., and Keck, W. (2010). Can we identify intergenerational policy regimes in Europe?, *European Societies* 12, 675–696.

Saraceno, C. (2008). Care leisten und Care erhalten. Zwischen Individualisierung und Refamilialisierung. *Berliner Journal für Soziologie* 2, 244-256.

Schmidt, A. E. (2013). Langzeitpflege in der Schweiz: eine europäische Perspektive. *CHSS 6*, 318-324.

Schneider, Ulrike (2006): Informelle Pflege aus ökonomischer Sicht, *Zeitschrift für Sozialreform* 52, 493–520.

Statistisches Bundesamt (2017). *Pflege im Rahmen der Pflegeversicherung: Ländervergleich – Pflegebedürftige*. Wiesbaden.

Strohmeier Navarro Smith, R. (2012). *Alterspflege in der Schweiz. Ein federal geprägtes Politikfeld im europäischen Vergleich*. Bern.

Strohmeier Navarro Smith, R. (2010). Familiarisation and Regional Variation in Long-Term Care Provision. A Comparative Perspective on Long-Term Care for Older People in Europe. *Rescaling Social Policies: Towards Multilevel Governance in Europe* (Ed. Kazepov, Y.), Farham/Burlington, 277-312.

Ungerson, C. and Yeandle, S. (2007). *Cash for Care in Developped Welfare States*. New York.

Walker, A. J., Pratt, C. C., and Eddy, L. (1995). Informal Caregiving to Aging Family Members: A Critical Review. *Family Relations* 44, 402–411.

Weaver, F. M., and Weaver, B. A. (2014). Does availability of informal care within the household impact hospitalisation?, *Health Economics, Policy and Law* 9, 71–93.

Werner, S., Kraft, E., Mohagheghi, R., Meuli, N., and Egli, F. (2016). Angebot und Inanspruchnahme von intermediären Strukturen für ältere Menschen in der Schweiz. Ergebnisse einer Kantonsbefragung und einer Auswertung der Statistik der sozialmedizinischen Institutionen. *Obsan Dossier* 52. Neuchâtel.