Professionalization of the long-term-care workforce in Germany – The role of policies and organized actors

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1 INTRODUCTION

Demographic ageing poses a challenge to all mature welfare states. One area in which these developments can already be felt and tackled is in long-term care for older people (LTC). The share of the aged population – and especially of extremely old people – has been increasing in recent decades and will continue to increase further in nearly all mature welfare states in the coming years (OECD, 2020b). Furthermore, societal contexts have changed. Women – who have traditionally taken on care duties for children and their elders – now increasingly opt for (part-time) paid employment in the labor market. Additionally, the size of families has declined in recent decades, and children now live farther apart from their parents (OECD, 2011). These developments have decreased families' capacity to provide care for their older members and have consequently led to an increase in the demand for formal LTC services.

The provision of LTC services is labor intensive. Translating this labor intensity into figures, labor costs for Germany are estimated to account for about three-fourths of all LTC costs (Kümmerling, 2016; Voges, 2002). Despite ongoing innovations in healthcare- and nursing-care treatments as well as technical innovations designed to facilitate the provision of care services, the high reliance on manpower is projected to persist into the future (OECD, 2020b). Furthermore, LTC staff are mainly responsible for the quality of care services (Castle, 2008; Schwinger et al., 2018), with most studies indicating that having more and more-highly qualified staff members leads to better care outcomes (Bostick et al., 2006; Comondore et al., 2009). Thus, the workforce in LTC is responsible for most costs in the LTC system as well as for the quality of provided care services.

Costs and quality have been the major LTC policy concerns in recent decades among many European LTC systems (Ranci & Pavolini, 2013). Governments have implemented various LTC policy reforms with a diversity of measures that aim to ensure the right balance between securing the financial stability of the LTC systems and providing a decent quality of care services. As the LTC workforce has a strong influence on both elements of this balance, LTC policy reforms should influence how the LTC workforce develops. However, it is unclear whether the quest for a decent quality of care leads to more LTC workers, to more LTC workers with higher skill levels, to better working conditions, or to higher social statuses and thereby also to the

professionalization of the LTC workforce. Conversely, it remains unknown whether the pursuit of financial stability leads to a smaller LTC workforce with lower skill levels, to poorer working conditions, or to lower social statuses and thus also to deprofessionalization.

Germany serves as an interesting case for investigating these questions due to its demographic development and the basic institutions of its LTC system. The share of old and the oldest of the old in Germany has continuously risen in recent decades and currently lies above both the OECD- and EU average (OECD, 2020a). On the contrary, Germany is only a medium spender on LTC and utilizes comparably high private out-of-pocket spending (OECD, 2020a). This focus on financial stability is built into the basic institutions of the LTC system. For example, benefits are capped, ambulatory care is favored over residential care, and unconditional cash-for-care benefits are available (Rothgang, 2010). Providing formal LTC services for an increasing population of older people by maintaining a financially reserved LTC system thus poses a challenge to the German political system, and the demographic and institutional context therefore leaves room for both the professionalization and deprofessionalization of the LTC workforce.

Furthermore, the question of what has influenced the developments of the LTC workforce is relevant. Both the design of LTC institutions and changes to this design induced by policy developments can influence the workforce in multiple ways. For example, generous support schemes targeted at family care – such as respite care or unbound cash-for-care schemes – lead to prolonged family care and lower take-up rates of formal LTC (Brandt et al., 2009; Eichler & Pfau-Effinger, 2009; Ungerson, 2004) and hence impede the growth of the formal LTC workforce. Moreover, staffing levels – which set benchmarks for the number and educational level of LTC employees – can regulate both the number and skill level of LTC workers (Blass, 2012; Gospel & Lewis, 2011).

However, institutions do not develop and change on their own. Political actors and their influence on reforms shape how institutions are built and implemented and therefore also how the LTC workforce develops. The role of organizational actors in shaping policy outcomes in different social-policy sectors has been demonstrated, for example, in the fields of employment relations (Bender, 2020), unemployment (Hegelich et al., 2011), healthcare (Bandelow, 2006), and pensions (Trampusch, 2004). However, for the field of LTC, both the role of organizations and their interest

in determining policies and thus also outcomes have largely been neglected due to the occupational organizations that represent LTC workers, which have been deemed to be too weak to influence LTC policies and developments within the LTC workforce (Kümmerling, 2016; Schroeder, 2018). Nevertheless, the role that organizations play in LTC should be investigated for two main reasons: First, the weakness of some organizations (e.g., those that represent the interests of LTC workers) might be a result of the strength of other organizations (e.g., those that represent the interests of employers). Second, research on how the interests of weak organizations can enter the policy process has revealed that stronger organizations can act as advocates on behalf of the interests of weaker organizations (Nullmeier, 2000; von Winter & Willems, 2000). Illuminating both the interests and the role that organizations play in LTC can hence contribute to explaining policy changes as well as the developments of the LTC workforce.

LTC is defined as healthcare- and social-care services "with the primary goal of alleviating pain and suffering and reducing or managing the deterioration in health status in patients with a degree of long-term dependency" (OECD, 2017). LTC is thereby relevant for the entire population – from children to (aged) adults – regardless of age. Care for the old-age population has the same definition as LTC, but the focus is on older adults (Daly & Lewis, 2000). The terms *older* and *old age* are thereby often operationalized in national and international databases as well as in publications to refer to the care of individuals aged 65 or older, but the terms can also refer to those aged 80 years or older – that is, the oldest of the old (OECD, 2011). The focus throughout the present study is on LTC for those 65 years or older, which provides a clearly defined research area. Furthermore, this age group represents both an expanding group as well as the largest group to receive continuous LTC. Although LTC and LTC for the old-age population have a different scope, the term LTC is used throughout the present study to refer to LTC for the old-age population for the purpose of simplicity.

1.1 Research questions and objectives

The present study encompasses an empirical case study of the developments of the German LTC workforce that (1) describes and evaluates the developments of the LTC workforce under the theoretical lens of professionalization and (2) explains these

developments in terms of LTC policy changes and organizational influence. Hence, two main research questions are posed and answered:

1. How has the LTC workforce in Germany developed in the past 15 years? In which areas has it become professionalized or deprofessionalized?
2. Which institutional changes and organizational aims and interests have influenced these workforce developments?

The study first describes, analyzes, and evaluates the developments of the German LTC workforce over the past 15 years under the theoretical perspective of professionalization. Second, it examines the LTC reforms during this period and relates them to workforce developments. Third, it analyzes the influence of interest organizations on policies and on workforce developments.

Empirical research on LTC-workforce developments in Germany – including elements of professionalization and deprofessionalization – has grown in recent years. This line of research has been spurred by the increasing availability of longitudinal data on recipients, institutions, and employees, which the Federal Statistics Office has published since the introduction of the LTC-insurance system in 1995 (Bundesregierung, 1997; Statistisches Bundesamt, 2005). The current literature on the labor market in LTC and on its trajectory thereby reaches different conclusions concerning the developments toward and the degree of professionalization. Many studies have found the status and development of LTC to be both professionalized and deprofessionalized at the same time (e.g., Gospel, 2015; Oschmiansky, 2010). The simultaneous assessments of professionalization and deprofessionalization have largely emerged from the evaluation of different dimensions and indicators. Working conditions are unanimously considered to be rather low and thus deprofessionalized (Kümmerling, 2016; Oschmiansky, 2010). In contrast, apprenticeship education in LTC is evaluated as having a high standard (Gospel, 2015). Moreover, the increasing number of academic study programs in care has been assessed as a step toward professionalization (Kälble, 2013). However, scientific knowledge and education does not reach hands-on care workers, and the employment of low- or marginally trained care workers has increased, which is evaluated as a sign of deprofessionalization (Gottschall, 2008; Krampe, 2014). Furthermore, autonomy and one's own decision-making power among LTC workers has increased, but with limited reach, which

impedes scholars' ability to evaluate developments in either direction (Fischer, 2010; Isfort, 2013; Kuhn, 2016).

This overview of the literature reveals that professionalization and deprofessionalization are processes that are understood and measured using various concepts and indicators. Many studies have relied on only one indicator or one dimension of indicators to evaluate the professionalization or deprofessionalization of the LTC workforce (e.g., Kälble, 2013; Oschmiansky, 2010) and have thereby neglected other important variables. The analysis in this study therefore aims to paint a coherent picture of workforce developments instead of focusing on one area or on a single set of indicators. This holistic approach based on professionalization theories proposes four workforce dimensions: quantity, skill level, working conditions, and a social dimension. Several indicators in each dimension are analyzed in order to paint a multifaceted picture of LTC professionalization- and deprofessionalization processes. Additionally, the use of both the most-recent data and a longitudinal perspective extends the present literature on professionalization processes in the German LTC workforce.

Furthermore, the review of the current literature reveals that the developments of the German LTC workforce can be explained mainly by the institutions of the LTC system (Auth, 2013; Blass, 2012; Theobald, 2008) and their intersection with migration- (Rada, 2016; Simonazzi, 2009), employment- (Kümmerling, 2016; Meyer, 2012), and education systems (Kuhlmann & Larsen, 2014; Roth, 2007). Only a few studies have adopted a longitudinal design that follows the development of policies and institutions over a defined period of time and that relates policy changes to LTC-workforce development (Auth, 2013; Oschmiansky, 2013). Moreover, studies rarely depart from explanations relating to institutions. Thus, only a few studies have discussed organizations and their role in shaping LTC policies and the trajectory of LTC workforces. This neglect of interest organizations is mainly attributed to the weakness of occupational organizations that represent LTC workers (Kümmerling, 2016; Schroeder, 2018). However, theories on how the interests of weak organizations can enter the political process have called this line of argumentation into question (Nullmeier, 2000; von Winter & Willems, 2000). Analyses of organizational influences on both LTC policymaking and LTC-workforce developments are built on two assumptions: First, assessing occupational organizations as weak (Kümmerling, 2016; Schroeder, 2018) does not preclude the existence of strong organizations in LTC

that are able to assert influence in policymaking processes. Second, even the interests of weak organizations – defined in this study as the aim of professionalization as represented by the occupational organizations of care workers – are able to enter the political process (Nullmeier, 2000; von Winter & Willems, 2000). Taking these assumptions and their empirical confirmation as a starting point, the present study argues that organizations and their interests should be integrated as explanatory factors into policy studies on LTC.

The results and implications of the present study not only have theoretical value; indeed, describing and analyzing workforce processes in LTC has benefits for policymakers, administrative bodies, and LTC workers themselves. For example, the study sheds light on the development and current extent of the shortage of workers in the LTC sector, which could both contribute to assessing current and future problems in the LTC sector and spur political action. Furthermore, based on the empirical results, the study proposes strategies that occupational organizations of LTC workers can use to reach their aim of professionalization.

1.2 Structure of the study

The present case study on the German LTC workforce adopts a time frame from 2005 to the present. The starting date of 2005 was chosen for two reasons: First, in the ten years following the introduction of the German LTC system in 1995, the system became societally accepted and institutionalized. Second, the first major reform of the LTC system was enacted in 2008, which makes 2005 an adequate time point for ascertaining the state of the LTC workforce before major changes to policies and institutions had been enacted. The study unfolds in seven chapters. After this general introduction, *Chapter Two* focuses on the theoretical background. The chapter is divided into three parts: The first part lays out the central terms and sketches different professionalization theories. The approach of Hartmann (1968) serves as a guideline for operationalizing workforce processes through a lens of professionalization. On this basis, four separate albeit interrelated dimensions are defined into which workforce developments are divided: quantity, skill level, working conditions, and a social dimension. In each of these dimensions, upward movements – occupationalization and professionalization – and downward movements – deoccupationalization and deprofessionalization – unfold. These terms are operationalized separately for each

dimension. The second part of the chapter reviews the current literature on professionalization in two respects: First, studies that analyze and evaluate the recent status and developments of LTC in Germany are reviewed. Second, the reasons for professionalization and deprofessionalization as discussed in both German and international studies on LTC professionalization are compiled. The third part of the chapter focuses on organizational actors and their aims, one of which is professionalization. Occupational organizations – which represent LTC workers' interests – are evaluated as weak in the existing literature (Kümmerling, 2016; Schroeder, 2018). Therefore, theoretical considerations as to how these interests can enter the political process are reviewed (Nullmeier, 2000; von Winter & Willems, 2000). One pathway toward integrating the aim of professionalization that is pursued by the occupational organizations of care workers into the policymaking process is via the advocacy of strong organizations. Hypotheses regarding which organizations can act as advocates for professionalization are derived from the general aims that Bandelow (2006) defined for the healthcare sector, and these hypotheses are transferred to the LTC sector. Trade unions and patient organizations are expected to act as advocates for professionalization, whereas business organizations and system organizations – such as LTC-insurance funds – are expected to advocate against professionalization. Social welfare organizations could theoretically advocate for either process.

Chapter Three explores the scope of workforce developments in the German LTC system. Focus is placed on describing and evaluating the societal context and the basic institutional characteristics of the German LTC system. Demographic development and financial investment in the system are depicted in comparison with data on other OECD and European countries. Germany has one of the oldest populations in the EU and the OECD, and its population is continuously ageing. This development has meant an increasing number of LTC recipients in Germany. Thus, there is room for an increase in the number of LTC workers – that is, for professionalization along the quantity dimension. However, comparatively low funding levels, an overproportional increase in the number of individuals who receive an unbound cash benefit, and the privatization of LTC provision act as constraints to professionalization developments in all dimensions.

Chapter Four analyzes the developments of the LTC workforce in Germany that have taken place since 2005 and focuses only on the developments of the formal LTC

workforce. At the beginning of the chapter, the data, methods, and operationalization of the analyzed indicators are described. The main data source for the chapter is the German Care Statistics (*Pflegestatistiken*), which are published every two years. The empirical results are divided into the four theoretical workforce dimensions – quantity, skill level, working conditions, and a social dimension. The quantity dimension is the only dimension for which a development in occupationalization and professionalization is evident for the whole period. The number of employees has been increasing continuously, albeit not sufficiently to circumvent the intensifying shortage of LTC workers. The skill level of the workforce has been deoccupationalizing as the share of apprenticeship-educated LTC workers has decreased, whereas the share of low-qualified LTC workers has been increasing. The level of professionalization has been low throughout the period, as indicated by a low share of academically trained LTC employees. Working conditions have been below average during the whole period; however, downward developments have halted in the most-recent years, and small improvements in wages and working times are now visible. Developments along the social dimension of the LTC workforce are the most ambiguous of all dimensions. LTC employees enjoy a high reputation and have increasingly organized in trade unions. Furthermore, boards of nursing and care have been established throughout the period; however, they began to dissolve at the end of the period. Thus, the social dimension shows upward and downward workforce trajectories. Taken together, the LTC workforce does not hold a status as a profession along all dimensions. However, steps toward professionalization have been made along the quantity dimension and have begun to unfold along the working-conditions dimension. Nevertheless, the low and decreasing skill level and low social integration have undermined these gains.

Chapter Five reveals how LTC policies and institutions change and how they contribute to developments in the workforce. Furthermore, the chapter evaluates the involvement of organizations in LTC reform processes. Since its establishment in 1995/1996, the German LTC system has focused on financial stability, as exemplified by the LTC benefits, which did not increase until 2008, the year of the first structural LTC reform since its establishment. Both this and the subsequent reform in 2012 continued along this path through limited benefit increases; however, implemented measures have been designed to improve care counselling and reveal that the aim of increasing quality has also gradually been integrated into reforms. The shift to quality as the main aim in policymaking was achieved with the launch of Care Strengthening

Act II in 2015. The reform implemented a new definition of *in need of care*, which was accompanied by the introduction of a new benefit system and benefit increases. This and the following reform in 2016 included small measures designed to improve staffing levels and the wages of care workers. Thus, the aim of professionalization was included in policies. Reforms in both 2017 and 2018 took up this focus on professionalization in LTC by implementing a new apprenticeship system and a variety of measures designed to ensure the future supply of LTC workers. The primary aims in the LTC reforms thereby moved from financial stability to quality and then to professionalization. The involvement of organizational actors in the reforms mirrored the shifts in reform aims. In the first reforms, the government strongly consulted system organizations, which were mainly interested in financial stability. In Care Strengthening Act II, patient organizations – which focus on the aim of quality – were highly involved. In the last two reforms, occupational organizations – which aim at professionalization – became more involved. Thus, the shift in primary aims of policies was accompanied by a shift in the involvement of organizations with similar aims in policymaking processes.

Chapter Six follows up on the policies discussed in the previous chapter. Public hearings – that is, consultative processes held by parliamentary committees in which organizations and experts are questioned on their ideas, positions, and interests regarding a reform proposal – provide the data for the analyses in this chapter. A quantitative and qualitative content analysis of the public hearings examines the stance of organizations toward the issue of professionalization. Occupational organizations advocate for professionalization in all dimensions yet sometimes represent their positions hesitantly. Trade unions are advocates for professionalization and are mainly interested in improving working conditions. Social welfare organizations represent a second strong advocate for professionalization. These organizations support professionalization interests – and especially higher wages and better working conditions – even though they take on their role as employers. The organizations expect a competitive advantage compared with private LTC facilities if professionalization measures are implemented. Patient organizations are in favor of professionalization; however, they formulate their interests in broad, non-specific ways and do not enforce professionalization by connecting these interests with other aims. System organizations and business organizations prevalently focus on deprofessionalization; however, their opposition to accepting collectively agreed-upon

wages has weakened over the years. Occupational organizations of physicians are the most opposed to professionalization and strongly argue against increasing competencies of and rights for LTC workers, which would directly threaten their own professional status. Overall, all organizations argue in favor of increasing the number of LTC workers. Furthermore, resistance to improving working conditions – and especially to increasing wages – has weakened. These dimensions – the quantity- and the working conditions dimension – also display upward trajectories throughout the period. Most resistance to professionalization concerns an increase in skill level and social status. The skill-level- and the social dimension also display deoccupationalization and deprofessionalization trajectories.

Chapter Seven draws conclusions from the results of the previous chapters. It takes up the central research questions, summarizes the results, and discusses the implications for political actors and for further research. The study establishes that workforce developments are dependent on policy developments, which are in turn shaped by the organizational actors in the field. Thus, the neglect of organizations and their interests in previous LTC policy studies, which relied on evaluating occupational organizations of LTC workers as weak, can no longer be maintained. For the future progress of professionalization in LTC, results indicate that despite a lack of organizational resources, professionalization can move forward. Occupational organizations of care workers should therefore focus on maintaining and extending strategic alliances with organizations with similar interests that can be connected to professionalization. Furthermore, the current shortage of LTC workers might pose a *window of opportunity* for voicing and pushing through more professionalization interests.

2 THEORETICAL BACKGROUND

What a profession is, what type of work and workers constitute a profession, and how work develops into a profession have been the subject of rigorous theoretical discussion. The term *profession* and derived terms, such as *professionalization* and *deprofessionalization*, have been employed in a multitude of ways in empirical studies on different strata of the workforce, such as with teachers (Carter Andrews et al., 2016; Hoyle, 1982) or nurses (Keogh, 1997; Pavolini & Kuhlmann, 2016; Yam, 2004). The varied understanding and adoption of terms can lead to different evaluations of workforce processes on the one hand and can influence which explanations of workforce developments are considered and discussed on the other hand (Pfadenhauer & Sander, 2010). Therefore, the present study requires a thorough definition of key terms regarding their meaning and conceptualization. This chapter details the theoretical background of the study in three main sections: First, it defines and operationalizes the central terms; second, it evaluates the empirical literature on LTC-workforce developments; and third, it adapts and extends an existing theoretical model that demonstrates how the aim of professionalization plays a role in the field of LTC policymaking.

The first section theoretically examines workforce developments under the lens of professionalization. The theoretical literature on what the term *profession* means and entails is summarized. Focus is placed on the processes that move a group of workers toward or away from the level of a profession. This discussion stems from the theoretical considerations of Hartmann (1968) and of Pavolini and Kuhlmann (2016) and is supplemented by considerations on employment conditions and atypical work (Ogura, 2005). This review of the theoretical literature on workforce developments under the lens of professionalization serves as the basis for the subsequent use of the above-mentioned considerations in the field of LTC. This conceptualization serves as a template on which empirical developments of the workforce can be empirically evaluated.

The second main section reviews the literature on LTC workforce processes and mainly investigates literature with a focus on Germany in addition to international literature by using two main questions: (1) How are developments in the LTC workforce evaluated, as professionalization or deprofessionalization? (2) What

explanations are given for these workforce processes? The review demonstrates that studies on German LTC professionalization select specific aspects of the concept. Encompassing professionalization studies are generally rare and rely on outdated data. Furthermore, explanations of workforce developments have mostly focused on institutional elements of the LTC system and on the general welfare state and have neglected organizational actors to a significant degree.

Hence, the third main section of the chapter develops a theoretical concept and hypotheses as to how the aim of professionalization can enter the policy process. The previous literature review in Section 2.2 revealed that the reason for the non-inclusion of organizational actors in explanations of workforce developments lies in the weakness of LTC workers' interest organizations. To understand this argument, the third section also discusses the difference between weak and strong interest organizations. One possible path toward representing weak interests in the political arena is via strong organizations that act as advocates for the interests of weak organizations. Hypotheses regarding what types of organizations could act as advocates for the professionalization aim of occupational organizations are therefore developed. The basic assumptions on which these hypotheses are built are taken from Bandelow's (2006) concept of primary aims in healthcare policy, which are transferred to the realm of LTC policy.

2.1 Workforce processes under the lens of professionalization

2.1.1 What is a profession?

The term *profession* is widely used in theoretical and empirical labor studies. The term relates to certain traits of and developments within a specific group of the working population whose members usually have a similar or the same level of education and employment. A profession thereby represents the final stage of labor development (Hartmann, 1968; Wilensky, 1964). However, what *profession* means, what traits it entails, and how it develops differ depending on the employed theory.

One prominent and succinct definition of the term profession is provided by Abbott (1988, p. 8), who states that "professions are exclusive occupational groups applying somewhat abstract knowledge to particular cases." Most theoretical schools on professions accept this basic definition; however, different scholars and schools of thought highlight different and sometimes conflicting characteristics. Nevertheless, all

theoretical streams agree on a few traits: First, professions are special occupations with characteristics that distinguish them from *mere* occupations, which again can be distinguished from pure work (Pfadenhauer & Sander, 2010). Second, professions have a cognitive basis. They rely on specific – normally scientific – knowledge, which is taught via relatively long-term university education in comparison with other educational degrees and occupations (Pfadenhauer & Sander, 2010). Third, professions use this cognitive specificity to monopolize their activities and tasks in order to dominate problem-solving in one realm of society. Finally, cognitive specificity and monopolization are accompanied by the emergence of professional associations that represent the professional group as a whole and defend the monopoly against threats. Nearly all theories highlight, expand on, and add to these characteristics and attributes (Pfadenhauer & Sander, 2010). Similarly, occupations that are depicted as professions are sometimes narrowly defined, which means that only three or four occupations are able to be labeled a profession (e.g., Luhmann (Kurtz, 2011); Oevermann, 1996). Sometimes, however, the definition of *profession* is broad, which results in ten or 20 occupations being classified as a profession (e.g., Parsons, 1939; Wilensky, 1964). Nearly all theories agree that physicians, lawyers, and the clergy can be labeled *professions* (Larson, 1977; Pfadenhauer & Sander, 2010).

Expanding on the concept of a profession, five influential schools of thought can be identified: the structural-functionalist school, the revised structural-functionalist school, the social-systems approach, the interactionalist school, and the power approach (Pfadenhauer & Sander, 2010). The classic structural-functionalist approach stems from the work of Talcott Parsons (1939), who emphasizes the importance of professions in the functioning of societies and depicts them as an expression of societal rationalization. According to Parsons, professionals draw on superior knowledge, which makes them rational decision-makers. Occupying crucial positions in society, professionals employ their knowledge and rational decision-making to ensure that societal processes continue to function (Parsons, 1939).

The second approach – that of Oevermann (1996) – revises Parsons' (1939) structural-functionalist approach and stresses professional ethos as a defining trait. Both Parsons and Oevermann consider theoretical and practical knowledge (*Habituswissen*) to form the basis of professions. This knowledge is important in fulfilling the professional role in relation both to one's own professional community and to clients. Autonomy, self-administration, and collegial control are also depicted

in Parsons' conception of professions; however, Oevermann stresses that these traits can only unfold under an inherent and joint professional ethos (Oevermann, 1996). Furthermore, Oevermann (1996) emphasizes the direct relationship between the client and the professional in his approach. This relationship is asymmetric and marked by limited autonomy of the client and their resulting and significant dependence on the knowledge and expertise of the professional. Nevertheless, the client–professional relationship must be voluntary. Furthermore, professionals make decisions on behalf of their clients in crisis situations and under a certain amount of uncertainty, which means that decisions must also be made despite the common lack of a reliable scientific background (Oevermann, 1996).

These thoughts are further developed in the third approach – that of Niklas Luhmann (Kurtz, 2011) and Rudolf Stichweh (1994) – which is embedded in systems theory. This problem-based approach places work with individuals at the center of the formation and emergence of professions (Kurtz, 2011). For Luhmann, professions serve as functional equivalents to communication media in societal systems in which a clear communication medium is missing (Kurtz, 2011). For example, money is the communication medium in the economic system. Every instance of communication in this system is allocated via the communication medium (i.e., money) to the binary code (i.e., paying / not paying). Generally, communication is oriented toward the positive side of the code. In societal systems without a clear communication medium, professions take over this role of allocation (Stichweh, 1994). During contact with the client, professionals work toward the allocation to a positive binary code (e.g., physicians work toward health instead of sickness). However, work with a client always involves uncertainty in terms of achieving a positive code (Kurtz, 2011). This role of professions has come under increasing threat by organizations, which incorporate professionals into their structure and thereby function as the actors that determine the allocation to a specific code (Kurtz, 2011).

These first three approaches emphasize the traits of a profession in relation both to its role in society and to the client relationship. The final two approaches to the concept of professions stress the importance of internal professional structures and of professional interests. The interactionist perspective (Hughes, 1963) assumes that the starting point for a profession exists in the client–professional relationship. This relationship builds on trust, professional expertise, and discretion. Moreover, the relationship with colleagues and the establishment and functioning of a professional

organization are considered equally crucial to the status of a profession. Professional organizations select and educate their apprentices and later colleagues. Therefore, only colleagues are competent to judge the quality of professional work. Furthermore, professional organizations influence societal structures by deeming themselves the responsible societal body for setting the rules and conditions for one realm of society (Hughes, 1963). Furthermore, professions are depicted as highly prestigious occupations (Hughes, 1963). Similar to Stichweh (1994) and Luhmann (Kurtz, 2011), Hughes (1963) has found that more and more professionals are becoming affiliated with organizations, which results in conflicting interests toward the organization on the one hand and toward the clients on the other hand.

The fifth approach is the power approach by Larson (1977). The focus of this approach is less-well determined than with the previous approaches at the level of the client–professional relationship or regarding the role of the profession for society. Instead, this approach centers around the group of professionals and their interests and actions. The core of this concept deals with professionals as an organized group that monopolizes both the occupation and the client market. The crucial and defining trait of professions is their monopolization of knowledge, of a certain market, of "the production of professional producers" (Larson 1977, 50), and hence of the education and licensing of later colleagues.

> Professionalization is thus an attempt to translate one order of scarce resources – special knowledge and skills – into an other – social and economic rewards. To maintain scarcity implies a tendency to monopoly: monopoly of expertise in the market, monopoly of status in a system of stratification. (Larson, 1977, p. xvii)

This monopoly – once established – is not eternal; indeed, it must be maintained by the profession. One crucial element of securing a status as a monopoly and a professional is represented by ensuring the scarcity of professionals.

> […] [T]he overproduction of professional producers may cause the price of professional services or labor to fall, and result in unemployment or underemployment of specialized and highly trained labor. This recurrent possibility jeopardizes the professional promise of social status: professional education and professional occupations become less certain means of securing social prestige and upper-middle class standards of living. In the long run, the attractiveness and the general social prestige of professional roles can be adversely affected. (Larson, 1977, p. 52)

Furthermore, the state is able to support and secure a professional monopoly and status (Larson, 1977), and governments can thereby opt for a top-down or a bottom-up

approach. In a bottom-up process, the professionalization efforts of an occupation are at one point supported and secured by the state (Neal & Morgan, 2000; Rueschemeyer & Seib, 1976), whereas in a top-down process, the state lays the groundwork for the professionalization of an occupation (Neal & Morgan, 2000; Siegrist, 1988).

Using all of these approaches as a guide, the present study adopts a basic concept of the term *profession* that can be summarized by four main points: (1) Professions are societally important occupations whose need and supply continuously fall below the level of societal demand. (2) Professions are high-skilled, academically trained occupations. (3) Professions are occupations with a high level of autonomy over the professionals' working contexts and conditions. (4) Professions are occupations with decision-making- and problem-solving power over professionals' own issues and over issues in the societal realm in which the professionals work.

The term *semi-profession* is related to the concept of *profession* and is often used in connection with occupations in the social sector. However, the term and its meaning are not integrated into the present study. Nevertheless, Box 1 briefly describes the term and the reasons for its exclusion here.

Box 1 – Semi-Profession

The term *semi-profession* is related to the concept of *profession*. Although the former concept is not used in this study, its meaning is discussed in this short excursus because the term is often used in connection with social-care occupations, such as nursing and care (Knijn & Verhagen, 2007). There are several concepts as to how semi-professions can be defined and what they lack in order to be defined as *full* professions. Oevermann (1996) argues that semi-professions involve the development of specific professional traits but lack at least one crucial aspect (e.g., habitus knowledge (*Habituswissen*)). Marshall (1939) also states that semi-professions establish certain professional traits but that the main obstacle to full professionalization is that semi-professions are subordinate to another profession. Based on his background in systems theory, Stichweh (1994) believes that professions work toward allocating instances of communication to a positive code in only one specific societal system, whereas semi-professions work in several societal systems and do not function as the social equivalent to a communication medium (Stichweh, 1994).

One of the most-cited definitions of *semi-profession* is by Etzioni (1964, 1969). In the preface of his edited book Semi-Professions and Their Organizations (Etzioni,

1969), he defines semi-professions as "[…] a group of new professions whose claim to the status of doctors and lawyers is neither fully established nor fully desired. […] [W]e shall refer to those professions as semi-professions. Their training is shorter, their status is less legitimized, their right to privileged communication less established, there is less of a specialized body of knowledge, and they have less autonomy from supervision of societal control than 'the' professions" (Etzioni, 1969, p. v). Furthermore, Etzioni also focuses on gender and claims "[…] that the typical professional is a male whereas the typical semi-professional is a female. […] It is difficult to determine if the semi-professional organizations have taken the form they have because of the high percentage of female employees, or if they recruit female because of organizational reasons, in all likelihood these factors support each other" (Etzioni, 1964, p. 89). Although this literature is frequently cited in connection with (often-female-dominated) social-work occupations (Kälble, 2005; Knijn & Verhagen, 2007; Schaeffer, 2011), at least three arguments speak against including the concept in the present study. First, the literature on semi-professionals suggests that they rank below the level of professionals; however, it is unclear if semi-professionalization is a pre-stage to professionalization or if it is an end-stage from which a move to a profession is not possible. Second, connected to the prior argument, it is unclear if the track to professionalization and to semi-professionalization is the same. Finally, although the literature compares professions and semi-professions, the relationship between semi-professions and other levels of labor – that is, occupation and work – remains undeveloped.

2.1.2 What is professionalization?

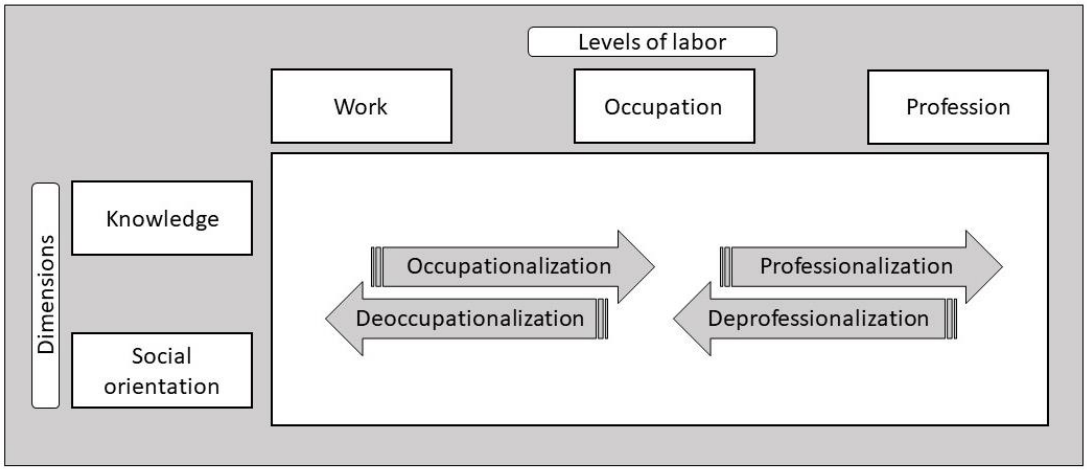
The classic theoretical approaches to professions focus primarily on the labor characteristics of the profession level of labor; however, other (lower) levels of labor and the boundaries between them are weakly defined. Furthermore, only a few classic theoretical approaches acknowledge, describe, and theorize about the process that leads toward or away from the level of profession (Larson, 1977; Wilensky, 1964). Wilensky (1964) is one of the few classical authors to conceptualize the process toward becoming a profession – that is, professionalization. He describes a traditional sequence of events that leads to professionalization: Work becomes a full-time occupation, schools are established that offer programs in the occupation, professional associations are formed, professionals become licensed and certified, and finally, a

formal code of ethics is adopted (Wilensky, 1964). In Wilensky's view and similar to the views of Luhmann (Kurtz, 2011), Stichweh (1994), and Hughes (1963), one major obstacle to this professionalization process is the affiliation of professionals with organizations, which poses a threat to the professional's autonomy and their service ideal toward the client. Furthermore, Wilensky (1964) emphasizes that service routines and pre-existing power structures act as barriers to full professionalization; however, he does not clarify if these ideal-typical steps toward professionalization unfold in the exact opposite direction when deprofessionalization occurs. Both processes – the movement toward and away from the level of a profession – are conceptualized by Hartmann (1968) and by Pavolini and Kuhlmann (2016) using similar concepts.

Hartmann (1968) defines three different levels of labor along a continuum: *work, occupation,* and *profession*. The level of *profession* is defined as a high-skilled, academic, free occupation and is distinguished from the level of *occupation,* which is defined as a special kind of work with the aim of financing a personal living and that requires specific knowledge and a combination of theoretical and practical knowledge. The level of *work* is mainly based on practical knowledge and less on a combination of knowledge (Hartmann, 1968). Consequently, *profession* marks the highest level on the continuum, *occupation* is placed in the middle, and *work* lies at the bottom (see Figure 1).

Hartmann divides the continuum into two dimensions – *knowledge* and *social orientation* – in order to differentiate between key aspects of development. The *knowledge dimension* deals with skills and educational achievements. The three levels of labor – *work, occupation,* and *profession* – are distinguished by the degree of systemization of knowledge, which increases from *work* to *profession*. The *social-orientation dimension* entails the social conditions and social importance of the different levels based on working conditions, prestige, power, and influence on society. The levels in the *social-orientation dimension* are distinguished by their degree of individualization and socialization, with the highest societal orientation in the level of *profession* and the highest individual orientation in the level of *work*. For both dimensions, transitions from the level of *work* to the level of *occupation* are termed *occupationalization*; for the opposite direction, such transitions are termed *deoccupationalization*. Accordingly, transitions from the level of *occupation* to the level of *profession* are called *professionalization*, and for the reversed process, such transitions are called *deprofessionalization* (Hartmann, 1968, pp. 199–202).

Figure 1: Levels of labor, dimensions, and processes according to Hartmann



Source: Based on Hartmann (1968: 204).

In the *knowledge dimension*, occupationalization is achieved by a combination of knowledge, which provides the occupational members with the appropriate instruments to fulfil their tasks. In this process, practical knowledge is more important than formal, scientific knowledge. In the professionalization process, theoretical knowledge becomes more important, and a scientification of knowledge develops. This scientification is evident in the theoretical description of problems, processes, and complex causal relationships as well as in the continuous analysis and search for explanations for problems (Hartmann, 1968, pp. 202–203). The dimension can be operationalized via educational degrees, including their duration, their breadth, and the degree of systematic knowledge implemented in them. Furthermore, indicators such as the breadth of scientific research and the orientation toward this research can be taken into account, as can different educational and further-training courses (Hartmann, 1968, pp. 204–207).

In the *social-orientation dimension*, the process of occupationalization unfolds at the level of the workers. An individualized understanding of work develops into a perception of belonging to an occupational group, which entails certain rights and powers in a specific economic sector. In the process of professionalization, the occupation strengthens its efforts to become a powerful societal and political actor, increases its value for the whole of society, and preserves its own cultural heritage. Hence, the value for society and the value society attaches to the whole profession increases. Furthermore, during the process of professionalization, a code of ethics is adopted, and an institutionalized influence on political and societal processes is built (Hartmann, 1968, pp. 202–203).

In both dimensions, the developments toward the level of *occupation* and *profession* can reverse. Knowledge can be lost, split into different specializations, or falsified. Likewise, professions with a high social orientation can individualize, as suggested by the fact that professionals affiliated with organizations cater to the aims of the organization rather than to the client's interests (Hughes, 1963; Kurtz, 2011; Stichweh, 1994). Thus, successful professionalization can always transform into deprofessionalization, and successful occupationalization can always transform into deoccupationalization (Hartmann, 1968, pp. 203–204).

According to Hartmann (1968), *professionalization* marks one specific process of workforce development. *Occupationalization*, *deoccupationalization*, and *deprofessionalization* define further workforce processes. The continuum with three different levels of labor and two dimensions enables a detailed description and evaluation of workforce developments. Furthermore, it prevents deterministic allocations because it is theoretically possible – although highly unlikely in real life – for a workforce to professionalize in the knowledge dimension but simultaneously deoccupationalize in the social-orientation dimension (Hartmann, 1968, pp. 210–212).

From the perspective of the five established professionalization streams, the definition of a profession – based on Hartmann's approach – can be criticized as being overly broad. Furthermore, the classic theories enable several paths toward a profession, which calls into questions whether the social-orientation- and the knowledge dimensions are sufficient to describe workforce processes. As an example, the social-orientation dimension pays little attention to working conditions, which play a more-important role in classic theoretical approaches.

In a more-recent, empirical study, Pavolini and Kuhlmann (2016) used a similar theoretical approach to that of Hartmann (1968) to measure and evaluate developments in the healthcare workforce. Similar to Hartmann, the authors divided the labor market into three levels: *high*, *middle*, and *basic*, which include physicians, nurses, and care assistants, respectively. Furthermore, Pavolini and Kuhlmann also defined two dimensions on which workforce developments unfold: the *trend dimension* and the *content dimension*.

> […] '[T]rend' refers to quantitative increases or reductions over time in the various components of the workforce. 'Content' comprises variations over time in terms of the type and the characteristics of labour contracts adopted (open ended vs. fixed term, full-time vs. part-time, number of

> working hours, etc.), and the changing skills and tasks associated to the profession. (Pavolini & Kuhlmann, 2016, p. 655)

The content dimension shows similarities to Hartmann's *social-orientation dimension*; however, the focus in the *content dimension* is on working conditions rather than on social status. The *trend dimension* includes different educational degrees but has a more-empirical focus than the theoretical focus Hartmann employed. It measures the number of workers with specific educational degrees and compares the development of the numbers in the *high*, *middle*, and *basic* levels with one another. Thus, the quantity of workers is more important than in Hartmann's *knowledge dimension*. A further similarity to Hartmann is that Pavolini and Kuhlmann (2016) acknowledge that processes in the two dimensions can be opposed to one another. The authors even go a step further and state that more than one process can unfold in one dimension and that these developments can be diametrically oppositional.

The *content dimension* is mainly concerned with working conditions (Pavolini & Kuhlmann, 2016). Part-time work, temporary work, workers looking for another job, and overtime work are indicators of this dimension. A high, middle, or basic level of professionalization in this dimension is not determined by fixed benchmarks for these indicators; rather, evaluations of upward and downward developments are based respectively on increasing and decreasing indicators over time and by comparing the development between different countries. Thus, Pavolini and Kuhlmann failed to deliver an empirical or a theoretical definition for the *high*, *middle*, and *basic* level – or, in Hartmann's (1968) terms, the level of *profession*, *occupation*, and *work* – of the *content dimension*.

For the level of profession, different theories define full-time work as a prerequisite (Etzioni, 1969; Wilensky, 1964). Thus, the level of profession can be associated with standard or typical employment, which "is generally defined as 'full-time employment in which the contract term is not limited'" (Ogura, 2005, p. 5). The other two levels – *occupation* and *work* – should theoretically have lower standards of working conditions. These working conditions can be defined by looking at considerations of employment conditions and non-standard forms of work. The level of *work* (the lowest level) should comprise unfavorable working conditions and therefore a high percentage of atypical employment, which is defined as "forms of employment not meeting this criterion [full-time, non-fixed employment]" (Ogura, 2005, p. 5). Atypical or non-standard employment includes part-time work, agency work, fixed-

term employment, and work outside usual working hours (shift work, night work, holiday work) and often also takes self-employed and vocational trainees into account (Ogura, 2005). These non-standard forms of employment are frequently considered to be connected with a weak emphasis on collective agreements and employment protection (Ogura, 2005). Furthermore, these types of employment have a higher risk of precarious working conditions, including low wages, low integration into social-security systems (e.g., unemployment insurance or pension systems), and opportunities for further education (Keller, 2018). Thus, if full-time, non-fixed-term employment constitutes working conditions at the level of the *profession*, atypical employment connected with precarious working conditions should be seen to occupy the low end of a professionalization continuum.

In general, Pavolini and Kuhlmann (2016) and Hartmann (1968) describe similar theoretical approaches to conceptualizing and operationalizing workforce processes under the lens of professionalization. Both define three different levels and two dimensions that resemble one another. Furthermore, both account for processes in both directions of the continuum. However, the dimensions highlight different aspects of workforce developments. Moreover, Hartmann focuses more on theorizing about how processes develop from one level to another, whereas Pavolini and Kuhlmann concentrate more on measurable indicators that can be compared in time and between different countries. Both approaches yield important information for the theoretical background of the present study. These approaches – together with the professionalization theories and the considerations of non-standard employment – form the basis for the conceptualization of workforce processes in LTC and the later operationalization and evaluation of the German case.

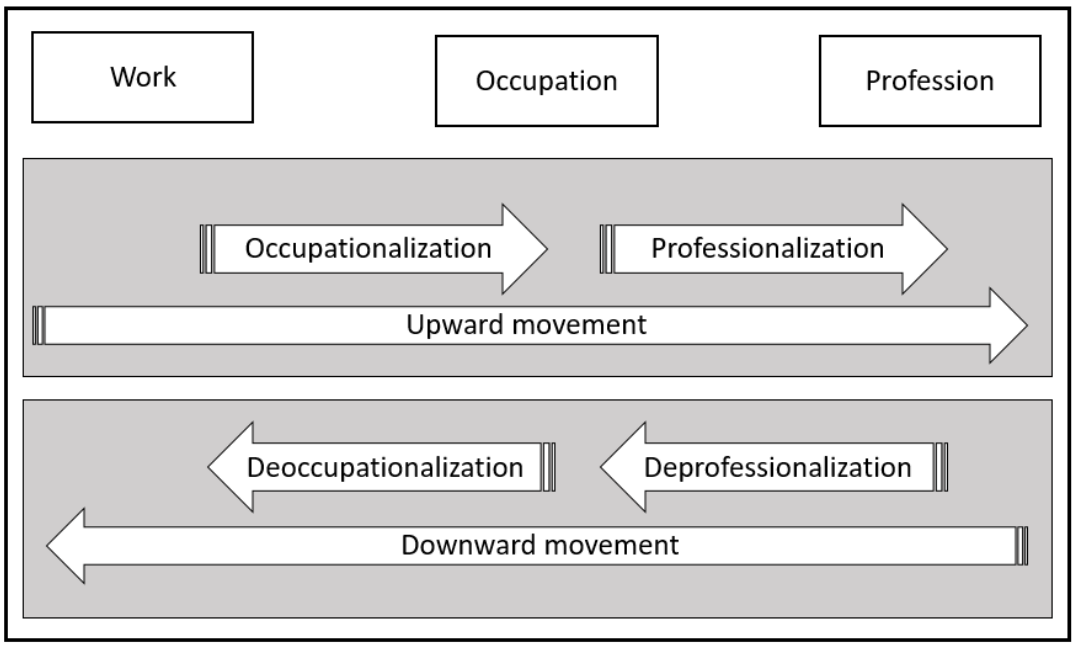
2.1.3 Conceptual framework – Dimensions of workforce developments in long-term care

The previous sections reviewed the definition and understanding of central terms, such as *profession* and *professionalization*. Next, these terms and theoretical approaches are adapted to fit the LTC sector, and a conceptual framework for the analysis of workforce developments in this sector is constructed.

Using the approaches of Hartmann (1968) and Pavolini and Kuhlmann (2016), a professionalization continuum with three different levels of labor is adopted that places *work* as the lowest level, *occupation* in the middle, and *profession* as the highest level.

Developments and movements between these levels are differentiated along four dimensions: quantity, skill level, working conditions, and a social dimension. For all dimensions, upward movements between the levels of *work* and *occupation* are termed *occupationalization*, and the opposite development is termed *deoccupationalization*. Upward movements between *occupation* and *profession* are called *professionalization*, and downward developments are called *deprofessionalization*. The terms *upward movement* or *upward development* are employed if occupationalization and professionalization occur simultaneously. Furthermore, they are used if developments cannot unequivocally be determined to represent occupationalization or professionalization. This usage also applies to the terms *downward movement* and *downward development* for the opposite processes (see Figure 2).

Figure 2: Conceptualization and central terms of workforce developments



Source: Own extension based on Hartmann (1968: 204).

The quantity dimension depicts the number of LTC workers and their development (see Table 1). It is based on the notion of societal relevance and of monopolizing the supply of workers in creating scarcity. A growing number of employees is interpreted as a sign of upward movement because a growing workforce is connected to rising societal demand and hence potentially to increasing societal relevance. Accordingly, a decreasing number of employees indicates downward movement. Furthermore, the lack of staff in relation to the number of clients or to the labor market demand is defined as an upward movement because the scarcity of workers is a defining trait of

professions (Larson, 1977). Oppositely, high unemployment in the sector of LTC is defined as a trait of the level of work.

Table 1: General conceptualization of the quantity dimension

Work	Occupation	Profession
High structural unemployment	Neither shortage of employees nor unemployment	Shortage of employees
Decreasing number of employees	Stable number of employees	Increasing number of employees

Source: Own compilation.

For the skill-level dimension, the definition of the levels of *work*, *occupation*, and *profession* are central (see Table 2). These levels are operationalized via educational degrees, which include entrance qualifications for these degrees (secondary education), the length of education, and the type of knowledge taught (practical, theoretical, scientific). The level of *work* requires no or lower-secondary education to become qualified for this level. No or only a basic healthcare- or LTC degree as an auxiliary care worker is required, which takes fewer than three years of training. Knowledge is primarily practical. Thus, workers without any qualification or with only a few weeks of initial qualification as well as auxiliary carers who need lower-secondary education and receive about one to two years of practical training are included in the level of *work*. The level of *occupation* includes medium-skilled workers with a practical and theoretical education in the field of nursing and care. An (upper-)secondary education for entering occupational apprenticeship education is required. Furthermore, training relies on practical and theoretical knowledge, which is taught over at least three years. Thus, mainly healthcare- and LTC nurses fall into the level of *occupation*, which also includes nurses with additional training or specialization. The level of *profession* includes all care workers with upper-secondary education and an educational degree in nursing or in a related field from a university or a university of applied science. The share of employees in each level and how each level develops over time determine how workforce developments are evaluated in this dimension. For example, a rising share of employees in the level of *work* compared with the level of *occupation* indicates deoccupationalization.

Table 2: General conceptualization of the skill-level dimension

	Work	Occupation	Profession
Occupational degree	None & auxiliary carers	Healthcare- and LTC nurse (including those with additional training and specialization)	Healthcare- and LTC nurse with scientific education
Length and type of occupational education / degree	0–2 years of education in the form of practical on-the-job training	At least 3 years of education in the form of a mixture of practical and theoretical training	At least 3 years of scientific education at a university (of applied science)
Length and type of entrance qualification / secondary education	None or lower-secondary education	(Upper-)secondary education	Upper-secondary education / entrance qualification for university (of applied science)

Source: Own compilation.

The dimension of working conditions (see Table 3) is closely aligned with the *content dimension* of Pavolini and Kuhlmann (2016) and with the concept of *atypical employment* (Ogura, 2005). Indicators that are constitutive of or associated with standard and non-standard employment are included: full-time employment, fixed-term employment, collective agreements, payments, employment stability, social-security coverage, and working hours. Working conditions for the level of *profession* are rooted in standard employment (Wilensky, 1964) – that is, full-time- and non-fixed-term employment. Only a small proportion of the workforce should have non-standard working conditions. In general, working conditions in LTC should be above average compared with those of the general workforce and should include higher-than-average wages originating from collective agreements. A professionalization of working conditions occurs if the indicators increase to above-average values, and a deprofessionalization occurs if indicators decrease to about average values. At the bottom end of the continuum, the level of *work* is associated with atypical forms of employment. Thus, above-average rates of part-time and minimal employment, agency work, fixed-term employment, and shift- and night work are constitutive of this level. Furthermore, wages, social-security coverage, and employment stability are lower than average because collective agreements are not in place. An occupationalization of working conditions occurs if the indicators increase to about average values, and a deoccupationalization occurs if indicators decrease to below-average values. The medium level on the continuum – *occupation* – lies between the working conditions of the *work*- and the *profession* level. Standard employment is the

norm, and the share of workers in standard employment in LTC should be similar to the share in the general workforce. The risk of precarious working conditions is low, and wages should be about equal to those of the general workforce. Thus, working conditions on the level of *occupation* mirror those across the whole workforce. However, data availability might pose a problem for some indicators, especially when obtaining data referring to each level. Hence, the analysis utilizes a comparison with the means for the whole workforce.

Table 3: General conceptualization of the working-conditions dimension

	Work	Occupation	Profession
General	Non-standard employment: fixed-term, part-time	Usually standard employment: full-time, non-fixed-term	Standard employment: full-time and non-fixed-term
Wages & working conditions	Low; below national average	Medium; about national average	High; above national average

Source: Own compilation.

The social dimension (see Table 4) is derived from Hartmann's (1968) *social-orientation dimension* as well as from profession theories focused on societal status, roles, and prestige. Generally, societal orientation and the sense of being an influential and relevant group of workers increases from *work* to *profession*. Professions receive high prestige ratings and have a high societal status. Thus, they generally lie at the top of comparative occupational scales. In addition, whether and how workers organize themselves and view their societal roles is decisive. The level of *profession* has an orientation toward the whole society because professionals view themselves as altruists who perform "services for 'the people,' 'society,' 'all people,' or 'everyone'" (Hartmann, 1968, p. 208, own translation). This orientation toward society links to occupational influence on societal processes and perceptions as well as on political decision-making, which is achieved via strong occupational organizations that are usually organized as professional boards of nursing and care (Hughes, 1963). These organizations should be highly involved in adopting a formal code of ethics, which is constitutive of a profession (Oevermann, 1996). Furthermore, the board of nursing and care or occupational organizations should be highly involved in educating their own aspiring professionals by setting their own rules and standards for admission and for completing education. Additionally, autonomy is fundamental to the level of *profession*. Professions have a high level of autonomy in their work, which means that

professionals are responsible for their clients and make their own decisions on behalf of their clients without interference from superiors (Hughes, 1963; Kurtz, 2011; Stichweh, 1994). On the other end of the professionalization continuum, the level of *work* is marked by low levels of autonomy, prestige, and decision-making power for society and for the workers. The prestige of LTC work should be among the lowest when measured on comparative occupational scales. For the level of *work*, no occupational organizations, code of ethics, or involvement in the education of apprentices exists. Workers have no autonomy as their work is standardized and supervised to a large degree. The level of *occupation* should lie between these poles. A certain level of standardization and supervision of work tasks should be present, yet the exact realization of the work should be performed autonomously. Prestige should be at a medium level. Similar to the level of *profession*, the level of *occupation* adopts a societal mandate; however, this mandate does not cover the whole society; rather, it only covers the specific economic branch – i.e., the LTC system. This societal mandate for the specific economic system should coincide with the presence of occupational organizations that are involved in decision-making procedures. However, these occupational organizations should mainly have consulting roles rather than decision-making roles. Thus, the education of apprentices is not in the hands of the members of the occupation themselves, but these members should be involved in curricula development and practical education. There is no formal code of ethics, but a set of non-binding ethical guidelines should exist.

Table 4: General conceptualization of the social dimension

	Work	Occupation	Profession
Self-organization	No occupational organization	Occupational organizations	Board of nursing and care
	No involvement in education of apprentices	Consulting role in education of apprentices	Rule-setting for education of apprentices
	No ethical guidelines	Set of non-binding ethical guidelines	Formal code of ethics
	Low autonomy in decision-making, standardization, and subordination	Medium autonomy in decision-making, still subordinate to others	High autonomy in decision-making
Societal function	Low prestige / societal status	Medium prestige / societal status	High prestige / societal status
	Low relevance for society	Relevance for health- and care sector	Relevance for functioning of whole society

Source: Own compilation.

All four dimensions highlight different aspects of workforce developments. Furthermore, the dimensions interact with one another, and developments in one dimension can affect those in another dimension. Moreover, although the dimensions are separate, evaluations as to when a workforce can be labeled a *profession* rely on all dimensions. Thus, all dimensions must always be examined in conjunction. Moreover, this general conceptualization of LTC-workforce developments under a lens of professionalization must be adapted to the specific national context. National education systems might not make it reasonable to take up three levels – especially in the skill-level dimension – and may instead require the adoption of two or four. For the specific adaptation to the German context, see the analysis of workforce developments in Chapter 4.

2.2 Workforce processes in long-term care – Prior evidence on developments and explanations

In the last two decades, a variety of empirical studies at the national (Blass, 2012; Oschmiansky, 2010) and international (Oschmiansky, 2013; Pavolini & Kuhlmann, 2016) level have focused on the developments of care workforces. These studies have sometimes been more general and examined healthcare-, LTC-, and social-care workers together (Gottschall, 2008), while at other times, they have been more narrow

and concentrated solely on one specific aspect, such as high-skilled LTC employees (Kälble, 2005). Only studies with a main focus on LTC for the old-aged are reviewed here. This review focuses on two questions: (1) How is the level and the development of the workforce evaluated with respect to professionalization processes? (2) How can the status of, developments within, and changes to the workforce be explained? Concerning the first question, only studies on or including Germany are reviewed in order to help determine (a) whether upward or downward LTC-workforce movements (or even movements in both directions) were found, (b) in which dimensions these movements were found, and (c) which indicators were used to determine the movement. The review reveals that the view of simultaneous professionalization and deprofessionalization is prevalent. Developments in the working-conditions dimension are unequivocally determined to represent deprofessionalization, whereas professionalization and deprofessionalization evaluations can be found both in the skill-level- and the social dimension. However, the review of the literature demonstrates the need for an all-encompassing, updated, and longitudinal analysis of workforce processes. Concerning the second question, evidence on the German LTC workforce is complemented by international evidence regarding which factors explain workforce developments. Explanations focus mainly on institutions of the LTC system and their intersection with institutions of the employment-, education-, and migration systems. However, explanations rely upon a static view of institutions and largely neglect institutional change. Furthermore, the role of political actors and how these actors influence policies and workforce developments is largely lacking.

2.2.1 Prior evidence on the development of the long-term-care workforce in Germany

Prior studies on LTC workforce processes in Germany have applied a variety of profession- and professionalization concepts; however, no single theory or theoretical stream stands out or is used more frequently. Some studies have focused on the question of whether LTC work encompasses the specific traits of a profession (Höhmann, 2009; Schaeffer, 2011), while other studies have adopted a less-static approach and examined processes of motion toward or away from a profession (Oschmiansky, 2013).

Studies on LTC-workforce developments in Germany have come to different conclusions. Some scholars have evaluated the developments nearly exclusively as

having been in the direction of professionalization (Burkhardt, 2018; Kälble, 2013; Krampe, 2014; Theobald & Chon, 2020), whereas other researchers have come to the conclusion of constant deprofessionalization in the German LTC workforce (Buestrich et al., 2008; Buestrich & Wohlfahrt, 2008; Kümmerling, 2016; Pfau-Effinger et al., 2008; Theobald et al., 2018). However, a large number of studies have adopted the view that both professionalization- and deprofessionalization traits and developments have evolved in recent years and decades, often even simultaneously (Auth, 2013; Blass, 2012; Fischer, 2010; Gospel, 2015; Gottschall, 2008; Höhmann, 2009; Isfort, 2013; Kälble, 2005; Kuhlmann & Larsen, 2014; Kuhn, 2016; Kümmerling, 2009; Oschmiansky, 2010, 2013; Schaeffer, 2011; Theobald, 2003, 2008; Voges, 2002). These different evaluations of the LTC workforce can be explained by the adoption of different dimensions and indicators and by the use of different time points and time frames. Furthermore, the evaluation of the German case has been influenced by including comparative country cases that set different baselines for comparison (Gospel, 2015; Oschmiansky, 2013; Theobald et al., 2018; Theobald & Chon, 2020).

Upon closer examination of the adopted dimensions and indicators, many studies can be found that focus on skill level and measures related to working conditions (e.g., Auth, 2013; Kümmerling, 2009). Indicators of the social dimension that measure prestige, autonomy, and decision-making power are less-often selected (Benedix & Kathmann, 2019). The number of employees is mentioned in many studies but generally serves as the context for and not an indicator of upward and downward workforce developments (e.g., Auth, 2013; Buestrich et al., 2008; Oschmiansky, 2013).

All studies classify working conditions in LTC as being below a professional status. This evaluation holds, irrespective of the applied indicators and time points. Indicators that are used include wages (Auth, 2013; Benedix & Kathmann, 2019; Gottschall, 2008; Kümmerling, 2009, 2016), pay in connection with collective agreements (Buestrich et al., 2008; Buestrich & Wohlfahrt, 2008), working time (Auth, 2013; Buestrich, 2005; Kümmerling, 2016; Oschmiansky, 2010, 2013), workload (Auth, 2013; Buestrich et al., 2008; Kümmerling, 2016; Theobald et al., 2018; Voges, 2002), and the standardization and taylorization of care work (Fischer, 2010; Höhmann, 2009; Schaeffer, 2011). The unequivocal picture of a low degree of professionalization and largely downward developments are restricted to the working-conditions dimension.

The results concerning the skill level and education of the workforce are less clear and entail evaluations of both professionalization and deprofessionalization. The institutionalization of formal care work and the tendency toward its expansion are generally taken as signs of professionalization because skilled formal care work has been replacing less-skilled informal work since the start of the LTC-insurance system (Auth, 2013; Kümmerling, 2009; Voges, 2002). Furthermore, there is a consensus that the general educational standard and skill level are rather high and rising in the German LTC workforce (Auth, 2013; Blass, 2012; Höhmann, 2009). This consensus also stems from comparisons with countries such as South Korea (Theobald & Chon, 2020) as well as Japan and the United Kingdom (Gospel, 2015). This high and rising educational standard is exemplified by the notion of a progressing number of academic study programs in care and nursing science at universities and universities of applied science over the past 30 years (Burkhardt, 2018). Some scholars have evaluated this increasing academic education as a pure professionalization step (Burkhardt, 2018; Kälble, 2013; Kuhlmann & Larsen, 2014), while other scholars have discussed that only management and educational functions rely on academic education and that scientific education and knowledge are virtually absent among hands-on care workers (Blass, 2012; Gottschall, 2008; Kälble, 2005; Schaeffer, 2011). Academization has thus been assessed to lead to elite professionalization instead of to an overall educational professionalization of the whole group of LTC workers (Krampe, 2014). Despite these professionalization trends, downward developments have also been depicted. Scholars have found that the growth of LTC correlates with an increase in the number of LTC employees with no or only short-term and on-the-job training who are involved in tasks beyond their specific competences (e.g., dispersing pharmaceuticals, wound management), which scholars evaluate as a downward trend (Buestrich et al., 2008; Gospel, 2015; Gottschall, 2008; Kälble, 2005; Kuhlmann & Larsen, 2014). Moreover, the amount of informal care by family and irregular migrants – who are both usually underqualified for work in LTC – remains significant in Germany (Eichler & Pfau-Effinger, 2009; Lutz & Palenga-Möllenbeck, 2010), which has led some scholars to the conclusion that LTC in Germany is rather unprofessionalized in the skill-level dimension (Pfau-Effinger et al., 2008; Theobald, 2003, 2008).

In the social dimension, studies have tended to evaluate LTC work mainly as not professionalized and moving further downward, and only a few studies have discussed

traits of and trends in professionalization. Concerning prestige and societal recognition, evidence is mixed. The societal prestige of LTC work has been found to be generally high (Isfort, 2013), but society does not recognize that specific and distinct skills are needed and must be rewarded adequately (Blass, 2012). Correspondingly, care workers themselves perceive that they are not valued by society (Isfort, 2013). However, these workers perceive of their work as being built on a clear ethos and a high and distinct skill level (Fischer, 2010). Concerning autonomy and decision-making power, some upward movements have been discussed, but the evaluation tends toward no professional status and downward movements. The introduction of boards of nursing and care at the federal level has been found to represent a step toward the professionalization of care (Kuhn, 2016; Schürmann, 2016). Furthermore, scholars have uncovered increasing autonomy of care work through the shifting of tasks from physicians to care workers but have also found that autonomy remains limited because care work is still performed under the supervision of physicians (Höhmann, 2009). Voges (2002) highlighted this evaluation of low autonomy in working processes and thus of deprofessionalization in the social dimension by pointing out that no exclusive tasks are defined for LTC workers. Only since 2020 has a definition of exclusive tasks been in place, which has been evaluated as a case of professionalization[1] (Benedix & Kathmann, 2019). Furthermore, the increasing standardization of care processes has been associated with downward developments in autonomy (Schaeffer, 2011).

Plenty of evidence exists for the working-conditions-, skill-level-, and social dimensions of LTC-workforce processes in Germany. However, most of the reviewed studies have adopted different concepts and definitions of *profession* and *professionalization*, which has led to the adoption of numerous indicators and to different evaluations. Only a handful of studies have examined workforce processes in more than one dimension and using several indicators (Auth, 2013; Kümmerling, 2009; Oschmiansky, 2013; Schroeder, 2018; Voges, 2002). Schroeder (2018) adopted current data, but his description of the workforce focused mainly on the most-recent cross-sectional data rather than on longitudinal data. All other studies have used data from no later than 2011. Thus, recent developments in the last decade – which has

[1] These *exclusive tasks* (*vorbehaltene Tätigkeiten*) include the collection and determination of individual care needs; the organization, design, and control of the nursing process; and the analysis, evaluation, assurance, and development of the quality of care (Gesetz über die Pflegeberufe - Pflegeberufegesetz, 2017 §4).

been marked by an increasing reform activity in LTC (Steffen, 2020) – have not been taken into account. As a result, there is a need for an updated analysis of LTC-workforce developments in Germany that relies on a consistent approach to *profession* and *professionalization* and that includes *all* dimensions of workforce developments while also employing longitudinal data.

2.2.2 Explanations of professionalization and deprofessionalization in prior research

The explanations that are given in the above-mentioned studies for the LTC-workforce developments in Germany are numerous. Most studies refer to the institutions of the LTC system and connect them to persistent values and ideas on the welfare state and to institutions and practices in related welfare-state systems, such as the employment system, the education system, and the migration system. However, only a few studies have employed explanations involving actors, especially interest organizations.

By first focusing on institutions and policies in the LTC system, a multitude of aspects are used to explain workforce developments, including the degree of institutionalization of the LTC system, the generosity of benefits, the type of provider, support schemes for family care (especially cash-for-care schemes), economization and taylorization of care, and the general care culture. Furthermore, other welfare-state systems, their institutions, and their intersection with LTC are used to explain LTC-workforce developments. The connection to the employment system has been widely adopted, especially to explain processes in the working-conditions dimension. Furthermore, the degree of regulation of employment relations, the extend of collective agreements, the existence and level of minimum wages, and regulations concerning staffing levels serve as explanations. Intersections with the education system are employed to explain developments in the skill-level dimension, and intersections with the migration system are discussed in connection with live-in migrant care.

The degree of institutionalization of the LTC system marks a first general explanation of upward movements. The establishment of the German LTC system in 1995/1996 has been evaluated as a professionalization step because formal care became acknowledged and structured by national rules and has been able to develop under a clear framework (Auth, 2013; Blass, 2012; Theobald, 2003, 2008).

A high generosity of public LTC benefits is generally associated with an expansion of the formal LTC workforce (Blass, 2012). The benefits provided by the German LTC

insurance only cover part of the total costs of care and the remaining part must be funded privately out-of-pocket by the LTC recipient (Rothgang, 2010). Scholars view this partial financing of care costs as an obstacle that prevents recipients from taking up formal LTC and have thus found it to hinder the expansion of LTC work (Kümmerling, 2009; Theobald, 2008).

Furthermore, the type of provider is related to upward and downward workforce developments in the working-conditions dimension. The working conditions in residential care and in facilities run by public or non-profit providers are usually higher than in ambulatory care and with for-profit providers (Auth, 2013; Comondore et al., 2009; Geraedts et al., 2016). Public and non-profit facilities set their wages based on national or federal public-pay schemes, which leads to higher wages than most private providers pay (Buestrich et al., 2008; Razavi & Staab, 2010; Rubery & Urwin, 2011). However, the decreasing coverage rates of collective agreements and the decreasing amount of acceptance of collective agreements by non-profit providers are considered to be an explanation for low and slowly increasing wages (Buestrich & Wohlfahrt, 2008). The small size of enterprises in ambulatory care precludes workers from some working rights. Furthermore, it is difficult for workers to organize due to the small number of colleagues and the type of work itself, which is mainly performed alone and with little contact between co-workers (Kümmerling, 2016). Moreover, in ambulatory care, wages comprise a higher percentage of the total budget than in residential care. Up to 90% of ambulatory-care costs stem from wages (Kümmerling, 2016). Hence, ambulatory care is more prone to keeping costs under control by limiting wages and wage increases.

Support schemes targeted at family caregivers (e.g., counselling, training, respite care, pension credits, cash-for-care schemes) (Courtin et al., 2014) have been evaluated as a reason for decreasing and slowly increasing LTC workforces. These schemes increase the length of informal care provision and thereby crowd out formal LTC work (Brandt et al., 2009). This process has been best documented for cash-for-care schemes, which are the most-prominent and expensive support schemes for family caregivers and differ in their degree of regulation. Rigid schemes in which the cash benefit must be spent on care and in which these expenses are checked by authorities lead to the market employment of informal carers, who usually enjoy the same employment rights as care workers employed by regular LTC providers. This kind of cash-for-care scheme has been evaluated as a formalization of informal care

(Ungerson, 2004). However, the skill level of these workers is low, which has lowered the skill level as well as the value of qualifications in care (Ungerson, 2004). Regulations on the German cash benefit are loose, and the benefit is dispersed to care recipients without any obligations as to how the money must be spent (Rothgang, 2010). This unbound cash benefit is evaluated as an important explanation for persistently high shares of informal care by family members (Eichler & Pfau-Effinger, 2009; Österle & Bauer, 2012). Overall, cash-for-care schemes and other support schemes for family caregivers do not serve as an impetus for beginning family care; however, they contribute to the intensification and prolongation of informal elderly-care work and especially to a crowding-out of low-skilled formal home care (Bonsang, 2009; Brandt et al., 2009; Dammayr, 2012; Eichler & Pfau-Effinger, 2009; Garcés et al., 2010; Grootegoed et al., 2010; Ungerson, 2004). Furthermore, unbound cash benefits spur informal care by migrants who live in the care-recipient's home (Bettio et al., 2006; Ungerson, 2004). These cash benefits are used to hire irregular migrant live-in care workers, especially if benefits are relatively high and a family-based care regime with low public provision of services is prevalent (Simonazzi, 2009). This applies to Germany, where the state assumes "the role of […] 'complicity': knowing and pretending ignorance at the same time, acting officially in a restrictive way, while tacitly accepting the violation of self-made rules" (Lutz & Palenga-Möllenbeck, 2010). The extent of live-in migrant care is not only influenced by the structure of LTC cash benefits but also dependent on further pull factors that stem from migration systems, such as an easy-to-access tourist- or student visa and recurrent regularizations of informal migrant care workers (León, 2010; Lutz & Palenga-Möllenbeck, 2010; Simonazzi, 2009). Thus, the expansion of support schemes for family caregivers has contributed to a prolonged provision of care by family members and of informal migrant care, and scholars have found these schemes to contribute to decreasing or slowed upward mobility in the quantity dimension.

A large amount of informal LTC and a small amount of formal LTC can also be attributed to the predominant care culture. The conservative and familialistic care culture in Germany has been found to contribute to a context in which professionalization is difficult to achieve (Eichler & Pfau-Effinger, 2009). The prevailing view – that care should be provided within the family (Hofpointner, 2008; Kuhlmann & Larsen, 2014; Simon & Flaiz, 2015; Theobald, 2003) – promotes an unwillingness to pay for formal services because family care is perceived as being

cheaper and of similar quality to formal services (Bailly et al., 2013). These views put pressure on wages and working conditions, especially for low-skilled and low-paid workers because they compete with *free-of-charge* family care (Bailly et al., 2013; Evers et al., 1994; Knijn & Verhagen, 2007). In this conservative care culture, ambulatory care takes legal precedence over residential care (Rothgang, 2010). Ambulatory care usually needs fewer workers than residential care because family members often take supporting roles in ambulatory care. Hence, this rule has been found to contribute to a slowly progressing quantity of formal LTC work (Blass, 2012; Kümmerling, 2009; Suanet et al., 2012).

Furthermore, the introduction and widespread implementation of economic and market principles have been posited as explanations for downward movements in the workforce. Partial financing of LTC costs, cost pressure on LTC facilities, the decreasing real value of benefits, and the underfunding of the social LTC insurance system (Rothgang, 2010) have led to a public and political discourse on fiscal constraints, which has been found to hamper professionalization and to contribute to the deprofessionalization of LTC work (Buestrich et al., 2008; Buestrich & Wohlfahrt, 2008; Gottschall, 2008; Hofpointner, 2008; Kümmerling, 2016; Theobald, 2003).

These economic principles have also guided the taylorization of care, which has been posited as an explanation for downward developments in the social dimension. The taylorization of LTC has been found to be connected to this economization or marketization of LTC. Taylorization entails a standardization of care work and a partitioning of care work into specific tasks that are billable on a minute basis (Eichler & Pfau-Effinger, 2009; Pfau-Effinger et al., 2008). This approach counters conceptions of holistic care – including emotional work, which is part of a professional ethos of care workers – and undermines the autonomy of care workers (Fischer, 2010; Pfau-Effinger et al., 2008).

Institutions in the labor market – and the intersection of these institutions with LTC institutions – has strongly influenced the working-conditions dimension. Institutions and policies of the general labor market resonate in the specialized labor market of LTC. Regulated labor markets with low overall wage inequalities have been argued to be mirrored by the LTC labor market and to provide a context in which the LTC workforce can potentially professionalize (Razavi & Staab, 2010). Deregulations that apply to the whole labor market – such as the German Hartz legislations, which were passed in 2002 and 2003 – are considered to have led to greater marginal employment

overall, which is reflected in the LTC sector (Oschmiansky, 2010, 2013). Furthermore, these policies have led to social investment and activation in unemployment policy. For LTC, this means that unemployed people work as additional care workers in facilities for one euro per hour. This work might have had activation effects for the unemployment system, but for LTC-workforce developments, it has been found to decrease skill levels, to reduce the recognition of skills in LTC, and to put pressure on the wages of low-skilled care workers (Buestrich, 2005).

The introduction of specific minimum wages in LTC has led to potential upward and downward effects on LTC-workforce developments concerning not only working conditions but also the quantity- and skill-level dimensions. On the one hand, minimum wages set a bottom line for wages; however, this only affects the wages of low-skilled care workers. Carers with a three-year apprenticeship education usually do not profit directly from minimum wages because their salaries are normally considerably higher than the minimum wage (Kümmerling, 2016; Meyer, 2012). Nevertheless, minimum wages may put pressure on the wage scale and lead to rising wages for the whole sector (Kümmerling, 2016). Furthermore, the pressure at the bottom of the wage scale may lead these workers to be replaced by higher-skilled workers who are more efficient and able to provide a wider range of tasks (Meyer, 2012). On the other hand, minimum wages may lead to downward movement in skill level, in working conditions, and in the demand for care services. These effects include increasing work intensity, the replacement of lower-skilled workers with technical solutions, the replacement of workers with irregular migrant workers, a reduction in care demand, layoffs, a decrease in quality in order to compensate for increasing wage costs, more private payments, and increasing contribution rates (Meyer, 2012). Thus, the introduction and the level of minimum wages may explain upward and downward movements of the LTC workforce.

The spread of collective agreements serves as an explanatory factor for the level and development of wages. A small spread of collective agreements has been found to contribute to low wages and working conditions that improve only slowly (Buestrich & Wohlfahrt, 2008; Kümmerling, 2016). Collective agreements are often negotiated under the (potential) threat that workers might go on strike if their demands are not met. This essential labor right is restricted for a considerable part of the LTC workforce. Workers with a Church-affiliated employer (Caritas and the Diakonie) lack the right to go on strike due to Church-affiliated labor laws. This prohibition to strike

has been found to be a clear hindrance to the enforcement of employment rights, better working conditions, and more decision-making power (Buestrich & Wohlfahrt, 2008; Zender, 2014).

A further intersection of labor market- and LTC institutions can be found in staffing levels. The German rule that at least 50% of care workers in institutional facilities must have completed a three-year apprenticeship education in a care- or nursing occupation has been found to promote and secure skill-level development and to serve as a barrier to unmanageable workloads (Blass, 2012; Gospel & Lewis, 2011; Höhmann, 2009; Kümmerling, 2016).

Increases in decision-making power have been associated with the introduction and growth of boards of nursing and care (Höhmann, 2009; Kuhn, 2016). However, with regard to Sweden and the UK, it is unclear whether the establishment of boards of nursing and care are overrated for reaching autonomy and market closure (Schürmann, 2016; Schwinger, 2016).

The education system and its connection to LTC serve as factors in explaining skill-level developments. Some scholars have attributed increasing skill levels and the growing recognition of care work to the establishment of national guidelines for LTC nurses in apprenticeship programs and to the introduction and establishment of scientifically based care- and management concepts (Burkhardt, 2018; Kümmerling, 2009; Roth, 2007).

Only a few studies have turned to actors to explain workforce developments. The low degree of autonomy of LTC workers has been explained by rigid hierarchies and the ever-prevalent leadership role played by physicians in LTC (Kälble, 2005; Simon & Flaiz, 2015). Furthermore, a general academization of LTC work is supposedly hindered by the current academic LTC elite, who are satisfied with their own professionalization (Krampe, 2014). Moreover, scholars connect poor working conditions and low autonomy to weak interest organizations, which are not able to enforce co-determination rights at the level of facilities and are too weak to influence the policy level (Kälble, 2005; Kümmerling, 2016; Schroeder, 2018).

The reviewed studies demonstrate that a variety of factors can contribute to and explain workforce developments. Studies have associated upward movements in the quantity dimension with a high degree of LTC institutionalization; a high level of generosity of public benefits; a low degree, low level of generosity, and strict rules for family-support schemes; a weak familialistic care culture; the introduction and

implementation of quantitative staffing levels; and difficult-to-access migration regimes. Upward developments in working conditions have been explained by a high share of residential care, a high share of public- and non-profit providers, the absence of a familialistic care culture, regulated labor markets, widespread collective agreements, full rights to go on strike, minimum wages, and strong occupational organizations. Scholars have ascribed upward movements in the skill-level dimension less to LTC institutions and have instead turned to the institutions of the labor market. Regulated labor markets, minimum wages, qualitative staffing levels, and an unestablished LTC elite have been posited as explanations for upward movements in the skill-level dimension. Occupationalization and professionalization in the social dimension have been associated with a low degree of taylorization of care, the establishment of boards of nursing and care, a weak physician profession, and strong occupational organizations.

Furthermore, the literature indicates that institutions and their development serve as the main explanations for workforce developments. Actors, however, are hardly associated with workforce developments, which comes as a surprise since research in other welfare-state areas – such as employment relations (Bender, 2020), unemployment (Hegelich et al., 2011), healthcare (Bandelow, 2006), and pensions (Trampusch, 2004) – has shown that organized actors influence policies and hence also developments in their fields. Pointing to the weakness of occupational organizations neglects this line of welfare-state research and furthermore disregards the fact that non-occupational organizations are involved in LTC. Indeed, other organizations might be strong and influence policy and workforce developments.

2.3 Representing interests in long-term care

The previous section pointed out that developments in the LTC workforce are rarely explained by the ideas, interests, and actions of political actors. However, in his study on the expansion of LTC in Germany between the 1970s to 1990s, Schölkopf (2000) stressed that whether and how LTC expanded stemmed from political actors' will and action.

> Indeed, this development [the expansion of LTC] was always preceded by specific *political decisions* on allocating subsidies for the construction of residential old-age facilities or the subsidization of labor costs. (Schölkopf, 2000, p. 121, own translation, italics in original)

For Germany, only a few recent studies have empirically addressed relevant organizational actors in the LTC field, their policy positions, and their role in the LTC arena. Schroeder (2018) examined organized interests at the individual level, the firm level, and the level of associations. Unfortunately, he discussed only the employee side in greater detail. He presented different organizations that are engaged in representing LTC employees but discussed only three organizations in greater detail: two occupational organizations – the German Care Occupations Association (DBfK) and the German Occupational Organization for Elderly Care Workers (DBVA) – and the trade union ver.di. Schroeder (2018) argued that most employee organizations lack a solid basis for membership and have only minor impact in the field of LTC. Similarly, Kümmerling (2016) hinted at the weak occupational organizations representing care workers and pointed to the common narrative of fiscal shortages as this narrative hinders greater participation and greater influence on policymaking and on working conditions in the care facilities. Even if occupational organizations are depicted as weak, these studies fail to show how large the organizations' influence actually is. Theoretically, it is even possible for organizations with low monetary resources and low participation rates to make their interests heard and thus to influence policymaking (Nullmeier, 2000; von Winter & Willems, 2000). Furthermore, all organizations that do not represent LTC workers are left out of the picture. How strong they are, which aims they pursue concerning LTC-workforce developments, and how influential these interests are is not part of the analyses of these studies.

2.3.1 Weak organizations and the representation of their interests

Organizational theories and theories of collective action focus on how and under what conditions interest organizations are able to assert their policy positions and interests (Offe, 1972; Olson, 1965). As Offe (1972) explains, the administration and effective representation of interests is mainly dependent on both organizations' *organizability (Organisationsfähigkeit)* and their *capacity for conflict (Konfliktfähigkeit)*. Organizability deals with the mobilization of resources to form associations of members with similar interests. Organizability increases through establishing a collective identity, through the existence and aggravation of an external threat, through symbolic and material gains, and through physical meetings and regular communication. In general, particular interests are easier to organize than general interests; hence, it is usually more difficult to organize large groups because the

problem of free riders increases with increasing group size. The problem of free riders arises when individuals do not participate in the organizational process but benefit from it (Olson, 1965). The successful realization of the interests of interest organizations is largely dependent on the groups' capacity for conflict. The organization needs to have the capability to collectively refuse activities that are relevant to the functioning of society or the societal system in which it acts. An organization does not need to refuse activities in every conflict; thus, not every labor conflict has to end in a strike. Even the credible threat of refusing activities – and thus the announcement of going on strike if the interest organizations' own interests are not met – is often sufficient to make opposed actors give in and accept the demands of the interest organization (Offe, 1972).

Organizations that represent occupational interests of (long-term) care workers in Germany are considered weak. This assessment follows from low participation rates of LTC workers in occupational organizations and trade unions (Gottschall, 2008; Kümmerling, 2016) and from the low potential of LTC workers to sanction employers if their interests are not met (Kümmerling, 2016; Schroeder, 2018). Thus, LTC organizability as well as the capacity for conflict are both assessed as being low and difficult to achieve. Scholars have mentioned several obstacles that hinder the ability of LTC workers to increase their organizability. General individualization trends in society limit people's willingness to engage collectively (Voges, 2002; Welskop-Deffaa, 2016). This individualization is also present in care work, in which workers in ambulatory LTC are especially likely to perform their work alone, which leads to a weak sense of identity with one's own occupational group and thereby impedes involvement in collective action (Kümmerling, 2016; Voges, 2002). A further obstacle is posed by the high ratio of female workers because women are assessed as having less time and interest to organize collectively (Welskop-Deffaa, 2016).

> The low level of association among care workers who are organized in an interest organization is one of the main reasons for the limited influence of occupational organizations and, in particular, of professional organizations. The low membership of long-term-care workers and their distribution among numerous occupational organizations are the greatest weaknesses of targeted occupational-interest representation [by organizations] in the social-care- and healthcare sector. (Voges, 2002, p. 314, own translation)

Furthermore, LTC employees have only a limited capacity for conflict. One reason is that employees of Church-affiliated employers are not allowed to go on strike (Voges,

2002; Welskop-Deffaa, 2016). A second reason involves low organizability: Due to the low participation rates of LTC employees in trade unions, these unions cannot credibly threaten employers with the option of a strike. Even in the case of a strike, a basic level of care would be ensured by the remaining care employees who are not members of a trade union (Schölkopf, 2000). Furthermore, working ethos and care traditions impede individuals' ability to fight for their own interests (Kümmerling, 2016; Schölkopf, 2000). Accordingly, Schroeder (2018, 142, own translation) concludes:

> In the elderly-care sector, a fragmented landscape of actors and interests with poor resources exists. (Schroeder, 2018, p. 142, own translation)

Limited organizability and capacity for conflict could thus be inferred to make it highly unlikely for LTC workers' interests to enter the political process and for these interests to be considered and enforced. The chances for interests of weak organizations to enter the political process are certainly lower than those of strong organizations; nevertheless, the aim of the professionalization of the LTC workforce that occupational organizations pursue can be represented and can succeed in the policy arena (Nullmeier, 2000; von Winter & Willems, 2000). The interests of weak organizations can be represented in policymaking if strong interest organizations take the role of advocates (von Winter & Willems, 2000). These strong interest organizations organize and articulate the interests of weak interests organizations if their own major interests and primary aims are in line with the interests of weak organizations and can be easily connected to them (Nullmeier, 2000). In most cases, strong interest organizations are willing to act as advocates because they have similar or connected interests and profit from their role as an advocate. Nevertheless, the chances are high that interests of weak organizations will change and deviate from their original intention and that these interests will be misused (von Winter, 1997; von Winter & Willems, 2000). A further strategy to integrate the interests of weak organizations into the political process is through elections in which parties that favor certain interests are elected (Schölkopf, 2000). However, this strategy is risky, has an unclear success rate, and is extremely indirect (Schölkopf, 2000). Thus, the most-viable strategy for occupational organizations that represent LTC workers is to find strong interest organizations that are able to act as advocates for their interests (Schölkopf, 1999).

> […] [A]ddressing "peripheral demands" and enforcing "weak interests" […] is not only dependent on organizability and the capacity for conflict. On the contrary, demands […] can also be realized indirectly if other organizations advocate for them. (Schölkopf, 2000, p. 122, own translation)

A further possibility for representing the interests of weak organizations stems from Nullmeier (2000), who emphasizes the symbolic power and discursive strategies of organizations that make it possible to become involved and to influence policy processes. *Argumentative power (Argumentationsmacht)* and *the ability to justify something (Rechtfertigungsfähigkeit)* play an important role in influencing policymaking. Argumentative power highlights the ability of interest organizations to bring a topic into the public discourse, and the ability to justify something includes stating and explaining the problems and the legitimacy of interests in a way that intrigues and concerns the public. Nullmeier (2000) argues that public communication rooted in common morality norms and the use of arguments of self-destruction serve as an effective justification strategy. An example of such a strategy would be suggesting that the whole social system could be at stake if the interests of weak organizations are not heard.

In conclusion, organizations that pursue the aim of LTC professionalization are considered weak due to their weak organizability and low capacity for conflict. Despite these weak interest organizations, occupational interests can still enter the political process and are able to be heard and met. Weak interest organizations can use discursive strategies to enter their interests into the public discourse and to legitimize them as public interests. Furthermore, they can find interests organizations or even political parties that can act as advocates for their interests.

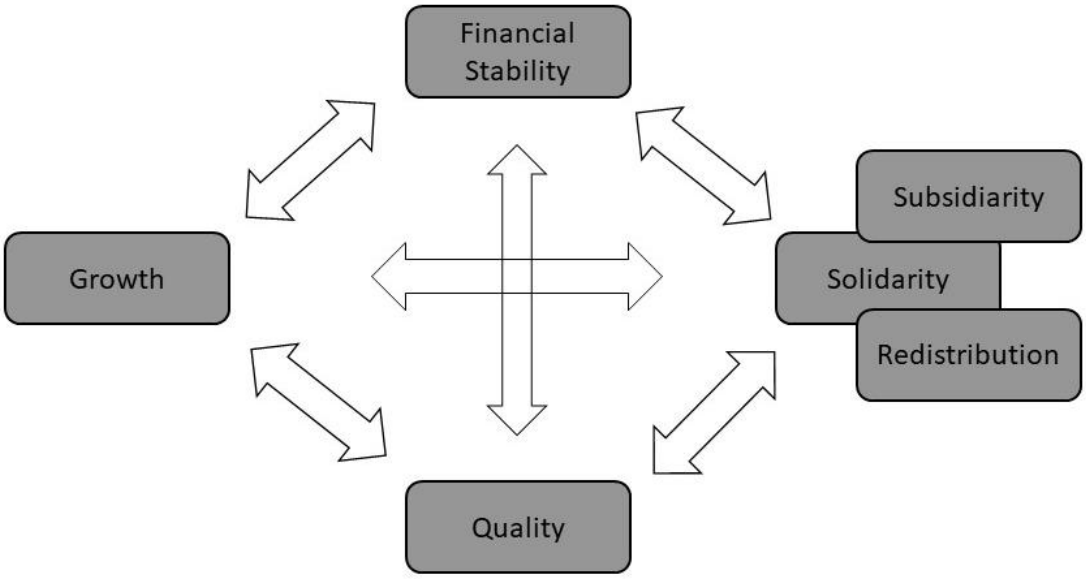
2.3.2 Aims in LTC reform processes

Strong organizations can thus act as advocates for the interests of weak organizations, which begs the question as to which organizations can potentially take up the role as an advocate for LTC professionalization. Before answering this question, we need to take one step back and examine which aims – other than professionalization – are present in the LTC field and how they relate to the aim of professionalization. Only organizations that pursue aims that align with the aim of professionalization can act as advocates. Based on their studies of healthcare policies and actors in Germany, Bandelow (2006) and Bandelow et al. (2009) developed hypotheses on actors' primary

aims in healthcare. These aims can be transferred to and used in the LTC field. Four primary aims are differentiated: *financial stability*, *quality*, *growth*, and *solidarity* (see Figure 3). *Financial stability* focuses on stabilizing or even decreasing expenditures in LTC. The aim of *quality* addresses an appropriate level of services and a high level of performance. *Growth* includes the expansion of profits in the LTC sector as well as the creation and security of jobs. The aim of *solidarity* has two meanings: *redistribution* and *subsidiarity*. *Redistribution* focuses on the equal provision of services to all beneficiaries, independent of income or other individual characteristics, while *subsidiarity* addresses the notion that care should be provided by the lowest-possible societal entity before the next entity steps in. For LTC, this can be translated to *family care before formal care* and *ambulatory care before residential care*. Most of these primary aims cannot be pursued simultaneously because all aims generally conflict with one another. However, it is possible for two or three aims to be combined and pursued together, though in most cases, one aim stands out as the most important.

> Thus, financial stability can come into conflict with growth and quality, particularly because the latter aims require an expansion of resources. Interest in growth can conflict with the aim of solidarity if public financial possibilities are limited and growth is only possible via additional private financing. Even quality and growth are not congruent, although discrepancies between them are the least apparent. Quality interests, however, can lead to a use of healthcare funds that deviates from the interests of national providers. (Bandelow et al., 2009, p. 15, own translation)

Figure 3: Conflicting primary aims in LTC policy



Source: Based on Bandelow et al. (2009, p. 17).

In Bandelow's theory, professionalization is not a primary aim, although physician- and nurse associations list their *professional project* (Larson, 1977) as their first objective in the healthcare sector. Similarly, professionalization constitutes the primary aim for occupational organizations of LTC workers (Voges, 2002, p. 290) and guides these actors' interests and actions to influence policymaking.

Overall, the aim of occupational organizations is to professionalize the workforce they represent, although some demands represent only small steps toward this goal that could be classified as occupationalization. However, the aim remains professionalization in the long run. Hence, in connection with aims, only the term *professionalization* – and not *occupationalization* or *upward movement* – is employed. The four aims presented by Bandelow might be more-often adopted in policymaking in the LTC field than is the aim of professionalization; however, professionalization is integrated as a primary aim in the framework. Nevertheless, many organizations include professionalization only as a secondary aim. If they act as advocates of occupational organizations, a different aim than professionalization is pursued as a primary aim, but this primary aim should not stand in conflict with the secondary aim of professionalization. Professionalization can be in conflict with all four other aims: however, similar to the aims of financial stability, quality, growth, and solidarity, some of the aims can be pursued more easily in accordance with professionalization than others.

The aim of financial stability is concerned with the efficient use of financial resources. A particular focus is placed on keeping public spending at a societally affordable level. The aim of financial stability is often justified by the threat of future increasing contributions and spending levels caused by demographic ageing (OECD, 2011). The professionalization of LTC work – especially regarding improvements to quantity, skill level, and working conditions – can in most cases only be achieved when financial resources increase. Thus, the aims of financial stability and professionalization stand in stark conflict.

> Since three-quarters of operating costs arise for personnel, this item is preferred for reducing costs. Budget problems are partly offset by mixing and cutting back personnel. (Voges, 2002, p. 307, own translation)

Voges' statement proposes not only that financial stability and professionalization stand in contrast, but also that financial stability corresponds with the opposite aim – deprofessionalization – in terms of a lower mixture of skills and fewer staff members.

Thus, organizations aiming for financial stability would advocate for or at least take into account deprofessionalization.

The aim of quality deals with better performance. What LTC quality entails and how quality is and can be measured have not been clearly specified scientifically or politically (OECD & European Commission, 2013). There are a number of quality dimensions (e.g., user safety, care coordination, patient-centeredness) and indicators (e.g., patient experiences, satisfaction, social activities, pressure ulcers, falls, unintended weight loss) (OECD & European Commission, 2013). For many countries, national policy guidelines on LTC quality as well as the nationwide continuous monitoring of certain quality indicators are largely lacking (OECD & European Commission, 2013). Improving quality indicators can be achieved by improving administrative and communicative processes (e.g., by setting up or tightening monitoring- or accreditation systems) and by refining and enforcing elderly-protection laws (OECD & European Commission, 2013). However, in most cases, it is necessary to increase financial input and thereby also real input. Furthermore, the number of staff in relation to LTC recipients (quantitative staffing levels) and the skill mix of staff (qualitative staffing levels) are essential for a variety of quality indicators. Studies that have investigated the effect of quantitative and qualitative staffing levels on the quality of care have mainly relied on US data and shown diverse results according to the indicators used for measuring quality. The evidence gathered by systematic reviews generally indicates that having more care workers and thus using more care hours has a positive effect on the quality of care provided, especially if studies with a better methodological approach are taken into account (Castle, 2008; Comondore et al., 2009; Hyer et al., 2011). However, a certain staff threshold must be surpassed in order to achieve quality gains, and a certain threshold exists beyond which having more care workers leads only to small increases in quality (Donabedian, 2003). The review by Bostick et al. (2006) found that a higher skill level is associated with higher quality. However, other reviews have been more reserved in coming to this conclusion and have indicated that higher skill levels might only positively influence the quality of specific indicators (Backhaus et al., 2014; Spilsbury et al., 2011). Furthermore, high levels of low-skilled workers have also been associated with higher quality in some studies (Spilsbury et al., 2011). The evidence is clearly mixed but tends to indicate that minimum quantitative and qualitative staffing levels influence the quality of care positively and furthermore ensure a well-educated workforce and a manageable

workload. Thus, the aim of increasing LTC quality connects with the aim of professionalization in the quantity- and skill-level dimension. The aims of quality and professionalization can therefore be pursued in close connection by organizations.

The aim of growth includes increasing opportunities for making profits and the expansion of employment (Bandelow, 2006). Increasing demographic ageing creates a context in which the number of dependent elderly people increases naturally.[2] Thus, more services are needed, which enables providers to expand and thereby increase the number of their employees. This natural growth can be slowed by policy decisions, but policies can also create additional growth (e.g., by loosening eligibility criteria or by setting up higher patient–carer ratios in facilities) (Schölkopf, 1999). These considerations lead to two possibilities for connecting the aims of growth and professionalization: On the one hand, growth induced by higher qualitative and quantitative staffing levels and greater financial and real input can align with the aim of quality and the aim of professionalization in the quantity-, skill-level-, and (potentially) working-conditions dimension. On the other hand, growth can be generated on the backs of LTC workers. Quantitative and qualitative understaffing and low wages can increase the profits of care providers (Auth, 2013; Buestrich, 2005). Hence, not only do growth and professionalization cancel each other out, but the aim of growth might be pursued in connection with the aim of deprofessionalization. Thus, how the aim of growth is interpreted and whether further primary aims – such as quality or financial stability – are involved determines whether professionalization or deprofessionalization are and can be included.

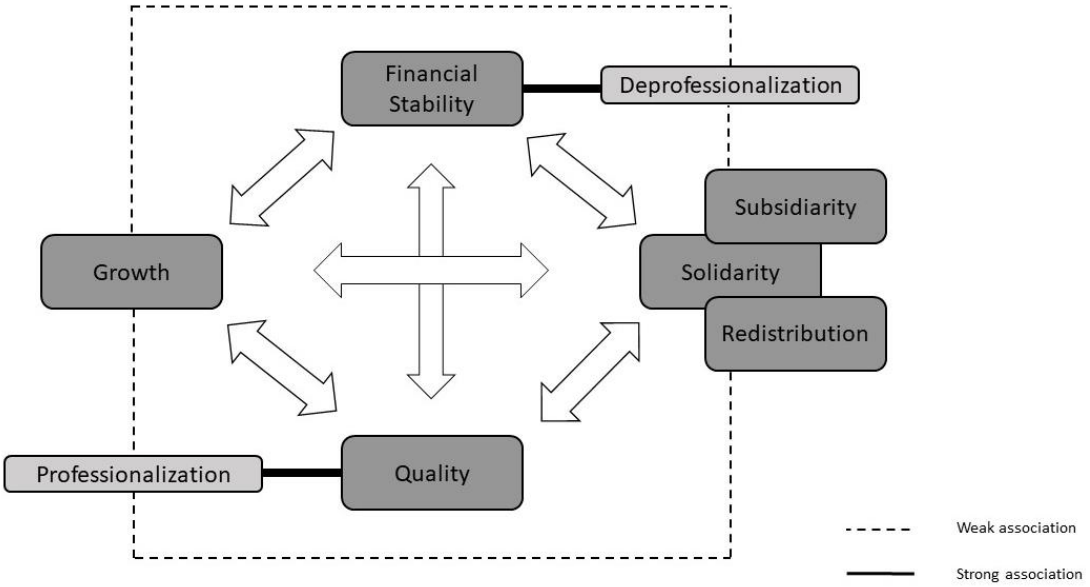
The aim of solidarity has two meanings: subsidiarity and redistribution. Theoretically, only the aim of redistribution is able to be pursued in connection with the aim of professionalization. Subsidiarity is concerned with shifting responsibility to the lowest-possible societal entity. In LTC, this means that the family is the first responsible institution for a dependent patient. Setting rules to incentivize family care and to disincentivize formal care services contributes to intensifying and prolonging informal elderly-care work and to crowding out (mainly low-skilled) home care (Bonsang, 2009; Brandt et al., 2009; Dammayr, 2012; Eichler & Pfau-Effinger, 2009; Garcés et al., 2010; Grootegoed et al., 2010). Thus, aiming at subsidiarity weakens formal LTC services due to a longer reliance on family care, and subsidiarity can thus

[2] See Section 3.1 for a discussion on demographic ageing and increasing demand for care services.

be associated with deprofessionalization in the quantity dimension. Defining the aim of solidarity in terms of redistribution relates to equal access to and conditions in the provision of LTC. Furthermore, solidarity means that economically stronger people should pay more contributions or pay for more care services privately than economically weaker people (Bandelow, 2006). Hence, fostering redistribution might increase the number of economically weak patients who access formal services, which would be positively linked to the professionalization aim because the formal care market and the demand for care workers would increase. However, overall, the connection between solidarity and professionalization is the weakest of all four primary aims. Thus, a strong role as advocates for or against professionalization taken by organizations pursuing the aim of solidarity does not follow from the theoretical considerations.

In sum, the aims of solidarity and growth connect with the aims of professionalization and deprofessionalization, respectively. Thus, each policy interest based on these primary aims must be evaluated tentatively by including the context and other target aims. Quality connects to professionalization. Organizations that aim at quality should assume the role of advocate for professionalization. Financial stability links to the aim of deprofessionalization. Thus, organizations that aim at financial stability should at least implicitly advocate for deprofessionalization. The tension between containing costs and increasing quality – which has been the most-decisive conflict line in LTC policy in recent years (Ranci & Pavolini, 2013) – is also the crucial line of conflict that divides organizations that advocate for and against professionalization. Figure 4 displays the four primary aims of LTC policymaking and their relation to the aims of professionalization and deprofessionalization.

Figure 4: Conflicting primary aims in LTC policy and their connection to the aims of professionalization and deprofessionalization



Source: Own extension based on Bandelow et al. (2009, p. 17).

2.3.3 Organizational aims and advocacy for professionalization

The considerations of how the aims of professionalization and deprofessionalization link with other primary aims in LTC can be transferred to organizations. In their studies, Schölkopf (2000) and Voges (2002) present organizations that they perceive as being important in the German LTC field: occupational organizations, trade unions, patient organizations, social welfare organizations, business organizations, system organizations, and education- and research organizations. The present study examines the primary aims that these organizations adopt as well as whether and how they advocate for professionalization.

Occupational organizations represent the interests of individuals with the same or a similar occupation (e.g., nurses or physicians) and primarily aim for the professionalization of the whole group of workers they represent. However, Voges declares that not all aspects of professionalization are equally important.

> Therefore, when it comes to exerting influence, aspects of self-control in accessing and practicing a profession are given greater priority than, for example, the immediate improvement of working conditions or material gratification. (Voges, 2002, p. 290, own translation)

Nevertheless, exactly which workforce dimensions are more-strongly pursued by occupational organizations also depends on the specific organization itself. Occupational organizations in care have evolved historically from different social

backgrounds and have developed different traditions, values, and principles, thereby leading to heterogeneous and conflicting interests within the group (Voges, 2002). Furthermore, conflicts between occupational organizations that represent different occupations (e.g., those representing physicians and those representing care workers) can develop. Moreover, occupational organizations and trade unions can stand in conflict with one another if both aim to gain the same members (Schölkopf, 2000). A discursive strategy for translating the particular aim of professionalization into a legitimate aim for the whole of society (Nullmeier, 2000) would be to connect professionalization to quality aspects (Voges, 2002).

Trade unions represent workers' interests. They have a much larger membership than occupational organizations as they represent not only employees with a similar occupation but also employees from one economic sector. Furthermore, trade unions are able to negotiate collective agreements. They aim for solidarity mainly in the sense of redistribution (Bandelow, 2006) and fight for increasing incomes and working conditions of employees, particularly for those organized in a trade union. Thus, professionalization in the working-conditions dimension is a primary aim (Schölkopf, 2000). Nevertheless, trade unions are also interested in low social-security contributions because high contributions diminish real incomes for the whole workforce (Voges, 2002). Therefore, it seems possible that some workforce dimensions – such as a larger number of employees or a higher skill level of the LTC workforce – are not supported or lobbied for if these particular care-workforce interests conflict with the interests of the whole workforce.

Patient organizations include all societal groups that represent the interests of old-aged patients and consumers in the care market and primarily aim at increasing quality (Bandelow, 2006). Patient organizations should hence be able to include professionalization as an aim and should thus generally be able to act as advocates for professionalization. Only if professionalization conflicts with patient interests (e.g., if it leads to higher private LTC costs) could patient organizations also adopt a deprofessionalization stance.

The group of business organizations includes all business associations and organizations of private providers of care services. For these associations and organizations, the aim of financial stability is central, and growth also plays an important role (Bandelow, 2006). These business associations and organizations are interested in low social-security contributions because high non-wage labor costs are

associated with negative consequences for the competitiveness of employers (Voges, 2002). Furthermore, they seek to gain profits and are therefore interested in growth. These primary aims should lead to advocacy for deprofessionalization. Voges points out that advocacy for deprofessionalization should be particularly strong for the working-conditions dimension.

> The interests of business associations are primarily focused on reducing non-wage labor costs and fostering a "low-cost" nursing occupation [...]. Therefore, they are rather skeptical about the professionalization of geriatric care, which is associated with higher wages. (Voges, 2002, p. 288, own translation)

Social welfare organizations include all non-profit LTC providers. They are organizations with a dual role: On the one hand, they are providers of LTC services and employers of LTC staff (Schmid & Mansour, 2007) and thus have the same primary interests as private provider organizations. On the other hand, social welfare organizations represent the interests of weak societal groups, such as those of LTC recipients (Schmid & Mansour, 2007). Thus, social welfare organizations could aim for financial stability and growth as well as for quality and solidarity in the sense of redistribution (Schölkopf, 2000). Hence, these organizations can choose which interests and aims to pursue. This choice might depend on and change based on the timing and content of each reform process. Therefore, social welfare organizations might advocate for professionalization in one case and for deprofessionalization in another case. Buestrich (2005) argues that social welfare organizations have been increasingly adapting to economic rationales, especially due to the increasing competition of private providers. In this case, interests would be close to those of business organizations, including advocacy for deprofessionalization. However, Voges (2002, p. 289) argues that the role as a social advocate should prevail, which would make social welfare organizations a possible advocate for professionalization:

> Due to their social advocacy and the workforce situation, they advocate for an appropriate gratification for carers' expertise. (Voges, 2002, p. 289, own translation)

System organizations include payer agencies and administrative bodies, such as healthcare and LTC funds. These organizations are mainly engaged in administering and financing LTC. Therefore, their highest priority is to use resources efficiently (Voges, 2002). In addition to financial stability, these organizations also adopt solidarity in the sense of redistribution as a primary aim due to the inclusion of

employer- and employee representatives on many of the administrative boards (Bandelow, 2006). However, Voges views financial stability as the more-important aim, which then also leads system organizations to serve as advocates for deprofessionalization.

> Under economic pressure, all payer agencies want to limit expenses for professional nursing work. An improved material bonus for nursing staff would inevitably conflict with this. (Voges, 2002, p. 288)

Research- and education organizations include actors that engage in the training of LTC workers and in research on the LTC system and the LTC workforce. These actors are mainly interested in better (re)financing education (Voges, 2002). Due to their close connection to LTC staff, they can be assumed to support the aim of professionalization, especially improving the skill level.

Occupational organizations should unequivocally aim at professionalization and should be supported in this aim by organizations from different groups. Trade unions should be strong advocates of professionalization and should pursue professionalization in the working-conditions dimension as one of their primary aims. Patient organizations and education- and research organizations should be further advocates. The role of social welfare organizations is ambiguous. Depending on the subject matter and the timing, they can advocate for professionalization as well as for deprofessionalization. Business organizations and system organizations should be advocates of deprofessionalization. Table 5 summarizes the organizations' primary aims and their expected role as an advocate for or against professionalization.

Table 5: Organizational actors' primary aims and hypothesized advocacy for professionalization

Actor	Primary aim(s)	Advocacy for professionalization (hypothesized)
Occupational organizations	Professionalization	Yes
Trade unions	Professionalization & redistribution	Yes
Patient organizations	Quality	Yes
Education- and research organizations	Quality	Yes
Social welfare organizations	Redistribution & quality or growth & financial stability	Both possible
Business organizations	Growth & financial stability	No
System organizations	Financial stability & redistribution	No

Source: Own compilation.

2.4 Summary

The terms *profession* and *professionalization* have various uses and entail different meanings. As a result, the theoretical foundation of the present study is formed by the above literature review of the most-prominent theories on professions and of two concepts used to theorize the pathways to and from the level of *profession* (Hartmann, 1968; Pavolini & Kuhlmann, 2016). Departing from these theoretical thoughts, a conceptual framework for describing and evaluating workforce processes in LTC under the lens of professionalization was developed. Workforce developments are divided into four dimensions: *quantity*, *skill level*, *working conditions*, and a *social dimension*. For each dimension, three levels of labor – *work*, *occupation*, and *profession* – and the requirements for the transition from one level to another were defined. These transition processes are termed *occupationalization*, *professionalization*, *deoccupationalization*, and *deprofessionalization*. The conceptual framework accounts for different speeds of development and for opposing processes both between and within the dimensions, thereby providing flexibility in the ability to determine the development of the LTC workforce. The general conceptualization is not bound to a specific time or national context and instead serves as a template for assessing LTC-workforce developments in a variety of contexts.

Previous empirical studies on the LTC workforce in Germany have adopted a variety of professionalization concepts, dimensions, and indicators. Many studies have

focused solely on one workforce dimension. Evaluating the status and development of the German LTC workforce depends on the adopted indicators and includes *exclusive professionalization-* and *exclusive deprofessionalization processes* as well as *simultaneous professionalization- and deprofessionalization processes*. Furthermore, the literature review reveals the need for an encompassing, longitudinal, and up-to-date evaluation of the LTC workforce in Germany. Explanations for workforce developments are numerous and mainly focus on LTC institutions and their intersection with labor market-, education-, and migration systems. Explanations relating to political actors only play a minor role. The main argument for neglecting organized actors is that the LTC workforce is weakly organized into occupational organizations and trade unions and thus lacks the ability to enforce its interests.

The present study questions the proposed argument in the literature that interest organizations – and occupational organizations, in particular – are not relevant to workforce developments in LTC. The *organizability* and *capacity of conflict* of occupational organizations might be low; however, the theoretical arguments as to how the interests of weak organizations can be represented in the policymaking process suggest that occupational organizations can integrate the aim of professionalization into the policymaking process using different means. Influential organizations with aims that are able to align with the aim of professionalization can act as advocates for LTC professionalization. From a theoretical standpoint, occupational organizations should rely on the advocacy of trade unions, patient organizations, and education- and research organizations. If these organizations advocate for the aim of professionalization and support corresponding policy measures, upward developments in the LTC workforce can unfold. On the contrary, business organizations and system organizations should support deprofessionalization. If these organizations are influential in policymaking processes, this could explain downward developments in the LTC workforce.

3 THE SOCIETAL CONTEXT AND INSTITUTIONAL BACKGROUND OF LONG-TERM-CARE-WORKFORCE DEVELOPMENTS

The previous chapter theorized which traits are fundamental to a profession and how the development toward a profession may unfold. However, whether and how the development toward a profession unfolds depends on several factors that are external to the LTC workforce. Professions do not develop in a vacuum. The specific national context – including the societal and the political system – set the stage on which workforce developments take place (Döhler, 1997; Neal & Morgan, 2000). Voges describes this embeddedness of workforce processes as follows:

> A profession arises or changes when there is a need and demand for specific work skills. However, need is not a fixed, constant measure, but rather the result of interpreting socio-cultural conditions and the welfare-state setting during a particular socio-historical situation. (Voges, 2002, p. 57)

This chapter lays out the context in which LTC-workforce developments take place and thereby demonstrates which factors are able to influence workforce developments, how these factors have developed in Germany, and what room for upward and downward movements of the German LTC workforce these factors enable. The first section reviews the international literature on societal and LTC institutional indicators and how these indicators can shape workforce processes. The second section focuses on Germany and reviews the most-important context factors and indicators for LTC-workforce developments, including the development of demographic ageing, female-employment patterns, financing, LTC recipients, and LTC facilities and provides an overview of the institutions of the German LTC system. The concluding section summarizes the results and discusses the scope of possibilities for upward and downward LTC workforce processes that the societal and institutional context provides.

Generally, the study focuses on developments since 2005. The year 2005 was chosen as a starting point for the empirical analysis as the first major reform of the LTC system was enacted three years later, in 2008. Choosing a year shortly before this reform allows the effects of policies to be analyzed. Quantitative data come from the

OECD database and the German Care Statistics and are examined in an international and European context, when possible. The basic setting and institutional developments of the German LTC system are sketched based on secondary literature.

3.1 Factors that influence the scope for workforce developments

The societal and political context shapes the scope of LTC-workforce developments. Concerning societal changes, demographic ageing and changing female-employment patterns are believed to impact the demand for LTC services. The demographic situation and its development do not determine the LTC market but serve as a major influence on it by shaping the demand for formal and informal LTC services (Schölkopf, 2000). Physical and cognitive health deteriorate with increasing age (Perenboom et al., 2004). Increasing morbidity and dependency with age are exemplified by data from German LTC insurance. In 2017, 1.0% of the German population aged 15 to 65 years old received benefits from LTC insurance. This share was significantly higher for older people: 7.1% for those aged 65 to 80 years and 58% for those aged 80 or older (own calculations based on Statistisches Bundesamt, 2018b). Increasing life expectancy and – in particular – the increase in the number of extremely old people should thus translate to a growing demand for elderly-care services. However, the extent to which demand for services increases as a result of increasing life expectancy continues to be scientifically debated and depends significantly on how morbidity develops or changes. Three hypotheses illustrate different possibilities as to how demographic ageing and increasing longevity could influence the demand for LTC services (Perenboom et al., 2004). First, the compression-of-morbidity hypothesis suggests that with increasing life expectancy, the onset of morbidity is also deferred to a later age. This delay in the onset of morbidity is expected to be at least as great as the increase in life expectancy, which leads to a compression of morbidity into a shorter time period at the end of life (Fries, 2003). Second, the expansion-of-morbidity hypothesis postulates the opposite effect: Increasing life expectancy should correspond with an increasing amount of time spent with health limitations. The onset of morbidity is not deferred to a later age; therefore, higher life expectancy only increases the time spent with health limitations (Gruenberg, 2005). Third, the equilibrium-of-morbidity assumption combines elements of both prior hypotheses: On the one hand, advancements in curative and nursing care lead to a decreased severity

and progression of health issues, while on the other hand, these advancements are accompanied by a greater amount of time spent with mild or moderate limitations (Manton, 1982). All three hypotheses have been supported in a diversity of empirical studies (Chatterji et al., 2015; Parker & Thorslund, 2007).

> Our systematic examination of the scientific literature shows that support for morbidity pattern hypotheses varies mainly according to the type of health indicator. Disability-related or impairment-related measures of morbidity tend to support the theory of compression of morbidity, whereas chronic disease morbidity tends to support the expansion of morbidity hypothesis. (Chatterji et al., 2015, p. 570)

However, demographic ageing includes not only longevity but also the ageing of the baby-boomer generation. This large generation is entering the age cohort of 65 and older, which is leading to a rising demand for LTC services, irrespective of the hypotheses on longevity and morbidity (Rouzet et al., 2019).

Care for the elderly is still provided to a considerable extent within the family, although the extent varies widely throughout Europe (Verbakel, 2018). Informal care by relatives remains highly dependent on women (Kotsadam, 2011; Lilly et al., 2007). High and increasing rates of both female labor force participation and full-time employment are considered to decrease women's capacity to provide informal care for elderly relatives (Kotsadam, 2011; OECD, 2011), which in turn should increase the demand for formal LTC services and workers (OECD, 2011). However, recent research has called into question whether and how much female labor force participation and full-time employment can explain the extent of informal care provision (J. M. Bauer & Sousa-Poza, 2015). This research stresses that a correlation only exists under specific conditions, such as low public provision of services (Gautun & Bratt, 2017) or a high extent of caregiving provided by obtaining a role as primary caregiver (Nguyen & Connelly, 2014). Thus, increasing demographic ageing and rising female (full-time) employment should lead to a higher demand for formal care services and thus expand the possibilities of upward workforce developments in all dimensions of professionalization.

These societal developments and the institutional structure and changes of the LTC system are mirrored by the development of LTC expenditure (Wittenberg et al., 2002). Public LTC expenditure reveals the willingness and responsibility of the whole society to finance LTC, whereas private LTC expenditure reveals the risk that individuals bear for financing their own LTC (OECD, 2011; Wittenberg et al., 2002). More total

financing and more public financing can be associated with a higher scope of upward LTC-workforce developments in all dimensions (Kümmerling, 2016; Voges, 2002).

Financing mirrors the institutional setup of the LTC system. This setup and change of rules and institutions – such as access criteria, cost-sharing, and the kind and setting of benefits – steer the demand for formal LTC services and thus also the scope of LTC-workforce developments (Bakx et al., 2015; Döhler, 1997; OECD, 2011). Rules on access to LTC services can increase or hamper demand. The definition of high-needs-based eligibility criteria and the inclusion of informal care resources in the assessment procedure reduce the eligibility and demand for LTC services (Bakx et al., 2015; OECD, 2011). Furthermore, means-testing based on strict rules on income or wealth limits those eligible for LTC services (Bakx et al., 2015). Limits or restrictions on LTC-cost reimbursements as well as (high) cost-sharing can lead to less consumption of LTC services by recipients (Bakx et al., 2015; OECD, 2011). Furthermore, the benefit package can influence the amount of care services. Many public LTC systems limit services to activities of daily living (ADL) and do not include services for instrumental activities of daily living (IADL) (OECD, 2011). In general, in-kind benefits are found to be more expensive and to generate a higher amount of formal LTC employment than are cash benefits, which incentivize at least the partial inclusion of informal carers (Bakx et al., 2015). Furthermore, residential care is usually more expensive than homecare, which is also due to the higher demand for workers in residential care (Kok et al., 2015; OECD, 2011; Spetz et al., 2015). Moreover, the type of provider can play a role in the scope of workforce developments. The working conditions in residential care and in facilities run by public or non-profit providers are usually better than in ambulatory care or with for-profit providers (Auth, 2013; Comondore et al., 2009; Geraedts et al., 2016). In Germany, public and non-profit facilities set their wages on the basis of national or federal public-payment schemes, which usually leads to higher wages than most private providers pay (Buestrich et al., 2008; Razavi & Staab, 2010; Rubery & Urwin, 2011). Hence, a large and increasing share of private and ambulatory providers should decrease the room for upward workforce developments.

3.2 Societal and institutional changes in Germany – The context of LTC-workforce developments

Germany poses an interesting case for analyzing workforce developments and how these developments are influenced by organizational actors because the societal and institutional context create room for both upward and downward workforce developments. Germany has a comparably large and growing aged population. The total number of people aged 65 or older – that is, the elderly – and the total number of people aged 80 or older – that is, the oldest of the old – increased between 2005 and 2017 (see Table 6). In 2005, 15.6 million people were aged 65 or older, which had increased to 17.6 million by 2017. The number of people aged 80 or older rose from 3.6 to 5.0 million over the same period. As a result, the share of the elderly and the oldest of the old population out of the whole population also increased in Germany (18.9% to 21.3% for the elderly and 4.4% to 6.1% for the oldest of the old, both between 2005 and 2017) (see Table 6). Germany's share of the elderly and oldest of the old was higher than both the EU- and OECD average over the whole period. Hence, the German population aged over the whole period and belonged among the oldest societies in the world.

Female labor force participation in Germany continuously rose from 66.9% to 74.0% between 2005 and 2017 (see Table 6). This rate was above the OECD- and EU average. However, a considerable share of female employment was part-time: 38.8% in 2005, which had decreased to 36.8% in 2017. Nevertheless, this was above the average in both the EU and the OECD, in which the share of part-time employment ranged from between 25% and 28% during these years (see Table 6). Overall, demographic ageing and the development of female-employment patterns provide a context for an expansion of formal LTC services and thus also for upward workforce developments in all dimensions.

Table 6: Number and share of old-aged people, female labor force participation, and female part-time employment in 2005 and 2017

		2005	2017
Number of people aged 65 years or older, in millions	Germany	15.6	17.6
Number of people aged 80 years or older, in millions	Germany	3.6	5.0
Share of population aged 65 years or older out of the total population, percentages	Germany	18.9	21.3
	EU 28	16.7	19.6
	OECD	13.8	16.9
Share of population aged 80 years or older out of the total population, percentages	Germany	4.4	6.1
	EU 28	4.1	5.5
	OECD	3.4	4.5
Share of female labor force participation, total labor force, percentages	Germany	66.9	74.0
	EU 28	62.2	68.0
	OECD	60.1	64.0
Share of female part-time employment, total labor force, percentages	Germany	38.8	36.8
	EU 28	27.4	26.9
	OECD	25.1	25.5

Source: Own calculations based on OECD, 2020a (date of data extraction: 18 March 2020).

Overall, spending for LTC in Germany as a share of GDP increased between 2005 and 2017 from 1.6% to 2.2% (see Table 7).[3] Similarly, per-capita spending nearly doubled from $550 to $1,100 over the same period (see Table 7). These German LTC-spending levels can generally be evaluated as medium in European comparison. France and Switzerland, for example, show roughly similar LTC-spending levels to those of Germany, whereas the Netherlands spent about twice the amount of Germany, and Portugal devoted only about half as much financing to LTC. However, Germany is among the European countries with the highest private LTC spending. Per capita out-of-pocket LTC spending increased from about $200 to $300 between 2005 and 2015 (see Table 7). Thus, about one-third of all LTC costs were private out-of-pocket expenditures in Germany. However, this share fell slightly from 34.0% to 31.6% over the period (see Table 7). Although there are European countries with higher shares of out-of-pocket LTC spending (e.g., 40% to 45% in Portugal), both France – a country with similar overall spending levels to Germany – and the Netherlands – a high-spending country in terms of LTC – had considerably lower private-spending levels

[3] No OECD or EU averages are provided by the OECD database for LTC spending indicators. Therefore, the comparison of Germany is based on a European sample of high-, medium-, and low-spending countries for the chosen spending indicators. Data for these other countries are not show in a graph or table for reasons of simplicity. For more information on spending indicators, see the Data and Methods Appendix.

(with shares of private out-of-pocket payments of about 20% in France and about 10% in the Netherlands). German total LTC spending increased over the investigated period, but expenditures over the whole period were at a medium level compared with other European countries. However, private LTC financing was considerably high in European comparison and amounted to about one-third of all LTC spending. Thus, the developments of LTC expenditures do not provide a context for the expansion of LTC services or thus for upward developments in any workforce dimension.

Table 7: LTC spending in Germany in 2005 and 2017

	2005	2017
LTC health- and social spending as a share of GDP, percentage	1.6	2.2
LTC health- and social spending per capita; current prices, current PPPs	$550	$1,100
LTC out-of-pocket payments (health and social) per capita; current prices, current PPPs	$190	$290 (2015)
LTC out-of-pocket spending (health and social) as a share of total LTC spending	34.0	31.6

Source: Own calculations based on OECD, 2020a (date of data extraction: 18 March 2020).

The German spending levels mirror those of the institutions of the LTC system, which were designed to limit public spending.[4] The German LTC system was introduced as a new and separate social-insurance system via a stepwise plan between 1995 and 1996 (Götting et al., 1994). This social-insurance pillar is separately managed but closely connected to the health-insurance pillar. Everyone insured under a mandatory public or private health-insurance fund is automatically enrolled in the LTC-insurance fund by the same insurer (Rothgang, 2010). In principle, the whole population holds mandatory public or private health insurance, which means that LTC insurance is equally widespread. LTC-insurance funds are organizationally and financially separate from health-insurance funds (Nadash et al., 2018).

LTC insurance is financed on a pay-as-you-go basis. Contributions are based on income but are not risk-related and are equally shared between employers and employees. Childless people older than 25 years have had to pay a higher contribution rate of 0.25% extra by themselves since 2005. Due to the pay-as-you-go financing, benefits could be paid out immediately after the implementation of the system. The

[4] The following paragraphs provide a brief overview of the German LTC system with a focus on enabling- and hindering factors for LTC-workforce developments. A detailed analysis and discussion of LTC reforms is provided in Chapter 5.

system launched in 1995 and initially only financed ambulatory LTC; since 1996, however, institutional LTC has also been financed (Götting et al., 1994; Rothgang, 2010). The contribution rate has risen constantly since the launch of the system and stood at 2.55% (2.8% for childless people) in 2017 (Bäcker, 2021; Nadash et al., 2018).

The German system has no age limit for the eligibility for benefits, yet about 80% of beneficiaries are 65 years or older (Rothgang, 2010; Statistisches Bundesamt, 2018b own calculations). In general, all benefits are capped, which means that a significant portion of LTC costs must be financed privately. If the beneficiary cannot afford the private payment, the social-welfare system – which is financed by municipalities – steps in (Rothgang, 2010). Ambulatory benefits are offered in kind, in cash, and as a mixture of the two. Benefits in institutional care as well as in day- and night care are only available in kind. The value of the cash benefit is about half that of the ambulatory in-kind benefit[5] (own calculations based on Statistisches Bundesamt, 2011; 2017), and the beneficiary is free to choose between the different forms of benefits (Rothgang, 2010). The original benefit system of 1995/1996 differentiated between three care steps (*Pflegestufen*): *Care Step I* included the lowest level of dependency and need for care, *Care Step III* the highest. In 2008, a new benefit level was introduced de facto. People with *impaired everyday expertise* (*eingeschränkte Alltagskompetenz*) – that is, mainly people with dementia – could receive cash and in-kind benefits. These benefits were commonly named *Care Step 0* (Bäcker, 2021; Nadash et al., 2018). At the beginning of 2017, a new benefit system was introduced based on a new definition of *in need of care*. The care steps were then transferred into a new benefit system of five care degrees (*Pflegegrade*) that aimed to include more dependent elderly people, especially by improving access for cognitively impaired elderly people. The level of dependency and thus the care degree is determined by a standardized assessment procedure pertaining to need but not to a person's means (as had also been the case for the care step). The Medical Service of the Statutory Healthcare Funds (Medizinischer Dienst der Krankenversicherung; MDK) performs this assessment for the publicly insured, and the private company Medicproof conducts the same task for the mandatorily privately insured (Nadash et al., 2018; Rothgang, 2010).

When evaluating how this LTC system shapes the development of the formal care market and thus also the LTC workforce, several institutions of the German LTC

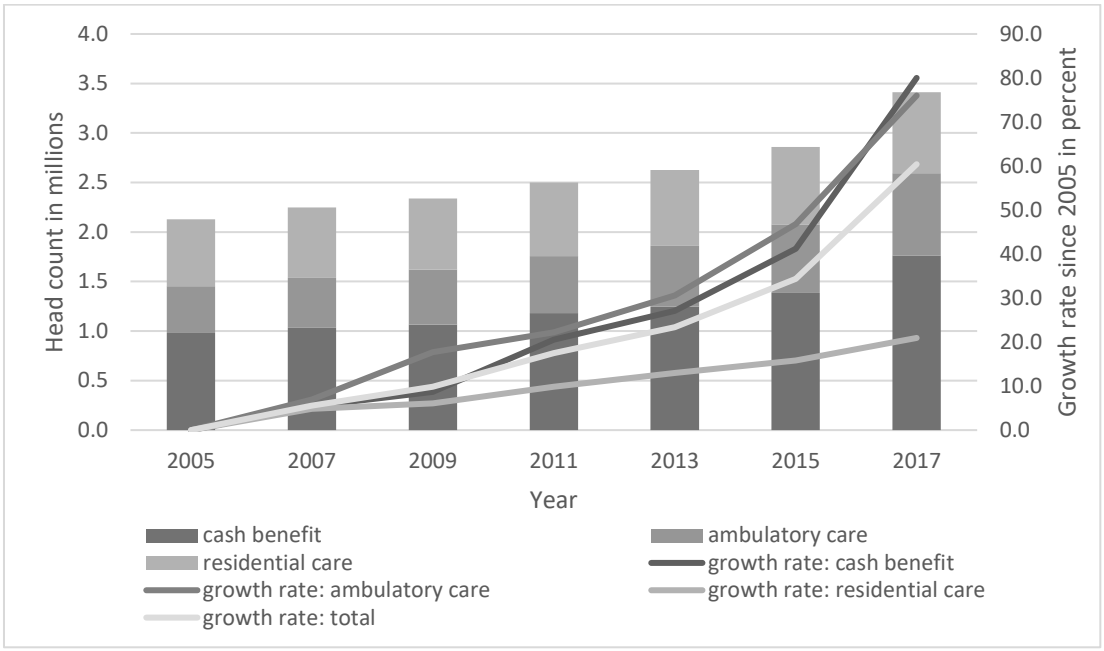
[5] The exact value depends on the care step / care degree and the specific amount of the benefits at a certain time.

system can be found to constrain demand and growth. The availability of unbound cash benefits encourages low-cost informal family care (Eichler & Pfau-Effinger, 2009; Österle & Bauer, 2012; Ungerson, 2004). Furthermore, capped LTC benefits limit market growth. However, assessment procedures that only take into account the need and not the means of a person and the extension of eligible people – especially for those with cognitive impairments – extend the market and the room for upward workforce movements.

Focusing on the number and development of care recipients (see Figure 5), a steady increase from 2.1 million to 3.4 million between 2005 and 2017 is visible,[6] which marks an increase of 60%. The increase in recipients was steepest between 2015 and 2017 and can be explained by the introduction of the new benefit system, which explicitly aimed at including people in the LTC-insurance scheme who had prior non-included medical and care conditions as well as low need (see the definition of the policy problem and the reform aim stated by the government in the draft legislation, Deutscher Bundestag, 2015). Recipients of all forms of care (cash benefits, joint or exclusive care by ambulatory services, residential services) increased continuously; however, the number of home-care recipients increased faster than the number of residential-care recipients. The number of cash-benefit recipients rose by 80.0%, and that of home-care recipients who used the help of formal services rose by 76.0%, whereas the increase was only 20.9% for residential-care recipients between 2005 and 2017 (see Figure 5). Hence, the share of residential-care recipients decreased from 31.8% to 24.0%, whereas the share of cash-benefit recipients increased from 46.1% to 51.7%, and that of ambulatory in-kind service recipients increased from 22.2% to 24.3% (see Figure 6).

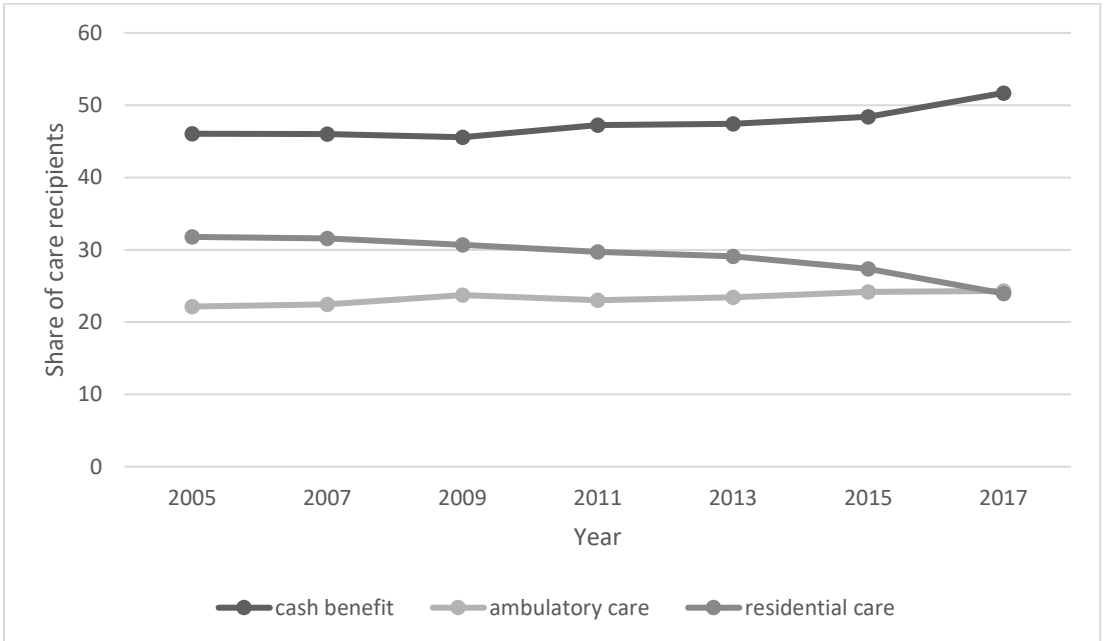
[6] The data for the year 2011 on home-care beneficiaries are not comparable with those from any other year due to changes in the administration of LTC funds as the LTC funds were the actors who provided the data. Therefore, changes between 2009 and 2013 must be evaluated with caution. The Federal Statistics Office estimates that the overall increase in care recipients was overestimated by about four percent in 2011 compared with the data from 2009 (Statistisches Bundesamt, 2013). Because these are only estimates, the official numbers – which are also published as such in the German Care Statistics reports – are used here.

Figure 5: Care recipients who received ambulatory care, residential care, and cash benefits; head count and growth rate between 2005 and 2017



Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b). Note: *ambulatory care* includes recipients who solely received ambulatory benefits and those who received a combination of ambulatory benefits and the cash benefit.

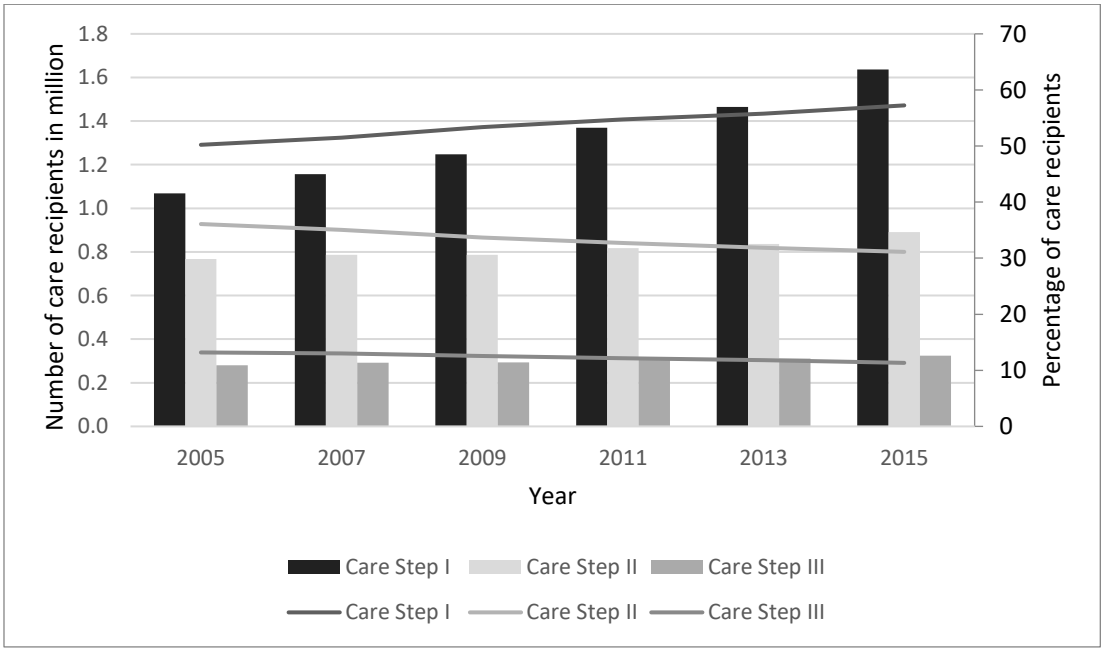
Figure 6: Share of care recipients who received ambulatory care, residential care, and cash benefits between 2005 and 2017



Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b). Note: *ambulatory care* includes recipients who solely received ambulatory benefits and those who received a combination of ambulatory benefits and the cash benefit.

The dependency of care recipients[7] is important as higher dependency is associated with more and a higher level of qualified care (OECD, 2020b). Over the whole period, most LTC recipients received benefits from *Care Step I* (the one with the lowest dependency) followed by *Care Step II* and *Care Step III* (the one with the highest dependency) (see Figure 7). The number of care recipients increased overproportionally in *Care Step I*, where the share of all care recipients rose from 50.2% to 57.2% between 2005 and 2015 (see Figure 7). Consequently, the relative weight of people in *Care Steps II* and *III* had decreased continuously. Overall, the increasing number of care recipients led to a rising demand for formal LTC services and thus to room for upward developments in the LTC workforce. However, the increasing share of recipients of cash benefits and the rising share of recipients with low dependency narrowed the room for upward movements.

Figure 7: Recipients of LTC benefits by care step, head count, and share of all recipients between 2005 and 2015

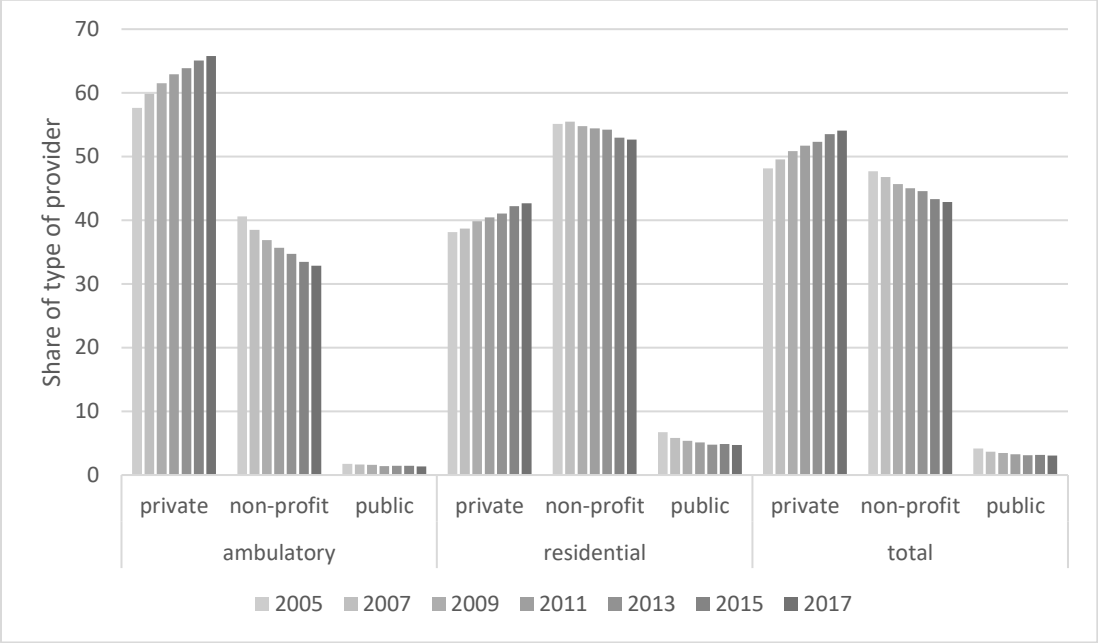


Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017). Note: No data for 2017 are provided because the number of dependency levels changed from three to five and data are thereby not comparable.

[7] Since 2017, the benefit system – which is based on and shows dependency – changed from care steps (ranging from zero to three) to care degrees (ranging from one to five). In general, all care recipients with only physical limitations moved from their original care step into the next-higher care degree (e.g., from former *Care Step 1* to *Care Degree 2*). For beneficiaries with cognitive limitations, the former care step was transferred to the second-next-higher care degree (e.g., from former *Care Step 1* to *Care Degree 3*) (Bäcker, 2021; Nadash et al., 2018). Hence, data on care steps cannot be recalculated into care degrees, or vice versa. Data relating to dependency levels are thus only provided until 2015 – i.e., the latest data available for care steps.

Similar to the number of LTC recipients, the total number of LTC facilities also increased from 21,000 to 28,000 between 2005 and 2017 (Statistisches Bundesamt 2007, 2018b). This equals an increase of about 30%, which is less than the increase in care recipients of about 60% during the same period. Roughly half of all facilities were ambulatory, and the other half were residential-care facilities. In 2005, private and non-profit providers had a market share of about 48% each (Statistisches Bundesamt 2007, 2018b). In 2017, private providers ran 54% of all facilities, while non-profit providers ran 42.9%. This privatization of care providers is evident in both ambulatory and residential care but was more pronounced in ambulatory care, for which private LTC facilities extended their market share from 57.6% to 65.8% between 2005 and 2017 (40.6% to 32.8% for non-profit ambulatory providers between 2005 and 2017) (see Figure 8). In residential care, non-profit providers still operated more facilities than private providers, though the gap narrowed. In 2005, private providers ran 38.1% of residential-care facilities, while non-profit providers ran 55.1%. In 2017, 42.6% of residential-care facilities were managed privately, while 52.6% were managed by non-profit organizations. Public facilities only played a minor and even decreased role, with a market share of 4.2% of all facilities in 2005 and of 3.1% in 2017. Public LTC facilities were mainly residential facilities. This privatization of LTC facilities provided unfavorable conditions for upward LTC developments, especially for the working-conditions dimension.

Figure 8: Share of LTC facilities by type of provider and type of care



Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b).

3.3 Summary

This chapter focused on the context in which LTC professionalization has developed. Several societal and institutional factors have influenced whether and how large the room for both upward workforce developments is as well as whether and how large downward developments could be. For Germany, demographic ageing, female-employment patterns, LTC financing, LTC recipients, LTC facilities, and an overview of the institutions of the German LTC system show developments that have left ample room for upward and downward movements among the LTC workforce. However, how large these workforce developments could be differs depending on the dimension under study – that is, *quantity*, *skill level*, *working conditions*, or the *social dimension*.

For the quantity dimension, context factors have predominantly created room for upward developments. Germany has an increasing old-age population that is in fact one of the oldest in both the OECD and the EU. This growing old-age population has translated to an increasing number of care recipients in the German LTC system, to which the loosening eligibility criteria for accessing LTC benefits has also contributed. Furthermore, female labor force participation has increased, which has opened possibilities for a higher number of formal and a lower number of informal LTC workers. However, there are also factors that may have constrained the increase in the number of workers. The rising share of ambulatory-care recipients – and especially of

those receiving cash benefits – as well as the overproportional increase in the number of recipients with the lowest dependency level may have limited the expansion of the workforce. Furthermore, the high part-time employment of women may have constrained an increasing LTC workforce as these women might have had and taken the time to provide care for their elderly relatives.

In the skill-level dimension, the development of the context factors has created possibilities for upward and downward workforce developments. The rising share of the oldest of the old and the extended access of demented patients in the LTC system might have increased the number of complex-care cases for which high-skilled labor is needed. However, decreasing dependency levels, the increasing receipt of cash benefits, and the high part-time employment of women might have created a context in which the demand for help with less-complex care cases has increased the most and has borne witness to an increase in the demand for and amount of low-skilled LTC workers.

For working conditions, the increasing overall financing of LTC might have created opportunities for upward movement. However, Germany's spending remains below average in international comparison, and a comparatively large share of LTC costs is financed by LTC recipients out of pocket. Furthermore, the privatizing provider structure of LTC facilities may have influenced working conditions. The working conditions in private facilities are usually poorer than in non-profit- and public facilities. Overall, the context factors hint more at downward developments in the working-conditions dimension.

Context factors should have had the smallest influence on the social dimension because the workers themselves – in conjunction with the involved actors in the field – should have mainly shaped the trajectory of the dimension. Nevertheless, the increasing number of older people and of LTC recipients should have led a situation in which LTC work is becoming a more-important issue in society. However, the medium level of spending on LTC and the high involvement of families in financing and in informal care might have created a setting in which formal LTC work is not valued as an important occupation by the public.

Based on the context factors, the greatest room for professionalization lies in the quantity dimension. For all other dimensions, societal and institutional developments have created possibilities for upward and downward workforce processes; however, these contextual factors only reveal how large the room for upward and downward

movements actually is and do not exclusively determine how the workforce has developed since 2005. Policy changes and the implementation of reform measures also affect the extent and direction of upward and downward workforce movements.

4 LONG-TERM-CARE-WORKFORCE DEVELOPMENTS

While the previous chapter demonstrated the room that each workforce dimension has for upward and downward workforce developments, the present chapter analyzes and evaluates these workforce developments by investigating how the LTC workforce has developed in Germany since 2005. The first section introduces data and methods, and the subsequent analysis of workforce processes is structured along the four workforce dimensions of *quantity*, *skill level*, *working conditions*, and the *social dimension*. The quantity dimension includes the development of the overall number of employees in LTC as well as the demand for LTC workers on the labor market. The skill-level dimension depicts the shares of employees with specific educational degrees and the number of employees in care-related university study programs. Thereafter, the analysis of developments in the working-conditions dimension builds on collective agreements, working times, temporary agency work, and wages. The social dimension takes into account societal reputation, unionization, the establishment of boards of nursing and care, and the involvement of representatives of LTC workers in the development and implementation of educational curricula. The final summary classifies the developments in all dimensions, connects them, and assesses them in light of theoretical considerations on professionalization.

In total, the LTC workforce showed upward and downward developments between 2005 and 2017. Upward developments mainly involved the quantity dimension, in which the number of employees increased. Furthermore, the demand for LTC employees – and especially those with a three-year apprenticeship education – intensified and exceeded the supply. In the skill-level dimension, the share of low-qualified workers rose, which constituted a deoccupationalization. Moreover, the share of academically trained employees remained low. However, the workforce specialized with respect to LTC skills. The share of employees who had obtained an occupational degree in LTC increased compared with employees with a degree in healthcare or social care. Working conditions were below the national average throughout the whole period. However, a stagnation of working conditions from the beginning of the 2010s and small upward developments in the most-recent few years became visible. Evidence in the social dimension is mixed. Societal reputation ranked high throughout the whole period, whereas the unionization rate and involvement in educational curricula were

low. Boards of nursing and care at the federal level developed, but the first boards began to devolve in more-recent years. Hence, taking all dimensions into consideration, LTC is clearly not becoming a profession, and developments have not unequivocally followed a professionalization track. However, the developments also do not show the opposite trajectory: The LTC workforce is not developing into a level of *pure* work, nor do all processes show deoccupationalization. The LTC workforce has been developing dynamically by beginning at different points on the professionalization continuum, moving in different directions, and developing with various speeds in the different dimensions. Overall, the degree of professionalism is higher in residential than in ambulatory care.

4.1 Data, methods, and operationalization of workforce processes in Germany

Different national data sources are used to describe workforce processes, with the German Care Statistics being the main source (Statistisches Bundesamt, 2007, 2009, 2011, 2013, 2015, 2017, 2018b). Further primary data are taken from the Federal Statistics Office (Statistisches Bundesamt, 2020), the Federal Ministry for Work and Social Affairs (Bundesministerium für Arbeit und Soziales, 2014), the Federal Labor Office (Bundesagentur für Arbeit, 2019a, 2020a; Deutscher Bundestag, 2020; Statistik der Bundesagentur für Arbeit, 2020a), and the German Civil Servants' Association (dbb, 2007, 2019). The adopted period for analysis is 2005 to the latest year available. Since data from the Federal Labor Office do not go back until 2005, the analysis is limited to shorter periods. To compare different indicators, the study uses the descriptive analysis of means within years. Moreover, to identify longitudinal changes within processes, the analysis utilizes growth rates of absolute numbers and relative changes between different time points.

4.1.1 Quantity dimension

The analyses in the quantity dimension build on three indicators: (1) the number of employees in LTC, (2) the number of unemployed people per job opening in LTC, and (3) the number of days a job opening in LTC remains open. The number of LTC employees (head counts) mirrors the size and development of the whole LTC workforce. An increasing number of LTC employees indicates a development toward

increasing societal significance and relevance, while a decreasing number shows a development toward less societal significance and relevance.

This measure only depicts the real situation and is unable to estimate the potential for growth in the sector. Therefore, two further measures help in estimating the demand for LTC employees: The first of these is the number of unemployed people per job opening in LTC, which can reveal either a shortage of staff or structural unemployment in the sector (Demary & Seyda, 2012). Scholars in the field usually speak of a shortage of staff if there are three or fewer unemployed people per open vacancy (Demary & Seyda, 2012). However, the shortage of skilled labor in an economic sector may be overestimated if workers with a similar qualification from a different sector can fill an open spot (Demary & Seyda, 2012). Concerning the LTC sector, healthcare workers could occupy these open vacancies. A second measure that is used to estimate demand in the labor market is the number of days a job opening is available (A. Bauer & Gartner, 2014; Demary & Seyda, 2012). This indicator measures the duration between the preferred recruitment day by an employer and the day a job vacancy is deregistered at the unemployment office. In general, an increasing duration indicates that it is more difficult for employers to find an appropriate employee for an open vacancy (Demary & Seyda, 2012). Both demand-side indicators give an impression of the amount of staffing shortage or structural unemployment. The indicators complement the mere depiction of the size of the LTC workforce by revealing whether growth could have been stronger if skilled labor had been available. An increasing and unsatisfied demand for LTC workers indicates a professionalizing development because it demonstrates the scarcity of workers, which is a defining trait of professions (see Larson, 1977, p. xvii).

The data on demand were taken from the Federal Labor Office (Bundesagentur für Arbeit, 2019a). Data were separated into LTC, health-nursing care, and the overall labor market. For all three sectors, it was possible to differentiate between helpers, skilled employees, specialists, and experts on the qualification level. As data on specialists and experts were either unavailable or of low quality, these categories were not taken into account. The category of helpers, however, matches roughly with the theoretically introduced level of work, while the skilled-worker category matches the level of occupation. Thus, the categories were renamed as such for the analysis. Helpers had completed only a short training, while skilled employees had completed at least a two-year apprenticeship education (Bundesagentur für Arbeit, 2019b).

4.1.2 Skill-level dimension

The skill-level dimension is operationalized via (1) the number and shares of employees in the three workforce categories of *work*, *occupation*, and *profession*, (2) the shares of LTC- and healthcare workers within the three categories, and (3) the number of graduates in care-related study programs.

Numbers and shares of employees in the three workforce categories are based on the German Care Statistics. These statistics provide data on employees with different educational degrees, and the data were sorted into the three workforce categories (see Data and Methods Appendix for detailed information on the original categories and how and why they were sorted into which workforce categories). One important remark concerns the different specializations in the German system of care occupations. In contrast to many other national systems, there is not just one stream of occupations in the medical and social-care sector (such as nurse or auxiliary nurse). Indeed, at the very beginning of the vocational education, a specialization is chosen in either regular healthcare, child healthcare, LTC for old-aged patients, or social care. Although this specialization seems to determine the usual workplace, in principle, all workers with these degrees can work in a variety of healthcare- and social-care facilities. This variance of social- and nursing-care occupations that are able to perform tasks exists throughout the entire professionalization continuum. The following section lays out how and why the different educational degrees of the German Care Statistics are included in a specific category.

The basis for including an original category from the German Care Statistics in one workforce category is determined by the length of education, the level of secondary education obtained for beginning the educational program, and the amount of practical and theoretical knowledge taught during the education program. For the category of *work*, no or lower-secondary education is required to enter vocational training. This vocational training takes fewer than three years and is mainly based on practical, hands-on work. The educational degrees included in this category are *auxiliary LTC nurse*, *auxiliary healthcare nurse*, and *auxiliary social-care nurse* (BIBB, 2009; Bundesagentur für Arbeit, 2017a, 2017i, 2017l).

For the category of *occupation*, medium to upper-secondary education is required to enter vocational education, which lasts at least three years and includes both practical and theoretical education (Bundesagentur für Arbeit, 2017b, 2017h, 2017j, 2017m). The vocational degrees and further-training degrees are included in the

category of occupation are: *LTC nurse*, *healthcare nurse*, *child-healthcare nurse*, *social-care nurse*, *occupational therapist*, *specialized caretaker for the elderly*, *local assistant with a state qualification*, *remedial teacher*, *family-care worker*, and *physiotherapist*. LTC nurse and healthcare nurse are by far the most-common educational degrees in this category and make up over 90% of all employees within it.

The *profession* category is defined by scientific education at a university (of applied science), which can only be entered by upper-secondary education. The degrees of *social pedagogue / social worker* and *other qualification in care at a university (of applied science)* are included in this category. Education in these study programs is mainly theoretical and includes topics such as medical and social care as well as management and social law (Bundesagentur für Arbeit, 2017q, 2017t).

The German Care Statistics include six additional educational categories, two of which are not included because they consist of a variety of care degrees, which makes it impossible to connect them with a specific workforce category. The four other categories do not relate to employees who work in direct care. Most of these uncategorized or miscellaneous employees who cannot be included in the workforce categories obtain positions without direct care involvement, such as administrative staff, cook, cleaning staff, or caretaker (Statistisches Bundesamt, 2011, p. 10). Approximately 50% of all employees in the long-term-care sector are classified into one of the three workforce categories, which include nearly all workers who are primarily involved in direct care. However, in all graphs that display the three workforce categories, the category *total* refers to the employees in all three workforce categories and not to all employees in the long-term-care sector.

An increase in the profession category compared with the work- and occupation category indicates professionalization, whereas a decrease indicates deprofessionalization. Moreover, an increase in the work category compared with the occupation- and profession category indicates deoccupationalization, whereas a decrease indicates occupationalization.

The analysis of the development of the relative sizes of the three workforce categories is complemented by an analysis of the internal structure of the educational degrees in each category. In fact, employees with a qualification as a(n) (auxiliary) LTC worker should be best trained for work in the LTC sector. However, other workers with training in healthcare and social care can also work in LTC. A development toward more (auxiliary) LTC workers suggests a specialization and a

separation of the LTC sector from other healthcare- and social-care sectors. Thus, this development suggests an upward movement, whereas decreasing shares of (auxiliary) LTC workers suggest a downward movement.

The third indicator in the skill-level dimension is the number of graduates from universities and universities of applied science in the subject areas of *social care* (*Sozialwesen*) and *health sciences* (*Gesundheitswissenschaften allgemein*) (Statistisches Bundesamt, 2018a, 2020). Three study programs fall under *social care*, and four fall under *health sciences* (see Table 8), among which the study programs *care science and management* and *healthcare science and management* are of particular relevance because they qualify graduates for complex care- and management tasks in LTC facilities (Bundesagentur für Arbeit, 2020b). Compared with the number of professional workers in LTC, the development of graduates reveals whether academically trained workers are employed in LTC to a lesser or higher degree.

Table 8: Study programs in social studies and general health sciences

Health-sciences study programs *Gesundheistwissenschaften allgemein*	Social-care study programs *Sozialwesen*
Health pedagogy *Gesundheitspädagogik*	Social work *Soziale Arbeit*
Healthcare sciences and management *Gesundheitswissenschaften / -management*	Social pedagogy *Sozialpädagogik*
Non-physician healthcare studies *Nicht-Ärztliche Heilberufe / Therapien*	Social-service studies *Sozialwesen*
Care sciences and management *Pflegewissenschaften / -management*	

Source: Based on Statistisches Bundesamt (2018a).

4.1.3 Working-conditions dimension

The analysis of workforce developments in the working-conditions dimensions builds on (1) collective agreements, (2) working times, (3) wage developments, and (4) temporary agency work. Unfortunately, longitudinal data on further indicators of working conditions – such as the type of working contract (e.g., permanent, fixed-term, self-employed, temporary work) and the organization and duration of working times (e.g., shift work, night work, on-call work) – are not available. The developments of collective agreements are sketched using secondary data and literature. For working times, the share of full-time, part-time, and marginal employment in the whole LTC workforce and in each workforce category is depicted and compared with the German

averages. Data on working times in LTC come from the German Care Statistics, and data on the German average come from the OECD. High and increasing levels of full-time employment indicate an upward development, while increasing levels of part-time and marginal employment indicate a downward development. Concerning wages, the Federal Labor Office provides average wages for LTC nurses and for auxiliary LTC nurses, but only since 2012 (Statistik der Bundesagentur für Arbeit, 2020a). These wages are compared with those of healthcare nurses and auxiliary healthcare nurses. Furthermore, the amount of the low wages is depicted (Deutscher Bundestag, 2020) in order to enable the evaluation of wage developments. Additionally, the minimum wage in care and its development are described and evaluated because the minimum wage marks the lowest hourly wages for employees in care since its introduction in 2010. Information on the minimum-wage development comes from the Ministry for Employment and Social Affairs and the national government (Bundesministerium für Arbeit und Soziales, 2014; Bundesregierung, 2021). Wages, the share of LTC employees with low wages, and minimum wages in LTC that are below the national average or the average for healthcare nurses or are increasing at a slower speed or even decreasing demonstrate downward developments. The description of temporary agency work is derived from secondary literature; however, data on this topic are only available beginning from 2014.

4.1.4 Social dimension

The social dimension includes an orientation toward being an influential and relevant group of workers and toward catering to benefits for the whole society. It is operationalized via (1) the unionization rate, (2) boards of nursing and care, (3) societal reputation, and (4) the involvement of LTC-worker representatives in the development of educational curricula. Analyses and evaluations of these indicators are often limited due to a lack of data – especially longitudinal data. The representation of workers' interests and how these interests are organized are based on the depiction and relevance of boards of nursing and care as well as on the unionization rate as reported by figures from the trade union ver.di (ver.di, 2011, 2019). In addition, longitudinal data on working ethos, autonomy, and prestige are scarce. The German Civil Servants' Association (dbb) holds a yearly survey in which it asks a representative sample of German society to evaluate the reputation of certain occupations (dbb, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019). Until 2012, the

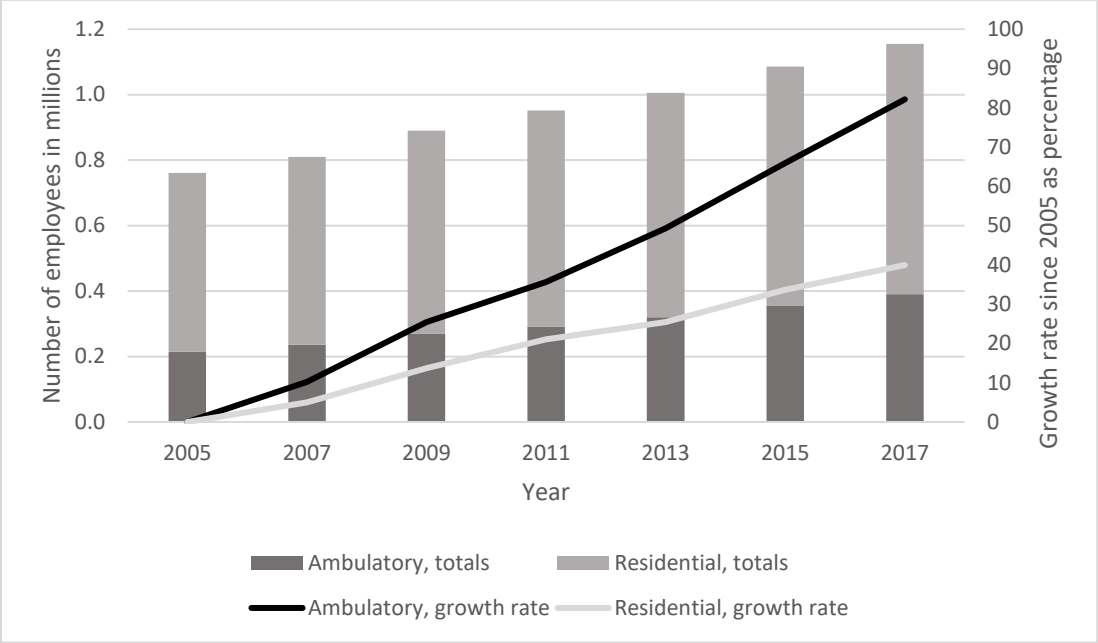
survey only included data on the reputation of healthcare nurses. Since then, the category has been extended to also include healthcare and LTC nurses, which have been split into two separate categories since 2019. The dbb publishes the percentage of respondents who evaluate the reputation of an occupation as being high or rather high (dbb, 2016). The involvement of LTC-worker representatives in apprenticeship education stems from their involvement in committees that develop and implement national and federal LTC curricula. High and increasing figures and developments for all indicators indicate upward movements.

4.2 Developments in the quantity dimension

The total number of employees in the LTC sector increased continuously from 760,000 to nearly 1.2 million between 2005 and 2017 (see Figure 9). This increase relied on rising numbers of employees in both ambulatory and residential care. The number of employees in residential care was larger, making up about 70% of all employees. However, the number of employees in ambulatory LTC rose more steeply than in residential LTC (i.e., there was an increase of 82.1% in ambulatory care and of 40% in residential care between 2005 and 2017).[8] Overall, the rising number of employees in LTC reveals that an increasing number of LTC employees was needed to meet the increasing number of LTC recipients. However, the data cannot show if the demand for LTC employees was satisfied or if it was higher than these numbers suggest.

[8] The reported numbers and trends relate to all employees in the LTC sector. Focusing only on the employees in the three workforce categories (the direct-care-related employees), the increase in the number of employees was lower, amounting to 66.4% in ambulatory care and 34.9% in residential care between 2005 and 2017. Furthermore, only about 60% of these employees worked in residential care (own calculations based on German Care Statistics).

Figure 9: Number and growth rates of all employees in the LTC sector



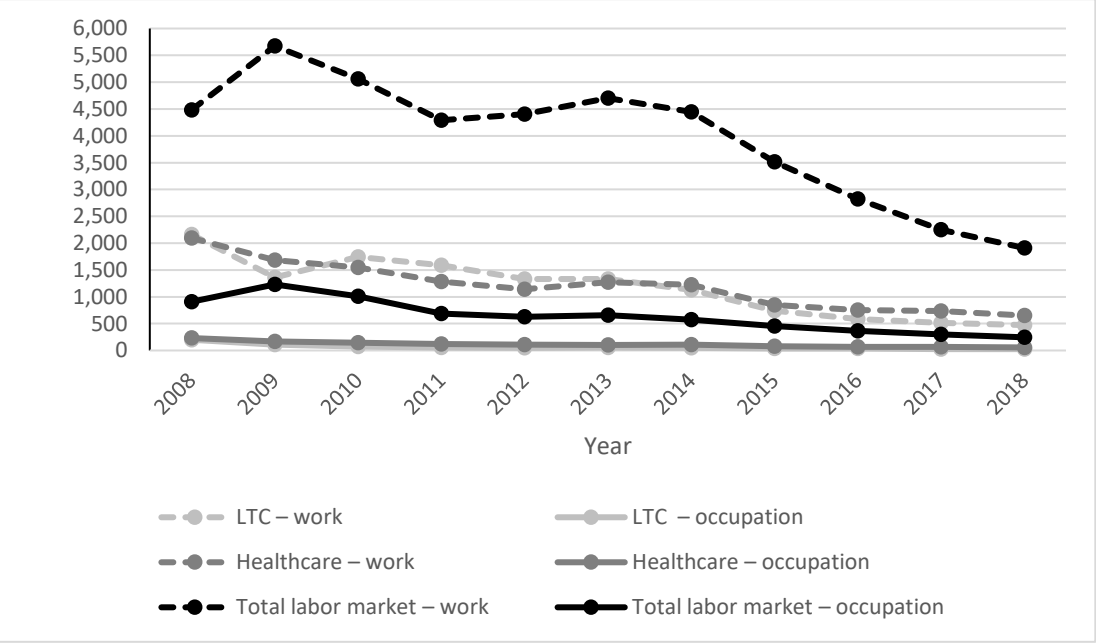
Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b).

The number of unemployed people per job opening is representative of the demand for LTC workers. Fewer than 300 unemployed people per 100 job vacancies represents the early stages of a shortage of workers, while fewer than 100 unemployed people per 100 job vacancies represents an acute shortage of workers (see Section 4.1.1 in this chapter and Data and Methods Appendix). In the LTC-occupation category, the ratio reveals that there has been a shortage of employees since 2008, with an average of 200 unemployed people per 100 vacancies (see Figure 10). This number fell below 100 after 2010 and dropped further to 25 in 2018. For the LTC-work category, the situation is different. In 2008, more than 2,000 unemployed people per 100 vacancies was representative of structural unemployment rather than a labor shortage. However, up to 2018, the number dropped sharply to about 470. Although this number shows no general shortage of employees, some regions might now be having difficulty finding LTC workers with a low qualification.

One strategy for filling the demand for LTC staff – and especially for those with an apprenticeship education in the occupation category – is to recruit workers with a similar level of education and skills. This labor could be recruited in the neighboring field of healthcare; however, the labor market in healthcare shows similar ratios and trends as the LTC labor market. In the occupation category, healthcare shows a similar starting ratio to LTC, with about 230 unemployed people per 100 vacancies in 2008.

This number decreased to about 60 in 2018, which marked a less-steep decrease and higher numbers than in LTC. However, over the whole period, a shortage of apprenticeship-educated healthcare nurses is evident. Thus, the demand for LTC employees cannot be satisfied by the recruitment of healthcare employees due to the lack of healthcare nurses themselves. Comparing the labor market in LTC with the entire German labor market, finding employment in LTC is easier than finding employment overall, especially for low-qualified workers.

Figure 10: Number of unemployed people per 100 job vacancies, LTC labor, healthcare labor, and total labor market

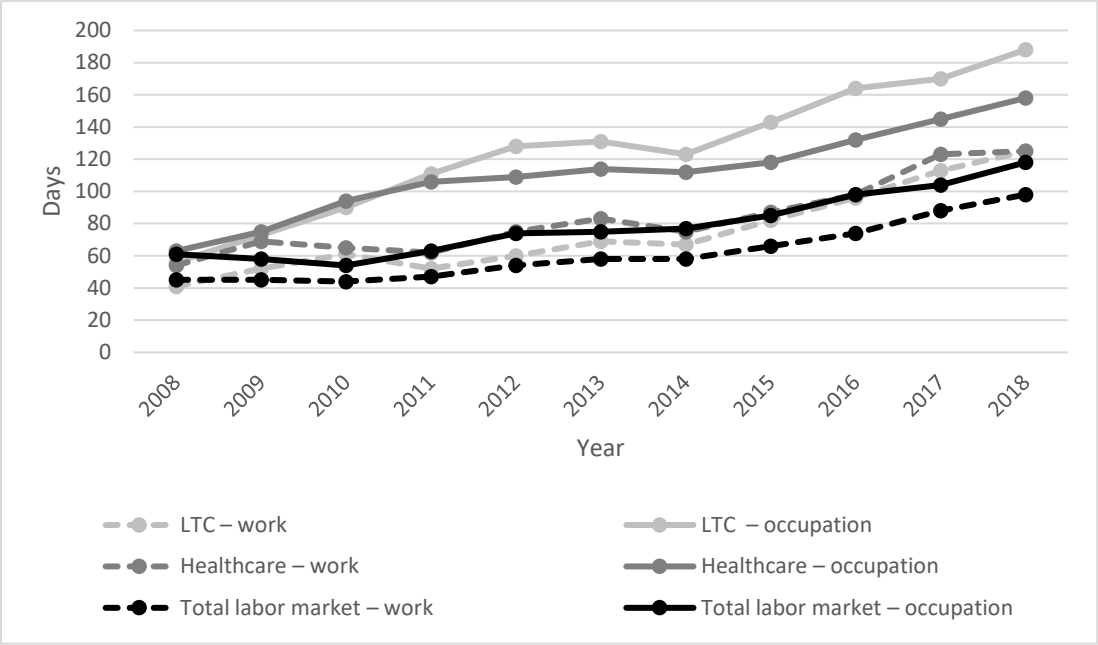


Source: Own calculations based on Bundesagentur für Arbeit (2019a).

The number of days until a vacancy at the unemployment office is deregistered reveals how difficult it is for employers to find employees. The development of this indicator (see Figure 11) supports prior findings. The number of days until a job opening is deregistered at the unemployment office increased for LTC, healthcare, and the total labor market for both educational categories between 2008 and 2018. In LTC, it took 41 days until a vacancy had been deregistered for the work category and 56 days for the occupation category in 2008. These figures increased to 125 and 188 days, respectively, in 2018. These durations and their developments are roughly similar to those in healthcare. However, for the occupation category, duration in healthcare was lower and increased more slowly than in LTC after 2011. In the total labor market, the time until deregistration was roughly similar to that of LTC in 2008. However,

durations were lower in the total labor market than in LTC in 2018 due to less-steep increases (98 days in the work category and 118 days in the occupation category).

Figure 11: Days until a job vacancy had been deregistered, LTC labor, healthcare labor, and total labor market



Source: Own calculations based on Bundesagentur für Arbeit (2019a).

Taken together, all the data demonstrate a growing demand for LTC employees. This growing demand is evident in the continuously increasing number of employees in LTC in both residential and ambulatory care, with the latter increasing more steeply between 2005 and 2017. Based on the increasing time needed for the deregistration of open vacancies and the decreasing ratio of unemployed people per job opening, it can be assumed that the workforce could have grown even more if the demand for employees had been able to be satisfied. A shortage of apprenticeship-skilled labor was particularly present after 2008 and intensified in the following years. The demand in this category could not be satisfied by the healthcare sector, which also lacked skilled labor. For the work category, a shortage of LTC labor was not evident over the whole period. Nevertheless, the decreasing ratio of unemployed people per job opening reveals that in this segment of the LTC workforce, a shortage of staff – at least in some regions – has been present in recent years and might develop nationally in the coming years. Moreover, employers have been searching longer for employees. Hence, overall, the increasing number of and demand for LTC staff hints at the increasing significance of LTC employees for society. Furthermore, the unsatisfied demand for employees signals one emerging trait of a profession.

Two pathways seem possible for coping with the lack of staff – and especially that of apprenticeship-educated employees. First, vacancies could remain open. This would hint at a higher workload for present LTC employees and lead to poorer working conditions. Furthermore, this might lead to a situation in which the increasing demand for formal LTC services could no longer be met due to staff shortages. Second, workers with lower levels of education could fill open vacancies that had originally been intended for apprenticeship-educated LTC employees. This would lead to a decreasing skill level in the workforce. These strategies and their consequences certainly do not cancel each other out; instead, they can occur and be pursued simultaneously.

4.3 Developments in the skill-level dimension

The developments in the skill-level dimension reveal the qualification of the staff involved in direct care. Figures 12, 13, and 14 display the share of employees in each workforce category and their growth rates since 2005. The category of *occupation* is the largest, followed by *work* and *profession*. Growth was constant between 2005 and 2017 and applied to the total care workforce, to ambulatory care, and to residential care. The number of employees involved in direct care increased constantly by 46.1% between 2005 and 2017 (66.4% in ambulatory care and 34.9% in residential care). Despite the constant growth over all workforce categories and forms of care, growth rates varied considerably, as displayed in the changing shares of the three workforce categories.

Beginning with the category of *profession*, only about 2–3% of the care workforce had a qualification at an academic level. The share of employees in the profession category was higher in residential than in ambulatory care, with about 3–4% in the former and 1–2% in the latter category. Shares declined slowly until 2017 due to a smaller increase in academic staff compared with all staff involved in direct care (25.6% compared with 46.1% between 2005 and 2017).[9]

The number of employees in the *occupation* category grew constantly between 2005 and 2017. The increase of 36.3% was smaller than the overall growth rate of

[9]The sharp increase in the *profession* category between 2005 and 2007 and the following drop in 2009 is due to the category of *other qualification in care at a university (of applied science)*. This increase has methodological reasons. In an e-mail correspondence, the Federal Statistics Office stated that due to small changes in the qualification-coding system, not every reporting unit had coded the qualifications correctly. Hence, there might be miscodings in this category. As there is no valid correction for these data, the official data for 2007 are displayed but not evaluated.

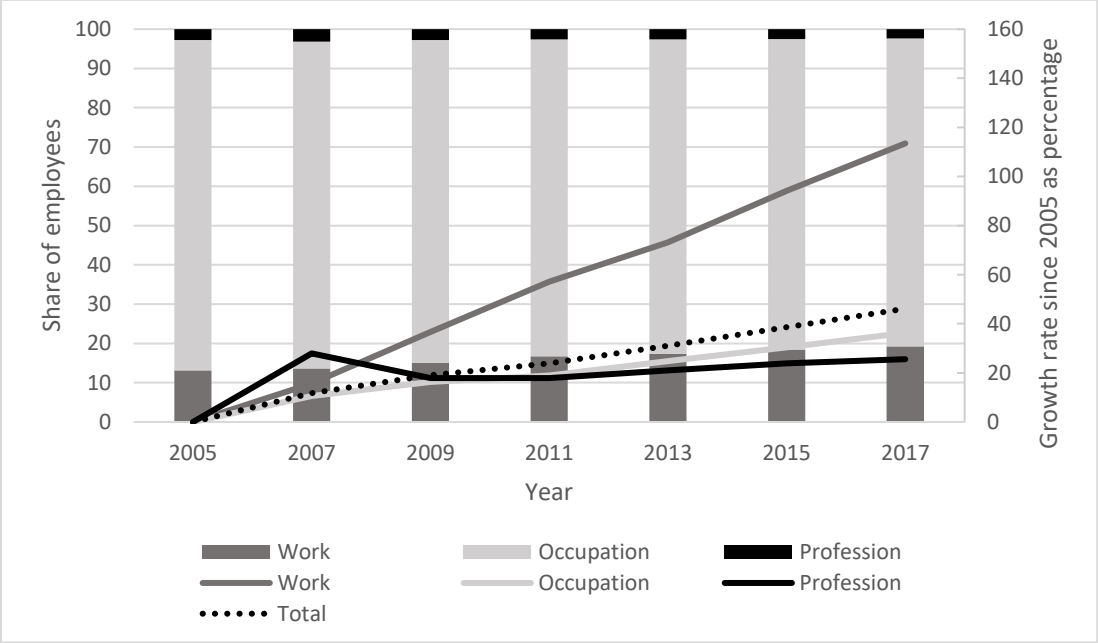
46.1%; hence, the share of employees in the occupation category decreased from 84.1% to 78.4% between 2005 and 2017. In ambulatory care, the share of employees in the occupation category was about six to seven percentage points higher than in residential care over the whole period. In 2005, 88% of employees in ambulatory care belonged to the occupation category, whereas this number decreased to 82.6% in 2017. In residential care, the shares decreased from 81.9% to 75.5% over the same period.

The share of employees in the *work* category rose steadily from 13.2% to 19.2% between 2005 and 2017. The share of employees was higher in residential than in ambulatory care (14.7% and 21.3% in residential care and 10.4% and 16.2% in ambulatory care in 2005 and 2017, respectively). The expansion of this category was also mirrored by the highest growth rate for all categories over the period (113.5%), which means that the number of employees in the work category more than doubled. In ambulatory care, the growth was even higher (159.6%), while in residential care, growth was a little lower (95.5%).

The analysis of the skill-level categories reveals that the category of *profession* was small and grew only slowly in absolute terms while decreasing in relative terms, which indicates a low level of professionalism coupled with a small deprofessionalization development. Furthermore, the *occupation* category decreased in relative terms, and the *work* category simultaneously increased with similar speed. These developments signal deoccupationalization. The deoccupationalization developments in the skill-level dimension indicate that the shortage of labor in the occupation category – which intensified in the quantity dimension – was compensated for by the employment of workers with lower education.

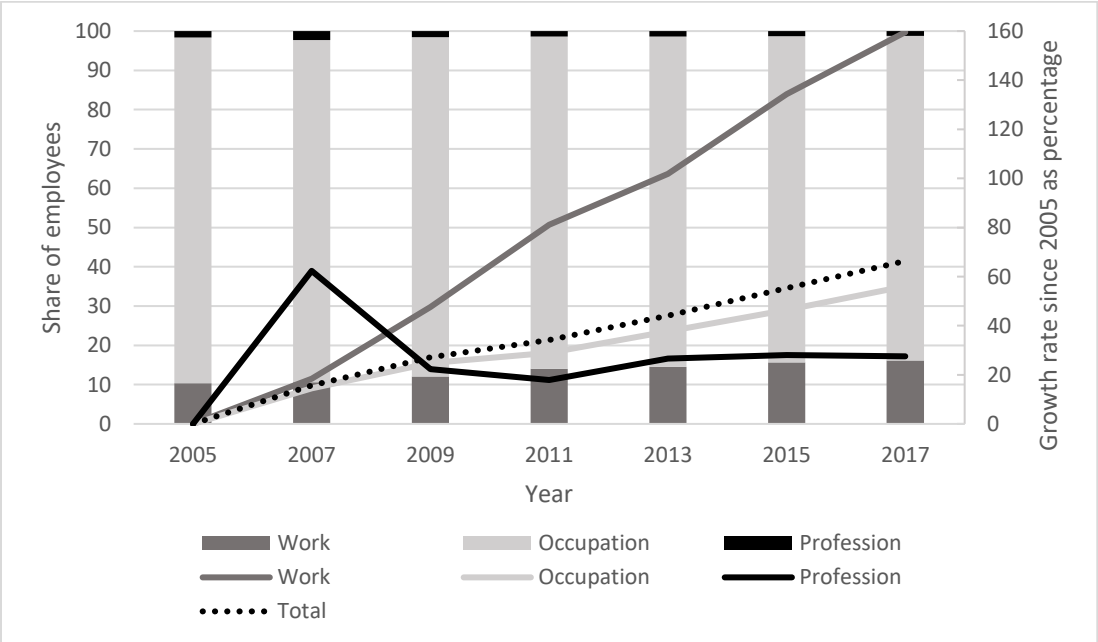
Substantial differences between residential and ambulatory care are apparent. The growth of the workforce in all categories was higher in ambulatory than in residential care. Furthermore, in residential care, the share of employees in the profession category as well as in the work category was higher than in ambulatory care. Hence, residential care is more professionalized as well as more deoccupationalized than ambulatory care.

Figure 12: Shares and growth rates of employees in workforce categories, totals[9]



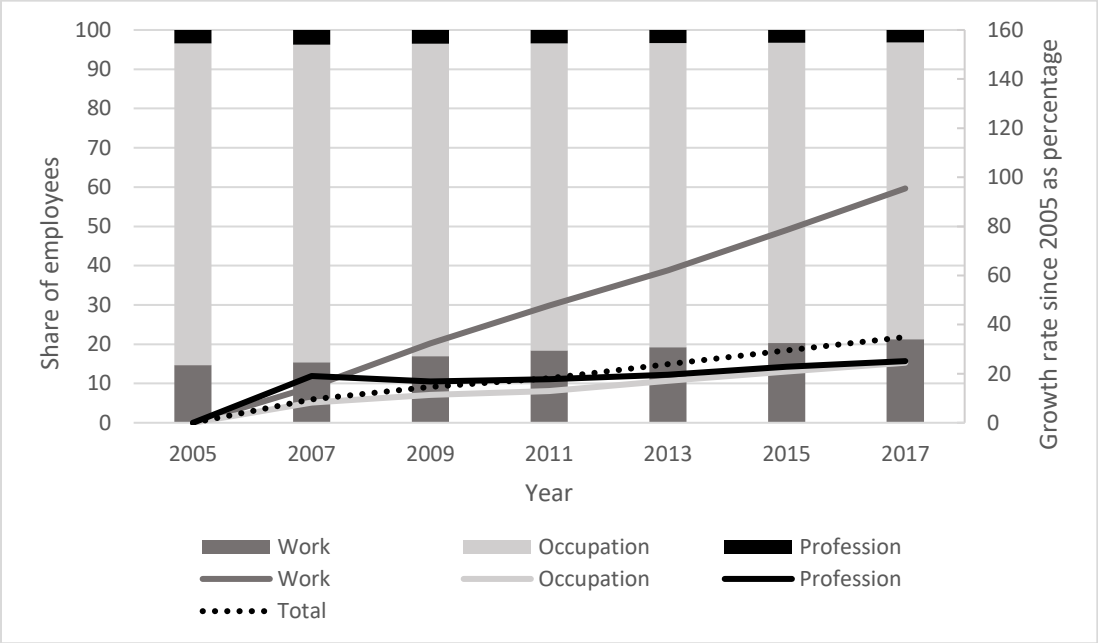
Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b). Note: *Total* refers to all employees categorized into *Work*, *Occupation*, and *Profession* and not to all employees in the LTC sector.

Figure 13: Shares and growth rates of employees in workforce categories, ambulatory care[9]



Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b). Note: *Total* refers to all employees categorized into *Work*, *Occupation*, and *Profession* and not to all employees in the LTC sector.

Figure 14: Shares and growth rates of employees in workforce categories, residential care[9]



Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b). Note: *Total* refers to all employees categorized into *Work*, *Occupation*, and *Profession* and not to all employees in the LTC sector.

A deeper examination of the different qualifications inside each workforce category reveals further developments (see Figures 15, 16, and 17). In the *occupation* category, healthcare nurses and LTC nurses account for more than 90% of all employees over the whole period. No other single educational degree exceeds 5% of the total employees in the occupation category. The shares of healthcare and LTC nurses developed contrarily. In 2005, 50.3% of all employees in the occupation category had a qualification as a LTC nurse, and 42% had a qualification as a healthcare nurse. This gap widened constantly over the following years, with 63.2% being qualified as LTC nurses and 30% as healthcare nurses in 2017. In ambulatory care, the share of healthcare nurses exceeded that of LTC nurses in 2005 (60.5% healthcare nurses and 30.9% LTC nurses). In the following years, the shares converged continuously, and in 2017, the share of ambulatory LTC nurses was higher than that of ambulatory healthcare nurses (51% and 42.6%, respectively). In residential care, LTC nurses have always been the dominant qualification and accounted for 61.9% of the workforce in the occupation category in 2005. This figure increased to 72.3% in 2017.

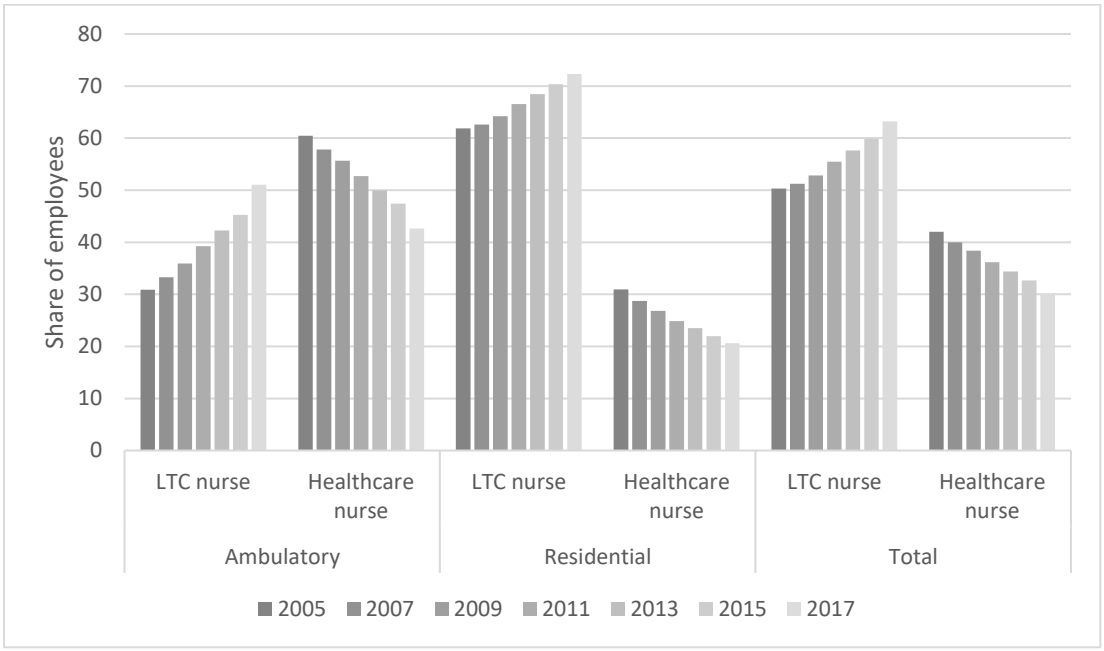
In the *work* category, a similar trend as in the occupation category is evident: In 2005, the share of auxiliary healthcare nurses (55.1%) was higher than that of auxiliary LTC nurses (43.6%). This relation changed in 2009, and by 2017, 69.2% of employees

in the work category had a qualification as an auxiliary LTC nurse, and 30.1% had a qualification as an auxiliary healthcare nurse. In residential LTC, the share of auxiliary LTC nurses exceeded that of auxiliary healthcare nurses after 2007, whereas this was only the case after 2013 for ambulatory LTC. Furthermore, the share of auxiliary LTC nurses was constantly higher in residential than in ambulatory care, rising from 46.5% to 74.6% in residential care and from 36.1% to 58.8% in ambulatory care between 2005 and 2017, respectively.

For the *profession* category, the developments are less explicit compared with the work- and occupation categories since the two study programs focus less on work in a specific sector or workplace. However, care-related study programs generally focus more on LTC-related issues than do social-work- and social-pedagogy study programs (Bundesagentur für Arbeit, 2020b). Social workers and social pedagogues constituted the majority of employees in the profession category from 2005 to 2017 despite an increase in university-trained care workers from 22.0% to 36.3% over the period. In contrast to the *work*- and *occupation* categories, the share of care-related academics was higher in ambulatory than in residential care over the whole period (30.7% and 47.8% in ambulatory care and 19.7% and 33.2% in residential care in 2005 and 2017, respectively).

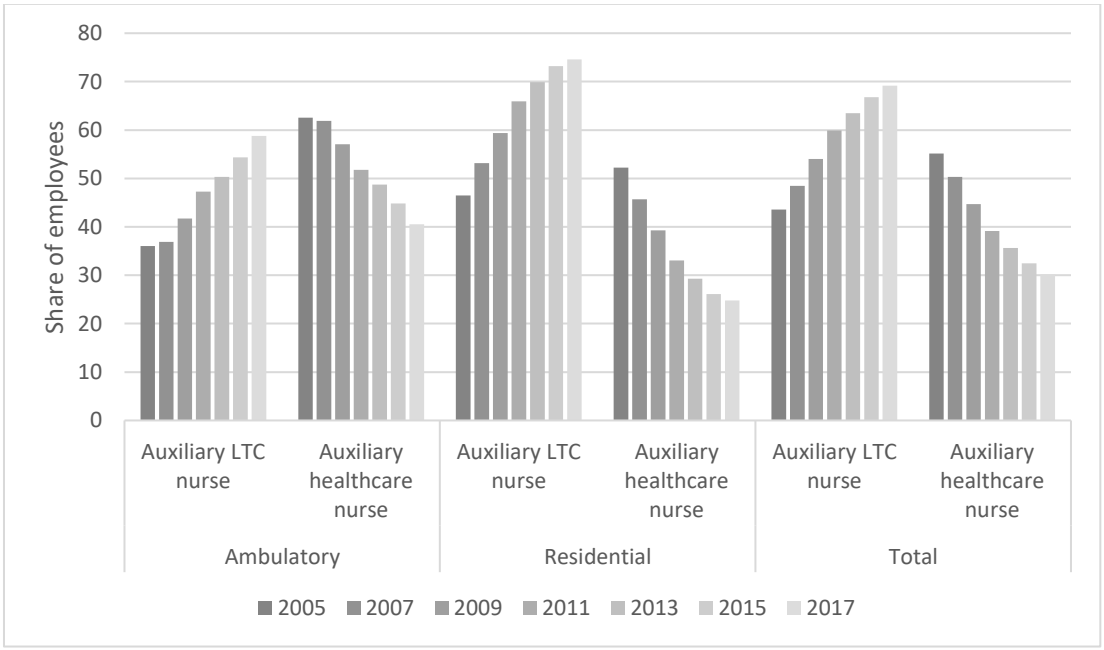
This closer examination of the qualifications in the three workforce categories reveals a continuous trend toward the employment of carers who are specifically trained for the field of LTC. Hence, the demand and supply of specific LTC skills instead of general care skills has increased, and a specific LTC labor market has developed. However, these developments apply in particular to the work- and occupation categories and are generally further developed in residential than in ambulatory care (except for the *profession* category). From a professionalization perspective, this specification in the qualification of employees indicates an upward development in the skill-level dimension.

Figure 15: Share of LTC nurses and healthcare nurses in the occupation category



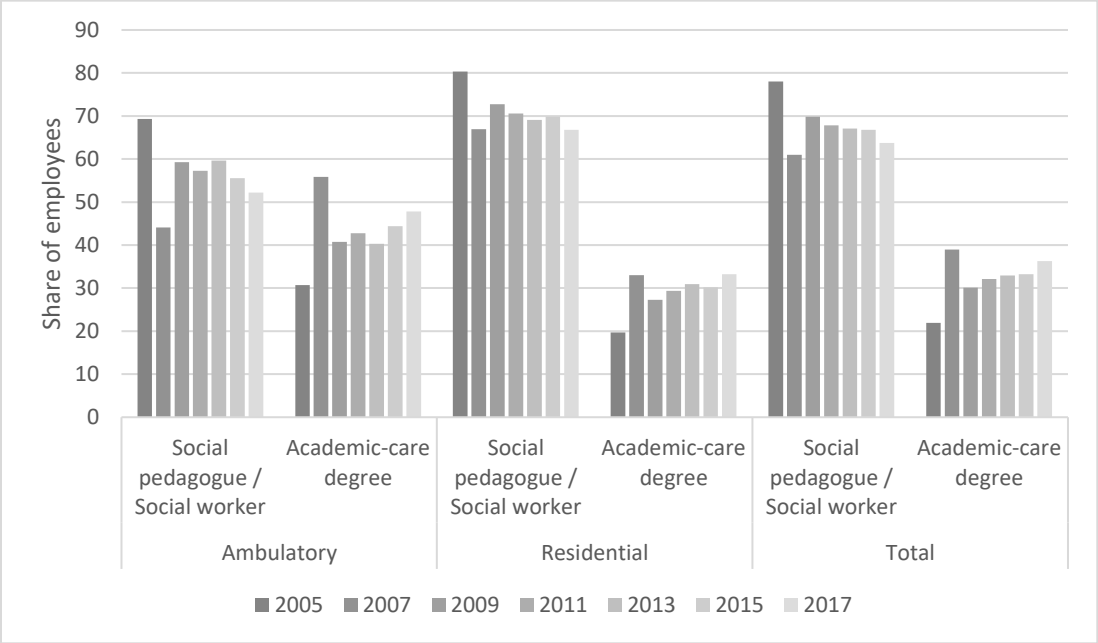
Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b).

Figure 16: Share of LTC auxiliary nurses and healthcare auxiliary nurses in the work category



Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b).

Figure 17: Share of social pedagogue / social worker and employees with an academic degree in care in the profession category[9]



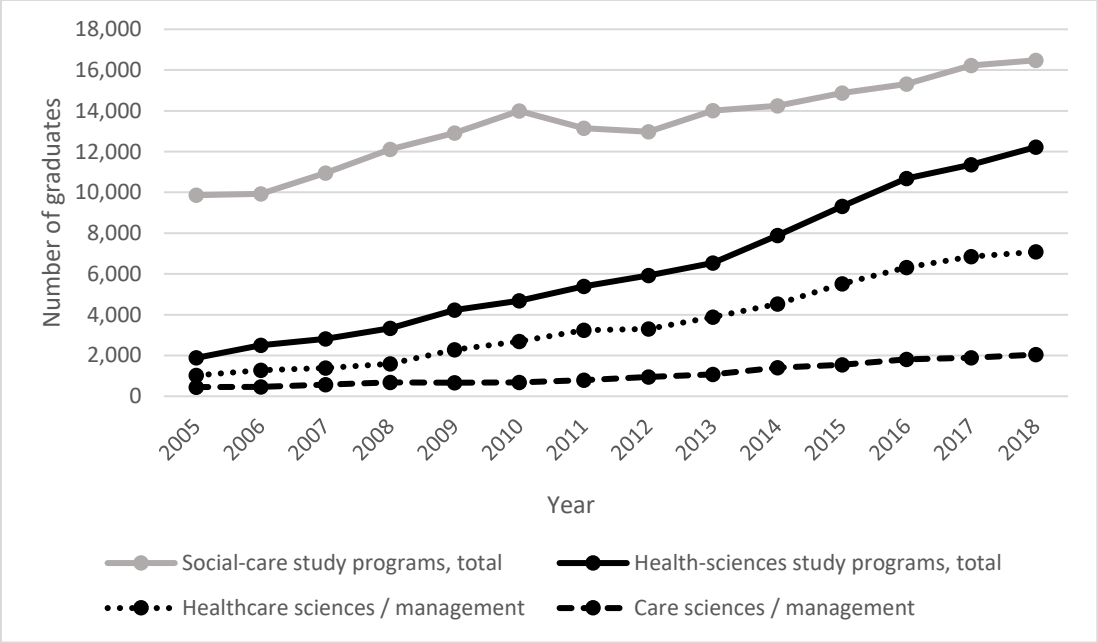
Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b).

Analyzing the number of graduates in social-care- and health-sciences programs at universities (of applied science) can reveal why the level of professionalism has been low and decreased in the skill-level dimension. A low, stagnating, or even decreasing number of social-care- and health-sciences graduates could explain the low number of professional employees. Furthermore, low, stagnating, or decreasing numbers in social-care study programs could explain the low level of specialization in the profession category. The number of graduates rose for social-care study programs as well as for health sciences study programs between 2005 and 2018 (see Figure 18). About 9,900 people graduated from programs in social-care sciences in 2005, which increased to about 16,500 in 2018. This rise in alumni was quite stable except for the years 2011 and 2012. In health sciences, the number of graduates increased constantly from 1,900 to 12,200 between 2005 and 2018. Healthcare science and management is the single most-significant study program within the group of health-sciences study programs and is mainly responsible for the growth of alumni in health sciences. The number of graduates in care sciences and management only increased slowly over the period.

Overall, the number of graduates reveals that professionally qualified staff were available. In 2005, nearly 12,000 people graduated from scientific study programs that qualified graduates for a professional job in LTC. By 2018, the number of alumni had

more than doubled to about 29,000. Furthermore, the increase in health-sciences study programs was higher than for social-care sciences. Hence, the total number of alumni would have allowed for an increasing number of professional employees and for the profession category in LTC to specialize with respect to LTC skills. However, either graduates of these study programs did not decide on a job in LTC, or there was no demand for these alumni in LTC.[10]

Figure 18: Number of graduates in social-care- and health-sciences study programs



Source: Own calculations based on Statistisches Bundesamt (2020). Note: *healthcare sciences / management* and *care sciences / management* are study programs under the subject area *health sciences study programs*.

4.4 Developments in the working-conditions dimension

The developments in the working-conditions dimension mainly involve working times and wages using longitudinal data. Furthermore, cross-sectional data on collective agreements are also included and discussed.

Working conditions are closely connected to the strength and spread of collective agreements because they define minimum working standards (Ebbinghaus, 2004). Bispinck et al. (2012) report that 39% of LTC nurses and 49% of auxiliary LTC nurses worked under a collective agreement. The coverage of collective agreements among

[10] Studies that questioned graduates about their whereabouts had a low number of participants and indicate that many of the graduates had found employment in the hospital sector (Claaßen et al., 2021; Dieterich et al., 2020).

LTC employees was thus lower than for all employees in health and LTC jobs (60%) for the year 2012. Private LTC facilities, in particular, did not join sectoral collective agreements and either opted for company-based agreements – which usually set lower working standards – or for no agreement at all (IAW, 2011). Employees in facilities covered by a collective agreement earned about 20% more than employees in facilities without such an agreement (Bispinck et al., 2012). The two Church-affiliated welfare associations of Caritas and the Diakonie have special tariff agreements and labor laws that are oriented toward public-payment schemes, but the key labor right to go on strike is denied to these employees (Schroeder, 2018).

Wages in LTC increased between 2005 and 2018. Data from the Federal Labor Office begin in 2012 and show a continuous increase in median monthly full-time wages for employees in the work- and occupation categories (see Figure 19).[11] In 2012, LTC nurses earned median gross wages of about € 2,400, which rose to about € 3,000 in 2019. Auxiliary LTC workers earned nearly € 1,700 in 2012, which increased to about € 2,150 in 2019. LTC nurses and LTC auxiliary nurses earned about € 500 to € 600 less per month than their counterparts in healthcare. Furthermore, LTC nurses earned just about € 100 more than auxiliary healthcare nurses in 2012. Beginning in about 2015, the wages of LTC nurses increased more quickly, which widened the gap between these two groups to about € 350 in 2019.

The share of full-time employees who received low wages – defined as less than two-thirds of the median wage in society – was relatively high in LTC, albeit decreasing (see Figure 20). 23.0% of LTC nurses received low wages in 2013, which decreased to 14.1% in 2019. For healthcare nurses, the share ranged from between eight and ten percent. The percentage for auxiliary LTC nurses was even higher: 62.6% received low wages in 2013, which decreased slightly to 60.3% in 2019. In comparison, only about one-third of auxiliary healthcare nurses received low wages.

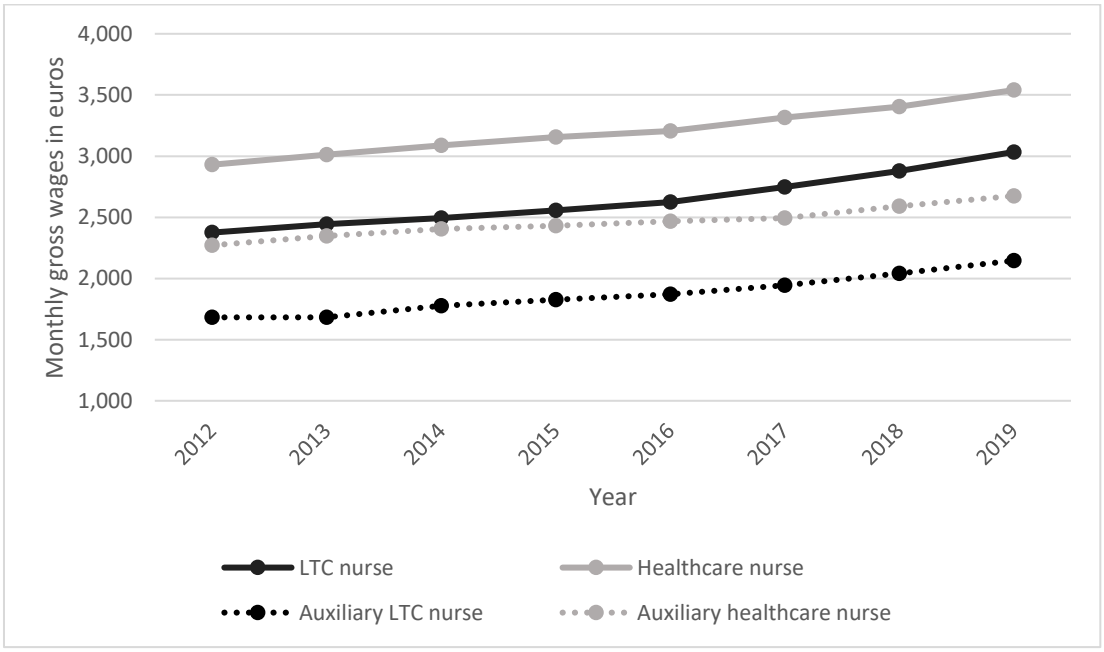
The median wages and the rates of low wages in LTC are connected with the minimum wage in LTC, which was introduced in 2010. This minimum wage mainly affects auxiliary care workers and unskilled employees in LTC but not healthcare- or LTC nurses because the latter receive wages considerably above the minimum wage (Meyer, 2012). The minimum wage differs for West Germany (including Berlin) and

[11] Wages for the profession category are not analyzed because the data from the Federal Labor Office for the profession category do not correspond to the profession category based on the German Care Statistics.

for East Germany. In 2010, it was set at €8.50 / €7.50 for West and East Germany, respectively, and it has increased several times since then. In 2020, the minimum wage was €11.35 and €10.85 for West and East Germany, respectively (see Table 9). The care minimum wage was introduced prior to the general minimum wage and was set higher. The general minimum wage amounted to €8.50 upon its introduction in 2015 and was set at €9.35 in 2020 (Bundesregierung, 2021).

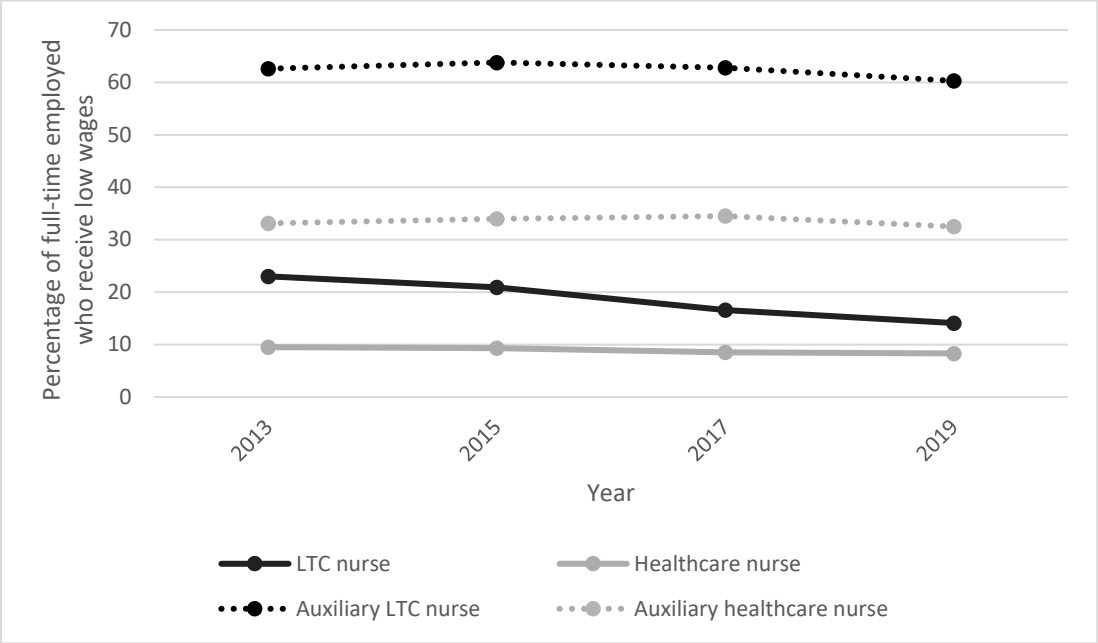
The rising wages in LTC and the minimum wage (which is higher than the general minimum wage) display a small upward movement – that is, an occupationalization in the remuneration of LTC work. However, the mere existence of a minimum wage to secure against low wages, the narrow wage gap between LTC nurses and auxiliary healthcare nurses, and the fact that one in seven LTC nurses continue to receive low wages demonstrate the low level at which this occupationalization of wages has unfolded.

Figure 19: Monthly gross wages for healthcare- and LTC employees, full-time wages, median



Source: Own calculations based on Statistik der Bundesagentur für Arbeit (2020a).

Figure 20: Percentage of full-time employees who receive low wages, healthcare and LTC



Source: Own calculations based on Deutscher Bundestag (2020). Note: *Low wages* is defined as less than two-thirds of the median wage in society.

Table 9: Development of the care minimum wage

Year	Care minimum wage (West / East) in euros
2010	8.50 / 7.50
2012	8.75 / 7.75
2013	9.00 / 8.00
2015	9.40 / 8.65
2016	9.75 / 9.00
2017	10.20 / 9.50
2018	10.55 / 10.05
2019	11.05 / 10.55
2020	11.35 / 10.85

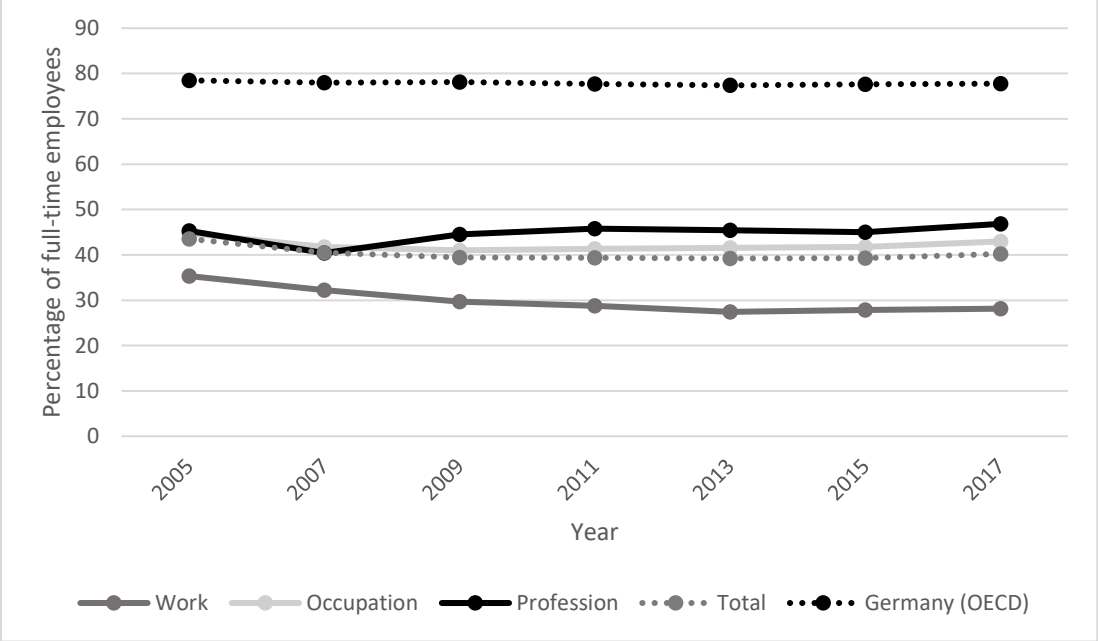
Source: Bundesministerium für Arbeit und Soziales (2014), Bundesregierung (2021).

Full-time employment is considerably less common in LTC than in the entire German workforce (see Figure 21). In the whole workforce, about 78% of employees work full time, whereas the figure for LTC employees in direct care work in 2005 was only 43.5% and had decreased to 40.2% by 2017. The share of full-time employment is highest for the profession category and lowest for the work category. In all three workforce categories, full-time employment decreased between 2005 and 2009 and stabilized afterward. In the work category, 35.3% of employees worked full-time in

2005, which decreased and leveled out at about 28% after 2011. In the occupation category, the full-time-employment rate was 44.7% in 2005 and decreased to 41% in 2009 and increased slightly to 42.9% in 2017. The profession category had the highest full-time-employment rate at 45.3% in 2005, which remained similar in the following years and even increased to 46.8% in 2017.[12]

Full-time employment was more prevalent in residential than in ambulatory care in 2005 (see Figures 22 and 23), and the gap continued to narrow up to 2017. Between 2005 and 2017, full-time employment decreased from 49.6% to 42.7% in residential care and increased from 32.5% to 36.5% in ambulatory care. The share of full-time employees in the work- and profession categories was similar in residential and ambulatory care in the year 2017 (about 28% for the work category and about 47% for the profession category). In the occupation category, full-time employment was still more prevalent in residential care than in ambulatory care in 2017 (38.0% in ambulatory and 46.6% in residential care).

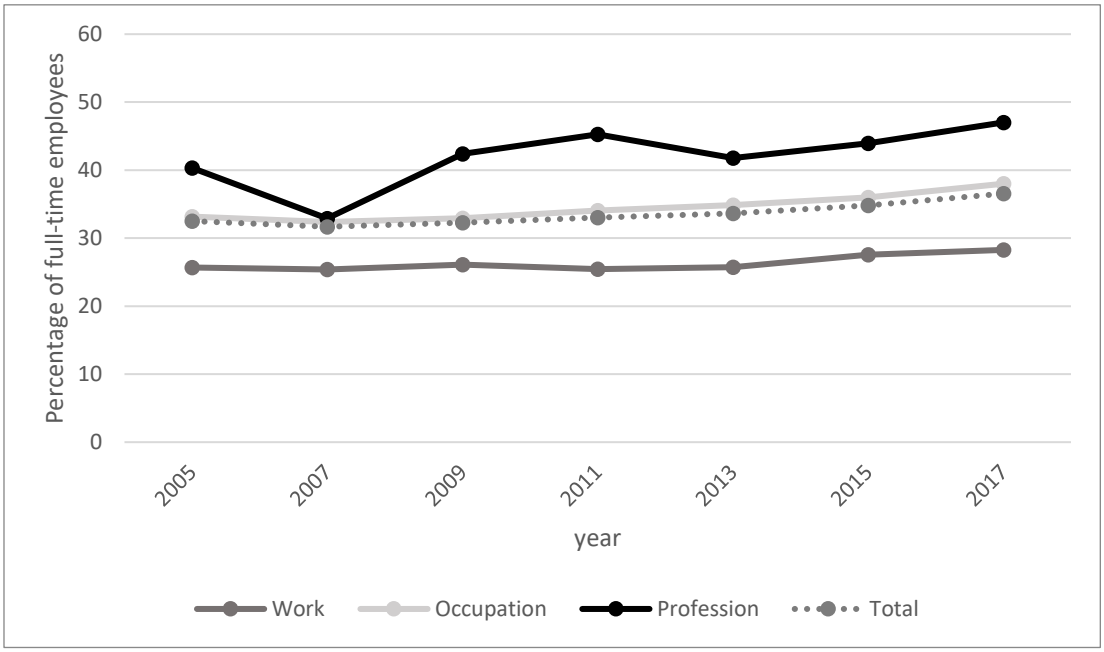
Figure 21: Percentage of full-time employment, total



Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b) and OECD, 2020a. Note: *Total* refers all employees categorized into *Work*, *Occupation*, and *Profession* and not to all employees in the LTC sector.

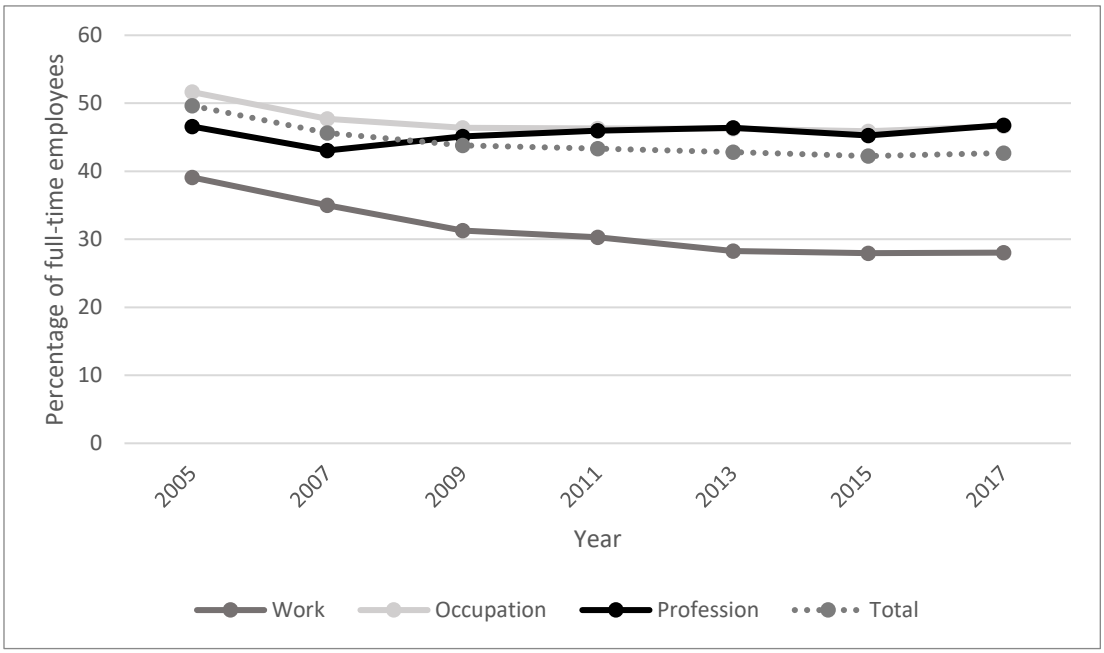
[12] The drop in the full-time-employment level in the profession category in 2007 was due to a large drop in the category *other qualification in care at a university (of applied science)* as there had been inconsistencies in that year's number of employees (see Footnote 9). These inconsistencies appear to have also been relevant for the full-time-employment rate.

Figure 22: Percentage of full-time employment, ambulatory



Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b) and OECD, 2020a. Note: *Total* refers all employees categorized into *Work*, *Occupation*, and *Profession* and not to all employees in the LTC sector.

Figure 23: Percentage of full-time employment, residential

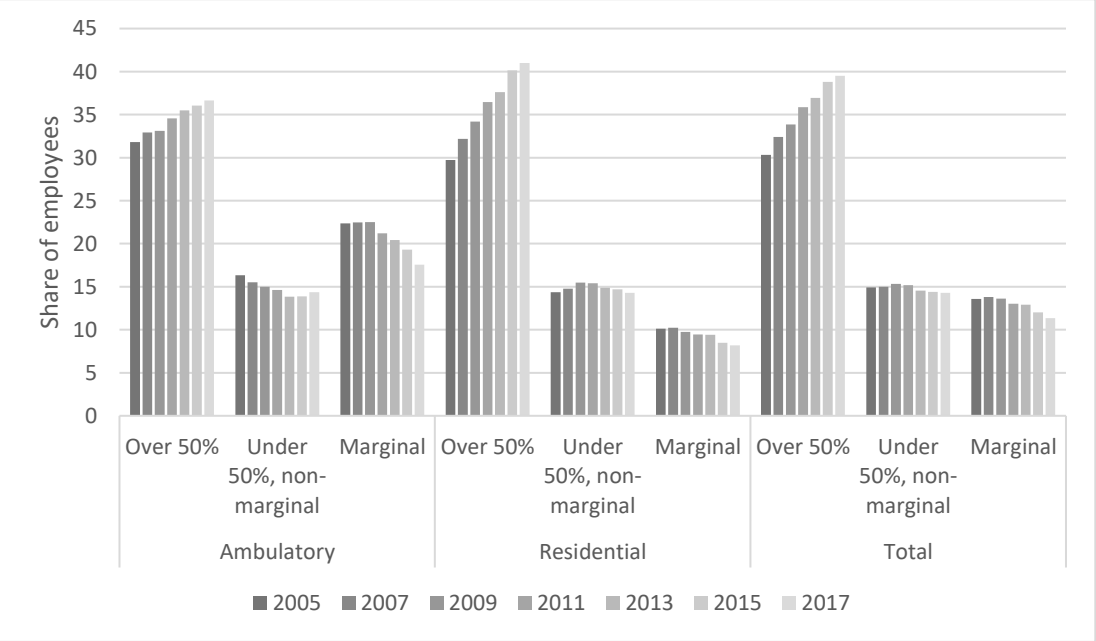


Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b). Note: *Total* refers all employees categorized into *Work*, *Occupation*, and *Profession* and not to all employees in the LTC sector.

Non-full-time employment can be investigated further, but only for the total number of employees (i.e., not for those only involved in direct care), which means that no analysis of workforce categories is possible. For the whole LTC workforce, a differentiation is made between part-time employment of more than 50%, part-time

employment of less than 50% that is above the threshold for marginal employment, and marginal employment. Part-time employment over 50% increased from 30.3% to 39.5% between 2005 and 2017 (see Figure 24). The share of employees in part-time employment under 50% and of those in marginal employment decreased slightly from 14.9% to 14.3% in part-time employment under 50% and from 13.6% to 11.3% in marginal employment between 2005 and 2017. The largest discrepancy between the levels in ambulatory and residential care appears for marginal employment. In residential care, about 10% of employees had a marginal-employment contract at the beginning of the period, which had decreased to about 8% by the end of the period. In ambulatory care, the amount of marginal employment was more than twice as high, lying at 22.4% in 2005 and decreasing to 17.6% in 2017.

Figure 24: Shares of employees in different forms of part-time employment



Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b). Note: Data cover all employees in LTC and not only those categorized into the three workforce categories of *work*, *occupation*, and *profession*.

Summarizing and evaluating the levels and developments in working times between 2005 and 2017, full-time employment was considerably less common in LTC than in the entire German workforce. Furthermore, full-time employment in LTC decreased from 2005 until 2017. Consequently, working times show low initial levels of occupationalization and professionalization, which even decreased further. However, the stagnating rate of full-time employment since about 2013, the increasing rate of part-time employment over 50%, the decreasing rate of part-time employment under

50%, and the decreasing rate of marginal employment signal small upward movements concerning working times.

Most LTC workers are dependent employees and are employed by one care facility. However, the issue of LTC employees at temporary work agencies who are placed by these agencies in different care facilities for different periods of time has gained significance in society and the LTC sector. Unfortunately, data on this form of employment are only available for a more-recent period. The number of temporary agency workers in LTC rose from 8,000 to 12,000 between 2014 and 2018. In 2019, the number dropped slightly, which is a trend that is also expected in future years due to new regulations (Statistik der Bundesagentur für Arbeit, 2020b). The share of temporary agency work in LTC was nearly two percent in 2019, which was slightly below the national average (Statistik der Bundesagentur für Arbeit, 2020b). However, unlike in many other sectors, temporary agency work in LTC is not associated with poor working conditions; rather, it is mainly associated with better-than-average working conditions. Temporary agency workers usually have more freedom to choose the shifts they want to work, work additional hours or shifts less often, and might also receive higher wages than regular care-facility employees (ver.di, 2020).

Concluding on the developments in the working-conditions dimensions, the initial level at which developments unfolded was below the German average. However, since about the middle of the 2010s, working conditions have stagnated and have even shown small signs of improvement in recent years, thereby signaling an emerging occupationalization development. This recent occupationalization development in the working-conditions dimension might be related to developments in the other workforce dimensions. The intensifying shortage of employees in the occupation category that is evident in the quantity dimension might have set off the small improvements in the working-conditions dimension as employers might have tried to gain new employees or to keep employees in the LTC sector by offering slightly higher wages and better working times.

4.5 Developments in the social dimension

The societal role depicted in the social dimension is measured by the organization of the workforce into boards of nursing and care, by the degree of unionization, by the involvement of workforce representatives in the development of curricula, and by

societal reputation. The organization of an occupation in the form of a board of nursing and care constitutes a defining trait of professions for many scholars (Hughes, 1963; Kuhn, 2016; Oevermann, 1996; Schürmann, 2016). Despite the ongoing debate on the effects of boards of nursing and care (Kuhn, 2016; Schwinger, 2016), these boards are considered institutions that effectively and powerfully represent the interests of the workforce in care. Boards of care and nursing represent and contribute to a high degree of societal recognition and value (Schroeder, 2018). In Germany, no national registration for care workers exists, nor does a national board of nursing and care. However, three of the sixteen federal states have recently introduced one. The first federal board of nursing and care was established in Rhineland-Palatinate in 2015 (Kuhn, 2016), with Lower Saxony following in 2017 (Pflegekammer Niedersachsen, 2018) and Schleswig-Holstein in 2018 (Pflegeberufekammer Schleswig-Holstein, 2020). The board of Lower Saxony will be closed during 2021 due to continuous critique, including critique from a survey of its members (Ärzteblatt, 2020). No other federal state has taken any concrete measures to implement a board of nursing and care (DBfK, 2020). The implementation of boards of nursing and care at the federal state level has characterized a step toward professionalization in recent years. However, the lack of implementation in most federal states and the closure of the board in Lower Saxony begs the question of whether this impetus will last.

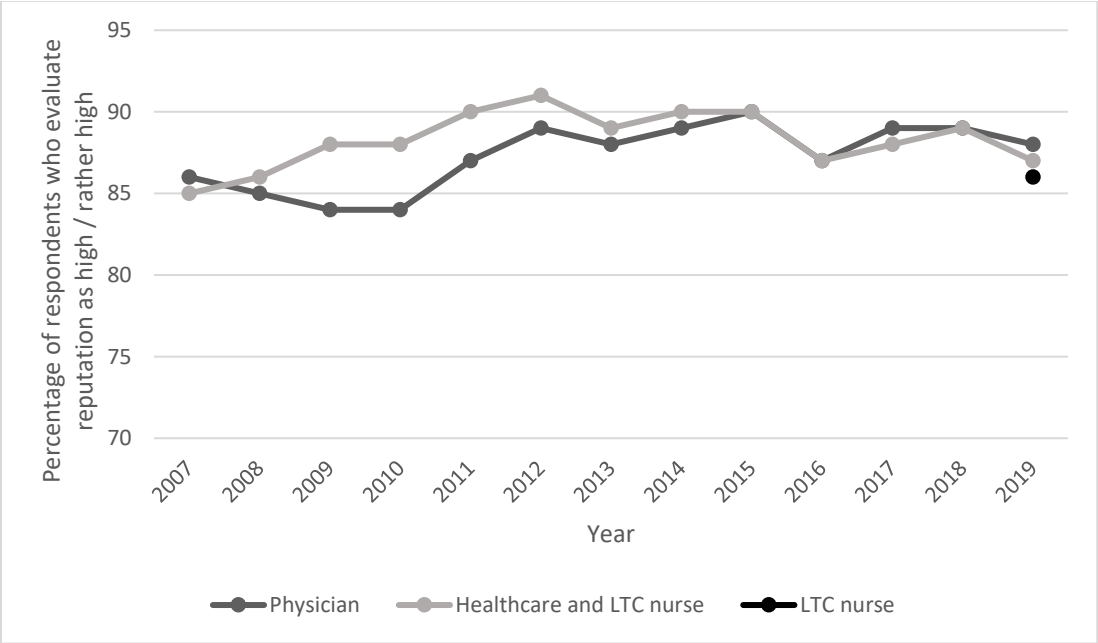
The union ver.di organizes LTC workers. Ver.di represents different groups of employees (for a more-detailed description of ver.di, see Section 5.2.2) and organizes LTC workers together with all employees in social-care-, healthcare-, childcare-, and confessional institutions into one of its sub-divisions. The number of organized employees in this sub-division rose from 345,000 in January 2007 to 385,000 in December 2018, which represents a growth of 40,000, or 10.5% (ver.di, 2011, 2019). The unionization rate for LTC workers alone is not available; however, unionization in the sub-division is rising, and the occupational power, representation, and resources in the field of health and care are hence also rising, which suggests an upward trend in the social power of LTC workers.

A high working ethos that goes beyond mere performance of one's duties is a central trait of professions (Oevermann, 1996). No comparable longitudinal data on the working ethos of LTC workers is available; however, several studies at different time points have found high levels of intrinsic motivation, social responsibility, and

occupational ethos (Schroeder, 2018; Voges, 2002). Conversely, abusive behavior of LTC employees toward patients has also been documented (Eggert et al., 2017).

A high level of prestige and acknowledgment by society is a prerequisite for a profession. The citizen survey on public services (*Bürgerbefragung öffentlicher Dienst*) by the German Civil Servants' Association (dbb) depicts the reputation of about 30 occupations each year since 2007. The survey has since included healthcare nurses and expanded the category to also include healthcare- and LTC nurses in 2012. Since 2019, healthcare and LTC nurses have been depicted in two separate categories. The survey asks respondents whether they find that a certain occupation enjoys a high or rather-high reputation. Between 85% and 91% of respondents evaluated the reputation of healthcare and LTC nurses as being high or rather high across the documented years (see Figure 25). Each year, healthcare and LTC nurses were among the top three of the evaluated occupational groups and achieved similar ratings as physicians. The separate values for healthcare nurses and LTC nurses in 2019 were similar, which indicates that the earlier values also represented LTC nurses.

Figure 25: Reputation of physicians, healthcare nurses, and LTC nurses evaluated as high or rather high



Source: Own calculations based on dbb (2007–2019). Note: Data are based on a representative survey of the German population. *Healthcare and LTC nurse* only included both occupations between 2012 and 2018 and included healthcare nurses for all other years.

The "production of professional producers" (Larson, 1977, p. 50) and thus also the involvement of LTC-worker organizations in the development of curricula is a further defining trait of professions. This involvement in curricula development demonstrates

the power of LTC workers and their role in the LTC sector. Until the end of 2019, the ordinance concerning training and examinations for LTC nursing (*Altenpflege-Ausbildungs- und Prüfungsverordnung AltPflAPrV*) had regulated apprenticeship education in LTC. This national law only regulated the general aspects of the apprenticeship program and left the development of specific curricula to the sixteen federal states, which formulated general directives (*Rahmenverordnungen*). A commission of experts usually developed these general directives. The presence of professional organizations of LTC workers in these commissions is an indicator of whether LTC-worker representatives were involved in curriculum-building.[13] In six directives, the name of the members of the commission and their organizational affiliation are stated (Bayerisches Staatsministerium für Unterreicht und Kultus, 2009; Hessisches Sozialministerium, 2009; Ministerium für Bildung, Frauen und Jugend des Landes Rheinland-Pfalz, 2005; Ministerium für Soziales und Integration & Ministerium für Kultus, Jugend und Sport Baden-Württemberg, 2010; Senatorin für Soziales, Jugend, Frauen, Integration und Sport Freie Hansestadt Bremen, 2017; Thüringer Ministerium für Bildung, Jugend und Sport). Only two of these six directives – one each from Bavaria and Baden-Wuerttemberg – were developed by including representatives of occupational groups. The German Care Occupations Association (DBfK) and the German Occupational Organization for Elderly Care Workers (DBVA) were involved in the directive from Bavaria and the German Care Council (DPR) in the directive from Baden-Wuerttemberg.

In 2020, the new general care apprenticeship was implemented. Apprentices in healthcare, child healthcare, and LTC must now complete the same apprenticeship program. After two years of general nursing- and care education, apprentices can choose to specialize in child healthcare or LTC or to further follow a general path in the final year. The general directive for this new care occupation has now been established at the national level and been developed with the help of eleven experts, none of whom is a representative of an occupational organization (Bundesministerium für Gesundheit, 2018; Fachkommission nach dem Pflegeberufegesetz, 2020). Most experts are researchers at academic institutions (six) or managers of nurse-training schools (four) (Bundesministerium für Gesundheit, 2018). One representative from the Catholic welfare association Caritas was included. In conclusion, it is evident that

[13] Two of the 16 general directives could not be obtained (Mecklenburg-Western Pomerania and Saxony-Anhalt).

occupational organizations have not had a major influence on curricula in the recent past and still do not exert a major influence today.

Summarizing the developments in the social dimension poses a challenge because the indicators are quite different, are not available for each time point of the investigation, and are not comparable. On the one hand, the working ethos of care workers and their reputation are high and suggest a status as a profession. Furthermore, the increasing unionization of care- and social workers as well as the introduction of boards of nursing and care in recent years reveal small occupationalization- and professionalization developments. On the other hand, the exact unionization rate of LTC workers is unknown, and the development of further boards of nursing and care seems to have been postponed until the distant future, which leaves the upward impetus on shaky ground. Moreover, the involvement of LTC-worker organizations in the development of LTC-apprenticeship curricula has remained low over the whole period, as revealed by the lack of involvement of occupational organizations in in the expert group in the curricula development of the new, general care occupation.

4.6 Summary

This chapter investigated the central question of how the LTC workforce has developed and how this development can be evaluated. By differentiating between four dimensions and several indicators in these dimensions, the analysis in this chapter painted a comprehensive picture of the LTC workforce and its developments since 2005. The different dimensions show upward as well as downward trends, sometimes even in the same dimension.

The quantity dimension displays a constant professionalization development. The number of employees in LTC has risen continuously. Additionally, the demand for LTC labor has increased since 2005. In particular, the demand for LTC nurses has been high and indicates a shortage of qualified labor. However, in recent years, a lack of auxiliary LTC nurses has begun to unfold. Healthcare employees have not been able to satisfy this shortage of LTC employees because the healthcare sector has also been dealing with labor shortages. The increase in the number of employees might have been even higher if sufficient labor had been available. The developments along the quantity dimension reveal that LTC is becoming an important sector in the German labor market and is taking on a significant role in society. This role particularly stems

from the intensifying shortage of staff, which is one defining trait of professionalism (Larson, 1977).

The skill-level dimension has shown a low rate of professionalism and a high rate of deoccupationalization on the one hand and specialization with respect to LTC skills on the other hand. A low and decreasing share of academic workers throughout the period is representative of the low rate of professionalism. This low rate cannot be attributed to a low number of academically educated social- and care graduates as their numbers have risen since the beginning of period. However, only a few of these graduates have found their way into employment in the LTC sector. It would be possible to speculate as to why graduates do not choose a career in LTC. For example, poor working conditions in LTC might drive graduates into other sectors. Furthermore, institutional factors and organized interests could also contribute to dampening professionalization in the skill-level dimension. In addition to deprofessionalization, a continuous deoccupationalization of the skill-level dimension has taken place since 2005. The number and share of employees with only marginal, mainly on-the-job training has increased. This increase might be related to the permanent shortage of LTC nurses and healthcare nurses, which has caused their spots to be filled by lower-educated staff. Despite the deprofessionalization- and deoccupationalization developments, the skill-level dimension has become specialized with respect to LTC skills. In 2005, the workforce consisted of an equal level of healthcare nurses and LTC nurses and of a higher level of auxiliary healthcare nurses compared with auxiliary LTC nurses. In 2017, LTC nurses and auxiliary LTC nurses – that is, employees specifically qualified for LTC work – dominated the workforce in LTC. This increasing specialization can be partly attributed to the introduction of the National Regulation of LTC Nurse Apprenticeships (AltPflG) in 2003. Additionally, a trend toward the separation of the LTC system from healthcare and social care – which was initiated by the introduction of LTC insurance itself in 1995/1996 – might have contributed to this skill-level specialization.

The working-conditions dimension reveals a deoccupationalized and deprofessionalized workforce because the most-important indicators of working conditions have consistently lain below the national average. The low level of collective agreements, the low level of full-time employment, the need to introduce a minimum wage, the wage level (which is below that of (auxiliary) healthcare nurses), and the high share of LTC employees who have received low wages demonstrate

deprofessionalized and deoccupationalized working conditions. However, the stagnation of the full-time-employment rate since about 2013, increasing wages (which have slowly converged on those in healthcare), and the decreasing share of low wages all indicate that downward developments of working conditions have come to a halt, and small signs of upward developments have even become apparent in recent years.

The social dimension combines opposing developments. Concerning reputation and working ethos, the LTC workforce appears to have become highly professionalized. Furthermore, the introduction of boards of nursing and care by three of the 16 federal states and the increasing unionization of care- and social-work employees indicates a step toward professionalization. However, it is unclear how long these developments will last. Indeed, the first board of nursing and care is about to close. Furthermore, LTC-worker representatives have demonstrated low involvement in the development of educational curricula, which implies a deoccupationalized workforce in this part of the social dimension.

The first conclusion – which stems from the analysis of the workforce dimensions – is that the LTC workforce has not developed uniformly or in a single direction. The initial level of each dimension on the professionalization continuum differs, as does the current level and the direction of developments. Hence, attempting to describe workforce developments in LTC by using a single term that captures everything does not do justice to the diversity of patterns and developments. Nevertheless, it is possible to order the dimensions by their current level and progress on the professionalization continuum since 2005. The quantity dimension has shown only upward developments. The increasing absolute number of and high demand for employees reveals that LTC is becoming an important sector in the German labor market. The developments in the working-conditions dimension have also moved mainly upward in recent years. The initial and current working conditions lie below the German average; however, stagnation since the mid-2010s and slow upward movements in recent years have moved this dimension to second place. The skill-level dimension has shown deoccupationalization and deprofessionalization, but the continuous specialization toward more LTC skills indicates an upward movement. The social dimension appears to have been the least-professionalized and least-professionalizing dimension since 2005. Despite a continuous high working ethos and a high reputation, societal influence by LTC workers via boards of nursing and care and via involvement in the

development of educational curricula has been low and has even decreased in recent years.

Although workforce dimensions are analyzed separately, developments in the dimensions might be interrelated and influence one another. The presented data hint at the possibility of a downward spiral in which developments in the quantity-, skill-level-, and working-conditions dimensions are linked. The shortage of employees appears to be being compensated for by the employment of low-qualified LTC employees, whose wages and working times are low, which might also be keeping working standards for higher-qualified care workers at a lower level. In turn, these low working conditions might be leading to low interest in beginning an apprenticeship in LTC and to beginning and continuing work in LTC. The option to work in a neighboring field applies mainly to higher-educated employees. The rising number of alumni in social care and health sciences and the low and decreasing share of professional care workers indicates that alumni indeed do not choose to work in LTC, but in sectors with better working conditions.

The analyzed workforce developments lead to initial hypotheses on the influence of institutions and organizational actors. If institutional developments and policy changes influence developments in the LTC workforce, their focus should mainly be set on changes that affect the number of employees and – in recent years – on working conditions but should be small on the skill-level- and social dimensions. Similarly, if organizational actors that promote professionalization influence workforce developments, they should also focus their advocacy on the former two dimensions.

5 LONG-TERM-CARE POLICIES AND ORGANIZATIONAL INVOLVEMENT

Developments in the LTC workforce can be influenced by several factors and processes. The previous chapter pointed to the possibility of interrelated workforce dimensions and the reinforcing processes between these dimensions. Furthermore, the scientific literature points to the general institutional setup of LTC systems (e.g., Auth, 2013; Blass, 2012; Theobald, 2008) and their intersection with both employment systems (e.g., Buestrich, 2005; Kümmerling, 2016) and education systems (e.g., Burkhardt, 2018; Roth, 2007) (see Section 2.2). However, a longitudinal analysis of LTC policies with a focus on the implemented primary aims and their potential impact on LTC workforces is missing. Moreover, actors are hardly associated with workforce developments, although they do have the power to influence workforces directly. For example, social welfare organizations are large providers of residential and ambulatory LTC services. Their employment policies and conditions directly influence who is employed and under what conditions, thereby directly affecting workforce developments (Buestrich, 2005; Wohlfahrt, 2017). Furthermore, organizations can indirectly impact workforce developments by influencing policies and thus institutional change according to their own interests (Bandelow, 2006; Schölkopf, 2000). However, recent literature only points to the (weak) role of occupational organizations and trade unions in influencing working conditions and professional autonomy and has neglected the role of additional organizations, such as business organizations or systemic actors (Kälble, 2005; Kümmerling, 2016; Schroeder, 2018).

This chapter aims first to show how LTC policies have developed and how these policies have been used to change LTC institutions. Special attention is paid to primary aims – in particular to financial stability, quality, and professionalization – and to how these aims are implemented in the reforms. Second, this chapter elaborates on which organizations participate and how they are involved in the policymaking process. The involvement of organizational groups and of the most-important single organizations is analyzed and evaluated based on the quantitative analysis of the public-hearing data. Third, the chapter assesses how policies and organizational involvement interrelate. Finally, the results of the policy- and organizational analyses are taken up and are

related to workforce developments. All analyses in this chapter begin in 2008 with the first major LTC reform. The last analyzed reform was passed in 2018.

5.1 Long-term-care reforms and their primary aims

The German LTC system was established in 1995/1996. In the following decade, all institutions and rules remained basically unchanged as no major reforms were enacted (Rothgang, 2010). However, since 2008, reform activity in the LTC system has been taken up, and seven encompassing reforms have been enacted: the Long-Term Care Further Development Act of 2008 (*Pflege- Weiterentwicklungsgesetz, PfWG*); the Care Redirection Act of 2012 (*Pflegeneuausrichtungsgesetz, PNG*); three separate acts called Care Strengthening Act I, II, and III of 2014, 2015, and 2016, respectively (*Pflegestärkungsgesetze I–III; PSG I–III*); the Care Occupation Reform Act of 2017 (*Pflegberufereformgesetz, PflBRefG*); and the Care-Worker Strengthening Act of 2018 (*Pflegepersonal Stärkungsgesetz, PpSG*) (see Table 10). These seven reforms are not the only LTC reforms to have taken place since the onset of the system, but they are the most significant, as revealed by the fact that public hearings were only held for these LTC reforms (see next paragraph).[14] Each of these seven reforms implemented a vast number of measures in different areas of the LTC system.

Six of the seven reforms were passed by a grand coalition of Social Democrats (*SPD*) and Christian Democrats (*CDU/CSU*). Only the Care Redirection Act of 2012 was passed by a coalition of Christian Democrats and Liberals (*FDP*). The Liberals were not part of the National Parliament from 2013 to 2017 and had thus not participated in the public hearings on the three Care Strengthening Acts and the Care Occupation Reform Act. The Greens (*Grüne*) and the Left (*Linke*) – both of which are parties of the political left – were in parliamentary opposition over the course of all reforms. The right-wing Alternative for Germany (*AfD*) entered the National Parliament as an opposition party in 2017 and was thus only involved in the public hearing on the Care Occupation Strengthening Act of 2018.

[14] There were two other reforms between 2008 and 2018: the Family Caregiver Leave Act of 2011 (*Familienpflegezeitgesetz*) and the Reconciliation of Family, Care, and Working Life Act (*Gesetz zur Vereinbarkeit von Familie, Pflege und Beruf)* of 2014, which were small in scope and left the central institutions of the LTC system unchanged. No public hearings were held for either act.

Table 10: Overview on most-important reforms to the LTC system and the LTC workforce

Name of reform	Year reform was passed	Year reform was implemented	Governing parties
Long-Term Care Further Development Act *Pflegeweiterentwicklungsgesetz (PfWG)*	2008	2008	CDU/CSU, SPD
Care Redirection Act *Pflegeneuausrichtungsgesetz (PNG)*	2012	2013	CDU/CSU, FDP
Care Strengthening Act I *Pflegestärkungsgesetz I (PSG I)*	2014	2015	CDU/CSU, SPD
Care Strengthening Act II *Pflegestärkungsgesetz (PSG II)*	2015	2017	CDU/CSU, SPD
Care Strengthening Act III *Pflegestärkungsgesetz (PSG III)*	2016	2017	CDU/CSU, SPD
Care Occupation Reform Act *Pflegeberufereformgesetz (PflBRefG)*	2017	2019/2020	CDU/CSU, SPD
Care-Worker Strengthening Act *Pflegepersonal-Stärkungsgesetz (PpSG)*	2018	2019	CDU/CSU, SPD

Source: Based on Bäcker (2021) and Steffen (2020).

The description of the reforms and implemented measures is based on the social-policy chronicles of Bäcker (2021) and Steffen (2020), the governmental reform proposals, and the subsequent laws. The implemented reform measures are described, and the primary aims that are implemented along with them – namely *financial stability*, *quality*, *subsidiarity*, *redistribution*, *growth*, and *professionalization* – are evaluated. Focus is placed on the aim of professionalization. Furthermore, the aims of financial stability and quality receive special attention in the evaluation because these aims are unequivocally connected to professionalization (quality) and to deprofessionalization (financial stability) (see Section 2.3.2). Furthermore, both aims have been shown to be the main guiding and conflicting aims in LTC policy in recent years in all European LTC systems (Ranci & Pavolini, 2013).

The German LTC system was established in 1995/1996 as a social-insurance system. Contributions are financed jointly by employees and employers. Benefits are available as cash benefits or as ambulatory- and residential-care services. Cash benefits are paid directly to the care recipient, and their use is at the care recipient's own discretion. The LTC system began with three benefit levels for each benefit type, which were called Care Steps I–III (*Pflegestufen*). The higher a recipient's dependency, the higher the Care Step and the higher the benefit a recipient received. Dependency is assessed by a standardized assessment procedure. All benefits of the

LTC system are designed as partial benefits, which means that co-payments for care costs apply (Götting et al., 1994; Rothgang, 2010).

All institutions, rules, and measures established in 1995/1996 remained basically unchanged for one decade.[15] Hence, benefits did not increase once until 2008 – not even as compensation for inflation. Consequently, the real value of LTC benefits decreased, and individual co-payments therefore increased (Rothgang, 2010). The absence of reforms and thus the lack of benefit increases until 2008 was a strategic action by the governing parties to decrease public costs for LTC and thus to achieve financial stability (Rothgang, 2010).

In 2008, the Care Further Development Act was enacted and implemented as the first major LTC reform. Several measures were implemented: contribution increases, benefit increases, a new benefit level, the introduction of caregiver-leave time (*Pflegezeit*), and the introduction of care-support centers (*Pflegestützpunkte*). The reform introduced the first benefit increases since the onset of the system, but the increases could not compensate for the prior loss of real value since the setup of the system (Rothgang, 2010). Benefits were raised in a stepwise fashion by defined amounts beginning in 2008; however, not all benefits were increased. Only cash benefits and ambulatory benefits for all dependency levels (Care Steps I–III) and residential benefits for the highest dependency level (Care Step III) were raised. Thus, residential benefits in Care Steps I and II remained unchanged. In justifying the law, the government argued that ambulatory benefits should take precedence over residential benefits and that these ambulatory benefits should therefore be increased.

> The current benefit amounts for home care do not sufficiently take into account the legally anchored principle that home care should take precedence over residential care. The changes in long-term-care-insurance benefits are therefore primarily aimed at expanding and supporting home-care structures. (Deutscher Bundestag, 2007, p. 39, own translation)

Furthermore, an additional benefit level – Care Step 0 – was introduced that applies to individuals with *impaired everyday expertise* (*eingeschränkte Alltagskompetenz*), which essentially translates to people with dementia. Furthermore, care-support centers (*Pflegestützpunkte*) and care counselling were introduced as support structures

[15] The only noticeable exception has been an increase in the contribution rate for people aged 23 and older who do not have at least on child. Since 2005, these individuals have had to pay an additional contribution rate of 0.25% by themselves as the additional contribution is not shared with the employer (Gesetz zur Berücksichtigung der Kindererziehung im Beitragsrecht der sozialen Pflegeversicherung, 2004).

for family caregivers and are funded by LTC insurance. The introduction of a caregiver-leave time (*Pflegezeit*) ensures the right of employees to take a maximum of six months off from their paid employment to care for a close relative. Basic social rights for the person taking the caregiver-leave time – such as contributions to pension, unemployment, and health insurance – are taken over by LTC insurance. However, there is no right for continued salary payment or any wage-replacement benefit. Moreover, regular, unannounced quality checks of care institutions, the results of which must be published, were introduced. Taken together, the reform had several aims: financial stability, quality, and subsidiarity. The aim of financial stability was pursued by the implementation of limited benefit increases, and the aim of subsidiarity was pursued by the introduction of caregiver-leave time and a focus on ambulatory-benefit increases. However, these measures also aimed at financial stability. Quality increases seem to have been the aim of the new benefit level and the tightened rules for quality checks. However, overall, financial stability was the primary aim, and the other aims held only secondary positions. The government made this priority of aims clear in its justification of the reform proposal, which stated that financial aspects must be considered first before measures for increasing the quality of care are discussed and implemented.

> For example, we need an answer to the question of how the general care and supervision needs of people with dementia-related disabilities, mental disabilities, or mental illnesses can be better taken into account without financially overburdening long-term-care insurance. (Deutscher Bundestag, 2007, p. 1, own translation)

The Care Redirection Act was passed in 2012 and took effect in 2013. It introduced a number of different measures, including increases in contributions and benefits, publicly subsidized private LTC insurance, the employment of additional care workers in residential care, and improvements in pension crediting. Furthermore, the benefits for people with *impaired everyday expertise* were increased for all forms of care. Further changes included easier access to pension crediting for family caregivers and increased choice in how homecare services can be used. Additional care workers[16] were required to be employed in residential nursing care, especially to care for beneficiaries with *impaired everyday expertise*. These additional care workers were

[16] The law refers to *additional care workers* (*zusätzliche Betreuungskraft*), but in common language, the term *everyday companion* (*Alltagsbegleiter*) is mainly used (Bundesagentur für Arbeit, 2017c).

required to have completed a short, mainly hands-on education program, and their role is described as follows:

> They should provide additional care services only under the guidance of qualified nurses, as part of a team, and in close cooperation with other specialists and should thereby support nursing staff. (Deutscher Bundestag, 2012, p. 46, own translation)

The most-discussed measure of the reform was the introduction of publicly subsidized private LTC insurance.[17] In order to incentivize people to insure privately against the risk of LTC, the state subsidized private LTC insurance plans that applied to a set of safety- and guaranteed benefit rules in the amount of five euros per month. The minimum monthly contribution was set at 15 euros, which included the state subsidy. The payment in case of later LTC dependency is in cash. Again, the reform adopted several aims, including financial stability, quality, growth, subsidiarity, and professionalization. The introduction of privately subsidized LTC insurance aimed at financial stability and growth. The goal of the measure was to unburden public LTC by shifting parts of the financing to the individual via support of the growth of a private insurance market. Benefit increases aimed at quality, and improved pension crediting aimed at facilitating family care and thus at subsidiarity. The employment of additional care workers is particularly interesting under the professionalization aim as the goal of the measure was to increase the number of care workers, but their increased employment undermined demands for the better education of care workers. Nevertheless, the primary aim of the reform was financial stability as the introduction of subsidized private LTC insurance was the main measure of the reform. This primary aim is evident in the reasoning for the introduction of the private LTC insurance, which was to foster the personal responsibility for the costs of LTC and to safeguard the financial stability of the social-LTC-insurance system.

> Complete financing of nursing care and support will continue to depend to a large extent on the adoption of personal responsibility. Additional private personal provision is therefore a central component of the financing of care services. (Deutscher Bundestag, 2012, p. 21, own translation)

In 2014, 2015, and 2016, a series of LTC reforms were passed as Care Strengthening Acts I, II, and III. The first of these reforms became implemented in 2015, while the

[17] Subsidized private LTC insurance is commonly referred to as *Pflege-Bahr* after the Minister of Health and Care at the time, Daniel Bahr. For a thorough description of the design of subsidized private LTC insurance, see Nadash et al. (2012).

latter two were implemented in 2017. Care Strengthening Act I raised contributions and benefits, extended benefits in the homecare setting, initiated a public fund to limit future contribution increases, and included a further extension of additional care workers. Benefits were increased by four percentage points for all forms of care and for all benefit levels as compensation for inflation over the previous three years. These benefit increases were accompanied by the introduction of greater flexibility in using short-term-, respite-, and day-, and night care. Furthermore, alternative living arrangements for care recipients were supported, the subsidies for measures to improve individuals' living environments were increased, and care recipients in homecare gained greater freedom to decide what kinds of services they wanted to use. The government justified these changes by "strengthening homecare arrangements" (Deutscher Bundestag, 2014, p. 1, own translation) and " by improving the quality of life of care recipients and by relieving family caregivers" (Deutscher Bundestag, 2014, p. 2, own translation). A further measure was the introduction of a public fund that was initiated with the intention of limiting future LTC social-insurance contributions. From 2015 until 2033, 0.1% of each year's contributions will be saved in this public fund with the aim of "distributing contribution increases more fairly across generations and of partially relieving future generations from increasing long-term-care-insurance contributions" (Deutscher Bundestag, 2014, p. 18, own translation). As in the prior reform act, Care Strengthening Act I also increased the number of additional care workers in residential-care facilities. The ratio of additional care workers to patients was set at 1:20, which is a reduction of the ratio of 1:24 that had been implemented in the Care Redirection Act. Overall, all implemented measures were small in scope and had several aims. Professionalization was a secondary aim as only the number of care workers was intended to be increased, but the educational standard decreased through the employment of additional care workers. The introduction of the public fund to limit future contribution increases reveals that financial stability was a significant aim. Furthermore, the small improvements for (informal) homecare arrangements indicate that subsidiarity was an aim in the reform and that these measures implicitly supported the aim of financial stability because informal homecare is the least-expensive form of LTC. However, these improvements also had the goal of increasing the quality of care, which was also highlighted by the further increase in the number of additional care workers. Therefore, the significance of financial stability as a primary aim appears to have decreased, whereas quality had developed into a more-important aim. This

balance between financial stability and quality aims can be deduced from the justification of the reform proposal:

> Social long-term-care insurance must be developed further and provide benefits that meet the changing needs and requirements of people in need of care as well as [the needs] of their relatives. […] Finally, provisions should now be made to meet foreseeable challenges in financing social long-term-care insurance that arise due to the demographic development in Germany without placing an unreasonable burden on future generations. (Deutscher Bundestag, 2014, p. 16, own translation)

Care Strengthening Act II was passed in 2015, and the major parts of the law came into effect in 2017. The law increased contributions, introduced a new definition of *in need of care* (which led to a new benefit system with increased benefits and uniform co-payments within the same residential facility), altered quality-assessment procedures, and introduced several small extensions for benefit recipients and family caregivers. The major change that the law introduced was the new definition of *in need of care*. The previous definition had been perceived as being overly strongly oriented toward deficits and physical impairments, and the new definition now also included physical, mental, and psychological impairments in order to assess the degree of dependency. Along with this new definition, care degrees (*Pflegegrade*) were introduced and replaced the prior care steps. Care degrees are labeled from one to five, with a higher number indicating a higher level of dependency. Benefits can still be received in cash, as ambulatory-care services, or as residential-care services. Benefit recipients under the old system were automatically transferred to the new benefit system. Beneficiaries received at least the same amount of benefits as under the old system, and those with mental impairments, such as dementia, usually received more benefits. Furthermore, the co-payment system for residential care was changed. Before the reform, individual co-payments would rise if the care step increased, which led to delayed reassessments of the care step as patients and their families tried to keep the lower care step and thereby also the lower co-payments for as long as possible. In order to change this practice, the reform introduced the same co-payments for each resident in the same residential-care facility. This means that co-payments can vary between facilities, but not within facilities. Furthermore, quality assessment and surveillance were reformed. The former arbitration board for quality assurance (*Schiedsstelle*) became a quality committee (*Qualitätsausschuss*) with more tasks and greater rights. The quality committee thus became responsible for elaborating, implementing, and monitoring new quality standards and for proposing new quantitative and qualitative

minimum-staffing standards in ambulatory and residential LTC. Further changes concerned the improved coverage of family caregivers in the unemployment- and pension-insurance system and the expansion of information- and consultation services for family caregivers. The central measures of this encompassing reform were the introduction of the new definition of *in need of care* and the related changes to the benefit system. These measures all primarily aimed at quality. Furthermore, the launch of a new quality-control system and the introduction of unified staffing standards reveal the high significance of the quality aim. Growth can be depicted as a secondary aim because the number of recipients was expected to increase after the implementation of the reform. Moreover, the implementation of improvements for family caregivers reveals that subsidiarity and financial stability were also aims of the reform. Nevertheless, quality was clearly the primary aim of the reform, and the government expressed it as an expectation of the reform:

> The new concept of *in need of care* will initiate a paradigm shift that will enable even more person-centered and needs-based care. The design of the benefit law in long-term-care insurance will enable an even-more-differentiated range of services and offerings that support local care for people with physical disabilities as well as for people with cognitive impairments. (Deutscher Bundestag, 2015, p. 61, own translation, italics added by author)

Care Strengthening Act III was passed in 2016 and implemented in 2017, the same year that Care Strengthening Act II took effect. The reform package was less extensive than the former, and its main intent was to implement the new definition of *in need of care* in other social codebooks and in regulations at the federal and municipal levels. The government intended to "strengthen the municipal level" (Deutscher Bundestag, 2016b, p. 1, own translation) via the implemented measures, and the reform focused especially on the provision of services at the local level. Municipalities now received more rights and obligations when it came to initiating pilot projects and building infrastructures in cooperation with LTC-insurance funds. One important new rule concerned care staff. Residential-care facilities – which are not bound by collective bargaining agreements – were now able to enforce wages up to the collective-bargaining level in care-rate negotiations. LTC-insurance funds and social-assistance providers had to recognize these wages as economic and to finance them accordingly. Overall, Care Strengthening Act III continued down the path taken by the prior reform and focused on quality as a primary aim, which was intended to be implemented at the local level. Furthermore, the interests of the LTC workforce were explicitly included.

The new rule that wages set by collective bargaining had to be accepted and refunded by LTC-insurance funds fostered interest in increasing wages, and professionalization was thus implemented as a secondary aim.

The Care Occupation Reform Act was passed in 2017 and has been gradually implemented since 2019. Unlike all previous reforms, this reform package did not change the LTC-insurance system; rather, it directly changed educational and occupational regulations for healthcare-, child-healthcare-, and LTC nurses. These three occupations – which have separate educational rules and occupational rights – are now being partially merged into the occupation of general nurse (*Pflegefachfrau / Pflegefachmann*) with an option for specialization in LTC or child healthcare. As before, the education program lasts three years. During the first two years, all apprentices receive the same general education. In the third year, apprentices can choose to further follow a general nursing education or to specialize in LTC or in child healthcare. Federal states have the opportunity to implement an interim examination after two years, which leads to a degree as a care assistant or auxiliary carer. However, whether and how this examination is implemented is up to the federal states, and passing the interim exam is not a requirement for finishing the apprenticeship with a final exam after three years. Academic study programs are being integrated into the framework of the new general-care occupation as these programs include an apprenticeship education and thus qualify graduates for work as a general nurse. Furthermore, schooling tuitions are being abolished; instead, apprentices must be remunerated for the entire duration of their education. The intention and aims of this reform deviate from all prior reforms as this reform only focuses on workers in healthcare and LTC. Therefore, aims such as growth, financial stability, and redistribution do not play an important role in the reform. Professionalization is the primary aim, and the government emphasizes different dimensions of the professionalization aim. Against a background of demographic ageing and the growing lack of care staff (Deutscher Bundestag, 2016a, p. 51), the reform "creates the necessary basis for a sustainable nursing education, for the necessary improvement in the quality of care, and for increasing the attractiveness of the care profession." (Deutscher Bundestag, 2016a, p. 51, own translation). Furthermore, the new general care occupation should "create a new, uniform image of 'care' that is characterized by its own professional self-image alongside the other health professions and that strengthens the identification as a professional" (Deutscher Bundestag, 2016a, p. 52,

own translation). Both statements show that improvements in the social dimension of care – attractiveness, self-image, and professional power – serve as an explicit aim of the reform, whose intention is to increase the number of care workers and the quality of care. Concerning the skill level of the future care workforce, the government will "continue to assume, however, that nursing staff who are trained at nursing schools and who receive an intermediate qualification will continue to form the strongest pillar of the professional field of nursing in Germany in the future" (Deutscher Bundestag, 2016a, pp. 52–53, own translation). Regarding the role of academically trained care workers, the government refers to a publication by the Science Council (*Wissenschaftsrat*) (Deutscher Bundestag, 2016a, p. 53), which is the most-important scientific advisory group of the government. Their publication points out that healthcare- and LTC needs will grow more complex in the future and that 10–20% of the direct-care workforce should therefore be trained academically (Wissenschaftsrat, 2012). Overall, the government is pursuing the aim of professionalization by addressing the quantitative increase in occupational care workers. This aim should be achieved by increasing the attractiveness of the work through the new education system and by offering a wider choice of career options and pathways and a (better) remuneration of apprenticeships. The government has also stated that it supports the aim of professionalization in the social dimension, but that an increase in the skill level dimension is not being pursued. Improving the quality of care has been cited as a secondary aim that should be achieved through the professionalization of the care workforce.

The Care-Worker Strengthening Act was passed in 2018 and implemented in 2019. The reform focuses on both LTC- and healthcare nurses. Concerning work in the LTC sector, a variety of measures were enacted that focus on employing more staff and improving working conditions. In residential care, 13,000 new jobs for care workers who were to be trained as LTC nurses were created. However, if no LTC nurse could be found after four months, the facility was allowed to employ an auxiliary LTC nurse. LTC funds bore the costs for these 13,000 new employees. The rule implemented in Care Strengthening Act III – which states that wages for care workers in residential-care facilities that rely on collective agreements must be found to be economical by the financing agents – was extended to the ambulatory-care sector. Furthermore, money was invested in digital infrastructure with the goal of relieving employees from increasing workloads. Moreover, working conditions were intended to be improved

through investments in workplace health-promotion programs and programs for reconciling work and family life. For family caregivers, access to rehabilitation services was improved. Additionally, the quality-control tool (*Pflege-TÜV*) was reshaped using new tools that were intended to be implemented in residential-care facilities in the second half of 2019. Furthermore, the cooperation of general practitioners and dentists with care facilities was intensified. Although the reform implemented a number of different measures, its primary aim was unambiguous: Against the background of current and future staff shortages in healthcare and LTC, which are coupled with increasing workloads and pressure, the government stated that professionalization in the quantity- and working-conditions dimensions was the primary aim.

> This law therefore aims to provide noticeable relief to the day-to-day work of nursing staff by improving staffing levels and working conditions in nursing care and geriatric care in order to further improve the care and support provided to patients and those in need of care. (Deutscher Bundestag, 2018, p. 1, own translation)

As professionalization is an explicit aim in the quantity- and working-conditions dimensions, it seems that professionalization in the skill-level dimension is only weakly supported – if at all – because the new vacancies for LTC workers can be taken up by auxiliary care workers after a waiting period. The professionalization aim is connected to the secondary aim of improving the quality of care.

The reforms since 2008 have led to numerous changes in the LTC system and to the workforce in LTC. Although each measure has brought with it a specific intention and aim, each reform has followed one primary aim. These primary aims have not remained constant throughout the reforms; instead, they have gradually changed. After the onset of the LTC system, the absence of reforms and thus the lack of benefit increases until the first major reform in 2008 was a strategic action by the governing parties to decrease public costs for LTC and thus to achieve financial stability. This aim of financial stability was pursued further as a primary aim in the Care Further Development Act of 2008 and the Care Redirection Act of 2012. Both reforms highlighted this aim through their investment in and facilitation of family care and thus aimed secondarily at subsidiarity. The aim of increasing quality was also taken up in both reforms but was clearly subordinate to the aim of financial stability. In Care Strengthening Act I in 2014, financial stability continued to serve as the primary aim; however, the aim of quality became more central in the implemented policy measures.

The shift to quality as the primary aim in policymaking was then accomplished by Care Strengthening Act II in 2015. The introduction of the new definition of *in need of care* and the new benefit system was mainly concerned with creating more benefits and with better integrating dependent people with mental impairments into the system. The aims of financial stability and subsidiarity only played a secondary role in the reform. The primary aim of quality was further pursued by Care Strengthening Act III in 2016, which also viewed professionalization as a secondary aim via a rule that funding agencies have to acknowledge collective wages. This shift toward professionalization was taken further by the Care Occupation Reform Act in 2017 and the Care-Worker Strengthening Act in 2018. Both reforms explicitly aimed at increasing the number of LTC workers. The Care Occupation Reform Act also aimed at fostering the professional identity of LTC workers, and the Care-Worker Strengthening Act focused on improving working conditions. Although the Care Occupation Reform Act implemented new rules for the qualification of healthcare- and LTC nurses at universities, increasing the overall skill level in LTC does not appear to have been an aim in either reform. In fact, the intent appears to have been quite the opposite, as indicated by the rule that open vacancies intended for apprenticeship-educated LTC nurses could be filled by auxiliary nurses after a four-month waiting period. Table 11 presents a simplified overview of the reforms and their primary aims.

The policy analysis reveals that the aim of financial stability has been less of a priority in policymaking since about 2012. However, the central institutions of the LTC system have not changed fundamentally and thus still include the aim of financial stability. For example, the German LTC system is still based on the guideline of ambulatory care over residential care. Furthermore, the family remains the most-important source of care and support for the elderly and this role is fostered by several institutions that support family care (including the unconditional cash benefit). These institutions have been slightly improved in nearly every reform. Moreover, co-payments in LTC have remained substantial and even rose during the period. For residential care, the co-payment rose between 1999 and 2015 from 12.4% to 28.7% in Care Step I and from 28.1% to 35.2% in Care Step III (Kochskämper et al., 2019). Hence, although not implemented as such in the reforms since 2015, the aim of financial stability remains important in in the LTC system because the system's main structures and institutions were designed with financial stability in mind, and these institutions have not changed significantly.

Table 11: Reforms in LTC and their primary aims

Name of reform	Year reform was passed	Primary aims implemented in reforms
Care Further Development Act (PfWG)	2008	Financial stability
Care Redirection Act (PNG)	2012	Financial stability
Care Strengthening Act I (PSG I)	2014	Financial stability (quality)
Care Strengthening Act II (PSG II)	2015	Quality
Care Strengthening Act III (PSG III)	2016	Quality (professionalization)
Care Occupation Reform Act (PflBRefG)	2017	Professionalization
Care-Worker Strengthening Act (PpSG)	2018	Professionalization

Source: Own compilation based on own policy analysis. Terms in parentheses mark a secondary aim that is roughly equal to the primary aim.

5.2 Public hearings – The role, function, and participation of organizational actors

Reforms – and thereby also the aims implemented in the reforms – are passed by the governing parties in Parliament. However, this does not mean that the governing parties are solely responsible for all measures and their specific design. All reform acts are discussed with organizational actors and individual experts in a coordinated parliamentary procedure called a public hearing (*öffentliche Anhörung*). Through these hearings, organizational actors take part in the official policymaking process and are able to issue their interests and aims on a reform proposal. The actors thereby have the possibility to influence the measures and the direction of the reform. Hence, if organizations influence the reforms, organizations that pursue similar aims to those implemented in a reform should be the most involved in the public hearing of that reform.

5.2.1 The role and function of public hearings

Public hearings are consultative processes held by the responsible parliamentary committee of the First Parliamentary Chamber (*Bundestag*) (Ismayr, 2009). For topics concerning LTC, the Health Committee (*Auschuss für Gesundheit*) is usually primarily responsible. Public hearings can be held for general policy proposals that have not yet become part of the parliamentary process and for reforms that have already been debated in Parliament but not yet passed by Parliament. For the majority of more-encompassing reforms, hearings are held (Ismayr, 2009), as was the case for all seven analyzed reforms. In these hearings, parties invite organized interest organizations and

individual experts according to their legislative shares. Prior to the hearings, invited experts and organizations are able to comment on the proposed reform act by submitting a written statement, though non-invited experts and organizations can also submit a written statement (Ismayr, 2009). However, the main part of the hearing is the oral discussion, during which the committee members ask questions and direct each question to one or more of the invited experts and organizations. The allotted time each party receives for questioning depends on the party's shares in Parliament (Ismayr, 2009). Each party can freely choose who should answer their question, but parties usually call experts and organizations "from whom they expect (to some extent) argumentative support of their own position" (Ismayr, 2009, p. 411, own translation). The proceedings in the public hearings are strictly ordered. It is uncommon for discussions – both between parliamentarians and between parliamentarians and invited organizations and experts – or heckling to take place during the hearings (Ismayr, 2009). Although organizations influence policymaking in many other ways (especially in more-informal ways), the hearings are an important way to publicize organized interests to both the whole Parliament and the interested public (Ismayr, 2009).

Public hearings fulfil at least three functions: informing, aggregating interests, and legitimizing (Spohr, 2018). First, public hearings inform the members of the parliamentary committees about a topic by providing them with additional information on different aspects of a reform proposal. Second, public hearings aggregate interests by showing the interests of different political and societal groups in light of opposing interests and by illuminating the potential effects of policies for different actors and societal groups. Third, opposition and the government both invite interest organizations and experts that back and thereby legitimize their own positions (Spohr, 2018).

Public hearings have been used to measure the involvement and influence of organizations in parliamentary decisions (Beyme, 1998; Eising & Spohr, 2017). However, the usage of public hearings as a data source has been criticized because influential interest organizations already participate informally in the initiation process of the reforms and are therefore less-frequently asked to comment on the proposed law in the oral part of the public hearings (von Winter, 2007a). Hence, weak interest organizations might appear more influential because they are invited and questioned by the government parties in the oral part of the hearings as often as are strong interest organizations because government parties can show that weak interests are also heard.

Moreover, weak interest organizations might appear more influential because they are invited and questioned by the opposition in order to present counter positions to the proposed reform (von Winter, 2007a). Public hearings certainly cannot reveal any information on informal influences by interest organizations in the early stages of drafting a law, but it is difficult to believe that there are highly influential actors that participate in these early stages and that are then excluded when debating and legitimizing a legislation publicly. Furthermore, for all organizations (even for those that have been involved informally), "committees are an important venue for organizations that want to move bills closer to their preferences" (Eising & Spohr, 2017, p. 319). Beyme (1998, p. 47) even goes so far as to claim that "invitations to hearings are a significant indicator of influence." Eising and Spohr (2017, p. 319) are more judicious in their argument that "[h]aving access to policy-makers signals political importance and is often a necessary step towards achieving influence, but is not equal to influence." In any case, the data of the public hearings on LTC bills in Germany serve as a rich database for analyzing actor constellations and the party alignments of interest organizations as well as for evaluating the arguments of a debate, its central conflict lines, and the positions of the interest organizations.

5.2.2 The presence of organizations in public hearings

A first step in analyzing the involvement of organizations involves determining which organizations participate in the public hearings. Hence, the appearance of each organization is counted, and organizations are ordered into predefined categories. Organizations are categorized according to the general interests they pursue. All categories – except for the last two in the list below, which are added with regard to the data – are adopted from Bandelow's (2006) and Voges' (2002) work. These categories are *occupational organizations*, *trade unions*, *social welfare organizations*, *business organizations*, *system organizations*, *patient organizations*, *education- and research organizations*, *other*, and *individual experts*. All organizations that participated in public hearings are ordered into these categories using information from the organizations' websites concerning their work, their interests, and their members.[18] The category of *occupational organizations* includes organizations that represent care staff, such as LTC- and healthcare nurses, social carers, and midwives as well as

[18] A list of all organizations and their categorization – including the number of written statements, the number of public hearings with at least one oral statement, and the number of total statements in all seven public hearings – is included in the Data and Methods Appendix (see Table 17Table 17).

representatives of physicians. *Trade unions* incorporate organizations that have the mandate to negotiate collective agreements. The category of *social welfare organizations* includes non-profit service providers. The category of *business organizations* also subsumes service providers, but organizations primarily represent private employers with economic interests and general business interests. *System organizations* are defined as organizations that are mainly involved in implementing reforms and organizing the administrative processes of the LTC system. These organizations are often state- or para-state actors or are at least highly regulated by laws. *Patient organizations* represent the interests of individuals who are involved in the LTC system as patients, patient groups, family caregivers, or general consumers. *Education- and research organizations* offer educational degrees and training for LTC workers or engage in research on care. Organizations are grouped into the category of *other* if they have multiple roles and a dominant role cannot be depicted. *Individual experts* form a separate category. Most experts are researchers who hold a professorship.

Overall, 153 organizations and 50 individual experts participated via written statements and/or in the oral part of the seven hearings. Table 12 reveals that the number of organizations in the categories varies considerably from between three for the category of trade unions to 41 for occupational organizations.

Table 12: Number of organizations in each category that participated in at least one of the seven public hearings on LTC reforms in the written or oral part (2008–2018)

Category of organizations	Number of organizations
Occupational organizations	41
Trade unions	3
Patient organizations	38
Social welfare organizations	11
Business organizations	27
System organizations	13
Education- and research organizations	10
Other	10
Individual experts	50

Source: Own data based on analyses of the seven public hearings on LTC reforms between 2008 and 2018.

The most-involved individual organizations in the public hearings – hereafter called *top organizations* – are identified via three separate analyses of the public-hearing

data: the *number of written statements*, the *number of public hearings with at least one oral answer*, and the *total number of oral answers* in all seven public hearings. In general, organizations that appear at the top of these three analyses are evaluated as top organizations.[19] These organizations have been continuously involved in the public hearings and thus constitute the core of an organizational LTC policy network. Twenty-two organizations are evaluated as being top organizations.[20] Table 13 lists these organizations and reveals the type of organization to which they belong. The category of education and research is the only group without a top organization. For all other categories, the number of top organizations varies from between two and seven. In comparing all categorized organizations and the list of top organizations (i.e., Tables 12 and 13), it is striking that occupational organizations yield the highest number of participating organizations, while only two occupational organizations belong to the top organizations. This finding might indicate that occupational organizations have a large desire to participate in policymaking and to belong to the organizational policy network in LTC but that their acceptance and inclusion by the political parties is rather low and difficult to achieve. The other extreme is occupied by the category of trade unions. Only three trade unions or peak organizations are engaged in the public hearings, two of which are among the most-influential actors in the organizational LTC network.

[19] For a full description of the methods adopted to obtain these top organizations, please refer to the Data and Methods Appendix.

[20] The focus of the study and this chapter is solely on organizational actors; however, similar to the analysis of the involvement of organizations, the analysis of individual expert involvement reveals that some experts are more involved in public hearings than others. Only five experts issued written statements on more than one law: Heinz Rothgang (4), Eckart Bomsdorf (2), Ralf Suhr (2), Klaus Wingenfeld (2), and Gregor Thüsing (2). These five experts and expert Stefan Görres are the only experts to provide an oral answer in at least two public hearings, with Heinz Rothgang even providing answers in four. Moreover, when it comes to the total number of oral answers, Heinz Rothgang stands out with 25 separate statements, followed by Joachim Wilbers (8), Gregor Thüsing (8), and Eckart Bomsdorf (6).

Table 13: Most-involved organizations in LTC reforms based on public hearings (2008–2018), and their hypothesized primary aims

Top organizations in organizational groups	Hypothesized primary aims of organizations
Occupational organizations	Professionalization
DBfK – German Care Occupations Association DPR – German Care Council	
Trade unions	Professionalization & redistribution
DGB – Federation of German Trade Unions Ver.di – United Service Labor Union	
Patient organizations	Quality
BAG Selbsthilfe – Federal Association for Self-Help BAGSO – National Federation of Senior Citizen Organizations DAlzG – German Alzheimer Society Deutscher Frauenrat – German Women's Council SoVD – Social Association Germany VdK – Social Association VdK Germany Verbraucherzentrale Bundesverband – Federation of German Consumer Organizations	
Social welfare organizations	Redistribution & quality or growth & financial stability
AWO – Workers' Welfare Association BAGFW – National association of the Free Social Welfare Organizations Caritas Diakonie Deutscher Paritätischer Wohlfahrtsverband	
Business organizations	Growth & financial stability
BDA – German Employers' Association Bpa – Association of Private Social Service Providers Kommunale Spitzenverbände – National Association of Municipal Peak Associations	
System organizations	Financial stability & redistribution
GKV Spitzenverband –Peak Association of Statutory Health and LTC Insurers PKV Spitzenverband – Peak Organization of the Private Health and LTC Insurers MDS – Medical Service of the Peak Association of Statutory Health and LTC Insurers	

Source: Own data based on analyses of the public hearings on LTC reforms between 2008 and 2018.

The top organizations from the same category should share the aims of their organizational category.[21] However, slight differences in interests and aims might arise from differences in the member of organizations, the history of the organizations, and the general purpose of the organizations. Hence, the top organizations are briefly

[21] In this section, the primary aims of organizations within the same category are only outlined. For a thorough theoretical discussion, see Section 2.3.3.

introduced, and possible deviations from the primary aims of the organizational category are outlined.

Occupational organizations should adopt professionalization as their primary aim as they represent the interests of a specific occupational group. The German Care Occupations Association (*DBfK, Deutscher Berufsverband für Pflegeberufe*) and the German Care Council (*DPR, Deutscher Pflegerat e.V. Bundesarbeitsgemeinschaft Pflege- und Hebammenwesen*) are the two top occupational organizations in the LTC reforms. The Care Occupations Association has roots that go back to the early 20th century, and it organizes individual care workers. Until the early 1990s, it mainly represented healthcare nurses' interests, but since then, the organization has also begun to represent healthcare, LTC, and child-healthcare nurses as well as auxiliary carers and carers with a university degree (Schroeder, 2018). Schroeder (2018) states that in 2018, the German Care Occupations Association had about 25,000 members, about 3,500 of whom were LTC nurses. The association was a founding member of the Care Council (DBfK, 2018a). The interests of the Care Occupations Association concern the professionalization of care occupations through self-organization, professional recognition, a board of nursing and care, and improved working conditions (DBfK, 2018b, 2020). The Care Council is an umbrella organization for different occupational organizations of care workers, including healthcare-, child-healthcare-, and LTC nurses as well as midwives (DPR, 2018a). At present, the Care Council has 16 member organizations (DPR, 2018b). The Care Council coordinates and pools the activities and interests of the member organizations and aims for better qualification and education, better career pathways, and better general conditions in care work. Moreover, self-administration and boards of nursing and care are backed by the Care Council (DPR, 2018a). In the public hearings, both occupational organizations should adopt professionalization as their primary aim, but due to the Care Council's form as an umbrella organization, its interests might be broader and more moderate than those of the German Care Occupations Association.

Trade unions organize employees and represent their interests, which should lead to professionalization and solidarity in the sense of redistribution as their adopted primary aims (Schölkopf, 2000). Ver.di (*Vereinigte Dienstleistungsgewerkschaft, United Service Labor Union*) is the union for all service workers and organizes more than 1,000 different occupations in the service sector. Ver.di can negotiate collective agreements in LTC; however, the structure of LTC providers (and particularly the

separate labor laws for Church-affiliated providers and the high number of private providers with only few employees) and the fact that a counterpart for negotiations on the employer side has long been missing[22] complicate and hamper collective bargaining. With this mandate to negotiate collective agreements, ver.di should especially support professionalization and focus on improving working conditions for LTC workers. The DGB (*Deutscher Gewerkschaftsbund, Federation of German Trade Unions*) is the umbrella organization for trade unions. Founded in 1949, eight trade unions are currently members, with ver.di being one of them. The DGB represents about six million individual members (DGB, 2018a). As an umbrella organization of unions, it does not negotiate collective agreements. Instead, the DGB's role is mainly to coordinate and support the activities of the member unions and to support the interests and rights of employees with a strong and consistent voice at the national and international level (DGB, 2018b). In the public hearings, DGB and ver.di should pursue similar interests and aims and primarily focus on the professionalization of working conditions. However, the DGB might formulate broader and more-moderate interests due to its role as an umbrella organization.

Patient organizations organize patients, informal caregivers, and consumers in the care market and should thus mainly advocate for the aim of quality. However, many of the patient organizations that participate in public hearings do not solely focus on LTC (Bandelow, 2006). The Federal Association for Self-Help (*BAG Selbsthilfe, Bundesarbeitsgemeinschaft Selbsthilfe*) represents the interests of people with disabilities and of the chronically ill and their relatives. The interests focus mainly on people of working age (BAG Selbsthilfe, 2018). The National Federation of Senior Citizen Organizations (*BAGSO, Bundesarbeitsgemeinschaft der Seniorenorganisationen*) is an umbrella organization of senior-citizen organizations and describes itself as a "lobby for older people in Germany" (BAGSO, 2018). The German Alzheimer Society (*DAlZG, Deutsche Alzheimer Gesellschaft*) is an association of self-help organizations of patients with Alzheimer's disease and their relatives (Deutsche Alzheimer Gesellschaft, 2018). The organization strives to increase societal awareness for Alzheimer's disease and to support patients and their relatives. The "relief of relatives" (Deutsche Alzheimer Gesellschaft, 2018) is a central

[22] The employer association bpa Arbeitgeberverband was only founded in 2015. Although it has strong ties with the organization Association of Private Social Service Providers (bpa), these two are separate organizations bpa Arbeitgeberverband (2020).

aim of the society. Social Association Germany (*SoVD, Sozialverband Deutschland*) and Social Association VdK Germany (*VdK, Sozialverband VdK Deutschland*) are two social organizations that both have their roots in the support for war victims after the First and Second World War. This similar orientation has led to competition between the two organizations that is still present today (von Winter, 2007b). Due to the natural decrease in the number of war victims over time, both organization now focus more on the disabled and the aged (von Winter, 2007b). The German Women's Council (*Deutscher Frauenrat*) is the umbrella organization of national women's organizations (Deutscher Frauenrat, 2018). Its activities are mainly targeted at the national political level and focus on all aspects of society in which gender issues and gender inequality play a role (Deutscher Frauenrat, 2018). The Federation of German Consumer Organizations (*vzbv, Verbraucherzentrale Bundesverband*) is the peak organization of consumer organizations and operated until 2013 under the Federal Ministry for Agriculture and Food. Since then, it has operated under the Ministry of Law (Verbraucherzentrale Bundesverband, 2018). As a consumer organization, its task is to fight for fair markets and consumer rights in a number of different fields (e.g., food, energy, finances). When it comes to LTC, the Federation of German Consumer Organizations represents the interests of consumers in the LTC market who are the recipients of care services (Verbraucherzentrale Bundesverband, 2020). In the public hearings, all of these patient organizations should thus adopt quality as a primary aim. However, for the Alzheimer Society, the aim of subsidiarity might also be important as the society advocates for patients and their relatives. For the Women's Council, subsidiarity would probably not constitute an adopted aim, but the council might focus its attention more on the primarily female workforce and thus explicitly adopt professionalization as a primary aim.

Social welfare organizations have a long history in the German welfare system and are free, non-profit organizations. It is difficult to hypothesize which aims and interests they pursue in LTC as they play a dual role (Schmid & Mansour, 2007): On the one hand, they are service providers and employers in LTC, which should indicate that growth and financial stability are their primary aims; on the other hand, they are advocates for weak societal groups, which should indicate that quality and redistribution are their primary aims. The National Association of the Free Social Welfare Organizations (*BAGFW, Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege*) is the umbrella organization of the six social welfare organizations,

which are Caritas (*Caritasverband*), the Diakonie (*Diakonisches Werk*), the Workers' Welfare Association (*AWO, Arbeiterwohlfahrt*), the Paritätischer (*Deutscher Paritätischer Wohlfahrtsverband*), the German Red Cross (*DRK, Deutsches Rote Kreuz*), and the Social Welfare Organization of the Jews in Germany (*ZWST, Zentralwohlfahrtsstelle der Juden in Deutschland*) (Sachße, 2011). The Paritätischer is an association of independent and neutral organizations in the social-care sector that does not provide (many) social-care services itself but functions as an umbrella organization for more than 9,000 social-care organizations (Schmid & Mansour, 2007). The Paritätischer concentrates on supporting the organizations and on organizing and voicing their interests (Schmid & Mansour, 2007). The Workers' Welfare Association has historically close ties to the labor movement and the Social Democratic Party (Schmid & Mansour, 2007). Caritas is organized within the structures of the Catholic Church (Schmid & Mansour, 2007). It is the largest social welfare organization in terms of employees, social-service recipients, and members (Schmid & Mansour, 2007). *The Diakonie* is organized within the Protestant Church (Schmid & Mansour, 2007). Special employment rules apply to both *Caritas* and the Diakonie as they are Church-affiliated organizations. The pay schemes are usually oriented toward public-payment schemes; however, the *guidelines for working contracts* (*Richtlinien für Arbeitsverträge, AVR*) are not collective agreements as they are not negotiated with trade unions (Thüsing, 2006). Furthermore, employees of Caritas and the Diakonie are not allowed to go on strike (Thüsing, 2006). These differences in labor rights might lead to different positions between Church-affiliated and secular social welfare organizations. As Church-affiliated social welfare organizations do not perceive the threat of a strike, they might more-strongly embrace their role as employers and pursue more growth aims that coincide with the adoption of more deprofessionalization positions than would their secular counterparts.

Business organizations are the providers of social-care services and hence also the employers of LTC workers. They should adopt growth and financial stability as primary aims (Bandelow, 2006; Voges, 2002). *The Association of Private Social Service Providers* (*bpa, Bundesverband privater Anbieter sozialer Dienste e. V.*) represents private social-care enterprises (bpa, 2018a). It does not have the competency to negotiate collective agreements, and the main task is thus to organize members' interests and to voice them to the public and to political actors (bpa, 2018a). According to the association's own statements on its website, it represents one-third

of all care organizations in Germany (bpa, 2018b). The German Employers' Association (*BDA, Bundesvereinigung der Deutschen Arbeitgeberverbände*) is the peak association of employer organizations in Germany. Its members are federal- and sector-specific employers' organizations, with the Association of Private Social Service Providers being one of them (BDA, 2020). All wage-policy competences lie at the level of the specialized employers' organizations, of which the individual companies are members. Therefore, the role of the German Employers' Association lies primarily in issuing and lobbying for general employer interests (Schroeder, 2007). The National Association of Municipal Peak Associations (*Bundesvereinigung der kommunalen Spitzenverbände*) unites the interests of German cities, towns, municipalities, and rural districts (Deutscher Städtetag, 2018). All three top organizations focus on the primary aims of organizations in this category – that is, growth and financial stability. However, the aim of growth should have a higher value for the Association of Private Social Service Providers and the German Employers' Association because these associations represent private employers, who perceive higher pressure to earn a profit than do public providers, which are represented by the National Association of Municipal Peak Associations.

System organizations are state- or para-state organizations that fulfil entrusted tasks from the state. Therefore, they generally focus on the appropriate functioning of the LTC system not only for the present but also for the future, which leads to the assumption that financial stability and redistribution are the primary aims of these organizations (Bandelow, 2006; Voges, 2002). The Peak Association of Statutory Health and LTC Insurers (*GKV-Spitzenverband*) has been the peak organization of all statutory healthcare and LTC-insurance funds since 2008 (GKV-Spitzenverband, 2018b). It is responsible for establishing general frameworks for all public-healthcare funds and negotiates contracts on reimbursement rules, staffing levels, and quality measures that apply to all statutory healthcare- and LTC funds (GKV-Spitzenverband, 2018a). The Peak Organization of the Private Health and LTC Insurers (*PKV-Spitzenverband*) is equivalent to the Peak Association of Statutory Health and LTC Insurers and represents all private healthcare and LTC funds (PKV, 2018). The Medical Service of the Peak Association of Statutory Health and LTC Insurers (*MDS, Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen*) is the peak organization of the *federal Medical Service of the Statutory Healthcare Funds* (*MDK, Medizinischer Dienst der Krankenversicherung*). The MDK performs the assessment

procedure for LTC applicants and determines their degree of dependency and benefit level (MDS, 2018). The MDS functions as an expert organization for informing statutory healthcare- and LTC funds, coordinating the federal MDKs, and securing the same standards for the medical-review process for all LTC applicants (MDS, 2018). These three top organizations might have different primary aims. In addition to their role of organizing framework agreements with service providers, private-insurance companies also offer additional private insurance for LTC (PKV, 2018). Thus, the Peak Organization of the Private Health and LTC Insurers should have a strong interest in a growing LTC market, which might stand in conflict with the aim of financial stability and thus open up the possibility of adopting professionalization aims or of not adopting deprofessionalization positions. The organization and supervision of the medical-review process in LTC gives the MDS a crucial position in reference to costs. How the MDS assesses a patient determines the amount of benefits a patient can claim and therefore the costs of the LTC system. Thus, financial stability might be a more-pronounced aim for the MDS than for other system organizations, which might lead to even-more-explicit support of deprofessionalization than is the case for any other system organization.

5.3 The involvement of organizational actors in LTC reforms

The previous section revealed which organizations participated in the public hearings and outlined how these organizations can deviate from the main aim of the organizational group to which they belong. Nevertheless, the question of how involved the top organizations and the organizational groups were in each hearing, which political party they were involved with, and how their involvement developed over time remain open and are addressed in this section. Involvement in a public hearing – which is conceptualized as giving an answer to a question that a political party directs toward one specific organization in the oral part of a hearing – reveals which organizations are potentially influential in the policymaking process (Eising & Spohr, 2017). The more an organization is involved in a public hearing and the more this involvement takes the form of answers to questions asked by a governing party (which decides on the final content of a reform), the higher the potential influence of an organization can be on the reform content. Thus, if organizations are influential actors in a LTC-policy-reform process and if they shape the direction of a reform, the

organizations that pursue the aims implemented in the LTC reforms should be involved the most, with particularly high involvement generated by questions from the government parties.

System organizations are hypothesized to aim nearly exclusively at financial stability (Voges, 2002) and should thus have been the most-involved actors in the Care Further Development Act and the Care Redirection Act as these reforms aimed at securing financial stability. These organizations should also have been the most involved in Care Strengthening Act I, in which financial stability remained the most-important aim. However, patient organizations – which are hypothesized to primarily focus on the aim of quality (Bandelow, 2006) – should have been roughly equally involved in this reform because quality is an important secondary aim. Patient organizations should have been the most-involved actors in Care Strengthening Acts II and III as quality constituted the primary aim in these reforms. In Care Strengthening Act III, professionalization was integrated as an important secondary aim, which should have led to a high involvement of occupational organizations as these organizations pursue professionalization as their sole primary aim (Voges, 2002). Accordingly, occupational organizations should have been the most involved in the Care Occupation Reform Act and the Care-Worker Strengthening Act, which aimed for a professionalized workforce. These hypotheses on organizational involvement in the public hearings only focus on the most-involved organizations; however, this does not mean that no other organizations participated or that the involvement of these most-involved organizations and of other organizations did not change. For example, trade unions should adopt professionalization as one of their primary aims and should hence have been more involved in the last three public hearings than in all other prior hearings. Table 14 depicts the hypothesized most-involved organizations in the seven LTC-reform hearings. The involvement of organizations – both as groups and individually – is measured by the share of answers in each public hearing (see Data and Methods Appendix for detailed information on data and methods).

Table 14: Hypothesized most-involved organizations in public hearings

Reform / Organizational group	PfWG	PNG	PSG I	PSG II	PSG III	PflBRefG	PpSG
System organizations	■	■	■				
Patient organizations			■	■	■		
Occupational organizations					■	■	■
Social welfare organizations							
Trade unions							
Business organizations							

Source: Own compilation. Note: Dark-grey cells mark the hypothesized most-involved organizations in each reform. Abbreviations, full name of reforms, and year reform was passed: Care Further Development Act (PfWG) in 2008, Care Redirection Act (PNG) in 2012, Care Strengthening Act I (PSG I) in 2014, Care Strengthening Act II (PSG II) in 2015, Care Strengthening Act III (PSG III) in 2016, Care Occupation Reform Act (PflBRefG) in 2017, and Care-Worker Strengthening Act (PpSG) in 2018.

5.3.1 The number and distribution of answers in the public hearings

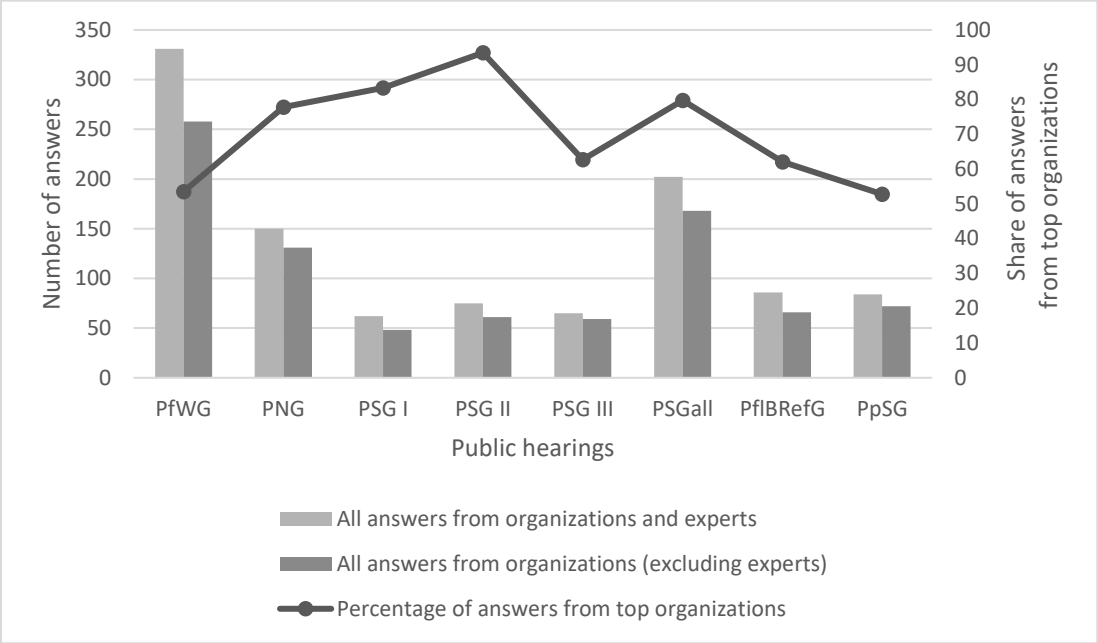
Overall, the public hearings display a consolidation process of the involved organizations. In the public hearings on the first two reform acts (i.e., Care Further Development Act and Care Redirection Act), the total number of answers were two to four times as high as in the five following reform hearings (see Figure 26). Furthermore, from the first to the fourth public hearing, the top organizations increased their share of answers from among the total number of answers given by organizations (see Figure 26). In the Care Further Development Act, about 50% of all answers were given by the top organizations compared with 90% of answers in Care Strengthening Act II. However, in the following three reforms, this share decreased to about 50–60%.

These numbers and developments can be explained in light of the historic policy background of the LTC system. The high number of total answers in the first two reforms might be connected to the long period without the implementation of any major reforms. No major reform was enacted after the setup of the LTC system in 1995/96 until the Care Further Development Act in 2008, and consequently, no public hearings on LTC reforms were held before then. As a result, information on problems in the LTC system and on the organizations in the system was missing. On the one hand, information on the deficiencies of the LTC system was scarce and incomplete,

and more questions might therefore have been asked than in later public hearings. On the other hand, information on the interests of organizations was missing, and connections and alliances between organizations and political parties might therefore been weak or undeveloped. Hence, the information-gathering function of public hearings seems to have been the most important in the first two hearings. After these first two public hearings, this lack of information seems to have been resolved, which led to fewer answers and a smaller number of organizations that were asked questions.

The decreasing share of answers given by top organizations since Care Strengthening Act III might reveal two developments: On the one hand, new organizations might be shown to have entered the LTC policy network; on the other hand, the development might have been related to the content of the reforms. The last two reforms (i.e., the Care Occupation Reform Act and the Care-Worker Strengthening Act) had a different focus compared with the first reforms. The Care Occupation Reform Act changed the occupational law and not the LTC-insurance law (Social Codebook XI). The Care-Worker Strengthening Act included measures for employees in LTC and in the healthcare system. Hence, the invited and involved organizations in the last two public hearings could have deviated more from the prior five public hearings. Thus, a changing policy network in the mid- to late 2010s is possible but cannot be deduced from the data.

Figure 26: Total number of given answers and percentage of answers from top organizations in the public hearings



Source: Own calculations based the public hearings on LTC reforms. Note: The *share of answers from top organizations* was calculated based on the total number of answers from organizations, excluding answers from individual experts. Abbreviations, full name of reforms, and year reform was passed: Care Further Development Act (PfWG) in 2008, Care Redirection Act (PNG) in 2012, Care Strengthening Act I (PSG I) in 2014, Care Strengthening Act II (PSG II) in 2015, Care Strengthening Act III (PSG III) in 2016, Care Occupation Reform Act (PflBRefG) in 2017, and Care-Worker Strengthening Act (PpSG) in 2018.

5.3.2 The involvement of organizations in the public hearings

The policy analysis revealed that reform aims moved from financial stability to quality and professionalization over the studied period. Organizations that pursue these aims as their primary aims were expected to have been most involved in the corresponding reforms. Overall, the comparison of primary-reform aims and the involvement of organizations with the same hypothesized primary aims reveals an overlap. Table 15 matches the hypothesized and actual most-involved organizations in the public hearings based on the share of answers that organizations gave to questions from government parties (see Figure 27). Financial stability was the primary aim of the first two reforms (i.e., the Care Further Development Act and the Care Redirection Act) and partly of the third reform (i.e., Care Strengthening Act I). System organizations can be seen – as expected – to have been the most-involved group as they were questioned the most from the government parties in all three reforms. However, the government parties posed the same share of questions to patient organizations (18.5%) in the first reform and to social welfare organizations (19.0%) in the third reform. Furthermore, the share of answers from system organizations to questions from the

government was about similar in the Care Redirection Act (~30%),which aimed at financial stability, as in Care Strengthening Acts II and III, which aimed at quality, although quality is not considered a primary aim of system organizations.

The aim of quality was the sole primary aim of Care Strengthening Act II. As expected, in the corresponding public hearing, patient organizations, which should pursue quality as their primary aim, gave the highest share of answers to questions from the government for all hearings (28.3%). However, in this public hearing, system organizations were again the most-involved organizational groups because the government parties questioned these organizations the most (32.1%). Furthermore, in the reforms prior and after (i.e., in Care Strengthening Act I and Care Strengthening Act III), quality was either the primary or an important aim, but government parties questioned patient organizations below the mean in all public hearings.

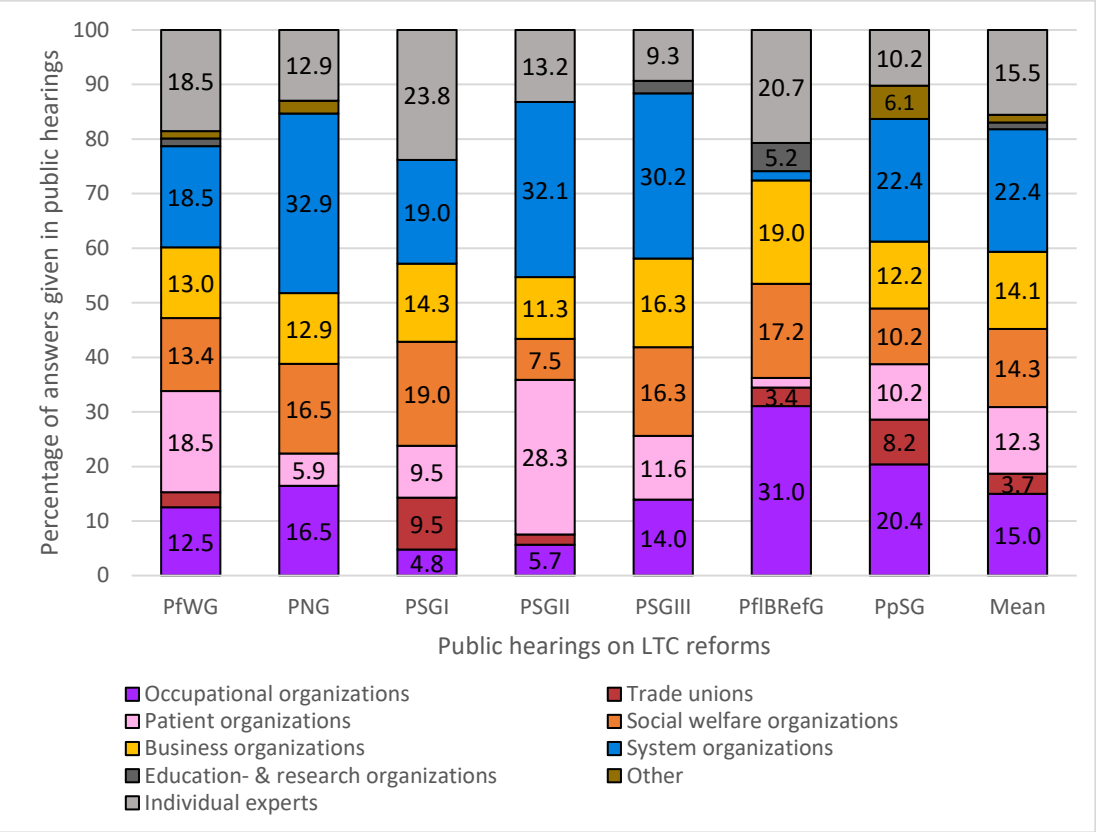
Professionalization was the primary aim in the last two reforms (i.e., the Care Occupation Reform Act and the Care-Worker Strengthening Act). As expected, occupational organizations, which should primarily pursue the aim of professionalization, answered a higher percentage of questions from the government than they did in any other reform. However, in the Care-Worker Strengthening Act, occupational organizations answered only the second-highest number of questions from the government (20.4%), with system organizations answering the most (22.4%).

Table 15: Hypothesized and actual most-involved organizations in public hearings

Reform / Organizational group	PfWG	PNG	PSG I	PSG II	PSG III	PflBRefG	PpSG
System organizations	X	X	X	X	X		X
Patient organizations	X			X			
Occupational organizations						X	X
Social welfare organizations			X				
Trade unions							
Business organizations							

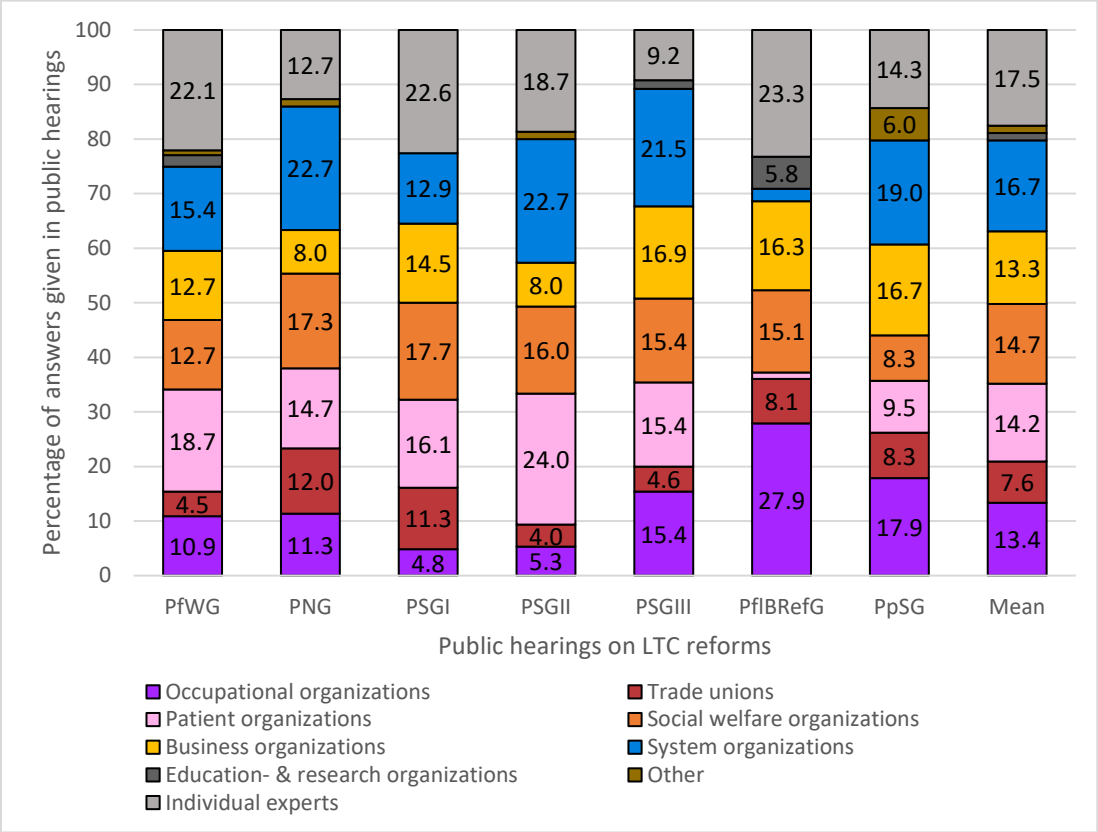
Source: Based on public hearings on LTC reforms. Note: Dark-grey cells mark hypothesized most-involved organizations in each reform, and X's mark actual most-involved organizations based on the share of answers organizations gave to questions posed by government parties in each public hearing. Abbreviations, full name of reforms, and year reform was passed: Care Further Development Act (PfWG) in 2008, Care Redirection Act (PNG) in 2012, Care Strengthening Act I (PSG I) in 2014, Care Strengthening Act II (PSG II) in 2015, Care Strengthening Act III (PSG III) in 2016, Care Occupation Reform Act (PflBRefG) in 2017, and Care-Worker Strengthening Act (PpSG) in 2018.

Figure 27: Share of answers given in public hearings by organizations to questions from government parties



Source: Own calculations based on public hearings on LTC reforms. Note: *Mean* refers to the mean of shares across the seven public hearings. Abbreviations, full name of reforms, and year reform was passed: Care Further Development Act (PfWG) in 2008, Care Redirection Act (PNG) in 2012, Care Strengthening Act I (PSG I) in 2014, Care Strengthening Act II (PSG II) in 2015, Care Strengthening Act III (PSG III) in 2016, Care Occupation Reform Act (PflBRefG) in 2017, and Care-Worker Strengthening Act (PpSG) in 2018.

Figure 28: Share of answers given in public hearings by organizations to questions from all parties



Source: Own calculations based on public hearings on LTC reforms. Note: *Mean* refers to the mean of shares across the seven hearings. Abbreviations, full name of reforms, and year reform was passed: Care Further Development Act (PfWG) in 2008, Care Redirection Act (PNG) in 2012, Care Strengthening Act I (PSG I) in 2014, Care Strengthening Act II (PSG II) in 2015, Care Strengthening Act III (PSG III) in 2016, Care Occupation Reform Act (PflBRefG) in 2017, and Care-Worker Strengthening Act (PpSG) in 2018.

Focusing on the involvement of organizational groups (see Figures 27 and 28) and the top organizations (see Figure 29) over time, system organizations stand out as the most-involved group of organizations in all public hearings – except for the Care Occupation Reform Act – when focusing on the share of answers given to questions from government parties. The involvement of system organizations stemming from questions from government parties was higher than their involvement stemming from questions from all parties. Across all reforms, they gave 16.7% of all answers and 22.4% of all answers to questions from government parties (see Figure 27 and 28). The Peak Association of Statutory Health and LTC Insurers constituted the central organization in the network of top organizations from the second to the fifth public hearing (see Figure 29). The Peak Organization of the Private Health and LTC Insurers was less central in most networks except for the public hearing on the Care Redirection Act, which introduced private, subsidized LTC insurance. This measure was proposed

by the Liberal Party, which also led the Federal Ministry of Health at the time of the reform and was thus responsible for the reform. 22.7% of the answers that the Liberal Party received to its questions came from the Peak Organization of the Private Health and LTC Insurers in this hearing (see Figure 29B). This is one of the largest ties between a governing party and a top organization in all public hearings and indicates a high involvement in the exact formulation of private, subsidized LTC insurance, for which the private insurance companies are the providers.

The involvement of business organizations appears to have been rather stable over all public hearings. Business organizations were questioned roughly equally by government parties and by all parties (overall mean: 13.3%; government mean: 14.1%). The highest involvement of business organizations – measured as the share of questions posed by government parties toward these organizations – occurred in the Care Occupation Reform Act (19%), which seems reasonable because business organizations were affected by the changing education system as future employers of the new care workers. At least one of the top business organizations participated orally in each public hearing. Political parties on the right (i.e., Christian parties and the Liberal Party) posed more questions to the top business organizations than did parties from the political left (i.e., the Social Democrats, the Greens, and the Left) (see Figure 29).

Social welfare organizations were continuously involved in all hearings and answered a similar share of question from all parties and from government parties (14.7% and 14.3%). The highest share of answers to questions from the government was achieved in Care Strengthening Act I (19%). Top social welfare organizations were present in all hearings (see Figure 29). They were asked questions from all political parties and showed no tendency to be more-frequently asked a question by the political right or left or by the government or opposition. Caritas was a central actor in all networks except for the last two reforms, which focused more on the aim of professionalization. The constant questioning of social welfare organizations from all parties did not enable a determination as to whether social welfare organizations had more-frequently pursued their interests as employers or as advocates of weak societal groups.

The extent to which patient organizations were involved varied strongly across the seven public hearings as they answered between 1.7% to 28.3% of questions posed by government parties. The highest involvement was achieved in Care Strengthening Act

II, which changed the definition of *in need of care* and the whole benefit system, both of which are part of the LTC system that have a direct effect on patient services and benefits. The lowest involvement was measured for the Care Occupation Reform Act. In the first five reforms, several top patient organizations were part of the policy network. These organizations completely vanished from the network in the Care Occupation Reform Act, and only one top patient organization was present in the network of the Care-Worker Strengthening Act (see Figure 29).

Trade Unions constituted a low-involved group across all public hearings, answering on average 7.6% of questions posed by all parties and 3.7% of questions posed by the government. Government parties did not ask trade unions a single question in two public hearings (Care Redirection Act and Care Strengthening Act III). The Left party received answers from at least one of the two trade unions involved in the top organization networks in every public hearing (see Figure 29). In each public hearing, the Left party received at least 10% of answers from the trade union ver.di. Although trade unions pursue the aim of professionalization as one of their primary aims and should thus have been especially involved in the last two public hearings, government parties only questioned trade unions more than average in the final hearing (i.e., the Care Workers Strengthening Act). Nevertheless, the share of answers to questions from government parties in this final hearing (8.2%) was below that of all other major organizational groups.

Occupational organizations were roughly similarly involved with all parties and with government parties (mean overall: 13.4%; mean government: 15.0%). The share of answers to questions posed by the governing parties varied from between 4.8% and 31.0%. The highest involvement of occupational organizations (31% of answers to questions from government parties) was achieved in the Care Occupation Reform Act, which was a reform that focused on professionalization. The Care Council and the Care Occupations Association were the only two occupational top organizations. At least one of these two organizations answered questions in each public hearing, and both constituted the central organizations in the Care Occupation Reform Act (see Figure 29F). The Care Occupations Association did not receive any questions from any party in Care Strengthening Reform Act III or in the Care Workers Strengthening Act, which were reforms that took place at the end of the period. This finding might reveal that the Care Occupations Association had lost significance in the policy network, especially in comparison with the Care Council.

Focusing solely on the networks of top organizations (Figure 29), the number of top organizations that were involved in the public hearings decreased over the course of all seven hearings. This finding might hint at a consolidation of the network of influential organizational actors in LTC policymaking and therefore also at a consolidation of LTC as a separate policy system. Furthermore, two organizations stand out as central organizations in all seven networks: Caritas and the Peak Association of Statutory Health and LTC Insurers (*GKV SV*).[23] These two organizations occupied central spots in the first five networks, which reveals that different parties posed questions to these organizations. It can thus be assumed that these two organizations had a particularly high influence in the policymaking process. The centrality of the Peak Association of Statutory Health and LTC Insurers was expected because financial stability – the primary aim of system organizations – was a continuous aim throughout the first five LTC reforms. However, the central role of Caritas was not hypothesized and therefore needs to be examined in greater detail. Caritas was involved in every reform except for the last one, whereas the National Association of the Free Social Welfare Organizations (*BAGFW*) – the umbrella organization of social welfare organizations – was involved in only three public hearings. Hence, Caritas appears to be a more-important organization for political parties than is its own umbrella organization. Furthermore, all political parties directed questions toward Caritas. Each party posed at least one question in at least three of the public hearings to Caritas, which shows that the information, the positions, and the aims that Caritas formulated in the public hearings were considered important and were taken into consideration by political parties from both the right and the left.

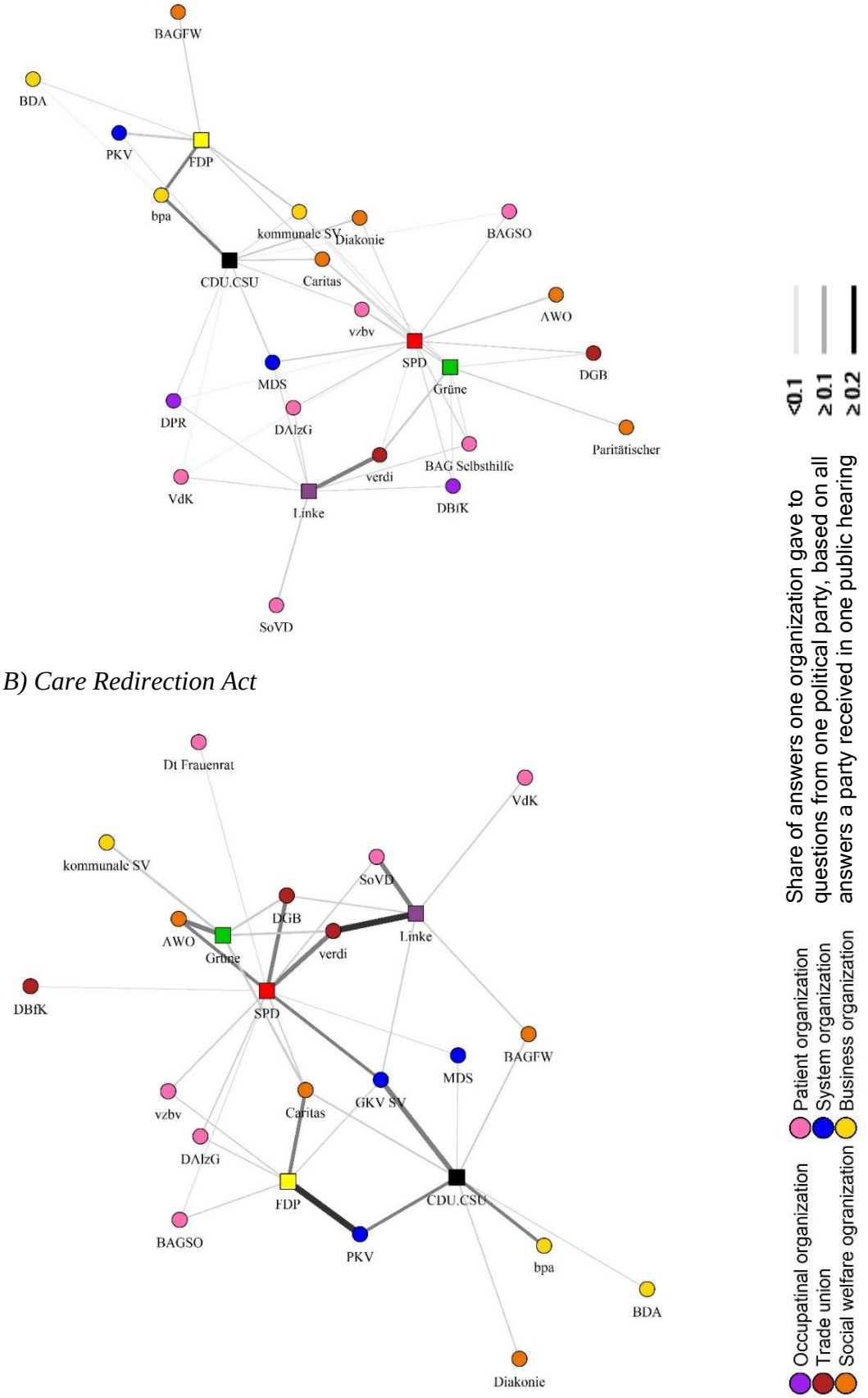
Hence, the policy networks of top organizations hint at an expected high influence of system organizations – and especially of the Peak Association of Statutory Health and LTC Insurers – on policymaking and an unexpected high influence of social welfare organizations – especially Caritas – on policymaking. The Care Council (*DPR*) and the Care Occupations Association (*DBfK*) became central actors in the Care Occupation Reform Act, and the Care Council was also a central actor in the Care-Worker Strengthening Act. This centrality of occupational organizations in the last two public hearings might be evidence of a shifting network in LTC policy in which

[23] The Peak Association of Statutory Health and LTC Insurers only began to participate in the public hearings with the Care Redirection Act because it had been founded in 2008, the same year in which the Care Further Development Act was implemented.

occupational organizations and therefore also the aim of and interest in professionalization had become more important. However, the centrality of occupational organizations might also only have been triggered by the content of both reforms and may therefore not continue in future public hearings.

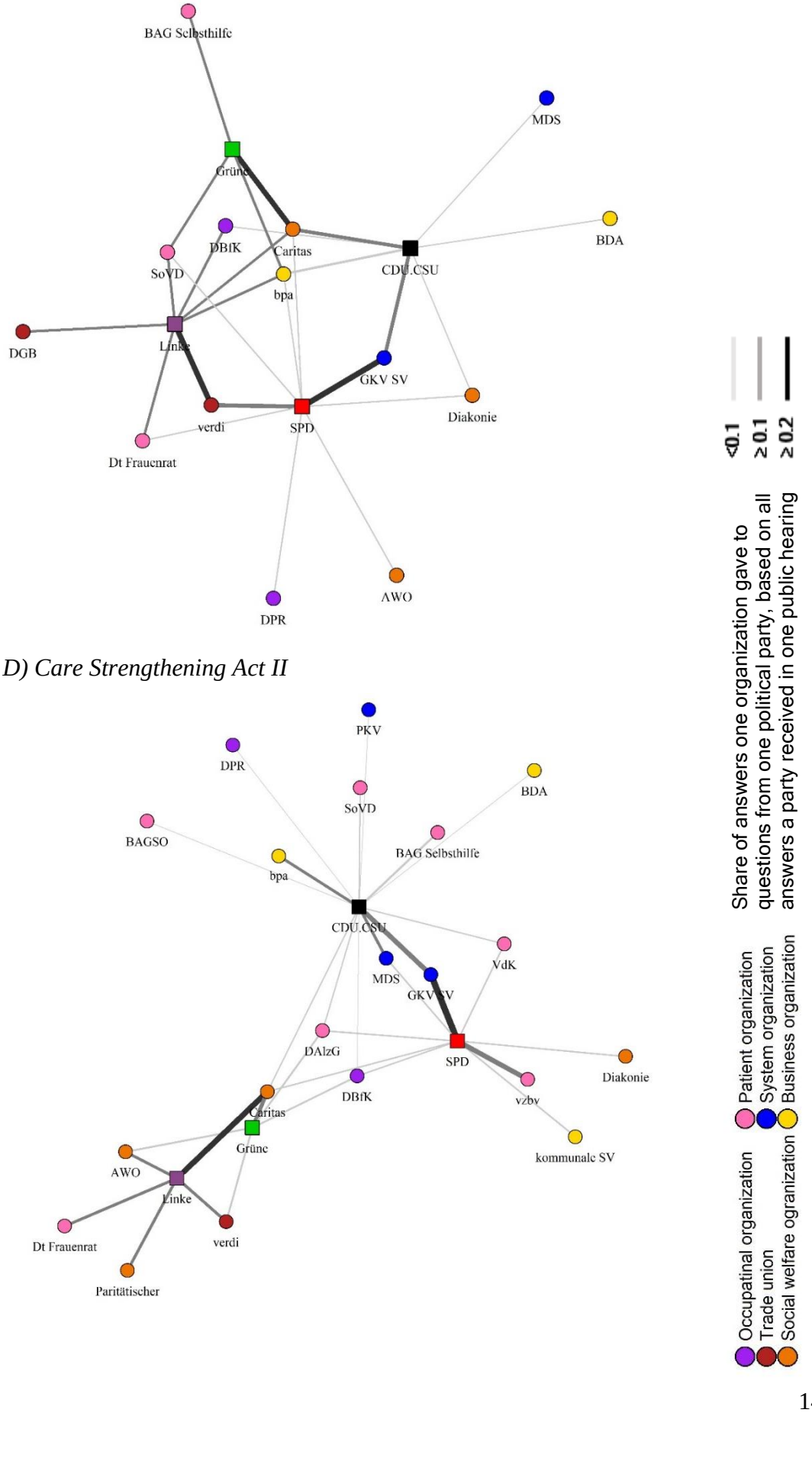
Figure 29: Networks of top organizations and political parties in public hearings

A) Care Further Development Act



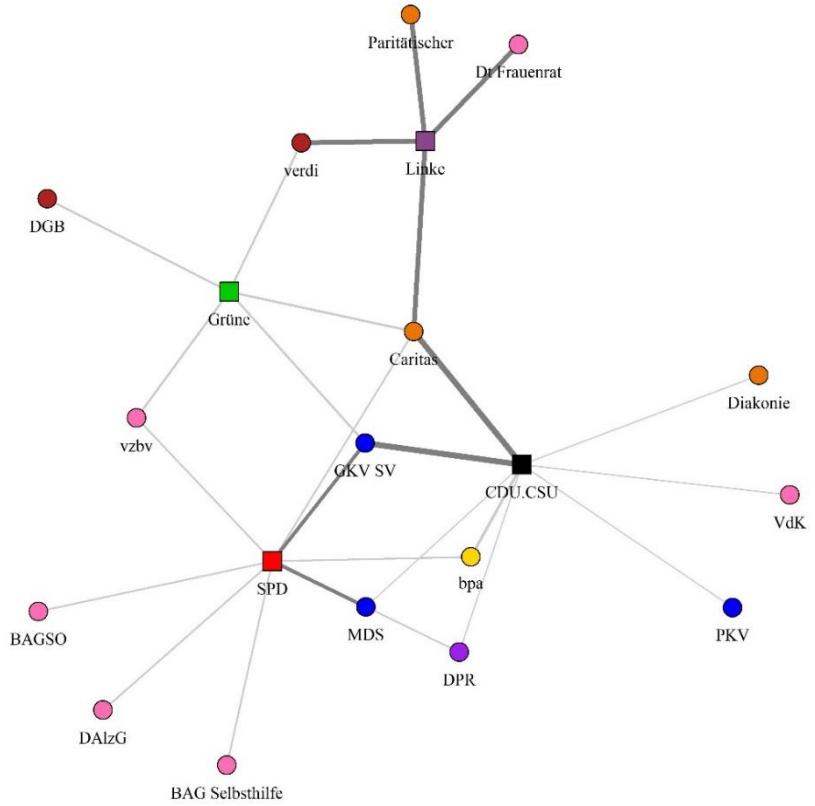
B) Care Redirection Act

C) Care Strengthening Act I

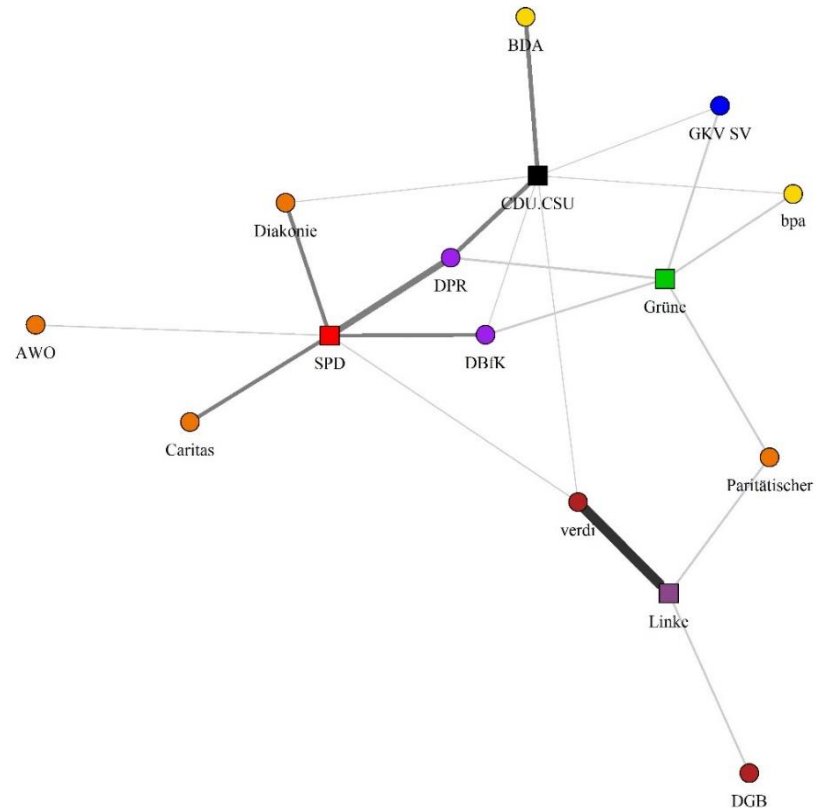


D) Care Strengthening Act II

E) Care Strengthening Act III



F) Care Occupation Reform Act

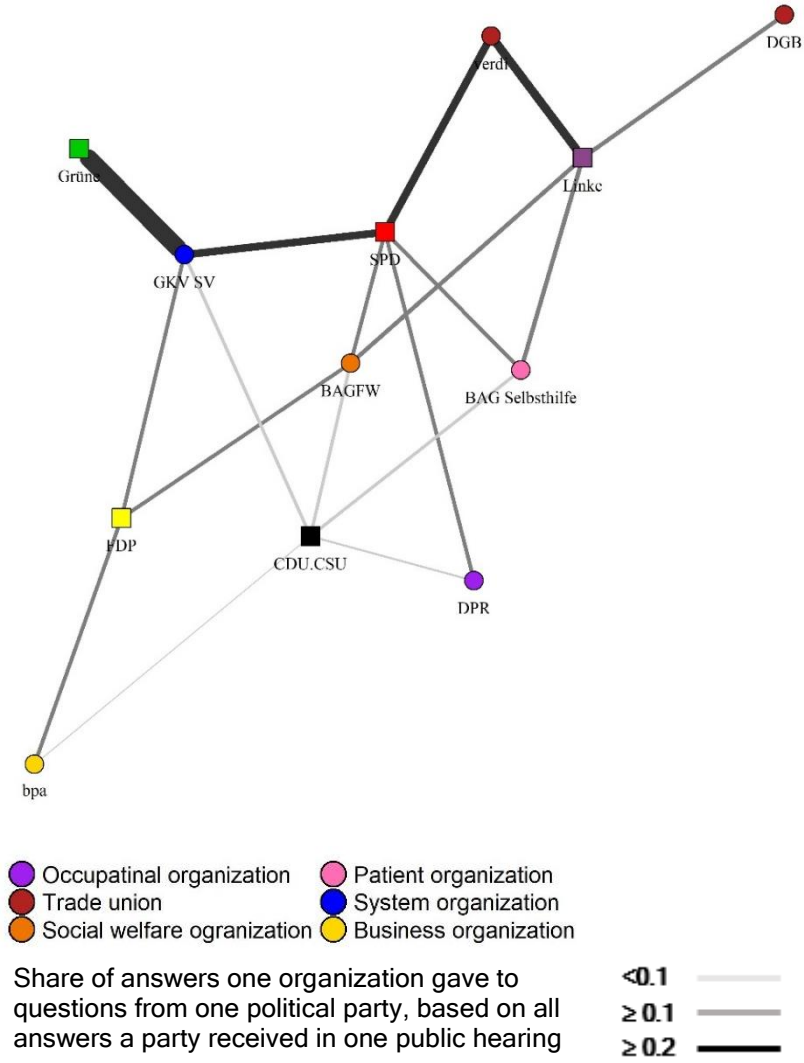


Share of answers one organization gave to questions from one political party, based on all answers a party received in one public hearing

Patient organization
System organization
Business organization

Occupatinal organization
Trade union
Social welfare ogranization

G) Care-Worker Strengthening Act



Source: Own calculations based on public hearings on LTC. In addition to the color, the thickness of each line illustrates how strong a tie between a party and an organization was. The thicker the line, the higher the share of answers a party received to its questions from one organization.

Abbreviations in Graphs: Occupational organizations: DBfK – German Care Occupations Association, DPR – German Care Council; Trade unions: DGB – Federation of German Trade Unions, Ver.di – United Service Labor Union; Social welfare organizations: AWO – Workers' Welfare Association, BAGFW – National Association of the Free Social Welfare Organizations; Patient organizations: BAG Selbsthilfe – Federal Association for Self-Help, BAGSO – National Federation of Senior Citizen Organizations, DAlzG – German Alzheimer Society, Dt Frauenrat – German Women's Council, SoVD – Social Association Germany, VdK – Social Association VdK Germany, vzbv – Federation of German Consumer Organizations, Business organizations: BDA – German Employers' Association, bpa – Association of Private Social Service Providers, kommunale SV– National Association of Municipal Peak Associations; System organizations: GKV SV – Peak Association of Statutory Health and LTC Insurers, PKV – Peak Organization of the Private Health and LTC Insurers, MDS – Medical Service of the Peak Association of Statutory Health and LTC Insurers.

5.4 Summary

The seven analyzed reforms – which changed the social-insurance system for LTC and the occupational laws for care workers – were passed between 2008 and 2018 and thus cover all major policy changes in LTC from the last ten years. The main aim in LTC policies before 2008 and in the first two major reforms (i.e., the Care Further Development Act of 2008 and the Care Redirection Act of 2012) was financial stability. This aim was pursued further in the three Care Strengthening Acts that were passed in 2015, 2016, and 2017, respectively, but only remained central in the first of these acts. Care Strengthening Act II implemented a new definition of *in need of care* and a new benefit system, which made quality the primary aim. Care Strengthening Act III also aimed at quality in addition to professionalization. With the following two reforms (i.e., the Care Occupation Reform Act of 2017 and the Care-Worker Strengthening Act of 2018), the aim of professionalization became the focus. Thus, policies aimed at financial stability before and until the early 2010s, aimed at improving quality by the mid-2010s, and have since aimed at the professionalization of the workforce. However, the aim of financial stability was constantly pursued because central institutions – such as partial funding of LTC costs and the high reliance on family care – remained stable.

Over the course of all reforms, measures that implemented the aim of professionalization focused on quantity, working conditions, and social status, but not on skill level. Since the early 2010s, measures for increasing the number of LTC workers have been implemented. The improvement of working conditions began to take center stage in the mid-2010s. Measures and improvements in both of these dimensions were implemented with the intention of triggering upward movements in the social dimension of the workforce. Increasing the educational and academic basis of the workforce was not an aim of the reforms; indeed, implemented measures for employing low-qualified workers were even intended to have the opposite effect – that is, deprofessionalization of the skill-level dimension.

The trend of incorporating professionalization as an aim in LTC policy since the mid- to late 2010s could be related to actual workforce developments. Investment in improving working conditions since the mid-2010s seems to have impacted the trajectory of developments in the workforce because working conditions did not

decrease further around that time but stagnated and have begun to show small signs of improvement in most-recent years. Furthermore, reform measures that aimed at increasing the educational and academic basis of LTC were largely neglected, which corresponds with developments in the skill level of the workforce, which showed constant deoccupationalization and deprofessionalization. Efforts to increase the number of employees began with the Care Redirection Act in the early 2010s, and the LTC workforce correspondingly increased throughout the 2010s. However, increases in the workforce had taken place even before the aim was implemented in policies. Nevertheless, implemented professionalization measures and aims correlate to a substantial degree with workforce developments in the dimensions. This correlation hints at an influence of policies on actual workforce developments. However, the analyses are not able to establish that the implemented policy measures actually caused the workforce developments.

System organizations – which are primarily interested in securing financial stability – are the group of organizations that was most-often questioned by government parties throughout all but one reform. This means that these organizations were most-frequently questioned in reforms aimed at financial stability but that they were also (one of) the groups of organizations that were most-frequently questioned by government parties in all other reforms, except for the Care Occupation Reform Act. This high involvement of system organizations in the public hearings comes as no surprise because financial stability – although actively pursued, particularly in the first three reforms – was still the aim that shaped the central institutions of the LTC system. Patient organizations aim for increasing the quality of care. As expected, they were highly involved in Care Strengthening Act II, which primarily aimed at quality. However, these organizations were less involved in Care Strengthening Acts I and III, which also implemented quality aims. Occupational organizations were – as expected – the most-frequently questioned group of organizations from the government in the reform acts that aimed at professionalization. Overall, the analyses reveal that the aims implemented in policies and the involvement of the organizations with the same aims overlap to a significant degree, which suggests that organizations influence the direction of reforms.

The development of the total number of answers in the hearings and the share of answers that top organizations contribute to all answers reveals the establishment and consolidation of a LTC policy network of organizations. In the first two public

hearings, the number of answers and the number of organizations that were asked questions were both higher than in the following hearings. This finding might be related to the lack of information on LTC-system deficiencies or on organizations and their interests and aims in LTC because the public hearing on the Care Further Development Act of 2008 was the first-ever hearing on a LTC reform. The consolidation of the LTC organizations as a policy network by the mid-2010s was challenged in the last two reforms, which focused on the aim of professionalization. The network of top organizations began to decrease in size because prior important actors – such as most patient organizations – were no longer included in the public hearings, which might reveal that the last two reforms were substantially different because they both targeted not only LTC but also healthcare workers, thereby including a second, different network of organizations. However, this finding might also hint at shifts in the most-influential organizations. For example, occupational organizations became more central and involved in the network. Nevertheless, the development of the total number of answers in the hearings, the share of answers that top organizations contributed, and the decreasing number of top organizations reveal that LTC and LTC policymaking have become an important and separate policy system.

The results reveal a congruence of aims implemented in the reforms and the involvement of organizations that purse similar aims. However, the analyses merely show the involvement of organizations in reform processes, and this involvement can hint at but cannot be interpreted as the influence of organizations on policymaking. Furthermore, the results do not reveal which topics the organizations actually discussed in the public hearings, which interests they advocated for, which aims they pursued, or whether and how topics, interests, and aims changed over the course of the ten years. Have professionalization aims become integrated due to changes in the positions that occupational organizations adopted? Are occupational organizations becoming more influential because other organizations are loosening their opposition to professionalization? On the other hand, have highly involved organizations that advocated against professionalization in early reforms changed their positions and aims such that they advocated for professionalization in later reforms? Social welfare organizations might provide an interesting case for studying these questions as they are integrated as central actors in all hearings (especially Caritas) and are hypothesized to be able to advocate both for and against professionalization. However, these

questions can only be answered by analyzing the actual statements of organizations in public hearings.

6 THE AIMS OF ORGANIZATIONS AND THEIR STANCE ON PROFESSIONALIZATION

The prior chapter laid out which groups of organizations and which individual organizations were involved in each public hearing. This involvement can hint at but is not equivalent to influence. In order to come closer to the actual influence that organizations have on LTC policies and to confirm the prior results, a quantitative and qualitative content analysis of the organizations' answers in the public hearings is performed. These answers can reveal the actual interests and aims of organizations in the reform processes. The central question of this chapter is: What aims do organizations pursue, and what stance do they take on the issue of professionalization?

The analyses reveal which organizations are supporters of and allies for professionalization and which organizations are mainly opposed to professionalization and instead support deprofessionalization. Emphasis is placed on the interests and aims of occupational organizations as these organizations represent LTC workers and should be the main supporters of the aim of professionalization. Furthermore, the shifting positions of an organization or an organizational group over time are highlighted in addition to the diverging positions and aims of organizations that belong to the same group.

The terms *position*, *interest*, and *aim* are frequently used in this chapter. Although all terms relate to *what the organizations want*, they are not used interchangeably. Interests and positions are employed when specific ideas and measures are discussed. The term *interest* thereby relates more to the exact content of an idea or measure, whereas the term *position* expresses more a stance or opinion on a specific measure or content item. The term *aim* refers less to specific ideas and measures and instead relates to a superior purpose and a generally desired outcome. Interests and positions are thus related to an overall aim.[24] In that sense, an organization might issue a statement on public spending on LTC (*interest*) and wish to decrease or freeze the amount of public spending (*position*). This interest and position together refer to a higher goal, which is

[24] The Oxford English Dictionary defines *interest* as the "relation of being objectively concerned in something," *position* as "an opinion, attitude, or viewpoint on a particular subject," and *aim* as "a desired outcome; an end aimed at; an objective, a goal; a purpose, an intention" (Oxford English Dictionary, 2021).

to secure financial stability (*aim*). Furthermore, professionalization constitutes and is identified as an aim because it marks the final step in the process toward a profession. The aim might also include measures with the goal of occupationalization or a general upward movement, but its main purpose is to achieve the highest rung on the ladder of the professionalization continuum and thus become a profession. Hence, the term *professionalization* instead of *upward movement* or *occupationalization* is used to refer to the aim (see Section 2.3.2).

The answers given in the public hearings are analyzed using a quantitative content analysis (Coe & Scacco, 2017; Neuendorf & Kumar, 2017). This analysis reveals which primary and secondary aims an organization pursued in public hearings. Furthermore, it reveals which organizations adopted professionalization as a primary and a secondary aim. Organizations that adopt professionalization as a primary aim can be evaluated as the main drivers of upward movements in the LTC workforce, whereas organizations that adopt professionalization mainly as a secondary aim can be described as allies. Occupational organizations are expected to predominantly adopt the primary aim of professionalization. Trade unions are also expected to adopt professionalization as a main primary aim together with the aim of redistribution. Patient organizations should primarily take up the primary aim of quality but should link this aim to the secondary aim of professionalization, which should make them a strong ally for professionalization. For social welfare organizations, the hypothesis depends on which role the organizations generally take on: the role of advocate for weak societal groups or the role of a business and employer organization. Adopting the first role, social welfare organizations should aim for quality and thus also for professionalization, whereas the second role is associated with the aim of growth and financial stability, which should be connected with the aim of deprofessionalization. System organizations should mainly take up the primary aim of financial stability, which should include interest in deprofessionalization. Figure 30 outlines the expected general position on the aim of professionalization for each organizational group along a continuum that ranges from the aim of professionalization at the one end and the aim of deprofessionalization at the other (see Section 2.3.3 for a detailed discussion of organizations' aims).

Figure 30: Organizations by their hypothesized stance on professionalization

Source: Own compilation based on theoretical considerations of primary aims.

The quantitative coding scheme employs a primarily deductive approach that relies on the theoretical considerations of primary aims of organizations in LTC (see Section 2.3.2). Hence, the aims of *financial stability*, *quality*, *growth*, *redistribution*, *subsidiarity*, and *professionalization* are employed as codes.[25] The code of *professionalization* is further divided into four dimensions based on professionalization theories: *quantity*, *skill level*, *working conditions*, and a *social dimension*. Each code is also present in its negated form (e.g., *against financial stability* or *against professionalization – quantity*). The coding unit is defined as one answer – in its full length – by one organization to a question from a political party in a public hearing. Each answer is coded with at least one of the codes that indicates the primary aim to which the answer alludes. Only one primary aim can be coded for each answer. However, answers might include several interests and positions that belong to several aims. In that case, the sections of the answer that include different interests are evaluated based on their importance. This evaluation rests on the position and the length of the argument in the whole answer. Primary interests should be longer and issued more toward the beginning of the answer compared with secondary interests. Consequently, for every answer in the public hearing, a primary aim is coded, and one or more secondary aims *can* be coded. The codebook that explains all instructions and the technical details for coding with the software MAXQDA is included in the Data and Methods Appendix.

The frequencies of primary and secondary aims are displayed as shares for each organizational group and as shares for each hearing. For the aim of professionalization, results are broken down into the four workforce dimensions. Furthermore, primary and secondary aims can be related and thereby reveal how frequently a specific primary

[25] There is also the code *other*, which includes statements that cannot be clearly associated with one aim, such as an interest in merging social and private LTC insurance. However, most statements that are coded as *other* deal with a topic outside of LTC (such as general healthcare or midwife care) or are only informative (see Data and Methods Appendix for more details).

aim was connected to a specific secondary aim. Shares that display how often organizational groups applied a specific aim in each public hearing are not shown due to the small number of given codes, which does not allow for disaggregating the data by organizational group *and* public hearing.

The qualitative content analysis (Mayring, 2015) follows up on the quantitative content analysis. All answers that have been coded as a primary or secondary aim with the codes of *professionalization* or *against professionalization* – which can also be labeled as *deprofessionalization* – in the quantitative content analysis are further examined by the qualitative content analysis. Each of these answers is summarized to reveal the main interest and the position on professionalization that is included. These summaries are then further condensed to infer the general position on professionalization of single organizations and of organizational groups.

The next section focuses on the results of the quantitative content analysis. Thereafter, the results of the qualitative content analysis are presented by focusing on each organizational group separately and evaluating its stance on professionalization. The final section of the chapter summarizes, evaluates, and interprets the findings.

6.1 Aims of Organizations in LTC reforms

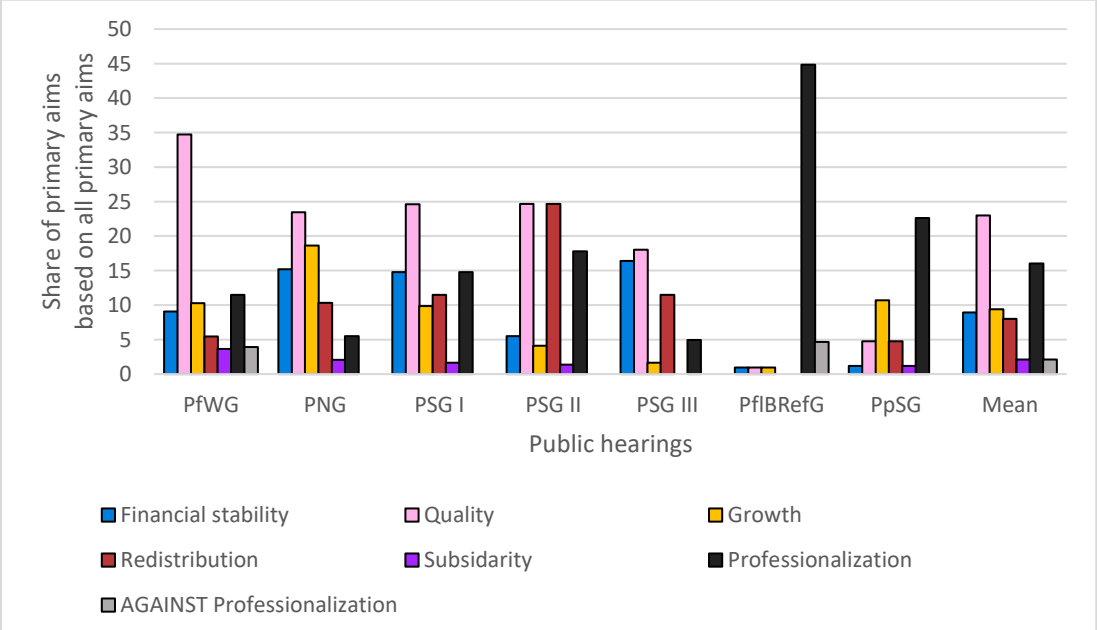
The results of the quantitative coding analysis reveal which aims were most advocated for in each public hearing and how organizations differed in their adoption of aims, especially with respect to professionalization. Overall, the aim of *quality* was the primary aim that organizations adopted the most in their answers. *Quality* was adopted as the primary aim in 23% of all answers from all seven public hearings. The aim of *professionalization* was the second-most-important primary aim (16%), followed about equally by the aims of *financial stability*, *growth*, and *redistribution* (each between 9.4% and 8.0%) (see Figure 31, mean).

Focusing on each of the seven public hearings (see Figure 31), *quality* was the most-pursued primary aim in the first five public hearings. In the first three hearings, the second-most-important primary aim was pursued at least 5% less than the aim of *quality*. In Care Strengthening Acts II and III, *quality* was still the most-important primary aim (24.7% and 18%), but *redistribution* (24.7% in the PSG II) and *financial stability* (16.4% in the PSG III) were about equally important. In the Care Occupation Reform Act and the Care-Worker Strengthening Act, the majority of answers included

professionalization as their primary aim (44.9% and 22.6%). Most other aims played only a marginal role in both of these public hearings and did not reach more than 5% (the aim of *growth* in the Care-Worker Strengthening Act was the exception, with 10.7%). In all public hearings, the primary aims of *subsidiarity* and *against professionalization* played only a minor role, with shares not exceeding 5%.

The adopted primary aims in the public hearings reveal the importance of the aim of *quality*. Furthermore, the results confirm that professionalization was the main aim in the Care Occupation Reform Act and the Care-Worker Strengthening Act. The aims of *financial stability*, *growth*, and *redistribution* were adopted to different degrees as primary aims in the public hearings. *Financial stability* – although implemented by all reforms and central in the first three reforms – was never the most-adopted primary aim in the public hearings. The most-adopted primary aims in the public hearings aligned to a large degree with the aims that were implemented in the LTC reforms. This congruence of adopted primary aims in the public hearings and implemented reform measures can most certainly be explained by organizations' efforts to connect their interests and aims to the main aims of the reform. Still, this congruence of adopted primary aims in the public hearings and implemented reform measures also hints at the influence of organizations on policymaking.

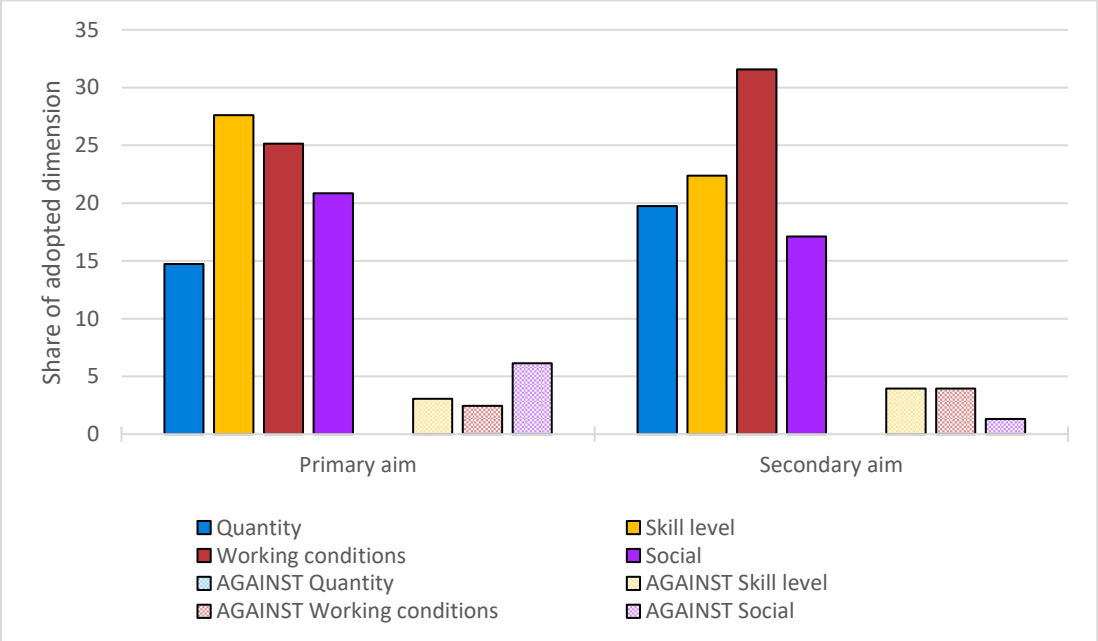
Figure 31: Share of adopted primary aims in each public hearing



Source: Own calculations based on public hearings on LTC. Note: For simplicity, the categories *negated primary aim* and *other* were excluded in this figure. *Mean* refers to the share based on all answers in all hearings. The percentages for the primary aims in the Care-Worker Strengthening Act were lower than in all other public hearings because about half of all answers in the hearing related to care in hospitals and were thus coded as *other*.

The aim of *professionalization* can be analyzed in greater depth by focusing on the four dimensions of *quantity*, *skill level*, *working conditions*, and the *social dimension* (and the opposition to these aims) (see Figure 32). Within the aim of professionalization, the most-adopted primary aim was a higher skill level (27.6%), followed closely by higher working conditions (25.2%) and the professionalization of the social dimension (20.9%). If professionalization was taken up as a secondary aim, the order of the dimensions changed. Higher working conditions were pursued the most (31.6%), followed by a higher skill level (22.4%) and a higher quantity (19.7%). Positions against professionalization were less frequent than those in favor of professionalization. In total, only about 10% of all primary and all secondary aims toward professionalization and deprofessionalization entailed the negative aim of *against professionalization*, which can also be called *deprofessionalization*. The aim of *against quantity* was not adopted in any of the public hearings.

Figure 32: Share of adopted dimensions within the (against) professionalization aim (all answers, all public hearings)

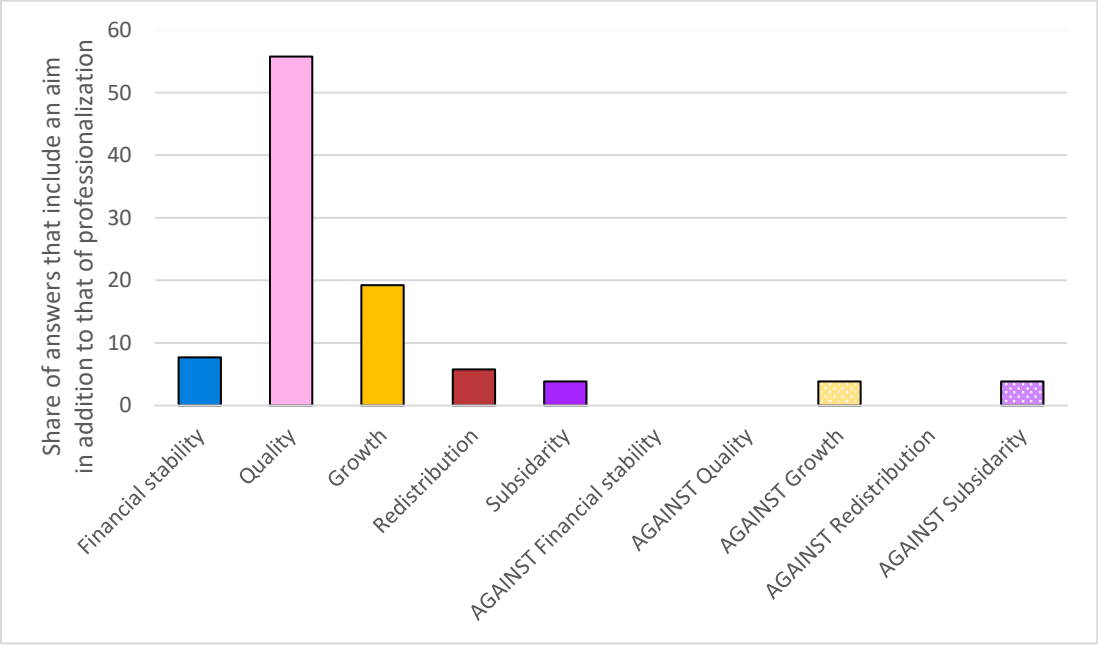


Source: Own calculations based on public hearings on LTC.

Answers in which *professionalization* (and not the aim of *against professionalization*) constituted a primary or a secondary aim but in which this aim was not the only aim advocated for comprised about 30% of all answers including the *professionalization* aim (52 of 172 answers). Figure 33 focuses on only these 52 answers and shows which aims in addition to professionalization occurred within one answer. More than half of all non-sole-professionalization aims appeared in connection with quality (55.8%).

The second-most-connected aim was growth (19.2%). All other aims fell below ten percent. The results reveal first that the aim of professionalization constitutes a viable primary aim that in most cases is adopted alone and without any other aim. Furthermore, the results highlight the theoretical assumptions that the aims of quality and growth are connected the most with the aim of professionalization.

Figure 33: Share of answers that include an aim in addition to that of professionalization

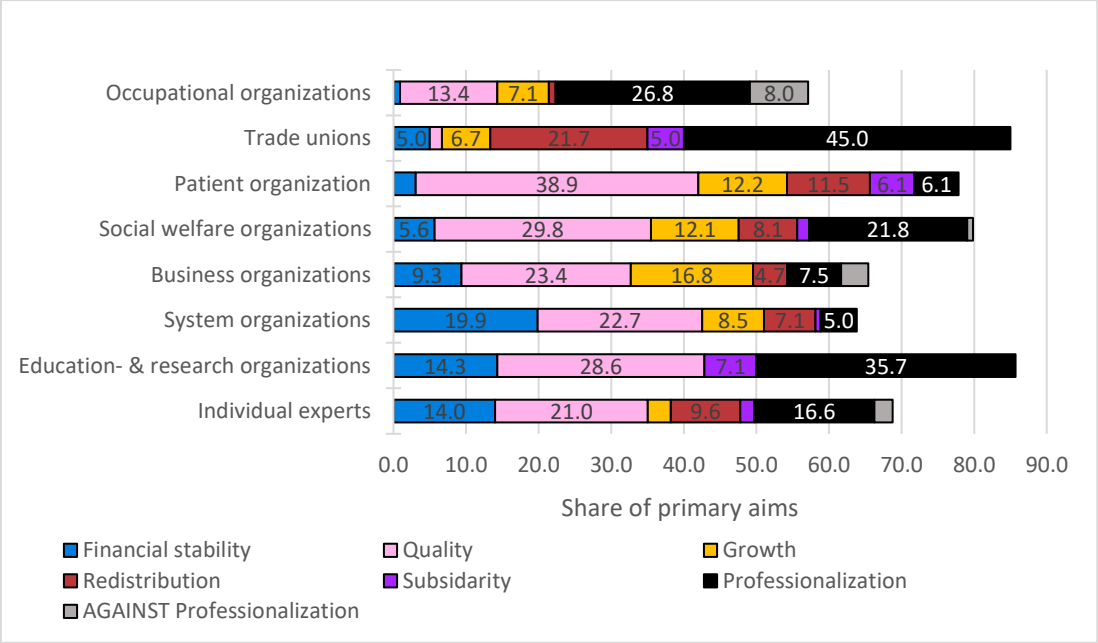


Source: Own calculations based on public hearings on LTC. Note: Shares were calculated using only answers with a primary and secondary *professionalization* aim that included a further primary or secondary aim.

Shifting now from the overall aims in the public hearings to the aims that the different organizational groups pursued (see Figure 34), in general, a high congruence between the expected primary aims and the primary aims that the organizations actually adopted is visible. Occupational organizations, trade unions, and patient organizations fully met the expected primary aim, whereas this only partially applied to social welfare organizations, business organizations, and system organizations. Occupational organizations and trade unions adopted *professionalization* as their primary aim the most in all of their answers in all public hearings (26.8% occupational organizations, 45% trade unions). Trade unions adopted *redistribution* as the second-most-important primary aim (21.7%). Patient organizations advocated the most for the primary aim of *quality* (38.9%). The results of these three groups met the expected primary aims. Social welfare organizations pursued the primary aim of *quality* (29.8%) the most, followed by the aim of *professionalization* (21.8%). The adoption of these aims

suggests that social welfare organizations are more inclined to their role as advocates for marginalized societal groups than to their role as business organizations and employers. However, business organizations also advocated the most for the primary aim of *quality* (23.4%), followed closely by the aim of *growth* (16.8%). System organizations adopted the primary aim of *quality* the most (22.7%), though this figure was roughly similar to the aim of *financial stability* (19.9%). The primacy of the *quality* aim for business organizations and for system organizations was not expected from the theoretical considerations as these organizations were expected to primarily advocate for *growth* and *financial stability*. However, these aims were only adopted as the second- or third-most-important primary aim. Education- and research organizations supported the primary aim of *professionalization* the most (35.7%), while individual experts supported the primary aim of *quality* the most (21%). Overall, the primary aims that the organizations pursued the most fit quite well with the expected primary aims. However, the aim of *quality* stands out as having been the most- or second-most-important aim for all organizations.

Figure 34: Share of primary aims by organizational group in all public hearings



Source: Own calculations based on the analysis of the public hearings on LTC. Note: For simplicity, categories *negated primary aim* and *other* were excluded from this figure.

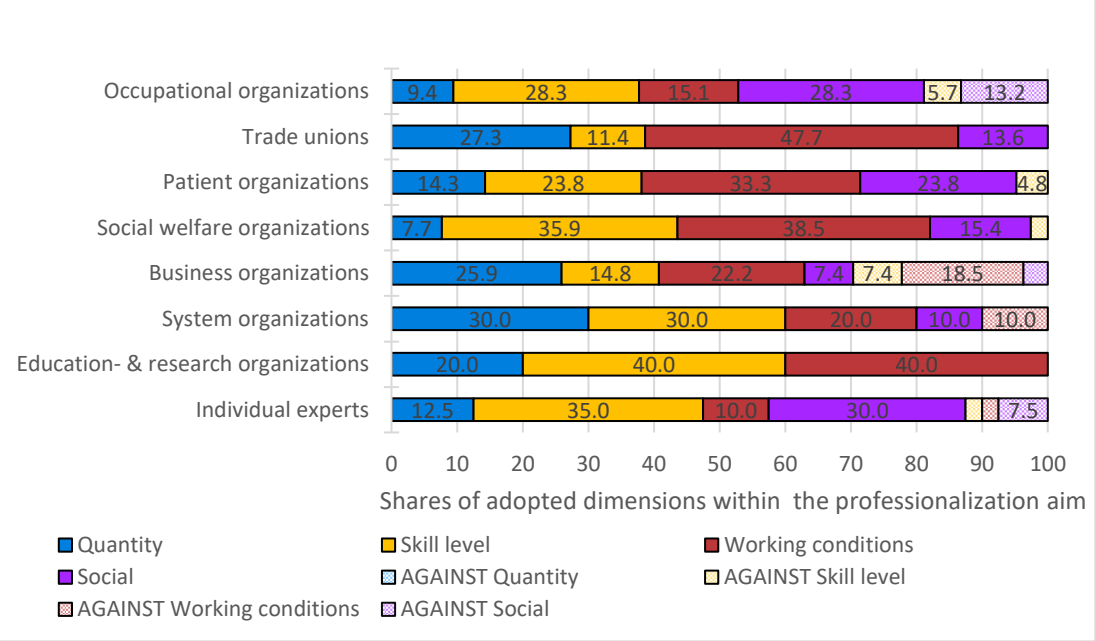
Upon examining the detailed *professionalization-* and *against professionalization* aims that the organizations issued in all hearings, the organizational groups can be seen to have emphasized different dimensions of these aims. Figure 35 shows how the dimensions of the aim of *professionalization* and *against professionalization* were

distributed for each organizational group. Occupational organizations focused on advocating for a higher skill level and for increases in the social dimension (28.3% each). These organizations also adopted the aim of deprofessionalization in the skill-level- (5.7%) and the social dimension (13.2%). Trade unions only advocated for professionalization and not for deprofessionalization. Nearly half of their answers that included a professionalization aim concerned working conditions (47.7%). For patient organizations, improving working conditions also comprised the main dimension for action within the professionalization aim (33.3%), which was closely followed by the skill-level- and the social dimension (23.3% each). Within the professionalization aim, social welfare organizations focused on advocating for higher working conditions (38.5%) and higher skill levels (35.9%). Business organizations advocated for increases in the quantity dimension the most (25.9%). Furthermore, business organizations seem to have been undecided or divided on the question of whether to advocate for or against improving working conditions because the share of answers within the professionalization aim was about equal for both dimensions (22.2% for and 18.5% against improving working conditions). System organizations were equally interested in a higher quantity level as well as in a higher skill level (30.0% each). Education- and research organizations focused on a higher skill level and on improving working conditions (40.0% each).

Regarding the aim of *against professionalization*, business organizations advocated against professionalization in three of the four dimensions, which is the most of all organizational groups. Furthermore, business organizations showed the highest share of answers of all organizational groups that argued *against professionalization* (sum of all *against* dimensions: 29.6%). Moreover, the dimension of *against working conditions* showed the highest value for an aim against professionalization for all occupational groups (18.5%). Occupational organizations advocated against professionalization in two of the four dimensions and had the second-highest share of answers against professionalization of all organizational groups (sum of all *against* dimensions: 18.9%). All other organizational groups only stated interests in one or none of the dimensions against professionalization. Consequently, business organizations appear to be the organizations that were most opposed to professionalization. This opposition was expected as business organizations had to finance and thus fear the costs of professionalization the most. Occupational organizations placed second concerning the adoption of aims against

professionalization, which was unexpected and counterintuitive as the role and tasks of occupational organizations should be to advocate for – and not against – professionalization. The qualitative content analysis in the next section reveals that the opposition to professionalization within the group of occupational organizations originated from the physician organizations.

Figure 35: Share of adopted dimensions within the (against) professionalization aim by organizational group



Source: Own calculations based on public hearings on LTC. Note: Shares were calculated based on all primary and secondary *professionalization*- and *against-professionalization* aims in all public hearings.

6.2 The Stance of Organizations on Professionalization in LTC Reforms

Analyzing which aims were advocated for both overall and in each public hearing and which organizational groups took up which aims reveals general developments. Furthermore, positions of organizations on the issue of professionalization become evident. However, the quantitative analyses of aims cannot show which individual organizations issued which specific interests or advocated for which specific measures in the public hearings. Furthermore, the quantitative analyses cannot reveal whether or which individual organizations of the same group set different foci or even took up opposing positions on an issue. Moreover, changing positions and aims over the course of the seven public hearings become lost in the quantitative analyses. Hence, a

qualitative content analysis of the answers that include the aim of professionalization or deprofessionalization is needed.

Looking first at the organizations that engaged in the topic of professionalization, the organizations that were highly involved overall – the top organizations (see Section 5.3) – were also widely engaged in the topic of professionalization. All occupational organizations, trade unions, social welfare organizations, and business organizations that were evaluated as top organizations included the aim of professionalization in at least one of their answers. Only three of the seven top patient organizations (Federal Association for Self-Help, Alzheimer Society, Women's Council) and one of the three top system organizations (Peak Association of the Statutory Health and LTC Insurers) engaged in the topic of professionalization. Six top organizations issued at least ten answers on professionalization in at least five of the seven hearings and thus emerged as organizations that represent the core organizational debaters of professionalization issues. These organizations are the two occupational organizations of the German Care Occupations Association (DBfK) and the German Care Council (DPR), the trade union ver.di, both Church-affiliated social welfare organizations of Caritas and the Diakonie, and the business organization the Association of Private Social Service Providers (bpa). These organizations and their interests and positions on professionalization issues are thus highly relevant both overall and for the groups of organizations to which they belong. However, all issued interests and positions on professionalization – including those of non-top organizations – are taken into account in the qualitative analysis of answers in the public hearings concerning the issue of professionalization. In most cases, a comparison over time is only possible for organizational groups and not for individual organizations. Therefore, most interests are presented as general interests over the whole period and are only described in greater detail if a development over time is visible. [26]

[26] This section reports the results of the qualitative content analysis and includes text references that diverge from the adopted reference style. The references first show the organization, then the abbreviation of the law on which the public hearing was held, and finally, the page number. This referencing system is chosen for two reasons: First, by using this system, organizations that issue a statement can be included, which is important for the analysis of organizational aims and interests. Second, the reference system only includes abbreviations of the laws on which the public hearings were held, which shortens the in-line references and increases the readability of the text. The public hearings, which were held in several separate sessions, include the additions _a, _b, _c, and _d, which refer to the first, second, third, and fourth session, respectively. The full references can be found under: Deutscher Bundestag - Ausschuss für Gesundheit (2008a, 2008b, 2008c, 2008d, 2012a, 2012b, 2014, 2015, 2016a, 2016b, 2018).

The occupational organizations of the German Care Occupations Association (DBfK) and the German Care Council (DPR), which both represent the interests of care workers from different sectors, argued for professionalization in all four dimensions. Both organizations demanded that more care workers be employed and that general staffing levels – which included quantitative and skill-level measures – be implemented (DBfK PfWG_d, 20; DPR PfWG_d, 19–20; DPR PSG II, 26; DPR PpSG, 15). In the skill-level dimension, the German Care Occupations Association (DBfK) and the German Care Council (DPR) argued for higher skill levels in general (DBfK PfWG_d, 23) as well as for a variety of specific measures designed to increase the skill level at both the top and the bottom of the workforce, including increasing the skill level for unskilled and auxiliary carers (DBfK PSG II, 21; DBfK PflBRefG, 34–35), setting binding language-proficiency levels for care workers (DPR PflBRefG, 12), increasing the required amount of academic education (DPR PfWG_d, 13), raising the entrance qualification for beginning an apprenticeship (DBfK PflBRefG, 19), creating a more interconnected and accessible system of occupational degrees (DBfK PflBRefG, 34–35; DPR PflBRefG, 34), and not allowing apprenticeship-trained care workers to be substituted by auxiliary care workers (DPR PpSG, 24). Concerning working conditions, the focus lay on demanding higher wages by acknowledging and refunding collectively agreed-upon wages (DBfK PfWG_a, 30; DPR PSG III, 29), but the definition of minimum wage levels for the different skill levels of care workers (DBfK PNG_a, 18) and an increase in remunerations for travel times in ambulatory care (DPR PpSG, 30–31) were also mentioned. Furthermore, similar working conditions for employed and self-employed care workers were demanded (DPR_PfWG_b, 59) in addition to a decrease in the amount of unwanted part-time employment (DPR PpsG, 24). In the social dimension, the German Care Occupations Association (DBfK) and the German Care Council (DPR) demanded greater inclusion in decision-making bodies (PSG II 7 & 14; DPR PflBRefG, 19 & 25). Furthermore, both organizations requested that LTC workers be required to have more competencies (DBfK PfWG_d, 14–15 & 23; DPR PfWG_d, 13; DPR PSG III, 33; DPR PflBRefG, 20).

The German Care Occupations Association (DBfK) seems to have been more hesitant in demanding the above-mentioned measures for professionalization, whereas the German Care Council (DPR) declared its interests and positions more forcefully. The quotations on the competencies of LTC employees illustrate this tendency as the

German Care Occupations Association (DBfK) asked for *new models* in healthcare, whereas the German Care Council (DPR) explicitly demanded a *definition of reserved tasks* and the *independent practice of medical practices* for care workers (see quotes DBfK PfWG_d, 14, DPR PflBRefG, 20). This stronger demand for professionalization measures by the German Care Council (DPR) is also visible in the phrasing of an answer in the hearing on the Care Occupation Reform Act, in which the introduction of the general care occupation was explicitly associated with the pathway toward a care *profession* (DPR PflBRefG, 19).

> That means, in particular, that the hierarchy between medicine and nursing care must be dismantled so that the competencies that nursing care brings to the table today or can bring to healthcare via new models are also able to take effect. (DBfK PfWG_d, 14)

> If we consider that we will have a care system in the future in which demographic developments will also affect occupational groups, both in professional nursing and in the medical profession, we will not be able to avoid defining exclusive activities [for care workers] under certain quality criteria. Therefore, this development should be welcomed in the context of securing a service supply for patients and residents. Highly qualified students and those who have earned a bachelor's degree will feel the greatest sense of frustration when they discover after three or four years that they have completed a demanding apprenticeship or academic program that does not qualify them for the independent practice of medicine. (DPR PflBRefG, 20)

> It is often argued that geriatric care, pediatric care, or nursing care as such should be abolished. Lady and gentleman delegates, we are talking about a new qualification for an autonomous care profession […]. (DPR PflBRefG, 19)

The German Medical Association (BAEK) and the National Association of Statutory Health Insurance Physicians (KBV) are also occupational organizations; however, they do not represent the interests of care workers, but of physicians. Both organizations mainly issued interests along the social dimension and took up the exact opposite position to that of both the German Care Occupations Association (DBfK) and the German Care Council (DPR). Both physician organizations advocated for no takeover of physician tasks by care workers and argued that supervision by physicians should remain in place, especially due to many legal and liability concerns (BAEK PfWG_b, 36; PfWG_d, 11 & 14; KBV PfWG_d, 12 & 15).

> However, we consider the transfer of primarily medical tasks that must be performed by physicians to be highly problematic due to liability-, content-, and economic reasons. (BAEK PfWG_d, 11)

Furthermore, the German Medical Association (BAEK) did not see the need for an increase in the skill level of LTC workers (BAEK PfWG_d, 14f) and instead supported the notion that LTC workers should receive more healthcare- and preventative services (BAEK PpSG, 26).

The first and most-important finding from the qualitative analysis of answers on the topic of professionalization from occupational organizations is that organizations that represent care workers and organizations that represent physicians have diametrically opposed interests on the topic of professionalization. Occupational-care-worker organizations pursued professionalization in all dimensions, whereas physician organizations advocated against a higher skill level and strongly against more rights of and responsibilities for care workers in the independent practice of medicine. A second finding concerns the two occupational organizations of care workers: the German Care Occupations Association (DBfK) and the German Care Council (DPR). Although both groups continuously advocated for professionalization measures, the German Care Council (DPR) was more progressive in making its demands than was the Care Occupations Association (DBfK). This progressive advocacy for professionalization measures might explain why the German Care Council (DPR) was better integrated into these public hearings – which primarily focused on professionalization – than was the Care Occupations Association (DBfK) (see Section 5.3.2 and Figure 29). In the Care Occupation Reform Act and the Care-Worker Strengthening Act, the government aimed to implement professionalization measures and thus relied on the strong demands for professionalization by the German Care Council (DPR) to back its proposed ideas instead of asking the Care Occupations Association (DBfK). Furthermore, both organizations were more direct concerning their interests and aims in the hearings toward the end of the research period than at the beginning.

The quantitative content analysis of answers revealed a high share of answers with a primary aim of professionalization for trade unions and social welfare organizations. Hence, organizations from these groups should be allies of the occupational-care-worker organizations in advocating for professionalization. Regarding the theoretical considerations, patient organizations should also be allies of professionalization, but their low adoption of professionalization as a primary aim does not hint at this role.

Focusing first on trade unions, ver.di (the United Services Union) and the DGB (the German Trade Union Confederation) both adopted professionalization as a primary

aim over the whole period, with ver.di being more involved in the public hearings and in the issue of professionalization than the DGB. Both trade unions demanded professionalization in all dimensions, but their focus lay on the dimension of working conditions, with special attention given to wages. In the working-conditions dimension, the trade unions requested generally higher wages (Ver.di PfWG_a, 20 & 21; Ver.di PpSG, 30), higher wages that should be based on collective agreements (DGB PfWG_a 30; Ver.di PfWG_a, 21; Ver.di PSG I, 15 & 34–35), and wages that should be similar to those of nurses in the healthcare sector (DGB PpSG, 36). Furthermore, their demand to generally improve working conditions (Ver.di PfWG_d, 23) was further specified by demands for reducing the workload of care workers (Ver.di PfWG_d, 20–21), decreasing overtime work and short-term changes in shift plans (Ver.di PflBRefG, 24), reducing unwanted part-time employment (Ver.di PNG_a, 25; Ver.di PpSG, 29), and improving the reconciliation of work and family life (Ver.di PNG_a, 25). These requests for professionalization in the working-conditions dimensions were often connected with the aim of ensuring enough LTC workers or with the aim of increasing the quality of care (e.g., Ver.di PfWG_a, 20; Ver.di PSG II, 15).

> Shortages of staff are a particular cause of supply shortages in services. The shortage of staff is one of the biggest problems we face. The number of apprentices is insufficient, and remuneration is often too low, especially in elderly care. We believe that one measure of quality in the system should be to ensure that higher remuneration is paid. (Ver.di PfWG_a, 20)

> Many care workers tell us that they cannot do their job until they retire because the working conditions and wages are not good. [...] I believe it is a political responsibility to increase the satisfaction of employees and to reduce the labor turnover rate in facilities. We have facilities with a turnover rate of almost 40 percent. That is alarming. We have therefore demanded that some measures be in place, such as one-on-two staffing, no-night-alone [policies], or solving the issue of practical education […]. (Ver.di PSG II, 15)

These two quotations reveal that trade unions connect the demand for better working conditions with ensuring the quality of care and the problem of staff shortages. Therefore, these unions demand defined staffing levels (DGB PpSG 36–37; Ver.di PfWG_a, 21; Ver.di PSG II, 15; Ver.di PflBRefG, 24; Ver.di PpSG 12) and more apprenticeship education (Ver.di PfWG_d, 20; Ver.di PSG I, 12–13 & 20–21). An increase in the number of workers in LTC should mainly involve LTC nurses (Ver.di PfWG_d, 19; Ver.di PNG_a, 42). If open vacancies cannot be filled by LTC nurses,

these spots should not be filled with auxiliary care workers (Ver.di PpSG, 29). Furthermore, trade unions advocate for easier pathways for low and unskilled workers to qualify for apprenticeship education (Ver.di PfWG_d, 19) and for a higher skill level of practical instructors (*Praxisanleiter*) (Ver.di PflBRefG, 35–36).

> In principle, we are very keen on having care be provided by apprenticeship-qualified workers. (Ver.di PfWG_d, 19)

> We also emphasize that it is imperative to maintain the qualitative staffing quota in order to ensure quality of care because the evidence shows that more staff alone is not enough; rather, the staff must be qualified. (Ver.di PpSG, 29)

Concerning the social dimension, co-determination rights played an important role for trade unions. These unions evaluated the rights of LTC workers – and especially of apprentices – as being low and therefore demanded that LTC workers have a greater say in their facilities by enabling work councils to have more supervision and co-determination on decisions made by the care facilities (Ver.di PSG III, 25; Ver.di PflBRefG, 21–22 & 24). In the social dimension, trade unions were in favor of LTC workers taking over more tasks from physicians if all jurisdictional aspects of this shift were settled (Ver.di PfWG_d, 20).

Thus, trade unions demanded professionalization measures in all dimensions. The strong focus on working conditions and especially on wages can be explained by trade unions' role as employee representatives in collective-bargaining processes. Trade unions were not only supporters of the professionalization demands made by the occupational organizations of LTC workers, but they were also initiators of demands to professionalize the LTC workforce. They made professionalization a primary aim in their communication in the hearings. Trade unions also connected their demands for professionalization both within the different dimension of the professionalization aim and with other primary aims. They argued that the implementation of professionalization measures in one dimension might induce positive effects in another dimension or that the implementation of professionalization measures might help to achieve other primary aims, such as quality. One example is the demand for an increase in skill level, which trade unions claimed would benefit the quality of care. Another example for this strategy is the demand for higher wages, which trade unions connected with fewer people exiting the care sector and thus to less-severe problems in finding care workers. This strategy of connecting the demand for professionalization with other aspects and with other primary aims makes professionalization more

appealing to organizations and political parties that have slightly different – albeit connectable – aims and interests to that of professionalization in public hearings.

The results of the quantitative content analysis revealed that patient organizations focused mainly on the aim of quality. On the one hand, quality has proven to have been the aim most connected with professionalization in the public hearings. Thus, patient organizations should be allies to occupational-care-worker organizations and advocate for professionalization. On the other hand, patient organizations displayed the second-lowest share of answers with a primary professionalization aim among all groups of organizations. This low share of answers with the aim of professionalization calls into question the role of these organizations as allies for professionalization. Overall, all adopted interests of patient organizations on the topic of professionalization were in favor of professionalization. However, the stated interests and positions were formulated in general terms. For example, more LCT staff was demanded (BAG Selbsthilfe PpSG, 21; DAlzG PfWG_b, 16–17; Women's Council PfWG_b, 45), but this was not connected with the demand for explicit and defined staffing levels, as was the case with trade unions and occupational-care-worker organizations. Furthermore, patient organizations advocated for higher wages for LTC workers (BIVA PflBRefG, 10–11; Women's Council PNG_a, 42–43; dt Stiftung Patientenschutz PpSG, 35–36), but again, this demand was not connected with any more-specific benchmark, such as the recognition of collectively agreed-upon wages. Only the remaining strong competition from family care was mentioned as an impeding factor in wage developments (Women's Council PSG II, 16–17).

> Another point is that the delegation of care to women or families also affects those employed in paid care work. This is because unpaid care always appears as an inexhaustible form of competition for paid care. If care work is unpaid, it has no economic value. This massively influences the willingness to remunerate formal care work appropriately and fairly. (Women's Council PSG II, 17)

Patient organizations generally favored a higher skill level (Women's Council PNG_a, 42–43), specific skills for care counsellors (DAlzG PfWG_b, 23–24), and a care staff that is able to work with care recipients from different migration- and religious backgrounds and those with different gender identifications (Women's Council – PSGI 35 & 107). In general, low-skilled workers should not substitute higher-skilled workers (DAlzG PSG II, 21). However, skill requirements should be lowered for domestic services if these services cannot be provided due to the low number of care

workers (dt. Stiftung Patientenschutz PpSG, 33). Specific demands for a higher skill level for auxiliary carers or for more care workers with an academic education are missing in this dimension. Furthermore, interest in professionalization in the social dimension was also formulated in general terms. Patient organizations advocated for a more-holistic approach to care (DAlzG PSG II, 21) and a higher recognition of care work (Women's Council PNG_a, 342–343).

Thus, patient organizations advocated for the professionalization of LTC in all dimensions. However, their interests and positions were quite broad and were only vaguely related to and connected with the patient organizations' primary aim of a higher quality of care. Thus, patient organizations appear to be allies of occupational organizations in their fight for professionalization. However, they do not promote the topic of professionalization or help it to become more widespread.

Social welfare organizations took a vital role in discussing professionalization, with the Workers' Welfare Association (AWO), Paritätischer, Caritas, and the Diakonie being the most-active social welfare organizations across the period. Social welfare organizations argued in favor of professionalization in all dimensions, with a sole deprofessionalization demand in the skill-level dimension. Professionalization in the working-conditions dimension and the skill-level dimension were argued for the most, whereas professionalization in the quantity- and social dimension seemed to be less important. In the skill-level dimension, social welfare organizations advocated for a decent skill level, which means that formal LTC work should not be substituted by voluntary work (AWO PfWG_b, 29; AWO PNG_a, 31; Paritätischer PfWG_b, 54; Diakonie PfWG_b, 28–29) and that high-skilled workers should not be substituted by auxiliary care workers (Caritas PSG I, 21). Furthermore, the education of apprentices should have priority over their work, which is why they should not be treated or evaluated as *full* care workers with the same workload as LTC workers who have completed training (ASB PflBRefG, 33; AWO PflBRefG 32–33). Moreover, the social welfare organizations demanded further training for care management (Diakonie PfWG_b, 14), easier pathways for workers with low-level care degrees to get into the educational program for the next-higher degree (Caritas PflBRefG, 33; Diakonie PflBRefG, 33), and proven German-language proficiency in order to begin apprenticeship education (DRK PflBRefG, 12). Concerning academic education, the Workers' Welfare Association (AWO) demanded increasing the academic education of LTC work in the Care Further Development Act (an early reform in the period;

AWO PfWG_d, 14), whereas in the Care-Worker Strengthening Act (a late reform in the period), the Workers' Samaritan Federation (Arbeiter-Samarita-Bund, ASB) asked whether academization had not gone too far because the number of vacancies in care that require an academic skill profile is too low to employ all graduates (ASB PflBRefG, 36).

> As the previous speakers have already pointed out, nursing has acquired its very own set of skills and competences over the past 10 years, but there is a considerable need to expand this even further. This can only be achieved by academizing nursing, including at the undergraduate level. (AWO PfWG_d, 14)

> In addition, there is a major concern that future care workers will be trained at universities with high expectations for managerial positions in future nursing companies. We fear that there are not enough adequate jobs for care workers with academic degrees. (ASB PflBRefG, 36)

In the working-conditions dimension, social welfare organizations advocated for reducing unwanted part-time employment, converting this form of employment into full-time employment (BAGFW PpSG, 28), and abolishing schooling tuitions (Caritas PflBRefG, 15; Paritätische PflBRefG, 24). However, the focus in the working-conditions dimension lay on payments. Social welfare organizations demanded that wages in the LTC sector should be adequate (Caritas PSG I, 21; Diakonie PfWG_b, 65–66) and should increase in order to reach the level of wages that are paid in the healthcare sector (Paritätischer PflBRefG, 38). Moreover, collectively agreed-upon wages should be evaluated as economical and be refunded using LTC funds (BAGFW PpSG, 37; Caritas PfWG_b, 56; Caritas PNG_a, 6, Diakonie PfWG_b, 56; Diakonie PNG_a, 6–7; Diakonie PSG III, 9). This fight for higher wages seems to counter the business interests of social welfare organizations because higher and collectively agreed-upon wages increase the costs for care facilities. A statement by the Diakonie hints at the reasons for this position:

> Furthermore, we wish for collectively agreed-upon wages to have an influence on the licensing of care facilities […]. (Diakonie PSG I, 15).

Social welfare organizations usually pay wages according to collective agreements (Buestrich et al., 2008; Razavi & Staab, 2010; Rubery & Urwin, 2011). The introduction of new rules – which include paying collectively agreed-upon wages – would thus not change any conditions for these organizations; however, it would change economic conditions for many private LTC facilities, which generally pay

below collectively agreed-upon wage levels (Buestrich & Wohlfahrt, 2008; Kümmerling, 2016). Thus, social welfare organizations seem to have lobbied for higher wages and for collectively agreed-upon wages in order to have a competitive advantage against private LTC facilities on the LTC market rather than out of genuine professionalization interests.

Social welfare organizations demanded more staff and the establishment of new staffing levels (BAGFW PpSG, 28 & 31; Caritas PSG III, 9–10); however, the extent of the organizations' interests and the specificity of these interests was higher in the skill-level- and working-conditions dimensions than in the quantity dimension. In the social dimension, social welfare organizations generally backed the idea of shifting the responsibility for tasks from physicians to care workers and of defining exclusive tasks for care workers (AWO PfWG_d, 14; Caritas PfWG_d, 14; Diakonie PfWG_d, 29).

> This means that care workers and physicians do not take anything away from one another, but must work hand in hand. The missing exclusive tasks in care indeed urgently need to be defined so that a clear demarcation and cooperation under liability law is possible. (AWO PfWG_d, 14)

Overall, social welfare organizations generally took positions that catered to the aim of professionalization. As they have a dual role as service providers and employers on the one hand and as advocates for marginalized social groups on the other hand, it comes as a surprise that virtually no deprofessionalization interests were adopted. However, the statement on collectively agreed-upon wages by the Diakonie reveals that taking up these professionalization interests and advocating for their implementation might indeed cater to the social welfare organizations' business interests. Generally, pay-, staffing-, and skill levels are higher in facilities that are run by social welfare organizations (Buestrich et al., 2008; Razavi & Staab, 2010; Rubery & Urwin, 2011). Implementing higher standards for staffing levels, skill levels, and working conditions would thus not change much for social welfare organizations. However, private facilities would have to invest more and earn lower profits. Competition in terms of prices between private facilities and social welfare organizations would thus be negligible, and the business model of private care facilities would be challenged. This would benefit social welfare organizations as they could regain market shares. Hence, social welfare organizations are strong allies for occupational-care-worker organizations in their aim to professionalize. However, this allegiance might not stem from genuine interests in professionalization, but from business considerations that align with professionalization interests.

The quantitative content analysis revealed that business organizations and system organizations adopted professionalization in a low share of answers in the public hearings, with business organizations also showing the highest share of answers with a deprofessionalization aim out of all the organizational groups. This finding indicates that business organizations and system organizations advocate for only a few or no further professionalization measures or even deprofessionalization measures. Focusing first on business organizations, they adopted interests and positions on both professionalization and deprofessionalization. Concerning professionalization, business organizations mainly focused on the quantity dimension. More staff and apprentices were demanded (BKSB PflBRefG 27; bpa PfWG_b, 38; bpa PNG_a, 36–37; bpa PflBRefG, 8; bpa PpSG, 34), as were univocal staffing levels in residential care (bpa PSG II, 26). However, the skill level of these care workers did not seem to be of high importance (bpa PpSG, 25).

> We have been saying for years, "Good care needs more time." We do indeed need more staff. But that will only help if we are able to recruit these employees. [...] In that respect, there is also no compelling reason to add a qualification requirement if it can be expected that it will actually be very difficult to fill these positions. We are very clearly in favor of the fact that it is not just about apprenticeship-qualified care workers. It is a matter of improving the care situation. It is a matter of more time. It is no good if we have 13,000 vacancies that cannot be filled. (bpa PpSG, 25)

The demand that skill levels were not be required to be too high was also evident in the evaluation that the entrance level to the new general-care occupation had been set too high (BDA PflBRefG, 7–8). However, concerns that the new care occupation would lower the specific knowledge of LTC workers were also expressed (BDA PflBRefG, 14). Regarding working conditions, the only topic the business organizations commented on was that of wages and payment levels. In the early reforms (i.e., the Care Further Development Act and the Care Redirection Act), arguments were made against accepting collectively agreed-upon wages and payment levels based on collective agreements as payment guidelines (BAGüS PNG_a, 7; bpa PfWG_b, 56). However, this position was to be abandoned if higher wages based on collective agreements were to be fully refunded by the LTC-insurance funds (bpa PNG_a, 7; bpa PSG III, 30). Exactly how genuine this approval of collectively agreed-upon payment structures was is unclear. The Association of Private Social Service Providers (bpa) stated in Care Strengthening Act III that it supported and wanted to hold onto economic competition based on prices. However, labor costs account for

about three-fourths of the total LTC costs (Kümmerling, 2016; Voges, 2002). Thus, competition in terms of prices is inevitably connected to poorer working conditions and lower wages in private LTC facilities compared with public and non-profit facilities.

> We would not have a problem if we were put in a position to pay similar wages as in the hospital. That would significantly improve our situation. But we would also have to answer the question of who should bear these additional costs. […]. If additional costs should be assumed neither by the insured nor by social assistance, they would have to be paid completely by long-term-care insurance. [...] We still think that a competitive orientation is the right way to go. We also consider it important that competition be reflected, among other things, in prices. (bpa PSG III, 30)

In the social dimension, only one answer was given that took the position that care workers should not take over tasks from physicians (VDAB PpSG, 35). Overall, business organizations demanded more employees in care and thus more professionalization in the quantity dimension. In all other dimensions, business organizations did not make professionalization a priority or even took on deprofessionalization interests and positions. For business organizations, a high and increasing skill level of the LTC workforce is not a priority. Furthermore, from their perspective, all wages in LTC should only rise to the level of collectively agreed-upon wages if the costs for these wage increases are fully covered by the LTC-insurance funds.

For system organizations, it is primarily the Peak Association of Statutory Health and LTC Insurers (GKV) that voiced interests and positions on professionalization. System organizations advocated for professionalization as well as for deprofessionalization. The Peak Association of Statutory Health and LTC Insurers (GKV) was in favor of uniform and transparent staffing levels (PSG II, 25–26). Furthermore, it feared that the shortage of staff in the LTC sector would increase due to the higher wages for care workers in the healthcare sector (GKV PpSG, 18–19).

> Because here is what is going to happen: The hospitals are not only going to buy out [the staff from] rehabilitation clinics, they are also going to buy out [the staff from] residential elderly care because they have a higher [wage] level. They will also buy out [the staff from] ambulatory care. (GKV PpSG, 18–19)

The Peak Association of Statutory Health and LTC Insurers (GKV) demanded that the tasks of care workers be compatible with their skill level (GKV PSG III, 28) and that

auxiliary carers generally not substitute apprenticeship-educated LTC nurses (GKV PpSG, 29).

> We are extremely critical with regard to the question that these 13,000 additional positions can also be filled by auxiliary care staff because the objective is to increase the quality of care. The law also states that additional staff should be able to provide all pre-residential services. This also includes case- and care management. I hold auxiliary care workers in high regards, but I do not believe that their training predestines them to take on care- and case management in the way we envision. (GKV PpSG, 29)

Concerning working conditions, only wages were discussed. In the Care Redirection Act, the Peak Association of Statutory Health and LTC Insurers (GKV) argued against the rule of accepting collectively agreed-upon wages as economical because this would increase costs for LTC funds and LTC recipients (GKV PNG_a, 7). However, this position changed gradually in Care Strengthening Act I. The Peak Association of Statutory Health and LTC Insurers (GKV) adopted a position in favor of adequate wages following the ruling of the national administrative court that stated that collectively agreed-upon wages must be accepted as economical (GKV PSG I, 15–16). This direction was further pursued by the statutory health-insurance fund AOK, which actively advocated for higher wages in Care Strengthening Act III (AOK PSG III, 30).

> In principle, we believe that wages that are determined in reimbursement negotiations should also reach the staff. That is the purpose of the regulations. The PSG I has taken an important step in this direction. However, what is incomprehensible in this context is that facilities that are not covered by collective agreements are treated differently than facilities that are covered by collective agreements. In our view, this is not equal treatment. Differences are also problematic when it comes to obligations to provide billing and documentation. There are examples in the federal state of Mecklenburg-Vorpommern in which we as payers agree or want to agree on higher wages in reimbursement negotiations with service providers who are not bound by collective agreements. However, the offer is not accepted because it would entail disclosure obligations. Therefore, we believe it would be reasonable to introduce regulations that would ensure that our offers are accepted. (AOK PSG III, 30)

The statement by the AOK alludes to the actual reason for advocating for higher wages in facilities without collectively agreed-upon wages. System organizations might not be interested in increasing wages for LTC employees in general, but they may want to gain insight into the internal billing of the care facilities. Only one answer of system organizations focused on the social dimension. It favored the shift of tasks from

physicians to care workers in rural areas with low physician densities (Vdek-AEV PfWG_b, 36).

Overall, system organizations do not seem to be strong advocates for or against professionalization. They advocated for enough LTC workers and for a decent skill level because they believed that both ensure quality. Concerning wages, the position of system organizations gradually changed. At first, cost considerations led to an opposition to accepting collectively agreed-upon wages as economical. Then, collectively agreed-upon wages began to be accepted as economical due to a court ruling. Finally, higher wages were actively demanded. The evidence suggests that the development toward this position is not rooted in the aim of professionalizing the workforce, but in the (self-)interest in monitoring the internal billing of care facilities. The advocacy for more competencies of care workers was only stated once and was formulated hesitantly.

Education- and research organizations only played a minor role in the discussion on professionalization interests. However, they took up professionalization interests in the quantity-, skill-level-, and working-conditions dimensions. They advocated for more apprentices (AAA PflBRefG, 11), a higher integration of academic education into apprenticeship education (Dekanenkonferenz PflBRefG 19–20; DGP PflBRefG, 20), and the abolishment of schooling tuitions (AAA PflBRefG, 22–23; VDP PflBRefG, 23).

6.3 Summary

What do the quantitative and qualitative content analyses of answers in the public hearings tell us about organizations' primary aims and their stance on the aim of professionalization? First, the primary aim that was most pursued in the public hearings is quality. For all organizational groups, this is the most- or second-most-pursued primary aim. Second, quality is the aim that was taken up the most in connection with the aim of professionalization. The frequent adoption of the aim of quality might be related to its solely positive connotation. However, what organizations actually mean when they demand an increase in the quality of care – and how genuine these interests and positions are – cannot be deduced from the results. Furthermore, the extent to which organizations back and further pursue the aim of

quality if other important aims for the organization (e.g., financial stability) are put in jeopardy might differ based on the group of organizations.

Furthermore, quality is the primary aim that was most pursued in the first five hearings in the studied period, while professionalization was most pursued in the last two hearings. Quality was not unexpected to be the most-important aim in the first five hearings; however, the first two hearings still heavily followed a financial-stability rationale, which was not evident in the answers of the organizations. As expected, the aim of professionalization was the most pursued in the last two hearings as the reforms placed professionalization as their main aim in the implemented measures. The quantitative results furthermore suggest that occupational organizations, trade unions, and social welfare organizations were the largest supporters of the aim of professionalization. All these organizational groups took up professionalization as their most- or second-most-adopted primary aim.

The qualitative content analysis deepens the understanding of the stance that organizations take on the professionalization of the LTC workforce. First, the analysis reveals that interests in professionalization were stable for most organizational groups over the whole period. Only a few interests in professionalization altered, which were limited to one specific interest in one dimension and did not relate to a shift from generally supporting the aim of professionalization toward supporting the aim of deprofessionalization, or vice versa. Second, the analysis reveals that the group of occupational organizations has to be divided when it comes to the aim of professionalization. Occupational groups that represent care workers and occupational groups that represent physicians had diverging interests in the professionalization of the LTC workforce.

Occupational organizations of care workers advocated – as expected – for professionalization in all dimensions. Trade unions, patient organizations, education- and research organization, and – to a certain degree – social welfare organizations were expected to be allies that advocated for professionalization, especially by connecting it to their own primary aims. Business organizations, system organizations, and – to a certain degree – social welfare organizations were expected to express interests that stood in opposition to the aim of professionalization. The analysis of the answers in the public hearings largely supports these expectations. By focusing on each dimension of the professionalization aim and taking into account changing positions over time, the results reveal more-nuanced positions.

Occupational organizations of care workers supported professionalization in all dimensions and adopted professionalization as their primary organizational aim. Trade unions are their strongest allies and also support professionalization in all dimensions. The improvement of working conditions was thereby the most-important dimension. Trade unions even brought up more measures and themes on how working standards should be improved than did occupational organizations. Furthermore, trade unions connected the interests in professionalization between the different workforce dimensions and with the aim of quality, which is a strategy that makes it easier for organizations and political parties to relate to their positions and more difficult for them to deny the relevance of the aim of professionalization. Patient organizations were expected to be a further strong supporter of professionalization because their primary aim of increasing quality could be and was often connected with the aim of professionalization. First, patient organization adopted the aim of professionalization in relatively few answers. Second, when they did so, the issued demands and measures were stated in broad terms and were loosely connected to the aim of quality. Thus, patient organizations are allies for occupational organizations in their fight for professionalization, but their voice in support of professionalization is more quiet than loud. Education- and research organizations generally only showed low involvement in the public hearings. Therefore, their engagement in the topic of professionalization was also generally low. However, these organizations support professionalization interests and could thus be identified as (weak) allies of occupational organizations. The role of social welfare organizations was expected to be ambivalent depending on which role they took up: that of a business organization and employer, which would be expected to go hand in hand with predominantly deprofessionalization interests, or that of a social advocate for weak societal groups, which would be expected to lead mainly to professionalization interests. Social welfare organizations mainly adopted interests in professionalization; however, their interests in increasing skill levels and especially in improving working conditions by implementing rules for the acceptance of higher and collectively agreed-upon wages does not seem to have stemmed from their role as social advocates, but rather from their role as business organizations and employers. The qualitative content analysis indicates that social welfare organizations expected a competitive advantage over private providers if higher working conditions and skill levels were to be implemented. Social welfare organizations are thus allies of professionalization; however they can be expected to only remain allies in the future

as long as they think that advocating for and implementing professionalization measures will give them a competitive advantage on the LTC market. If this belief changes, the organizations' stance on professionalization might also change. Business organizations positioned themselves – as expected – largely against the aim of professionalization. However, they also advocated for more staff in LTC. Furthermore, they developed from a position against higher wages and the acknowledgment that collectively agreed-upon wages are economical and serve as benchmarks to a position in which they could accept these measures if higher wages were fully refunded by the LTC-insurance funds. Hence, a small movement away form a general opposition to the aim of professionalization was visible. For system organizations, a similar position on professionalization as for business organizations can be depicted. System organizations also originally argued against acknowledging collectively agreed-upon wages but departed from this position in later public hearings. System organizations were further interested in an adequate amount of care workers and appropriate skill levels. Thus, these organizations were not generally opposed to professionalization interests; however, they also did not strongly advocate for them. The occupational organizations of physicians are most opposed to the professionalization of LTC workers. They did not see a need for a higher skill level of the LTC workforce. This position was connected to the interest for which they most-strongly lobbied. The occupational organizations of physicians argued against a shift of tasks from physicians to care workers, against defining exclusive tasks for these care workers, and against the care workers' independent practice of medical procedures. First, this shift would take away tasks and responsibilities – and therefore also power – from physicians not only in the healthcare sector, but also in the field of LTC. Second, it would put physicians' own role as professionals under pressure because task shifts would strengthen the societal role and the social status of LTC workers – an occupation with which physicians compete for competencies and recognition.

Focusing on the four workforce dimensions, the aim of professionalization in the quantity dimension was the strongest aim within professionalization and was backed by organizations from different groups. The backing for professionalization in the skill-level- and working-conditions dimensions was less-widely adopted yet still pursued by a variety of organizations. Support for professionalization in the social dimension was the lowest compared with all dimensions, and opposition to professionalization was the strongest.

In the quantity dimension, all organizational groups were in favor of increasing the number of LTC workers except for the occupational organizations of physicians, who did not issue a statement on the topic in the public hearings (see Figure 36 B). Of course, the organizations may differ in how much they thought that the workforce had to increase, in whether they thought that new staffing levels in residential and ambulatory care were needed, and in how exactly they thought that staffing levels should be shaped. However, the fact that all organizations evaluated the number of staff in LTC as being too low is a strong basis on which general organizational support and organizational pressure on political decision-makers for more LTC workers can be built.

When examining the skill-level dimension, differences between the organizations become apparent (see Figure 36 C). Occupational organizations of physicians were opposed to a higher skill level. Business organizations did not issue many statements in this dimension. However, they feared that the entrance levels to the new general-care apprenticeship had been set too high, which does not suggest that there was interest in increasing the knowledge base of LTC work. System organizations can be ordered somewhere in the middle between professionalization- and deprofessionalization interests in the skill-level dimension. These organizations asked for adequate skill levels and only supported the substitution of higher-skilled workers by lower-skilled workers if there was no chance to find workers with the adequate skill level on the labor market. This position tended more toward the aim of professionalization. However, these interests were formulated in general terms and left room for interpretation. All other organizational groups – the occupational organization of care workers, trade unions, patient organizations, social welfare organizations, and education- and research organizations – showed interests that generally supported professionalization in the skill-level dimension. However, only occupational organizations of care workers, education- and research organizations, and social welfare organizations advocated for a higher number and share of academic education, which is one crucial aspect of professionalization. The social welfare organizations also expressed interest in academization in the earliest public hearing (i.e., the Care Further Development Act) but questioned it in one of the most-recent public hearings (i.e., the Care Occupation Reform Act). Thus, the support for increasing the skill level generally concerned low-educated workers – such as auxiliary carers – and had little to do with academization. Hence, most organizations might have

found common interest in an occupationalization of the skill level. However, occupational-care-worker organizations had only low backing for their aim of academization, which is a crucial step toward professionalization.

In the working-conditions dimension, a vast number of different measures were proposed that would lead to upward developments for the LTC workforce, such as a shift from unwanted part-time- to full-time work, decreasing the overall workload and working hours, and increasing measures for medical prevention. However, higher wages and the introduction and acceptance of collectively agreed-upon wages as benchmarks for payment structures were the most-discussed measures across all organizations and time points. Occupational organizations, trade unions, patient organizations, and social-welfare organizations supported higher and collectively agreed-upon wages. Business organizations and system organizations both stood in opposition at the beginning of the period, but both gradually gave up their strict opposition to accepting and widely implementing collectively agreed-upon wages (see Figure 36 D). Employers stated that they could imagine higher wages and paying wages according to collectively agreed-upon levels if these costs were fully refunded by the LTC-insurance funds. This move has the potential to lead to higher wages as the opposition to higher and collectively agreed-upon wages became less pronounced. This reduced opposition to collectively agreed-upon wages also has the potential to open new opportunities to argue for and implement further improvements in working conditions.

The social dimension is the workforce dimension in which organizations expressed the least interest. Trade unions demanded more co-determination rights for care workers in their care facilities, and occupational organizations of care workers demanded their own decision-making bodies. However, the most-prevalent theme in this dimension was moving competencies and responsibility from physicians to care workers and defining exclusive tasks for care work. This issue appears to have been the most-controversial professionalization issue in the public hearings because most organizations were either fully in favor or fully against the development (see Figure 36 E). Occupational-care-worker organizations, trade unions, and social welfare organizations were in favor of moving competencies and responsibility away from physicians and toward care workers and of defining exclusive tasks for care work. System organizations supported these measures if the provision of physician services was too low in a region. However, business organizations – and especially physician

organizations – were opposed. For physician organizations, this was the most-important issue concerning the aim of professionalization. A takeover of physician tasks by care workers would devaluate the work of physicians, contribute to the professionalization of care workers, and at the same time enhance the deprofessionalization of physician work. Therefore, the social dimension can be depicted as the dimension in which the interests and opinions of organizations were the furthest apart and a convergence of positions in the future seems unlikely.

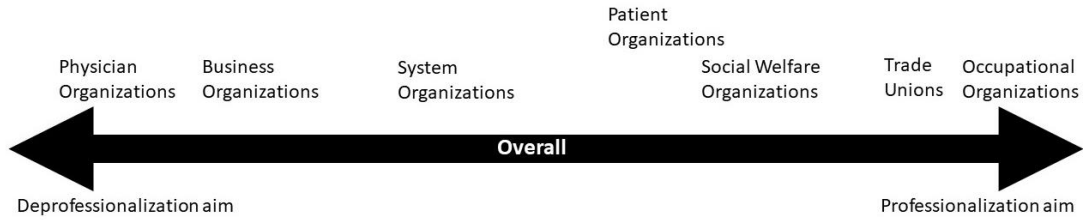
Taking all dimensions together (see Figure 36 A), occupational organizations of care workers demanded a complete professionalization of the care workforce. This comes as no surprise as these organizations built their existence on this aim. Trade unions were also highly interested in the professionalization of the care workforce and prioritized the working-conditions dimension over other workforce dimensions. Social welfare organizations were also interested in professionalization. They focused on the skill level and on wages mainly because they perceived a competitively advantageous position against private care facilities if these measures were implemented. Patient organizations also issued statements in favor of professionalization, but these were very broad. Education- and research organizations were also in favor of professionalization, but their involvement was too low to determine a nuanced position on professionalization in general or in the four dimensions.[27] These five organizational groups can thus be ordered on the professionalization side on the continuum, whereas system organizations, business organizations, and occupational organizations of physicians can be ordered on the deprofessionalization side. System organizations occupy a position close to the middle as they favored more workers and a decent skill level in order to ensure the quality of care. They also moved to a position of supporting higher wages and could imagine task shifts from physicians to care workers. Business organizations adopted similar positions as system organizations on professionalization. However, they were opposed to increasing the skill level, which moves them closer to the deprofessionalization end. Occupational organizations of physicians are located close to the deprofessionalization end as they did not issue virtually any professionalization demands and instead strongly argued for no new competencies and no defined tasks for care workers in the social dimension. The overall position and the position of organizational groups in each dimension can be

[27] Therefore, the group of education- and research organizations is not included in Figure 36.

depicted as schematic figures along a professionalization–deprofessionalization-aim continuum, as shown in Figure 36.

Figure 36: Positioning of organizational groups on professionalization–deprofessionalization continua

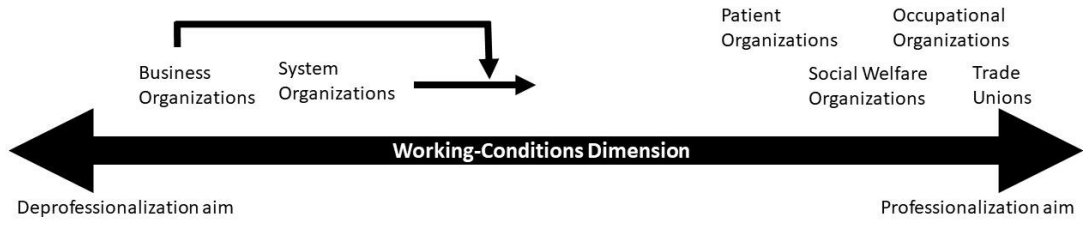
A)



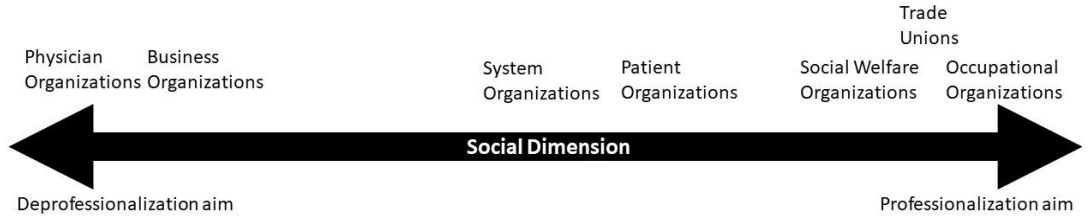
B)

C)

D)



E)



Source: Own compilation based on quantitative and qualitative content analyses of the public hearings on LTC.

7 CONCLUSION – WORKFORCE DEVELOPMENTS AND THE ORGANIZATIONAL FIGHT FOR PROFESSIONALIZATION

Ensuring adequate and affordable LTC services for the dependent old-age population is a major current and future social-policy challenge not only for Germany, but for all advanced welfare states. The ageing of the baby-boomer generation, increasing longevity, decreasing family resources for providing informal care, and the introduction of the LTC-insurance system have led to growing demand in Germany for formal LTC service over the last 15 years. As societal changes continue to unfold, the LTC system is coming under pressure to provide adequate and affordable LTC services both today and in the future. Bringing together a financially stable LTC system on the one hand and securing decent quality of care on the other hand pose a continuous challenge for policymakers.

LTC workers find themselves in the midst of these challenges. First, LTC is a labor-intensive economic field, with about three-quarters of all LTC costs – depending on the type of LTC – relating to the workforce (Kümmerling, 2016; Voges, 2002). Second, LTC workers are highly responsible for the quality of care. A variety of studies that have focused on different contexts of LTC and on various quality indicators have revealed that a certain threshold in the number of LTC workers and their skill level must be met in order to ensure an adequate quality of care (Backhaus et al., 2014; Castle, 2008; Comondore et al., 2009; Hyer et al., 2011; Spilsbury et al., 2011). Additionally, the standards that are set for the quality of care and thus also for the workers in care have increased. Quality standards have moved past the mere provision of bodily care and now include psychological well-being, societal participation, and prevention. For example, new research on Alzheimer's disease and special demands for cognitive and occupational therapies place high demands on knowledge and continuous further training for employees in LTC (OECD, 2020b). Furthermore, the population of the aged is becoming more diverse as it includes an increasing number of individuals with different cultural, religious, and migration backgrounds whom LTC workers encounter and must address and incorporate into their work (Caceres et al., 2020; Khan & Ahmad, 2014).

Striking the right balance between financial stability and quality in LTC systems requires continuous adjustments to LTC institutions by policymakers. These adjustments not only affect LTC recipients (e.g., through higher or lower copayments

or by resulting in more or less time for care services allotted to each patient), but they also impact the LTC workforce. Whether LTC policy reforms focus on quality – which, in principle, means high(er) spending – or on financial stability – which, in principle, entails less and limited spending – either opens up opportunities for upward and professionalization developments of the workforce or constrains these opportunities and even incentivizes downward and deprofessionalization developments. As policies and the LTC workforce are torn between an increasing demand for care and thus also ensuring an adequate quality of care on the one hand and securing the financial sustainability of the LTC system on the other hand, the direction in which the LTC workforce has been developing has remained unclear. As a result, the following questions have also become relevant: How has the LTC workforce in Germany developed in the past 15 years? Has the quest for a decent quality of care led to more LTC workers, to more LTC workers with higher skill levels, to better working conditions, or to higher social statuses and thus also to the upward movement and professionalization of the LTC workforce? Similarly, has the pursuit of financial stability led to the opposite process – that is, to downward developments and deprofessionalization – by resulting in a smaller LTC workforce and a workforce with lower skill levels, poorer working conditions, and lower social statuses?

Demographic developments and societal changes provide the background against which developments in the LTC workforce unfold. However, the rising number and share of the aged population does not inevitably translate to more LTC workers. Similarly, the rising number and share of severely impaired LTC patients does not automatically initiate a mechanism that increases the number of high-skilled LTC workers. Whether a rising number of dependent aged people and severely impaired LTC patients results in more and better-skilled LTC employees depends both directly and indirectly on the institutions of the LTC system and on the development of these institutions. For example, the number of LTC workers can be influenced by the extent of support measures for informal care providers as well as by the implementation and adjustment of quantitative staffing levels. However, these policy measures do not develop in a vacuum; rather, they are shaped by the political actors of the LTC system. The influence of political actors – and especially of interest organizations – on policy reforms has been established for different fields of social policy, such as employment relations (Bender, 2020), unemployment (Hegelich et al., 2011), healthcare (Bandelow, 2006), and pensions (Trampusch, 2004). However, LTC studies have thus

far rarely integrated organizations or organizations' aims and interests as explanatory factors for policy changes in LTC or for LTC workforce trajectories. These considerations led to the second question investigated by the present study: How do policies and the influence of organizations shape developments in the LTC workforce?

The empirical results from the workforce analysis, the policy analysis, and the analyses of organizational involvement and of organizations' aims display high congruence. Hence, the study makes a strong case for systematically including organizations and their interests and aims as explanatory variables when analyzing processes and developments in the LTC sector – and especially those of LTC workforce trajectories. The inclusion of organizations and their interests and aims as explanatory variables follows from the case study of Germany; however, the underlying conceptual framework can be transferred to further country cases. Future studies in different national settings could thus deepen our understanding of the organizational influence of LTC organizations on policymaking and on the development of LTC workforces.

7.1 Theoretical Contribution

The present study contributes to professionalization theories and to organizational-interest politics. *Profession* and *professionalization* are abstract theoretical concepts. Scientific theoretical contributions on these concepts developed mainly between the 1960s and 1980s and embed *profession* and *professionalization* in broad theoretical approaches on the structure and functioning of society. These theories define certain traits or benchmarks in order for an occupational group to be classified as a profession. Departing from these rigid criteria for defining *profession* and *professionalization*, both terms have entered public speech in rather broad and non-theoretical terms. Indeed, the term *profession* can be replaced by words such as *specialist*, *expert*, and *skilled employee*. The present study took up neither these theoretically rigid approaches nor the vague definitions applied in some of the recent scientific literature. Instead, the study used the term *professionalization* to describe a flexible theoretical framework in which *profession* defines one end on a continuum. This framework allowed for an analysis of the development of a workforce – the LTC workforce – from different angles. At the same time, the study employed the same theoretical framework to examine policy measures by their impact on professionalization developments and

to illuminate the professionalization interests of different interest organizations. Employing the same theoretical framework to analyze workforce developments, policy measures, and organizational interests enabled connections between these areas to be drawn and established. The identified connections enhance our understanding of workforce processes and the factors that shape them.

Connecting workforce developments to institutions, policies, and organizational actors' interests and aims thereby extends our knowledge on processes and links in the LTC sector. Previous studies have mainly only scratched the surface of the reasons for upward and downward workforce developments. The role and interests of organizational actors in the LTC sector have been particularly heavily neglected, although their influence on social policy has been demonstrated for sectors such as employment relations (Bender, 2020), unemployment (Hegelich et al., 2011), healthcare (Bandelow, 2006), and pensions (Trampusch, 2004). The neglect of organizations in the field of LTC has been justified by the weakness of occupational organizations of care workers. Scholars have assessed the organizations' organizability and capacity for conflict as low, which has led to the evaluation that occupational organizations of care workers play a negligible role in interest formation and representation (Kümmerling, 2016; Schroeder, 2018). However, even if occupational organizations of care workers are weak, this should not lead to the conclusion that all organizations involved in the LTC sector are non-influential actors. Hence, studying organizations in the LTC system contributes to understanding whether and how organizations influence LTC policies and workforce developments.

Furthermore, the present study demonstrated that even the interests of organizations that prior research has assessed as weak can enter the political arena. One possible pathway for interests of weak organizations to enter the policymaking process is through the advocacy of powerful organizations with similar or connected aims. The analyses in the present study demonstrated that the aim of professionalization maintained by occupational organizations of care workers became more salient through the advocacy of other organizations, such as trade unions and social welfare organizations, in particular. Another pathway to including the interests of weak organizations is by the opening of a *window of opportunity*. In LTC in Germany, this window has been opened gradually via the intensification of the labor shortage. This development first shifted political and public attention to the LTC workforce and second facilitated a discussion about the relevance of professionalization measures. As

labor shortages in LTC develop and exist not only in Germany, but also in many European and OECD countries (OECD, 2020b), the *window of opportunity* to include the interests of weak organizations and to move the professionalization of the LTC workforce forward might exist in many national contexts.

7.2 Findings

The findings of the present study can be divided into three categories: developments of the LTC workforce, policy developments, and organizational influence on both policies and workforce developments. German LTC institutions have displayed ample room for upward and downward workforce developments. On the one hand, the general increase in the number of LTC recipients and the slowly increasing amounts of spending in the LTC sector have left room for professionalization and occupationalization. On the other hand, generally mediocre spending levels in international comparison, a high level of out-of-pocket spending, an overproportional increase in the number of ambulatory LTC recipients and LTC recipients who receive cash benefits, and the privatization of service provision have left room for deprofessionalization- and deoccupationalization trajectories. Hence, Germany represents an interesting case for studying LTC-workforce developments as the context leaves ample room for upward and downward workforce developments and thus also ample room for policies and for organizations to influence these developments.

The developments of the workforce have unfolded along four dimensions: *quantity*, *skill level*, *working conditions*, and a *social dimension*. The workforce developments showed no uniform trend, which means that no general upward or downward movement has been apparent when considering all dimensions and their development over the past 15 years at once. Instead, the dimensions each had different starting points along the continuum, and developments have been heterogenous over the whole spectrum, ranging from deoccupationalization to professionalization depending on the dimension. Within some dimensions, simultaneous upward and downward developments have even occurred.

The quantity dimension has shown only upward movements. The number of employees in LTC has increased continuously; however, this rise has not satisfied the demand for LTC workers – and especially for apprenticeship-educated LTC nurses.

Healthcare nurses could not compensate for the lack of these employees because the demand for employees has exceeded their supply. The increase in the number of LTC employees and the simultaneously intensifying shortage of LTC workers demonstrate the increasing significance of the LTC workforce. Furthermore, the shortage of employees is an essential trait of professions. Hence, the developments in the quantity dimension indicate professionalization.

The skill-level dimension has shown upward and downward developments. The share of low-qualified care workers has increased over time, which has also led to a decreasing share of apprenticeship-educated care employees. However, the share of academically trained workers has remained low – with only about 2% of care employees having obtained university education – but stable over time. This stagnation has unfolded despite rising levels of graduates in social- and care-related academic study programs. The fact that graduates have not opted for employment in the LTC sector hints at non-attractive working conditions. Furthermore, the workforce has become more specialized in terms of having completed education specifically designed for work in the LTC sector. Within the LTC sector, the share of LTC nurses and auxiliary LTC nurses who are specifically trained for work in LTC has increased compared with (auxiliary) healthcare nurses, child healthcare nurses, and (auxiliary) social-care nurses. It is questionable whether the increase in skill level that goes hand in hand with this specialization outweighs the increase in low-trained care workers and the corresponding decrease in skill level. Therefore, the developments in the skill-level dimension indicate mainly deoccupationalization and deprofessionalization.

In the working-conditions dimension, working times and wage levels are decisive. The full-time-employment rate has remained low over time and initially decreased, but this trend came to a halt around 2010. Furthermore, marginal employment has been more common in LTC than in the entire labor market, but it has decreased slightly since the early 2010s. Nominal payment levels in LTC have increased steadily. Furthermore, the wage gap between (auxiliary) LTC employees and higher-paid (auxiliary) healthcare employees has diminished, but payment levels have remained lower in the LTC sector than in the healthcare sector. Hence, the evidence points toward non-professionalized – and in many cases, not even occupationalized – working conditions. However, in the most-recent years, downward movements have stopped, and small signs of upward movement have become apparent.

In the social dimension, high societal-prestige levels and the recent establishment of boards of nursing and care at the federal level point to a professionalizing dimension. However, the first board of nursing and care has already begun to dissolve. Furthermore, the low participation rates of organizations that represent LTC employees in educational and apprenticeship-related committees is representative of the low decision-making power that occupational organizations of care workers have regarding their own educational curricula. Thus, the professionalization developments in the social dimension have been countered by deprofessionalization- and deoccupationalization developments.

Overall, the analysis of the developments of the LTC workforce reveals that professionalization is not a one-way street. Indeed, professionalization and occupationalization on the one hand and deprofessionalization and deoccupationalization on the other hand unfold simultaneously. This finding highlights the theoretical angle on professionalization adopted throughout the present study. Professionalization is a flexible process that might (nearly) be reached in one dimension (most notably in the quantity dimension) but that is far away and even moving farther away from this goal in other dimensions (most accentuated in the skill-level dimension). As not all dimensions show the level of a profession or a professionalization development, LTC could be labeled as not being *a profession*. Although the empirical results allow for this conclusion, the analysis proposes departing from general evaluations and allocations (i.e., evaluating an entire group of working people as a profession or not a profession) and instead closely examining and evaluating where professional traits exist and are developing and where these traits are devolving and becoming less obtainable. These fine-grained results – especially when examining all dimensions of the workforce at once – allow political actors who are interested in LTC professionalization to direct their actions and power toward the dimension that they think needs the most attention.

In a second step, the study turned to explanations for the workforce developments by conducting a policy analysis of LTC reforms. This policy analysis examined which aims were mainly adopted in the reforms and which measures that focused on the workforce were implemented. The German LTC system was established in 1995/1996. Only about a decade later was the first structural reform to the system enacted. This lack of reforms led to the declining actual value of benefits and enhanced the financial-stability rationale that had already been implemented in the basic institutions of the

LTC system (capped benefits, the priority of ambulatory over residential care, high incentives to take up family care). The aim of financial stability served as a guide for the first two major structural reforms: the Care Further Development Act of 2008 and the Care Redirection Act of 2012. In addition to a focus on financial stability, both reforms introduced small measures that aimed to increase the quality of care. This emerging shift in policymaking aims was taken further in Care Strengthening Act I of 2014 and especially in Care Strengthening Act II of 2015. The latter act implemented a new definition of *in need of care* that included an expansion of eligibility and major changes to the benefit system, with new benefit levels and higher benefits for the majority of LTC recipients. Care Strengthening Act III of 2016 was a minor act that aimed to connect and harmonize the new rules of the LTC system with those of other social-security systems. The three Care Strengthening Acts primarily implemented the aim of quality but also paved the way toward a stronger focus on LTC-workforce issues by implementing measures on accepting collectively agreed-upon wages and on staffing-level requirements. The Care Occupation Reform Act of 2017 and the Care-Worker Strengthening Act of 2018 both set their focus on the workforce in LTC. The Care Occupation Reform Act implemented a new general care-apprenticeship system that integrated the previously separate apprenticeships for healthcare nurses, LTC nurses, and child healthcare nurses. Since 2020, apprentices have received a general education in care and have been able to specialize in LTC or child healthcare in the third (i.e., the final) year of their education. The political aim with this reform was to attract more apprentices and to increase the flexibility of care employees in order to enable them to work in healthcare- and LTC facilities. The Care-Worker Strengthening Act also focused further on measures for increasing the number of LTC workers by implementing measures designed to improve working conditions. Thus, the final two reforms had professionalization as their primary aim. Overall, the main aims implemented in the reforms have moved from financial stability to quality and then to professionalization.

Focusing only on the aim of professionalization and the implemented measures that have specifically targeted the LTC workforce, over the course of all reforms, measures have primarily focused on the quantity- and working-conditions dimensions and have secondarily focused on the social dimension. Measures that would directly impact skill levels have not been adopted. Since the early 2010s, measures designed to increase the number of LTC workers have been implemented. Improving working conditions has

come into focus since the mid-2010s. Measures and improvements in both dimensions have aimed to trigger increases in the social dimension of the workforce, while increasing the educational and academic basis of the workforce has not been an aim of the reforms. Measures for employing low-qualified workers have even been implemented despite the understanding that these measures would likely trigger deoccupationalization developments in the skill-level dimension.

The development toward incorporating professionalization as an aim in LTC policy since the mid- to late 2010s has coincided with workforce developments. Implemented measures in the working-conditions-, skill-level-, and quantity dimensions have correlated to a substantial degree with actual developments in the LTC workforce. Investments in improving working conditions since the mid-2010s have overlapped with developments in the working-conditions dimension. Around the same time, the worsening of working conditions came to halt and began to show small signs of improvement. Furthermore, the neglect of measures aimed at increasing the educational and academic foundation of LTC and at promoting low-qualified additional-care workers began to correspond with developments in the skill-level dimension, which had shown constant deoccupationalization and deprofessionalization. Efforts to increase the number of employees began with the Care Redirection Act in the early 2010s. As the LTC workforce grew throughout the 2010s, implemented policy aims and actual workforce developments began to overlap; however, increases in the workforce had taken place even before the aim was implemented in policy. Nevertheless, implemented professionalization measures and aims correlate to a substantial degree with workforce developments in the dimensions. This correlation suggests that policies have influenced actual workforce developments.

The trajectory of the reforms, the implemented measures, and the specific design of these reforms and measures have been developed by a multitude of political actors. Interest organizations are political actors that are formally involved in the policymaking process. They are consulted via public hearings, which were held for all analyzed LTC reforms. In these public hearings, organizations are able to issue their opinions on a proposed bill. Empirical research on the most-important interest organizations in the LTC sector and thereby also on the influential actors has thus far been missing. Hence, the present study analyzed which organizations participated in the public hearings, what aims they pursued, and what stance they took on the professionalization of the LTC workforce. The aggregation of the results of these

analyses revealed the influence of interest organizations on LTC policies and thus also on LTC-workforce developments. This measurement of influence constituted the third part of the results.

A first step toward influence is involvement. Only organizations that are involved in public hearings and thus also in the policymaking process can be influential actors. The more an organization or an organizational group is involved in a hearing (and especially if this involvement is based on questions from government parties), the higher the possible influence on the proposed reform and the design of a measures is. Furthermore, if involvement is strongly connected to influence, organizations and organizational groups with aims similar to those implemented in the reforms should be involved the most. System organizations such as health- and LTC funds should be the main advocates for the aim of financial stability and should thus have been involved the most in the first two public hearings. Patient organizations such as the Alzheimer Society should be interested primarily in increasing quality and should thus have been the most-involved organizational group in Care Strengthening Acts I–III. The main aim that occupational organizations should pursue is professionalization; therefore, they should have been the most-involved organizations in the last two reforms – namely the Care Occupation Reform Act and the Care-Worker Strengthening Act. These hypotheses were largely confirmed by the analysis of the frequency of answers by the organizations in the public hearings. Indeed, system organizations were the most-involved organizational groups in the first two hearings. Patient organizations were the most-involved group in Care Strengthening Act II, which was the most-encompassing reform of those that aimed for quality. Occupational organizations were involved the most in the final two reforms, which primarily implemented the aim of professionalization. Thus, implemented aims in policies and the hypothesized primary aim of the most-involved organizational groups largely fit together.

Moreover, the policy analysis and the analysis of organizational involvement reveals that financial stability played the most-important role in LTC policymaking. The aim of financial stability played a major role in all reforms as institutions that maintain financial stability (e.g., capped benefits or a priority of ambulatory care over institutional care) remained largely untouched. Furthermore, system organizations – which are primarily interested in financial stability – were the most or second-most involved organizations in the public hearings by the government in all reforms except

for the Care Occupation Reform Act. These findings reveal that financial-stability aims were highly relevant in all reforms.

Involvement "is often a necessary step towards achieving influence, but is not equal to influence" (Eising & Spohr, 2017, p. 319). Hence, the aims that organizations actually advocated for and the stance of these organizations on the aim of professionalization were analyzed. Both the number of answers in the public hearings that adopted professionalization as an aim and the qualitative content analysis of these answers reveals which organizations are in favor of and which are opposed to the professionalization of the LTC workforce. The analyses reveal that organizations can be grouped into leading organizations for and advocates of professionalization on the one hand and into opponents of professionalization on the other hand.

Occupational organizations of care workers and trade unions took up the role of leaders for the aim of professionalization. Occupational organizations of care workers – most notably the German Care Occupations Association (DBfK) and the German Care Council (DPR) – advocated for professionalization in all dimensions. This finding is not surprising as the entire purpose and legitimation of these organizations rely on the representation of care-workers' interests. The German Care Council was stronger and more progressive in the formulation of its demands for professionalization than was the German Care Occupations Association. This progressive support of professionalization measures might explain why the German Care Council was more involved than the Care Occupations Association in public hearings that primarily focused on professionalization. In the Care Occupation Reform Act and the Care-Worker Strengthening Act, the government aimed to implement professionalization measures and thus relied on the strong demand for professionalization by the German Care Council to support and powerfully legitimize its proposed ideas. This greater ability to justify the demand for professionalization (Nullmeier, 2000) by the German Care Council was unexpected as the council is an umbrella organization that represents several organizations of care workers and must thus represent more and more-diverse interests than the German Care Occupations Association, which only represents healthcare and (auxiliary) LTC nurses.

The trade unions ver.di and the DGB are not only advocates for and supporters of the aim of professionalization, but they are also leading organizations in establishing workforce topics and the aim of professionalization of the LTC workforce. These unions focused particularly on the professionalization of the working-conditions

dimension and focused within this dimension on wages. This focus can be explained by trade unions' role as representatives of workers in collective bargaining and in all issues concerning the workplace. In comparison with occupational organizations of care workers, trade unions have a greater general organizability and capacity for conflict, which they especially used in the early hearings to introduce the topic of professionalization. Furthermore, trade unions connected demands within the workforce dimensions with one another and with the aim of increasing quality. These connections justify the demand for professionalization and make the aim of professionalization appealing to other organizations and political parties that do not hold professionalization as their primary aim but pursue aims that are connected to professionalization. Hence, trade unions display what Nullmeier (2000) refers to as *strong argumentative power* and a high *ability of to justify* interests in a topic.

Social welfare organizations are strong advocates for professionalization. Professionalization was the second-most-adopted primary aim after the aim of quality, and social welfare organizations focused specifically on demands for a higher skill level and higher payments within the aim of professionalization. These demands did not stem from the genuine aim for professionalization of the LTC workforce; rather, they stemmed from economic considerations. Compared with private LTC facilities, social welfare organizations expected competitive advantages from the implementation of professionalization measures. Private facilities usually pay lower wages and have poorer working conditions than social welfare organizations. Implementing professionalization measures up to the level of those that social welfare organizations provide their employees would thus only affect private facilities and weaken their business model, which is built on competition in terms of prices.

Patient organizations are only weak advocates of professionalization and mainly issued statements that involved the aim of quality. Theoretically and empirically, this aim of quality is strongly connected with the aim of professionalization. However, patient organizations only adopted general statements in favor of professionalization and did not connect them with the aim of quality or any other aim, which reveals a low *ability to justify* the relevance of professionalization.

System organizations, business organizations, and occupational organizations of physicians take up positions that tend more toward the aim of deprofessionalization. Of these three organizational groups, system organizations adopted the most-neutral position on professionalization issues in the reforms, with the position moving from

one that is against professionalization to an about neutral position over time. Business organizations were more-strongly opposed to professionalization, especially in the skill-level dimension; however, similar to system organizations, they adopted more-neutral positions on wage increases in reforms toward the end of the research period. The movement of these two organizational groups might be related to the increasing shortage of care workers. In order to find LTC workers and to keep them in LTC, a position against collectively agreed-upon wages or a higher skill level in the early reforms might have been abandoned as these measures had been considered to contribute to solving the problem of the intensifying labor shortage.

Occupational organizations of physicians are the group that is most-strongly opposed to professionalization, and this opposition was most accentuated in the social dimension. These organizations particularly argued against the enlargement of rights and duties, the definition of exclusive tasks, and the independent practice of specific medical procedures by care workers. These measures directly interfere with and threaten physicians' own status as a profession and call into question their status as the highest-ranked and most-important occupation not only in the healthcare, but also in the LTC sector.

The results of the different analyses – workforce developments, policies, organizational influence – have value on their own; however, they relate to one another and display certain connections and patterns. Several examples indicate that workforce developments, policy measures, and organizational influences are interrelated. The quantity dimension is the only workforce dimension that has solely moved upward and became professionalized. At the same time, all organizational groups have shown a genuine interest in increasing the number of LTC workers. There was essentially no opposition to this aim. The uniform support for more LTC employees might also explain why increasing the number of LTC employees became a major policy aim in the last two reforms.

The skill-level dimension has displayed a downward trend, as indicated by an increasing share of low-qualified LTC employees, a decreasing share of apprenticeship-educated care employees, and a low level and a stagnation of academically educated employees. On the one hand, this deoccupationalization trend can be explained by the shortage of apprenticeship-educated LTC- and healthcare nurses. Lower-qualified LTC workers seem to have occupied positions that originally would have been filled by apprenticeship-educated care employees. On the other hand,

policies actively fostered deoccupationalization. The Care Redirection Act and Care Strengthening Act I invested general tax money in the employment of *additional care workers* – that is, care workers with marginal education in care. Furthermore, organizations acted less strongly as advocates for professionalization in the skill-level dimension compared with other dimensions. This low support for a higher and academic skill level is exemplified by a statement made by one social welfare organization in which the question was posed as to whether academization had not gone too far because the number of vacancies in care that required an academic skill profile was too low to enable all graduates to be employed.

Working conditions in LTC began at a low level and are currently still lagging behind those of the general workforce and the healthcare sector. However, deoccupationalization and deprofessionalization tendencies have come to a halt. In recent years, small upward trends in working times and wages have become visible. These developments correspond with policies that have gradually intensified the focus on working conditions. In particular, payment levels and their acceptance have been discussed and implemented on several occasions. However, only the last reform – the Care-Worker Strengthening Act – explicitly took up working conditions. Still, the focus of this reform lay more on low-level measures, such as more healthcare prevention and better reconciliation measures between family- and working life, instead of on working time and payment structures. This increased focus on working conditions might also stem from the strong advocacy of trade unions and social welfare organization in this dimension, which pushed the topic onto the agenda in several public hearings.

The social dimension is the least professionalized of all four workforce dimensions. Upward developments have been small and even reversed on occasion. Correspondingly, policy activity in the area has been small. The introduction of the new general care occupation was connected with occupational organizations' hope that care workers would achieve a general upward mobility and an increase in occupational co-determination rights in educational curricula. However, the main intention of the reform was to increase the attractiveness of the apprenticeship program and to increase the number of care workers. Achieving a higher status for and greater recognition of care workers was only an indirect effect that was meant to be triggered by the implemented reform measures. The low upward trajectory of the workforce and the low policy investment in the social dimension can be related to organizational

interests. Measures in the social dimension were the most contested of all dimensions. The main theme taken up in the reforms was the shift in the responsibility for tasks from physicians to LTC workers and the definition of genuine care tasks. Organizations adopted diametrical stances on these issues, with occupational organizations of care workers arguing strongly for the issues and occupational organizations of physicians arguing relentlessly against them. This disagreement on the development of the social dimension might thus have led to the neglect of the dimension in policymaking and may have resulted in a largely deprofessionalized status in the dimension and in a deadlock that will impede raising the social status of the LTC workforce in the future.

Considering all dimensions, the opposition of system organizations as well as the opposition of business organizations to the implementation of measures that would foster upward movements of the workforce became less pronounced over the course of the reforms. Business organizations evolved from a clear opposition to professionalization to more-nuanced positions, such as the acceptance of collectively agreed-upon wage levels if these wages were fully refunded. System organizations abandoned their opposition to collectively agreed-upon wages and even supported their implementation. This shift in system organizations – which were the most-addressed organizations by the government parties in six of the seven public hearings – toward the aim of professionalization might explain why professionalization was able to take up a more-important role throughout the reforms and public hearings.

Furthermore, the context in which workforce developments, policies, and organizational influences unfolded must be considered. Demographic ageing progressed, informal care resources decreased, and the number of LTC recipients rose. Thus, more people became directly (e.g., as patients or as LTC employees) and indirectly (e.g., as informal secondary caregivers) involved in the LTC sector. These developments led to generally increasing public attention on issues in the LTC system. Moreover, the outlined context factors contributed to the progressing intensification of the labor shortage in LTC. This labor shortage is a defining trait of professions. The evidence in this study supports Larson's definition of professionalization: "Professionalization is thus an attempt to translate one order of scarce resources – special knowledge and skills – into an other – social and economic rewards" (Larson, 1977, p. 17). The shortage of LTC staff has increased since the mid-2010s. This shortage might have been a favorable context in which demands for

professionalization (e.g., increasing wages and decreasing workloads) were able to be formulated and integrated into the policymaking process. Furthermore, the shortage of employees might have led some organizations – business organizations and system organizations, in particular – to abandon or reduce their opposition to professionalization demands because only better working conditions were able to attract new employees to LTC. Due to this decreased opposition to professionalization, policies that fostered higher wages and better working conditions became added to the agenda and were implemented. The first results of these policies are evident in the working-condition dimension of the workforce with the halt of downward developments and even the appearance of small upward developments. However, how long this *window of opportunity* – which increases in size with increasing levels of the labor shortage – will remain open is difficult to estimate. Furthermore, whether this *window of opportunity* is used to initiate changes in further workforce dimensions (i.e., the skill-level- and social dimensions) remains to be seen.

Further notable connections apart from professionalization exist that highlight the influence of organizations on LTC policies. Which political parties interact with which organizations was visualized by networks for each public hearing. In some of these hearings, the connection between one political party and one organization was remarkably strong. One example is the strong connection between the Liberal party and the Peak Organization of the Private Health and LTC Insurers in the Care Redirection Act. This bill implemented a private, state-subsidized LTC-insurance system that was enacted under Liberal Health Minister Daniel Bahr. Private LTC funds are among the organizations that have profited most from this implementation because they have been able to offer additional private-insurance plans. Hence, the strong connection between the Liberal party and the Peak Organization of the Private Health and LTC Insurers hints at organizational influence. A further example is the Peak Association of Statutory Health and LTC Insurers, which constituted one of the central players in the networks. The connection to at least one of the governing parties was strong in nearly all public hearings, and opposition as well as governing parties posed questions to the Peak Association of Statutory Health and LTC Insurers. This might explain the continuous inclusion of financial-stability aims across all reforms. Furthermore, social welfare organizations are important organizational actors and were centrally involved in all public hearings, with Caritas nearly always occupying a central position. The results on the stance on professionalization illustrate that social

welfare organizations generally show high internal consistency in their answers and hence have many opportunities to present their interests. Their power to launch professionalization interests might even be greater than for trade unions because political parties from all political directions pose questions toward social welfare organizations, whereas trade unions are mainly questioned by the left opposition parties of the Left and the Greens.

Overall, the findings reveal that organizations in LTC are important actors that influence the policymaking process, which in turn impacts on workforce trajectories. The claim that occupational organizations of care workers are weak and thus that their interests and aims not important or heard can be rejected. These organizations' aims and interests are included in the policymaking process by the organizations themselves and by the powerful advocates of trade unions and social welfare organizations. However, occupational organizations have become stronger themselves, as is apparent in the central position of the German Care Occupations Association and the German Care Council in the Care Occupation Reform Act. These results and conclusions can be drawn for the German case. However, the conclusion *that* organizations are influential actors in the LTC system and are able to influence workforce trajectories is a general conclusion. Thus, it would be important for further case- and comparative studies to investigate which organizations are central and influential in other countries and whether there are similarities to the German case.

7.3 Limitations and implications for further research

The results of the present study establish a connection between workforce developments, policies, and organizational influences. However, the results cannot be interpreted to show a direct influence of organizational interests on policies or on workforce developments; rather, the presented evidence can be interpreted as the *smoking gun*. In order to establish that organizations have an undoubtedly direct influence on LTC policies and on the development of the LTC workforce, qualitative interviews are needed. Interviews with politicians who have been part of the health councils and with the lobbyists of the organizations could unveil the direct and indirect pathways of influence and the specific policies that have been shaped by organizational influence. However, these interviews are difficult to obtain, especially if they include questions on informal influences and lobbying. Therefore, public-hearing documents

constitute the best available data for demonstrating the relevance of organizations and their influence in the field of LTC.

The present case study illuminates the connection between workforce developments, policies, and organizational interests for the German LTC system over the past 15 years. Factors and developments within the LTC system were thereby used to explain LTC-workforce developments and revealed that internal processes are at least just as important to changes in the LTC system as are external processes, such as demographic or societal changes. Nevertheless, the developments outlined in this study are time- and context-specific and cannot be transferred to other countries without adapting them to the specific case(s). However, the theoretical and methodological approach of the present study can serve as a framework for research in different national LTC settings.

Furthermore, the role of social welfare organizations in the German LTC system should be investigated in greater detail. First, these organizations are a main actor in LTC due to their involvement in nearly all hearings and to the function as a central actor in the discussion on measures that influence the LTC workforce. Second, social welfare organizations are able to adopt both professionalization- and deprofessionalization interests and are thus theoretically the only organizations in the German case that are able to influence policy and therefore also workforce developments in either direction. Third, social welfare organizations can be used to illuminate the discrepancy between the *talk* and *actions* of organizations.

Theoretically, social welfare organizations can adopt the role of an employer and business organization or of an advocate for marginalized societal groups. Taking up the first role suggests that social welfare organizations would adopt deprofessionalization as an aim, whereas the second role is associated with the aim of professionalization. Empirically, social welfare organizations were found to have adopted the first role but to nevertheless have advocated for professionalization in the public hearings. The probable reason for this advocacy is that these organizations likely consider the implementation of measures for professionalization to be a competitive advantage against private facilities. In the policymaking processes up to today, the adoption of the role of employer has led social welfare organizations to advocate for professionalization. However, if social welfare organizations are no longer convinced that the advocacy for professionalization would lead to a competitive advantage, neutral positions – or even deprofessionalization positions – could be

adopted in future policymaking processes. In this case, a large and influential advocate for professionalization would be missing. However, the reasons for arguing in favor of professionalization measures might also be partly triggered by social desirability. Social welfare organizations might want to be publicly recognized as advocates for the weak and not as business organizations. Thus, adopting the aim of professionalization might be a strategic action. The present analysis cannot rule out this possibility.

The case of social welfare organizations serves as an example that *talk* and *actions* of organizations can diverge. In 2019, a collective agreement was prepared that aimed to apply to all care facilities (see Rademaker, 2021 for an overview). Usually, collective agreements are negotiated between employer organization and trade unions and apply to a specific group of employers or to an individual employer and thus do not span an entire economic sector. However, the Federal Ministry of Labor and Social Affairs has the power to declare a collective agreement binding for the whole sector. Still, this can only happen if the employer organization and the trade union that has negotiated the collective agreement represent a large share of employers and employees within the sector. In LTC, this is not the case because both employers and employees are only weakly organized. Hence, in order to make the collective agreement binding for the whole sector, it would have been necessary for the Church-based social welfare organizations of Caritas and the Diakonie – both of which employ a large number of LTC workers – to ratify the agreement. However, Caritas opted not to ratify the collective agreement, which meant that the adoption of the collective agreement for the whole LTC sector failed (Rademaker, 2021). This decision sparked criticism by employee representatives and within the federal government. In an interview with the newspaper Die Zeit, the president of Caritas declared that the decision would not be revoked. He justified the decision by pointing to Caritas' wages, which were higher than those in the collective agreement and might not have been refunded if they had ratified the agreement. The reporter then commented that there must have been ways of sorting this problem out and asked, "Is the goal not actually more about wanting to keep your competitors at a distance – that is, wanting to ensure that you continue to pay more than the others in order to have an advantage in recruiting care workers?" to which the Caritas president responded, "I don't believe so" (Gutensohn, 2021, own translation). First, the actions by Caritas support the results of the present study. Social welfare organizations generally adopt the role of employer and business organizations as opposed to the role of social advocates. Second, the

example illustrates the discrepancy between *talk* and *action*. The *talk* in the public hearings about increasing wages and working conditions for LTC workers were not backed by *action*. The moment that Caritas had the opportunity to improve working conditions for thousands of LTC workers (i.e., those working in private facilities), they decided not to follow the aim of professionalization and instead to assess their own economic interests as more important.

On the one hand, this example illustrates one limitation of the present study. The analyses of organizations and their aims and interests in LTC policy and the LTC workforce focused mainly on *talk* rather than *actions*. However, analyses that focus on actions would need to know which organizations are relevant and influential in the LTC sector. As this information has not been available thus far, further studies could depart from the analyses in the present study. On the other hand, this example highlights the ambiguous role that social welfare organizations play and the vast amount of power they exert on processes that influence the trajectory of the LTC workforce. Hence, a more-nuanced and deeper analysis of the *talk and actions* of social welfare organizations could yield finer-grained explanations of policy changes and of the trajectory of the LTC workforce.

For further studies in different countries, social welfare organizations might not appear very interesting because these types of organizations might not even exist. However, the analysis of social welfare organizations in Germany revealed important points of departure for the analyses of organizational influences in LTC that can be used in case studies of other countries. First, it is important to determine and analyze organizations that can theoretically adopt positions both in favor of and against a certain topic because these organizations might be able to shift public and political opinion in either direction. Second, it is important to determine which organizations are able to influence both *talk* and *action* as these organizations would have the ability to influence workforce processes in two ways: First, they could influence process via their *talk* in consultative policymaking processes and via their *actions* in actively shaping working conditions. In Germany, both of these points apply to social welfare organizations, which makes these organizations the most-influential group of organizations in terms of workforce developments.

The analyses in the present study focused on the time before the COVID-19 pandemic. During the pandemic, working conditions in care work and labor shortages – not only in intensive-care units, but also in LTC facilities – have become both a

public- and a political concern. It might be fair to say that the attention that has been paid to the care workforce due to the pandemic is greater than could have ever been achieved by any political actors without a pandemic. The extent to which the current situation has created and opened a new *window of opportunity* for implementing professionalization measures remains to be seen. The fact that the collective agreement that should have been binding for the whole LTC sector failed in early 2021 (i.e., during the pandemic) does not lead to the conclusion that the pandemic has accelerated upward trajectories of the LTC workforce.

7.4 Implications for political actors

The results of the present study have implications for the work of political actors. Occupational organizations of care workers and trade unions – that is, organizations that are primarily interested in the professionalization of LTC work – should aim to connect their demand for professionalization with a further primary aim or with the solution to a current problem. For example, advocating for higher wages by referring to the societal value of care work or to the higher wages of healthcare nurses only appeals to organizations and political actors that are already in favor of higher wages and the professionalization of LTC work. Instead, the interests and aims of opposed actors need to be addressed in order to win them over to agreeing to higher wages in LTC. One option would be to connect the demand for higher wages to the demand for more LTC workers and thus to present higher wages as a solution for keeping and employing new care workers in the LTC sector and thus to solving the problem of staff shortages.

In particular, the current and intensifying shortage of apprenticeship-educated LTC nurses – coupled with the emerging lack of low-educated LTC workers – has created a favorable external situation for the professionalization demands of occupational organizations of care workers and trade unions. The demand for apprenticeship-educated nurses cannot be satisfied, and job vacancies can no longer be filled by lower-educated LTC workers or by healthcare nurses. This situation might pose a *window of opportunity* for professionalization. The recent reforms (i.e., the Care Occupation Reform Act and the Care-Worker Strengthening Act) have already embarked on the path of increasing the number of LTC employees and improving the working conditions of these employees. Occupational organizations of care workers and trade

unions can also use this situation to advocate for further professionalization in the skill-level- and social dimensions. Specific measures that foster professionalization – such as collectively agreed-upon wages, more pathways for career progression, or the independent practicing of medical procedures by care workers – could be connected to increasing the attractiveness of work in LTC and thus to alleviating the lack of LTC workers.

Furthermore, occupational organizations of care workers and trade unions should extend their cooperation with organizations that can advocate for professionalization in light of the advocating organizations' own interests. More specifically, patient organizations that have thus far only weakly advocated for professionalization should be urged to invest more in the advocacy for LTC-professionalization-policy measures as these measures would also benefit the organizations' primary aim of quality. For example, the Alzheimer Society focuses on increasing the quality of the care situation for Alzheimer patients and their families. Caring for these patients requires specialized training of LTC employees and constant further training due to new pharmaceutical and therapeutical innovations. However, the Alzheimer Society draws no particular connection between the adequate care for patients with neurodegenerative diseases and the demand for increasing the skill level of LTC workers. Thus, occupational organizations of care workers should foster strategic cooperation with patient organizations in order to push professionalization issues to a more-prominent position in the discourses on LTC reforms.

Organizations with the aim of LTC professionalization should recognize that becoming a profession takes place along different dimensions and at different speeds. Therefore, organizations should focus their efforts on dimensions to which other organizations and political actors express the least opposition. Since 2005, this opposition has been lowest in the quantity dimension, which has resulted in professionalization developments. In recent years, less opposition to professionalization has occurred in the working-conditions dimension, especially concerning the acceptance of collective agreements and higher wages. Hence, the greatest effort in pushing professionalization should be invested in this dimension as the prospects for success appear highest. The empirical results show that opposition to professionalization is strongest in the social dimension, with independent practicing of medical procedures by care workers and the takeover of tasks from physicians being the most-contested demands. Focusing on these elements before implementing higher

working standards and increasing the share of academic LTC employees does not seem promising. However, a new *window of opportunity* for taking up these topics might open as the problem of service provision of general practitioners in rural areas progresses. Occupational organizations could then argue that this problem could be eased by transferring certain tasks – specifically those concerning LTC patients – to highly educated academic LTC labor forces.

APPENDIX – DATA AND METHODS

This Data and Methods Appendix describes in detail the used data and adopted methods in the empirical chapters. The appendix is structured according to the data sources. The specific empirical chapters in which the data are used are referenced.

OECD Data

OECD data, which are mainly used in Chapter 3, were taken from the OECD database (OECD, 2020a). The date on which OECD data for a specific indicator were extracted is mentioned in the caption of each figure. Each indicator is explained in the particular section of the chapter in which it is taken up. However, the financing indicators need a more-thorough description, which is provided below.

The OECD splits LTC financing indicators (see Chapter 3) into LTC health expenditure and LTC social expenditure, which are defined as follows:

> Therefore, long-term care (health) in SHA 2011 includes personal "body help" type services (*e.g.* help with ADL) under health expenditure, while "assistance or home help" type services (*e.g.* help with IADL) should be separately counted as long-term care (social) outside the core health care boundary and recorded under the *health care-related* category (HCR.1). If, however, long-term care (social) services are also delivered as part of a service package in which a medical or nursing care component dominates, then the expenditure for these should also be included under health care, and *vice versa*. This aside, the health accounting framework leaves open the possibility to identify total long-term care spending, that is, the aggregate of the health and social components, which may be of greater policy relevance. (OECD, 2017, p. 61)

Although the OECD stresses that total LTC spending can be determined by adding LTC health expenditure and LTC social expenditure (OECD, 2017), this is not possible for a large number of OECD countries because they do not provide, irregularly provide, or have only just begun to provide data for LTC social expenditure. Germany is one of the countries that provides continuous data for both LTC spending components. The spending indicators adopted in Chapter 3 are: *total LTC spending as a share of the GDP, total LTC spending per capita (at current prices and current PPPs), LTC household out-of-pocket payments per capita (at current prices and current PPPs)*, and *LTC household out-of-pocket spending as a share of all per-capita*

LTC spending. These indicators all display the added amount of LTC health spending and LTC social spending. Due to the limited data availability, no OECD or EU mean is provided in the OECD dataset, nor could these means be calculated in any reasonable way. Hence, other European countries are included as references for Germany's spending levels. At least one of the highest and lowest European spenders for a particular indicator are chosen. It must be kept in mind that there might be OECD countries with higher and lower spending levels than the chosen countries but that did not provide the data for either LTC social spending or LTC health spending and could thus not be included.

German Care Statistics

The German Care Statistics served as the main source for depicting the number and development of care facilities, care recipients, care workers with different occupational degrees, and working times. The German Care Statistics are published by the Federal Statistics Office every two years, and therefore, only bi-yearly data are available (Statistisches Bundesamt, 2007, 2009, 2011, 2013, 2015, 2017, 2018b). The published data stem from the peak organizations of the public and private LTC insurers and from a survey of ambulatory and residential-care facilities (Statistische Ämter des Bundes und der Länder, 2015a, 2015b). Data show values from December of the respective year (Statistisches Bundesamt, 2007). Furthermore, data from the German Care Statistics relate to all people who receive benefits under the German long term care insurance, irrespective of the type of insurer (public or private) or the age of the insured. This means that mentally or physically disabled people who are younger than 65 years old are also included in the statistics. For some indicators (mainly for those that include recipients), differentiation by age is possible. However, for most indicators that are relevant to the study (e.g., LTC workers, working times, care facilities), it is not possible to differentiate between LTC for older and younger disabled people. Hence, all analyses based on the data from the German Care Statistics relate to LTC for all ages. Still, older adults constitute the largest share of LTC recipients. Across all years, about 80% of LTC recipients are 65 years or older (own calculation based on German Care Statistics).

Data from the German Care Statistics are used to describe and analyze developments in the skill-level dimension. The German Care Statistics provide data

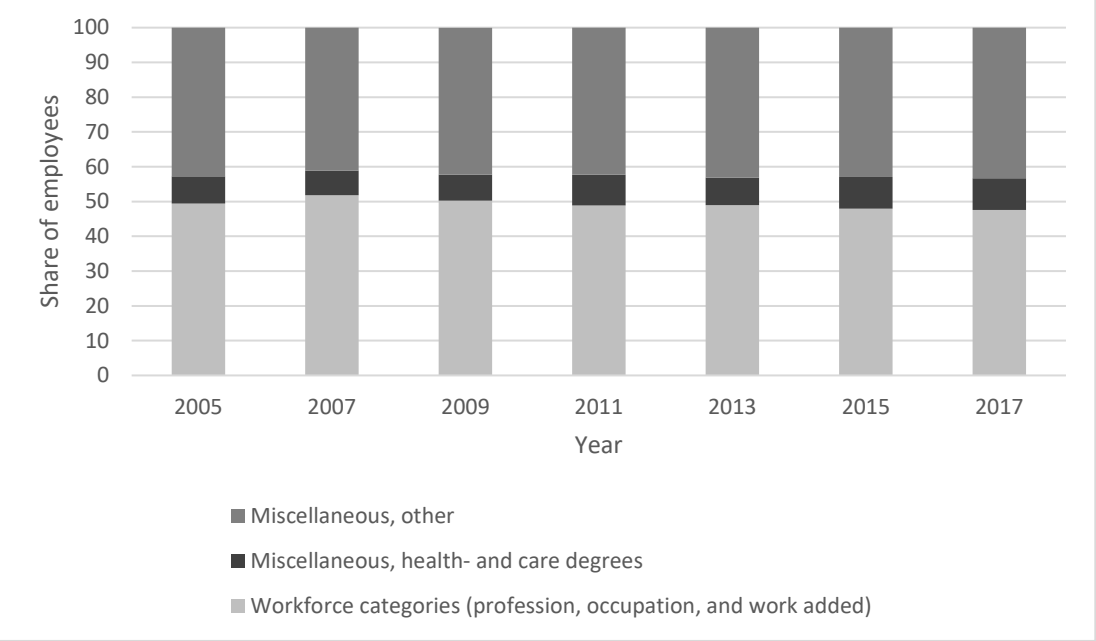
on the number of employees in ambulatory and residential care with a specific occupational degree. These data are not based on official statistics of registered care workers as care workers have never been required to register in Germany (Statistische Ämter des Bundes und der Länder, 2015a, 2015b). Data originate from questionnaires that are answered by the managers of the care facilities. These self-reported data by care facilities could have a higher error rate than official statistics of registered nurses and must thus be evaluated with some caution. The categories of occupational degrees that are included in the German Care Statistics change only slightly (see Table 16 for all original degrees and their inclusion in the three workforce categories). In 2007, the degree of physiotherapist was added to the list of degrees. Since 2013, apprentices have been registered in a separate category. Before, they were included in the category *without occupational degree*. Of the 21 occupational categories that the German Care Statistics has listed since 2013, 15 include one specific degree (e.g., *LTC nurse* or *healthcare nurse*) and six include various degrees (e.g., *other nursing- and care occupation* or *other occupational degree*). Only the 15 categories with a specific degree can be ordered into one of the three workforce categories of *work*, *occupation*, or *profession*. Employees with these degrees are mainly involved in direct care.

Two of the six original categories that cannot be included in the workforce categories include employees who are also mainly involved in direct care: *other non-physician healthcare occupation* and *other nursing- and care occupation*.[28] Unfortunately, there is no way to differentiate between different degrees within these categories because the categories are included as such in the original questionnaire and are not added up afterward by the publishers of the German Care Statistics (Statistische Ämter des Bundes und der Länder, 2015a, 2015b). All other employees in the field of LTC who are not categorized into the three workforce categories mainly perform non-direct care through work as administrative staff, cooks, cleaning staff, or caretakers. The German Care Statistics state that "the other qualifications are usually not directly related to care" (Statistisches Bundesamt, 2011, p. 10, own translation). Figure 37 reveals that less than 10% of employees in LTC have jobs that are directly related to

[28]Examples of vocational degrees that are likely included in these categories are additional / support carers (*Alltagsbegleiter/in*) (Bundesagentur für Arbeit, 2017c) and social- and care assistants (*Sozialassistent/in*) (Bundesagentur für Arbeit, 2017u), which would belong to the *work* category. Furthermore, dieticians (*Diätassistent*) (Bundesagentur für Arbeit, 2017d), masseurs (*Masseur*) ((Bundesagentur für Arbeit, 2017o), and additionally educated occupations, such as LTC workers with further specialized vocational degrees (e.g., care managers (*Pflegedienstleitung*)) (Bundesagentur für Arbeit 2017p), should be part of this category and would belong to the workforce category of *occupation*.

care but that are not able to be included in any of the three workforce categories. About 50% of employees in LTC are involved in direct care and are able to be included in the three workforce categories.

Figure 37: Percentage of employees categorized into workforce categories and as miscellaneous



Source: Own calculations based on German Care Statistics (Statistisches Bundesamt 2007–2017, 2018b).

The 15 categories with a specific occupational degree are included in one of the three workforce categories based on the entrance qualification for the degree and the length of education. The category of *work* is marked by no or lower-secondary education as an entrance level and by fewer than three years of vocational education, which is mainly based on practical, hands-on work. The category of *occupation* is marked by medium to upper-secondary education as an entrance level and at least three years of practical and theoretical education. The *profession* category is defined by scientific education at universities (of applied science), which can only be entered with upper-secondary education (*Abitur / Fachabitur*). Information on these items was obtained from an online platform that is run by the Federal Labor Office (Bundesagentur für Arbeit, 2020a).

Three occupational degrees are included in the work category: *auxiliary LTC nurse*s, *auxiliary healthcare nurses*, and *auxiliary social-care nurses*. Education in these three vocational degrees is regulated by the federal states, which leads to differences in the duration of and entrance level for the study programs (BIBB, 2009).

Usually, studies last one to two years and require at least lower-secondary education as a prerequisite. Graduates perform basic social and medical tasks and support higher-educated staff members in their work (Bundesagentur für Arbeit, 2017a, 2017i, 2017l). One important degree that would also belong to the work category is missing in the dataset: additional care worker (*Alltagsbegleiter/in*) (Bundesagentur für Arbeit, 2017c). This degree was implemented in 2008 to get additional care workers into residential-care facilities (Bundesagentur für Arbeit, 2017c). The degree is only loosely regulated and usually includes at least 160 hours of theoretical education and three weeks of practical education, for which no secondary education is needed (GKV-Spitzenverband, 2016). As the number of these additional care workers has increased due to several reforms in recent years, the Federal Ministry of Health estimates that about 50,000 additional care workers were employed in 2017 (Bundesministerium für Gesundheit, 2017). Therefore, the size and development of the work category might have been underestimated.

The occupation category includes the following vocational degrees and further-training degrees: *LTC nurses*, *healthcare nurses*, *child healthcare nurses*, *social-care nurses*, *occupational therapists*, *specialized caretakers for the elderly*, *local assistants with a state qualification*, *remedial teachers*, *family-care workers*, and *physiotherapists*. The first four degrees are the most common and are all regulated under national law. Entrance is granted with medium-secondary education (*Realschulabschluss*), and the program encompasses three years of a mixture of practical and theoretical knowledge (Bundesagentur für Arbeit, 2017b, 2017h, 2017j, 2017m). For example, the education of LTC nurses includes at least 2,100 hours of theoretical lessons and 2,500 hours of practical education (§1 AltPflAPrV, 2002/26.11.2002). The education of occupational therapists requires a medium-secondary education and lasts three years (Bundesagentur für Arbeit, 2017f). *Specialized caretakers for the elderly*, *local assistants with a state qualification*, and *remedial teachers* are further educational degrees in addition to vocational degrees and have a duration of one to four years ((Bundesagentur für Arbeit, 2017e, 2017g, 2017n). The choice to include *family-care workers* and *physiotherapists* in the occupation category stems from the most-common forms of education for these occupations. *Family-care workers* are administered at the federal level. The entrance level may range from lower- to medium-secondary education, and the duration of the education can in some cases last fewer than three years. However, three years is the usual length

of education in this apprenticeship (Bundesagentur für Arbeit, 2017k) that leads to inclusion in the occupation category. A *physiotherapist* degree can be obtained either by an apprenticeship or by academic studies at universities of applied science. In most cases, *physiotherapists* have an apprenticeship education (Bundesagentur für Arbeit, 2017r, 2017s), and the degree is thus sorted into the occupation category. Although the category of *physiotherapist* has only existed since 2007, in the dataset of the German Care Statistics, the category has been included since 2007 in the workforce category of *occupation* and thus in the analyses of the present study because it is missing only for one time point: the year 2005. Additionally, the number of physiotherapists is low, and the inclusion of the category of *physiotherapists* thus does not severely influence or change the overall numbers and developments in the workforce category of occupation.

The profession category includes the degrees of *social pedagogue / social worker* and *qualification in care at a university (of applied science)*. Education in these study programs is mainly theoretical and includes topics such as medical and social care as well as management and social law (Bundesagentur für Arbeit, 2017q, 2017t). Generally, bachelor's degrees have a duration of three years, master's degrees a duration of two years. Upper-secondary education is needed to enter these study programs (Bundesagentur für Arbeit, 2017q, 2017t).

The *miscellaneous* category is divided into health- and care degrees and all other degrees that could not be included in the three workforce categories. The health- and care degrees in the miscellaneous category include the two categories that are directly related to care: *other non-physician healthcare profession* and *other nursing- and care occupation*. All other degrees in the miscellaneous category are not directly related to care: *other caretaking occupation*, *other occupational degree*, *without occupational degree*, and *vocational (re)training*. Table 16 displays the original categories and the regrouping into the workforce categories. All numbers and shares that show totals in the skill-level dimension report the employees in the three workforce categories of work, occupation, and profession and do not depict all employees in LTC.

Table 16: Degrees in German Care Statistics and sorting into workforce categories by duration of education and entrance requirements

Name of the educational degree / qualification (categories of German Care Statistics)	Duration of education / entrance qualification	Reference
Work		
Auxiliary LTC nurse *staatlich anerkannte/r Altenpflegehelfer/in*	1–2 years lowest school degree	Bundesagentur für Arbeit, 2017a
Auxiliary healthcare nurse *Krankenpflegehelfer/in*	1–2 years lowest school degree	Bundesagentur für Arbeit, 2017i
Auxiliary social-care nurse / worker *Heilerziehungspflegehelfer/in*	1–2 years lowest school degree	Bundesagentur für Arbeit, 2017l
Occupation		
LTC nurse *staatlich anerkannte/r Altenpfleger/in*	3 years medium school degree	Bundesagentur für Arbeit, 2017b
Healthcare nurse *Gesundheits- und Krankenpfleger/in*	3 years medium school degree	Bundesagentur für Arbeit, 2017j
Child healthcare nurse *Gesundheits- und Kinderkrankenpfleger/in*	3 years medium school degree	Bundesagentur für Arbeit, 2017h
Social-care nurse *Heilerziehungspfleger/in; Heilerzieher/in*	3 years medium school degree	Bundesagentur für Arbeit, 2017m
Occupational therapist *Ergotherapeut/in*	3 years medium school degree	Bundesagentur für Arbeit, 2017f
Specialized caretaker for the elderly *Fachhauswirtschafter/in für ältere Menschen*	Further training Prior occupational degree	Bundesagentur für Arbeit, 2017g
Local assistant with a state qualification *Dorfhelfer/in mit staatlichem Abschluss*	Further training Prior occupational degree	Bundesagentur für Arbeit, 2017e
Remedial / curative teacher *Heilpädagogin, Heilpädagoge*	Further training Prior occupational degree	Bundesagentur für Arbeit, 2017n
Family-care worker *Familienpfleger/in mit staatlichem Abschluss*	Usually 3 years Usually medium schooling degree	Bundesagentur für Arbeit, 2017k
Physiotherapist *Physiotherapeut/in (Krankengymnast/in)*	Usually 3 years Medium to highest schooling degree	Bundesagentur für Arbeit, 2017r, 2017s
Profession		
Social pedagogue / social worker *sozialpädagogischer/sozialarbeiterischer Berufsabschluss*	At least 3 years Highest schooling degree	Bundesagentur für Arbeit, 2017t

Qualification in care at a university (of applied science) / academic care degree *Abschluss einer pflegewissenschaftlichen Ausbildung an einer Fachhochschule oder Universität*	At least 3 years Highest schooling degree	Bundesagentur für Arbeit, 2017q
Miscellaneous – Health- and care degrees		
Other non-physician healthcare occupation *sonstiger Abschluss im Bereich der nichtärztlichen Heilberufe*		
Other nursing- and care occupation *sonstiger pflegerischer Beruf*		
Miscellaneous – other		
Other caretaking occupation *sonstiger hauswirtschaftlicher Berufsabschluss*		
Other occupational degree *sonstiger Berufsabschluss*		
Without occupational degree *ohne Berufsabschluss*		
Vocational training, (re)training *Auszubildende/-r, (Um)Schüler/in*		

Source: Own compilation based on German Care Statistics and Bundesagentur für Arbeit (2020a).

Employment data from the German Federal Labor Office

Data on the number of unemployed people, the number of job vacancies, and the days it takes for a vacancy to be deregistered after the preferred employment date were obtained from the German Federal Labor Office (Bundesagentur für Arbeit, 2019a). The data show the state for the 30th of June of each year. All three indicators are available for LTC, health-nursing care, and the overall labor market. For all three sectors, it is possible to differentiate on the qualification level between *helpers*, *skilled employees*, *specialists*, and *experts*. Helpers complete a short training, skilled employees at least a two-year apprenticeship education, specialists at least further training on top of the apprenticeship and up to a three-year academic bachelor's degree, and experts a scientific education of at least four years (Bundesagentur für Arbeit, 2019b). For the present study, only the data for helpers and skilled employees are used because data on the unemployed in the categories of specialist and expert are either not available or of low quality. The helper category in the dataset roughly matches the theoretically introduced work category, and the skilled-employee category matches the occupation category. Therefore, the categories are renamed as such. All

data are available for the years 2008 to 2018 except for data on the whole labor market, which are only available from 2014 on.

Comparing the number of unemployed and the number of open vacancies in an economic sector shows the degree either of structural unemployment or of labor shortage. In general, a shortage of labor is evident if the number of unemployed and the number of vacancies are similar or if the number of vacancies exceeds the number of unemployed. However, over- and underestimations of the shortage of labor in a sector can occur for several reasons. One significant problem is that not all open positions are reported to the unemployment offices. Estimations assume that only every third position is reported. Hence, the threshold for a shortage of staff is usually defined as three or fewer unemployed people per vacancy (Demary & Seyda, 2012). Furthermore, there are differences in the reporting of vacancies to the unemployment office for vacancies with lower and higher educational requirements. Vacancies with lower educational requirements are more-often reported than are those with higher educational requirements (Demary & Seyda, 2012). Thus, the threshold for a staffing shortage should be set lower for lower occupational degrees. Moreover, the shortage of labor in an economic sector can be overestimated if workers with a similar qualification can fill the open spots (Demary & Seyda, 2012). In the LTC sector, healthcare workers could occupy these vacancies. Thus, the number of unemployed people per job opening is an indicator that can reveal staffing shortages or structural unemployment; however, the prior considerations show that over- and underestimations of the extent of a staffing shortage or structural unemployment are possible. Hence, the indicator needs to be evaluated with caution.

Public Hearings

Public hearings have been held for all seven major LTC reforms since 2005 (see Section 5.1). The public hearings of the first two of these reforms – the Care Further Development Act and the Care Redirection Act – were split into several sessions that are nevertheless considered to represent one hearing.

Top organizations

The most-involved individual organizations in the public hearings – hereafter called *top organizations* – are identified via three separate analyses of the public-hearing data: the number of written statements, the number of public hearings with at least one

oral answer, and the total number of oral answers. First, the total number of written statements is counted, thereby revealing which organizations are themselves interested in participating and expressing interest in the LTC field. The number of written statements for each organization ranges from zero to seven as only one written statement could be issued in each of the seven hearings. Second, the number of hearings in which an organization answered at least one question is analyzed, which reveals the regularity of involvement in public hearings. Again, numbers range from zero to seven. Third, the total number of answers in all seven hearings is counted for each organization, which reveals the overall involvement of an organization. The number of answers ranges between zero and 56. Table 17 displays all 153 participating organizations ordered by organizational category, the 50 individual experts, and the values for the three analyses for each organization and expert. For each of the three analyses, the (roughly) top 25 organizations (best 15%) are taken for further analysis (see Table 18). This means that organizations that gave at least five written statements, that participated orally in at least four public hearings, and that gave at least ten answers in all seven public hearings are extracted, and their values for the three analyses are contrasted.

Table 19 presents the top 25 organizations (top 15%) for all three analyses. The comparison of these organizations reveals that the overlap of organizations is high as a total of 30 organizations are further evaluated. Sixteen of these 30 organizations are within the top margin in all three analyses (figures in bold in

Table 19). These sixteen organizations are all evaluated as top organizations in the LTC policy network. Six organizations hold values inside the top margin in two lists, eight in only one list. Not all of these 14 organizations are evaluated as top organizations due to several considerations. BAGüS, DRK, and VDAB are excluded from the sample of most-important organizations in LTC because they only appear in the list of the written statements and are themselves thus only interested in being involved in the public hearings but not in being evaluated as important actors by the political parties because the parties did not pose a high number of questions to these organizations. AOK and Vdek_AEV are healthcare funds and are excluded as they only show a high number of answers but low continuous involvement and self-participation. BAEK, DKG, and KBV are excluded because they are organizations of the healthcare system and the questions they answered mainly focused on healthcare-

related elements and reform topics; therefore, these organizations are mistaken for being actors in the LTC network even though they are actors within the healthcare field. All other organizations are included, resulting in 22 organizations that have formed the most-important organizational actors in the LTC policy field since 2008. All organizations that are evaluated as top organizations are marked in bold in

Table 19.

Table 17: All organizations that participated in one of the seven public hearings in any form

Full name	Abbreviation	Number of written statements	Number of hearings with at least one answer	Total number of oral answers
OCCUPATIONAL ORGANIZATIONS				
Bundesärztekammer	BAEK	5	2	14
Bundesverband für Ergotherapeuten in Deutschland e.V.	BED	1	0	0
Berufsverbande Kinderkrankenpflege Deutschland e.V.	BeKD	1	1	2
Bundesverband der Berufsbetreuer/innen e.V.	Berufsbetreuer_innen	1	0	0
Bundesverband der Freien Berufe	BFB	1	1	1
Bund freiberuflicher Hebammen Deutschlands e.V.	BfHD	1	1	1
Bundesarbeitsgemeinschaft Hauswirtschaft	BGG-HW	1	0	0
Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege	BGW	1	0	0
Bundesarbeitsgemeinschaft der Heilmittelverbände e.V.	BHV	1	0	0
Bundesverband Lehrende Gesundheits- und Sozialberufe	BLGS	1	0	0
BundesPsychotherapeutehKammer	BPtK	1	0	0
Bundesverband unabhängiger Pflegesachverständiger und PflegeberaterInnen e.V.	BvPP e.V.	1	0	0
Bundesverband Osteopathie e.V.	BVO	1	1	1
Deutsche Aktuarvereinigung	DAV	1	1	7
Deutscher Berufsverband für Pflegeberufe e.V.	DBfK	7	5	16
Deutscher Bundesverband für Logopädie e.V.	DBL	1	1	1

Deutsche Berufsverband für Soziale Arbeit e.V.	DBSH	1	0	0
Deutscher Berufsverband für Altenpflege e.V.	DBVA	2	1	4
Dachverband Deutscher Heilpraktikerverbände e.V.	DDH	1	1	1
Deutscher Fachverband für Hausgeburtshilfe	DFH	1	1	1
Deutscher Facharztverband e.V.	DFV	1	1	2
Deutsche Gesellschaft für Kinder- und Jugendmedizin	DGKJ	1	1	3
Deutsche Gesellschaft für Manuelle Medizin	DGMM	1	0	0
Deutschen Gesellschaft für Palliativmedizin	DGP	1	1	2
Deutscher Hebammenverband e.V.	DHV	2	1	3
Deutscher Pflegerat e.V.	DPR	7	6	23
Deutscher Pflegeverband e.V.	DPV	3	0	0
Deutscher Verband der Ergotherapeuten e.V.	DVE	1	0	0
Deutscher Verband der Leitungskräfte für Alten- und Behinderteneinrichtungen e.V.	DVLAB	1	0	0
Deutscher Hausärzteverband	Hausärzteverband	1	1	1
Bundesverband selbstständiger Physiotherapeuten - IFK e.V.	IFK	1	1	1
Kassenärztliche Bundesvereinigung	KBV	3	2	10
Kassenzahnärztliche Bundesvereinigung	KZBV	2	2	3
Marburger Bund Bundesverband (Verband der angestellten und beamteten Ärztinnen und Ärzte Deutschlands e.V.)	Marburger Bund	1	0	0
Pflege in Bewegung	PiB	1	1	1
Fachgesellschaft Profession Pflege e. V.	Pro Pflege	1	1	4
Verband für Anthroposophische Pflege e.V.	VfAP	1	0	0
Verband der Krankenhausdirektoren Deutschlands e.V.	VKD	1	0	0
Verband der Osteopathen Deutschland e.V.	VOD	1	1	4
Verband Physikalische Therapie	VPT	1	0	0
Zentralverband der Physiotherapeuten/Krankengymnasten e.V. /Deutscher Verband für Physiotherapie e.V.	ZVK	1	2	3

TRADE UNIONS				
Beamtenbund und Tarifunion	dbb	4	2	2
Deutscher Gewerkschaftsbund	DGB	6	6	16
Vereinten Dienstleistungsgewerkschaft	Ver.di	7	7	42
SOCIAL WELFARE ORGANIZATIONS				
Arbeitsgemeinschaft christlicher Schwesternverbände und Pflegeorganisationen in Deutschland e.V.	ADS	1	0	0
Arbeiter-Samariter-Bund	ASB	2	1	2
Arbeiterwohlfahrt	AWO	5	5	17
Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege	BAGFW	6	3	14
Bundesvereinigung Lebenshilfe für Menschen mit geistiger Behinderung e. V.	BVLH (Lebenshilfe)	4	2	3
Deutscher Caritasverband e.V.	Caritas	5	6	47
Deutschen Evangelischen Verband für Altenarbeit und Pflege e.V.	DEVAP	1	1	1
Deutsches Rotes Kreuz	DRK	5	3	3
Der Paritätische Wohlfahrtsverband Gesamtverband	Dt Paritätischer WV	6	4	6
Diakonisches Werk der Evangelischen Kirche in Deutschland e.v.	EKD (Diakonie)	5	6	22
Volkssolidarität Bundesverband e.V.	Volkssolidarität	4	3	6
BUSINESS ORGANIZATIONS				
Arbeitgeber- und BerufsVerband Privater Pflege e.V.	ABVP	1	1	1
Bundesverbandes Ambulante Dienste und Stationäre Einrichtungen e.V.	bad e.V.	1	1	4
Verband des Einzelhandels am Wirtschaftsstandort Stadt	BAG	1	0	0
Bundesarbeitsgemeinschaft der überörtlichen Träger der Sozialhilfe	BAGüS	5	2	3
Bundesarbeitsgemeinschaft Hauskrankenpflege e.V.	B.A.H.	2	0	0
Bundesvereinigung der Deutschen Arbeitgeberverbände	BDA	6	5	10
Bundesverband Deutscher Privatkliniken e.V.	BDPK	3	1	3
Bundesverband Haushaltsnaher Dienstleistungsunternehmen e.V.	BHDU	1	0	0

Bundesverband Häusliche Kinderkrankenpflege e.V.	BHK	1	1	1
Bundesverband der kommunalen Senioren- und Behinderteneinrichtungen e.V.	BKSB	3	3	3
Bundesverbandes privater Anbieter sozialer Dienste e.V.	bpa	7	7	41
Bundesvereinigung Spitzenverbände der Immobilienwirtschaft	BSI	1	1	1
Bundesverband Gesundheits-IT bvitg e.V.	bvitg	1	1	1
Bundesverband Medizintechnologie e.V.	BVMed	2	0	0
Deutscher Evangelischer Krankenhausverbande e. V.	DEKV	1	0	0
Deutsche Krankenhausgesellschaft	DKG	4	4	15
Deutscher Landkreistag	DLT	2	1	3
Deutscher Städtetag	DST	3	3	5
Gesellschaft der Kinderkrankenhäuser und Kinderabteilungen in Deutschland e.V.	GKinD	1	1	2
Hauptverband des Deutschen Einzelhandels	HDE	1	0	0
Janssen-Cilag GmbH		1	0	0
Katholischer Krankenhausverband Deutschlands e.V.	KKVD	1	0	0
Bundesvereinigung der kommunalen Spitzenverbände	kommunale Spitzenverbände	4	3	11
optic 66		1	0	0
Bundsinnungsverband für Orthopädie-Technik	Orthopadie Technik	1	0	0
Verband Deutscher Alten- und Behindertenhilfe e.V.	VDAB	5	3	3
Zentralverband des Deutschen Handwerks	ZDH	1	1	1
SYSTEM ORGANIZATIONS				
AOK Bundesverband	AOK	1	2	15
BKK Dachverband e.V.	BKK	1	0	0
Gemeinsamer Bundesaussschuss	G-BA	1	1	1
GKV-Spitzenverband	GKV-Spitzenverband	6	6	56
IKK e.V.	IKK	1	1	4
Institut für das Entgeltsystem im Krankenhaus GmbH	InEK	0	1	3
Kaufmännische Krankenkasse	KKH	1	0	0

Medizinischer Dienst der Spitzenverbände der Krankenkassen e.V.	MDS	5	5	23
Verband der privaten Kranken und Pflegeversicherung	Medicproof	0	1	1
Verband der privaten Krankenversicherung e.V.	PKV	7	4	21
Verband der Angestellten Krankenkasse	VdAK	0	1	3
Arbeitsgemeinschaft der Spitzenverbände der Krankenkassen zugleich für die Spitzenverbände der Pflegekassen	VdAK_AEV	1	1	13
Verband der Ersatzkrankenkassen e.V.	vdek	1	1	1
PATIENT ORGANIZATIONS				
Allgemeiner Behindertenverband in Deutschland "Für Selbstbestimmung und Würde" e.V.	ABiD	1	1	2
Arbeitsgemeinschaft der deutschen Familienorganisationen/ Deutscher Familienverband e.V.	AGF	0	1	2
Aktionsbündnis Patientensicherheit	AB Patientensicherheit	1	0	0
Aktion Psychisch Kranke	APK	1	1	3
Bundesarbeitsgemeinschaft Selbsthilfe von Menschen mit Behinderung und chronischer Erkrankung und ihren Angehörigen e.V.	BAG Selbsthilfe	6	5	17
Bundesarbeitsgemeinschaft der Senioren-Organisationen e.V	BAGSO	4	4	8
Bundesarbeitsgemeinschaft Wohnungsanpassung e.V.	BAG Wohnungsanpassung	1	1	1
Bund der Versicherten e.V.	BdV	0	1	2
Bundesinteressenvertretung und Selbsthilfeverband der Bewohnerinnen und Bewohner von Altenwohn- und Pflegeeinrichtungen e.V. Bundesinteressenvertretung der Nutzerinnen und Nutzer von Wohn- und Betreuungsangeboten im Alter und bei Behinderung e.V.	BIVA	3	3	5
Bundeskonferenz zur Qualitätssicherung im Gesundheits- und Pflegewesen e.V.	BUKO-QS	1	1	2
Bundesverbandes für Körper- und Mehrfachbehinderte e.V.	Bvb_Körper und	1	1	1

	Mehrfachbehinderung			
Deutsche Arbeitsgemeinschaft Selbsthilfegruppen e.V.	DAG SHG	1	0	0
Deutsche Alzheimer Gesellschaft e.V.	DAlzG	6	4	15
Deutscher Blinden- und Sehbehindertenverband e.V.	DBSV	1	0	0
Deutsche Gesellschaft für Care und Case-Management e.V.	DGCC	0	1	1
Deutsche Gesellschaft für Versicherte und Patienten e.V.	DGVP	1	1	3
Deutscher Verein für öffentliche und private Fürsorge	Dt Verein	4	3	4
Deutscher Frauenrat	Dt Frauenrat	4	5	11
Deutsche Stiftung Patientenschutz	Dt Stiftung Patientenschutz	3	2	4
Deutscher Schwerhörigenbund e.V.	DSB	1	0	0
Die Fachverbände für Menschen mit Behinderung (CBP (Caritas), Lebenshilfe, Antropoi, BeB, bvkm	Fachverbände	1	0	0
Familienbund der Katholiken	Familienbund	1	0	0
Forum selbstbestimmter Assistenz behinderter Menschen e.V.	ForseA	1	1	8
Greenbirth e.V.	GreenBirth	1	1	1
Handel statt Misshandeln - Forum Altern ohne Gewalt	HSM	1	0	0
Initiative Demenzversorgung in der Allgemeinmedizin	IDA	1	0	0
Interessenvertretung Selbstbestimmt Leben in Deutschland e.V. - ISL	ISL	1	1	1
Kuratorium Deutsche Altershilfe e.V.	KDA	1	1	2
Pflege-Selbsthilfeverband e.V.	Pflege-SHV	1	0	0
Gesellschaft für Qualität in der außerklinischen Geburtshilfe e.V.	QUAG e.V.	1	0	0
Deutschen Rheuma-Liga Bundesverband e.V.	Rheuma-Liga	1	0	0
Sozialverband Deutschland	SoVD	5	4	12
Stiftung Libenau		1	0	0
Sozialverband VdK Deutschland e.V.	VdK	5	4	8
Verbraucherzentrale Bundesverband e.V.	vzbv (Verbraucherzentrale)	6	4	17
wir pflegen – Interessenvertretung begleitender Angehöriger und Freunde in Deutschland e.V.	wir pflegen	1	0	0

WIR! Stiftung pflegender Angehöriger	WIR Stiftung	1	0	0
EDUCATION- AND RESEARCH ORGANIZATIONS				
Arbeitskreis Ausbildungsstätten für Altenpflege in Deutschland	AAA	1	1	2
Dekanenkonferenz Pflegewissenschaft		1	1	1
Deutsche Akademie für Gerontopsychiatrie und psychotherapie e.V.	DAGPP	1	0	0
Deutsche Gesellschaft für Gerontologie und Geriatrie	DGGG	1	1	5
Deutsche Gesellschaft für Hebammenwissenschaft e.V.	DGHWi	1	0	0
Deutsche Gesellschaft für Pflegewissenschaft	DGP	1	1	1
Deutsches Netzwerk für Qualitätsentwicklung in der Pflege	DNQP	2	1	1
Deutsches Zentrum für Altersfragen	DZA	2	1	1
Hochschulverbund Gesundheitsfachberufe e.V.	HVG	1	1	1
Verband Deutscher Privatschulverbände e.V.	VDP	1	1	1
OTHER				
Bundesagentur für Arbeit	BA	1	0	0
Bundesarbeitsgemeinschaft der Freiwilligenagenturen e.V.	bagfa	1	1	1
Bundesarbeitsgemeinschaft Kind und Krankenhaus	BaKuK	1	0	0
Deutsche Gesellschaft für Gerontopsychiatrie und -psychotherapie e.V.	DGGPP	1	0	0
Deutscher Hospiz- und PalliativVerband e.V.	DHPV	1	2	4
Deutscher LandFrauenverband e.V.	dlv	1	0	0
Deutsche Rentenversicherung Bund	DRV	2	1	2
gematik Gesellschaft für Telematik-Anwendungen	gematik	0	1	1
Verbändedialog Psychatrische Pflege	BFLK, BAPP, DFPP, BAG; DGSP, DGPPN, DGP	1	0	0
Verband der Universitätsklinika	VUD	1	1	2
INDIVIDUAL EXPERTS				
Bienstein		0	1	3

Bierth	0	1	2
Bomsdorf	2	2	6
Dielmann	1	1	4
Drude	1	1	3
Eisenreich	1	1	3
Felder	0	1	1
Frey	0	1	2
Fussek	1	1	2
Germeten-Ortmann	1	1	4
Goerres	1	2	5
Gress	1	1	1
Grüner /Schilder	1	1	2
Hagen	0	1	2
Halletz	1	1	2
Hasseler	0	1	2
Herdes	0	1	1
Hoberg	1	1	1
Hoffmann	0	1	2
Jacobs	0	1	2
Jassim-Guddorp	0	1	1
Johannes	0	1	4
Kaffenberger	0	1	1
Kochskämper	1	1	1
Kollex	1	1	1
Laue	0	1	5
Mennemann	1	1	3
Meunier	0	1	2
Pogdal	1	0	0
Raffelhueschen	1	1	3
Rossbruch	1	1	1
Rothgang	5	6	22
Schmaehl	1	1	4
Schnabel	0	1	2
Schneekloth	1	1	2
Schreyögg	0	1	3
Simon	1	1	3
Sodan	1	1	3
Spoerr	0	1	1
Suhr	2	2	4
Thuesing	2	2	8

Udsching	0	1	1
Vogler	0	1	2
Wallrafen-Dreisow	0	1	2
Weidner	1	1	4
Welti	1	1	5
Weskamp	0	1	1
Wilbers	1	1	8
Windhorst	0	1	3
Wingenfeld	2	2	3

Source: Own data based on analyses of the public hearings on LTC reforms between 2008 and 2018.

Table 18: Number of organizations that issued a certain number of written statements, the number of public hearings with at least one oral answer, and the overall number of oral answer in the public hearings

… written statements were issued	by … organizations.
0	7
1	98
2	10
3	7
4	8
5	**10**
6	**8**
7	**5**
At least one oral answer was given … times	by … organizations.
0	52
1	61
2	10
3	9
4	**8**
5	**6**
6	**5**
7	**2**
… oral answer were given overall	by … organizations.
0	52
1–9	77
10–14	**8**
15–19	**8**
≥ 20	**8**

Source: Own data based on analyses of the public hearings on LTC reforms between 2008 and 2018. Values in bold mark the threshold for inclusion in the further analysis of the evaluation of the top organizations.

Table 19: Top organizations based on written and oral statements in public hearings

Abbreviation of organization	Number of written statements	Number of hearings with at least one answer	Number of oral answers
AOK	1	2	**15**
AWO	**5**	**5**	**17**
BAEK	**5**	2	**14**
BAG Selbsthilfe	**6**	**5**	**17**
BAGFW	**6**	3	**14**
BAGüS	**5**	2	3
BAGSO	4	**4**	8
BDA	**6**	**5**	**10**
Bpa	**7**	**7**	**41**
Caritas	**5**	**6**	**47**
DAlzG	**6**	**4**	**15**
DBfK	**7**	**5**	**16**
DGB	**6**	**6**	**16**
DKG	4	**4**	**15**
DPR	**7**	**6**	**23**
DRK	**5**	3	3
Dt Frauenrat	4	**5**	**11**
Dt Paritätischer WV	**6**	**4**	6
EKD (Diakonie)	**5**	**6**	**22**
GKV-Spitzenverband	**6**	**6**	**56**
KBV	3	2	**10**
Kommunale Spitzenverbände	4	3	**11**
MDS	**5**	**5**	**23**
PKV Spitzenverband	**7**	**4**	**21**
SoVD	**5**	**4**	**12**
VDAB	**5**	3	3
VdeK_AEV	1	1	**13**
VdK	**5**	**4**	8
Ver.di	**7**	**7**	**42**
vzbv (Verbraucherzentrale)	**6**	**4**	**17**

Source: Own data based on analyses of the public hearings on LTC reforms between 2008 and 2018. Figures in bold are within the threshold for top organizations. Organizations in bold are top organizations and are therefore analyzed further.

Measuring the involvement of organizations in the public hearings

Involvement in a public hearing is conceptualized as giving an answer to a question that a political party directed toward one specific organization in the oral part of a hearing. The involvement of organizational groups is displayed as the share of answers that all organizations within an organizational group gave out of all answers that were given in a public hearing or out of all answers that were given to questions from the government parties in a public hearing (see Figures 27 and 28). The means that are displayed in both figures and referred to in the text were calculated based on the shares in the seven hearings. The means referring to the total number of answers given in all seven hearings are not displayed and evaluated because they would be highly influenced by the high number of answers in the first two public hearings.

Network graphs of the political parties and the top organizations display top organizations' involvement in the public hearings. The tie between a party and an organization reveals the percentage of answers a party received from one specific organization during one hearing. As examples, if one party received answers from just one organization in one public hearing, the share is 100%; if one party received ten answers in total and five of these answers were from the same organization, the share is 50%. The network graphs for each hearing depict these shares as ties between an organization and a party. The thickness and the color of the lines between organizations and parties indicate the strength of the tie. Lines in light grey have values under 10%, medium-grey lines a value ≥ 10%, and dark-grey lines a value ≥ 20%. In addition, the position of the node of an organization hints at the centrality of the organization in the network. Organizations' answers were counted with the help of the software MAXQDA. Network graphs were developed with the software R (package igraph).

Codebook for the quantitative analysis of organizational aims in the public hearings on LTC

The purpose of this codebook is to analyze primary and secondary aims of organizations in public hearings on LTC policies. The coding unit is defined as one answer – in its full length – given by one organization or individual expert to a question from a political party. Multiple codes can be applied to each answer. One code must be attached to the answer as a primary aim (it is not possible to attach two codes as primary aims), but several codes can be attached as secondary aims.

Coding relates to aims in LTC. These aims were built deductively based on the work of Bandelow (2006) and Bandelow et al. (2009) and the theoretical additions made in this study (see Section 2.3). Hence, the following codes are employed: *financial stability*, *quality*, *growth*, *redistribution*, *subsidiarity*, and *professionalization*. Furthermore, the code *other* was added, which is attached to answers that do not relate to LTC or that do not state a clear aim. The code of *professionalization* is further divided into the four workforce dimensions that are based on professionalization theories: *quantity*, *skill level*, *working conditions*, and a *social dimension*. Answers in the public hearings might reveal interests that are in direct opposition to one of the aims. Therefore, all codes are also able to be coded in their negated form: for example, *against financial stability* or *against professionalization – quantity*.

All codes can be employed to mark a primary or a secondary aim. Primary aims relate to the most-important objective in an answer; secondary aims to all other, less-important objectives in an answer. If several aims are touched on in one answer, it is necessary to evaluate which is the primary aim and which is (are) the secondary aim(s). This evaluation is based on the importance of the sections of the answer that include the different aims. When evaluating the importance of an aim, the position and the length of the argument in the whole answer are essential. Primary aims should be longer and expressed more toward the beginning of the answer compared with secondary aims.

Concerning the technical aspects of coding with the software MAXQDA, primary and secondary aims are distinguished by attaching different values to the codes. The attached values are 75 for a positive, primary aim and 25 for a positive, secondary aim. Furthermore, the value of 15 is possible if a differentiation between two secondary aims is made. If the aim of the code is alluded to in its opposed, negative form, the value of 5 is attached to the code. An opposed, negative, secondary aim is given the value of 1. Table 20 shows all positive codes, their definitions, the instructions for coding, and examples from the public hearings on LTC.

Table 20: Codes, instructions, and examples for the quantitative content analysis of primary and secondary aims of LTC organizations

Code	Definition / Instructions	Example[29]
Financial stability	This aim includes interests and positions that focus on the revenue and expenditure used to create a financially sustainable LTC system. On the one hand, the aim contains positions on and interests in decreasing LTC expenditure (in absolute and / or relative terms), such as shifting the financial burden of LTC to other actors or systems (e.g., to the healthcare system or to patients and their families), promoting and incentivizing (cheaper) ambulatory and informal care, disincentivizing (expensive) residential care, checking the efficiency of care providers, and preventing financial fraud. On the other hand, the code incorporates interests and ideas that (would) increase the revenue of the system, such as increasing social-security contributions, increasing or abolishing the social-security-contribution ceiling, and using different funds and funding methods for higher revenues. Furthermore, interests in implementing or extending privately funded LTC are included.	The question of how loads are distributed in this system is a very important normative question. Who pays what? How much personal responsibility can we expect? Unlike illness, long-term care can generally be planned. There are some exceptions, such as with people who become dependent on care at a very young age. In that case, we can think about exceptions to the rules. But the question is: What should things look like for the majority of the population? (PpSG, 35, own translation) I therefore suggest that we determine how many billions [of euros] could be saved each year if the principle of "prevention or rehabilitation before care" were to be implemented in a targeted manner. Countless scientific studies have shown that billions could be saved. It is finally time to draw the necessary conclusions. (PfWG_b, 44, own translation)
Quality	This aim adopts Donabedian's (2003) definition of quality in care. Quality is split into the categories of *outcome*, *process*, and *structure*. *Structure* refers to the institutional setting that directly and indirectly influences the quality of care. It comprises the implementation, advancement, and standard setting for quality checks of institutions and providers, for counselling services for patients and their families, for integrating patients into decisions, and for need-assessing procedures. *Process* refers to the provision of care. It includes the quality of provision and the coordination of interfaces with other systems and actors (e.g., GPs,	Contacting the long-term-care-insurance funds and nursing-home supervision in order to enable event-related quality checks to be carried out in addition to the planned three-year cycle should be encouraged. Of course, it is conceivable that the test intervals could be shortened even further in the future. I have already indicated this. However, shortening the intervals for quality checks to three years is an important step for the time being, and one that we very much welcome. (PfWG_a, 20, own translation) In any case, it should be ensured that improved services for dementia patients are actually provided in the

[29] Text references in the example section diverge from the adopted reference style. The references show the abbreviation of the law on which the public hearing was held and the page number. This referencing style is similar to that chosen in Chapter 6 and has the advantage that it shortens the in-line references and increases the readability of the text. The public hearings, which were held in several separate sessions, include the additions _a, _b, _c, and _d, which refer to the first, second, third, and fourth session. The full references can be found in Deutscher Bundestag - Ausschuss für Gesundheit (2008a, 2008b, 2008c, 2008d, 2012a, 2012b, 2014, 2015, 2016a, 2016b, 2018).

	medical specialists). *Outcome* focuses on how to improve the care recipient's situation, which includes fostering patients' independence, involvement, and self-determination. Furthermore, all interests that demand the introduction of a new definition of the term *in need of care* (*Pflegebedürftikeitsbegriff*) are coded here.	corresponding residential facilities [...]. (PfWG_b, 15–16, own translation) We are committed to ensuring that older people have a legal right to an annual geriatric assessment. This is because only early diagnosis, prevention, and rehabilitation can bring about a sustainable improvement to the health of elderly people and to those in need of care in nursing homes. (PfWG_d, 9, own translation) We strongly encourage that the new definition of in need of care be introduced soon and that the path of individual or partial solutions not be pursued any further. (PNG_a, 30, own translation)
Growth	This aim includes interests and positions that aim to extend the LTC system via new or expanded benefits. Furthermore, statements favoring more competition and market mechanisms in the system are included. Moreover, the code covers interests and positions that would lead to increasing one's own profits or to an enlarged role in the system.	Of course, we too would have liked to see an expansion of benefits for those with dementia in terms of individual benefits and not just as a part of pooling benefits. (PfWG_b, 56, own translation)
Redistribution	This aim includes interests in and positions on the equal treatment of individuals in the LTC system and their equal access to and conditions for LTC benefits, such as having the same opportunity / choice to receive the form of care a patient wants, having a similar level of residential and ambulatory benefits, having an equal inclusion of and benefits for mentally and physically impaired patients, and having equal copayments in residential care. Furthermore, interests in and positions on the reduction or abolishment of private copayments and a decrease in the number of patients who need to apply for social-assistance benefits due to high private LTC costs are covered by this code. Moreover, statements aimed at the (automatic) adjustment of benefits for LTC (in order for the ratio of benefits and co-payments to remain the same) are part of this code.	The greatest impact is felt by households with the lowest incomes, which have to pay relatively high co-payments. The burdens also have an impact on social assistance if the co-payments can no longer be paid. Dependence on social assistance is also increasing. We see that the whole thing is now leading to a two-class care system. [...] We therefore also see a need for action on the financing issue. Solidarity-based financing must be strengthened. (PNG_a, 24, own translation) Of course, those who can afford additional private insurance will benefit. Those who actually need it most will not be able to. (PNG_b, 25–26, own translation)
Subsidiarity	This aim includes interests and positions that improve and foster family care, such as better inclusion of family caregivers in social-insurance systems and (easier) access to any form of respite care.	We consider the envisaged social-security regulations during caregiver-leave time to be indispensable. Most of the people who will take this leave will be women, who in any case often have a broken career history for other

		reasons, such as raising children, so every month of contribution payments counts. (PfWG_b, 58, own translation)
Professionalization	This aim includes interests and positions that focus on the workforce in LTC. All coding is done along the four codes relating to workforce dimensions.	
Quantity	This aim includes interests and positions that foster / increase the number of employees in LTC by increasing the total number of workers in LTC, the number of high-skilled employees, the number of low-skilled employees, and the number of apprentices. Furthermore, interests in establishing or tightening quantitative and / or qualitative staffing levels are covered by the code.	We do indeed need more staff. But that will only help if we can attract these employees. (PpSG, 25, own translation) We suggested investing this 0.1 percent in training. I said something about that earlier. We could use it to finance around 70,000 apprenticeship positions analogously to healthcare-apprenticeship positions. (PSG I, 20, own translation) As was expressed by care workers and auxiliary care workers, it is of course necessary for us to think about having a qualified mixture of staff in the future. (PSG II, 26, own translation)
Working conditions	This aim includes interests and positions that foster the working conditions of care workers. It refers to better working conditions in general, for example, to keep workers in their occupation. Furthermore, the code contains demands for higher wages, such as the demand for higher wages in general, the implementation / increase of minimum wages, the recognition of payments based on collective agreements, the payment of apprentices / the abolishment of schooling tuitions, and the remuneration of travel time. Payments for family caregivers are not covered under this code and instead fall under the code of *subsidiarity*. Moreover, statements regarding better working times are part of this code, such as a reduction of overtime work, a reduction of unwanted part-time work, increased / new measures for combining work and family lives for LTC employees, and introducing / improving health measures for the workforce.	However, we also see a clear obligation on the part of employers in elderly long-term care to create conditions that improve care provision for the elderly and – above all – the working situation for employees. (PpSG, 30, own translation) Of course, long-term care for the elderly is in direct competition with nursing care for the sick. We all know that one-quarter less is paid in long-term care. [...] In that sense, we demand an increase in remuneration for long-term care [...]. (PpSG, 36, own translation) Staff shortages and work intensification have a direct impact on apprenticeship education. Apprentices in the caring occupations suffer above all from overtime, short-term- and unplanned transfers and they work under time pressure. The lack of time on the part of their practical instructors also plays a major role for the apprentices. (PflBRefG, 24, own translation)
Skill level	This aim includes interests and positions that favor a higher educational and skill level of employees in LTC, for example, via increasing the number of academically trained LTC workers, implementing / increasing minimum standards for apprenticeship	[...] for me, the logical step can only be in academic education. There, too, we lag behind all other European countries. It is difficult to understand why we are foregoing the corresponding potential. (PfWG, 23, own translation)

	qualification, introducing / increasing qualification standards for low-qualified care workers, and increasing further qualification programs. Moreover, the position that no substitution of highly qualified workers by low-qualified or volunteer workers should occur is covered under this code.	On the other hand, we need appropriate quality standards as part of the reform of care-apprenticeship education. Above all, we need to focus on practical training. (PflBRefG, 24, own translation) In the future, unskilled workers will need significantly better qualifications, targeted support, feedback, supervision, and motivation. (PSG II, 21, own translation) From our point of view, the 13,000 positions must be demonstrably additional and – above all – qualified personnel. That explicitly means apprenticeship-skilled carers. (PpSG, 29, own translation)
Social	This aim includes interests and positions that increase the significance of the care occupations in comparison with other occupations and that increase the number of care occupations' tasks and the occupations' role for (the functioning of) society. It covers, for example, increasing the attractiveness of LTC work and thus the appreciation and recognition of LTC workers, demands for a holistic care approach, and increasing the involvement and power of LTC workers in the care facilities in which they work as well as in political decision-making processes. Furthermore, interests and positions are included that would increase the competencies and rights of LTC workers. Increasing competencies relates to taking over tasks from physicians and to the definition of exclusive tasks that are only allowed to be performed by specifically trained LTC nurses. A delegation of tasks from physicians to care staff – which means that care staff do not take over responsibility – is evaluated as being opposed to this interest.	[...] to create a right for the corresponding professions and to ensure that within the framework of self-administration [...], quality is built up and ensured from below. Quality assurance can then take place via self-administration through supervision from colleague to colleague. This has the inestimable advantage of making competition become an element of quality assurance. (PfWG_d, 16–17, own translation) In today's day-to-day practice, good cooperation means that the doctor who has to fill out the prescription contacts the ambulatory care service and asks what he or she should prescribe. Therefore, we wonder why we should not entrust those who have expertise in home nursing in the future. (PfWG_d; 13, own translation)
Other	This code includes interests and positions that do not focus on LTC (for the elderly). Furthermore, statements that express no interests at all are subsumed in this code. These are informative statements that simply state facts or statements that re-state the political party's question. Moreover, three topics that usually allude to a multitude of aims are included here: (1) the merging of compulsory private and social insurance, (2) decreasing	There is no serious answer to this question. This can already be seen from the range mentioned. Of course, an estimate does not usually include an exact figure, but rather a range. But here, the range is quite large. This shows that we have a problem with the available data. So, my short answer is: I cannot answer the question. (PSG I, 34, own translation) In concrete terms, this means that the boundary between statutory and private

	bureaucracy, and (3) the opposition or agreement to the introduction of a general-care occupation / apprenticeship (if no other aims – e.g., professionalization – are expressed).	long-term-care insurance must be abolished and that civil servants, the self-employed, and those with voluntary private insurance must take out statutory insurance at a certain point in time. (PSG II, 19, own translation) In this respect, standardization must be welcomed so that a uniform standard is created and this hyper-documentation can be abandoned. However, I would like to point out that there is a question as to whether the expert standards would give rise to new documentation requirements that would run counter – in part or in full – to the actual pursuit of reducing bureaucracy. (PfWG_a, 17, own translation) I believe that long-term care will benefit from the generalist approach. This [approach] describes new occupational qualifications and represents more than the addition of the three previously existing occupations. Nursing care for the elderly will benefit from this new professional qualification. It is already very closely linked to nursing- and ambulatory care. Nursing care for the elderly will benefit considerably from the joint qualification and the joint competencies that are acquired there. (PflBRefG, 17, own translation) It must be assumed that the generalist system will a priori entail lower subject-related qualifications compared with the current training system. (PflBRefG, 29, own translation)

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